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Confused?
Improving Outcomes in Patients with Altered Mental Status and Delirium

Presented by:
Gina Dubuisson PT

Learning Outcomes
After this course, participants will be able to:

- Identify at least two implications that altered mental status has on patient outcomes in the acute and post-acute care setting.
- Differentiate between acute and chronic causes for altered mental status in the hospital setting.
- Define the physical therapist’s role in improving outcomes using critical care environment evidence-based assessment and treatment approaches.
- Develop a discharge and caregiver education plan for the altered mental status patient population.
- Identify at least three common pharmacological and metabolic causes for altered mental status in the hospital setting.
Disclosure

- The speaker does not present with any conflict of interest and have no financial relationships to disclose in regards to the content of this presentation.

Case Highlight

- 87 year old female brought into ED by granddaughter who reports 2-3 days of altered mental status, poor PO intake, increased sleepiness and unsteady gait and fall on day of admission.
- PMHx: COPD, HTN, CVA 10 years ago, emphysema, breast CA with right mastectomy 35 years ago.
- PLOF: Ambulating (I) without device, assist with stairs, (I) with ADLs and light meal prep. Granddaughter does all cooking, shopping and is primary caregiver and reports patient is active and usually A & O x4.
Altered Mental Status 1,2,3,4

- Altered mental status (AMS), confusion and behavioral changes are common chief complaints in the ED and ICU
- Present in 4-10% of ED admissions but higher in certain demographics
- Description is vague with lack of standardized terminology
  - Multiple synonyms:
    - lethargy, confusion, psychosis, disorientation, hallucinations, agitation, stupor

Altered Mental Status 1,2,3,4

- AMS is not a disease condition, but a symptom that can be due to multiple medical conditions
- AMS means, when compared to normal state of mentation:
  - There is disorientation
  - Abnormal thought content
  - Perceptual abnormalities
Altered Mental Status $^{1,2,3,4}$

- AMS is not a disease condition, but a symptom that can be due to multiple medical conditions
- AMS means, when compared to normal state of mentation:
  - There is disorientation
  - Abnormal thought content
  - Perceptual abnormalities

Statistics$^4$

Age Distribution based on 110,000 admissions

- < 40 years 36%
- 40-60 years 22%
- > 60 years 42%
What is Delirium?\textsuperscript{1,2,3,5}

- A clinical manifestation of acute CNS dysfunction caused by underlying physiological condition:
  - Systemic disease, primary CNS disease, environment, drugs
- Hallmarked by fluctuations in level of:
  - Attention, consciousness and orientation
- It is \textit{acute}- developing over hours or days
- It is \textit{transient}- usually reversible, symptoms improve with improvement of acute illness
- Disorganized thinking
- Sleep/wake cycle disturbance with vivid nightmares and hallucinations
Physiology of Delirium

- Impaired cerebral oxidative metabolism due to acute illness
- Abnormalities in neurotransmitters—particularly reduction in cholinergic transmission
- Inflammatory markers are generated
- Impacts arousal mechanism of thalamus and brain stem resulting in altered consciousness
Incidence

- Most cases of acute mental status change and confusion can be attributed to delirium and not to chronic CNS dysfunction.\(^1,2\)
- Risk factors for AMS and delirium vary across hospital settings\(^7\)
- Present in 10%-20% of older patients admitted to ED
- 30% of older patients will develop delirium during hospital stay\(^3,7,8\)

Incidence\(^3,7,8\)

- Delirium develops in approximately 60-80% of ICU patients
- Rates of up to 87% in critically ill patients
- Estimated that 60-80% of cases of delirium go undiagnosed
- Cases missed in ED have higher 6 month mortality rates\(^2\)
Impact

- Annual impact of $4 to $16 Billion
- Associated with increase in length of stay (LOS) up to 14 days
- Increased mortality rates of 19% in 6 months to 1 year post incident
- Misdiagnosis in ER may double mortality rates
- Increases rate of functional decline
- Doubles the risk of being institutionalized

Impact on Care

- Interferes with accurate history
- Prolongs examination, testing and number of tests
- Increases the probability of misdiagnosis
- Increases use of chemical or mechanical restraints
- Decreased mobility leading to increased fall risk
- Prolonged ventilation
- Associated with prolonged cognitive impairment
Impact on Care

