

FACILITATOR'S GUIDE

DELIRIUM AND DEMENTIA

MODULE 8 IN THE DEMENTIA STARS SERIES

dementia STARs

NEW ZEALAND DEMENTIA FOUNDATION

CHT Healthcare Trust
WE TAKE GREAT CARE OF OLDER PEOPLE
Aged Care Fund

WELCOME!

In this kit you will find all the resources you need to run an engaging 45-60 minute introductory staff education session on reducing the risk of delirium, focused on people living with dementia. The Dementia STARs education is particularly suitable for direct care workers across a range of settings.

This Delirium Dementia STAR module will be particularly useful if it is offered as the final module on the series of Dementia STARs, as it provides a chance to build on and reinforce the previous modules. However, it can also stand alone.



This Dementia STARs education kit is a partnership between the New Zealand Dementia Foundation and CHT Aged Care Fund. The content is based on the concept of an unfolding case study, with the session revolving around the story of Judy Jones and her daughter Karen. We would like to acknowledge and thank

- Jane Byrd, Community College of Philadelphia, whose Ace-Z case study of Judy and Karen for the National League for Nursing has been adapted here, with permission.
- Danielle Wilde, Royal Free London NHS Foundation Trust, whose work on the CAPER resource has been adapted for the section on care partners
- PINCHES ME kindly and Think Delirium resources were developed by Susan Gee and colleagues at the Canterbury DHB.

You can find our other Dementia STARs kits at nzdementia.org/dementia_STARs

Ngā mihi nui from the Dementia STARs Team

Short Trainings in Awareness and Responsiveness

dementia STARs



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1. Getting started

Delirium and dementia

CREATING A SHARED

CULTURE OF CARE

The Dementia STARs programme is an opportunity to effectively enhance the skills of individual learners and to reinforce a shared culture of person-centred dementia care: this is the heart of all we do at our place.

Research shows that face-to-face active learning is more effective for home-based and aged residential care staff than watching videos or reading written material [1,2]. Interactive training in a small group where teaching is interspersed with frequent discussion and opportunities to ask questions is not only more effective[3,4], it is preferred by learners [5,6]. Furthermore, this type of training can also help to strengthen team cohesiveness and shared values [1,2].

Congratulations on joining the Dementia STARs journey with your team to reinforce great person-centred dementia care at your place.



TIPS FOR USING THIS KIT

If this is the first time you've used one of the Dementia STARs kits – welcome!
We're delighted that you are joining the Dementia STARs whānau.
We've put together some tips to help you know what to expect from the kit.

This guide

The facilitator's guide is just that. It's a guide and a starting point. Don't feel that you have to say things exactly the way that we have said them on the page. You can download the resources to print for the session from the Dementia STARs webpage.

The questions and activities

You will notice that we give lots of suggestions for places where you can ask the group for ideas or to engage in an activity, rather than just telling them the information. This is something you may well already do so you'll know that it is a helpful way to keep people engaged. Being interactive is a better way for adults to learn.

Audiovisual resources

We have provided a Powerpoint resource for each kit, which contains a variety of content to help run an engaging session. If you don't have access to audiovisual equipment, don't be put off from running the session. Check out the content provided and adapt.

> RELATIVELY FEW PEOPLE LEARN WELL FROM SITTING AND LISTENING TO LECTURES; IT IS IMPORTANT THAT TRAINING IS ENGAGING
>
> – BUZ LOVEDAY [7]

The PowerPoint slides

The PowerPoint slides generally have only a few key words on them, supported by compelling images. Having what you want to say written out in detail on PowerPoint slides can be reassuring for a presenter, but it is not so great for your audience:

- A lot of text can make it harder for the learners to really listen to what you are saying when they are also paying attention to the words on the slide.
- A lot of text can be off-putting for people who don't read so well.
- A lot of text can be boring, especially if the presenter just reads out the text.

That is why we use images as much as we can and to only have a few words on each slide. The idea is that the PowerPoint slides complement what you say and makes it easier for the learners to understand, rather than just repeating what you say. This facilitator's guide is here for you to help you feel confident and remember what you want to cover. The PowerPoint slides themselves - they are for your audience!

The images in the slides are only licensed for use for Dementia STARs. Please do not use the images for any other purpose as this will violate copyright.

The expert video clips

There are video clips of people with professional and lived experience embedded in the PowerPoints. This is our way of giving you some company as you present. It means you can draw on experts and on different perspectives. It also means that you get to bring in some variety of faces and voices, which can help to give a little boost to engagement and interest. The videos can help to reinforce an aspect of the session.

As the video clips are embedded in the PowerPoint presentation, you do not need access to YouTube or the internet to show them. You can hover and click in the slide.

The animated stories

In some of the kits, there is an animated 'whiteboard' video embedded in the PowerPoint. These are a way of sharing case studies. Because cases studies tell a story, they are often much better remembered than 'facts'.

The handout

Each kit has a summary handout to remind your learners about key messages.

The feedback form

You will find a one page feedback form in each kit. Feedback can help you make future education sessions better, and can provide evidence that the training has had an impact.

We may email you as follow-up to seek feedback on the Dementia STARs resources. If we do, we will ask you if you would be willing to share your learners' anonymous evaluation responses.

The going further list

We have included a list of five resources that provides some further detail on the topic for keen learners (or for yourself).

