

# Best care for older people everywhere

The toolkit 2012





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## Disclaimer

*Best care for older people everywhere* — *The toolkit* is not intended to give information or guidance about how to diagnose or treat patients' primary diagnosis or reason for admission to hospital. Rather, it is a guide on how to prevent and minimise the problems associated with hospitalisation that can occur in addition to the primary diagnosis.

All sections of *The toolkit* focus on interventions that will improve the functional status of hospitalised older people. The need for tailored interventions due to clinical conditions, such as therapeutic diets or interventions that require the expertise of specific health care professionals, have not been addressed.

## Accessibility

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## Abbreviations list

<b>3MS</b>	Modified Mini-Mental State Examination	<b>Intervention</b>	Therapeutic diagnostic procedures, increasing nursing care or monitoring.
<b>AAC</b>	Augmented and Alternative Communication	<b>IQCODE</b>	Informant Questionnaire on Cognitive Decline in the Elderly
<b>ACAS</b>	Aged Care Assessment Service	<b>MEMS</b>	Modified Elderly Mobility Scale
<b>ACD</b>	Advance Care Directive	<b>MHR</b>	Medication History and Reconciliation
<b>ACP</b>	Advance Care Planning	<b>MMSE</b>	Mini-Mental State Examination
<b>AMT</b>	Abbreviated Mental Test	<b>MNA-SF</b>	Mini Nutrition Assessment Short Form
<b>ASSIST</b>	Acute Screening Swallow in Stroke and TIA	<b>MRI</b>	Magnetic Resonance Imaging
<b>BPSD</b>	Behavioural and Psychological Symptoms of Dementia	<b>MRS</b>	Medication Risk Screen
<b>CAAS</b>	Continence Aids Assistance Scheme	<b>MST</b>	Malnutrition Screening Tool
<b>CAM</b>	Confusion Assessment Method	<b>MUST</b>	Malnutrition Universal Screening Tool
<b>COAG LSOP</b>	Council of Australian Governments Long Stay Older Patients Initiative 2006-2010	<b>NARI</b>	National Ageing Research Institute
<b>Comprehensive Assessment</b>	A detailed inter-disciplinary process incorporating history taking, examination, observation, measurement, testing and evaluation regarding medical, physical, social, cultural and psychological dimensions of need.  It aims to diagnose the exact nature of problems in order to plan and deliver appropriate preventions, interventions and management strategies to reduce identified or potential risks.  Person-centred assessment is conducted in partnership with patients and their families or carers.	<b>NGT</b>	Nasogastric Tubes
<b>CT</b>	Computerised Tomography	<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>DEMMI</b>	The de Morton Mobility Index	<b>NIMC</b>	National Inpatient Medication Chart
<b>DSM-IV</b>	Diagnostic and Statistical Manual of Mental Disorders-IV	<b>NOPAIN</b>	Non-Communicating Patient's Pain Assessment Instrument
<b>DVA</b>	Department of Veterans' Affairs	<b>NPS</b>	National Prescribing Service
<b>EBIT</b>	Evidence Based Identification Tool	<b>NRS</b>	Numeric Rating Scale
<b>ED</b>	Emergency Department	<b>PACSLAC</b>	Pain Assessment Checklist for Seniors with Limited Ability to Communicate
<b>FAM</b>	Functional Assessment Measure	<b>PAINAD</b>	Pain Assessment in Advanced Dementia
<b>FEES</b>	Fibreoptic Endoscopic Evaluation of Swallowing	<b>PEG</b>	Percutaneous Endoscopy Gastrostomy
<b>FIM</b>	Functional Independence Measure	<b>PEPA</b>	Program of Experience in a Palliative Approach
<b>FMP</b>	Functional Maintenance Program	<b>OT</b>	Occupational Therapy
<b>GEM</b>	Geriatric Evaluation and Management	<b>ReVIVE</b>	Recruitment of Volunteers to Improve Vitality in the Elderly
<b>GP</b>	General Practitioner	<b>RUDAS</b>	Rowland Universal Dementia Assessment Scale
<b>GSS</b>	Gugging Swallowing Screen	<b>SHPA</b>	Society of Hospital Pharmacists of Australia
<b>HACC</b>	Home and Community Care	<b>SNAQ</b>	Simplified Nutrition Appetite Questionnaire
<b>HELP</b>	Hospital Elder Life Program	<b>SNAQ®</b>	Short Nutritional Assessment Questionnaire
<b>IC4OP</b>	Improving Care for Older People	<b>SSSL</b>	Safer Systems Saving Lives
		<b>TENS</b>	Transcutaneous Electrical Nerve Stimulation
		<b>TOR-BSST</b>	Toronto Bedside Swallowing Screen
		<b>TRAC</b>	Triage Rehabilitation and Aged Care
		<b>VA&amp;EP</b>	Victorian Aids and Equipment Program
		<b>VAS</b>	Visual Analogue Scale
		<b>VDS</b>	Verbal Descriptor Scale
		<b>VMBS</b>	Videofluoroscopic Modified Barium Swallow
		<b>WHO</b>	World Health Organization

# Introduction

Welcome to *Best care for older people everywhere – The toolkit*, 2012 edition. *The toolkit* provides clinical information and identifies tools and resources that can help health services to improve care for older people in hospital and throughout the care continuum. It forms part of the Victorian implementation of the Council of Australian Governments Long Stay Older Patients (COAG LSOP) initiative, which defines older people as those aged 65 years or over and Aboriginal or Torres Strait Islanders aged 45 plus.

Further information about Victoria's approach is available at <[www.health.vic.gov.au/older](http://www.health.vic.gov.au/older)> and below in the *Policy* section.

A philosophy of person-centred care underpins the overall approach to *The toolkit* and its accompanying tools and resources. This means treating older people with respect and as equal partners in the healthcare relationship.

Functional decline is a reduced ability to perform activities of daily living due to a decrease in physical or cognitive functioning [1]. It is the focus of this toolkit because of the high percentage of older patients (34–50 per cent) who experience functional decline in hospitals.

Functional decline can occur as early as day two of hospitalisation. In 30 per cent of hospitalised older people, functional decline is unrelated to their primary diagnosis. At three months following discharge only 50 per cent recover from functional decline. This can adversely affect a patient's choice of discharge destination from hospital and their ability to return to their preferred setting [1].

Many interdependent problems, including under-nutrition, falls, skin tears, pressure ulcers, delirium, depression and pain, can be prevented or minimised during hospital admission. This can reduce an older person's length of stay in hospital, thereby further minimising the risk of functional decline and leading to improved independence on discharge.

The 2012 update of the *The toolkit* includes the new domains of *Communication*, *Pain*, and *A palliative approach to care*, along with information regarding advanced care planning and swallowing impairments.

*The toolkit* is closely aligned to the Australian Commission on Safety and Quality in Healthcare National Safety and Quality Health Service (NSQHS) standards <<http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/NSQHS-Standards-Sept2011.pdf>>. While *The toolkit* was not developed in response to the national standards, it provides a valuable resource to assist health services with planning to meet them. To access a matrix document, developed by South Australia Health, that highlights the link between the NSQHS standards and *The toolkit* visit <[www.sahealth.sa.gov.au/wps/wcm/connect/b7dfcb804aac5ecf9305f37633bbffe0/NSQHSStandardsToolkitMatrix-PHCS-SandQ-1205.pdf?MOD=AJPERES&CACHEID=b7dfcb804aac5ecf9305f37633bbffe0&CACHE=NONE](http://www.sahealth.sa.gov.au/wps/wcm/connect/b7dfcb804aac5ecf9305f37633bbffe0/NSQHSStandardsToolkitMatrix-PHCS-SandQ-1205.pdf?MOD=AJPERES&CACHEID=b7dfcb804aac5ecf9305f37633bbffe0&CACHE=NONE)>

## Why should I be concerned about functional decline in older people?

### Older people are the main clientele of Victorian hospitals

Although people aged over 65 years comprise less than 14 per cent of the Australian population [2], they account for 35% of hospital admissions and almost half of hospital bed usage [3]. In Victoria, more than 46 per cent of multi-day patient stays are for patients aged over 70 years. The majority of this hospital usage is for appropriate acute and subacute care.

A very small proportion of hospital stays among older people in Victoria are due to people waiting for residential aged care beds. (In a Victorian hospital bed census conducted in June 2005 only 367 people were waiting for residential care, a 40 per cent reduction from the 2001 census.)

### The Victorian population is ageing

Between 2003 and 2021, the Victorian population is predicted to increase by 19 per cent. However, during that same period, the proportion of people aged 70–84 years and 85 years and over is expected to increase by 59 per cent and 74 per cent respectively. As the population ages, we can expect to see greater numbers of older people in Victorian hospitals. Hospital use increases with age, as older people are more likely to suffer from chronic illnesses and experience acute health problems, such as heart attacks, falls and fractures.

### Hospitals can be dangerous for older people

Some of the problems that older people experience in hospital include:

- under-nutrition and dehydration – due to older patients' inability to manage their meals and drinks independently, unfamiliar or unpalatable hospital food, missed meals due to conflicting appointments or interrupted meals and reduced appetite due to illness or lack of activity
- decreased mobility and loss of independence – due to patients staying in bed, lack of incidental activity, illness, pain or impairment
- pressure injuries – due to poor mobility or lack of circulation
- incontinence – due to lack of mobility, poor orientation to the toilet, lack of access to toilets, use of continence aids, constipation or effects of medication
- falls – due to impairment, environmental hazards or poor orientation
- delirium – due to infection, sleep deprivation, immobility, dehydration, pre-existing cognitive impairment or medication
- medication errors – due to taking incorrect medication, incorrect dosages or medication side effects
- depression – due to ill health, loss of function or poor recovery
- communication breakdowns – due to vision, hearing and/or speech impairments.

These problems occur in addition to the patients' presenting conditions. They can impede recovery, increase length of stay and lead to reduced functioning, not only when compared to pre-morbid functioning, but when compared with a person's functioning on admission to hospital.

### What can I do to reduce functional decline in older people?

As clinicians working in a hospital we can make a difference. What we do, or don't do, will affect an older person's likelihood of functional decline. An important thing we can do is to be person-centred in our practice. Put simply, this means treating older people with respect and as partners in the healthcare relationship. We need to listen to the older person, take time to get to know them and engage with them as an equal.

There are some very practical things we can do; for example, we can ensure every patient is oriented to the ward environment so they:

- know how to get to the bathroom
- have a call bell within reach
- know where the nurses' station is
- know where to go for meals, if dining in a dining room.

Patients may need to be reminded on more than one occasion.

### **Encourage incidental activity and independence**

It is very important that older people are kept as mobile and independent as possible while in hospital. This will help to reduce falls, improve appetite, reduce muscle deterioration and reduce the risk of pressure ulcers.

### **Encourage self-care**

It is important to encourage older people to do as much as possible for themselves. Personal activities of daily living that can be maintained in hospital include showering, dressing, shaving and applying make-up. These activities not only promote independence but help patients to maintain their dignity and encourage them to participate in other activities.

### **Encourage hydration**

Adequate hydration is very important in reducing the risk of infections, delirium and incontinence. Ensure fluids are:

- palatable to the patient
- replenished regularly
- within reach, and that the patient can refill their glass or get help to do so.

### **Ensure adequate nutrition**

Adequate nutrition is important to reduce the risk of functional decline. Ensure:

- food is palatable to patients
- patients have adequate set-up and access to their food
- patients have enough time to eat
- distractions during mealtimes are limited
- swallowing impairments are identified and appropriately managed.

### **Monitor skin integrity and take steps to prevent pressure areas and skin tears**

- Avoid using soap.
- Encourage patients to remain as mobile as possible.

These are just some of the things you can do. There are more tips on reducing patients' risk of functional decline in *The toolkit*.

## How was *The toolkit* developed?

### Policy

In November 2003 the Victorian Government launched the Improving Care for Older People (IC4OP) policy (see <[www.health.vic.gov.au/older](http://www.health.vic.gov.au/older)>). The objectives of the policy were to:

- better understand older peoples' healthcare needs
- improve integration of care
- adopt a strong, person-centred approach.

Substantial health service achievements as a result of the IC4OP initiative can be found online at <[www.health.vic.gov.au/subacute](http://www.health.vic.gov.au/subacute)>.

Just as IC4OP was winding up, funding was secured from the COAG LSOP initiative for 2006 to 2010. This initiative aims to prevent people reaching a 35-day stay in hospital and divert the potential requirement for a residential aged care placement.

The COAG LSOP funding provided Victoria with the opportunity to continue to build on the existing IC4OP and Hospital Admission Risk Program (HARP) initiatives. Victoria's implementation of COAG LSOP has focused on improving the capacity of health services to provide more appropriate care for long-stay older patients in public hospitals and, where possible, reduce avoidable or premature admissions of older people to hospitals. In the event that a hospital admission is required, improved care would focus on minimising the functional decline of older people.

The 2012 edition of *The toolkit* continues to build on the foundation set by the IC4OP policy.

### Evidence base

A number of national resources that aim to support improved care of older people have been developed. The resources, available at <[www.health.vic.gov.au/acute-agedcare](http://www.health.vic.gov.au/acute-agedcare)>, have contributed to the information contained within this toolkit, in particular, the 2004 *Best practice approaches to minimise functional decline in the older person across the acute, subacute and residential aged care settings*, which is available online at <[http://docs.health.vic.gov.au/docs/doc/B7EBD633505C09E5CA257852000F0D42/\\$FILE/functional-decline-manual.pdf](http://docs.health.vic.gov.au/docs/doc/B7EBD633505C09E5CA257852000F0D42/$FILE/functional-decline-manual.pdf)>.

In preparing to develop *The toolkit*, the department engaged the authors of the best practice document, the Clinical Epidemiology and Health Service Evaluation Unit at Melbourne Health, to update the resource. Published in 2007, this resource can also be found on the acute aged care website listed above.

The best practice document, and its updated version, identify the following areas of functional decline: cognition (which includes delirium, dementia and depression); mobility, vigour and self-care; continence; nutrition; and skin integrity. Three additional domains were included in the 2009 edition of this toolkit due to their potential impact on the functional decline and quality of care of older people: assessment; person-centred practice; and medication.

## Development of *The toolkit* 2009 edition

While the best practice documents provide evidence-based guidelines, a need was identified for a resource that could provide practical, user-friendly tools to assist staff working in hospitals to minimise functional decline in older people. *The toolkit* aims to provide a ‘how to’ approach to accompany the information in the resource, make it more accessible to clinicians working in hospitals, and support the transfer of evidence-based guidelines into practice.

Work on *The toolkit* began in July 2007, with 10 health services appointed as lead agencies for a specific domain under the umbrella of minimising functional decline of older patients in hospital settings. Each lead agency worked in conjunction with at least two partner agencies, and a regional representative (see Table 1), to identify or develop resources within their domain of expertise.

**Table 1: COAG LSOP The toolkit domain teams**

Domain	Lead agency	Partner agencies	Regional partner
Assessment	Western Health	Alfred Health <sup>1</sup> Northern Health	Loddon Mallee
Skin integrity	Eastern Health	Austin Health Alfred Health	
Continence	Austin Health	Eastern Health Southern Health	Hume
Person-centred practice	Northern Health	Southern Health Latrobe Regional Hospital	
Mobility, vigour and self-care	Peninsula Health	Austin Health Eastern Health	Gippsland
Nutrition	Alfred Health	Melbourne Health Peninsula Health	
Delirium	Melbourne Health	St Vincent's Health Western Health	Barwon-South Western
Dementia	Ballarat Health	Barwon Health St Vincent's Health Western Health	
Depression	Southern Health	Calvary Healthcare Bethlehem Melbourne Health	Grampians
Medication	St Vincent's Health	Werribee Mercy Northern Health Peninsula Health	

<sup>1</sup> Formerly Bayside Health

Each domain team conducted a literature and resource review to explore resources and tools available in their domain area. They then field tested the resources and tools in one, or more, parts of their own and their partner health services' and decided which tools should be included in *The toolkit*.

The National Ageing Research Institute (NARI) provided ongoing support for health services, developed the framework and compiled *The toolkit*.

### Development of *The toolkit* 2012 edition

A four-month field test and evaluation of the first version of *The toolkit* began in August 2008 before going to print in 2009. A second evaluation of the accompanying website ([www.health.vic.gov.au/older/toolkit](http://www.health.vic.gov.au/older/toolkit)) was undertaken six months after it was launched in May 2010. These evaluations identified opportunities for further expanding *The toolkit*.

Although advance care planning was mentioned in the 2009 edition under person-centred practice, there was an opportunity to expand this information in the 2012 edition. The advance care planning information in the 2012 edition was provided by the department's Ageing and Complex Care Unit, with input from *The toolkit* review advisory committee.

Additional areas were soon identified: pain; communicating with older patients with vision, hearing and/or speech impairments; and swallowing impairments were all seen as impacting on functional decline in older people in hospital.

For some older people in hospital, best care does not have minimising functional decline as a primary aim, therefore a domain devoted to a palliative approach to care has been included in the 2012 edition, which was completed in January 2012.

The same method was used to develop the *Pain* and *Communication* domains, as well as for the *Swallowing* information included after the *Nutrition* domain:

- A review of the current literature was conducted.
- Scoping surveys were sent to health services across Victoria to identify current practices and resources.
- Key messages and resources were identified from the literature and surveys.
- Identified resources were reviewed to ensure the best resources would be included.
- The new sections were written to be consistent with the rest of *The toolkit*.
- Experts in the respective fields reviewed and recommended amendments to the drafts.

The *Pain* domain was completed in June 2010 and the *Communication* domain was completed July 2012. It is important to note that within the context of the new *Communication* domain the term communication is narrowly defined, referring only to patient–staff interactions within a hospital setting. Furthermore, this domain only considers vision, hearing and speech impairments commonly experienced by older patients. Language barriers and other barriers to communication are not addressed in this domain.

The information for the *Swallowing* domain was completed July 2012. The *Palliative approach to care* domain was developed with the guidance of an expert advisory group using a similar process as outlined above, only this time including focus group testing. Focus groups with health service staff were undertaken at one metropolitan and one regional Victorian health service to determine what staff already knew and would like to know about taking a palliative approach to care with older patients. Key messages and resources were identified from both the literature and the focus groups.

The department engaged NARI to work on updates for the 2012 edition, with *The toolkit* advisory committee providing assistance and advice throughout.

## Who should use *The toolkit*?

*The toolkit* can be used by anyone interested in improving the care of older people in hospital settings. It can be used in different ways by clinicians, team leaders and people with organisation-wide responsibilities.

Clinicians can use *The toolkit* as a stand-alone resource that will give them a 'how to' guide to minimising functional decline in older people.

Team leaders, quality managers and project officers can use *The toolkit* to introduce or evaluate practices and processes within their team, ward or hospital.

Although the focus is mainly on acute and subacute hospital care, some of the tools and resources may be applicable to pre-admission, community or residential care settings.

## How can I use *The toolkit*?

This toolkit is a hardcopy guide. The resources and reviews contained within it can be found at <[www.health.vic.gov.au/older/toolkit](http://www.health.vic.gov.au/older/toolkit)>.

Each domain has a representative symbol used to indicate where further information can be found within another domain. It is a recognised limitation of the 2012 print edition of *The toolkit* that the 2009 domains have not been updated to link to the information added in 2012.

The domains, symbols and relevant sections and information are outlined in Table 2.

## Domain symbol guide

Table 2: Domain symbol guide to refer to throughout the toolkit

Section	Symbol	Domain	Section	Symbol	Domain
1		Person-centred practice	9		Delirium
2		Advance care planning	10		Dementia
3		Assessment	11		Depression
4		Communication	12		Continence
5		Mobility, vigour and self-care	13		Medication
6		Nutrition	14		Skin integrity
7		Swallowing	15		Pain
8		Cognition	16		A palliative approach to care

**Each domain contains:**

- five tips (main things to remember) about the domain that you might like to use as a starting point
- information about the domain
- why the domain is important
- how to identify problems in the domain area
- how to prevent these problems from occurring
- how to manage the specific issues if they do occur, including strategies for patients and their families or carers
- what needs to be considered for discharge
- an illustrative case study.

Within each of these sections, other symbols indicate where further information can be located, as shown in the Table 3.

**Table 3: Symbols for further information, resources or tools**



**Further reading or reference**



**Information for families or carers**



**Resource or tool**



**Training or educational resource**

The tools and resources referred to in each section can be accessed online at <[www.health.vic.gov.au/older/toolkit](http://www.health.vic.gov.au/older/toolkit)>.

It is a recognised limitation of the 2012 print edition of *The toolkit* that the 2009 edition domains do not reflect the results of a review of *The toolkit* website completed in 2011.

A relaunch of the updated website is scheduled before the end of 2012.

Embedded in the website version of *The toolkit* are links to relevant tools or resources.

The link will take you to a resource review that contains relevant information about the resource or tool including:

- name and setting
- who it is to be used by
- who it is to be used for
- structure of the tool
- availability and cost

- field testing results if applicable
- applicability in rural settings
- person-centred principles
- training requirements
- administration
- data collection and analysis
- psychometric properties
- strengths and limitations
- further reading and references.

In many cases the actual resource or tool is located within the resource review under 'Availability and cost'.

Some tools have a field-testing template embedded in the review. This has been completed for tools and resources that were developed by the domain leads as part of this project. These include information about how the tool was tested and the main findings.

Copies of some resources or tools are not included in *The toolkit* due to copyright or other issues.

Refer to the resource reviews for information on how these can be obtained.

## Implementing *The toolkit*

Although there are many ways to approach implementation, with no one way considered correct, the approach outlined in the following section is based on the 'how to' guide.

The 'how to' guide has been developed for governments and health services, at both the organisational and team levels, highlighting that a range of activities are required to support implementation. The guide, *Turning knowledge into practice in the care of older people*, can be found online at <[www.health.vic.gov.au/acute-agedcare](http://www.health.vic.gov.au/acute-agedcare)>.

In implementing *The toolkit*, health services:

- don't have to use all the tools and resources available
- should not look to *The toolkit* as the only source of tools and resources available.

Networking with other health services is recommended and sharing other tools and resources is encouraged.

### Steps for successful implementation

The five steps, adapted from *Turning knowledge into practice in the care of older people*, are:



#### 1. Define

The project definition phase involves identifying the 'area of interest' or potential problem area. This is when to ask 'What do we want to achieve?'.

All quality improvement projects begin with the question, 'What are we trying to accomplish?'. This involves identifying an 'area of interest', which, depending on your setting and your patient or client population, could be as broad as 'improving the care of older people', or it could be as specific as 'preventing falls among older people in hospital' or 'introducing a process to reduce post-operative delirium'.

So how do you actually decide where to start in improving care for older people?

If there are no clear priorities for addressing the care of older people in your organisation, or if there seems to be conflicting priorities, a formal group exercise called a quality impact analysis can be useful.

This is a brainstorming activity that enables a structured consideration of the potential problems and opportunities for improvement. As with all brainstorming activities, it is important that you involve relevant stakeholders in this activity to avoid bias.

Based on a list of problems or potential quality initiatives, as well as supporting data, copies of the relevant knowledge resources and other inputs, the group may be asked to identify five things that:

- are done frequently in relation to the care of older people
- involve risk for older people
- are of concern to staff or clients in relation to managing older people.

Participants are then asked to score each item based on the frequency, risk level and general level of concern. Scoring may be, for example, from one to three, where one equals low frequency, risk or concern, and three equals high frequency, risk or concern. The highest scoring topics should indicate the priority of topics for attention and should be confirmed with appropriate data. The activity may be adapted to address a range of other criteria, such as cost or clinical effectiveness.

## 2. Diagnose

There are several steps to consider in diagnosing priority areas for implementation. These include baseline data collection and identifying gaps in service provision.

Some domains contain audit tools to help diagnose the current status of care. These audit tools can be used to collect baseline data and assess these service gaps.

Other methods to identify priority areas include complaints data, consumer reference groups, incident reports, key performance indicators, clinical indicators and opinions of staff.

*The toolkit* can be used to implement a number of domains across the continuum of care or a targeted approach can be used to identify one specific issue in one specific ward.

### Prioritise guideline recommendations

- It is important to identify a starting point for implementation.
- The starting point should be an area in which there is good support and adequate resources, and in which visible gains can be achieved. Early successes will help generate further support for more complex and risky implementation.
- Diagnosing the current status of the health service will help identify priorities.
- As the domains are interdependent, sustained implementation of one domain will lead to improvements in other domains.

### Identify facilitators

- It is important to identify and utilise facilitators in implementation.
- Quality committees are important resources to approach. They have expertise and resources that can assist in implementation.
- Senior staff and clinical leaders can also be beneficial to implementation.

### Identify barriers

- It is important to recognise that there will be barriers to implementation.
- Potential barriers to implementation should be identified early in planning and strategies developed to overcome them.
- Barriers related to infrastructure can be challenging to overcome.

### Plan for sustainability

- It is important to plan for the ongoing sustainability of changes.
- Refer to the *Sustain* section below for how to incorporate sustainability into planning.

### Plan for evaluation

- It is important to plan to evaluate the implementation from the beginning.
- Evaluation data can be used to demonstrate uptake and sustainability and generate support for the implementation.
- Refer to the *Measure impact* section for further evaluation methods.

### **Assess costs**

- Implementation may have associated costs.
- It is important to research and estimate costs and benefits to provide reasons for undertaking the implementation.

### **3. Intervene**

- *The toolkit* provides the resources to use during the implementation phase.
- Select and adapt the resources best suited to the needs of your health service.

Every resource does not need to be implemented to be successful and improve care.

### **4. Measure impact**

- Your health service may have developed performance indicators that can be used to measure performance.
- Any baseline data can also be collected again to compare the results before and after implementation. This may include complaints data, consumer reference groups, incident reports, key performance indicators, clinical indicators and the opinions of staff.

### **5. Sustain**

There are many strategies to build sustainability into the proposed changes.

#### **Redesigning systems**

- Redesigning systems that support implementation is a powerful way to build-in sustainability.
- Adjusting systems that support implementation provides a solid support for ongoing sustainability.
- Redesigning systems can be a large and complex task, requiring support from many different stakeholders.

#### **Documentation**

- Appropriate documentation is necessary to measure implementation and sustainability.
- Documentation can act as both a reference and a communication tool. It also can help in training and education, as well as measuring the impact of changes.

#### **Measurement**

- It is important to include transparent measures to monitor implementation.
- Regularly record and establish a feedback protocol. This will allow staff to monitor their progress and see how implementation is changing the care they provide.

#### **Training and education**

- For ongoing sustainability, it is necessary to provide adequate training for staff and service users to effectively use, and benefit from, implementation. This may need to include both initial and refresher training and ensure training is available for new staff.

## References

1. Clinical Epidemiology and Health Service Evaluation Unit: Melbourne Health 2004, *Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care settings*, Australian Health Ministers' Advisory Council, Melbourne.
2. Australian Bureau of Statistics 2010, Population by age and sex, regions of Australia, 2010, cat. no. 3235.0, viewed 7 August 2012, <[www.abs.gov.au/ausstats/abs@.nsf/mf/3235.0](http://www.abs.gov.au/ausstats/abs@.nsf/mf/3235.0)>.
3. Department of Health and Ageing 2007, *The state of our public hospitals, June 2007 report* [online], Commonwealth of Australia, viewed 7 August 2012, <[www.health.gov.au/ahca](http://www.health.gov.au/ahca)>.

# Person-centred practice



## Five facts everyone should know about person-centred practice

1. Person-centred practice is a cornerstone domain that underpins all other domains within *The toolkit*.
2. Person-centred care is a philosophical approach to service delivery and service development, ensuring that service systems are developed in partnership with older people and/or their carers.
3. Person-centred care can be developed and evidenced in day-to-day practice that ensures that individual older people and their carers are involved in decision making regarding their care.
4. Person-centred practice is an approach to patient care and service delivery that is evidenced in organisational policies, models of care and staff actions.
5. With consistent and persistent change to practice to incorporate person-centred care, it is foreseen that, over time, this will become a part of organisational and work group culture.

## What is person-centred practice?

Person-centred practice is treatment and care provided by health services that places the person at the centre of their own care and considers the needs of the older person's carers [1].

It is also known as:

- person-centred care
- patient-centred care
- client-centred care.

Person-centred practice is treating patients as they want to be treated.

## Why is person-centred practice important?

- When you get to know patients well, you can provide care that is more specific to their needs and therefore provide better care.
- As a result of promotion and facilitation of greater patient responsibility, patients are more likely to engage in treatment decisions, feel supported to make behavioural changes and feel empowered to self-manage.

A literature review found that person-centred practice can make a positive difference to health outcomes and patient satisfaction, and can improve healthcare workers' sense of professional worth [2].

## Philosophy of care

Person-centred care underpins the information presented in *The toolkit*. The National Health and Hospitals Reform Commission recommended 'people and family centred care' as the first principle for guiding the delivery of healthcare [3].

It describes this as healthcare that is:

- responsive to individual differences, cultural diversity and the preferences of the people receiving care
- easy to navigate
- provided in the most favourable environment.

Hospital staff 'are human beings, our patients or clients are human beings, and it is shared humanity that should be the basis of the relationship between us' [4].

## What are the principles of person-centred practice?

### Getting to know the patient as a person

Healthcare workers need to get to know the person beyond the diagnosis and build relationships with patients and carers.

### Sharing of power and responsibility

Respecting preferences and treating patients as partners in setting goals, planning care and making decisions about care, treatment or outcomes.

### Accessibility and flexibility

Meeting patients' individual needs by being sensitive to values, preferences and expressed needs. Giving patients choices by providing timely, complete and accurate information they can understand, so they can make choices about their care.

### Coordination and integration

Working as a team to minimise duplication and provide each patient with a key contact at the health service. Teamwork allows service providers, and systems working behind the scenes, to maximise patient outcomes and provide positive experiences.

### Environments

Physical and organisational or cultural environments and policies are important, enabling staff to be person-centred in the way they work.

### Further information



For further reading on the principles of person-centred practice, refer to ***Person-centred practice: guide to implementing person-centred practice in your health service.***

## What can I do to become more person-centred in my practice?

Culture change requires a long-term effort. It starts with analysing individual, team or organisational practices to identify areas requiring development. For this reason, the recommended tools allow each individual, team and organisation to identify and improve in areas that are uniquely important.



The healthcare decision making process can be a positive example of promoting truly person-centred care. For example, **advance care planning is strongly linked to person-centred care. Advance care planning engages patients using different types of participation [5]:**

- information – providing accurate, timely information to patients about future treatment and care options either in written and verbal form
- consultation – having purposeful discussions with patients about wishes and preferences for future care
- partnership – using a joint decision making approach that takes the person's preferences into account even when they do not have capacity to fully participate in decision making
- delegation – using consumer driven decision making according to preferences
- control – using consumer-driven decisions and planning in relation to future care and wishes.

Refer to the following resources and tools to assist in improving person-centred care in practice.