- Increased caregiver burden:
  - Anxiety
  - Time
  - Support staff and caregivers
  - Risk of readmission
  - Risk of falls
  - Likelihood of discharge to other care facility
  - Difficulty with communication
  - Unable to follow through with care instructions

Delirium Subtypes

- **Hyperactive**: more common in younger population
- **Signs**: Inattention, agitated, restless, combative
  - Associated with increased risk of self-extubation, falls and over sedation
  - Richmond Agitation-Sedation Score (RASS) of >0
  - More likely to be caused by alcohol or drug withdrawal
Delirium Subtypes \(^{2,3,11}\)

- **Hypoactive**: most common type and most commonly misdiagnosed
  - **Signs**: Inattention, lethargy, decreased mental and physical activity
    - Associated with increased risk of aspiration, pulmonary embolism and decubitus ulcers
    - Usually RASS score of \(<0\)
    - More likely due to metabolic dysfunction

- **Mixed**: involves fluctuation between hyperactive and hypoactive

- **Delirium Tremens**: very serious alcohol withdrawal syndrome
  - May occur with withdrawal after years of alcohol abuse
  - Can last for several months
  - May have long lasting effects
Who’s at Risk for Delirium and AMS?\(^1,3,7\)

- Persons with underlying dementia are at highest risk
- History of: depression, HIV, CHF, alcohol abuse, stroke, epilepsy
- >70 years old
- Multiple comorbidities
- Patients in the ICU or CCU
- Visual or hearing impaired
- Malnutrition or tube feeding
- Narcotics, benzodiazepine or anticholinergic properties, antidepressants and muscle relaxants associated with a 3 to 11 time increased risk\(^12\)
- BUN/creatinine ratio >18 or bilirubin >2.0

Hospitalization Risk Factors\(^1,8\)

- Lack of interaction
- Isolation
- Lack of daylight
- PO intake restrictions
- Chemical and physical restraints
- Sleep deprivation
- Immobility
- Catheters
Common Causes of Delirium and AMS

Systemic
- Sepsis/infection
- Hypoxia
- Electrolyte imbalance
- Acute MI
- Hypothermia/hyperthermia
- Malnutrition
- Renal/Liver failure
- Trauma
- Blood sugar

Polypharmacy
- Alcohol/drug withdrawals
- Opioids
- Sedative withdrawal
- Anticholinergics
- Sleep deprivation
- Pain
- Indwelling catheter
- Toxic substance exposure

Drug/Environmental

CNS
- Stroke
- Hemorrhage
- CNS infection
- Tumor

Cause Comparison by Age

% of top 3 causes in >60 y-o | % of top 3 causes in <60 y-o
--- | ---
Cerebrovasc. | 36 | 35
System/organ | 20 | 11
Infection | 10 | 3
Drug/Toxicity | 35 | 2
System/organ | 20 | 11
Metabolic | 10 | 3
Case Study Analysis

- CT: Negative for acute disease and stroke, mild microvascular changes
- Chest X-ray: + for mild bibasilar infiltrates, but patient with no cough
- BUN was abnormal
- Pt’s BP was frequently elevated during stay

PT Evaluation:
- CG for bed mobility and transfers
- Ambulatory with RW with CG and mod vc for decreased safety
- Inattentive, decreased recall, decreased command following
- BP was elevated with activity and pt reported fatigue
- Nursing reported patient was somewhat agitated at times, but none noted by PT

Case Study Analysis

- Granddaughter reported it was taking 40 minutes to eat because she wouldn’t pay attention to what she was doing
- Required frequent redirection by PT, very distracted by items in environment and desire to go home
- Pt reported she felt terrible and knew that she couldn’t walk, but she needed to go home and clean up because she left a mess
- Pt was oriented to year and month but did not recall:
  - Falling at home before coming to ED
  - Being in the ED
  - Why she was in the hospital
What is Dementia?