The certificate

We provide a certificate of attendance for you to give learners at the end of the session.

The webinar version

We have a version of each education session available as a video 'webinar'. This does not have exactly the same format as the in-person session you will run (there are no activities in the webinars), but you can use the webinar version to help a staff member 'catch up' if they have missed the in-person session, or to help orientate a new staff member.



MĀ TE HURUHURU, KA RERE TE MANU
FEATHERS ALLOW THE BIRD TO FLY

– MAORI PROVERB

WHAT'S IN THE FACILITATOR'S NOTES?



This is the PowerPoint slide you are showing

Many of our clients are in pain

We know that pain is common amongst older people. All sorts of things commonly cause pain or discomfort. [1]

This is our suggestion about what you might say for this slide

A number in brackets is a reference. You can find the list of references at the end of the guide

What are some of the common aches and pains we see?

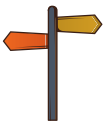
This is a suggestion about a question to ask the learners to increase engagement

Perhaps the most common types of pain they come across will be falls, back pain, arthritis, urinary tract infections, and pressure sores [8, 9] but the list can include almost any part of the body.

We also provide some examples of common responses



This symbol indicates that an audiovisual resource is embedded in the PowerPoint



This symbol indicates a choice



Activity

This symbol indicates a class activity



This symbol prompts you to add information about what happens 'at your place'

MEET THE EXPERTS

Here are some of the faces that you will meet in the Dementia STARs resources.



MATTHEW CROUCHER: MEDICAL

Matthew is the chair of the New Zealand Dementia Foundation. He is a Psychiatrist of Old Age, a Senior Clinical Lecturer, and leads the South Island Regional Dementia Initiative. Matthew is a prominent figure in teaching, training, research and service management advice in the older person's mental health sector.



MACKENZIE EBBETT: REGISTERED NURSE

Mackenzie is the Nurse Manager of a specialist cognitive impairment ward at Burwood Hospital. She is a passionate champion for person-centred care in this environment to optimise the level of functioning of older people with delirium and/or dementia by offering specialist assessment, treatment, care, support, and education.



ASHLEIGH FARR: SPEECH LANGUAGE THERAPY

Ashleigh is a Speech Language Therapist with decade of experience across a wide range of roles. Ashleigh has been active in expanding her skills in dysphagia and communication disorders in patients with more complex presentations including people living with dementia.



SUSAN GEE: ACADEMIC

Susan Gee has a background in psychology and gerontology. As a researcher and educator Susan is passionate about strengthening and embedding understanding and best-practice person-centred care to help amazing people provide great day-to-day support for people living with dementia.



TRACEY HAWKES: OCCUPATIONAL THERAPIST

Tracey is an Occupational Therapist with over two decades of clinical experience. She facilitates the 'Walking in Another's Shoes' dementia education programme for home-based support staff. Her focus is helping care staff to develop the confidence and person-centred tools to support older people to live more independent and fulfilled lives.



LARA HITCHCOCK: NURSE

Lara is a Registered Nurse in a Memory Assessment Clinic. Lara has specialised in the field of dementia care for over 20 years. In her current role she provides assessment, information, and support to those newly diagnosed with dementia and their care partners. She acts as a specialist resource to colleagues and is active in quality improvement to improve the care of those living with dementia.



HONEY MOHAN: CARE WORKER

Honey is a care worker in an aged residential care facility. She is a graduate of the Walking in Another's Shoes dementia education programme. Honey is passionate about getting to know each of the people she supports as a unique person, and she loves her job.



CHERYL NETTLETON: WHĀNAU / FAMILY SUPPORTER

Cheryl's introduction to dementia was when her husband started to display out-of-character behaviours around the age of 50. Cheryl has since founded carers' groups to bring whānau carers together for mutual support. Cheryl also helps to educate people about dementia from her perspective as a wife and family member in the hope that it strengthens an emotional connection to people living with dementia.



NICK UYS: WHĀNAU / FAMILY SUPPORTER

Nick worked in the pharmaceutical industry for many years. He was married to his beloved wife Anne for 44 years and became Anne's full-time carer until Anne entered aged residential care. Nick is committed to sharing his perspective as a carer within dementia education programmes as a way to make a positive impact. .

2. Running the session

Delirium and dementia





LEARNING OBJECTIVES: DELIRIUM AND DEMENTIA

When supporting a person living with dementia,

01 Learners are aware of the importance of delirium identification, management, and prevention

02 Learners can identify possible delirium superimposed on dementia

03 Learners are able to support people in distress due to delirium

04 Learners are able to engage empathetically with care-partners

05 Learners understand common preventable triggers for delirium and are confident in addressing these for an individual.

FACILITATOR'S NOTES FOR DELIRIUM AND DEMENTIA

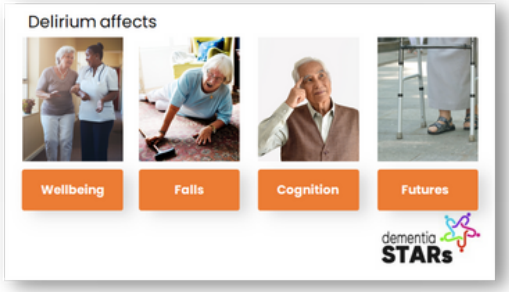
Delirium is common amongst people living with dementia. In fact, research suggest that people living with dementia are more likely to get delirium than people without a dementia.