### Further information



*Person-centred practice: guide to implementing person-centred practice in your health service*



*Advancing practice of patients and family centred care: how to get started*



*Patient and family centred care: a hospital self-assessment inventory*



*Improving the environment for older people in health services: An audit tool*



*Benchmarking Person-Centred Care Statewide Survey*



*Benchmarking Person-Centred Care Statewide Survey: Instructions for use*



*Nursing best practice guideline: client centred care*



*Essence of care: patient-focussed benchmarks for clinical governance*



*Patient rehabilitation charter for in-patients*



*Patient rehabilitation charter for in-patients: staff accompaniments*



*Human rights and responsibilities charter: protection of freedoms and rights for everyone in Victoria.*

Refer to the following table for recommendations of resources to assist in improving person-centred care in practice. Recommended resources can be located on the accompanying website:  
<[www.health.vic.gov.au/older/toolkit/index.htm](http://www.health.vic.gov.au/older/toolkit/index.htm)>

Principles of person-centred practice	Key elements	Top resources
1. Getting to know the patient as a person	Patient and family or carer support	<i>Client centred care: nursing best practice guidelines</i> Planetree < <a href="http://www.planetree.com">www.planetree.com</a> >
	Holistic assessment	<i>Essence of care patient-focused benchmarks for clinical governance</i>
2. Sharing power and responsibility	Goal setting	Person-centred healthcare: good practice < <a href="http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm">www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm</a> >
	Care planning and decision making	Consumer, Carer and Community Participation Information < <a href="http://www.health.vic.gov.au/consumer/index.htm">www.health.vic.gov.au/consumer/index.htm</a> > Respecting Patient Choices: An Advanced Care Planning Initiative Ottawa Health and Research Unit Victorian Department of Health Care Planning < <a href="http://www.health.vic.gov.au/acp">www.health.vic.gov.au/acp</a> >
	Case conference	Person-centred healthcare: good practice < <a href="http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm">www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm</a> >
	Patients, families and carers as advisors and in quality improvement	Consumer, carer and community participation information < <a href="http://www.health.vic.gov.au/consumer/index.htm">www.health.vic.gov.au/consumer/index.htm</a> > Institute for Family-Centered Care < <a href="http://www.familycenteredcare.org">www.familycenteredcare.org</a> > <i>Developing a new approach to koori hospital liaison services final report</i>
	Patients' rights and responsibilities	<i>Rehabilitation charter</i>
3. Accessibility and flexibility	Information and education for patients and families	Consumer, carer and community participation information < <a href="http://www.health.vic.gov.au/consumer/index.htm">www.health.vic.gov.au/consumer/index.htm</a> > Victorian Charter of Human Rights and Responsibilities < <a href="http://www.justice.vic.gov.au/humanrights">www.justice.vic.gov.au/humanrights</a> > <i>Client centred care: nursing best practice guidelines</i>
	Language and different cultures	Centre for Culture, Ethnicity and Health < <a href="http://www.ceh.org.au">www.ceh.org.au</a> > The Picker Institute < <a href="http://www.pickereurope.org">www.pickereurope.org</a> >
	Resource availability to patients and families	Person-centred healthcare: good practice < <a href="http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm">www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm</a> > <i>Client centred care: nursing best practice guidelines</i> Planetree < <a href="http://www.planetree.com">www.planetree.com</a> >
	Triage	Person-centred healthcare: good practice < <a href="http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm">www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm</a> >

Principles of person-centred practice	Key elements	Top resources
4. Coordination and integration	Charting and documentation and minimising duplication	<i>Client centred care: nursing best practice guidelines</i> <i>Essence of care: patient-focused benchmarks for clinical governance</i> < <a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_info&amp;products_id=230">www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_info&amp;products_id=230</a> >
	Making sense of services including key person and single access point	The Picker Institute < <a href="http://www.pickereurope.org">www.pickereurope.org</a> > Person-centred healthcare: good practice < <a href="http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm">www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm</a> > <i>Client centred care: nursing best practice guidelines</i> <i>Well-written health information: a guide (July 2000)</i>
	Discharge planning and post discharge follow up	<i>Incorporating patient and care concerns in discharge plans: patient centred checklist</i> Improving Care for Older People < <a href="http://www.health.vic.gov.au/older/improvingcare.pdf">www.health.vic.gov.au/older/improvingcare.pdf</a> > Person-centred healthcare: good practice < <a href="http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm">www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm</a> >
5. Environments	Leadership, mission statements, recruitment, use of volunteers, orientation, quality	Planetree < <a href="http://www.planetree.com">www.planetree.com</a> > Consumer, carer and community participation information < <a href="http://www.health.vic.gov.au/consumer/index.htm">www.health.vic.gov.au/consumer/index.htm</a> > American Hospital Association < <a href="http://www.aha.org">www.aha.org</a> >
	Attitudes and organisational culture	Enhancing Practice Program <i>Victorian Charter of Human Rights and Responsibilities</i>
	The physical environment	Improving the environment for older people in health services: an audit tool < <a href="http://www.health.vic.gov.au/older">www.health.vic.gov.au/older</a> > Planetree < <a href="http://www.planetree.com">www.planetree.com</a> > Institute for Family Centered Care < <a href="http://www.familycenteredcare.org">www.familycenteredcare.org</a> >
	Transport	Person-centred healthcare: good practice < <a href="http://www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm">www.nari.unimelb.edu.au/pchc/pchc_good_practice.htm</a> >

## How can I measure person-centred practice?

Evaluating the broader picture of person-centred care as a philosophy of care takes additional planning. Generally, evaluation involves repeating the assessment you initially completed to see if the results differ.

### Further information

For further information and guidance on evaluating person-centred practice in health services, refer to *Person-centred practice: guide to implementing person-centred practice in your health service*. Patient and carer satisfaction surveys can also be used to help measure person-centred practice in a health service:

-  [\*COAG LSOP Initiative Assessment domain – Excel database instructions\*](#)
-  [\*Patient satisfaction survey\*](#)
-  [\*Patient satisfaction survey: pre-intervention database\*](#)
-  [\*Patient satisfaction survey: post-intervention database\*](#)
-  [\*Carer satisfaction survey\*](#)
-  [\*Carer satisfaction survey: pre-intervention database\*](#)
-  [\*Carer satisfaction survey: post-intervention database\*](#)
-  [\*Post-discharge patient satisfaction survey\*](#)
-  [\*Post-discharge patient satisfaction survey: pre-intervention database\*](#)
-  [\*Post-discharge patient satisfaction survey: post-intervention database\*](#)
-  [\*Post-discharge carer satisfaction survey\*](#)
-  [\*Post-discharge patient satisfaction survey: pre-intervention database\*](#)
-  [\*Post-discharge patient satisfaction survey: post-intervention database\*](#)
-  [\*Tell us about your stay.\*](#)

## Further information



Refer to the following resources to assist improving person-centred care in practice regarding medical treatment, consent and advance care planning:



information published by the Office of the Public Advocate, Victoria, phone (03) 9603 9500 or 1300 309 337, or visit:  
<[www.publicadvocate.vic.gov.au](http://www.publicadvocate.vic.gov.au)>



*Can your adult patient consent?*



*Medical/dental treatment for patients who cannot consent: the person responsible*



enduring power of attorney: medical treatment



refusal of medical treatment



guardianship and administration



Australian Resource Centre for Healthcare Innovations (ARCHI) <[www.archi.net.au](http://www.archi.net.au)>



*Consent: patients and doctors making decisions together*



Darzins P, Molloy W, Strang D 2000, *Who can decide? The six step capacity assessment process*, Memory Australia Press, South Australia



*End-of-life treatment and care: good practice in decision making (a draft for consultation).*

The above mentioned resources can be located at:

<<http://www.health.vic.gov.au/older/toolkit/02PersonCentredPractice/index.htm>>

## References

1. Department of Health 2012, *Improving care for older people: a policy for health services*, viewed 25 July 2012, <[www.health.vic.gov.au/older/policy.htm](http://www.health.vic.gov.au/older/policy.htm)>.
2. Dow B, Haralambous B, Bremner F, Fearn M 2006, *What is person-centred health care? A literature review*, Department of Human Services, State Government Victoria, Melbourne.
3. National Health and Hospitals Reform Commission 2008, *Principles for Australia's health system*, viewed 25 July 2012, <[www.health.gov.au/internet/nhhrc/publishing.nsf/content/principles-lp](http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/principles-lp)>.
4. Curtin L 1979, 'The nurse as advocate: A philosophical foundation for nursing', *Advances in Nursing Science*, vol. 1, no. 3, pp. 1–10.
5. Department of Health 2011, *Doing it with us not for us: strategic directions 2010-2013*, State Government of Victoria, Melbourne.



# Advance care planning



## Advance care planning

According to the 2011 *National framework for advance care directives*, advance care planning is 'a process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known so they can guide decision making at a future time when the person cannot make or communicate their decisions' [1].

Advance care planning helps ensure an individual's choices are respected for future medical treatment.

Advance care planning programs operate within some health and aged care settings to support decision making. However, people can choose to discuss advance care planning or their preferences for future care or end-of-life decisions in an informal setting with family members or significant others.

Advance Care Plans have broad scope and they relate to decisions about:

- healthcare – care, treatment and services to diagnose, maintain or treat a medical condition
- medical treatment – administration of therapy or medications to prevent disease, restore or replace body function or to improve comfort and quality of life
- other personal matters – including residential arrangements, employment, holidays, visitors and care of pets.

Advance care planning is relevant to everyone. However, people with chronic and progressive conditions should be prioritised, particularly where loss of decision making is a likely consequence of their condition.

It is important to note that preferences for future care are not static, so Advance Care Plans need to be reviewed on a regular basis and whenever patients indicate their wishes have changed. This may be when there is a change in health or other circumstances that may impact on their decisions.

Health professionals need to check if patients have an Advance Care Plan and understand their responsibilities to make decisions with respect to patients' previously stated wishes. Where situations are complex or unclear, guidance from the health service's legal department or the Office of the Public Advocate may be required.

In Victoria advance care planning can lead to:

- a common law Advance Care Directive (ACD), that is, one recognised by the courts that apply earlier court decisions, or
- a statutory ACD, that is, one authorised by a law made in legislation.

### Statutory ACDs

A statutory ACD can include:

- an enduring power of attorney (medical treatment) made under the *Medical Treatment Act 1988* that appoints a substitute decision-maker called an agent, or
- an enduring power of guardianship made under the *Guardianship and Administration Act 1986* that appoints a substitute decision-maker called an enduring guardian, and/or
- a refusal of treatment certificate (under the *Medical Treatment Act*).

A statutory ACD is legally binding if the required form is completed, the adult making it was competent at the time of making it and it has not been revoked.

### Common law ACD

A common law ACD is simply a written appointment of a substitute decision-maker or a statement of preferences or instructions made by a competent adult for future healthcare. An ACD guides substitute decision-makers for when there is a later loss of decision making capacity. There are no specific requirements as to forms or witnessing.

There is no requirement for an ACD regarding future medical treatment to be in writing. However, there will be much less uncertainty about whether it is legally binding if it is. The lack of a written document may give rise to genuine and reasonable doubts about validity and current applicability.

Further, there is no requirement for any witness or signature for common law ACD documentation. However, it is much better for there to be a witness.

A common law ACD that appoints a substitute decision-maker is legally binding provided that:

- the adult was competent and signed voluntarily, without any undue influence
- there is no evidence of a later appointment or revocation.

A person appointed in writing as a substitute decision-maker outranks a person not appointed in writing. The hierarchy of substitute decision-makers is enshrined in legislation (Medical Treatment Act). Therefore, it is preferable that the appointment of a substitute decision-maker is made by completing an enduring power of attorney (medical treatment) to ensure the person's wishes are clearly documented and are legally binding.

An ACD will be stronger if it contains evidence that, when signed, the person was competent and not unduly influenced. Further:

- The use of witnesses may make an ACD stronger, as may the qualifications of a witness, for example, a doctor.
- A more recent ACD may be stronger as there may be less doubt about its currency.
- An ACD that clearly contemplates the current clinical circumstances will reduce doubt about its applicability.
- An ACD will be stronger if it avoids vague or imprecise language. For example, to say, 'I refuse life-sustaining treatment unless I can be sure of a reasonable quality of life' is very difficult to apply because the question of what is 'reasonable' will vary from person to person. 'In the event the majority of the medical team treating me believes I have suffered brain damage that would prevent me from living and caring for myself alone in my current home, I refuse life-sustaining treatment', would be stronger.

Further information and resources about advance care planning include the following.



The Department of Health advance care planning website has links to educational resources, frequently asked questions and health service contacts (where they are funded). **The Advance care planning implementation strategy for Victoria** will be accessible on the website when available in 2012–13: <[www.health.vic.gov.au/acp](http://www.health.vic.gov.au/acp)>



**Victorian Quality Council's 'next steps' training resource:**  
<[www.health.vic.gov.au/qualitycouncil/activities/training.htm](http://www.health.vic.gov.au/qualitycouncil/activities/training.htm)>

-  Cancer Council Victoria's advance care planning fact sheet and related documents:  
<[www.cancervic.org.au/how-we-can-help/practical-help](http://www.cancervic.org.au/how-we-can-help/practical-help)>
-  Respecting Patient Choices is a branded approach to advance care planning. The website has general information and resources for health practitioners:  
<[www.respectingpatientchoices.org.au](http://www.respectingpatientchoices.org.au)>
-  The Office of the Public Advocate (OPA) is an independent statutory body established by the Victorian Government. The OPA works to protect and promote the interests, rights and dignity of people with a disability. Forms for making statutory ACDs, multilingual fact sheets, and the Take control kit for making powers of attorney are available from the website: <[www.publicadvocate.vic.gov.au](http://www.publicadvocate.vic.gov.au)>
-  Northern Health's advance care planning website:  
<[www.nh.org.au/advance-care-planning/w1/i1002033](http://www.nh.org.au/advance-care-planning/w1/i1002033)>
-  Alfred Health's advance care planning website:  
<[www.alfredhealth.org.au/Page.aspx?ID=489](http://www.alfredhealth.org.au/Page.aspx?ID=489)>
-  Take control, a kit for making powers of attorney and guardianship from Victoria Legal Aid and the Office of the Public Advocate, is available via two websites:  
<[www.legalaid.vic.gov.au/695.htm](http://www.legalaid.vic.gov.au/695.htm)>  
<[www.publicadvocate.vic.gov.au/publications/121](http://www.publicadvocate.vic.gov.au/publications/121)>

## Case study

Mrs Coutts is a 70-year-old retired teacher. Her husband died 10 years ago from cancer. She was diagnosed with Alzheimer's disease two years ago and soon after moved in with her daughter. She also has a son who lives 200 km away and rarely visits.

### Scenario 1

When she was diagnosed with Alzheimer's disease her doctor recommended she begin planning for her future but her daughter did not want her mother to worry and persuaded her that it would 'be okay' without an Advance Care Plan.

Mrs Coutts has now presented to the emergency department by ambulance with her daughter. She is unwell after cutting her upper leg while gardening. Her cut is infected; she has a high fever and is confused and vomiting.

Mrs Coutts is admitted to intensive care where she is treated for septicaemia; however, Mrs Coutts goes into kidney failure. The medical team approach her son and daughter and want to know if they should treat the kidney failure.

Mrs Coutts' daughter is unsure what her mother would want, and her son insists that the medical team do everything they can to keep her alive.

### Scenario 2

When she was diagnosed with Alzheimer's disease Mrs Coutts' doctor recommended she begin planning for her future. Her daughter did not want her mother to worry, but her doctor made a compelling case for advance care planning and Mrs Coutts persuaded her daughter that she would worry less if there was a plan in writing.

Mrs Coutts' advance care plan includes nominating her daughter as her enduring power of attorney (medical treatment) and stating her wishes in a common law advance care directive (ACD) designed by her local public hospital. Her ACD is signed and witnessed by her hospital doctor, who also stated that he believed she had cognitive capacity to make the ACD when she did. Mrs Coutts' ACD states that should she suffer heart, lung, liver or kidney failure she does not want life sustaining measures. She also has a discussion about her wishes with her GP and has lodged copies of her ACD in her health history at the GP's clinic.

Mrs Coutts has presented to the emergency department by ambulance with her daughter. She has a letter from her GP that explains her current health issue and her stated wishes. She is unwell after cutting her upper leg while gardening. Her cut is infected; she has a high fever and is confused and vomiting.

Mrs Coutts is admitted to intensive care where she is treated for septicaemia; however, Mrs Coutts goes into kidney failure. Because her daughter, as enduring power of attorney (medical treatment), and the treating team are aware of Mrs Coutts' wishes in relation to life-sustaining treatment and organ failure they do not treat the kidney failure.

Mrs Coutts is accommodated in a quieter part of the hospital and is made comfortable. Her daughter and son and close friends are able to spend time with her. She dies peacefully two days later.

Mrs Coutts' daughter is sad because she will miss her mother, but satisfied that by making her comfortable they were respecting her wishes.

## Reference

1. Working Group of the Clinical Technical and Ethical Principle Committee of the Australian Health Ministers' Advisory Council that advises the Australian Health Ministers' Conference 2011, *A national framework for advance care directives*, Australian Health Ministers' Advisory Council.





## Five facts everyone should know about assessment

1. The aim of screening is to identify people who would benefit from further assessment.
2. Assessment aims to identify and diagnose the exact nature of problems (medical, social, physical, functional, psychological or cognitive). A person's pre-morbid level of functioning should provide baseline information and be used to inform care and discharge plans.
3. Comprehensive assessment should be an interdisciplinary, multidimensional, continuous process and include a focus on functioning as well as medical issues.
4. Care planning and discharge planning are interrelated, continuous processes dependent on comprehensive assessment.
5.  Patients and their families or carers must be included in the assessment process, as this is essential for a person-centred approach.

## Introduction to assessment

Assessment is a broad term that applies to collecting information that allows risks and diagnoses to be identified. It is about describing and understanding the important issues for a person during their hospital stay to keep them safe, prevent them getting worse and to correct whatever has caused them to present to hospital. Comprehensive assessment refers to an assessment that considers and integrates all the important issues.

A comprehensive, multidimensional, interdisciplinary assessment leads to the ability to develop a care plan that is patient-centred. Clear consensus as to how this should be undertaken in an Australian hospital context is lacking [1].

Assessment is frequently not a linear process. Assessment, care planning and discharge planning processes are interrelated and a change in one of these may prompt a need to re-visit the others. This section will demonstrate the relationship between assessment, care planning and discharge planning when preventing and managing functional decline during hospitalisation.

A key challenge with this domain is the lack of a gold standard in assessment and screening tools for older people. Research has confirmed the value of comprehensive assessment in the management of older people [1]; however, there are many methods currently in use. In the absence of a gold standard, this section covers the intended outcomes for assessment, which then informs the processes within health services that support an older person throughout their healthcare journey.

A broad approach is required to ensure that a person entering health services receives the right care, at the right time and in the right place.

It is anticipated that health services will vary in their approach to providing screening and assessment of older people. The commonality across all health services is the need to ensure that practices and processes maximise the identification and management of the functional decline of older people, across all domain areas. This suggests that organisations review current practices to streamline assessments to ensure older people are not being asked the same questions by several people. Rather, that the right questions are being asked at the right time.



At all times during assessment, it is essential that a person-centred approach is used.

For the purposes of *The toolkit*, this section aims to provide tools that can be used for screening and assessing the risk of functional decline of older people in hospital settings. The section does not purport to address all types of assessment or provide discipline-specific or disease-specific assessment tools. Domain-specific sections of *The toolkit* may contain more specific tools for screening or diagnostic tools.

Like the person-centred practice domain of this toolkit, assessment applies across all the domains. The main purpose of this section is to illustrate ways that identify the need for more detailed assessment of an older person's functional ability. This will lead to identifying what the possible next steps should be, which may be a comprehensive assessment, more in-depth assessment of a particular domain, or a discipline-specific assessment.

In choosing preferred tools to use within your health service, you would need to evaluate what is currently used and identify areas for improvement in both practice and processes to support best practice in this domain.

## Why is assessment important for older people in hospital?

Assessment helps to proactively manage functional decline of older people during a hospital admission. Screening and assessment should clearly link with a person's inpatient care planning and discharge planning. These should be continually reviewed throughout the person's admission as their preferences and needs are more clearly understood.

Comprehensive assessment provides a framework to ensure all areas of potential risk are covered, including often under-recognised areas, such as depression and delirium.

Within the current context of brief length of stays in an acute setting, rapidly identifying risks is critical to ensure that safe and effective pathways are developed for managing the needs of older people.



A person-centred approach must underpin screening and assessment so that clinicians understand:

- an older person's preferences and needs
- the needs of an older person's family or carers
- an older person's pre-admission status.

### Further information



Refer to *A guide for assessing older people in hospitals* [1].

## Screening and assessment

### Screening



Screening is a filtering process that aims to identify the presence of health problems, or risk of a health problem occurring. Screening identifies people who would benefit from further assessment. Person-centred screening is conducted in partnership with patients and their families or carers.

Screening older people should be undertaken on presentation by the admitting staff as part of a routine process. This may be undertaken in pre-admission, the emergency department or other parts of the health service.

Screening can be repeated at any time during an episode of care, particularly if there is a change in health status [1].

Screening is crucial to detecting and preventing functional decline across all domains and, along with assessment, should trigger appropriate action and follow-up.

Examples of screening tools include:



**Identification of Seniors at Risk Screening Tool (ISAR)**



**InterRAI Screen**



**Functional Assessment Screening Tool (FAST)**



**Vulnerable Elders Survey (VES-13)**



**Community Assessment Risk Screen (CARS).**

### Comprehensive assessment



Comprehensive assessment is a detailed interdisciplinary process incorporating history taking, examination, observation, measurement, testing and evaluation, regarding medical, physical, social, cultural or psychological dimensions of need. It aims to diagnose the exact nature of problems in order to plan and deliver appropriate preventions, interventions and management strategies. Person-centred assessment is conducted in partnership with patients and their families or carers.

Comprehensive assessment can be undertaken by any member of the interdisciplinary healthcare team who has sufficient knowledge and skills. Ideally it should be completed within the patient's first 24 hours in hospital.

Examples of comprehensive assessment tools include:



**InterRAI Comprehensive Assessment Tool: Acute**



**Caulfield Hospital Interdisciplinary Assessment Tool (IDAT).**

## How should the information collected during screening and assessment be used?

Screening should be used to:

- identify people who would benefit from more comprehensive assessment and management processes
- identify issues or risks that require more complex diagnostic assessment
- establish an older person's pre-morbid level of functioning.

Comprehensive assessment should be used to:

- get to know the patient in detail
- identify the nature of problems identified through the screening process
- prescribe appropriate risk minimisation, interventions and management strategies
- minimise further decline and maximise functional independence
- reduce risks
- facilitate care planning and effective discharge planning, starting at presentation.

For screening and assessment to be effective, the information obtained must be used to develop appropriate treatment, care and management strategies to reduce identified risks and promote a return to an optimal level of functioning. A well-planned and streamlined documentation system is essential for effectively using the information obtained during screening and assessment.

Again, there is no gold standard in care planning. Consideration needs to be given to documentation, team communication, planning, clinical handover and other activities that will streamline communication across the healthcare continuum. This may include transferring older people from acute to subacute settings, or within acute settings from one ward to another.

A care plan is developed and implemented following the initial assessment and is updated following reviews of progress or changes in the patient's status. The aim of a care plan is to meet the individual patient's needs and goals. This may include therapeutic interventions, education and communication within, and between, the team and ongoing service providers or services to ensure that functional independence is maximised throughout hospitalisation and on discharge. It is provided to all relevant parties with the patient's consent.



Each patient will have different needs and expectations identified during the person-centred assessment processes. An interdisciplinary approach to care that actively consults and collaborates with the patient and their family or carers will promote the best possible outcomes.

For working instructions, supporting documentation and evaluation of an interdisciplinary documentation system in a subacute hospital, refer to the documents outlining the interdisciplinary documentation system used at Caulfield Hospital, Alfred Health:



***Interdisciplinary documentation system: work instructions***



***Interdisciplinary documentation system: evaluation***



***Functional maintenance care plan.***

Clinical handover documentation can also contribute to effective treatment, care and management:



**Clinical handover sheet.**

## How do I know if effective screening and assessment is occurring?

File audits can be used to help measure whether screening and assessment are being completed adequately in a health service. The quality of the screening and the assessment can be measured by the quality of the care planning and the discharge plan.

Patient and carer satisfaction surveys can also be used to measure the quality of the screening, assessment, care planning and discharge planning processes. Examples of patient and carer satisfaction surveys can be found in the person-centred practice section of *The toolkit*.

### Further information

Please refer to the following audit tools and databases. Instructions and an explanation of their use are included within the documents:



***Functional maintenance screening and assessment file review audit tool***



**Functional maintenance screening and assessment file review audit databases**

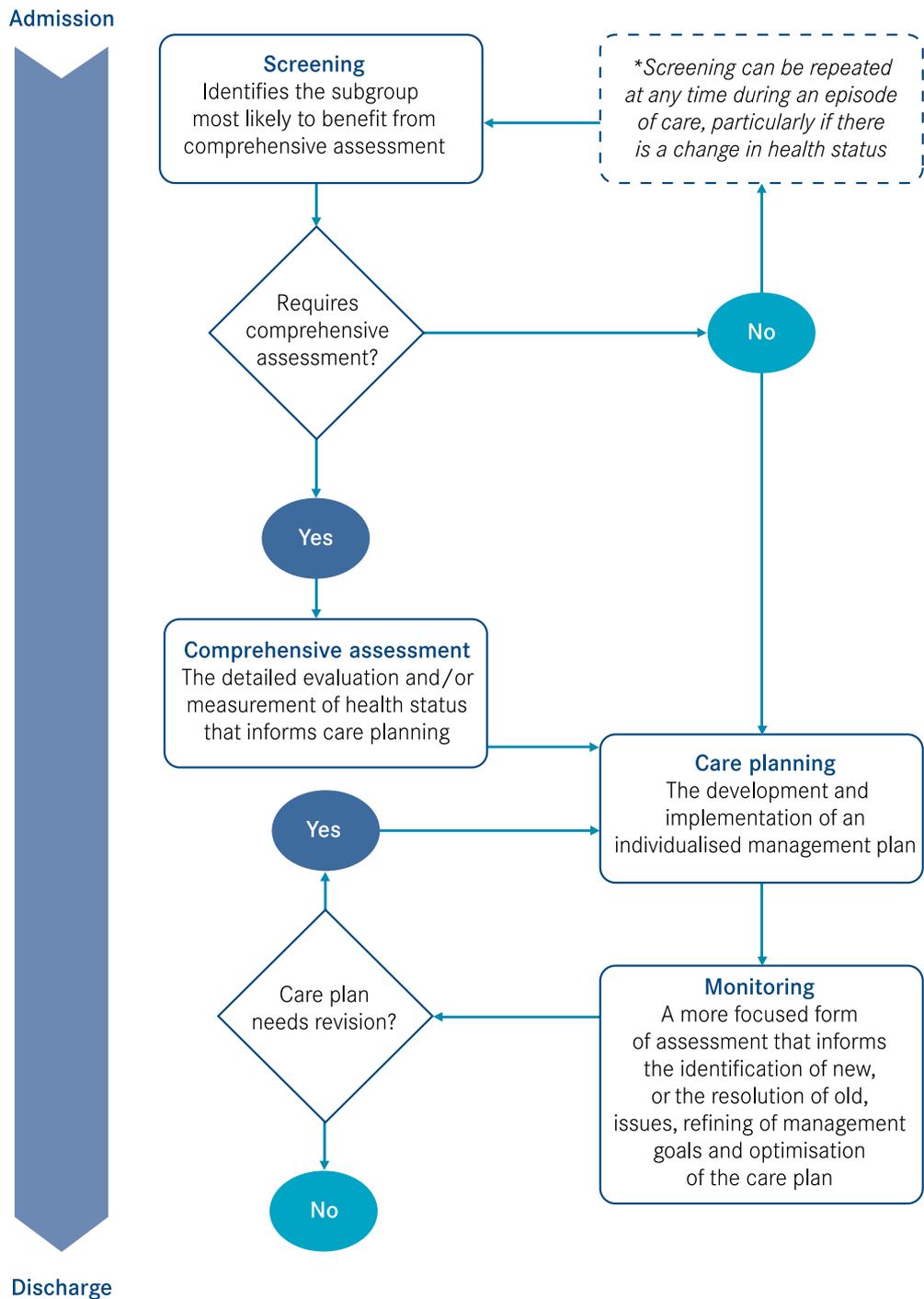


**Pre-intervention staff survey**



**Staff survey databases.**

## Model for screening and assessment of older people in hospital



## Case study

Mrs Bennett is an 81-year-old widow who presents to the emergency department of a local hospital, accompanied by her daughter, Maureen. Mother and daughter live next door to each other. Mrs Bennett lives independently and prepares her own meals while her daughter works full time and checks in with her daily.

Maureen, the eldest of Mrs Bennett's six children, has brought her mother to the hospital after consulting NURSE-ON-CALL. In recent weeks Mrs Bennett has had occasional chest pain and some breathlessness, but when Maureen checked on her mother this evening she found her struggling for breath and in pain.

Throughout her life, Mrs Bennett has been a competent homemaker, a busy gardener and active in community life. She struggled after her husband's death 17 years ago and experienced some depression for which she was admitted to a clinic. However, she eventually adjusted to the loss of her husband and returned to a busy life.

### Scenario 1

Mrs Bennett is admitted to a cardiac ward and treatment includes a range of medications and observation to determine her tolerance to treatment. Maureen, or one her siblings, visit Mrs Bennett daily. Mrs Bennett and her six adult children are a close-knit family. It is difficult for nursing staff to answer all their questions.

Over the first four days of Mrs Bennett's stay, nursing staff observe and Mrs Bennett reports increasing incontinence. During the day she regularly leaks urine and sometimes does not reach the toilet in time. She complains of tiredness because she needs to use the toilet during the night. Nursing staff explain that this is a common side effect of the furosemide prescribed to treat her condition.

Mrs Bennett has two falls in her room.

Nursing staff assess that Mrs Bennett needs more time to adjust to her condition and treatment, to access continence aids and to learn to manage the side effects of treatment.

After four days of treatment Mrs Bennett's original symptoms abate. The ward medical officer examines her, assesses her as stable and recommends discharge.

For further information about Mrs Bennett's needs, assessments are sought from the ward physiotherapist and the hospital psychology department.

During her assessment, the physiotherapist notes that Mrs Bennett uses furniture to steady herself as she moves around her room. Mrs Bennett tells the physiotherapist that she doesn't feel confident anymore and is frightened of falling again. The physiotherapist identifies postural hypotension and recommends against discharge due to: the risk of falls; Mrs Bennett's gait instability; and decline in her mobility.

The following day, a hospital psychologist visits Mrs Bennett and finds she is not ready to be discharged and is anxious and at risk of depression in reaction to the side effects of her treatment. She assesses Mrs Bennett as rightly concerned that she will not be able to manage at home. She is worried about falling, embarrassed about her incontinence and is anxious about the possibility of increased dependence on her daughter.

Over the next week Mrs Bennett is provided with a walking frame and other aides. Nursing staff provide and explain continence aids to Mrs Bennett. The psychologist talks to Mrs Bennett and Maureen about Mrs Bennett's adjustment to the treatment. Medication for depression and anxiety are discussed but Mrs Bennett says she'd like some time 'to see how it goes' before she adds more medication (and further possible side effects) to her regime.

Mrs Bennett is eventually discharged home. Mrs Bennett and Maureen are provided with material about a range of community supports including Meals on Wheels, her local council's home-help service and district nursing.

At home it takes Mrs Bennett several months to adjust to her new circumstances. She has several further falls that result in bruising. Eventually a community-based service is engaged, which recommends some home modifications such as a handrail in the bathroom.