Dementia - A progressive disorder developing over months to years

Characteristics:
- Cognitive and memory impairments that result in impaired activities of daily living
- Few medical diagnoses defined by the inability to perform functional activity
- Usually with the presence of any of the following: aphasia, apraxia, agnosia
- Level of consciousness and reasoning are usually consistent
Dementia Statistics

- Affects about 5 million Americans
- 2/3 of people diagnosed are female
- 50% of people >85 years have some form of dementia
- Alzheimer’s is the 6th leading cause of death in the US
- In 2018 Alzheimer’s and other dementias care cost estimated at $277 Billion
- 16.1 million Americans provide unpaid care to those living with dementia

Physiology of Dementia

- Due to structural and chemical changes in the brain:
  - Shrinkage of brain tissue
  - Reduction of white matter
  - Deterioration of brain cells
  - Loss of synapses
- 4 main types:
  - Alzheimer’s
  - Vascular
  - Lewy Body disease
  - Frontotemporal
- Dementia with Lewy bodies can mimic delirium
Physiology of Dementia \textsuperscript{13,14}

- Progressive changes in areas that control:
  - Memory
  - Motor and sensation
  - Executive control centers for emotions, behavior, judgment and reasoning
  - Formal speech and language

- Simple bedside differentiating test may be used:
  - Span tests
  - Months of the year/days of week backwards
  - Serial numbers

## Clinical Changes with Dementia \textsuperscript{13,15}

<table>
<thead>
<tr>
<th>Memory</th>
<th>Language</th>
<th>Impulse control</th>
<th>Task performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty learning new things</td>
<td>Miss 1 every 4 words</td>
<td>Say whatever they are thinking</td>
<td>Think they can and will perform better than actuality</td>
</tr>
<tr>
<td>Immediate past memory loss</td>
<td>Word finding deficits even with cues</td>
<td>Swearing, racially and sexually inappropriate language</td>
<td>Performance very affected by stress level</td>
</tr>
<tr>
<td>Cannot ID self or others in pics</td>
<td>Vague and repeat often</td>
<td>Respond quickly and strongly to perceived threats (flight/flight)</td>
<td>Say 1 thing and do another</td>
</tr>
<tr>
<td>Absent minded but not jogged by cues</td>
<td>Increased automatic responses</td>
<td>Decreased insight</td>
<td>Lack of perception of danger</td>
</tr>
<tr>
<td>Confabulates (use old memories as new)</td>
<td>Covers up</td>
<td>Inappropriate gestures</td>
<td>Increased falls and injuries</td>
</tr>
</tbody>
</table>
Falls in Patients with Dementia

- 8 times more likely to fall
- Aspects contributing to fall risk:
  - Autonomic symptoms
  - Depression
  - Decreased insight, safety and problem solving
  - Decreased functional mobility
  - Caregiver training
  - Home safety and adaptation

Differentiating the 3 D's: Delirium, Dementia, Depression

- Depression- A mood disorder with pathologically depressed mood and low energy being predominant features
- Orientation and consciousness are intact
Symptoms of Depression

- Loss of interest in things they once enjoyed
- Incomplete tasks–not because of memory
- Lack of focus and attention
- Excessive sleepiness or insomnia
- Angers easily
- Increased fatigue
- Expressing feelings of hopelessness
- No true cognitive impairments and symptoms don’t fluctuate through-out the day

Comparison of the Signs and Symptoms

<table>
<thead>
<tr>
<th></th>
<th>ONSET</th>
<th>COURSE</th>
<th>PROGRESS</th>
<th>ATTENTION</th>
<th>MEMORY</th>
<th>REASONING</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEMENTIA</td>
<td>Slow, insidious</td>
<td>Slow, progressive 6-15 years average.</td>
<td>Slow, variable</td>
<td>Distracted</td>
<td>Decreased recent and immediate</td>
<td>Impaired-judgement and abstract thinking</td>
</tr>
<tr>
<td>DELIRIUM</td>
<td>Sudden, abrupt, hours to days</td>
<td>Short, fluctuating, worse at night</td>
<td>Stable, improves</td>
<td>Impaired, fluctuates</td>
<td>Impaired recent and immediate</td>
<td>Disorganized, distorted</td>
</tr>
<tr>
<td>DEPRESSION</td>
<td>Coincide with major life change</td>
<td>Situational fluctuation</td>
<td>Variable, coincides with incidents</td>
<td>Distracted, but minimal</td>
<td>Patchy, selective</td>
<td>Intact, but overly hopeless, apathy</td>
</tr>
</tbody>
</table>
Delirium Superimposed on Dementia