So what is delirium? Let's hear from Dr Matthew Croucher as he gives us a brief introduction to delirium.

Play Matthew's video

As Matthew said, if we can spot the trigger for the delirium and get on top of it, the delirium itself will often clear up in a few days. But delirium is serious for people living with dementia



Delirium affects wellbeing. Delirium can be frightening and distressing for the person and those that support them[8].

Delirium is strongly associated with an increased risk of falls. Research shows that when teams successfully reduce delirium they also reduce falls[9-11].

Delirium can affect cognition permanently. Some people living with dementia won't return to their previous level of cognitive functioning after having a delirium, and on average the rate of cognitive decline is steeper after having a delirium[12,13].

Delirium affects futures. People living with dementia who develop delirium are more likely to need help walking, to be admitted into hospital, or to die within the next year [14-17]. People who have one episode of delirium are more at risk of delirium again in the future.

So it's very important that we

- Suspect delirium if a person suddenly experiences changes
- Support people if they do develop delirium
- And help to prevent delirium from occurring in the first place



Suspect

As care-workers you aren't expected to diagnose delirium. Don't wait to be 100% sure. If you SUSPECT someone has a delirium, report it to the right person.



At your place: Who should learners report to?

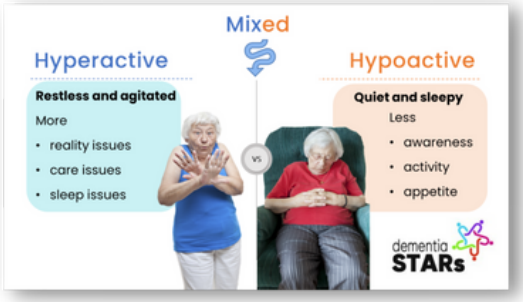
What does delirium look like?

For someone living with dementia, we see 'worse than usual' confusion when they have a delirium. It is a change from what is normal for them.



The symptoms develop suddenly, usually over a few hours or days.
Delirium makes it hard for people to pay attention and focus their thoughts. There is a change in how alert or awake people are.
The person may fluctuate between being more confused and seeming okay in the same day.

Delirium can look very different because there are different types of delirium



Some people with delirium have hyperactive delirium. They are restless and agitated. The delirium is winding them up:

- The person may have hallucinations or delusions. The person may see things that aren't there like spiders climbing the walls. Or they may believe things that aren't true like thinking that people are trying to poison them.
- We may see more care issues because the person is getting upset when we are trying to provide personal cares because they don't understand or because they are misinterpreting what is going on. For example, one gentleman believed that he was going to be gassed to death in the shower. You can imagine how strongly he fought because of the reality that he was in.
- We may see sleep issues, with the person finding it very hard to settle down to sleep at night and when they do sleep they may have nightmares or night terrors.

Hyperactive delirium can be very distressing for the person and those that love and support them.

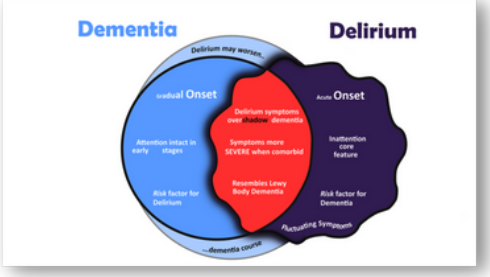
Some people with delirium have hypoactive delirium. They are quiet and sleepy. It is almost like they have been sedated. It may be harder than usual to get them to respond to us, they may move less and eat less.

Some people have mixed delirium – they go back and forth between being agitated and being sleepy

Q *Which type of delirium do you think is hardest to spot?*

A Hypoactive delirium (the quiet and sleepy type). It is easy to overlook someone with a mild hypoactive delirium as they are "no problem". People with the hypoactive type of delirium tend to have worse long-term impacts from the delirium [g-j]

When we are supporting people living with dementia, we have a situation where the delirium is superimposed on top of existing cognitive changes. That can be harder to spot, and symptoms of delirium can get misinterpreted as the dementia getting worse. [diagram adapted from 18]



So to go back to basics, dementia is an umbrella term for chronic progressive changes in the brain.

There are a lot of different types of dementia illness. The most common type is Alzheimers Disease. You may have also heard of some other types of dementia like vascular dementia, frontotemporal dementia, Lewy Body dementia, or mixed dementia. The thing that these different types of dementia have in common is that they have a **gradual onset**. There is a slow progression of cognitive decline across time.

In contrast, delirium has that **sudden onset**. It comes on in a matter of days or sometimes even hours.

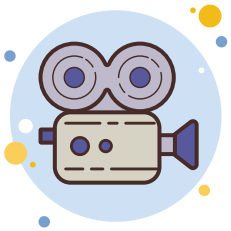
With dementia you are asking 'are they different from last year?'. With delirium you are asking 'are they different from yesterday?'.

One of the hallmarks of delirium is the problem with attention. If you ask someone living with Alzheimers type dementia what they had for breakfast they might say "Oh I can't remember" or they might say "cereal" even though you know today they had toast. If you ask someone with delirium what they had for breakfast they may not even answer the question because they can't pay attention. Or they say something about those pesky spiders because they got distracted by them.

We do see some variation across the day for many people living with dementia, with many people being at their best in the morning. With delirium we may see new and more dramatic fluctuations across the day, with the confusion and other symptoms coming and going.