## Scenario 2

Using the following strategies from *The toolkit*:



***Patient and family-centred care: a hospital self-assessment inventory***



***Advancing practice of patients and family centred care: how to get started***



**Caulfield Hospital Interdisciplinary Assessment Tool (IDAT)**



**Berg Balance Scale**



**Tinetti Assessment Tool: Balance**



**For tools, refer to *Minimising the risk of falls and falls injuries - guidelines for acute, subacute and residential care settings* (tools supplement)**



At a ward meeting early in Mrs Bennett's admission, nursing staff discuss how to engage collaboratively with Mrs Bennett's large family. The ward social worker uses the hospital's ***Patient and family centred care: a hospital self-assessment inventory*** and approaches Mrs Bennett and Maureen to discuss how the hospital staff can work effectively with Mrs Bennett and her family. A family meeting is planned to occur before discharge.



In the first days of Mrs Bennett's admission, nursing staff suggest an assessment. The medical and nursing staff, physiotherapist, psychologist and social worker use the **Caulfield Hospital IDAT** to complete a comprehensive assessment.

After Mrs Bennett responds to treatment and the side effects emerge each member of the assessment team keeps each of the domains in view with an initial emphasis on:

- the medication and side effects – looking at Mrs Bennett's prescribed medications, types, dosage and timing of administration
- the balance between treatment benefits of symptom abatement versus falls risk and continence issues
- resolution of the hypotension, again to address falls risk
- need for continence aids
- Mrs Bennett's psychological discomfort at her changed functioning and her need for immediate and ongoing support.

Each of the professionals confers as necessary to make adjustments to Mrs Bennett's treatment regime. The physiotherapist and the medical officer work particularly closely with Mrs Bennett to find the best balance between treating symptoms and minimising side effects. This is done over 24 hours.

Mrs Bennett's medications are adjusted to find a combination that minimises the hypotension and incontinence. Particular effort is made to eliminate nocturia because Mrs Bennett finds that tiredness especially impacts her mood. She learned in her earlier experience of depression after her husband's death that if she 'gets a good night's sleep' she is more able to manage 'whatever comes (her) way'.

Measures taken to address Mrs Bennett's risk of falling in hospital include a commode chair in her room for night use; the physiotherapist provides a walking frame and some training to familiarise Mrs Bennett. Mrs Bennett maintains her mobility in hospital.

Mrs Bennett's family request a family meeting, which is held on the ward within 24 hours of the request. The medical officer and physiotherapist attend and the social worker convenes. With Mrs Bennett's permission, the staff report on her condition and the challenge of treating her symptoms while minimising the side effects and risks. Family members ask a lot of questions.

Prior to discharge, a discharge summary is sent to Mrs Bennett's GP to explain what happened and asks the GP to continue to monitor Mrs Bennett.

By the time Mrs Bennett is discharged, the incontinence has been reduced, but Mrs Bennett still chooses to use pads as a failsafe. A regimen has been devised whereby she takes medication early in the morning and only needs to get up once in the night to go to the toilet. Dosages are reduced to minimise the hypotension. The risk of falls is reduced but arrangements are made for an assessment for some modifications at home (a rail in the bathroom and toilet) to further reduce risk.

Each of these strategies contributes to alleviating Mrs Bennett's anxiety and she leaves hospital relatively confidently.

## Reference

1. Centre for Applied Gerontology Bundoora Extended Care Centre Northern Health 2004, *A guide for assessing older people in hospitals*, Australian Health Ministers' Advisory Council, Melbourne.

# Communication



## Five facts everyone should know about communicating with older people with vision, hearing and/or speech impairments

1. Hospital staff should always ask older patients if they have impairments associated with vision, hearing and/or speech (and/or their family or carers when appropriate) and about what strategies they use to improve communication.
2. Time taken to communicate is not wasted. It is more efficient and safer to know what patients need and what they are experiencing than to guess [1].
3. Hospital staff should check mutual understanding by confirming with patients the information they give to staff and receive from staff [1]. Qualified interpreters should be used appropriately.
4. Recurring communication difficulties can have serious consequences for psychosocial wellbeing [2, 3].
5. Hospital staff should never assume older patients with vision, hearing and/or speech impairments have cognitive difficulties.

## What is communication?

Within the context of this domain the term communication is narrowly defined, referring only to patient–staff interactions within a hospital setting. Furthermore, this domain only considers vision, hearing and speech impairments commonly experienced by older patients. Language barriers and other barriers to communication are not addressed in this domain. Hospital staff should, however, use qualified interpreters appropriately when English is not the primary language of patients. For older patients with vision, hearing and/or speech impairments who primarily speak languages other than English using qualified interpreters may be even more important for good communication.

Communication is vital for gathering and sharing information, establishing and maintaining relationships and directing the behaviour of others [3].



Effective communication is an activity that depends on both clear expression and full comprehension [4]. In hospital settings, working with patients' experiences and using person-centred practices will help staff determine older patients' comprehension and improve communication.



Communication is important to person-centred healthcare [5]. Successful communication depends on the characteristics of the individuals involved and the communication setting [6]. For example, some older patients may have vision impairments so hospital staff should use methods other than written handouts to provide information. In hospital settings, understanding how to optimise communication is important for safety and efficiency.

A respectful attitude is important for good communication [7].

## Why is it important to consider vision, hearing and speech impairments when communicating with older people in hospital?

Poor communication between hospital staff and patients:

- potentially impacts on quality of care
- can affect overall patient recovery
- can affect the length of hospital stay [8].

Many older people with a vision, hearing and/or speech impairment experience frequent communication breakdown [3], and recurring communication difficulties can have serious consequences for psychosocial wellbeing [2, 3].

There may be a number of underlying reasons why an older person in hospital is having trouble communicating. Age is a major predictor of vision and hearing loss [9], and because changes to vision and hearing occur normally with age, many older patients will have both vision and hearing impairments to some degree (although such impairments may be minor) [2]. Older patients who have combined vision, hearing and speech impairments are not uncommon in hospital.



When vision and hearing are drastically reduced, the resulting communication difficulties are sometimes mistaken for cognitive difficulties. Confusion, inappropriate responses to questions, and disorientation can be caused by age-related hearing and vision impairment. Furthermore, sensory decline often develops slowly, which may contribute to inaccurate assumptions by family that an older patient is experiencing cognitive decline. A significant impairment to vision and/or hearing may be present before the problem is diagnosed [9].



However, cognition may legitimately play a role in communication difficulties. For tools and resources for common cognitive problems in older patients refer to the cognition, delirium, dementia and depression domains.



**Information for when cognition affects communication**

## How do vision, hearing and/or speech impairments affect communication?

Vision, hearing and speech impairments should never adversely affect the quality of care provided to an older patient.

The degree to which vision, hearing and/or speech impairments affect communication varies depending on individual characteristics and situational factors.



**An education resource for hospital staff on sensory changes and communication in older adults is available from the John A Hartford Foundation Institute for Geriatric Nursing: <[www.evidence2practice.org/topics/index.htm](http://www.evidence2practice.org/topics/index.htm)>**

### Vision

Vision is important for understanding non-verbal communication cues. Gestures, lip reading, contextual cues, facial expressions and eye gaze are important non-verbal elements to communication that may be missed by an older patient with vision impairment [3].



**Information on common vision impairments in older adults – refer to page 56 of *The toolkit***

### Hearing

It is common for an older person's ability to understand speech to change gradually with age because of hearing changes. These hearing changes typically:

- cause reduced speech discrimination
- cause speech to sound distorted, especially in noisy environments
- result in an older person perceiving only part of a spoken message [3].



**Information on common hearing impairments in older adults – refer to page 57 of *The toolkit***

### Speech

Speech is the most common mode of routine communication in hospital between staff and patients. Speech impairments range from mild (where there is only an occasional problem) to severe (when a patient may have lost all ability to use and/or understand speech). If a patient is unable to use speech as an effective form of communication hospital staff should work with the patient (and family or carers if appropriate) to find and/or use effective alternative modes of communication.



**Information on common speech impairments in older adults – refer to page 58 of *The toolkit***

## How can I recognise a potential communication problem because of vision, hearing and/or speech impairments?

In addition to specific examinations of vision, hearing and speech, the following can help hospital staff recognise potential communication problems [2]:

- a patient's self-report of communication difficulty
- an informant's report of communication difficulty
- a patient's medical history
- a patient's appearance (such as eye glasses, hearing aids)
- communicative behaviour (such as repeated requests to speak louder, positioning for better ear or eye orientation, difficulty finishing sentences).

Behavioural signs of vision loss will vary with individuals, but the following might indicate an older person is having difficulty seeing:

- viewing habits, like holding material very close or at an odd angle, or squinting and sitting unusually close to the television
- inability to recognise familiar faces
- poor grooming habits, such as stains on clothing, mismatched clothes or unbrushed hair
- changes in orientation or increased confusion, especially in familiar areas
- unsure movement, stumbling, shuffling gait or dragging feet, or changes in stance
- inability to find small objects, such as keys or jewellery
-  • weight loss or preferring to eat alone (because of difficulties preparing food or seeing food on the plate or table) [9]
- changing posture for better eye orientation [2].

Behavioural signs of hearing loss will also vary with individuals, but the following might indicate an older person is having difficulty hearing:

- increasing volume on a television or radio and/or sitting closer than usual
- leaning closer to the speaker during conversations
- cupping a hand over the outer ear during conversations
- difficulty communicating on the telephone
- difficulty communicating in a noisy environment
- inappropriate responses to questions or comments unrelated to the topic of discussion
- repeating requests to speak louder
- difficulty hearing high-pitched sounds like a ringing telephone, or the inability to locate the source of a sound [9]
- changing posture for better ear orientation
- frequently adjusting hearing aids
- speaking in an inappropriately loud voice
- dominating conversations
- staring intently at the lips of the speaker [2].

While hospital staff may be able to identify a speech impairment by initiating a conversation with an older patient, some patients will be sensitive or embarrassed about speech impairments and may avoid conversations or situations that would highlight their impairments. As a result, an older patient with a speech impairment may appear shy, insecure, uncommunicative, angry or aggressive [4]. As dental difficulties are a common cause of speech impairment in older adults, difficulty eating, pain when eating and/or signs of mouth discomfort should be investigated.

Vision, hearing and/or communication impairments should always be considered as possible contributing factors if an older person displays behaviours of concern such as:

- decreased sociability or friendliness
- increased time spent in isolation and inactivity
- uncharacteristic outbursts (because of frustration)
- a dramatic change in behaviour or change in longstanding habits, which should be investigated [9].

Identifying later-in-life sensory losses can be challenging when older patients deny the severity of such losses [6]. An older person might deny the severity of sensory losses for several reasons:

- They might not realise the severity.
- They may be grieving the loss, and this grief may include denial, anger, frustration, shame or depression.
- They may think they will be treated differently or forced to move elsewhere [10].

For patients with severe sensory losses, frustrating communication encounters would be common, and it may be helpful for hospital staff to explicitly name the frustration for older patients [6].

## What can I do if I recognise that someone has a problem communicating because of vision, hearing and/or speech impairment?

All older patients with problems communicating should have their hearing and vision tested and mouth examined by an appropriately qualified health professional. Those with persistent speech impairments should be referred to a speech pathologist. Not all communication issues can be fully or appropriately addressed during an inpatient hospital admission, but all attempts should be made to support optimal communication strategies during the admission and appropriate post-discharge referrals completed. (A full hearing test and hearing aid prescription is best completed post discharge, but environmental strategies and assistive listening devices may be used during a hospital admission to support improved hearing.)



Communication can be improved by ensuring the best possible environment and by adjusting your communication style to fit the needs of the older patient [9]. Looking at and attending to patients during communication attempts can help you learn the patient's non-verbal cues [1]. Working with the patient's experience using person-centred practices can help determine understanding.

Communication will be improved when an older patient is most alert [1]. When cognitive status and/or attention are low, conversations should be brief, and important discussions delayed until the patient is more alert [11].

Hospital staff, as communication partners, should undertake the following:

1. Determine how each patient best communicates.
2. Pause/wait to allow time for the patient to participate in the interaction.
3. Confirm the message communicated by the patient with the patient.
4. Use augmented and alternative communication (AAC) strategies to support communication if required [1].

Ways hospital staff members can improve their immediate environment for communication include:

- Check that lighting is adequate (ask each patient about lighting; some people see better with brighter light, others do not [10]).
- Reduce reflective glare (use blinds or curtains to control window glare [10]).
- Reduce visual distractions.
- Reduce background noise [2].
- Use available assistive devices.
- Make sure AAC aids are positioned for easy physical and visual access by the patient.

For health-service-level strategies to improve the environment for communication with older people see:



**page 17 of Working with people with vision loss by Vision Australia [10]**



**Improving the environment for older people in health services – an audit tool**



**Assessable design for public buildings from Vision Australia:**

**[www.visionaustralia.org/info.aspx?page=721](http://www.visionaustralia.org/info.aspx?page=721).**

There are many ways hospital staff members can improve communication with older patients [9] when they first meet them:

- Before speaking, make sure you have the listener's attention [9].
- Address patients by their names. Check that this is their preferred name or way of being addressed [10].
- Introduce yourself. Not everyone can see your identification. Not everyone can recognise your voice.
- When in doubt, ask the older patient what to do to improve communication.
- Stay in the same room with the patient.
- Tell the patient when you are leaving the room [9].
- Tell the patient if someone new has entered the room [10].

Use your voice, language and body:

- Look directly at the patient when speaking.
- Make eye contact.
- Use facial expressions.
- Do not hide your face.
- Do not shout. Shouting may distort your voice and facial expressions.
- Do not speak with objects in or covering your mouth.
- Speak clearly, at a moderate rate of speed [9].
- Pause/wait to allow time for the patient to participate in the interaction, while maintaining eye contact and using an expectant facial expression [1].
- Decrease your distance from the patient if necessary.
- Use everyday language, don't avoid words like 'see,' 'look,' and 'hear' [10].
- Use accurate and specific language when giving directions and describe what is happening (for example, *Please roll up the shirt sleeve of your left arm. Bill, I am going to give you a needle in your upper left arm now.*) [10]

Work with each patient's understanding:

- Rephrase if the message is not understood [9].
- Confirm important points [9].
- Repeat/clarify/rephrase/simplify when necessary [2].
- Be patient and positive. Allow the older patient to do tasks at his or her own pace [9].
- Use a clock face to tell an older patient who is visually impaired where food is on a plate or where other items are located (for example, *Your tea is at two o'clock*) [9].
- Use AAC strategies to support communication if required [1].
- Use assistive and adaptive equipment as appropriate.

These recommendations improve communication for every patient and should be part of everyday practice.



**A useful tip sheet for staff when working with older patients with hearing impairments is available from Alfred Health.**



**A useful tip sheet for staff when caring for patients who are visually impaired is available from Vision Australia: <[www.visionaustralia.org/info.aspx?page=644](http://www.visionaustralia.org/info.aspx?page=644)>**

For older patients who cannot effectively communicate with speech, AAC strategies may be useful. Unaided AAC techniques may involve using other parts of the patient's body, such as the hands, face or feet, for communication, for example:

- sign language
- pantomimes
- gestures
- eye-blink systems
- facial expressions [1].

Sign language interpreters should be made available on request. A number of hard of hearing and deaf people may use an oral interpreter for speech reading. An oral interpreter should be made available on request [12].

 **Auslan SignBank is an internet-based Auslan (the native sign language of the Australian deaf community) database: <[www.auslan.org.au](http://www.auslan.org.au)>**

 **For guidelines for working with people who are culturally deaf, see Deafness and mental health guidelines for working with people who are deaf and hard of hearing [12].**

 **Information and resources for working with the deaf community in Victoria are available from the Vicdeaf website: <[www.vicdeaf.com.au](http://www.vicdeaf.com.au)>**

Aided AAC strategies require materials external to the patient and hospital staff. The most common AAC strategies used in hospitals are:

- pictures
- alphabet boards
- pen and paper
- communication books
- computers that 'speak' [1].

 **Tips for communicating with someone using a communication board/book or computer that speaks can be found on pages 16 and 17 in Communication access for people who have communication disabilities [7]: <[www.mcass.gov.on.ca/documents/en/mcass/accessibility/DevelopingStandards/Communication\\_Access\\_ENG\\_no\\_ack.pdf](http://www.mcass.gov.on.ca/documents/en/mcass/accessibility/DevelopingStandards/Communication_Access_ENG_no_ack.pdf)>.**

Importantly, staff who do the following reportedly increase the effectiveness of communication with patients who cannot use speech:

- Take the time necessary.
- Persist until the message is understood.
- Be willing to ask for help (from family, a speech pathologist, other staff).
- Share what you have learned with other staff members [1].

## What are the care or management principles I should follow if an older person has a vision, hearing and/or speech impairment?



The key to successful communication with people with sensory impairments is the ability to adapt to the needs of the situation. Older people with vision, hearing and/or speech impairment often have good suggestions on how to best communicate with them [6]. Working with patients' experiences and using person-centred practices can help determine understanding and improve communication.

In many cases it will not be possible to completely correct older patients' communication impairments [2]. And, in many cases, older patients will not benefit from amplification alone and will require specialised interventions [3].

When impairments persist, a rehabilitation approach may be useful including:

- assessing the nature and extent of the impairment
- diagnosing causes
- medical and surgical intervention where required
- using adaptive aids emphasising medical, behavioural and social management [3].



A multidisciplinary team approach to care planning that includes the older patient and his or her carers is best practice in person-centred healthcare [5]. Input from the audiology, dentistry, nutrition, occupational therapy, optometry/ophthalmology, psychology, social work and speech pathology departments may be required in addition to nursing and medical.



Validated tools for assessing pain in patients with cognitive impairments and severe communication difficulties should be part of a care plan for all older patients who cannot effectively use speech to communicate with hospital staff.



Prioritising goals must consider the older patient's psychosocial and physical condition and level of dependence on carers [3]. See Person-centred practice domain

Where appropriate consider referrals for interventions such as:

- fitting hearing aids
- fitting eye glasses
- fitting dentures
- removing excessive ear wax (cerumen) from the ear canals
- medication for otitis
- surgery for otosclerosis (immobilisation of the stapes)
- cataract extraction and implanting an artificial lens
- corneal transplant
- speech therapy
- language therapy.



**A useful follow chart from Alfred Health describes a process for identifying and helping older patients who are hard of hearing.**

## Sensory aids

The most common aids for vision impairments are eye glasses.



**For patients requiring an eye examine the Optometrists Association Australia Victoria website provides a search function for finding local optometrists:**

**<[www.optometrists.asn.au/Default.aspx?alias=www.optometrists.asn.au/victoria](http://www.optometrists.asn.au/Default.aspx?alias=www.optometrists.asn.au/victoria)>**

Optometrists provide primary eye care including assessing vision and eye health checks.

Optometrists can refer to an ophthalmologist and low vision services if required. Most eye tests are covered by Medicare but patients should be encouraged to check, if cost is an issue. Many optometrists bulk bill. Glasses and contact lenses are not covered by Medicare.



**The Australian College of Optometry provides low cost eye-care services to eligible Victorians: <[www.vco.org.au](http://www.vco.org.au)>**

In addition to eye glasses, helpful devices for vision impairments include [10]:

- magnifiers (torch magnifiers, hand-held magnifiers, stand magnifiers, telescopic aids, closed-circuit television)
- large-print diaries, teledex, pill dispensers, clocks and watches
- talking clocks and watches, bathroom and kitchen scales, computers
- liquid level indicators
- needle threaders
- writing frames
- signature guides
- writing pads with dark lines
- tactile watches and clocks
- white identification canes.

All of these devices are available from Vision Australia. Vision Australia can also provide advice about which devices are the most suitable for each patient [10].



**For an adaptive technology guide from Vision Australia see:**

**<[www.visionaustralia.org.au/info.aspx?page=1230](http://www.visionaustralia.org.au/info.aspx?page=1230)>**



**For information on equipment funding options from Vision Australia see:**

**<[www.visionaustralia.org.au/info.aspx?page=2120](http://www.visionaustralia.org.au/info.aspx?page=2120)>**

The most common aids for hearing impairments are hearing aids. Hearing aids can make conversational speech more audible; they can also amplify different frequencies by different amounts, which can help with speech clarity. However, hearing aids do not eliminate distortions that may be present and therefore do not restore normal hearing [2]. Furthermore, patients must be trained in and have the vision and dexterity to insert the earmould, replace batteries, manipulate controls, and undertake routine maintenance.

The Hard of Hearing Project at Caulfield Hospital (Alfred Health) produced many useful resources for hospital staff to help patients with hearing aids:



**Hearing aid ward kits**

-  **Hearing aids**
-  **Obtaining hearing aids**
-  **Hearing aid operation**
-  **Checking hearing aids**
-  **Hearing aid repair procedure.**

In addition to hearing aids, other helpful assistive devices include [12]:

- amplified telephones, portable telephone amplifiers
- personal amplifiers
- induction loops
- teletypewriters
- television amplifiers
- infrared systems
- captioning
- FM (frequency modulated) systems
- alert systems (for the door, phone, vibrating alarms, visual smoke detectors, remote pagers)
- cochlear implants.

For more information and descriptions of these products see page 51 of *Deafness and mental health guidelines for working with people who are deaf or hard of hearing* [12].

Some health services will have assistive listening devices available for patients to borrow while in hospital. Information about such devices should be available to staff and patients.

#### **Assistive listening devices available at Caulfield Hospital (Alfred Health)**

For patients requiring audiology assessments, hearing aids and/or other assistive devices a number of services and resources are available. Patients should be made aware that in some cases there will be a cost associated with obtaining hearing services and devices.

 **A directory of audiology services available in Victoria can be found at:**  
<[www.audiology.asn.au/pdf/service/asa-vic.pdf](http://www.audiology.asn.au/pdf/service/asa-vic.pdf)>

 **The Australian Government Hearing Services Program provides vouchers for hearing assessments and devices to eligible clients. Patients will need to apply for the voucher program:** <[www.health.gov.au/hear](http://www.health.gov.au/hear)>

 **Better Hearing Australia provides free professional hearing loss management services:**  
<[www.betterhearing.org.au/node](http://www.betterhearing.org.au/node)>

 **Hearservice has a reduced price scheme for eligible clients:**  
<[www.hearservice.com.au/information.asp?id=21&t=Reduced+Price+Scheme](http://www.hearservice.com.au/information.asp?id=21&t=Reduced+Price+Scheme)>

 **Crystal Clear Hearing Clinics are available for ear wax removal:**  
<[www.crystalclearclinic.com.au](http://www.crystalclearclinic.com.au)>

For assistive devices:



**Oricom:** <[www.oricom.com.au/categories/oricom-easy-phones](http://www.oricom.com.au/categories/oricom-easy-phones)>



**Telstra Disability Equipment Program:** <[www.telstra.com.au/abouttelstra/commitments/disability-services/disability-equipment-program/?red=/disability/catalogue](http://www.telstra.com.au/abouttelstra/commitments/disability-services/disability-equipment-program/?red=/disability/catalogue)>



**Word of Mouth Technologies:** <[www.wom.com.au](http://www.wom.com.au)>

### Provide therapy, training and education to the patient

Patients can be provided with therapy as well as training and education about using various strategies to improve communication, including:

- lip reading
- perception of non-verbal cues
- speech discrimination training [3]
- decreasing distance between themselves and their communication partner
- reducing distractions (such as background noise, glare)
- using assistive devices and sensory aids [2]
- using conversational repair strategies and clarification requests effectively [3]
- undertaking appropriate speech and language therapy [13]
- using AAC strategies [1].

Patients who are alert and stable but unable to communicate using speech are candidates for AAC tools and strategies [1].

When providing written information to patients with vision impairments Vision Australia recommends the following [10]:

- Use a black marker on white paper (make sure the print size and thickness is adequate).
- Use upper and lower case letters (do not use capitals only). This gives more shape to words for better visibility.
- Do not underline words.
- For printed materials use a strong contrast (for example, black type on white paper).
- Univers, Arial or Helvetica font styles minimum of 12 point (ideally 18 point) are recommended.



**For brochures and educational materials about Vision Australia services, independent living, and technology and training solutions for patients with vision impairments see:** <[www.visionaustralia.org/info.aspx?page=794](http://www.visionaustralia.org/info.aspx?page=794)>.

Most of these materials can be ordered in braille, audio cassette, CD, print, MP3, disk and large print.



**For more information about speech and language therapy see chapter 6.5 of the Clinical guidelines for stroke management from the National Stroke Foundation [13].**

## Provide training and education to families and carers

Families and carers need to be aware of the sensory, communication and psychosocial consequences of vision, hearing and speech impairments. Families and carers can be provided with training and education about improving communication, and can encourage older patients to use their communication aids and any effective communication strategies [3].

## Impacts on other domains of care

It is important to be aware that vision, hearing and speech impairments and associated communication difficulties will impact on other domains of care for older patients. The following are just a few examples.



Mobility, vigour and self-care may be more difficult for some visually impaired older patients and precautions, assistive devices and/or assistance may be appropriate. Patients may be more at risk of falls because of visual impairments, not hearing safety instructions from staff, or not being able to ask for assistance easily.



Nutrition may be negatively impacted if older patients cannot see the food on their plates, and they may have difficulty preparing food at home.



While differentiation between vision, hearing and speech impairments and cognitive impairments are important to make sure older patients receive the most appropriate care, hospital staff should also recognise that dementia and depression may also be present and further confound communication difficulties.



Continence may be affected if an older patient has difficulty finding the toilet, or difficulty communicating the need for the toilet.



Staff should check that older patients clearly understand medication instructions, and are able to identify which medications they should be taking.



Skin integrity may be at risk if older patients have difficulty seeing obstacles or are reluctant to get out of bed in an unfamiliar environment.



Some older patients may have difficulty communicating that they are in pain.

Hospital staff are encouraged to use tools and resources from the other domains of care. However, clinical knowledge and experience are required to select appropriate tools when working with older patients with vision, hearing and speech impairments. If further information or education is required, staff should consult with clinical experts in those areas to implement best practice.



**Assessment and management of communication disorders – clinical practice guidelines from Western Health**



**Sensory loss practice guidelines from Barwon Health**



**Hard of Hearing Project at Caulfield Hospital (Alfred Health)**



**St Vincent' Health, Victoria's first deaf and hard of hearing friendly health service resource guide**

## What can patients, families or carers do to improve communication in hospital and at home when a vision, hearing and/or speech impairment is present?

Families and carers often have useful strategies for enhancing communication with older patients, and they should be encouraged to share their knowledge with hospital staff.

Families and carers can help to make sure older patients have their appropriate communication aids in hospital and that they are working. For example, eye glasses are worn or are within reach if resting, and hearing aids are properly inserted, have batteries and are turned on.

Families and carers can encourage older patients to use their prescribed communication aids. For example, many older people do not wear their prescribed hearing aids because a period of adjusting to sound qualities and background noise is necessary [2].

Families and carers can participate in training and education regarding ways to improve communication.



It may be important to explain to families and carers that vision, hearing and/or speech impairments are causing older patients' communication difficulties. Carers frequently perceive that older adults with dual vision and hearing loss have dementia [3].

## What should I consider when planning discharge to help an older person with vision, hearing and/or speech impairments?

If AAC strategies are required, practice should preferably occur before discharge from hospital [13].



Older adults with a vision, hearing and/or speech impairment are susceptible to social isolation [3]. Vision and hearing impairments are moderately related to depression and anxiety in older adults with poor social and carer support [3]. Older patients may feel isolated and depressed at being excluded or unable to contribute to family conversations at home and less able to communicate through the telephone [6]. To help maintain their psychosocial wellbeing, many older people with severe sensory impairments would benefit from regular contact with a healthcare worker who is trained in the necessary communication skills [2].

Group therapy and conversation groups can be useful for some patients with speech impairments and should be made available longer term [13].

Visually impaired older adults may have difficulty performing activities of daily living and/or instrumental activities of daily living [14].

Appropriate support after leaving hospital is therefore vital for the wellbeing of an older patient with a vision, hearing and/or speech impairment.



**For daily living tips for people with vision impairments see pages 10–18 of Working with people with vision loss from Vision Australia [10].**



**Tip sheets for independent living for people with:**  
<[www.visionaustralia.org/info.aspx?page=795#Eye](http://www.visionaustralia.org/info.aspx?page=795#Eye)>



**Tip sheets on orientation and mobility for people living with vision impairments are available from Vision Australia: <[www.visionaustralia.org/info.aspx?page=795#Eye](http://www.visionaustralia.org/info.aspx?page=795#Eye)>**



**Information on support groups in Victoria for people living with vision impairments are available from Vision Australia: <[www.visionaustralia.org.au/info.aspx?page=1977](http://www.visionaustralia.org.au/info.aspx?page=1977)>**

## Case study

Mr Mackenzie is a 69-year old retired mechanic living at home with his wife of 40 years. He is admitted to a general medical ward after open surgery to remove his gall bladder.

### Scenario 1

Mr Mackenzie's wife accompanies him, chatting happily as a nurse orients them to the ward. Mr Mackenzie is quiet, only nodding his head when spoken to by staff.

Mr Mackenzie's wife spends the first two days helping to care for her husband in hospital and Mr Mackenzie makes good progress in his recovery. His pain is under control and he is sitting out of bed and using the toilet. Before leaving on the second day his wife mentions to the nurses that she has a medical appointment of her own the next day and she will not be in to see her husband until the afternoon. She asks that someone remind her husband of her appointment in the morning 'because sometimes he forgets these things and gets upset.'

Mr Mackenzie wakes the following morning and presses the call button for a nurse. He is upset. He cannot find his glasses and he needs to use the toilet. The nurse locates his glasses on the overbed tray beside him and asks if there is anything else he needs. Mr Mackenzie waves his hand dismissively and the nurse leaves. Less than two minutes later Mr Mackenzie's call bell rings again and the nurse returns. He is angry and wants to know where his wife is. The nurse explains that she had an appointment of her own and would be in later that day. She asks if there is anything else he needs and he shakes his head. She leaves because breakfast is being brought to Mr Mackenzie. When another nurse returns later with Mr Mackenzie's medication he notices that he has not touched his breakfast. Mr Mackenzie simply waves a hand dismissing the food and responds to the nurse's questions with low grunting noises and shakes of his head. Mr Mackenzie spends the rest of the morning lying in bed wearing earphones he brought from home. Just before lunchtime Mr Mackenzie's call bell again rings. When the nurse responds she finds Mr Mackenzie's roommate yelling in pain on the floor of their shared bathroom. He is holding his arm. He says he slipped on the wet floor in the bathroom. Upon investigation the nurse discovers a puddle of urine on the floor left by Mr Mackenzie because he had difficulty seeing the toilet.

### Scenario 2

When orienting Mr Mackenzie to the ward the nurse speaks directly to Mr Mackenzie. When she tries to confirm his understanding he asks on two occasions for her to speak louder and the nurse asks if Mr Mackenzie has hearing aids. He tells her he does not and she asks when was the last time he had his hearing checked. Mr Mackenzie says that he doesn't know, 'a long time ago, maybe.' The nurse kindly suggests that he might benefit from having his hearing checked. She volunteers to give him some information and explains that while in hospital he can borrow some assistive equipment if he is having trouble hearing. She stresses the importance of communicating with and understanding his caregivers in hospital. She then records the possibility of a hearing impairment in his medical record. During orientation the nurse also takes note of Mr Mackenzie's eye glasses and asks about his vision. He says the glasses help but he has macular degeneration and his eyesight won't ever be perfect.