- Patients with dementia are very susceptible to delirium particularly the hyperactive type
- Special care should be taken with those who suffer from Lewy Body dementia whose symptoms of fluctuating cognition and arousal, hallucinations and delusions can mimic delirium
- Pain, boredom, loneliness, social stress, difficulty communicating can increase agitation in patients with dementia

Impact of Delirium on Discharge

- Increased discharge to an institutional setting
- Increased risk of readmission if delirium did not resolve upon discharge from ED
- High risk of failed discharge
- Increased 6 month mortality
- Estimated 13-19 % of older ED patients discharged home still had delirium
Case Study Follow-up

- Patient is discharged home with family day after PT Evaluation with recommendation for:
  - 24 hour supervision
  - Mobility with RW
  - Homecare
- Pt returns to ED 1 day later, s/p fall at night while trying to go to the bathroom
- Fall resulted in left hip fracture and received ORIF
- Pt discharged to Inpatient Rehabilitation Facility, 2 days post-op
- Granddaughter reports patient may not have been taking her medication as prescribed

Impact of Pain on Mental Status and Delirium

- Common chief complaint in ED admissions
- Modifiable risk factor for delirium and frequent cause of agitation
- Pain is commonly reported in cardiac, trauma, surgical and ICU patients both at rest and during daily procedures
- Many critically ill patient are unable to subjectively report pain due to AMS, sedation or ventilation
- Surveys of discharged ICU patients report:
  - Pain as a common reason for insufficient sleep
  - Pain as their most traumatic memory of ICU stay
Clinical Practice Guidelines for Pain, Agitation and Delirium (PAD) \textsuperscript{5,11}

- In 2002 the “Clinical Practice Guidelines for the Sustained Use of Sedative and Analgesics in the Critically Ill Adult” was published
- In 2013 guidelines revised by a 20 person multi-disciplinary, multi-institutional taskforce from the American College of Critical Care Medicine
- The “Clinical Practice Guidelines for the Management of Pain, Agitation and Delirium in Adult Patients in the Intensive Care Unit” was completed after 6 years of collaboration
- Reportedly one of the most extensive set of critical care clinical guidelines ever published

Clinical Practice Guidelines for Pain, Agitation and Delirium in the Critically ILL (PAD) \textsuperscript{5,11}

- Evidence-based and patient-centered guidelines emphasizing the importance of:
  - Recognizing and managing pain
  - Preventing, recognizing and managing delirium
  - Minimizing the use of sedation and improving agitation management
- Emphasizes an interdisciplinary and integrated approach to treatment
- Uses terms:
  - “recommend” - strong evidence
  - “suggest” - weak evidence
  - “do not recommend”
PAD- Pain Guidelines 5,8,11

- Strongly recommend assessing and treating pain prior to administering sedation
- If pain is well controlled in the critically ill and mechanically ventilated patients, there is less need for sedation, less agitation and improved interaction with the environment
- Appropriate pain management results in decreased ICU LOS
- Recommend administration of light analgesics or relaxation techniques prior to painful daily procedures to improve outcomes
  - Wound care, trach care, mobility (especially for trauma), chest tube

PAD- Pain Management Guidelines 5,8,11

- Recommend IV opioids as first–line drug class for non-neuropathic pain in the critically ill, patients with trauma and burns
  - Research finds it actually reduces risk of delirium
  - High dose IV opioids should not be used to the point that they have sedating effects
- Supplement with non-opioid analgesics to decrease opioid use such as: gabapentin, carbamazepine, NSAIDS
- Consider epidurals for rib fractures and other thoracic pain
- Do not recommend that vitals and observational pain scales be the only tools used to monitor pain
PAD- Pain Assessment Guideline ⁵,⁸,¹¹

- Pain needs to be monitored in all critically ill patients every 2-3 hours
  - Treated within 30 mins of assessment and reassessed in 30 mins
  - Reduces use of analgesics, decreases LOS and time of ventilation
- Highly recommend use of the Behavioral Pain Scale (BPS) and the Critical Care Pain Observation Tool (CPOT)
  - Most valid and reliable tools for patients who are:
    - Critically ill
    - Mechanically ventilated
    - Those who cannot self report (except for brain injury)