So dementia has slowly progressing changes. When a person living with dementia develops delirium, the delirium symptoms overshadow the dementia.

Let's meet Judy Jones and her daughter Karen [19]. We are going to follow their story for the rest of our session. Judy Jones is an 85yearold retired preschool teacher who you are supporting. Joseph, her husband of 50 years, died seven years ago. Karen Jones is Judy's daughter.



Play video of Judy and Karen Jones

What do you think is going on with Judy? (follow up as required, e.g., What made you think that? What type of delirium?)



Delirium superimposed on dementia.

Dementia: Karen talks about long term cognitive changes that have progressed across several years: memory problems, then having difficulty with the bills, then having difficulty with appropriate clothing choices.

Delirium: Judy is clearly different than the picture we get from Karen just last week. She is agitated and distressed, she is confused about where she is and that her daughter is not present, she is seeing / hearing things that aren't there.

This fits with hyperactive delirium superimposed on dementia.

So the big question we ask for delirium is: are they different today?

Has there been a sudden change?



Thanks to your report of the change in Judy, the GP visits. It turns out that the cough is aspiration pneumonia and Judy is also diagnosed with hyperactive delirium. (The delirium is superimposed on top of her existing dementia of the Alzheimer type)



Today you are supporting Judy while she is experiencing what you now know to be delirium.

Judy is obviously distressed. How could we help to settle and reassure her? Shall we start off by telling her to "calm down" and repeating that there are no children under the bed, it's all in her head?



No. The experience is very real for Judy. That approach is likely to end up as an argument you can't win and Judy being even more upset.

So what could we do to help settle and reassure Judy? (You can prompt for some of these ideas by more direct questions if they don't emerge)

Respond to Judy's emotions [20].

- Don't argue about the facts. Let Judy know that you can see how upsetting this is. Reassure her that she is safe and that you are here and want to help.
- Don't lie. You don't have to pretend that you can see the children too. This usually doesn't help anyway.
- Keep calm, even when she talks about things or events that aren't real.
- In this scenario encouraging Judy to shift from her bedroom to a different room may help Judy to remove herself from her experience of 'the children'.
- Ask Karen to visit or to talk to Judy on the phone. Judy is calling for her daughter and the presence of Karen as a familiar person might be very reassuring for her
- Judy has a hyperactive delirium and is 'over alert', so overstimulation can wind things up further. There may be ways we can reduce the risk of Judy feeling overwhelmed, for example, turning off the tv or radio, reducing bright light, or just having one support person in the room at a time.
- If Judy wants to move we'll help her do this safely. We don't want to get into a cycle of repeatedly asking Judy to "sit down", 'sit down' 'sit down' because it may just wind her up even further.
- Gently remind Judy about who you are, what time of day it is, and where she is.

Additional points:

Delirium can cause a person to act out of character. Even though it is hard, try not to take what they say or do personally. They are not thinking clearly and are not themselves.

A person may or may not remember the experience of delirium afterwards. Some people may be distressed by memories of the upsetting hallucinations they had or how they acted. So they may need continued understanding and support even after the delirium has past.

One of the key things to remember is to respond to the emotion. The children under the bed may not be real but Judy's distress is very real.



Karen arrives but things get pretty tense

[read out loud]
"You should have known it was more than a cold, how did you let her get pneumonia? I feel like I can't trust you to look after Mum."



There are lots of labels we could use for how Karen is acting. We can see Karen as [21]:

- Aggressive
- Difficult
- Critical
- Unrealistic
- Demanding



But how might Karen be feeling? Let's listen a bit more carefully:



[read out loud]
I thought Mum and I were managing ok but this has really thrown me. I'm really busy at work and now I had to take today off to be with Mum.
I love Mum...but I'm feeling overwhelmed. Maybe I should have given up work. How are we going to cope if her dementia has got this bad? Mom had been coughing, and now, I feel terrible! I thought she just had a cold. I should have known this was more than a cold.
You should have known it was more than a cold, how did you let her get pneumonia? I feel like I can't trust you to look after Mum.

How might Karen be feeling?

Possible answers:

- Scared about what's happening to Judy
- Worried that Judy is getting worse
- Overwhelmed and worried about how she is going to cope
- Guilty -That she has failed as a carer
- Conflicted / guilty about having us (paid care-workers) involved: what if Judy is just another client to us and we don't really care. It can't be the same care as someone who really loves her
- Frustrated that we (paid care-workers) seem to ignore her or think that we know better
- Alone -That no one cares how she is doing and no one really understands
- Angry that her wonderful mother has been reduced to this

How does thinking about how Karen is feeling change the way we take her comments and how we respond?

Some learners will be able to respond to Karen's emotion and distress, and her love and concern for Judy. They may look for ways to provide / link Karen with validation, reassurance and education.

It's possible some learners will express frustration about 'difficult' care-partners. Allow an honest conversation. It may be helpful to provide / draw out stories of how passionately people feel they have to 'fight' for good care for the person they love. Do they think they would 'battle' if they felt they had to? Reinforce how thinking about the emotion may be helpful.

Anger is pretty normal in this type of situation. It's how people feel when they are losing control and things aren't going the right way. The problem with anger is that it can feel personally directed at us – after all, you can't be angry 'at delirium' – so where will those feelings go? If we get defensive that can make things worse.