While Mr Mackenzie's wife is at hospital one of the nurses notices that she provides a great deal of assistance. She helps with opening his meal packaging, tells him what he is eating, gets up with him when he uses the toilet and often tries to speak on his behalf.

So when Mr Mackenzie's wife asks the nurses to remind her husband that she will not be able to come to hospital in the morning, the nurse suggests they go and confirm his understanding of the situation and work together to make sure he will have the help he needs.

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## Further reading

### Common vision impairments in older adults

Most vision impairments in older adults result from age-related or pathological changes to the eyes. Normal age-related changes, called presbyopic changes, include:

- increased sensitivity to glare
- dryness of the eyes
- increased need for light
- slower distance accommodations
- slower adjustments to different light conditions
- reduced depth perception
- reduced contrast sensitivity
- reduced hue discrimination [1].

The four pathologies that primarily cause vision impairment in older adults are:

- cataracts
- diabetic retinopathy
- glaucoma
- macular degeneration [2].

 For information and pictures of how these four conditions affect vision see page 5–8 of **Working with people with vision loss by Vision Australia [3]**.

  More information for staff, patients and families about glaucoma can be found on the **Glaucoma Australia website: <[www.glaucoma.org.au](http://www.glaucoma.org.au)>**

  More information for staff, patients and families about macular degeneration can be found on the **Macular Degeneration Foundation website: <[www.mdfoundation.com.au](http://www.mdfoundation.com.au)>**

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3. Vision Australia 2012, *Working with people with vision loss*, Vision Australia, Sydney.

## Common hearing impairments in older adults

Hearing is likely to change with age. Age-related changes can occur to the outer, middle and inner ear. Heredity, illness, accidents and exposure to environmental noise are contributing factors to age-related hearing impairment [1].

The following types of hearing loss are common in older people.

### Conductive hearing loss

Conductive hearing loss occurs when the ability of sound to travel through the outer and middle ear is affected. Impacted or occluding earwax is a common cause of conductive hearing loss in older people and should be managed medically.

Age-related changes to the ear canal, tympanic membrane and ossicles do not normally impair hearing significantly [2].

### Sensorineural hearing loss

Sensorineural hearing loss occurs when there is damage to the inner ear or to the neural pathways from the inner ear to the brain. Presbycusis is the most common cause of sensorineural hearing loss in older people: it is a multifaceted problem caused by a non-uniform pathological condition [3]. Presbycusis often causes an inability to hear certain pitches [1, 3]. In most cases high-pitched/high-frequency sounds (like 'th' and 'f') are lost first and reduced speech discrimination results. Presbycusis can cause speech to sound distorted, particularly in noisy environments.

Both conductive and sensorineural hearing loss can be helped with amplification aids (such as hearing aids). The amount of benefit obtained will depend on the type and degree of the hearing loss, as well as individual factors.

### Tinnitus

Along with reduced ability to hear and discriminate words some older people also experience tinnitus. Tinnitus is characterised as hearing ringing, buzzing, swishing or clicking sounds, even when no such environmental sound exists [1]. Tinnitus is a symptom of a malfunction in the hearing system [4]. There are many possible triggers of tinnitus including [4]:

- exposure to excessively loud noise
- extreme stress or trauma
- age-related hearing loss
- some prescription and non-prescription drugs.



**The Tinnitus Association Victoria offers a range of support services for people with tinnitus: <[www.tinnitus.org.au](http://www.tinnitus.org.au)>**

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## Information on common speech impairments in older adults

In older adults the main causes of speech impairment are stroke or other neurologic difficulties, dental difficulties and dry mouth (xerostomia) (dry mouth is a common side effect of some medications) [1]. Impairments resulting from poorly fitting dentures or other dental difficulties may have other consequences including poor nutrition and persistent mouth pain [1].



### Mouth Care Program at Caulfield Hospital (Alfred Health)



**Oral healthcare domain – the toolkit** from SA Health: <[www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+information/Health+information+for+the+clinician/Best+care+for+older+people+everywhere+-+The+toolkit/Oral+health+care+domain+-+The+toolkit](http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+information/Health+information+for+the+clinician/Best+care+for+older+people+everywhere+-+The+toolkit/Oral+health+care+domain+-+The+toolkit)>



**Information for hospital staff on communication problems following stroke is available from Speech Pathology Australia:** <[www.speechpathologyaustralia.org.au/library/3.1\\_Communication\\_Problems\\_following\\_a\\_Stroke.pdf](http://www.speechpathologyaustralia.org.au/library/3.1_Communication_Problems_following_a_Stroke.pdf)>

Degenerative neurological disorders, dementia and transient ischemic attack (TIA) are other commonly reported underlying causes of speech impairment in older adults [1].

Dysarthria, dyspraxia and dysphasia (also sometimes referred to as aphasia) are common speech impairments in older adults.

## Dysarthria

Dysarthria is a motor speech impairment that may result in:

- changes to speech volume
- changes to voice quality, such as sounding harsh
- nasal-sounding speech
- slurred speech
- speech sounding all the same volume or pitch [2].

Dysarthria can be caused by damage to the nerves that control the muscles of speech or from structural damage to the muscles [3]. Dysarthria may range from mild slurring of speech to profound impairment where no sounds or words can be produced.



### Information for patients and families about dysarthria



**A tip sheet for hospital staff on dysarthria:** <[www.royalrehab.com.au/publications/dysarthriabrochure.pdf](http://www.royalrehab.com.au/publications/dysarthriabrochure.pdf)>



### Strategies for working with patients with dysarthria from Alfred Health

## Dyspraxia

Dyspraxia is a speech impairment caused by damage to the speech control centres of the brain, which may result in:

- difficulty finding the correct mouth position to make or coordinate sounds
- difficulty making smooth transitions between sounds and words [2].

Dyspraxia severity can range from mild, with an occasional mispronounced sound in a word, to severe, resulting in a total inability to produce speech.



### **Information for patients and families about dyspraxia/s**

#### **Dysphasia**

Dysphasia is a language disorder resulting in impaired speaking and trouble understanding speech, reading and writing due to damage to the language centres of the brain [1, 2]. Dysphasia and aphasia are sometimes used synonymously [4]. Experiencing dysphasia has been compared to being in a foreign country when you do not speak the language – you know what you want but you have problems understanding others or expressing yourself [5].

Dysphasia may result in:

- being unable to recognise sounds
- losing the meaning of words
- not understanding longer, more complex sentences
- knowing what something is but not being able to say its name
- substituting words or sounds while talking
- being able to say main words but not being able to link them into a sentence
- getting stuck on words or sounds
- finding automatic language such as counting or saying ‘hi’ in response to a greeting easier than less automatic speech such as explaining what they had for breakfast
- difficulty explaining things clearly
- difficulty understanding or using body language
- difficulty recognising and understanding letters or words
- difficulty remembering and understanding lengthy sentences
- difficulty recalling details from long stories
- difficulty forming letters into words and subsequently forming sentences
- difficulty organising ideas into logical stories [2].

Some patients with mild dysphasia may only have occasional difficulty thinking of words or difficulty understanding long and complex information, while others with severe dysphasia will be unable to speak at all or, when they speak, it will be jargon without recognisable meaning. Severe dysphasia can also mean that some patients cannot understand speech at all. Some types of dysphasia mean that patients have difficulty speaking but can understand speech normally; however, difficulties understanding and speaking often occur together to different degrees.



### **Information for patients and families about receptive aphasia**



### **Information for patients and families about expressive aphasia**



### **Information for patients and families about aphasia**



### **Tips for patients having difficulty thinking of a word from Alfred Health**



**Information and resources for patients, families and hospital staff are available from the Australia Aphasia Association: <[www.aphasia.org.au](http://www.aphasia.org.au)>**

 **Strategies for working with patients with dysphasia from Alfred Health**

General speech impairment tools

 **Indicators for referral to speech pathology from Melbourne Health**

 **Tips for patients with speech impairments from Alfred Health**

# Mobility/vigour/self-care



## Five facts everyone should know about mobility, vigour and self-care

1. The ability to mobilise and participate in self-care is fundamental for interaction and control within a person's environment.
2. Screen or assess older people for falls risk and take action to minimise the likelihood of falls.
3. Provide supervision for walking or transfers for older people at risk of falls.
4. Maintain or retrain an older person in skills of activities of daily living and self-care.
5. Encourage physical activity via incidental exercise and participation in functional maintenance or enhancement programs, as appropriate.

## What is mobility, vigour and self-care?

Functional mobility is the capacity to move from one position (sitting, lying down, standing and so on) to another, to enable participation in normal daily routines and activities. Functional mobility includes bed mobility, transfers, walking, wheelchair mobility, driving and taking public transport. Having independence in functional mobility tasks significantly reduces the level of long-term care required by an individual with a disability and allows an individual to participate in a range of self-care, productive and leisure activities, thereby promoting a sense of self-worth and actualisation [1].

Vigour is the active strength or force of body or mind [2]. For example, in addition to the need for mobility, a person's ability to function is also determined by their energy levels, endurance, motivation and cognitive capacity.

Self-care is the personal care carried out by a person in hospital, for example, eating, bathing, personal grooming and toilet hygiene. An older person might require assistance or instruction from a healthcare worker for these tasks.

## Why is it important to consider mobility, vigour and self-care when working with older people in hospital?

The ability to mobilise and participate in self-care is fundamental for interaction and control within a person's environment.

By maintaining mobility and adequate self-care it is possible for older people to maximise their:

- opportunities for personal independence
- social connectedness
- security
- activity
- dignity.

Age-related functional decline means that older people are more susceptible to de-conditioning [3]. For people living in the community, loss of the ability to mobilise and participate in self-care safely can determine the range of support services required. For people living alone, this loss of ability can result in placement into residential care.

For those entering hospital, mobility and self-care are often key measures used by healthcare workers to predict length of stay, discharge destination and the requirement for support services. For this reason, it is essential to ensure that a patient's mobility and capacity for self-care is maintained or improved during a hospital stay. This will provide them with the opportunity to return to their previous level of function and social situation wherever possible. During a hospital stay, a person-centred partnership with the older person is necessary to ensure mobility and self-care are maintained or improved.



Mobility and self-care are fundamental to many of the other domains addressed in *The toolkit*.



For example, an older person's ability to walk to the toilet may help them maintain continence, and promoting mobility and active participation in self-care is recommended for minimising the risk of depression, delirium and under-nutrition.



## Maintaining mobility, vigour and self-care in relation to falls

Falls, related injuries and loss of confidence due to the fear of falling are common causes of morbidity in Australia. In hospital and residential care settings, the risk of falling is even greater than in the community setting because of acute illness, increased levels of chronic diseases and different environments and routines [4].

In the acute hospital setting, falls rates of between two and seven falls per 1,000 bed days have been reported [4]. This translates to up to four falls per day in a 500-bed hospital, or over 1400 falls per year.

Between 30 – 40 per cent of falls in hospitals cause injuries [4], most commonly resulting in soft tissue injuries, fractures and cranial trauma. Even when no injury has occurred, the patient often loses confidence in their mobility, which can cause them to reduce their walking and other activities. Over time, this results in de-conditioning and increases their risk of further falls and functional decline [4].

Research evidence indicates that interventions to minimise falls risk can reduce the risk of falling and fall-related injuries, even in older people at high risk of falling. Staff involved in direct care in hospital and residential care settings have a key role in successfully implementing falls risk minimisation activities [4].

Maintaining mobility, vigour and participation in self-care during an older person's hospital stay can maintain their independence, reduce the likelihood of falls and fall-related injuries, and minimise loss of confidence due to fear of falling.

## What are the benefits to an older person in maintaining their mobility, vigour and self-care in hospital?

The ability to walk, climb stairs, transfer in and out of bed, shower, dress and toilet are related to an older person's level of strength, balance and endurance.

Maintaining strength, balance and endurance during a hospital stay is essential to:

- maintain or improve independence
- prevent de-conditioning that can result in functional decline due to the physiological changes following a period of inactivity or low activity
- maintain or increase muscle strength that occurs through an appropriate amount of physical activity and mobilisation
- decrease the risk of muscle shortening, joint distortions and reduced muscle capacity that occurs with immobilisation
- decrease cardiovascular de-conditioning that can occur with prolonged periods of bed rest
- decrease reduced aerobic capacity that can occur through changes in muscle metabolism
- reduce admission to long-term residential care services
- reduce the likelihood of falls [3].

## What care or management principles should I follow to ensure maximum mobility, vigour and self-care for older people in hospital?

The following eight recommendations [3] can ensure maximum mobility, vigour and self-care during an older person's hospital stay and after discharge:

1. Perform a comprehensive assessment for falls and fracture risk, mobility and functional status.
2. With input from the patient and family or carer, develop an individualised care plan and encourage appropriate incidental activity and minimise bed rest throughout the day.
3. Assess and modify the environment to encourage independence and mobility.
4. Consider individual or group exercise training for muscle strength, endurance and balance.
5. Assist in the retraining of activities of daily living.
6. Consider nutritional supplementation where food intake is inadequate, in combination with strengthening exercises to maintain or improve muscle mass and strength. Be aware of the evidence that some older people displace food intake when supplements are introduced, so this needs to be done carefully under the supervision of a dietitian.
7. Supervise walking and transfers in those identified to be at risk of falling.
8. Consider transitional care needs and community-based strategies for minimising post-discharge falls and maintaining ongoing strength, mobility and vigour.

The following sections provide examples of resources to support the implementation of these guidelines.

## How do I screen and assess for mobility, vigour and self-care?

Screening tools for this domain can highlight people who are at greatest risk of:

- de-conditioning — a decline in strength, balance and endurance during their hospital stay
- falls
- loss of independence with self-care.

Screening tools can also be scored to determine the level of a person's risk. This can assist to confirm a person's improvement or decline on follow-up.

Assessment tools are used to identify underlying risk factors that contribute to a person's overall risk and prompt a more detailed assessment to develop a care plan with appropriate strategies that address areas of identified risk related to de-conditioning.



Person-centred screening and assessment should always be conducted in partnership with the older person and their family or carer.

A number of mobility and functional assessment tools can be used by healthcare professionals:



**Berg Balance Scale**



**de Morton Mobility Index (DEMMI)**



**Modified Elderly Mobility Scale (MEMS)**



**Timed Up and Go Test**



**Tinetti Assessment Tool: Balance**



**Barthel Index**



**Functional Independence Measure (FIM) and Functional Assessment Measure (FAM)**



**Performance Orientated Mobility Assessment.**

These tools can also be useful as outcome measures for program evaluation.

### Further information



For further information on these tools, refer to *Mobility and functional assessment tools*.

## How do I screen and assess for falls risk?



If a screening tool recognises that a person is at risk of falls, a falls risk assessment should be conducted. Assessment tools identify the falls risk factors that contribute to the patient's overall risk of falls and fall-related injuries [4]. Person-centred screening and assessment are always conducted in partnership with the older person and their family or carer.



A range of falls risk screening and assessment tools have been evaluated and published in the Victorian Quality Council *Minimising the risk of falls and fall-related injuries guideline pack*.

### Further information



For guidelines, refer to *Minimising the risk of falls and falls injuries – guidelines for acute, subacute and residential care settings*



For tools, refer to *Minimising the risk of falls and falls injuries – guidelines for acute, subacute and residential care settings (tools supplement)*.

Some tools have the potential to be used as either a screening or an assessment tool. Refer to *Summary of falls risk screening tools and falls risk assessment tools* for further information.

## How can I prevent falls in older people identified as at risk?

Once a falls risk assessment has been completed, an individualised action list aimed at reducing the risk of falls and fall-related injuries should be developed and implemented, in partnership with the older person and their family or carer.

For more comprehensive guidelines to develop individualised action plans, the following supplements can be used to incorporate this practice into organisational departments:



For guidelines, refer to the Victorian Quality Council *Minimising the risk of falls and falls injuries – guidelines for acute, subacute and residential care settings*



For a suite of resources for Australian hospitals and residential aged care facilities, refer to the New South Wales Falls Prevention Network



Prevention of Falls Network Europe



Falls Prevention for Older People: A program of national workshops on risk factors and prevention strategies



Falls risk assessment tool.



## What can I do to promote mobility and self-care during an older person's hospital stay?

### Sitting out of bed

Encourage patients to sit out of bed if possible. Staying in bed unnecessarily can have a detrimental impact on a person's overall function.



Sit-out-of-bed initiatives are simple strategies to minimise functional decline that organisations can embed into everyday practice, for example, assisting patients to eat meals out of bed.

### Promote independence in self-care

- Encourage patients to dress each day if possible.
- Find out about patients' usual routines at home and try to maintain these in hospital (for example, what time of the day they usually shower). This helps with orientation to the ward and regular sleeping patterns. It is important to base ward routine on patient preferences and usual routines, rather than staff preferences.
- Include patients in self-care programs, such as cooking groups or self-care education sessions.
- Practise activities of daily living with a patient prior to discharge.
- Work with older people and their family or carers to assess and source any equipment that may be required at home.

### Hospital environment

The hospital environment is important in promoting mobility and self-care in older people.

A number of tools can be used to assess the hospital environment to promote mobility and self-care in older people:



**Improving the environment for older people in health services: an audit tool**



**Older person friendly ward round**



**Individual environmental checklist**



**Actions for minimising individual environmental risk factors**



**For further information on these tools refer to Environmental assessment tools.**

## How can I encourage optimal mobility, vigour and self-care in hospital?

There is good evidence to support using interdisciplinary interventions that include a component of exercise to reduce in-hospital length of stay. This can increase the proportion of patients discharged directly home and reduce the cost of stay for older acute hospital inpatients [5]. Exercise alone has not been shown to influence acute hospital length of stay. For this reason, it is important that exercise is used as part of a multidisciplinary intervention to be effective in preventing de-conditioning of older people in hospital.



The following sections outline a range of interventions to consider as part of an interdisciplinary strategy. Interventions should be discussed and implemented in partnership with the older person and/or their carer.

### Encourage incidental activity

Incidental activities are those where physical activity occurs as part of routine activities, for example, walking to the toilet (rather than using the commode), transferring and dressing. This form of exercise, through encouraging independence with functional tasks, is the easiest to promote and perform in the acute setting.

Minimising bed rest by increasing the number of incidental activities during the day can help to maintain muscle mass, strength and mobility, and reduce agitation in older people.

A benefit of performing incidental activity is that it involves activities people are familiar with, so is less anxiety-provoking than starting a new physical activity. It also has a purpose, so if a person is not interested in a formal physical activity program, these personal care and domestic tasks are a beneficial form of exercise [3][6].

The summary overleaf outlines some practical strategies that have been implemented in hospital settings throughout Australia to enhance the culture of the wards for both staff and patients in:

- promoting incidental activity
- minimising bed rest
- preventing functional decline.

**Encourage patients to:**

- dress (consider the possibility of wearing their normal day clothes and footwear)
- get out of bed and move around the ward, with supervision as required
- sit out of bed as soon as it is considered safe to do so



- walk to the toilet, with supervision as required



- eat meals out of bed, preferably in a communal dining room where available and appropriate.

**Sitting out of bed for meals enables patients to:**

- see their food, food supplements and medications properly
- see orientation clues like clocks, calendars, signs and photos
- feed themselves if they are able or better facilitate feeding
- swallow more safely
- digest food and medications
- breathe deeply
- communicate with other patients
- be less dependent
- feel better about themselves
- maintain their level of function.

**Assist patients to:**

- mobilise for personal care activities as much as possible
- practice mobilisation, under the prescription, direction or instruction of a physiotherapist
- undertake Thera-Band strengthening exercises (under the prescription, direction or instruction of a physiotherapist).

**Educate staff to:**

- create a continence and mobility plan that fits with patients sitting out of bed for meals

- adjust bed heights to allow for safe, independent, transfers
- provide an environment that encourages incidental exercise
- provide aids to assist with optimal transfers for patients getting out of bed
- avoid using bed rails, which may limit mobility and be a hazard
- improve their knowledge of the risks of restricting mobility and provide strategies to prevent de-conditioning.

## **Individual and group exercise**

Exercise programs can be administered in both individual and group settings, and may include strength, balance, functional retraining and aerobic (or endurance) exercises.

Although there is limited evidence to draw conclusions of the benefits of exercise alone for people in hospital, as a component of an interdisciplinary intervention, evidence has indicated that individual or group exercise may:

- increase the number of patients who are able to return home after discharge
- reduce length of stay for older people
- reduce the cost of a hospital stay [5].

Refer older patients to physiotherapy for an individual or group exercise regimen.

## **Retrain activities of daily living**

Activities of daily living include mobility and self-maintenance activities (feeding, grooming, dressing, bathing, personal hygiene, toileting and skin management) [7]. Bathing and dressing can be divided into upper-body and lower-body management [8].

Maintaining and retraining these skills is important to extend a person's ability to live independently.

To retrain, staff may need to:

- retrain older patients in their personal care skills
- provide training in alternative strategies for self-care where necessary
- provide aids to assist with optimal independence (such as appropriately designed seating)
- ensure bed and chair heights are optimal for independence
- include patients in self-care programs, such as cooking groups and self-care education sessions
- provide verbal encouragement and guidance to promote independence.

## **Supervision for those 'at risk'**

If a person is using a gait aid or is acutely unwell, always supervise walking and transfers.

Supervision can be reduced as medical stabilisation occurs and familiarisation with the environment and equipment is achieved. Physiotherapists should be consulted if staff are in doubt about the supervision needs of patients [3].

Adequate nursing staff levels are important to ensure that the maximum possible amount of mobility can occur. This will enable staff to provide appropriate levels of supervision.

Other strategies to ensure patient mobility updates are communicated effectively between staff include:

- mobility sections in care plans
- entries in a medical record
- using a whiteboard
- daily handovers
- the Gait Aid Colour Coding System.



The **Gait Aid Colour Coding System** is a common, yet simple and practical way to inform all care staff of an individual's supervision needs.

### Management for falls risk



Risk indicators, actions for injury prevention and hints and tips to assist in eliminating personal risk factors (for example: leg muscle weakness and de-conditioning; poor balance and unsteadiness in walking; and loss of confidence or fear of falling) have been clearly outlined in ***Minimising the risk of falls and falls injuries – guidelines for acute, subacute and residential care settings (quick reference guide)***.

### Multidisciplinary interventions

A number of functional maintenance programs (FMPs), otherwise known as functional enhancement programs, have been developed by various health organisations. These programs offer a multidisciplinary approach to preventing de-conditioning in hospital. FMPs should be undertaken in partnership with the older person and their family or carer.



To review the main components of FMPs operating in health services in 2008, refer to ***Elements of functional maintenance programs***.



For brief descriptions of FMPs operating within some Victorian health services in 2008, refer to **Functional Maintenance Programs**.

## What can patients, families or carers do to maintain mobility, independence and reduce the risk of falls?

Ensuring both patients and their families or carers are aware of the benefits of keeping active in hospital and participating in self-care, where possible, promotes independence within the hospital setting. Educating people about strategies to prevent falls during a hospital stay is important to reduce the likelihood of fall-related injuries.

A booklet has been designed to encourage people to be aware of what they can do for themselves while in hospital.

### Further information



**Information about falls for patients, families and carers.**

## What should I consider when planning discharge to help older people maintain mobility, vigour and self-care?



Person-centred discharge planning must be undertaken in partnership with the older person and their family or carer(s).



Ensure the effective transfer of information regarding a person's mobility needs and falls risk, refer to ***Effective transfer of falls risk information***.



Falls risk screening and assessment tools that can be used to assess risk of falls in the emergency department, and as admission screening tools for use by community-based services include:



 Provide referrals to appropriate community services for older people at risk of falls following discharge. For examples of services, refer to ***Services to support a patient at risk of falls post-discharge***.

 Provide written resources and discuss them with patients and their family or carers. Refer to ***Further information for patients and carers about preventing falls post discharge***.

 Encourage and facilitate physical activity beyond discharge. For tools and programs refer to ***Why it is important for an older person to engage in physical activity beyond discharge***.

## Case study

Mr Brown is 86 years old and lives independently. He usually uses a walking stick in the community. He has no community services in place and manages his own personal and domestic care. Mr Brown's only family, a daughter, lives interstate.

After Mr Brown slipped and fell in his bathroom at home, his daughter, who was visiting at the time, phoned an ambulance. Mr Brown was then admitted to the emergency department (ED) with a possible fractured wrist.

### Scenario 1

Due to high demand in the ED at the time of his arrival, Mr Brown was triaged and instructed to return to the waiting area where he waited with his daughter for approximately two hours. During his waiting period, Mr Brown was instructed not to eat or drink and became increasingly agitated and confused. Once in the ED, the admitting doctor completed a full medical examination, requesting an X-ray and a full blood screen. Mr Brown was put on a drip and informed to remain in bed until test results became available.

Soon after, Mr Brown's daughter informed one of the nurses that her father had appeared more confused than usual in recent days, and was quite unsteady on his feet. The nurse lifted the cot sides and told Mr Brown not to walk on his own, but this information was not noted in the medical history, nor reported to the medical officer. A falls risk assessment was not performed. Given it was now late in the evening and there was an expected delay in blood results and X-rays, it was suggested to Mr Brown's daughter that she go home and call the ED first thing in the morning. Overnight, Mr Brown became increasingly confused, pulled out the drip, and climbed the cot side. He fell, and sustained lacerations to his face.

Mr Brown's daughter returned the next day. She was distressed that inadequate measures had been taken in her absence to manage her father's risk of falls, particularly as she had specifically informed the nurse of his confusion and unsteadiness. Mr Brown had now been in ED for 14 hours and remained in bed during the entire period.

Mr Brown was transferred to the ward but waited several hours before being seen by the doctor and no information would be available regarding test results until the doctor arrived. On assessment, the medical officer asked all the 'same questions' of Mr Brown and his daughter. X-ray results confirmed a fractured wrist and Mr Brown was sent to have his arm cast later that afternoon.

As Mr Brown remained on a drip due to severe dehydration and resultant kidney problems, his mobility remained severely restricted over the three-day period. On day three, Mr Brown was assessed by the physiotherapist, who confirmed significant de-conditioning and the need for a period of rehabilitation before returning home. A mobility routine was not commenced as Mr Brown was expected to be transferred for rehabilitation as soon as a bed became available.

Although Mr Brown's wrist was plastered on day two, his eating difficulties were not assessed until day four when he was seen by the occupational therapist. In the meantime, Mr Brown needed support from his daughter to set up his meal so he could eat it. There were several food items not eaten because Mr Brown could not manage with the cast when his daughter was absent.

Mr Brown's confusion began to subside with re-hydration, but his food intake remained restricted due to difficulties with using utensils. The occupational therapist provided advice and education but, by this time, Mr Brown had noticeably lost weight since first arriving to hospital.

The overall experience of the hospital stay was very stressful for Mr Brown and his daughter, with long periods of waiting and not being kept informed. Due to the de-conditioning (in mobility, weight, mental state and functional independence) experienced in the early days of hospitalisation, it was necessary to extend Mr Brown's hospital stay to include a period of rehabilitation. This could have been prevented with more proactive care and understanding of Mr Brown's needs.

## Scenario 2

The following strategies from *The toolkit* were utilised:

- use of a global screening tool on admission
- domain and discipline-specific assessment and management where indicated by screening or clinical observation
- use of a **falls risk screening and assessment** tool, given history of fall
- provision of adequate supervision to facilitate maintenance of mobility
- use of a **fall alert system** to ensure effective communication regarding mobility status
- consideration of appropriate environment to facilitate incidental activity
- involvement in a **functional maintenance program**
- provision of targeted strength and balance exercises by a physiotherapist
- management of risk factors contributing to falls risk (hydration, nutritional status, cognitive status)
- assessment of home environment prior to discharge
- comprehensive discharge planning for ongoing management of mobility and falls risk
-  • provision of comprehensive discharge summary to facilitate ongoing care
- encouraging and facilitating physical activity beyond discharge.



In the ED, a global screen was administered and the admitting doctor completed a full medical examination, X-rayed Mr Brown's wrist and confirmed that it was fractured. A falls risk screen was conducted using a falls risk assessment tool; Mr Brown scored 13/20, indicating he was at a 'medium' risk of falls. He was also diagnosed with severe dehydration, de-conditioning and weight loss. These additional factors automatically increased his falls status to 'high', and a falls alert was commenced immediately. Mr Brown also received a Hodkinson Abbreviated Mental Test score of 5/10 (moderately impaired).

Mr Brown's fractured wrist was cast and, as a result of a full assessment, ED staff recommended care strategies, which were then transferred onto Mr Brown's care plan. Some of the recommendations included: using the Gait Aid Colour Coded System, supervision or assistance for all mobility with his walking stick and a trial of hip protectors. Mr Brown underwent a medication review by the pharmacist in the ED and was referred to a dietitian. During his stay in the ED, Mr Brown was supervised to and from the toilet (rather than using a bed pan), and was encouraged to sit in a suitable, height-adjusted chair to increase his level of incidental activity.

The ED staff identified Mr Brown as frail and at risk of functional decline, prompting an accelerated transfer to the specialist acute geriatric unit. Building upon the ED's care recommendations on the interdisciplinary care plan, Mr Brown was targeted for the functional maintenance program (FMP).



On arrival, an occupational therapist assessed Mr Brown's independence and safety in personal care and provided recommendations to all staff. An individual environmental checklist



was conducted to maximise Mr Brown's ability to mobilise around his room safely. The physiotherapist conducted an assessment and enrolled Mr Brown in an individually tailored functional maintenance program. Nursing staff supervised and encouraged him to dress, sit out of bed during the day, eat meals out of bed and ambulate to the toilet with supervision, as required. He was also instructed by the physiotherapist to perform tailored strength and balance exercises, including Thera-Band exercises and daily ambulation (supervised walks through the ward) with a walking stick the physiotherapist had adjusted and trained him to safely use. These interventions assisted Mr Brown to regain his stamina and maximise his ability to participate in self-care activities.



Mr Brown's confusion began to subside with re-hydration. Protected meal times and prescribed dietary recommendations increased his nutritional status. A second Hodkinson



Abbreviated Mental Test was performed and Mr Brown's confusion had improved (9/10 – intact). Another falls risk screen was conducted. Mr Brown was now at a 'low' risk of falls (7/20), if using a stick indoors.

-  At a team meeting, the nurse unit manager recommended that a family meeting be arranged for Mr Brown prior to discharge home to optimise his ongoing mobility, safety and nutrition.
-  At the family meeting, Mr Brown, his daughter, a physiotherapist, occupational therapist and dietitian were present. The dietitian presented Mr Brown with dietary recommendations for his return home, and referred him to Meals on Wheels. This was arranged to begin a couple of days before his daughter left, as his ability to cook independently was limited by being able to only use one arm.
-  The occupational therapist arranged a home visit to assess Mr Brown's home environment, and informed him and his daughter about the home safety checklist resource. Mr Brown and his daughter were keen to conduct this checklist together on their return home and his daughter offered to improve any aspects of the home environment that were flagged, before her return to Queensland (for example, moving furniture, installing a night light, removing clutter or mats, organising a handyman to install rails).
-  The physiotherapist encouraged Mr Brown to consider joining a physical activity program or group. Mr Brown and his daughter were shown the local physical activity directory for older people. Mr Brown expressed that he was not interested in joining a walking program but would consider a local strength training group. The physiotherapist was able to inform Mr Brown that particular strength training groups had transport support options that could assist him while he was unable to drive, and offered Mr Brown the relevant registration forms for his doctor to sign before discharge.
-  Prior to discharge, a discharge summary was sent to Mr Brown's GP to explain what had happened and to request the GP to continue to monitor him once he returned home.