Behavioral Pain Scale (BPS) ⁷,¹⁸,¹⁹

- 3 subscales scored from 1-4
- Subscales:
  - Facial expression
    - Relaxed, partially tightened, full tightened, grimace
  - Upper limb movement
    - No movement, partially bent, fully bent, retracted
  - Compliance with mechanical ventilation
    - Tolerating movement, coughing but tolerating, fighting ventilator, unable to control ventilation
- Minimal score of 3 (no pain), max score of 12 points (severe pain)
**Critical Care Pain Observation Tool (CPOT)** \(^7,^9\)

- For critically ill and those unable to self-report - multiple descriptors
- 4 domains:
  - Facial expression - No muscular tension, tense-frowning, levator contraction, orbit tightening
  - Body Movements - absence of movement, protection, restlessness
  - Muscle tension - relaxed, rigid/tense, very tense or rigid
  - Compliance with ventilation - tolerating, coughing, fighting ventilator
    - Or verbalization - talking in normal tone/no sound, signing, crying out/sobbing
  - Minimal score of 0 (no pain), max score of 8 (severe pain)

**PAD - Agitation Guidelines** \(^5,^11\)

- Agitation is often associated with adverse clinical outcomes
- Common causes: pain, delirium, withdrawal, hypoglycemia, hypoxemia, hypotension
- Sedation is commonly used to address agitation, but this can also lead to adverse outcomes:
  - Increased mortality
  - Increased delirium
  - Long term cognitive deficits
PAD- Agitation Guidelines \(^5,^{11}\)

- Use of non-pharmacological interventions as first-line intervention is highly recommended, including:
  - Pain management
  - Comfort - room temperature, positioning
  - Reorientation
  - Sleep promotion:
    - Reduce light and noise at night
    - Designated quiet time during day
    - Allow sun and daylight during day
    - Group care activities
    - Limit night-time care activities

PAD- Agitation Guidelines \(^5,^{11}\)

- Sedation with non-benzodiazepines (propofol and dexmedetomidine) is preferred over benzodiazepines in mechanically ventilated patients
- Some sedatives are known to disrupt REM sleep\(^8\)
- Titrated and light sedation in ICU is associated with:
  - Improved outcomes
  - Shorter LOS
  - Shorter periods of ventilator dependence
PAD-Sedation Guidelines

- **Targeted sedations strategy (TSS)** - Sedatives must be used with a specific sedation scale end-point in mind
- It is recommended that daily sedation interruptions or a light continuous level of sedation is used for patients on mechanically ventilation
- Light level of sedation is defined as a level of consciousness and responsiveness enabling the following of 5 specific commands:
  - Open eyes, maintain eye contact, squeeze hand, stick out tongue and wiggle toes

Assessing Sedation

- Most valid and reliable tools for measuring depth of sedation in the ICU are Richmond Agitation-Sedation Scale (RASS) and Sedation-Agitation Scale (SAS)
- **RASS** - Has 10 levels ranging from combative tounarousable
- **SAS** - Has 7 levels ranging from dangerous agitation tounarousable
RASS-Richmond Agitation-Sedation Scale $^{4,11,20}$

- Easy to administer, relevant in all settings
- 10 Point scale:
  - +4 (Combative) to +1 (Restless)
  - 0 Alert and calm
  - -1 (Drowsy) to -5 (Unarousable)

To administer:
1. Patient is observed
2. Name is called and response noted
3. Name may be repeated and then asked to look at examiner

SAS- Sedation Agitation Scale $^{11,21}$

- Valid in various settings and populations
- Easy to administer, multiple descriptors
- 7 point scale
  - 7 - thrashing, pulling at tubes, climbing
  - 4 - calm, awakes easily
  - 1 - unarousable, no response to noxious stimuli

To administer:
1. Observe response to name
2. If no response apply physical stimuli- shaking.
3. No response- observe response to noxious stimuli
Strategies aimed at prevention were more successful than treatments

Recommend interdisciplinary approach including

- Standardized education
- Printed protocols
- Family intervention

Routine monitoring of patients for delirium using valid reliable tools:

- The Confusion Assessment Method (CAM)
- Delirium Screening Checklist (DSC)
- Both have an ICU specific version (CAM-ICU and ICDSC)

Assessing Delirium—Confusion Assessment Method (CAM)

Confusion Assessment Method (CAM)

Assesses the patient on the presence of 4 features:

1. Acute onset of mental status change or fluctuation
2. Inattention
3. Disorganized thinking
4. Altered level of conscious