Care-partners are experts about the family member they support.

They know the person's history and its meaning to them: their interests, their likes and dislikes, their joys and their fears.

They may hold the key to understanding the person's communication and behaviour if the person is having trouble expressing themselves.



How might Karen be a big help while we are supporting her mother [21]?

- Karen can spend time with Judy to help her feel calm and connected
- We can get her on the phone when Judy is agitated.
- Karen can help us understand Judy's perspective, for example that children have been very important in Judy's life as a mother and preschool teacher. I wonder if Karen knows who Susan is?
- Karen can help us get to know her mother and what helps to make her feel safe and what interests her.
- Karen can help Judy trust us.

At your place: Does your organisation have a document for care-workers recording information about interests etc, such as the care plan summary?

It is now three months later and the delirium is long gone. You are still supporting Judy. You've got great communication with her daughter Karen and all of you are keen for Judy to be able to remain at her current level of care.



Now our focus is turning to preventing delirium – in Judy's case preventing another episode of delirium



Is Judy at high risk of developing a delirium again? Why?

Yes Judy is at high risk because she is living with dementia (higher risk) and she has had delirium before (higher risk).



Having a dementia automatically puts older people into the high risk category for delirium, and the more other risk factors the person has the higher their risk of delirium.

Some of the main risk factors the person may bring with them into our care include:

- Having had a previous delirium, like Judy
- Poor vision: Not being able to read the newspaper headlines even when they are wearing their glasses. Our brains expect a certain level of sensory input. If our brain in deprived of sensory input it increases the risk of delirium.
- Being very frail or fracturing their hip or being severely unwell makes people more vulnerable, Interestingly that includes being severely depressed.

When a person has these existing vulnerabilities they are already a bit wobbly – and the more vulnerabilities they have the more wobbly they are –and it takes less to tip them over into a delirium.

Even something minor that we might not notice may trigger a delirium for someone who is vulnerable. We can think of the threshold being lower for what it takes to tip them over into a delirium



The most successful approach to preventing delirium is to target the common triggers that might tip a vulnerable person over into a delirium.

Anything that can be done to remove a trigger can help prevent delirium.



There is a lot of agreement in the research literature about the preventable risk factors we can focus on to effectively reduce delirium.

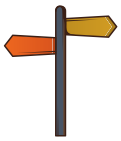
We can summarise these with a mnemonic –

PINCHES ME kindly

So the PINCHES comes from:
P for pain,
I for infection,
N for nutrition, and
C for constipation.
H is hydration,
E is for exercise, and
S is for sleep.

The ME from medication and environment and the kindly is how we do it [22].

The good news is that research shows that when we have a proactive 'think delirium' environment in place that tackles these possible triggers, we can reduce delirium by a third. The pioneer in the field was Sharon Inouye [pronounced "In-oh-ay"] and colleagues back in 1999 [17]. In the decades since a number of studies around the world have confirmed that we can reduce delirium by a third[22,23].



If your learners have previously completed the other Dementia Stars modules, you can run the prevention section as an activity to embed previous learning. Complete the activity below, and then have the groups share their answers as you go through the PINCH factors (pages 26-27).

OR

If you are using this module as a stand-alone session you can talk the learners through the content for the PINCH factors (pages 26-27). Skip the activity below and go directly to page 26.



Activity: Judy Jones and PINCHES ME kindly for learners who have completed all the Dementia STARs modules

Need: Summary handouts from relevant previous Dementia STAR sessions (see resource section)



Introduce the activity:
PINCHES ME kindly brings together a lot of what we have learnt together across dementia STARs. You are in a very good place to be able to spot if the different areas that we have covered in other sessions are a risk for Judy and to have ideas about what you might try.

Split the class into 4 groups / pairs. Provide the instructions out loud to each group so that the whole class can hear. (If your class is small, you could combine infection and hydration)

Group 1: Pain
Do you remember that when we were listening to Karen's story, we saw that Judy was using a walker? That's because she has severe arthritis in one of her hips, so Judy is at risk of pain. What might you do about that?

- Provide the pain module summary handout to the group.

Group 2: Infection
Do you remember that Judy was diagnosed with an aspiration pneumonia? That's one of the most common infections that triggers delirium amongst older people. So Judy is at risk of infection.
We want to help make sure that Judy is swallowing safely. What might you do about that?

- Provide the eating well and hand-under-hand handouts.

Group 3: Nutrition and constipation
Even though Judy has recovered from her pneumonia she is still losing weight and just doesn't seem to have the appetite to eat much. What might you do about that?

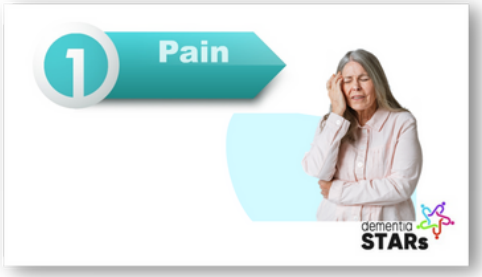
- Provide the eating well handout

Group 4: Hydration
Judy has been getting headaches and being a little more irritable than usual. You're wondering if she might be a bit dehydrated even though she's not complaining about being thirsty. What might you do about that?

- Provide the hydration handout.