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## Five facts everyone should know about nutrition

1. Under-nutrition in hospitalised older people is common and poorly recognised. Nutrition risk screening on admission is essential for early problem identification and management.
2. Under-nutrition or declining nutritional status may impact on other domains of functioning.
3. Nutrition is the responsibility of the whole organisation. Food is an important part of the treatment and care of patients.
4. Older people often need assistance and encouragement to enable them to meet their nutritional requirements in hospital.
5. Simple strategies that involve the interdisciplinary team (such as protected mealtimes and communal dining) can assist with optimising nutritional intake.

## Why is nutrition important for older people in hospital?

Older people are at a high risk of under-nutrition.

- Under-nutrition occurs in 25–30 per cent of hospitalised older patients.
- Under-nutrition is a risk for 46–61 per cent of older hospitalised patients [1–6].

Under-nutrition is a state of energy, protein or other specific nutrient deficiency that produces a measurable change in body function and is associated with worse outcomes from illness.

Under-nutrition is reversible with nutritional support [1].

Under-nutrition can contribute to functional decline, increased hospital length of stay and increased hospital complications such as infections, longer rehabilitation and increased mortality [7, 8, 9].



Poor nutritional status and illness can be a cause of muscle loss, which may result in decreased mobility, instability and falls [2].



Weight loss in older people is associated with increased risk of bone loss, hip fractures and pressure ulcers [3].

A low body mass index (BMI) at discharge (less than 22kg/m<sup>2</sup>) has been identified as an independent predictor of developing a new disability in basic activities of daily living [4].

**Causes of under-nutrition in older people include the following:**

Physiological	Psychological	Social
Reduced appetite	 Depression	Social isolation
Reduced smell and taste	 Delirium	Inadequate knowledge about food, nutrition and food preparation
Dental health issues	Anxiety	Poverty or food insecurity
Gastrointestinal changes	Grief	Inability to access an adequate food supply
Swallowing disorders	Cognitive impairment	
Increased dependence		
 Reduced mobility		
 Polypharmacy		

Although there is no one method of determining under-nutrition, low BMI, recent weight loss and poor appetite are used as markers [5].

## Under-nutrition or declining nutritional status will impact on other domains of functioning



### **Skin integrity**

Good nutrition and hydration is important in maintaining healthy skin and plays a key role in wound healing.



### **Mobility**

Good nutrition is important in maintaining muscle mass and strength which, in turn, are important for maintaining mobility. In addition, being physically active assists with stimulating appetite and therefore assists with maintaining good nutrition. Queensland Health's *Preventing falls and harm from falls in older people: Best practice guidelines for Australian hospitals and residential aged care facilities* includes information on the role of nutrition.



### **Depression**

Loss of appetite and weight loss can be a sign of depression. Therefore, being depressed can have a significant impact on nutritional status.



### **Delirium**

Impaired cognition can impact food intake due to poor concentration and confusion about eating.



### **Medication**

A range of medications may impact on food intake, including appetite-reducing medications and medications that cause nausea.



### **Dementia**

Some people with dementia may develop specific swallowing problems or other problems associated with eating. These may include not recognising food or feeding utensils, impulsive overloading of the mouth, and being distracted from the task of eating.



### **Continence**

Optimal fluid and fibre intake are important aspects of any continence management plan.

There are increasing numbers of older people who are overweight and obese. Obesity in an older person can be associated with poor physical performance, functional limitations, cardiovascular disease, diabetes and high blood pressure [6]. However, even in this group, unintentional weight loss has been shown to increase mortality [10]. Therefore, weight loss is not encouraged unless current weight significantly impacts on quality of life. Only well older people should attempt weight loss.

## What are the causes of under-nutrition in older people in hospital?

Factors relating to the food supply, such as nutritional adequacy, range of choices and the individual's cultural, religious or personal requirements or preferences are all causes of under-nutrition in older people in hospital.

Inadequate staffing resources for meal set-up, feeding assistance and encouragement may compromise access to food. Positioning of meal trays out of reach and difficulty in opening packaged foods can also restrict food access.

Environmental and social factors around eating can be an issue. These include the physical environment (for example, a dining room compared with bedside eating or the presence of unpleasant sounds or smells in the eating environment), social interactions at mealtime and insufficient time to eat a meal before it is taken away or becomes too cold to consume.

Other causes include:

- interruptions to mealtimes by ward rounds, medication rounds and therapy sessions unrelated to food intake or nutrition
- fasting for tests and procedures or other reasons for missed or interrupted meals
- staffing factors including knowledge, attitudes and priority given to nutrition by staff, including the nature of interactions between older patients and care providers at mealtimes



- cognitive impairment and depressed mood



- reduction in appetite due to illness or inactivity.

It is important that all staff are aware of the importance of nutrition and mealtimes, and that the above factors are addressed to ensure older people receive adequate nutrition [5, 6, 11, 12].

### Pre-education survey

Before commencing any intervention, it is valuable to determine staff knowledge and attitudes regarding nutrition for older people. This questionnaire can be used to establish the importance staff place on nutrition, barriers and current practice. This should be used as a baseline survey before implementing tools and resources.



#### LSOP Nutrition Education Program: Pre-education survey

This questionnaire can be adapted for use as an online survey

### Functional decline and nutrition education

It is important that all staff gain an understanding of the role of nutrition in functional decline and the impact of hospitalisation on food intake. The following PowerPoint slides were developed to guide a presentation to staff. The presentation outlines the link between functional decline and nutrition, defines under-nutrition and its causes, specifies a minimum adequate intake for older patients and addresses ways to improve an older person's nutrition in hospital.



#### Functional decline and nutrition

Due to some of the specific nutrition content of this presentation, a dietitian would be best suited to give this presentation.

## What can be done to help older people maintain nutrition?

The nutritional care of older people in hospital is the responsibility of the whole organisation.

An eight-step interdisciplinary framework of best practice to prevent under-nutrition in older people during hospitalisation has been developed for Australian hospitals, based on previous work in the UK by Age Concern [3]. The steps are outlined below; however, given the extent of under-nutrition among older people and its consequences, it is strongly recommended this section is read in more detail (refer to Further reading, page 96).

### The steps of the framework

#### 1. Assessment

A nutrition risk screen should be undertaken on admission and at regular intervals. If a patient consumes less than 50 per cent of their meals on three consecutive days this should prompt staff to refer to a dietitian. Discipline-specific forms and recommendations are available throughout this section.

#### 2. Listening

Hospital staff must listen to older people, their relatives and carers, and incorporate their comments into the patient's nutrition care plan.

#### 3. Interdisciplinary nutritional maintenance plan

All ward staff must become food aware. A range of recommendations are available to support this process. Simple strategies are important, such as ensuring meal trays are placed within reach of patients and that food packaging can be opened.

#### 4. Professional guidelines

Hospital staff must follow their own professional codes and guidance from other bodies. A range of hospital and professional guidelines and policies are listed in this section.

#### 5. Introduce protected mealtimes

Appropriate assistance and sufficient time to eat meals should be provided. Mealtimes need to be protected to ensure non-urgent ward activities do not interfere with patients eating their food.

#### 6. Identify those requiring mealtime assistance

Establish a system of simple identifiers for patients requiring assistance at mealtimes that is located near the patient (for example, bedside identifiers or identifying trays).

#### 7. Use volunteers and family or carers, as appropriate, to assist patients at mealtimes

#### 8. Discharge

Ensure nutrition is a focus in discharge planning. Clearly communicate plans so they are understood by patients, their families and carers, and any healthcare professionals providing ongoing care. This may include advice about: meal preferences; feeding positioning; set-up; equipment; encouragement techniques; supplements required; special diets; or ongoing dietitian referrals or management. Maintaining optimal nutrition is a key factor in preventing readmission and maintaining functional capacity upon discharge.

### Further information



*Eight-step interdisciplinary framework for the prevention of under-nutrition*

## Nutrition assistants

Nutrition assistants are allied health assistants who provide focused care on the food and nutritional needs of patients. There is evidence in the literature of the effectiveness of this emerging role in improving nutritional outcomes for older patients (refer to Further reading, page 104).

### Further information

For further analysis of the role of nutrition assistants, refer to:



***Role of nutrition assistants in a hospital setting***



**Refer to a sample position description for a nutrition assistant**



***Nutrition assistant competency standards assessment tool.***

## Food service



With the knowledge that many older patients are at high risk of under-nutrition and may suffer from poor food intake during hospitalisation, one of the key issues to be addressed is the food supply itself. Hospital food services need to be flexible to meet the requirements of older people and to be person-centred. Unfortunately, too often food is regarded as one of the 'hotel' services of a hospital. Yet for most older patients, food is a treatment and an important aspect of care (refer to Further Information, page 105).

### Further information



**Refer to further information on food services.**

## How can I recognise problems with nutrition?

Many older people will come to hospital with evidence of under-nutrition.

The following are indications for patients to be referred to a dietitian for a comprehensive assessment of their nutritional status and development of a management plan:

- body mass index (BMI) less than 22 kg/m<sup>2</sup>, or seeming underweight
- recent loss of appetite
- loose-fitting clothes, jewellery or dentures
- difficulties with chewing or swallowing, or evidence of tooth decay
- significant, unintentional weight loss of over three kilograms (or half a stone) in the last three to six months
- poor intake or refusing meals
-  • constipation or diarrhoea
-  • frequent infections
-  • pressure ulcers.

Under-nutrition is often poorly recognised and can have a significant impact on the outcomes of hospital admission, and may contribute to functional decline in an older person. Many older people are already at risk of under-nutrition on admission to hospital, and the impact of illness and hospitalisation may further compromise their nutritional status. Patients should be routinely weighed during hospital admission to establish their nutritional status and the effectiveness of treatments.

A more formal way of ensuring that all patients are assessed for under-nutrition, or being at risk of under-nutrition, is to introduce routine nutrition risk screening on admission. At-risk patients who are identified early on in their admission and receive timely nutrition management, including referral to a dietitian, will have a shorter length of stay.

### Nutrition risk screening

Screening is a rapid and simple process that can be undertaken by staff other than trained nutrition professionals.

Nutrition risk screening is recommended [5, 14] for all older people on admission to hospital. Screening should be completed within the first 24 hours of admission, but where the assessment is complex (for example, non-weight-bearing patients), nutrition risk screening should be completed within 72 hours of admission.

Five nutrition risk screening tools have been selected from a large range of tools available [15–17]. All these tools have been identified as quick (less than 10 minutes) to complete and can be completed by all members of the healthcare team.

The choice of tool should be made based on the healthcare setting, who will be conducting the screening, training requirements, likely compliance and the availability of follow-up care.

 Currently there is no clear choice as to which tool is preferred, although the **Mini Nutrition Assessment Short Form (MNA-SF)** was specifically developed for older people.

 For further information and analysis of the tools to guide selection, please refer to ***Recommended screening tools at a glance***.

Other nutritional risk screening tools include the following:

 **Malnutrition Universal Screening Tool (MUST)**

 **Malnutrition Screening Tool (MST)**

 **Short Nutritional Assessment Questionnaire (SNAQ®)**

 **Simplified Nutrition Appetite Questionnaire (SNAQ).**

 For a case study and further information about the steps involved in introducing a risk screening program, refer to the ***Introducing a nutrition risk screening program*** case study.

## What can I do if I recognise that someone has problems with nutrition?

Older people in hospital often have higher needs for energy, protein and nutrients. More energy, protein and nutrients are required to correct underweight, reverse weight loss, recover from surgery, fight infections and heal wounds.

To provide a guide to the suggested minimum amounts of food required by older patients, it is recommended that the following amounts of food be consumed daily:

- two small serves of meat, fish, poultry or eggs (60 g cooked)
- two small serves of fat or oils (one serve = one teaspoon of margarine or oil)
- three serves of dairy foods – full fat (one serve = 250 mL milk, or 30 g cheese or 200 g yoghurt)
- three serves of fruit (fresh, canned or stewed)
- four serves of vegetables (including one serve of potato)
- five or more serves of breads and cereals – preferably wholegrain (one serve = one slice of bread, or half a cup of rice or pasta or three quarters of a cup of breakfast cereal)
- six to eight cups of fluid.

This is the **minimum** intake and some older people will require even more food. If patients are unable to consume this quantity of food, a referral to a dietitian is required for ways to enhance intake or other alternatives.

### Ways to enhance the nutritional intake of older patients

- Identify food preferences and usual intake by asking the patient or their family/carers. Communicate these preferences to food services, the dietitian and staff completing menus.
- Ensure appropriate positioning for meals. The recommended position for patients to consume meals is seated in a chair at a table. Check the table is the correct height for the chair and the food is within easy reach of the patient.
- When patients need to eat in bed, they should be sat upright and supported in this position. Clear the overbed table of unnecessary items or items that make for an unpleasant eating environment (for example, urine bottles).
- Provide assistance with set up and access. Ensure the meal tray is placed within reach. Patients may also need assistance with positioning, reaching items on the tray (for example, cutlery) or preparing food items. Many foods are served in unfamiliar and difficult-to-open packaging. Ensure items are opened and positioned within reach and that the older person is aware of the items.
- Provide encouragement. Often older people will have small appetites due to limited activity, illness or mood. Frequent prompting and encouragement with meals in these cases is essential. This may extend to tasting meal items or identifying the most important items to consume. The most nourishing foods should be consumed first. Avoid filling up on low-energy, low-nutrient-value fluids. For example, have the main meal in preference to soup or have a milk drink at the mid-meal instead a of cup of tea.

- Monitor and observe intake and weight. Observe the amount of food consumed by older people, including both meals and mid-meals. Food record charts provide an invaluable record of food intake, especially when a patient's recall may be limited. The charts allow staff to understand meal patterns and food intake over the full day. Weekly weight can be used to measure the changes in nutritional status and the success of nutrition management.
- Minimise interruptions. In hospital, many patients have their meals interrupted by routine ward activities, tests, procedures or visitors. Limit these interruptions and ensure patients have sufficient time to consume meals to help maximise their food intake (refer to Further reading, page 108).
- Minimise fasting periods and missed meals. Fasting for procedures or missing meals can significantly impact on food intake. It is important to develop strategies to minimise the frequency and length of fasting, especially in older patients. Due to their limited muscle reserves, older people are much more at risk of decline due to periods of fasting and missed meals. Staff should have alternatives for meals if meals are not available after fasting.
- Provide a social environment for eating. Eating in a group environment will enhance food intake and recognises the important social aspects of eating. Opportunities for patients to consume meals together are encouraged (refer to Further reading, page 109).
- Allow time for meals and snacks. Older people often take longer to consume meals. Sufficient time should be allowed for patients to complete their meals in an unhurried manner.
- High-energy, high-protein drinks or supplementary fluids may be prescribed for patients. These have been shown to be beneficial to patients who are under-nourished or at risk of under-nutrition [138]. Such fluids are most commonly given in-between meals. Provide encouragement and ensure patients consume them. It is important to watch for displacement of food. Many older people are likely to reduce their food intake when consuming a supplementary drink. Doing so will result in no net change in total energy intake.
- Make a referral to a dietitian. Dietitians can be involved in many aspects of older patients' care. They provide comprehensive assessments of nutritional status, advice on specific diets and management of older patients at nutritional risk. The dietitian can liaise with food services to ensure patients' specific needs and preferences are met. The dietitian will also play a key role in discharge planning.

### Further information

-  Refer to *Assisting with feeding: promoting independence at mealtimes* to guide an education session with staff. It outlines the importance of assisting patients with eating through appropriate set-up, supervision and prompting.

## What are the care or management principles that I should follow to maintain adequate nutrition for older people in hospital?

### Protected mealtimes and communal dining

Addressing nutrition requires an interdisciplinary approach and all members of the healthcare team should be engaged.

Protected mealtimes and communal dining focus on improving factors that impact on the nutritional intake of many hospitalised older patients: interruptions to meals, the requirement for additional assistance and the social aspects of eating.

It is acknowledged that it may not be possible to implement all aspects of these strategies, but the principles can be adapted to suit individual settings.

Introducing protected mealtimes and communal dining may take time to plan and require executive support and cultural change to ensure they become embedded in practice. It is important that all staff involved in patient care participate in planning, training and implementation.

Please refer to page 108 –112, for further information regarding protected mealtimes and communal dining.

### Further information



***Eight-step interdisciplinary framework of best practice to prevent under-nutrition***



***Protected mealtimes and Guidelines to create a supportive communal dining environment in an aged care subacute unit.***



## What needs to be considered when planning discharge to help older people maintain adequate nutrition?

It is important that older people are monitored for ongoing signs of under-nutrition or a decline in nutritional status following discharge from hospital. For many, their treatment to correct under-nutrition will continue after discharge from hospital. It is important that weight loss is reversed and under-nutrition corrected. This ensures optimal health to reduce susceptibility to further illness or decline in function.



The following questions about nutrition should be considered when developing a discharge plan in consultation with an older person and their family or carer:

- Have other issues that may impact on the food intake of older people been adequately addressed and resolved? These issues may include dental issues, polypharmacy, nausea, pain and depressed mood.
- Does the discharge summary provide information to the GP or case manager about the older person's risk of under-nutrition and the interventions required? Including the person's weight on discharge will assist with ongoing monitoring.
- Does the older person who is under-nourished, or at risk of under-nutrition, understand the importance of correcting this? Do they know the correct amount of food to eat each day? Will they require additional support to make sure they meet these recommendations?
- Does the older person have access to an adequate and complete food supply on discharge? For example:
  - » If delivered meals (for example, Meals on Wheels) are required, check how the older person will manage other meals throughout the day or food on days when meals are not delivered.
  - » What cooking facilities does the older person have at home and are they able to use them safely?
  - » Check about needs for shopping, including method of transport.
- If an older person lives alone, are there opportunities for the older person to become involved in social dining opportunities (formal or informal)?
- If an older person requires a special diet, such as texture-modified diets or thickened fluids, does the older person or their family or carer understand the recommendations for this? Have they been provided with sufficient information on foods to include and food preparation?
- If there is an ongoing need for nutritional supplements? Does the older person or their family or carer understand where to access an ongoing supply, how much is required daily and for how long? Can they manage to prepare or open these?
- If an older person is being discharged to residential care, has information on feeding position, food preferences and the type of assistance or encouragement required been provided in handover? Consider having a feeding care plan developed to assist this.
- Does the older person require follow-up appointments with a dietitian? Has a referral been made to a community-based or Home and Community Care (HACC) dietitian? Is the older person aware of these appointments and do they understand the importance of them?



Provide carers with the pamphlet, *Is an older person you care about under-nourished?*

## What can patients, families or carers do to help an older person maintain adequate nutrition in hospital and at home?

Tips for patients and carers to help maintain adequate nutrition in hospital:

- Communicate any concerns about nutrition to staff. This includes reporting:
  - » any recent unintentional weight loss
  - » having eaten little, or a change in appetite in the last five to 10 days
  - » changes in the way clothes, jewellery or dentures fit (if these have become loose it can indicate significant weight loss)
  - » medical conditions or medications that require a special diet or affect appetite and food intake, including diabetes, swallowing or chewing difficulties and indigestion
  - » regular use of nutrition supplement drinks.
- Ask to be weighed on admission and at regular intervals throughout the hospital stay.
- Tell staff about food preferences and usual food intake patterns.
- Alert staff to any problems related to food intake, food access or concerns relating to nutrition during hospitalisation. All ward staff can assist with addressing problems and concerns. The patient services assistants who deliver meals and provide assistance with menus can also help.
- There is a limited amount of space at the bedside. Ensure overbed trays are kept clear of unnecessary belongings.
- For some patients, having a familiar person to encourage or assist in eating can be helpful, but others may be reluctant to eat in front of visitors. Therefore, please carefully consider whether to visit during mealtimes or be aware visitors may be asked to leave the ward during mealtimes.
- Where a patient has particular cultural or personal preferences the kitchen is unable to cater for, it may be appropriate for family or friends to bring in food from home. Any food bought from outside the hospital should be managed in accordance with the appropriate hospital food safety guidelines and policies.



Provide patients with the brochure ***Don't go hungry in hospital***, designed to alert them to ways they can improve their nutrition in hospital.

### Tips for carers to help maintain adequate nutrition at home

It is important that older people are monitored for ongoing signs of under-nutrition or decline in nutritional status following their discharge from hospital.

- Encourage the older person to visit a doctor for a check-up and ask to go with them to discuss any concerns.
- Visit the older person during mealtimes and get a sense of what their regular diet is like and if they have any difficulties eating.
- If appropriate, have a look in their fridge and cupboards. A lack of food, too much of the same foods, or rotting or expired food may signal a problem.
- Even people who get meals delivered (for example, Meals on Wheels) may not be eating enough and their diet could still need supplementing. Delivered meals are only part of the daily diet for any older person. Meals on Wheels is designed to provide clients with a third of their daily energy and half of their daily protein needs.
- Provide assistance with shopping.

- Display posters in wards to provide patients and carers with some key messages about nutrition during hospitalisation, for example, ***Don't go hungry in hospital (poster)***.



Provide carers with the pamphlet ***Is an older person you care about under-nourished?***

### Further information

A number of resources are available for addressing good nutrition for older people at home. However, these resources address nutrition in older people who are well and may need to be adapted to suit an older person recovering after hospitalisation or illness.



Dietitians Association of Australia education brochures: ***Healthy eating. Healthy ageing, and Make every mouthful count.***



Refer to the Department of Health website for ***Well for life: Improving nutrition and physical activity for older people at home.***



Refer to the HACC publication ***Good food and health advice for older people who want to help themselves.***



Refer to the department's HACC website for the ***Nutrition risk resource manual.***

## Case study

Mr Watts is a 78-year-old male admitted to the local acute hospital following a fall in the street while shopping. His injuries included a broken arm, facial bruising and skin tears to his shin and above his eyebrow, which require sutures. Mr Watts previously has been fit and active. His blood tests indicate he has mild anaemia (Hb 94g/l).

Mr Watts lives alone. His wife, Betty, was placed in a nursing home following a stroke 10 months ago. Prior to this, Betty performed the majority of household tasks including the cooking. At home, Mr Watts' routine revolves around visiting Betty and ensuring he is there to help feed her at lunchtime. As a result, Mr Watts will often skip his own lunch and is too tired in the evening to prepare a meal.

Mr and Mrs Watts' son lives 45 minutes away. He has his own young family. He visits once a fortnight and rings weekly.

Mr Watts' son reports to staff that his father has become more withdrawn over the past few months and that he has noted his phone conversations are limited. He is also aware that his father no longer attends the regular activities he shared with his wife, such as bowls.

### Scenario 1

After six days, Mr Watts is transferred to a subacute hospital for slow stream rehabilitation. Mr Watts spends most of his time alone in his room and eats very little of the hospital food as it is difficult for him to eat with only one arm while his broken arm is plastered. He receives little help from staff at mealtimes.

Eventually Mr Watts is referred to a dietitian at a team meeting during his second week of admission because he is experiencing loss of muscle mass and lacks the strength to participate in the available exercise programs. The wounds from his fall are healing very slowly.

The dietitian identifies that Mr Watts is malnourished because his BMI is less than 18.5 and he has lost a further three kilograms while in hospital. Mr Watts is able to describe to the dietitian his usual food intake at home and the problems he has been having in hospital. The dietitian prescribes high-protein drinks. Mr Watts is happy to try to drink these but he struggles to open the tetra packs these drinks come in. Many drinks return on his meal tray unopened. Staff notice this but they are too busy to spend time assisting Mr Watts with his meals. Only half the nurses are available on the ward at mealtimes because the other nurses are on their meal breaks during patient mealtimes.

Eventually Mr Watts recovers enough to be discharged home. Mr Watts will need to continue having high-protein drinks to help him return to his usual weight. The dietitian provides him with a recipe for this and encourages him to prepare it at home. She suggests Mr Watts follows up monitoring his weight via his GP, but this is not communicated to the GP in the medical discharge summary.

Unfortunately when Mr Watts gets home he becomes confused about how to make up the high-protein drinks because it is an unfamiliar task. Mr Watts also lacks the motivation to do this as his appetite remains poor and he is possibly experiencing an unrecognised depressive episode. Mr Watts reverts to his previous arrangements of visiting Betty and having poor nutritional intake. Therefore he remains under-nourished and loses further weight.

Noticing a decline in his function and self-care, his GP arranges for an aged care assessment service (ACAS) assessment for low-level residential care.

## Scenario 2

The following strategies from *The toolkit* were utilised:

- Identification and management of risk factors contributing to under-nutrition (for example, depression and psychosocial issues).
- Use of validated nutrition risk screening tool to identify nutrition risk. For further information refer to **How can I recognise problems with nutrition**.
- Use of a clear hospital policy that guides management of under-nutrition.
- Interdisciplinary assessment and management of nutrition issues.
- Mealtime assistance.
- Benefits of communal dining. For further information refer to **Protected mealtimes** and **Communal dining**.
- Use of patient education materials. For further information refer to **What can patients, families or carers do to help an older person maintain adequate nutrition in hospital and at home**.
- Comprehensive discharge planning for ongoing prevention of under-nutrition strategies. For further information refer to **What needs to be considered when planning discharge to help older people maintain adequate nutrition**.



Mr Watts is identified on admission as having a mild depression and is started on antidepressants.

After six days, Mr Watts is transferred to a subacute hospital for slow stream rehabilitation.



As part of the admission, the nursing staff complete a **nutrition risk screening** using the MNA-SF. Mr Watts' score is three, indicating a risk of under-nutrition. The key indicators for this low score are a significant loss of appetite, weight loss of 16 per cent in six months, depression, psychological stress and low BMI (18.5 kg/m<sup>2</sup>).

Guided by the hospital policy for patients at risk of under-nutrition, Mr Watts is referred to the dietitian and placed on a high-energy, high-protein diet, which includes a high-protein milk drink. The nurse also requests for his meals to be cut up.

The dietitian sees Mr Watts the next day. He is able to describe to the dietitian his usual food intake at home and the problems he has been having in hospital. Mr Watts enjoys the high-protein drinks he has been receiving at morning tea and is happy to include another one with his dinner. He also finds that he is managing to eat more of the main meal now that it is cut up.



The dietitian provides Mr Watts with education on the importance of improving his nutrition to ensure he regains strength, reverses weight loss and heals his fracture and skin tear. She also leaves him a brochure on eating in hospital.

He is very grateful that the nurses will help to spread his toast at breakfast and the ward assistant helps put the soup in a mug and open his sandwiches.



The ward Mr Watts is admitted to has a small communal dining room. The occupational therapist suggests to Mr Watts that he might enjoy eating his lunch meal there with some other patients. The occupational therapist also provides some modified cutlery and crockery to assist Mr Watts to eat more easily with one arm. Mr Watts agrees to try this and finds that one of the other patients in the dining room is a friend from bowls. The two gentlemen enjoy sitting together over their meals and Mr Watts finds that he is starting to consume more of his meal. Towards the end of his admission, Mr Watts is also reporting that his mood has improved, in response to the antidepressants and support he is being given, and his appetite is also improving.

In consultation with Mr Watts and his son, his discharge plans are developed. He is safe to return home, but his nutrition remains a concern. He has gained three kilograms during his four-week admission. The social worker arranges for Mr Watts to receive frozen delivered meals four days each week and negotiates with Betty's nursing home that Mr Watts can have access to a microwave to heat up a frozen meal during his visit. Mr Watts had heard of a community bus to assist him with shopping. The social worker encourages Mr Watts to participate in this for the social aspects but also to provide more support to him while shopping for food. In addition, Mr Watts' family are encouraged to share a meal with him during their visits.



The social worker provides them with an information brochure about identifying the signs of under-nutrition.

Mr Watts will need to continue having high-protein drinks to help him return to his usual weight. The dietitian provides him with a recipe and he is able to practise preparing it in the occupational therapy kitchen before his discharge.

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## Further reading

# Eight-step interdisciplinary framework for the prevention of under-nutrition

### Step 1: Older people should be assessed for the signs of under-nutrition or the risks of becoming under-nourished on admission and at regular intervals during their stay.

Assessment of under-nutrition, or the risk of becoming under-nourished, requires an interdisciplinary approach. All older people admitted to hospital should be assessed for the risk of under-nutrition as part of a comprehensive interdisciplinary admission assessment.

Screening and assessment comprises three components:

- screening all inpatients on admission to determine their nutritional status
  - comprehensive assessment for patients identified on screening as under-nourished, or at risk of becoming under-nourished
  - weekly screening of patients not initially identified as at risk (for monitoring).
1. **Screening** of nutritional state should be completed on admission to identify those older patients who are under-nourished or at risk of under-nutrition. This includes:
    - » weight, height, body mass index (BMI)
    - » use of a nutritional risk screening tool
  2. In addition, **comprehensive interdisciplinary assessment** should include identifying factors that contribute to risk of under-nutrition for all older patients including the following.

#### Medical:



Refer to this *Nutrition checklist for doctors* for appropriate investigations, factors to assess and referrals to consider. **Appendix 1**

#### Nursing:

- Seek information about social/cultural issues such as culturally appropriate meals and personal preferences.
- Seek information from patients, family/carers regarding nutrition/meal preferences and feeding support needs.
- Assess the need for supervision and assistance required with meals.

#### Occupational Therapist (OT):

- A functional assessment of disability and environmental modification is required, including prescribing necessary aids and providing advice about the positioning of meal trays and chairs.

#### Speech pathologist:

- Review and recommendations for managing oro-pharyngeal dysphagia.
- Assessment and management of oral hygiene issues.
- Assessment and management of communication issues.
- Assessment for the need for a texture-modified diet.

#### Physiotherapist:

- Assess the level of mobility and develop an individualised functional weight-bearing exercise program, plus any additional specialised physiotherapy for specific conditions.

#### Dietitian:

- A full nutrition assessment for those at risk of under-nutrition using a nutrition screening tool.

#### Recommendations for specialised diets and nutritional supplements. Nutrition (or dietetic) assistant (where this role exists):

- The role of a nutrition assistant can be valuable in assisting with the assessment phase, especially with nutrition risk screening and seeking information about social/cultural and personal preference issues, and taking appropriate action to address these issues.

#### Dental/oral health screen:

- Each health service will need to identify which discipline is responsible for completing the dental/oral health screen. It may be completed by nursing, medical or speech pathology staff, depending on local protocols.
- The following references may help with screening and assessing dental and oral health issues:



» *The development of an oral health screening tool (OHST) for people with chronic disabilities and for older people who are dependent on others for care*, Bethlehem Healthcare, Melbourne: <[http://www.health.vic.gov.au/healthpromotion/downloads/fr\\_bethlehem.pdf](http://www.health.vic.gov.au/healthpromotion/downloads/fr_bethlehem.pdf)>



» *Oral health for older people: a practical guide for aged care services*, Department of Human Services, Melbourne: [http://www.dhsv.org.au/oral-health-resources/guides-and-resources/#Oral\\_health](http://www.dhsv.org.au/oral-health-resources/guides-and-resources/#Oral_health)



» *Oral Care Protocol*, Caulfield General Medical Centre. *Appendix 2*

### 3. Ongoing monitoring for all inpatients.

All older patients should be weighed weekly during their admission to identify any patients who are experiencing weight change.