Patient must positively possess the features in area 1 and 2 or either 3 or 4
Intensive Care Delirium Screening Checklist (ICDSC)\textsuperscript{12,14,15}

- Eight item checklist with 1 point for each item present
- Each section is based on DSM criteria for Delirium
  - Attention
  - Awareness
  - Timing/fluctuation
  - Memory deficit
  - Sleep disturbance
  - Psychomotor
  - Corroboration data: lab findings, diagnostic testing
  - Other cognitive disorders

Guideline for Delirium\textsuperscript{5,8,9}

- Benzodiazepine may be a risk factor for development of delirium and use of non-benzodiazepines for sedation reduces risk
- No evidence that any pharmacological intervention is effective in prevention
- Recommend use of non-pharmacological interventions as the first line of treatment for delirium
  - Early mobilization,
  - Sleep promotion
  - Hydration
  - Use of sensory aides
  - Reorientation
The ABCDEF Bundle

- Care bundle developed by Vaskeleski provides a systematic approach to implementing guidelines
- Developed to decreased incidence of ICU acquired delirium and ICU acquired weakness
- To be performed daily on mechanically ventilated or sedated patients in the ICU to decrease LOS and improve outcomes
- Based on PAD guidelines- but without pain focus
- Includes daily spontaneous wakening trials (SAT)
- Includes daily spontaneous breathing trials (SBT)
- Patient and family-centered

The ABCDEF Bundle

A - daily spontaneous awakening trials
B - daily spontaneous breathing trials, combined with A
C - choice of analgesia and sedation-adjusted based on response in A & B
D - delirium assessment
E - early mobility and exercise
F - family engagement and empowerment
Implementing PAD and ABCDEF Protocols

- Study involving surveys of ICU intensivist in 47 countries looked at knowledge and use of the protocols found the following themes:
  - Most were not using the recommended assessments for pain, delirium or agitation
  - Only 1/3 assessed for ICU-Acquired Weakness (ICU-AW)
  - Early mobility was often prescribed but there was no dedicated mobility team
  - Family involvement was encouraged but there was a lack of standardized education tools

Implementing PAD and ABCDEF

- A pilot study to identify factors influencing implementation looked at data from 4 San Francisco hospitals:
  - There was a stringent implementation strategy and an implementation team
  - Training involved webinars, in-person training, site visits, conference calls, written and online materials
  - Factors influencing implementation were:
    - Organization/structure of ICU
    - Patient safety and quality improvement structure
    - Prior experience with implementing protocols
    - Implementation planning
    - Leadership quality
    - Documentation prompts
Implementing PAD and ABCDEF

- **Facilitators:**
  - Multidisciplinary and cross-disciplinary team education
  - Computerized protocols and order-sets
  - Pre-printed protocols and checklists
  - Multidisciplinary rounds
  - Point of use electronic reminders
  - Discipline specific practice feedback
  - Implementing performance and gap analysis

- **Barriers:**
  - Lack of standardized documentation
  - Lack of written protocols
  - Decreased understanding of team member roles
  - Non-specific and single faceted educational tools
  - Lack of family education
  - Lack of standardized assessments
Barriers to Early Mobilization

- Over sedation or poor timing of sedation
- Agitation
- Delirium
- Enforced bedrest
- Staff perception, comfort level and education
- Hemodynamic instability
- Lack of equipment and personnel
- Organizational culture
- Multidisciplinary education and coordinated care is important to improve all barriers

Evidence for Early Mobilization

- Multiple studies show benefits of early mobilization in:
  - Prevention and reduction of delirium
  - Reduction in:
    - ICU LOS
    - Overall hospital LOS of up to 3 days
  - Reduction in ICU acquired weakness (ICU-AW)
  - Decrease incidence of decubiti, DVT and pneumonia
- Multiple studies show the efficacy and safety of providing physical therapy in the ICU, critical care setting and even patients with mechanically ventilation
- However estimated that only 25% of ICU patients receive early rehabilitation
Evidence for Early Mobilization\textsuperscript{23,24,25,26,27}

- Since patients with dementia are at higher risk for developing delirium
- Aerobic exercise is associated with reduced risk of cognitive impairment and dementia\textsuperscript{28}
- Regular exercise is important for patients with dementia:
  - May assist with behavior management
  - Reduces:
    - Fall and fracture risk
    - Mortality rates