Give the groups some time to come up with suggestions then bring the class back together. Have the groups report back for the relevant sections as you go through the PINCHES ME Kindly on pages 26 and 27.

Pain



Do you remember that when we were listening to Karen's story we saw that Judy was using a walker? That's because she has severe arthritis in one of her hips, so Judy is at risk of pain.

Either talk your learners through material below OR get a group to report their suggestions:

If we can help manage her pain we can help prevent delirium. People living with dementia may be less able to communicate that they are in pain or problem solve themselves so we need to be more proactive to:

- Observe – rather than waiting for Judy to tell us she is in pain, we can ask. We can watch out for signs of pain in Judy's expression, body language or changes in what she is willing to do.
- Understand – we can understand that Judy may express pain through her behaviour.
- Communicate – we'll report it if we suspect pain
- Help – we can realise that stress can make pain worse, so we may be able to provide reassurance and distraction.

Infection



Do you remember that Judy was diagnosed with an aspiration pneumonia? That's one of the most common infections that triggers delirium amongst older people. So Judy is at risk of infection. We want to help make sure that Judy is swallowing safely.

Either talk your learners through material below OR get a group to report their suggestions:

Aspiration pneumonia is caused when food 'goes down the wrong way'.

If you notice that someone coughs when they are eating, raise your concerns. A speech language therapist can assess whether a change in food texture may help safe swallowing. If Judy has been recommended a modified texture diet, we would make sure we understand what is involved and help support her.

The other really common infectious cause of delirium is urinary tract infections. One of the best ways to prevent UTIs is to encourage people to stay hydrated and we are going to look at that separately.

Nutrition and constipation



Even though Judy has recovered from her pneumonia she is still losing weight and just doesn't seem to have the appetite to eat much.

Either talk your learners through material below OR get a group to report their suggestions:

Many older people living with dementia have small appetites and we can think about how to encourage Judy to eat by making the most of the food experience. Having company when eating can often encourage people to eat more. Large meals can be overwhelming and we can think about little and often.

Constipation: You may be surprised to know that constipation can trigger delirium too. Regular toileting and lots of fluids, fibre, and exercise can help prevent constipation.

Hydration

Judy has been getting headaches and being a little more irritable than usual. You're wondering if she might be a bit dehydrated even though she's not complaining about being thirsty.



Either talk your learners through material below OR get a group to report their suggestions:

Dehydration impacts on cognition as it becomes more severe and will result in a delirium if it is not reversed. When someone like Judy is older and has a dementia, they may be less able to detect thirst. That means that we need to be more proactive about encouraging hydration and not wait until Judy feels thirsty.

We can use a range of strategies to provide more opportunities for favourite drinks and food throughout the day.

We have looked at our PINCH of PINCHES ME kindly, let's look at the rest

Exercise

Optional: We talked about moving as part of our falls module: move, improve, remove. What are some of the ways that we might encourage Judy to keep moving and mobile?



We can encourage Judy to keep moving and mobile by:

- Encouraging exercise
- Being open to opportunities to encourage movement, like walking with Judy to the table rather than bringing the meals to her
- Addressing anxiety about walking (especially if Judy has had a fall)

That movement might also help with pain, and appetite, and constipation, and sleep.

Sleep

A normal sleep / wake cycle helps to prevent delirium.



If you are providing support around Judy's bed time, you can encourage familiar bedtime routines and rituals that help her relax and know that it is bedtime and time to sleep. A warm drink and a little snack an hour or so before bedtime can be useful.

But even if we aren't around at bedtime we can still help. Remember "active days help peaceful nights". Activities, routine, and companionship can help a person distinguish between night and day, as well as tire them out to get a good night's sleep.

Light during the day can also help us sleep at night. We can make sure we open the curtains to let in natural light during the day. If we can find a way for Judy to spend some time outside during the day, that can tick all the boxes!

Medication

Some types of medication can increase the risk of delirium, as can being on lots of different medications. Judy's health care team may review her medications to check if they are all needed.



Some types of medication can contribute to delirium if they are stopped suddenly. Always report your concerns if you notice that someone isn't taking their medication as intended.

Environment

Engaging with our surroundings and being aware of what is going on around us can help prevent delirium.



Be HOUSE proud:

- Help Orientate by dropping reminders into conversation about where they are and what's going on.
- Use Sensory aids: Make sure that glasses and hearing aids are working, and worn – for glasses that might include cleaning them.
- Engage in lots of activities –cognitively and socially stimulating things or just providing some nice sensory input.

Optional question. What are some ideas for sensory engagement from the sensory session that you might try for Judy in your role?

Kindly

The fact we are needed in a person's life generally indicates that things aren't perfect for them. Be calm. Be patient. Be mindful of them as a person and their emotional needs, actually just be kind. When we are stressed our bodies produce cortisol, and increased cortisol is associated with higher risk of delirium. So a great environment and kind care can have a physiological impact to help prevent delirium.



These are all things that we hope we might be doing anyway, but PINCHES ME kindly reminds us to be thinking about these things consistently. It's that consistency that helps prevent delirium.
Thinking PINCHES ME kindly is also an important part of our strategy when we are managing an episode of delirium too – we need to get those triggers out of play.

What a huge amount we have covered today, and what a huge amount you have all contributed. I think the people you support (like Judy)will be in safe hands as you suspect, support, and prevent delirium.

Provide summary handouts, certificates, and feedback forms.