Weight loss in consecutive weeks or poor oral intake among older patients should be triggers for further assessment by a dietitian. Poor oral intake will be observed by nursing staff, and if a patient consumes less than 50 per cent of their meals on three consequent days then this should initiate referral to a dietitian.

Appropriate modifications to care plans should be made and actioned if a patient becomes at risk of under-nutrition. In addition, if a patient develops other risk factors that may impact on nutrition during their admission, plans should be developed to prevent nutritional decline before weight loss occurs. The contributing factors include illness or a change in functioning.

## **Step 2: Listening – Hospital staff must listen to older people, their relatives and carers.**

As indicated in step 1 older people should be consulted about hospital menus, meal requirements and cultural and personal preferences. Seeking information about preferences and habits from relatives and carers is also important to support eating and adequate nutrition during a hospital stay, especially for those patients with cognitive or mental health issues who may not be able to easily communicate about these issues themselves. Staff need to incorporate information gathered from patients, their families and carers into the patient's nutrition care plan.

Primarily, gathering this information will be performed by nursing staff, or the nutrition assistant (where this role exists), but all staff can contribute to gathering this information when they are interacting with relatives and carers and ensure it is documented and actioned appropriately.

Liaison between nursing staff, dietetic staff (ward) and kitchen/food services should occur to ensure preferences can be catered for. Where a patient has a particular cultural or personal preference that is not possible for the kitchen to cater for, then further discussion with a dietitian should occur. It may be appropriate for the family to bring in food from home. Any food bought from outside the hospital should be managed in accordance with the appropriate hospital food safety guidelines and policies.

## **Step 3: Interdisciplinary nutritional maintenance plan – All ward staff must become 'food aware'.**

Supporting older people to maintain good nutrition during a hospital stay requires an interdisciplinary approach to both assessment and management.

The interdisciplinary nutritional maintenance plan for an older patient should be individualised and based on addressing the risk factors identified in their interdisciplinary assessment.

All older patients will have the following aspects addressed in their nutritional maintenance plan:

- personal preferences and habits including tailoring meal plans to ensure preferences and needs are met
- use of staff to assist with meals as required such as encouragement and prompting, positioning, monitoring intake, supporting menu ordering and ensuring appropriate meals are delivered from the catering department, assisting with opening food packaging or ensuring specialised eating utensils are accessible
- high-intensity functional weight-bearing exercise – an individualised program based on the patient's ability, as prescribed by a physiotherapist
- ensuring good hydration such as access to water jugs or coolers, or suitable alternatives.

In addition, some patients, based on their interdisciplinary assessment, may also require one or more of the following to be included in their nutritional maintenance plan:

- nutritional supplements and specialised diets
- food fortification
- treatment for depression
- management of medical problems including medication impacting on nutrition and appetite, where possible
- implementation of an oral care protocol
- using specialised feeding and seating aids and equipment as prescribed by an OT
- specialised physiotherapy treatment for specific conditions
- having staff assist with meals for specific feeding or behavioural management
- dental review and treatment.

Nutrition assistants, where these roles exist, will help implement these individual care plans to support optimal nutrition, in collaboration with the interdisciplinary team.

In addition, non-clinical staff, such as patient services assistants, may require education and modified work practices to ensure they contribute to supporting nutritional maintenance. Simple strategies like ensuring meal trays are placed within reach and helping to open food packages should be provided as a minimum for all patients.

**Step 4: Professional guidelines – Hospital staff must follow their own professional codes and guidance from other bodies.**

All staff should support patient choice and dignity in their nutrition-related conduct. Staff will follow all relevant hospital and professional guidelines and policies available. These include:

-  **Australian and New Zealand Society for Geriatric Medicine 2007, *Position statement no. 6 – Under-nutrition and the older person:***  
<<http://www.anzsgm.org/documents/PosStatement6revisedsep07.pdf>>
-  **Australian Society for Geriatric Medicine 2004, *Position statement no. 12 – Dysphagia and aspiration in older people:***  
<[www.anzsgm.org/documents/PS12DYSPHAGIA2010cleanfinal.pdf](http://www.anzsgm.org/documents/PS12DYSPHAGIA2010cleanfinal.pdf)>
-  **Speech Pathology Association of Australia 2004, *Position paper – Dysphagia: General.***  
<[http://www.speechpathologyaustralia.org.au/library/clinical\\_guidelines/dysphagia\\_general.pdf](http://www.speechpathologyaustralia.org.au/library/clinical_guidelines/dysphagia_general.pdf)>
-  **National Institute for Health and Clinical Excellence 2006, *Nutrition support in adults – oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical Guideline 3:***  
<<http://www.nice.org.uk/guidance/CG32>>
-  **Dietitians Association of Australia. *Evidence-based practice guidelines for nutritional management of malnutrition in adult patients across the continuum of care* (currently under development)**
-  **National Health Service (Scotland) 2002, *Nutrition for physically frail older people – best practice statement*, Nursing and Midwifery Practice Development Unit:**  
<<http://www.healthcareimprovementscotland.org/default.aspx?page=12072>>
-  **Department of Human Services 2002, *Oral health for older people: a practical guide for aged care services:***  
<[http://www.health.vic.gov.au/dentistry/downloads/older\\_peopleguide.pdf](http://www.health.vic.gov.au/dentistry/downloads/older_peopleguide.pdf)>

In addition to these professional guidelines, health services may have local organisational policies that need to be followed that impact on nutritional care. For example, food brought from outside the hospital, infection control, communal dining, protected mealtimes, food service policies, oral care and nutrition support.

### **Step 5: Introduce protected mealtimes.**

Older patients need to be given appropriate assistance and enough time to eat meals. Mealtimes need to be protected to ensure all non-urgent ward activity, such as ward rounds, drug rounds, tests and therapy, do not interfere with patients having sufficient time and support to eat their meals.

Environmental adaptations, such as minimising other ward distractions and visitors, can assist in ensuring calm, unhurried mealtimes. Introducing a nutrition assistant role to help with mealtime support can strengthen protected mealtimes at a ward level.

Where possible, establishing a pleasant, communal dining area for patients who are ambulatory (with or without assistance) will encourage the social aspects of dining plus provide easier supervision and support.

### **Step 6: Identify those requiring mealtime assistance.**

Establish a system of simple identifiers for those patients needing help at mealtimes that is located near the patient (such as bedside identifiers, identifying trays or menu cards).

Identifying those patients needing mealtime assistance will be the responsibility of nursing staff, together with the dietitian and speech pathologist, where appropriate, and the system of identification will need to be established in conjunction with the hospital's food service department.

### **Step 7: Use volunteers and family members, where appropriate.**

Where appropriate, consider using appropriately trained volunteers for patients with visual impairments, or those needing encouragement to eat. Family members may also want to, or be willing to, provide assistance and consideration should be given to involving them in planning for mealtime support. Any food brought from outside the hospital should be managed in line with hospital food safety policies and guidelines.

However, given that support at mealtimes is required for main meals three times a day, seven days per week, and mid-meals are in addition to this, constant staffing resources are needed to provide mealtime assistance for patients requiring this support. Therefore, volunteers and family members may only be suitable to supplement the assistance provided by nursing and nutrition assistants. Where the patient has swallowing difficulties, speech pathology should be consulted to provide advice and training for family members on safe feeding techniques.

### **Step 8: Discharge – Ensure nutrition is a focus in discharge planning.**

Maintaining and, wherever possible, improving nutrition needs to be a focus in discharge planning with patients and their relatives and carers. All patients should have their weight recorded prior to discharge to assist with measuring the nutritional outcomes from their inpatient stay and to assist with developing appropriate plans for nutritional maintenance after discharge.

The plans for nutritional maintenance upon discharge need to be clearly communicated and understood by patients and their family/carers plus any healthcare professionals providing ongoing care. Plans may include advice about meal preferences, feeding positioning, set up, equipment and encouragement techniques, supplements required, special diets needed and ongoing dietitian referrals or management. Maintaining optimal nutrition is a critical factor in preventing readmission and maintaining functional capacity upon discharge.

## Appendix 1

### Nutrition checklist for doctors

Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_

Problems with **swallowing/dentition** Y N (if Yes refer to Speech pathology/dentist)

**Anxiety** Y N Consider referral to Psychiatry

**Depression** Y N

Geriatric Depression Scale score \_\_\_\_\_

**Dementia** Y N

#### The medication checklist

Polypharmacy (>4meds) Y N

Meds. reviewed with respect to impact on appetite and nutrition Y N

- Antibiotics Y N
- Opiates Y N
- Digoxin Y N
- SSRI Y N
- L-Dopa Y N
- Theophylline Y N
- NSAID's Y N
- Anticonvulsants Y N
- Chemotherapeutic agents Y N
- Azathioprine Y N
- Sulphasalazine Y N
- Acyclovir Y N
- Calcium anatagonists Y N

**Metabolic problem/infection** Check CRP, UEC, FBE, Lymphocytes LFT, TFT, CMP, MSU

#### Current symptoms:

- Anorexia Y N
- Nausea Y N
- LOW >5% in 3/12 Y N ----- > investigate cause
- Abdominal pain Y N ----- > investigate cause
- Diarrhoea Y N ----- > ? overflow
- Constipation Y N ----- > PR/AXR
- Headache/Vertigo Y N ----- > exclude CNS causes
- Pain Y N ----- > investigate and treat

#### Co morbid conditions

- Cancer
- Malabsorption
- CVA/Neurological condition
- CCF
- Other \_\_\_\_\_

#### Special diet required

- # PEG/NGT feeds
- # Chronic renal failure
- # Chronic liver failure
- # Fluid restriction

## Appendix 2

### Alfred Health Dental/ Oral Hygiene Protocol

Impaired masticatory function may impact on food selection and lead to unbalanced diets in older adults; further several oral conditions including painful mucosal disorders, oral dryness or the pain and discomfort associated with periodontal disease or caries may be related to difficulty chewing.

Alfred Health has an oral care protocol in place. The implementation of the Nutritional Maintenance Plan should encourage use of the oral care protocol as standard procedure.

#### **Protocol for patients/residents who are self-caring or dependent for mouthcare with healthy teeth and gums:**

- A soft toothbrush and toothpaste
- Rinse with water
- Oral care after every meal

#### **Protocol for patients/residents who are self-caring or dependent for mouthcare with coating and oral debris:**

- A soft toothbrush and toothpaste
- Rinse with a solution made up Peter Mac Mouthwash™ according to the directions provided
- Oral care after every meal

#### **Severe tongue coating (adapted from Bethlehem Oral Care Protocol1)**

- Using a swab apply a mucolytic cough syrup to the tongue, eg. Benadryl™ expectorant cough syrup (ensure that only clean swabs are placed in the mixture). This is used to break down the protein that binds material coating the tongue.
- Leave for 5 minutes and wipe with a clean wet swab (ensure that only clean swabs are placed in the mixture)
- Repeat this procedure using milk of magnesia. This is used to neutralise the acidity within the material coating the tongue and hence reduce microbial growth
- Repeat after oral intake

#### **Inflammation/erythema**

- Soft toothbrush and toothpaste
- Rinse with a solution made up Peter Mac Mouthwash™ according to the directions provided with the product
- Oral care after every meal

#### **Minor mouth ulcers**

(Definition 2: small 1-10 mm in diameter, 1-6 at a time, heals within 7-10 days)

- Soft toothbrush and toothpaste
- Rinse with a solution made up Peter Mac Mouthwash™ according to the directions provided with the product
- Application of a topical anaesthetic gel (2% lignocaine)
- Oral care after every meal

### **Major mouth ulcers**

(Definition 2: large 1 cm or <, found any area of oral mucosa including dorsum of tongue and palate, slow healing 10-40 days)

Medical management required

### **Candida**

- A soft toothbrush and toothpaste
- Rinse with water
- Medical management with anti fungal preparation, such as nystatin drops

### **Xerostomia**

- A soft toothbrush and toothpaste
- Rinse with water
- Frequent sips of water
- Artificial saliva
- Grape seed oil with peppermint oil<sup>3</sup> (2 drops to 100 mL of grape seed oil). As recommended by the Speech Pathologist

### **Dry lips**

- Water soluble lip moisturiser – such as Vitamin E cream<sup>4</sup>

### **References**

1. Bethlehem Oral Care Protocol 1998
2. Scully, C. 2004. Aphthous ulcers. E-medicine <<http://www.emedicine.com>>
3. Cooke C. Ahmedzai S. Mayberry J. (1996) Xerostomia-a review. *Palliative Medicine*. 10(4):284-92.
4. Nursing Management (2003) Oral care update: from prevention to treatment. 32 (Suppl 3): 1–11

## Role of nutrition assistants in a hospital setting

Nutrition assistants are effective in significantly reducing mortality and improving energy intake in older patients following a hip fracture [1]. They have also been shown to improve the timely identification of under-nutrition in older patients and improve the efficiency of dietitians' work in direct patient care. They can support the implementation of nutrition management plans.

There is limited evidence to demonstrate that nutrition assistants improve clinical outcomes such as length of stay and weight change. This is likely due to the difficult nature of measuring nutrition interventions and the complexity of the problems older patients have. Based on the prevalence of under-nutrition in hospitalised older patients and the support needs of the older person, the role of nutrition assistants is a legitimate one to pursue.

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Increased food intake [1]</li> <li>• Reduced wastage</li> <li>• Reduced mortality [1]</li> <li>• Increased focus on nutrition at ward level</li> <li>• Supports other strategies (protected mealtimes, communal dining, nutrition risk screening, functional maintenance programs (FMP))</li> <li>• Improved liaison with the food services department</li> <li>• Improved timeliness of food choices</li> <li>• Increased assistance with meals – eating, set-up, promoting, meal choice</li> <li>• Better use of dietitian skills, workforce planning</li> </ul>	<p><b>Limitations</b></p> <ul style="list-style-type: none"> <li>• Training – in-house training currently required</li> <li>• Potentially compartmentalising of domains of care</li> </ul>
<p><b>Enablers</b></p> <ul style="list-style-type: none"> <li>• Employing people with existing skills – nutrition students, overseas trained dietitians</li> <li>• Links with an FMP and cognitive activities</li> <li>• Executive support</li> <li>• Education of staff on the role and benefits</li> <li>• Ward-focused resource – operational links to ward nurse unit manager</li> <li>• Accountability to the nutrition and dietetics department</li> </ul>	<p><b>Barriers</b></p> <ul style="list-style-type: none"> <li>• Cost for funding of permanent positions</li> <li>• Lack of ready workforce (limited training available)</li> <li>• Ward staff understanding of role and responsibilities</li> <li>• Territorial nature of ward culture</li> </ul>

### Reference:

1. Duncan DG, Beck SJ, Hood K, Johansen A 2006, 'Using dietetic assistants to improve the outcome of hip fracture: a randomised controlled trial of nutritional support in an acute trauma ward', *Age Ageing*, vol. 35, no. 2, pp. 148–153.

## Food services

Unfortunately, too often food is regarded as one of the 'hotel' services of a hospital. Yet for many patients, food is a treatment and an important aspect of adequate care. Rather than looking at cost savings in reducing menu choices and wastage, we should be ensuring there is an adequate food system that allows patients to consume the required amounts of food and fluid to meet the nutritional needs. This will enable patients to recover faster and have a shorter length of stay.

With an optimal food system, appropriate food supply options are available to meet a patient's needs throughout the care continuum from the emergency department through to subacute care. For example, this may include ensuring the availability of texture-modified food options, including thickened fluids, in the emergency department for older patients (for those patients who may already be on this type of diet at presentation) or ensuring that mid-meals across a hospital are continued, rather than ceased as a cost-saving measure.

For an older person who has a longer length of stay, the impact of the food supply is especially critical to their recovery. All hospital staff (clinical and non-clinical) should acknowledge that food service is an important part of the treatment and care of patients [1].

One of the barriers to identifying the role of food in the clinical domain is the lack of clinical governance arrangements on food services and the ability to establish comprehensive links between the food supply and clinical outcomes. Establishing a clinical governance system that links hospital food service and outcomes is essential to ensuring an organisation-wide commitment to addressing under-nutrition in all patients.

### 1. Set guidelines and standards:

- Establish a committee to oversee the quality and standards of food services. This committee would make recommendations about the role of food in patient care and improvements to the food service based on clinical needs while balancing the organisation's financial needs. This committee should represent all key stakeholders within the organisation. It is essential to include executive/senior support from both clinical and food services areas. Clinician members should include representatives from the nutrition and dietetic department and speech pathology, as well as senior nursing representation from key program areas. Food services department representation may also include both staff responsible for food preparation and also food delivery (environmental services) management.
-  Nutrition standards have been developed by the Department of Human Services Menu Planning Group. These standards clarify the nutritional expectations of food served in Victorian hospitals and provide guidance for developing site-specific nutritional standards. These standards provide recommendations on the number of meals and mid-meals offered daily, the food and fluid items to be included for each meal, and the nutritional quality based on measurable food-based criteria. Hospital food services committees should use these standards as a basis for planning and monitoring the food service:  
<[www.health.vic.gov.au/archive/archive2011/patientfood/nutrition\\_standards.pdf](http://www.health.vic.gov.au/archive/archive2011/patientfood/nutrition_standards.pdf)>

## **2. Regular measurement to ensure performance and compliance with agreed standards:**

A range of audits can be undertaken to establish performance and compliance with the agreed standards. They provide an opportunity for self-regulation of food services in addition to the mandatory safety requirements. They can also be implemented to establish a baseline level and measure improvements following the introduction of standards.

Each representative of the food services committee should have the opportunity to conduct an audit so that responsibility is shared and all members develop a collaborative understanding of the food prepared and the quality of the service provision.

- **Weight audits:**  
To ensure compliance with agreed meal serving sizes.
- **Temperature audits:**  
To ensure meals are served at safe and palatable temperatures. The temperature can be checked at plating and ward level.
- **Tasting panel**  
The purpose of the tasting panel is to ensure the food services department provides meals that are consistent, appropriate/appealing and in line with the 'menu nutrition standards'. The taste panel can also include a consumer representative.  
The following aspects of the meal service are reviewed: temperature, aroma, composition, aesthetics, flavour, texture and apparent adherence to standard recipes.  
The tasting panel results offer constructive feedback to the production team that encourages reviewing all meal components for consistency. Feedback from the production team regarding corrective actions/initiatives is then tabled at subsequent taste panels.
- **Patient satisfaction**  
The success of the menu is measured in part by patient satisfaction surveys. The surveys are used to examine the components of the patient meal delivery, with a focus on improving customer satisfaction.
- **Tray accuracy**  
A comprehensive tray audit can be conducted on a regular basis to ensure the correct delivery of meal selection and tray items.
- **Food wastage**  
An observational audit of meal trays at the conclusion of a meal service provides information on the adequacy of food intake. One technique to assist with this observation is taking digital photos of meals and comparing them with a complete standard meal.

These audits may not be a direct measure of food intake or nutritional status but provide an indication of the acceptability of the menu and food served.

Additional information can also be gathered for reporting food- and nutrition-related incidents. These many include incorrect meals (especially relating to texture-modified diets), missing meal items or food quality.

In combination with information from nutrition-related clinical indicator data and/or the reporting prevalence of under-nutrition, audits provide evidence of the importance of food in the clinical care domain.

### **3. Identify mechanisms for organisational reporting of nutrition outcomes:**

To ensure nutrition is given sufficient priority, it must have the support of executive staff. It is essential to establish regular reporting lines to a hospital-wide clinical governance committee. While it is difficult to easily make the link between food service quality measures and clinical nutrition outcomes, there is a need to consider indicator data for both food service and clinical outcomes together within a clinical governance framework.

#### **Reference:**

1. Allison SP 2012, Hospital food as treatment, viewed 2 August 2012, <[www.bapen.org.uk/professionals/publications-and-resources/bapen-reports/hospital-food-as-treatment](http://www.bapen.org.uk/professionals/publications-and-resources/bapen-reports/hospital-food-as-treatment)>.

## Protected mealtimes

Even the highest quality food is of no nutritional value if a patient doesn't have the opportunity to consume it. Missing meals, or experiencing interruptions during mealtimes, can compromise a patient's food intake, which could have a negative impact on their nutritional status, recovery and length of stay.

Changes in routines related to food, limited access to preferred foods and limited assistance at mealtimes are among the identified causes of functional decline in older people admitted to hospital. A protected mealtimes program involves focusing ward activities on the service of food and providing patients with support, assistance and encouragement at mealtimes. It emphasises to all staff, patients and visitors the importance of mealtimes as a part of care and treatment for patients.

Protected mealtimes have been extensively trialled and evaluated within the National Health Service (NHS) in the United Kingdom. Successful implementation occurred when: the organisation had a policy related to protected mealtimes; there was promotion of the initiative; and there was clear communication and leadership at all levels of the organisation.

Evaluations of the protected mealtime initiatives have demonstrated a reduction in food wastage, a reduction in patients' complaints about meals, and increased satisfaction. Patients were more likely to gain weight on wards where protected mealtimes were introduced. In addition, there was an improved level of teamwork and higher staff morale on wards where protected mealtimes were introduced.

The following analysis provides a summary of the main considerations for successfully implementing protected mealtimes.



**Further reading of the National Health Service (NHS) National Patient Safety Agency's *Protected Mealtimes Review: Finding and Recommendations Report*: <<http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/cleaning-and-nutrition/nutrition/protected-mealtimes>>**

### Audit tool

Before implementing protected mealtimes, baseline data about the number and types of interruptions should be conducted. This not only provides information on the extent of the problem, but will also be helpful in identifying problem areas that need to be targeted in the implementation.

The audit should be conducted by members of the interdisciplinary team to allow all staff the opportunity to develop an understanding of the problem. Involving leading nursing staff, especially at the ward level, will help engage other nursing staff in the initiative.

The audit tool is designed to observe individual patients during a mealtime. Included in the six domain areas are meal set-up, assistance provided and interruptions. It provides valuable information on the way in which patients are provided and supported with meals and eating.

Repeating this audit will help to demonstrate the success of your protected mealtimes implementation and identify areas for further improvements.



**Baseline Protected Mealtime Audit**

## Policy

Having an organisational policy that addresses protected mealtimes has been shown to be a critical factor in successful implementation. This document outlines the general principles of protected mealtimes and can be further adapted to suit individual organisations.



### Policy Title: Protected Mealtimes

## Education Program

It is important that all staff gain an understanding of the need for and the principles of protected mealtimes. The following PowerPoint slides have been developed to guide a presentation to staff. It outlines the principles of protected mealtimes, includes a case study and allows for result reporting from local audits.



### A Practical Guide to Protected Mealtimes

In addition to this, a video developed by the National Health Service is available and recommended. Please refer to the resource review section of the toolkit for further information.

## Evaluation

The *Staff knowledge/attitudes questionnaire* can be used for pre-education evaluation. The Post-education survey can be used to obtain feedback on the protected mealtimes education session.



### Pre - Education Survey Protected Mealtimes Post - Education Survey

## Communal Dining

Social and environmental factors are important influences of food intake. Studies demonstrate increases in food intake when the social and environmental surroundings are improved, and when people dine together.

Using a supervised dining room can increase opportunities for patients to enjoy the social aspects of mealtimes and increase food intake, and can potentially lead to weight gain and improvements in nutritional status and rehabilitation.

Reasons for establishing communal dining:

- A regular mealtime taken in a calm, unhurried and social atmosphere promotes eating. Therefore, patients who can be moved from their bedrooms to a suitable dining area are likely to improve their nutritional intake.
- The social atmosphere of communal dining can help increase food consumption through interactions and encouragement with other patients, and also through having staff in the dining room.
- Communal dining environments are often more 'home-like' or 'normal' experiences for patients than eating off an overbed tray, either in or beside a bed, which in turn supports optimal intake.

### **Guidelines to create a supportive communal dining environment in an aged care subacute unit.**

*Please note: Some of these principles for communal dining for older patients can also be adapted to other care settings such as acute hospital units. Most have been sourced from literature about residential care settings.*

### **Environmental considerations**

- The dining room should be in an easily accessed, quiet, uncluttered room, with good lighting and preferably external windows.
- Tables and chairs should be at suitable heights for comfortable eating and safe transfers. Chairs should be stable, have arms, and support patients during sit-to-stand transfers. Tables and chairs should be height-adjustable to enable flexible accessibility for patients in wheelchairs or needing seating arranged at differing heights.
- Tables should be small (to seat four people), with hygienic, washable surfaces.
- Although tablecloths can make a room more attractive and home-like they can become a problem, with patients trying not to spill or drop food. This may lead to embarrassment and take away the ambience of the meal. Tablecloths also create an unstable surface if a patient inadvertently uses that surface for support when standing.
- Tables should be enhanced with flowers and serviettes.
- The room decor could be enhanced with suitable pictures.
- Flooring should be non-slip and easily cleaned.
- The furniture arrangement should allow for easy interaction between the patients and assisting staff.

### **Preparation for eating**

- Patients who need help with their food should have meals 'set up' before beginning their meal, such as having appropriate utensils beside their plate, food cut up, lids removed from containers, and bones and fat cut away from meats.
- Patients eating in the dining room should be encouraged to wear appropriate clothes.
- Patients should be well informed about mealtimes so they can prepare, including allowing time to use the toilet beforehand and to get to the dining room.
- The ward routine should incorporate toileting prior to mealtimes.
- The ward routine should incorporate patients washing their hands before mealtimes. Staff supervising and assisting in the dining room must also ensure they have washed their hands before the meal.
- Patients needing help to mobilise should be given this support before mealtime so they are positioned comfortably before the food arrives.
- The needs of patients with hearing and sight difficulties should be given every consideration before mealtime including seating them where they can easily chat with other patients, having their hearing aids in place, and served appropriate foods to minimise confusion with managing utensils, for example, soups presented in mugs and bread already buttered.
- Consideration should also be given to which patients are seated together to maximise socialisation and minimise any possible behavioural and relationship issues.

### **During mealtimes**

- The dining area should be supervised to ensure that: all patients receive the correct foods; no eating or swallowing problems are occurring (such as difficulty consuming food and fluids); patients can open packaging; they are assisted and encouraged where required; they don't need to use the toilet urgently; and any behavioural issues are managed.
- Staff in the dining room need to ensure a quiet, no-fuss approach, with clear communication to each patient. It is best that staff sit with patients and engage in conversation or activities

conducive to encouraging intake (such as a staff member assisting patients with their meals or having a cup of tea, glass of water or snack themselves. It is not a time to write notes, chat with other staff members, stand over tables looking on or any other activity that doesn't help patients feel comfortable eating).

- Music may be an added incentive to dining if presented as a background, non-invasive sound, suitable for the occasion.
- The overall noise level of the dining room should be minimised, with televisions turned off and other ward noises reduced. Reducing noise helps patients maximise concentration on the meal and the social atmosphere of the dining room.
- The dining room may be supervised by a range of different staff as determined by local hospital procedures. However, it has been found to be helpful to engage the broad interdisciplinary team in this activity, especially because they are usually available during weekday lunchtimes. This supports all staff to make nutrition a high priority in their activities and encourages a ward culture that values protected mealtimes. One model is to have different disciplines rostered on different days. This may include nursing, allied health and medical staff, as well as nutrition assistants.

#### **Protected mealtimes**

- Protected mealtime strategies apply, that is, meals should only be interrupted for urgent clinical interventions (refer to the protected mealtimes policy in this toolkit).
- Medications due at mealtime should be given immediately prior to, or after, the meal to avoid disruption.

#### **Patient selection**

- In-services for all ward staff to promote appropriate patients eating in the dining room with staff supervision is beneficial. This includes patient services attendants (those staff whose role encompasses the food delivery), nursing staff, physiotherapists, occupational therapists, medical staff, dietitians, nutrition assistant, speech pathology and social workers.
- Patients who are ambulatory, with or without assistance, should be invited to eat in the dining room. The ward should promote a culture that it is expected that all patients eat in the communal dining room unless acutely ill, non-weight-bearing, or the patient has a strong expressed personal desire not to eat in the dining room.
- All patients should have the choice of eating in the dining room including those receiving texture-modified diets or enteral nutrition because it recognises the importance of the socialisation aspects of mealtimes.
- It helps for ward staff to plan a list of patients to be invited and encouraged to eat in the dining room each mealtime.
- Patients with an infectious disease status should have their meals in their rooms according to usual hospital infectious diseases procedures.
- Where the ward has only a small communal space that isn't suitable for all patients to eat together at each meal, consider targeting those patients who will most benefit from the opportunity for communal dining (such as those who are already under-nourished or at risk of under-nourishment and who appear to respond well to the social interaction the dining room offers to maximise their food intake).
- During any infectious outbreak, a decision to stop communal dining should be made in conjunction with the infection control department.

## Addressing the barriers to communal dining

There can be significant barriers to implementing communal dining. These may include:

- ward environment or available space for a dining room
- the need to mobilise patients to and from dining room
- patient mix and acuity
- staff practice and routines – including meal breaks
- staff awareness and understanding of the benefits
- staff awareness and training of their role in dining – supervision, interaction and engagement with patients
- patient attitudes or resistance to eat in the communal dining room
- safety concerns (right food, right person)
- ensuring patients get supervision and assistance.

It is therefore important to engage a wide number of staff in planning for a communal dining room. The following questions have been developed for staff focus groups to help identify barriers and enablers for communal dining.

### Focus Group Questions



#### Communal Dining Focus Group 2008

### Roles and Responsibilities within the Communal Dining Room

The following document (in poster format) provides an outline of the delineation of roles and responsibilities of staff in the communal dining room. This example is taken from a subacute hospital where meals are plated at the ward level. It can be adapted to suit different ward environments.



#### Communal Dining Room - Roles & Responsibilities

### Education Program

The following 'PowerPoint' slides have been developed to guide a presentation to staff. It outlines the key principles for establishing a Communal Dining program.



#### Communal Dining – an important strategy for preventing under-nutrition in hospitalised older patients

### Evaluation

The *Staff Knowledge/Attitudes Questionnaire* can be used for pre-education evaluation. The *Post-Education Survey* can be used to obtain feedback on the Communal Dining education session.



#### Pre - Education Survey Protected Mealtimes Post - Education Survey

# Swallowing



## Five facts everyone should know about swallowing

1. Swallowing is a complex process involving numerous nerves and muscles of the mouth, throat and oesophagus.
2. Older patients with swallowing impairments are at risk of choking, under-nutrition, dehydration and developing aspiration pneumonia.
3. Poor oral hygiene significantly increases the risk of patients with swallowing impairments developing pneumonia [1–3].
4. Older patients who are severely ill and/or have a disability and/or those with stroke, Parkinson's disease and/or dementia are especially at risk of developing swallowing impairments [4].
5. Any suspicion of a swallowing impairment in older patients should be followed up by an appropriately trained health professional.