What Type of Early Mobility\textsuperscript{24,25}

- Dependent on comorbidities and contraindications
- Programs which included:
  - PROM/ AROM/ AAROM
  - Sitting edge of bed activities
  - Standing
  - Out of bed to chair
  - Ambulation
  - All deemed feasible and effective in the critically ill and ventilated patient
- Programs involving NMES and Cycle Ergometer are being implemented but no specific protocol recommendations to date\textsuperscript{29}
Increasing Treatment Success

- Treating patients with delirium particularly the hyperactive type can be challenging and overwhelming
- These are the patients who are more at risk for over sedation and resulting sequelae are most in need of mobilization
- These are all strategies that we can share with caregivers and families to decrease burden of care upon discharge

The C.A.L.M.E.R. Approach

- Developed to teach Physicians how to handle encounters with difficult patients
- Research found that response to difficult patients might range from acquiescence and anger to scorn and disrespect
- Physician's inability to listen objectively and show empathy can lead to misunderstanding of patient concerns and history
- Approach helps to decrease feelings of distress and lack of control
The C.A.L.M.E.R. Approach

Catalyst for change (not responsible for it)
Alter your thoughts to change your feelings
Listen before reacting
Make an agreement with the patient
Educate
Reach out and debrief

Gentle Persuasive Approach (GPA)

- Evidence-based, person centered approach to caring for patients with dementia and delirium
- Focuses on extensive education of staff to:
  - Prevent responsive behavior
  - De-escalate behavior
  - Manage patient’s fear and anxiety
- Study reported prior to training, staff:
  - Felt unable to cope with behavior related to delirium and dementia
  - Called “Violence Codes” more often
  - Used restraints more frequently.
**GPA**

31,32

**Principles:**
- Develop person centered care
- Determine reason behind abnormal behavior
- Educate on impact of dementia and delirium on brain
- Use environmental, emotional and interpersonal communication strategies to diffuse behavior
- Use suitable, respectful self-protective and physical interventions in response to physical behavior

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**First Impressions are Important**

- Form a connection with the patient during your initial interaction, it’s all about how you communicate:
  - Visually
  - Verbally
  - Physically
  - Emotionally
  - Individually/Spiritually
Visual

- Approach slowly and within visual range
- Use visual cues and ensure they can see you
- Pause at edge of public space—gently knock or pull door/curtain
- Make eye contact
- Stand to their dominate side to communicate

Verbal

- Listen
- Talk to them like adults—yelling doesn’t help
- Keep it short and simple—no medical terms
- Use positive 1 step directions
  - Ex. “Time for exercise” “This way.” “Put this on.”
- Yes/No questions
- Use their name
- Give your name
- Give them time to response—deficits in attention, processing and initiation. Repeat with same words.
- Limit distractions
Physical

- Approach slowly
- Respect intimate space
- Offer your hand and introduce yourself
- Use gestures, props and physical guidance
- Demonstrate
- Don’t forget the power of touch- have them hold the item
- Sense of smell is one of the last ones to go- use it for cues, especially for ADLs. Scent of lotions, soaps, shampoo communicate time for ADL.

Emotional and Individual

- Ask them about themselves, family, pets, vocation, vacation, hobbies
- Use the information to help:
  - Encourage and motivate them
  - Distract or redirect them
PT and Restraint-Free Alternatives

- Make recommendations for safe mobility, keeping in mind that status may fluctuate
  - Be clear with recommendation based on patient status
- Include orientation and cognitive tasks in treatment to decrease confusion
- Encourage hydration, sleep promotion and toileting
- Encourage clustering care to decrease agitation and improve sleep
- Low beds and recliners
- PT’s are integral in providing the E and F of the ABCDEF protocol

Managing the Behavior in the Moment

- The best ways to change behaviors are:
- **Distractions** - Turn their attention to something else in the moment
- **Substitutions** - Substitute the item, person or activity that may be a trigger. Ex. Camouflaging doorways, music, dolls, story time
- **Engagement** - Use active engagement in hobbies and favorite activities especially during sun-downing.
- Sometimes we have to live in their world
- Omission is ok
Tips for Caregivers  