AT YOUR PLACE

Here are a few questions to reflect on before you facilitate the session, to help make the session relevant and effective in your organisaton.

DELIRIUM RESOURCES

Does your organisation have a delirium risk form? How are all staff made aware of the identified risks? How are these integrated into the care plan? How is a diagnosis of dellirium documented and shared?

LINE OF COMMUNICATION:

Who (specifically) should learners talk with if they have concerns about delirium?

ORGANISATIONAL CULTURE:

Does you organisation have delirium awareness as a priority? If your organisation is keen to embark on quality improvements around dementia to support this education, a Delirium Aware Toolkit for managers is available at https://www.sialliance.health.nz/programmes/health-of-older-people/useful-resources/

YOUR CHECKLIST FOR THE DAY

Here are some of the things you may want to take with you

- [ ] Audiovisual equipment with PowerPoint presentation loaded
- [ ] Whiteboard pens and either a whiteboard or large paper pad to record learners' responses for activities
- [ ] This facilitator's guide
- [ ] Summary handout (2 pages)
- [ ] Going further handout
- [ ] For activity (if applicable): Pain, Infection, Hydration, Eating Well handouts
- [ ] Feedback forms
- [ ] Certificates of completion
- [ ] If applicable, you may wish to bring print-outs of the delirium prevention resources used at your place.



3. Resources

Delirium and dementia

DELIRIUM AND DEMENTIA

ARE THEY DIFFERENT TODAY?

During your interaction with the person today,
have you noticed a sudden change in any of these things?



It could be a delirium: report it.



If you notice sudden changes for the worse in thinking, memory or personality, report it immediately. When there are more changes, more severe changes, and/or the changes last longer, it is more likely that a delirium is present.

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THINK DELIRIUM PREVENTION & MANAGEMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha



One third to one half of delirium that occurs while older people are in our care can be prevented by addressing these risk factors

Think
PINCHES ME
kindly

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GOING FURTHER...
5 GREAT RESOURCES ON DELIRIUM

1 BOOKLETS

THINKdelirium, CDHB, has resources available including booklets for staff and families on tips for addressing risk factors and poster

http://edu.cdhb.health.nz/Hospitals-Services/Health-Professionals/think-delirium/Pages/default.aspx



2 POSTER



Are they different today? This poster summarising recommendations for addressing risk factors was developed in residential care by a collaboration from Tees in the UK.

https://pbs.twimg.com/media/DVJN9HoX4AYT2f7.jpg

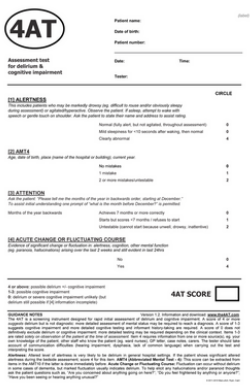
3 VIDEO



#DeliriumReady (UK) has a 4 minute summary video about delirium superimposed on dementia and a 5 minute summary of being delirium ready that contain a lot of useful information

https://madeinheene.hee.nhs.uk/PG-Dean/Faculty-of-Patient-Safety/Delirium-Project/Delirium-Resources

4 TOOLS



The 4AT is a tool that can be used to screen for delirium

https://www.the4at.com/

5 HANDOUTS



The Stop delirium project, from the European Delirium Association, has supporting materials available including seven 'pathway' handouts for different risk factors and a video. These were developed in residential care settings.

http://www.europeandeliriumassociation.org/stop-delirium-project_teaching-material.html

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Feedback on DELIRIUM & DEMENTIA

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY DISAGREE
I understand more about deliirum	○	○	○	○	○
I feel more motivated to prevent delirium	○	○	○	○	○
I will be able to use what I learnt in my work	○	○	○	○	○
It was worthwhile coming	○	○	○	○	○

WHAT IS THE MOST IMPORANT THING YOU LEARNED TODAY?

WHAT IS YOUR GENERAL FEELING ABOUT THIS EDUCATION SESSION?

WHAT ARE YOU GOING TO DO DIFFERENTLY?

THANK-YOU FOR YOUR FEEDBACK, IT IS APPRECIATED

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CERTIFICATE

OF COMPLETION

_____

has completed the Dementia STARs
Delirium and Dementia Module

Date _____

Signed _____

Organisation _____

DELIRIUM

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Resource & activity sheets

On the following pages you will find additional handouts to use during the PINCHES ME kindly activity during the session:

- Pain module handout
- Hand under hand technique handout from Eating well module
- Eating well handout
- Hydration handout

PAIN AND DEMENTIA: THINK O.U.C.H.

YOU HAVE A SPECIAL ROLE

Some people living with dementia aren't able to say that they are in pain or make it better. Remember O.U.C.H.



O: OBSERVE

Ask about pain. Learn about the person and what is normal for them. Look and listen for clues from their face, body language, noises, behaviour, and mood.



U: UNDERSTAND

Pain is personal: only the person can know their own pain. We can't decide that someone "shouldn't" be feeling pain. If you see change in the person, consider pain.



C: COMMUNICATE

Ask for information to help you understand,, families can be a helpful resource. Report likely pain. Describe the clues as clearly as you can.



H: HELP

Comfort, reassurance, and distraction can help. If you make a change to help pain check if it made a difference. No? Report and try something else. Yes? Share what works.