## Why is it important to consider swallowing when working with older people in hospital?

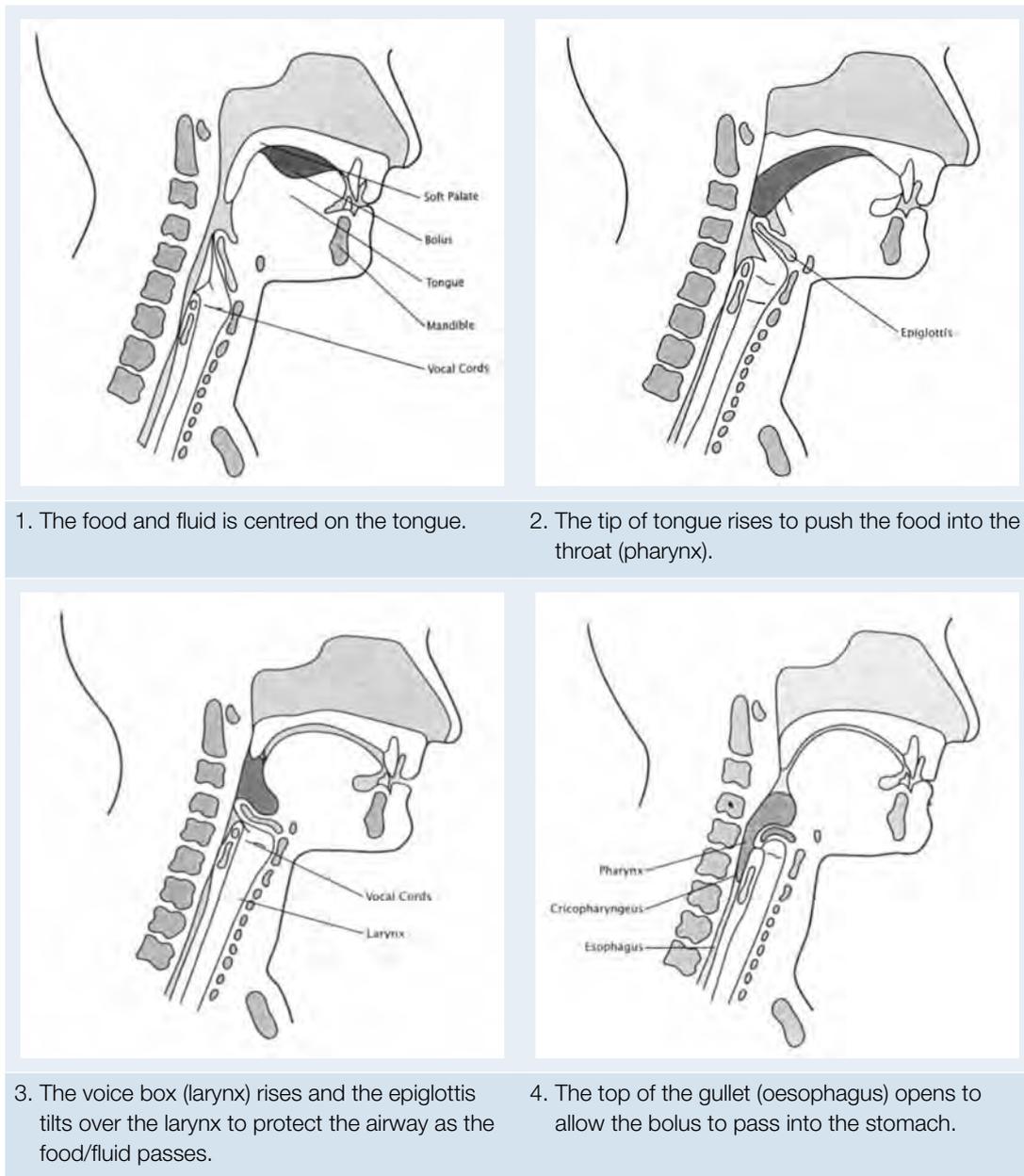
The commonly used medical term for swallowing impairment is dysphagia. Dysphagia is frequently identified in older patients. The prevalence of dysphagia increases with age, with estimates of 40–50 per cent of older people in residential care having dysphagia [4–6]. Dysphagia can impact on physical, social and psychological health. It can lead to under-nutrition, dehydration, infections, disability, increased length-of-stay and death [5, 7]. For some older patients and their families, food and drink signify love and caring and are important to social and cultural identity. Having dysphagia or not being able to eat and drink may lead to anxiety and poor psychosocial wellbeing [8]. Older patients with dysphagia who are reluctant to eat in front of others are at risk of social isolation [8].

Patients with dysphagia are at increased risk of aspiration. Aspiration is the inhalation of material into the larynx and lungs [4]. The most common aspiration syndromes in older patients are aspiration pneumonitis and aspiration pneumonia. Aspiration pneumonitis is a reactive process in the lungs caused by inhaling irritants such as vomitus. Aspiration pneumonia is an infectious process caused by inhaling secretions or food that have been colonised by bacteria. Aspiration pneumonia and pneumonitis commonly overlap [4]. Aspiration pneumonia is the most common cause of death in patients with dysphagia due to neurological disorders [4].

## What is swallowing?

Swallowing is a complex process involving the numerous nerves and muscles of the mouth, throat and oesophagus. The following is only a simplified outline. For a description of swallowing in greater detail, please see <[www.nature.com/gimo/contents/pt1/full/gimo1.html](http://www.nature.com/gimo/contents/pt1/full/gimo1.html)>.

The following diagrams describe a normal swallow.



Source: Dr Amanda Scott, Alfred Health

Swallowing can be divided into four phases [9].

- 1) The initial phase refers to the cognitive response to food and fluid and ability (cognitive and physical) to use utensils to feed oneself.
- 2) The oral phase is where food is chewed and mixed with saliva, and food and fluid is pushed into the pharynx by the tongue.
- 3) The pharyngeal phase begins when the food or fluid reaches the pharynx and triggers the swallow reflex, which results in protecting the airway and the food or fluid passing into the oesophagus.
- 4) The oesophageal phase is where the upper oesophageal sphincter relaxes and contractions of the smooth muscle of the oesophagus and gravity push the food and fluid towards the lower oesophageal sphincter, which relaxes and food is pushed into the stomach.

## What are swallowing impairments?

Dysphagia can be classified as:

- oral/pharyngeal dysphagia, or
- oesophageal dysphagia.

### Oral/pharyngeal dysphagia

Oral/pharyngeal dysphagia occurs in the oral and/or pharyngeal phases of swallowing.

Drooling, difficulty transferring food and fluid from the mouth to the pharynx, and residue of food and fluid in the mouth are characteristics of oral phase dysphagia.

Pharyngeal phase dysphagia is characterised by difficulty initiating the swallow reflex, and impaired transfer of food and fluid into the oesophagus [4].

Older patients who are severely ill and/or have a disability and/or those with stroke, Parkinson's disease and/or dementia are especially at risk of developing swallowing impairments [4]. In approximately 75 per cent of older patients with oral and pharyngeal dysphagia there is a neurologic cause. Stroke, dementia and Parkinson's disease are common underlying neurologic problems that may cause this type of dysphagia in older patients.

Dysphagia involving the oral and pharyngeal phases of swallowing is more common in older patients than oesophageal dysphagia [4].

### Oesophageal dysphagia

Oesophageal dysphagia occurs in the oesophageal phase of swallowing. Common causes of oesophageal dysphagia include cancer, Zenker's diverticulum, infection, inflammation, motility disorders and medications [4]. People with oesophageal dysphagia often describe the sensation of food sticking to or getting hung up at the base of the throat or chest [10].

## How can I recognise a potential problem with swallowing?

Common complaints by older people with dysphagia while eating include:

- food or medications sticking in the mouth, throat or chest
- coughing or choking
- having undigested food or fluid coming out of the nose or mouth [4].

Other possible indicators of dysphagia include:

- poor mouth hygiene
- tongue, facial, lip weakness
- a wet-sounding voice, or gurgled breathing after swallowing
- increased respiration rate [11].

Some older patients will not report swallowing difficulties to hospital staff because they may:

- be embarrassed
- not want to eat when other people can see them
- not recognise the severity of the problem
-  • have difficulty communicating
- have been dealing with the difficulties as a longstanding issue.

Medications that may affect swallowing include:

- antidepressants
- antipsychotics
- antihistamines
- benzodiazepines
- antiparkinsonians
- antispastic agents [11].

 Reports of weight loss or loose fitting clothes may indicate poor nutrition and the possibility of dysphagia should be considered where appropriate.

### Aspiration

Older patients with a history of recurrent pneumonia should be reviewed and the possibility of dysphagia and aspiration considered [4].

Clinical signs and symptoms of aspiration include:

- coughing
- choking on food
- dyspnoea (shortness of breath)
- crepitations (clicking, rattling or crackling noises in the lungs)
- consolidation (a firm, dense mass in the lungs) [4].

Suspicion and recognition of dysphagia is especially important in older patients because 'silent aspiration', where material enters the airway but does not trigger the cough reflex, is common (in more than 50 per cent of patients who aspirate). In many cases fever or sudden deterioration in oxygen saturation may be the only signs [4].

## Screening

-  Identifying known swallowing impairments and signs and symptoms should occur at admission. The assessment domain contains examples of useful comprehensive screening and assessment tools.

The 2011 position of the Australian and New Zealand Society for Geriatric Medicine states, 'when appropriate, the clinical suspicion of aspiration by a physician should be followed up by bedside swallowing evaluation by a speech pathologist, and supported by further investigations when indicated' [4].

There is, however, evidence supporting bedside screening for dysphagia [6] and formal screening, referral and assessment protocols for all patients who have had a stroke [7, 12–16].

The Clinical guidelines for stroke management (2010) were unable to conclude which screening tool was most useful but mention two that are considered well developed and validated [7]:

-  **Gugging Swallowing Screen (GSS)**

-  **Toronto Bedside Swallowing Screen (TOR-BSST).**

-  According to the *Clinical Guidelines for stroke management*, sensitivity of bedside dysphagia screening in stroke can be improved with monitoring oxygen saturations [7, 17–19]. Non-specialist hospital staff can be trained to use swallowing screening tools, although ideally screening should be undertaken as part of a comprehensive assessment by a speech pathologist [7].

-  **Clinical guidelines for stroke management**

-  **& Victorian Stroke Clinical Network Victorian Dysphagia Screening Model:**  
<<http://health.vic.gov.au/clinicalnetworks/stroke/activities.htm>>

-  **Indicators for referral to speech pathology from Melbourne Health**

-  **Dysphagia screening guidelines, speech pathology referral procedure, speech pathology assessment procedure and forms from Barwon Health**

-  **Clinical practice guidelines for after-hours dysphagia screening from Goulburn Valley Health**

-  **ASSIST dysphagia screening tool policy and procedure from Northern Health**

-  **Dysphagia clinical practice guideline from Western Health**

## What can I do if I recognise that someone has a potential problem with swallowing?

It is important that any suspicion of dysphagia be followed up by appropriately trained health professionals. A clinical swallowing assessment performed by a speech pathologist is recommended. This assessment will inform recommendations for dietary modifications and rehabilitation [4].

Where there is clinical suspicion of aspiration a videofluoroscopic modified barium swallow (VMBS) study is the most commonly used test to confirm dysphagia and the presence of aspiration. During a VMBS study various consistencies of food mixed with barium are fed to the patient to evaluate his or her swallowing [4]. Speech pathologists coordinate and conduct VMBS studies [7].



### **Information for patients, families and carers about videofluoroscopy**

Alternatively, or sometimes as an adjunct [4], a fiberoptic endoscopic evaluation of swallowing (FEES) may be recommended. A FEES involves inserting an endoscope through the nose to directly watch a patient swallow [4]. Only specialists with recognised training and credentials can conduct a FEES [7].

When the cause of an older patient's dysphagia remains unclear after initial testing, further specialist support may be required. Referral to a gastroenterologist for oesophageal dysphagia or to an ear, nose and throat specialist for oral and pharyngeal dysphagia may be required for further investigations [4].

## What are the care or management principles I should follow if an older person has a problem with swallowing?



The care plan for older patients with dysphagia will depend on history, clinical investigations, cause and prognosis [4]. For example, dysphagia resulting from stroke is temporary in about 90 per cent of cases and older patients may have realistic goals for improving swallowing [7], whereas in older patients with dementia and Parkinson's disease dysphagia is progressive and a palliative approach to care may be more appropriate [4].

For older patients with dysphagia, where appropriate, care plans should consider:

- treating underlying disorders



- nutrition and hydration

- swallowing rehabilitation [4].



A multidisciplinary team approach to care planning and management, which includes the older patient and his or her carers as members of the team, is considered best practice in person-centred care [20].



**Speech Pathology Association of Australia position paper on dysphagia:**

[www.speechpathologyaustralia.org.au/library/Clinical\\_Guidelines/Dysphagia\\_General.pdf](http://www.speechpathologyaustralia.org.au/library/Clinical_Guidelines/Dysphagia_General.pdf)



### **Nutrition and hydration**

Nutrition and hydration are very important. Under-nutrition and dehydration can compromise an older patient's rehabilitation, and cause further deterioration in swallowing ability [4]. Diets should be modified according to swallowing ability, as recommended by a speech pathologist and based on the results of a swallowing assessment. Some older patients will be able to swallow food and drink with certain physical properties but not others. For example, many older patients with neurologic disorders have difficulty with thin fluids, but can swallow thickened fluids safely [4].

Dietitians can assist in optimising the nutritional status of older patients.

The Dietitians Association of Australia and the Speech Pathology Association of Australia have developed standardised labels and definitions for texture-modified and thickened fluids for patients with dysphagia [21]. Hospital staff (and, where appropriate, patients, families and carers) involved in feeding and food preparation or procurement should be familiar with these standards and definitions. These standards aim to improve safety and efficiency by ensuring hospital staff, patients, families and carers have the same understanding when speaking about and identifying texture-modified and thickened fluids.

For accurate descriptions of the standardised labels and definitions see:

 [www.speechpathologyaustralia.org.au/library/Poster.pdf](http://www.speechpathologyaustralia.org.au/library/Poster.pdf)

 <http://onlinelibrary.wiley.com/doi/10.1111/j.1747-0080.2007.00153.x/pdf>.

Appropriate texture-modified food and thickened fluids should be available to patients as needed, 24 hours a day, in every department and ward.

 Nutritional supplements should be offered to older patients whose nutritional status is poor or deteriorating [7]. The nutrition domain of this toolkit provides many other useful recommendations for monitoring and optimising nutrition among older patients. Clinical knowledge and experience is required to select tools and resources appropriate for use with older patients with swallowing impairments.

 **Alteration of diets policy and procedures at Alfred Health**

### Swallowing rehabilitation

There are both direct and indirect strategies used to prevent complications and improve swallowing [7]. Direct (or compensatory) strategies include:

- fluid and diet modification (see above)
- safe swallowing practices [7], such as only feeding patients when
  - » they are awake
  - » they are sitting as upright as tolerated
  - » they are in an environment free of distractions
  - » they are not rushed
  - » the amount per mouthful is not excessive
  - » coughing, choking and gurgling voice are being monitored
  - » mouth care is undertaken regularly.

 **Some hints for minimising risk of aspiration in dysphagic patients from Caulfield Hospital (Alfred Health)**

 **Information for patients, families and carers about safe swallowing from Alfred Health**

Indirect strategies include:

- oral musculature exercises
- stimulation of the oral and pharyngeal structures [7].

Each patient's swallowing assessment will inform speech pathology recommendations for swallowing rehabilitation.

Swallowing rehabilitation should include education for older patients and carers about the use and effectiveness of the strategies recommended.

 All hospital staff and carers involved in feeding older patients with swallowing impairments should receive appropriate training in feeding and swallowing techniques [7]. Nutrition assistants can help with eating and feeding in hospital where appropriate.

## Nil by mouth orders and tube feeding

For some older patients feeding tubes may be required to maintain nutritional status if it is not possible to do so through oral feeding [4]. Nasogastric tubes (NGT) inserted through the nose, and percutaneous endoscopy gastrostomy (PEG) inserted directly into the stomach through the abdomen, are commonly used. A systematic review in 2010 concluded there are no statistical differences between mortality rates and overall complications in using either NGT or PEG [22].



For some patients, quality-of-life considerations, advance care planning decisions and/or discussions with the patient and/or family may mean tube feeding is inappropriate [4].



For patients with a progressive life-threatening disease, a palliative approach to care planning is appropriate. Allowing a patient to eat and drink even when it is unsafe may be preferable to tube feeding and nil by mouth orders for some older patients, especially if it provides enjoyment [4].

Even with tube feeding there is a risk of pneumonia from aspiration of saliva and stomach contents [4]. Professional mouth care from an oral hygienist and/or dentist has been shown to reduce pneumonia in older patients [1, 3, 4, 23].



**Clinical guidelines for stroke management [7]**



**Best practice guidelines for oral care and secretion management (Western Health and La Tobe University)**



**Oral healthcare domain – the toolkit from SA Health:**  
<[www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+information/Health+information+for+the+clinician/Best+care+for+older+people+everywhere+-+The+toolkit/Oral+health+care+domain+-+The+toolkit](http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+information/Health+information+for+the+clinician/Best+care+for+older+people+everywhere+-+The+toolkit/Oral+health+care+domain+-+The+toolkit)>



**Mouth care program at Caulfield Hospital (Alfred Health)**



**Free fluid protocol at Caulfield Hospital (Alfred Health)**



**Nil by mouth information for patients, families and carers from Melbourne Health**

## What can patients, families or carers do for swallowing problems in hospital and at home?

Swallowing rehabilitation should include education for older patients and carers about the use and effectiveness of the strategies recommended.

Families and carers involved in feeding older patients with swallowing impairments should receive appropriate training in feeding and swallowing techniques [7].

Patients, families and carers should be encouraged to:

- adhere to safe eating and feeding practices
- undertake prescribed therapy.

Family meetings can help resolve and avoid conflicts and misunderstandings about care planning.



All older people should be offered the opportunity to undertake advance care planning [24].



**Information for patients, families and carers about dysphagia and texture-modified diets from Bendigo Health and Melbourne Health**

## What should I consider when planning discharge to help an older person with swallowing problems?



Person-centred goal setting and care planning should advise discharge planning.

Hospital staff should be confident an older patient can maintain adequate nutrition and hydration after discharge. This may require:



- prescribing nutritional supplements (see nutrition)
- providing education, training and/or ongoing support regarding safe swallowing practices, mouth care and food preparation.

There is a risk of social isolation in older patients with dysphagia because they may be reluctant to eat in front of others [8].

A palliative approach to care for some patients may mean other goals will be more important than maintaining nutrition and hydration.

Regular support from health professionals will be required if swallowing impairments cannot be resolved before leaving hospital.

## Case study

Mrs Myer is an 85-year-old widow. She has a very large family: nine children, 18 grandchildren and 26 great-grandchildren. About 10 years ago she moved into a flat one of her sons built for her on his property, but aside from heavy maintenance she looks after the flat and all her self-care needs independently. Her health has generally been good but she has slowed down somewhat since last winter when she had pneumonia. Since the pneumonia she finds she gets out of breath if she walks too far or tries to clean the entire flat without a break. Her GP hasn't found any particular cause for the shortness of breath and has told her it is just her body telling her to take it easy. For a while now Mrs Myer has been preparing herself softer foods at home because she finds them easier to eat. She mentioned this once to her GP and he told her he has many older patients who also prefer softer foods. She concluded that it must just be a part of getting older. Mrs Myer presented to the ED after falling heavily down the concrete stairs outside church. She appears dehydrated and has severe bruising on her right arm and shoulder, which restricts the use of her arm. The ED staff plan to admit Mrs Myer to monitor her, improve her hydration and start her on physiotherapy.

### Scenario 1

Mrs Myer tells the ED staff that it has been several hours since she's eaten or had anything to drink. When the hospital staff bring her a sandwich and some biscuits she tells them she usually has softer foods because she finds them easier to eat. The staff tell her the only food they have available are sandwiches and biscuits, so perhaps she should eat the sandwich because it is softer. When Mrs Myer is transferred to an acute ward her usual diet is not mentioned in her case notes.

Once on the acute ward Mrs Myer needs help eating and undertaking self-care. Her very large family sets up a roster so every day she is visited by at least one of her children or grandchildren. Mrs Myer's family help her with her meals. They remove packaging and cut her meals into bite-sized pieces she can manage with her left arm. She doesn't mention her usual diet because of what she was told in the ED about sandwiches and biscuits being 'the only food they have available.' She assumes on the ward there are no options other than what appears on her standard menu. She eats only a small amount at every meal. She gets tired and breathless easily and her shoulder hurts if she sits up for too long. She is most comfortable lying on her left side so one of her sons suggests she eat lying down if it is too much effort. Lying down to eat causes Mrs Myer to regularly cough so she continues to eat very little.

Over the next few days Mrs Myer becomes very weak and develops a chest infection, which needs to be treated with antibiotics. She becomes too unwell to undertake physiotherapy and plans for her discharge are postponed. Her family is concerned and when she leaves hospital they want her to leave the flat and move into the main house where she can be better supported.

## Scenario 2

Mrs Myer tells the ED staff that it has been several hours since she's eaten or had anything to drink. When the hospital staff bring her a sandwich and some biscuits she tells them she usually has softer foods because she finds them easier to eat. A nurse asks what difficulty she has with hard foods and Mrs Myer tells her she sometimes coughs and becomes short of breath when she eats certain foods like dry biscuits. The nurse then asks if she has ever been assessed by a speech pathologist for swallowing difficulties and Mrs Myer says no. The nurse then refers Mrs Myer to speech pathology. The referral is included in her case notes when Mrs Myer is transferred to an acute ward, as are details of her usual diet.

Until speech pathology can see Mrs Myer she is provided with her usual diet of soft food. During Mrs Myer's first meal on the ward her family is there to help. They open packaging and make sure she can eat the soft foods using her left arm. A nurse checks with Mrs Myer that the food provided is similar to what she usually eats at home, that she is sitting upright to eat, and that she is able to take appropriate mouthfuls. The nurse listens for coughing, choking or a gurgling voice as Mrs Myer eats. When speech pathology conducts a screening it suggests Mrs Myer should undergo a full assessment to confirm the exact nature of her swallowing difficulties. In the meantime Mrs Myer continues her soft food diet and information is provided to Mrs Myer and her family about safe swallowing practices and the importance of mouth care. Although she requires several rest breaks during meals Mrs Myer is able to eat her usual amount of soft foods at each meal. She continues to undertake physiotherapy and will be assessed by speech pathology before she is discharged.

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# Cognition



Cognitive functioning can have a significant impact on an older person's health and wellbeing. Cognitive impairment can result from a number of conditions, including delirium, dementia and depression:



**Delirium** is an acute organic disturbance of higher cerebral function associated with an impaired ability to attend to the environment.



**Dementia** is a general term used to describe a form of cognitive impairment that is chronic, generally progressive and occurs over a period of months to years.



**Depression** is a multifaceted syndrome, comprising a constellation of affective, cognitive, somatic and physiological manifestations in varying degrees from mild to severe.

A range of symptoms and behaviours are associated with different types of cognitive impairment. Some symptoms are similar across delirium, dementia and depression, and an accurate diagnosis is important.

Refer to *Differentiating the three D's – dementia, delirium, and depression* (on the next page) for a comparison of characteristic features.

## How can I recognise and prevent cognitive decline?

The following actions are recommended to prevent cognitive decline and maintain cognition and emotional health:



Establish the patient's pre-morbid cognitive status. Include and consider the patient and their carer or family.



Perform a proactive assessment for delirium risk.

An accurate diagnosis is important. Assess cognitive status and consider the need for specialist geriatric or psychiatric assessment.

Provide optimal pain management.

Implement measures to prevent cognitive functional decline:

- » Undertake early medical evaluation.
- » Consider behavioural and psychosocial interventions.



» Optimise environmental stimulation and familiarity with surroundings.

## Differentiating the three D's – dementia, delirium and depression

Feature	Dementia	Delirium	Depression
<b>Onset</b>	Slow and insidious – deterioration over months or years	Sudden – over hours or days	Often abrupt – may coincide with life changes
<b>Course</b>	Symptoms are progressive over a long period of time; not reversible	<ul style="list-style-type: none"> <li>• Short and fluctuating – often worse at night and on waking</li> <li>• Usually reversible with treatment of the underlying condition</li> </ul>	Typically worse in the morning. Usually reversible with treatment
<b>Duration</b>	Months to years	Hours to less than one month – not often longer	At least two weeks – can last for months or years
<b>Psychomotor activity</b>	<ul style="list-style-type: none"> <li>• Wandering/exit seeking or</li> <li>• Agitated or</li> <li>• Withdrawn (may be related to coexisting depression)</li> </ul>	<ul style="list-style-type: none"> <li>• Hyperactive delirium: agitation, restlessness, hallucinations</li> <li>• Hypoactive delirium: sleepy, slow-moving</li> </ul>	<ul style="list-style-type: none"> <li>• Usually withdrawn</li> <li>• Apathy</li> </ul>
<b>Alertness</b>	Generally normal	Fluctuates – may be hypervigilant through to very lethargic	Normal
<b>Attention</b>	Generally normal	Impaired – difficulty following conversation, fluctuates	Normal
<b>Mood</b>	Depression may be present in early dementia	Fluctuating emotions – for example: anger, tearful outbursts, fear	<ul style="list-style-type: none"> <li>• Depressed mood</li> <li>• Lack of interest or pleasure in usual activities</li> <li>• Change in appetite (increase or decrease)</li> </ul>
<b>Thinking</b>	Difficulty with word-finding and abstraction	Disorganised, distorted, fragmented	Intact – themes of helplessness and hopelessness present
<b>Perception</b>	Misperceptions usually absent (can be present in Lewy body dementia)	Distorted – illusions, hallucinations, delusions; difficulty distinguishing between reality and misperceptions	Usually intact (hallucinations and delusions only present in severe cases)

### References:

Clinical Epidemiology and Health Service Evaluation Unit and Delirium Clinical Guidelines Expert Working Group 2006, *Clinical practice guidelines for the management of delirium in older people*. Victorian Government Department of Human Services, on behalf of the Australian Health Ministers' Advisory Council (AHMAC), Melbourne.

Registered Nurses Association of Ontario 2003, *Screening for delirium, dementia and depression in older adults*. RNAO, Toronto, Canada.

Toronto Best Practice Implementation Steering Committee, 2007, *Recognizing delirium, depression and dementia (three d's): comparison chart*. Ontario Ministry of Health and Long-Term Care.

# Delirium



## Five facts everyone should know about delirium



1. Impaired cognition is not a 'normal' part of ageing and may be due to delirium, dementia or depression.



2. Delirium is a common and serious problem in older hospitalised people, which is frequently overlooked, misdiagnosed and poorly managed.
3. Delirium is usually caused by an underlying acute health condition, which requires investigation and treatment.
4. Many cases of delirium can be prevented by addressing modifiable risk factors and incorporating environmental and clinical practice strategies into the care of older people.
5. It is important to involve family members and carers in the process of diagnosing delirium. They will often notice subtle changes in an older person's cognition and behaviour, which could be an indication of delirium.

## An awareness of delirium is important when working with older people in hospitals. Why?

- Ten to 15 per cent of older people admitted to hospital are delirious at the time of admission, and a further five to 40 per cent are estimated to develop delirium while in hospital [1].
- In general medical units, approximately 20 per cent of older patients will experience delirium during their hospitalisation [2]; reported rates are higher in people undergoing cardiac or hip surgery [3, 4].
- Delirium in older hospitalised people is often overlooked or misdiagnosed due to limited staff knowledge of delirium features or a perception that all cognitive impairment is due to dementia [5, 6].
- Older people who experience delirium are at greater risk of falls, functional decline and cognitive decline. Delirium is also associated with higher mortality and morbidity, increased length of hospital stay and admission to residential care [7].
- Several studies have reported patients are frequently discharged from hospital with persisting symptoms of delirium [8].

A range of factors that can affect an older person's risk of developing delirium in hospital have been studied. Some factors are related to characteristics of the person (predisposing) and some are related to their current illness or the hospital environment (precipitating) [9].

Predisposing	Precipitating
 Pre-existing cognitive impairment, for example, dementia	 Malnutrition
 Depression	 Dehydration
Age 70 years and older	 Addition of three or more medications during hospitalisation
Visual impairment	Severe medical illness
Hearing impairment	Infection
History of alcohol abuse	Abnormal serum sodium
Previous episode of delirium	Use of indwelling catheter
	Use of mechanical restraint

### Further information

 For a poster for staff, refer to *Delirium: the interrelationship between patient vulnerability and precipitating insult*.

 For a risk screen, refer to **> 70 years delirium risk screen**.

Identifying and addressing an older person's predisposing risk on admission, and minimising exposure to precipitating risk factors during hospitalisation, can reduce the incidence of delirium [10].

 For guidelines, refer to *Clinical practice guidelines for the management of delirium in older people*.



## What is delirium?

Delirium is a transient mental disorder characterised by a disturbance of consciousness with a reduced ability to focus, sustain or shift attention. It also involves a change in cognition (such as memory deficit) or the development of a perceptual disturbance. Delirium develops over a short period of time and the disturbance fluctuates during the course of the day [11].

Delirium usually only lasts for a few days but symptoms may persist for weeks or even months [12].

Delirium may be divided into three 'subtypes', which refer to the level of psychomotor activity or arousal [13]. These subtypes include:

- hyperactive – characterised by increased motor activity, restlessness, agitation, hallucinations and delusions and inappropriate behaviour
- **hypoactive or 'quiet' delirium** – characterised by reduced motor activity, lethargy, withdrawal, drowsiness and staring into space
- the **'mixed'** subtype, which shows alternating features of the other two forms.



Hypoactive delirium is the most common presentation in older people and can be mistaken for a lack of motivation, dementia or depression [14].

## Further information



For tips on engaging staff in education, refer to *Lessons learned during field-testing*.



For a presentation for staff, refer to *Delirium Awareness Raising Presentation: Implementation resource toolkit to minimise functional decline in the domain of delirium*.



For guidelines, refer to *Clinical practice guidelines for the management of delirium in older people*.



## Can I help prevent delirium?

A range of strategies to prevent delirium and manage delirium symptoms have been studied [15].

The following strategies may help to prevent delirium in the older person:

-  • Encourage and assist the patient with eating and drinking (to reduce risk of dehydration and under-nutrition).
  -  • Ensure that patients who usually wear hearing and visual aids are assisted to use them.
  -  • Optimise communication (for example, use interpreters and liaison staff).
  -  • Avoid psychoactive drugs.
  -  • Avoid constipation.
- Ensure that lighting and noise levels are appropriate to the time of day.
  - Provide orienting information (for example, the name and role of staff members, large-font clock and calendar).
  - Encourage the family or carer and friends to visit and be involved in patient care.
  - Promote relaxation and sufficient sleep and discourage daytime napping.
  - Promote cognitive stimulation.
  - Ensure that pain relief is adequate.
  - Avoid room changes (may increase disorientation).
  - Avoid use of indwelling catheters.
  - Avoid use of mechanical restraints [16, 17].

The Yale Delirium Prevention Trial was the first controlled clinical trial to demonstrate that delirium could be prevented in older hospitalised people [10, 18]. The program included interventions, delivered by highly trained and supervised volunteers, to address six modifiable risk factors for delirium: cognitive impairment; sleep deprivation; immobility; vision and hearing impairment; and dehydration. A significant reduction in both the incidence and duration of delirium was demonstrated in those people who received the intervention. More recently, the program has become known as the Hospital Elder Life Program (HELP) and has been widely implemented in the United States [18, 19].

The HELP program has been adapted to the Australian healthcare setting, in the Recruitment of Volunteers to Improve Vitality in the Elderly (ReVive) program, at the Prince of Wales Hospital in Sydney, and has shown similarly promising results [20].