- Improving Nutrition:
  - Patients with dementia may lose the sense of taste very earlier - try more seasoning and aromatic spices
  - Check dentition and hygiene
  - Minimize distractions
  - Play soothing music
  - Red is one of the last detectable colors - use red plates or brightly colored dinnerware
  - Kids snacks, finger-foods, ready to eat, easy to dissolve, things drinkable through a straw
  - No one likes to eat alone - join them or just talk

- Keeping them in safely:
  - Hide keys
  - Place audible alarms on doors and windows
  - Place “STOP” sign on exit doors or camouflage with mural
  - Fence or close off dangerous areas - pools, hot-tubs, dead bolts on basement/cellar doors
  - Remove stove knobs on stove
  - Lower temperature on water heater
  - Lock up - medicines, alcohol, firearms, power tools, ladders
  - Child-proof locks
Tips for Caregivers

- Improving the environment can decrease triggers and anxiety
- Cover or remove large mirrors—reflections can be confusing
- Close shades tightly at night—shadows and outside lights can increase confusion
- Keep the bathroom door open or label door

Tips for Caregivers

- Remind them to perform hygiene:
  - Brush teeth and perineal care
  - Set-up and label items so they are easy to find
  - Leave notes and lists in bathroom
- Leave reminder notes in kitchen
- Pick out clothes or limit choices
- Pet therapy, reminiscing over old pictures and videos help reduce agitation 35,36
Sleep Disturbance 15,17,35

- Sun-downing or Late day confusion can occur between 2pm and 7pm but can continue through-out night

- Things to try:
  - Stick to a nighttime routine
  - Keep appointments and more strenuous activity in am, especially ADLs
  - Avoid stimulants
  - Keep evening meals light
  - Keep lighting bright in afternoon to encourage wakefulness
  - Close curtains, keep lights on in evenings
  - Keep pm activities low stimulus- ex. reading, calming music
  - No napping or strenuous exercise 4 hours before bed

Caregiver Burden 15,17

- Resistiveness to Care (RTC)- presence of resistive behavior during care/ADL related tasks
  - Had greatest correlation to increased reports of caregivers burden.

- Most common reasons for transfer from home to a nursing home are: illness, absence or death of caregiver

- Inability to meal prep was a frequent reason for transfer to a facility among other ADLs

- Difficulty dealing with behavioral problems increased risk of transfer to a facility- especially apathy, aggression, depression, restlessness

- Caregivers wanted to be more educated on dealing with communication deficits, confusion and combative ness
Problem Solving for Safe Discharge Home

**Acute conditions: Delirium**
- Plan for 24 hour assistance until symptoms improve to baseline
- Plan for now and improvement in long term
- Caregiver education: written, easy to understand instructions in primary language
- Consider more restrictive assistive device
- Home safety checklists
- HEP - including cognitive tasks
- Temporary first floor set-up with close proximity to caregiver with lower sleeping surface
- Encourage consistent sleep cycle

**Chronic conditions: Dementia**
- Short to long term planning-plan for worsening condition
- Recommend 24 hour assistance as symptoms are progressive
- Caregiver education - written, easy to understand, in primary language
- Recommend permanent first floor set-up with close proximity to caregiver and lower sleeping surface
- Home safety checklist with education on potential permanent modifications
- Keep routines and sleep cycle consistent
Home Safety Technology

- Video monitoring devices
- Home hub devices for:
  - Reminders for medicine and other tasks
  - Music
  - Picture slide shows
- Fall risk apps
- Simple audible alarms: sensor pads, door alarms/chimes, bells
- Cognitive engagement: puzzles, apps, video games

Resources for Caregivers

- Training and education programs for caregivers
  - STAR-C
  - REACH II
- Family Caregiver Alliance - www.caregiver.org
- Alzheimer’s Association - www.alz.org
- Merck Manual
Summary

- Delirium often goes unrecognized and misdiagnosed
- Delirium itself places people at high risk for further complications and death
- It is important for PT’s to recognize the signs and symptoms of delirium and the difference in presentation compared to other conditions
- Physical Therapists are an important part of the Guidelines for management of patients with pain, agitation and delirium in the acute care setting in order to improve outcomes
- Physical Therapist can provide invaluable education to all caregivers to improve outcomes and safety of this population

Less Confused?

Questions?
THANK YOU!

- Contact Information

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References

References


References