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HAND UNDER HAND TECHNIQUE™

Developed by Teepa Snow, this simple technique helps us do tasks WITH the patient.

1. **Take their dominant hand** as if you were going to shake hands.
2. **Move your grip to hold their thumb.**
3. **Rotate you hand so that their hand is on top.** (keep chatting meanwhile)
4. **Move so that you are beside them shoulder to shoulder** but still in sight (or if you can't do that, make sure to get down to their eye level).
5. **You hold the utensil.**
6. **"Listen' to what their arm is doing for cues to help get the pace right.**

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TOP QUICK TIPS EATING WELL AND DEMENTIA

Eating well

As dementia progresses there can be lots of changes that impact on whether someone feels like eating.

This means that many people living with dementia are not eating well, and there are high rates of malnutrition.

Encourage

- Make the most of the experience: make food a pleasure, get to know the person and what they like.
- Make the most of senses: use contrast and make the food appealing, make up for losses of taste and smell; involve the person.
- Make the most of food: try little and often, snacks, and added energy.

Enable

- Make eating easier: consider adaptive equipment and finger food.
- Make assistance enabling: we want to enable the person to do as much as possible. Consider the Hand under Hand™ technique.

Adapt

- Adapt for swallowing problems: Watch out for coughing around meals as a sign, support modified diets.
- Adapt by problem solving: If a person isn't eating well, brainstorm reasons why and try out a range of ideas.

And remember

Food can be a sign of love and a source of pleasure.
Kilojoules and nutrients are important but food is so much more than that.



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HYDRATION AND DEMENTIA

Helping hydration is a simple way you can make today a better day for the people you support: it improves mood, alertness, and energy and helps to prevent many health problems.

Don't wait

Water is good for our organs, brain, heart, joints, and skin. As we age our thirst, kidney function, and body water reserves decline which makes us more at risk of dehydration. Older people may not show the usual signs of dehydration like thirst or darker urine. Don't trust thirst to guide drinks: we need to be proactive.

Hydrate

Make a daily routine with frequent moments for drinking, so that people are prompted to drink one of their preferred drinks in their preferred cup. Try to make drinks appealing and noticeable. Provide company if you can. Mornings can be a great time to boost fluid. We can provide fluid through a wide range of drinks, juicy fruit and vegetables, soups and sauces.

Stick to thick

If someone has been put on a thickened fluid diet by a speech language therapist then it is important that we stick to it. This helps to prevent aspiration pneumonia. Mildly thick fluid is like apricot nectar, moderately thick is like golden syrup, and extremely thick is like instant pudding. Possible tricks to look out for are food that melts like ice cream or jelly, fruits that are very juicy, and meals with mixed textures. Thickened fluid can be less appealing so we can think about flavour, temperature, and finding options that are expected to be thicker.



Don't wait, hydrate!

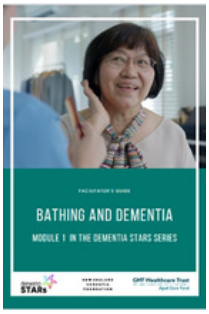
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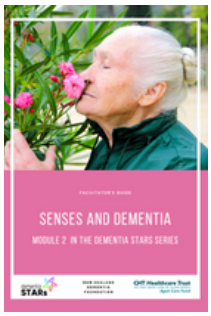
CONTINUE LEARNING WITH THE DEMENTIA STARS SERIES

We are delighted to offer eight Dementia STARs modules in this series. The Dementia STARs programme is an opportunity to reinforce a shared culture of person-centred care. Each kit offers all the tools needed to run an engaging introductory education session for direct care-workers and other staff.

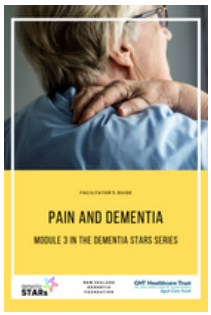
You can find the full series online at nzdementia.org/Dementia_STARs



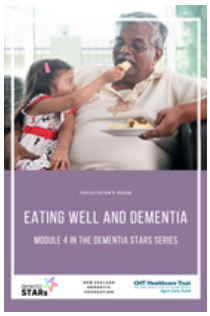
1: Bathing and dementia



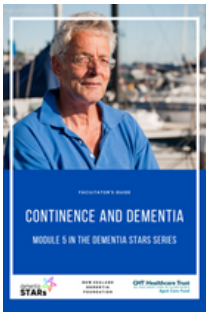
2: Senses and dementia



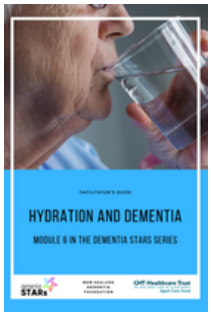
3: Pain and dementia



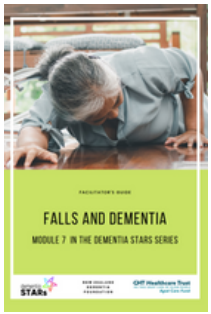
4: Eating well and dementia



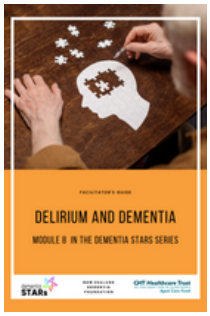
5: Continence and dementia



6: Hydration and dementia



7: Falls and dementia



8: Delirium and dementia

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