### Further information



For a more complete summary of these models, refer to *Models of care for the prevention and management of delirium*



*Improving the environment for older people in health services: an audit tool*



For a poster for staff, refer to *Prevention of delirium*



For guidelines, refer to *Clinical practice guidelines for the management of delirium in older people*



Hospital Elder Life Program



## How can I recognise delirium?

It is important to establish the role of the family or carers in identifying delirium. It is often a family member or carer who first notices a change in an older person's cognition or behaviour.

A sudden change in an older person's mental status, behaviour or self-care abilities is indicative of delirium and should always be investigated [21, 22].

Symptoms of delirium fluctuate through the course of the day and are often worse at night.

Symptoms include:

- difficulty focusing, sustaining or shifting attention
- disturbance of the sleep-wake cycle, for example, agitated or restless at night and drowsy during the day
- disorientation to place and time
- impaired recent memory
- speech or language disturbances, for example, rambling speech
- increased or decreased psychomotor activity
- emotional disturbances, for example, fearfulness, irritability, anger, sadness
- hallucinations and delusions.

### Delirium detection and diagnosis

The *Diagnostic and statistical manual of mental disorders iv* (DSM-IV) criteria [11] is the 'gold standard' for delirium diagnosis. A number of delirium screening or diagnostic tools have been developed based on the DSM-IV criteria.

**The Confusion Assessment Method (CAM)** has been the most widely studied delirium diagnostic tool and enables non-psychiatrically trained clinicians to quickly detect delirium in a range of settings [23]:

- The CAM diagnostic algorithm comprises the four cardinal delirium features: (1) acute onset and fluctuating course; (2) inattention; (3) disorganised thinking; and (4) altered level of consciousness.
- A diagnosis of delirium, according to the CAM algorithm, requires that *both* the first and second criteria are present, and *either* the third or fourth.

#### Delirium assessment tools:



*Confusion Assessment Method: Training manual and coding guide*



*Validation of the delirium rating scale-revised-98: Comparison with the delirium rating scale and the cognitive test for delirium*



*Delirium symptom interview*



The Hartford Institute for Geriatric Nursing in the United States has developed a range of web-based videos and written resources to assist with staff education. Refer to the TRY THIS® and How To Try This series for:



- *How to Try This: Detecting delirium* (article)

- *The Confusion Assessment Method* (article)

- *Delirium: The under-recognized medical emergency* (video)



For a poster for staff, refer to *Detection of delirium*



*Clinical practice guidelines for the management of delirium in older people.*



#### Screening for cognitive impairment

Detecting delirium in older hospitalised people may be improved by implementing a delirium screening protocol in high-risk settings (for example, cardiac and orthopaedic surgery). This might involve a formal cognitive assessment on admission (using a validated cognitive assessment tool) and regular repeated cognitive assessments. If evidence of deterioration in an older person's cognitive status were detected, this would lead to the use of a delirium assessment tool (for example, CAM).

An older person's cognitive status should be formally assessed on admission to settings even where there is a lower risk of developing delirium. If cognition is impaired, the onset of the impairment should be established because it may be due to delirium (refer to *Differential diagnosis*). Pre-existing cognitive impairment is a major risk factor for developing delirium.

#### Cognitive assessment tools

The most commonly used cognitive assessment tools are the **Mini Mental-State Examination (MMSE)** [24] and the **Abbreviated Mental Test (AMT)** [25]. The MMSE has been criticised for its lack of sensitivity to mild cognitive impairment and the **Modified Mini Mental-State Examination (3MS)**[26] was specifically developed to address this limitation.

Cognitive assessment tools have also been criticised for failing to take into account educational level, literacy and English proficiency, and tools such as the Mini-Cog [27] and the **Rowland Universal Dementia Assessment Scale (RUDAS)** [28] have been developed for use with people from culturally and linguistically diverse backgrounds.

The **Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)** [29] is completed by someone who knows the person being assessed well. Informant-based questionnaires provide complementary information on a person's cognitive status and may be used in situations where testing a person's cognition is difficult due to illness, dysphasia or literacy deficit.

### Further information

-  **Abbreviated Mental Test (AMT): Differences in use of abbreviated mental test score by geriatricians and psychiatrists**
-  **Mini-Mental State Examination (MMSE)**
-  **Modified mini-mental state exam (3MS)**
-  **Mini-cog**
-  **Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE).**
-  **For an English version of the short IQCODE, refer to Short Form of the Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE). Free usage is available to healthcare professionals for research or clinical purposes. However, the authors wish to be kept informed of any research using the IQCODE.**
-  **The Hartford Institute for Geriatric Nursing in the United States has developed a range of web-based video and written resources to assist with staff education Refer to the TRY THIS<sup>®</sup> and How To Try This series.**
-  **For a poster for staff, refer to *A model for the prevention and management of delirium in hospitalised older people*.**
-  **For a multicultural cognitive assessment scale, refer to The Rowland Universal Dementia Assessment Scale (RUDAS) [28, 30].**

## Differential diagnosis



The most common difficulty in diagnosing delirium is determining whether a person has dementia or delirium because these conditions have similar presenting features. However, the fundamental difference is that delirium occurs suddenly, while the onset of dementia is slow and insidious.



Depression and delirium may also have similar presenting symptoms such as apathy, withdrawal and tearfulness. Again, the fundamental difference is in onset of the condition – ‘depression’ describes a negative change in mood that has persisted for at least two weeks, whereas delirium develops over a matter of hours or days [31].

To provide appropriate care, clinicians must be able to differentiate between changes in mental status due to dementia, and those related to an acute health condition.

Delays in investigating and treating delirium, or initiating inappropriate treatment, can have serious consequences for an older person’s health and wellbeing [32, 33].

Refer to ***Differentiating the three D’s – dementia, delirium, and depression*** for a comparison of characteristic features.

## Further information

Further information, tools and educational resources on differential diagnosis include:



Milisen K, Braes T, Fick DM, Foreman MD 2006, ‘Cognitive assessment and differentiating the 3 Ds (dementia, depression, delirium)’, *Nursing Clinics of North America*, vol. 41, pp. 1–22



The Hartford Institute for Geriatric Nursing in the United States has developed a range of web-based video and written resources to assist with staff education. Refer to the TRY THIS® and How To Try This series



*Recognizing delirium, depression and dementia (3D’s)*



*Screening for delirium, dementia and depression in older adults*



*The 3-D’s: Depression, delirium and dementia: Resource guide.*



## What can I do if I recognise an older person has delirium?

The first step in delirium management is to identify and treat the cause or causes [34]. This involves:

- collating recent medical history (for example, a change in cognition, medication changes, dietary intake, falls, bowel and bladder function).
- physical examination (for example, vital signs, mental status).
- investigations (for example, urinalysis, full blood examination, chest X-ray).

Attention should also be given to relieving symptoms associated with delirium. There is considerable overlap between strategies to prevent delirium and strategies to manage the symptoms [35, 36]:

- Provide reorientation and reassurance when attending to the patients' needs.
  - Use simple language and ask single questions.
  - Educate the patient (where possible) and their family or carer about delirium.
  - Encourage the patient's family or carer and friends to be involved in their care, if this is calming to the patient.
  - Ensure that pain relief is adequate.
  - Encourage independence in activities of daily living.
  - Minimise environmental injury risks (for example, use of a high-low bed in its lowest position).
  - Avoid mechanical restraints – these may increase agitation, injury-risk and functional decline [37].
  - Institute relaxation strategies to assist with normalising sleep patterns.
  - Consider the need for specialised one-to-one nursing care (for example, if the patient is at high risk of falls).
  - Optimise communication (for example, use interpreters and liaison staff).
-  • Avoid antipsychotic medications – these may worsen delirium or contribute to the risk of falls and immobility [38].
-  • Encourage and assist the patient with eating and drinking (to reduce the risk of dehydration and under-nutrition).
-    • Assist the patient to mobilise (for example, to the toilet) to reduce the risk of developing pressure areas and incontinence.

For more information on models of care for preventing managing of delirium, refer to ***Models of care for the prevention and management of delirium.***

## Further information

For further information, tools and educational resources on the management of delirium, refer to:



Harding S 2006, *Delirium*, Department of Health and Ageing, Commonwealth of Australia, Canberra



For information and posters for acute care, residential aged care facilities and community settings, refer to *Poole's algorithm: Nursing management of disturbed behaviour in older people* [39]



The Hartford Institute for Geriatric Nursing in the United States has developed a range of web-based video and written resources to assist with staff education. Refer to the TRY THIS® and How To Try This series.



*Clinical practice guidelines for the management of delirium in older people* [40]



For a poster for staff, refer to *Multicomponent management of delirium symptoms*



*Physical restraint – part 1: use in acute and residential care facilities* [41]



*Physical restraint – part 2: minimisation in acute and residential care facilities* [42]



*Caregiving strategies for older adults with delirium, dementia and depression.*



## Pharmacological management of delirium symptoms

Pharmacological therapy for managing delirium symptoms should be reserved for people experiencing severe behavioural or emotional disturbance [40].

A 'severe behavioural or emotional disturbance' may be defined as one that threatens the person's own safety or the safety of others, interferes with essential medical or nursing care or causes significant distress to the person experiencing it [43].



The appropriate use of antipsychotic medication in older people requires attention to the following recommendations:

- The indication(s) for use of the medication should be documented in their medical history and reviewed regularly.
- Only one antipsychotic medication should be used at a time.
- The patient should be started on a low dose of antipsychotic medication.
- The patient should be reviewed frequently and medication dosage increased incrementally, if necessary, to achieve relief of symptoms.
- Prescription of antipsychotic medication should be accompanied by instructions regarding medication dosage and administration and the frequency with which a medical physician should review the patient's status [44, 24, 25].

### Further information

Further information and tools on pharmacological management of delirium include:



Pharmacological management of the delirious patient with severe behavioural or emotional disturbance in ***Clinical practice guidelines for the management of delirium in older people*** [40]



***The prevention, diagnosis and management of delirium in older people: concise guidelines*** [34]



***Practice guideline for the treatment of patients with delirium*** [45]



***Australian medicines handbook drug choice companion: aged care*** [43].

## What are the care or management principles I should follow if an older person has delirium?

All healthcare settings should consider implementing a structured approach to screen for delirium in older people.

The approach taken will depend on the level of risk for developing delirium in each setting (see *Screening for cognitive impairment*).



An older person's cognitive status should be formally assessed on admission to hospital.



Older hospitalised people should be encouraged and assisted to mobilise; this may promote normal sleep patterns.



Involve the older person's family or carer in their care.



Exercise caution when prescribing antipsychotic medication to older people with delirium.



Provide people who have experienced delirium, and their family or carers, with information about the condition.

Modifiable risk factors for developing delirium in older people should be addressed:



• Ensure adequate fluid intake.

- Avoid indwelling catheters.
- Avoid mechanical restraints.
- Ensure people who wear visual and hearing aids are assisted to use them.
- Avoid frequent room changes.
- Any sudden change or decline in an older person's cognition, behaviour or self-care ability is indicative of delirium and should be investigated.
- Delirium in the older person is typically caused by an acute health condition, which requires prompt investigation and treatment.
- Ensure that older people receive adequate pain relief.
- Employ environmental, behavioural and social strategies to manage the symptoms of delirium.
- Increase staff knowledge and awareness about delirium.
- Orientation and cognitive enhancement strategies should be utilised to help minimise confusion in the older person, provide:
  - » regular orientation to person, place and time
  - » large-font clock and calendar in patient areas
  - » lighting appropriate to the time of day
  - » cognitively stimulating activities (for example, newspaper discussion, exercise group).

### At night

Employ overnight strategies that promote sleep and assist with orientation to time.

Maintain a quiet environment (for example, use vibrating pagers rather than call bell).

Keep lighting to a minimum.

Delay non-essential observations or treatments if the person is asleep.



Provide family or carers with the option of staying overnight with an older person who is experiencing delirium.

## What should I consider when planning discharge for a person with delirium?

An older person's cognitive function and ability to manage at home may decline following an episode of delirium in hospital.

An older person may require a period of rehabilitation before returning home or community services support upon their discharge to home. Regardless of whether an older person is returning to their own home or to residential care, the following points provide a checklist for discharge planning:

- Document the episode of delirium in the patient's discharge summary, including details of any persisting symptoms.
  - Document any follow-up or monitoring to be completed by the older person's GP.
  - Consider the older person's need for additional support, for example, referral to inpatient or community services.
  - Provide written information about delirium to people who have experienced it and their family or carers (for example, a consumer brochure about delirium).
  - Ensure the older person and their family or carers are aware of who to contact should they have any ongoing concerns.
  - Consider the older person's need for post-delirium counselling [46].
-  • Document the older person's functional status on the discharge summary, compared with their pre-morbid status.
  -  • Involve the older person and their family or carer in discharge planning.
  -  • Document any changes to the older person's medications in their discharge summary.
  -  • Document the older person's cognitive status on the discharge summary, compared with their pre-morbid status.

### Further information

Further information, tools and educational resources for planning discharge include:

-  **Remembering carers in discharge: some prompts**
-  **Information brochure for consumers and their family or carers in *clinical practice guidelines for the management of delirium in older people* [40]**
-  **For more information refer to *Tips for discharge summaries*.**

## What can patients, families or carers do to help a person with delirium in hospital and at home?

The following points may assist family members or carers to care for an older person who is at risk of developing delirium:



- Bring a list of all medications the older person is taking (including over-the-counter medicines) to the hospital.



- If the older person wears glasses or hearing aids, bring these to the hospital (make sure the hearing aids have new batteries).



- Encourage and assist the older person to have adequate food and fluids.

- Having some familiar things around can be comforting (for example, family photos, their own dressing gown, a blanket for the bed).
- People can lose track of time in hospital. It may help to gently remind the older person about the time of day, the day of the week and the month. You could also talk about where the older person is, and why.
- Let staff know if you notice that your relative/spouse/friend seems more confused than usual, or is experiencing memory problems.

The following points may assist family or carers with the care of an older person experiencing delirium:

- People with delirium find it reassuring to see familiar people. Visit as often as possible; however, it is preferable to have fewer visitors over a longer period of time, so it may help to work out a 'visiting' roster with family members or friends.
- Speak slowly in a clear voice.
- Tell the person your name and call them by name; it may help them focus their attention.
- Remind the person where they are, and what day and time it is.
- Open the curtains in the room.
- If the person wears glasses or hearing aids, help them put them on.
- If the person is agitated or aggressive, don't try to restrict their movements; it may make things worse.
- Sometimes people see or hear things that aren't real when they have delirium. Don't argue about details; focus on the person's feelings and reassure them.
- Let staff know any personal information that may help calm and orient someone with delirium, for example, names of family and friends, favourite music or significant life events.

### Further information

For further information, tools and resources refer to:



**Information brochure for consumers and their family or carers in *clinical practice guidelines for the management of delirium in older people* [40]**



**For tips to avoid confusion in hospital refer to *Tips to avoid confusion in the older hospitalised person* (adapted from HELP)**



**Hospital Elder Life Program (HELP).**



## Case study

Mr Schwartz is an 82-year-old man, who wears glasses and has some hearing loss. Mr Schwartz had a fall at home while changing a light bulb and his neighbour, who heard his calls for help, found him on the floor and called an ambulance. He was taken to hospital, where an X-ray revealed that he had a fractured neck of femur.

Prior to his presentation at the emergency department (ED), Mr Schwartz was living alone at home independently.

### Scenario 1

In the ED, the admitting doctor completed a medical examination [1] and prescribed morphine for Mr Schwartz's pain. An indwelling catheter (IDC) was inserted [2].

Following surgery to repair the fracture Mr Schwartz was admitted to the orthopaedic ward. His pain was managed with regular paracetamol and codeine [3]. The IDC was removed the following morning [4]. He was referred to physiotherapy for mobilisation and rehabilitation [5].

Two days later, the physiotherapist found Mr Schwartz was difficult to rouse during the middle of the afternoon. She documented in Mr Schwartz's history that he was unable to participate in physiotherapy due to his sleepy state [6].

When Mr Schwartz's daughter visited later that day, she found that he had not eaten any of his evening meal. He seemed confused and unable to keep track of their conversation. She was very concerned about her father's deterioration and mentioned it to the nurse who was looking after him. The nurse, who had only met Mr Schwartz that afternoon, told his daughter that it was not uncommon for older people to be a 'bit confused' for a couple of days after having an anaesthetic [7].

The next afternoon when Mr Schwartz's daughter visited, he was less responsive than the day before. He was in bed and seemed unaware of her presence; staring into space. She spoke to the nurse, who took a set of observations (temperature, pulse, respirations, blood pressure and oxygen saturation) and tested Mr Schwartz's urine, which showed signs of infection.

The nurse notified the medical registrar, who reviewed Mr Schwartz and diagnosed delirium and prescribed antibiotics to treat the infection. On further investigation, Mr Schwartz was also found to be constipated and a bowel management regimen was developed.

As his confusion reduced and his activity levels improved, Mr Schwartz resumed physiotherapy and was referred to occupational therapy for assistance in regaining his independence with self-care and transfers.

After another week on the ward, Mr Schwartz was much improved and he was able to ambulate 25 metres with a frame and supervision. A referral was made to the triage rehabilitation and aged care (TRAC) team, who recommended ongoing rehabilitation in a geriatric evaluation and management (GEM) unit.

## Scenario 2

The following strategies from *The toolkit* were utilised:

- Establish the patient's cognitive function at admission by performing a cognitive assessment, using a validated instrument.
- Identify and manage risk factors associated with the development of delirium in older people (for example, indwelling catheters, constipation, infection).
- Identify and investigate signs and symptoms of delirium (for example, decline in function, change in cognition, alertness, perception or attention).
- The knowledge and awareness that confusion is not a normal part of ageing.
- Interdisciplinary communication and documentation.



- Use of patient and family or carer education and information brochure.



- Use of delirium prevention and managements strategies (for example, mobilisation, ensuring that patient is wearing hearing and vision aids, orientation, maintaining adequate hydration).



In the ED, the admitting doctor completed a medical examination [1], including an **Abbreviated Mental Test (AMT)**, which indicated that Mr Schwartz's cognitive function was normal. The doctor prescribed morphine for Mr Schwartz's pain. [2] The call bell was placed in Mr Schwartz's reach and he was assisted to use a urinal as required.



Following surgery to repair the fracture, Mr Schwartz was admitted to the orthopaedic ward. His pain was managed with regular paracetamol and codeine [3], and he was commenced on a bowel regime to monitor and prevent constipation. The IDC inserted during surgery was removed the following morning [4] and Mr Schwartz was monitored for any signs of urinary retention or infection [5]. He was referred to physiotherapy and occupational therapy for mobilisation, rehabilitation and falls prevention training.



Two days later, the physiotherapist found Mr Schwartz was difficult to rouse during the middle of the afternoon. She noted in Mr Schwartz's history that he was unable to participate in physiotherapy due to his sleepy state [6] and notified the nurse looking after him.

The nurse, who had only met Mr Schwartz that afternoon, referred back to Mr Schwartz's notes from the ED and noted the decline in his cognitive function. He took a set of observations (temperature, pulse, respirations, blood pressure and oxygen saturation) and tested Mr Schwartz's urine, which showed signs of infection.



The nurse documented: the results; his observations of Mr Schwartz's behaviour; and his conversation with the physiotherapist in Mr Schwartz's medical record. He also notified the medical registrar who reviewed Mr Schwartz and diagnosed delirium. Mr Schwartz was prescribed antibiotics to treat the infection.



When Mr Schwartz's daughter visited later that day, she found that he had not eaten any of his evening meal. He seemed confused and unable to keep track of their conversation. She was very concerned about her father's deterioration and mentioned it to the nurse looking after him [7]. The nurse explained that Mr Schwartz was experiencing delirium, due to a urinary tract infection, and once the infection cleared he should return to his usual self. He provided Mr Schwartz's daughter with a brochure about delirium in older people.



The nurse suggested Mr Schwartz's daughter could encourage and assist him with eating and drinking if she felt comfortable doing so. Nursing staff also implemented some environmental and clinical strategies to help manage Mr Schwartz's confusion, which included ensuring he was wearing his glasses, that the lighting in his room was appropriate to the time of day and noise was kept to a minimum at night.

As Mr Schwartz's confusion resolved and his activity levels improved, he resumed physiotherapy. He was also referred to the unit's Functional Maintenance Program (FMP), where an allied health assistant assisted him with regaining his independence with self-care, transfers and mobility.

Once Mr Schwartz was able to ambulate 25 metres with a frame and supervision, a referral was made to the triage rehabilitation and aged care (TRAC) team. TRAC recommended ongoing rehabilitation in a geriatric evaluation and management (GEM) unit to ensure Mr Schwartz regained his premorbid level of independence prior to discharge home.

## Further reading

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## Palliative care and delirium

- *Guidelines for a palliative approach in residential aged care* [47]
- *Medical care of the dying* [48]. The Victoria Hospice Society in Canada published the 4th edition of this textbook in 2006. Refer to an excerpt from the chapter *Confusion, delirium, and dementia in palliative care*.

## Alcohol withdrawal delirium

- *Management of alcohol withdrawal delirium. An evidence-based practice guideline* [49].

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# Dementia



## Five facts everyone should know about dementia

-  1. Assessment of cognitive function, early identification and management of dementia is vital given the impact of dementia on patients and families or carers.
2. Family or carer knowledge of medical and personal history, communication style, preferences and routines should be discussed and utilised to facilitate the most appropriate management of the patient with dementia.
3. The **Cognitive Impairment Identifier** can be used to promote effective communication between the patient with memory and thinking difficulties, and all hospital staff.
4. Cognition-friendly hospital design must take into account the patient's decline in memory and their ability to navigate the environment safely and effectively.
5. Effective communication between the patient with dementia and all hospital staff involves introducing yourself, ensuring you have eye contact, remaining calm and talking in a matter-of-fact manner, involving carers, keeping sentences short and simple, focusing on one instruction at a time, allowing time for responses, repeating yourself to ensure you have been understood and not providing too many choices.

## An awareness of dementia is important when working with older people in hospitals. Why?

Hospitals are foreign places to most people with dementia. Unfamiliar routines, people and environments often increase the confusion level of patients with dementia and, in turn, trigger changes in behaviour and emotions.

It is important to acknowledge and integrate a diagnosis of dementia into care planning, as dementia impacts on all aspects of care, treatment and planning a patient will experience in hospital.

Delivering patient care is a complex undertaking, further complicated by the multifaceted nature of dementia. It is inevitable that, on occasions, schedules and expectations will not be met and patients will misinterpret efficiency for insensitivity. This often results in resentment or even anger. These patients are often labelled as 'difficult' by staff.

-  The concept of adapting an environment to cater for the needs of a person with a physical impairment is well accepted. However, acceptance of dementia as an impairment and the need to adapt the care environment to meet specific needs of people with dementia is less understood. It is unrealistic to expect a patient with dementia to adapt to, and accommodate, the hospital environment.

Engaging and involving the carers of people with dementia is essential. Carers can play an invaluable role throughout the hospital stay. Drawing on their unique knowledge and experience in caring for the patient will assist hospital staff in planning and delivering care. When carers are informed about what to expect during an admission, and how they may work with the hospital staff, the quality of patient care will be improved.



Hospitals can assess how well their structures, processes, policies, practices and cultures support evidence-based practice for the care of patients with dementia through using a tool developed for this purpose, the **Evidence Based Identification Tool (EBIT)**.

## What is dementia?

Dementia is a term used to describe a series of conditions that can affect a person's ability to think, remember, understand, make judgements, communicate and interact socially.

It is not normal for older people to develop memory or thinking difficulties. However, dementia is common and generally under-recognised. An admission to hospital may be the first opportunity to initiate investigations that lead to a diagnosis.

The incidence of dementia increases with age:

- Any person can develop dementia, but it is more common after the age of 65 years.
- For females aged 65–69 years, dementia affects one person in 80, compared with one person in 60 for males.
- For both males and females aged 85 years and over, dementia affects approximately one person in four [1].
- At present, more than 230,000 Australians are living with dementia; 25 per cent are from Victoria.
- More than 1,000 people are newly diagnosed with dementia each week.
- It is estimated that dementia will affect more than 730,000 people by 2050, unless there is a medical breakthrough [2].

Alzheimer's disease is the most common cause of dementia, and accounts for between 50 and 70 per cent of all cases.

Dementia ranks as the fourth leading cause of death among people aged 65 years and over.

## Types of dementia

Dementia is a collection of symptoms resulting from many possible causes and disease processes.

### Alzheimer's disease

Alzheimer's disease is the most common form of dementia. Accounting for 50–70 per cent of all cases, it is a physical condition that attacks the brain, resulting in impaired memory, thinking and behaviour. In the early stages, the symptoms of Alzheimer's disease can be subtle. However, it often begins with lapses in memory and difficulty in word-finding for everyday objects.

### Vascular dementia

This is the second most common form of dementia. Vascular dementia is a broad term for dementia associated with problems with circulation of blood to the brain.

### Dementia with Lewy bodies

A common form of dementia, this form of dementia shares many similarities with Alzheimer's disease and is caused by the degeneration and death of nerve cells in the brain. The name comes from the presence of abnormal, spherical structures called Lewy bodies that develop inside the nerve cell.

### Younger onset dementia

Sometimes called early onset dementia, this term is used to describe any form of dementia diagnosed in people under the age of 65 years.

## How is dementia diagnosed?

There is no definitive test for diagnosing dementia. Findings from a variety of sources and tests build a diagnosis. The process can be complex and time consuming. Sometimes a diagnosis is uncertain and may be conveyed as 'possible' or 'probable'. Despite this uncertainty, a diagnosis is accurate about 90 per cent of the time [3].

There are two key elements to diagnosis:



- identifying and eliminating other conditions that show similar symptoms, for example, depression or delirium.
- identifying which disease process is causing the dementia.

**The Diagnostic and statistical manual of mental disorders IV (DSM-IV)** criteria for the diagnosing dementia are accepted as the gold standard for this condition [4]. It is only when a patient meets the DSM-IV criteria that a formal diagnosis of dementia can be made.

### Further reading

For further information on the DSM-IV criteria for dementia and diagnosing dementia:



***Understanding dementia: a guide for hospital staff***



***Diagnosing dementia***



***Dementia resource guide [5].***



***Behavioural and psychological symptoms of dementia (BPSD): education pack (Module 1)***

## Cognitive function assessment

Assessing cognitive function is a very important step in the diagnostic process for dementia. Tests are used to determine the extent of any memory or thinking problems and can be used to track their progression over time. Knowing the extent of cognitive impairment will also help the hospital care team modify the environment and care plan to best meet the needs of the patient.

Dementia screening tests can be quite brief and simple, such as giving the date, copying a diagram, learning a short list of words or naming common objects.

Commonly used brief assessments include the:



**Mini-Mental State Examination (MMSE)**



**Modified Mini-Mental State Examination (3MS).**



**For information about the Abbreviated Mental Test (AMT), refer to *Differences in use of abbreviated mental test score by geriatricians and psychiatrists*.**

Some patients perform well on brief screening tests, but memory and thinking impairments may be found with more comprehensive testing. Some tests have been shown to have educational, social and cultural bias.



**The Rowland Universal Dementia Assessment Scale (RUDAS), developed in Australia, is an example of a screening tool suitable for use in culturally and linguistically diverse populations.**



**The clock-face drawing test is commonly used to complement other quick assessments of cognitive function, such as the MMSE [6].**

Brief screening tests can also be followed up by more detailed tests of function. Neuropsychological tests examine different areas of function, such as memory, language, reasoning, calculation and ability to concentrate. These tests are able to distinguish between different patterns of decline and are therefore important in helping to identify the individual's particular type of dementia.

### Further information

For further information, refer to:



***Position paper 10: Early diagnosis of dementia***



***Diagnosing dementia: a reference paper.***

## Differential diagnosis



A common difficulty is determining whether a person has dementia or delirium because these conditions have similar presenting features. The fundamental difference is that delirium occurs suddenly, while the onset of dementia is slow and insidious.



Depression and dementia may also have similar presenting symptoms, and may both be present at the same time.

In order to provide appropriate care to an older person, clinicians must be able to differentiate between changes in mental status due to dementia and those that may be due to an acute health condition.

A range of symptoms and behaviours are associated with different types of cognitive impairment. Some symptoms are similar across delirium, dementia and depression, therefore, an accurate diagnosis is important.

Refer to **Differentiating the three D's – dementia, delirium and depression** for a comparison of characteristic features.

### Further resources

For further information, tools, and educational resources on differential diagnosis refer to:



Milisen K, Braes T, Fick DM and Foreman MD 2006, 'Cognitive assessment and differentiating the 3 Ds (dementia, depression, delirium)', *Nursing Clinics of North America*, vol. 41, pages 1–22.



*Screening for delirium, dementia and depression in older adults*



The 3-D's: depression, delirium and dementia: resource guide



*Recognizing delirium, depression and dementia (3 D's).*



The Hartford Institute for Geriatric Nursing in the United States has developed a range of web-based videos and written resources to assist with staff education. Refer to the TRY THIS® and How To Try This series for:

*Assessing and managing delirium in persons with dementia* (article)

*How to Try This: Delirium superimposed on dementia* (article)

*Delirium: The under-recognized medical emergency* (video)

## Who diagnoses dementia?

Without a diagnosis prior to admission, investigations may be commenced in hospital. However, it will take longer than the duration of an acute admission to come to any conclusions regarding a person's cognitive status. A referral to an appropriate service for follow-up post discharge is essential because there are benefits to early diagnosis.

Discharge correspondence with the GP is important when memory and thinking difficulties are identified during an admission. This may include results of dementia or delirium screening performed while an inpatient. The GP will provide ongoing primary care for the patient and will direct or coordinate the process of diagnosis and management.



Memory clinics incorporate a range of specialists involved in diagnosing dementia. They provide diagnostic services for all types of dementia. In Victoria, Memory clinics are known as **cognitive dementia and memory services (CDAMS)**.

Specialists such as neurologists, geriatricians, psycho-geriatricians, psychiatrists and neuro-psychologists have more detailed knowledge of memory and behaviour changes associated with dementia and may perform, or arrange, in-depth assessments. In Australia, a specialist must confirm the diagnosis of Alzheimer's disease in order for a patient to be eligible for subsidised Alzheimer's medications.



**Aged care assessment services (ACAS)** are independent, multidisciplinary teams that conduct comprehensive, medically based assessments for frail older people needing community services or aged care residential services. They assist older people and their family and carers identify the type of care that will best meet their needs, put them in contact with relevant services, make recommendations about the level of care required and approve eligibility for certain services and packages.

## Medical investigations

When a patient is suspected of having dementia, the following pathology tests should be performed: full blood examination, urea and electrolytes, liver function tests, thyroid function tests, vitamin B12, folate, calcium and random glucose.

Additional tests may be required depending on clinical indications.

Imaging of the brain using computerised tomography (CT) scans or magnetic resonance imaging (MRI) within 12 months of presentation of symptoms is a necessary part of making a diagnosis of dementia.

## What can I do if I recognise that someone has dementia?



- Exclude other causes of cognitive impairment, such as delirium and depression.
- Determine if a formal diagnosis exists (check with family or carer, medical records and GP).
- Assess the patient's cognitive function and perceptions of what is happening to them.



- Educate staff to recognise people with dementia. Several conditions mimic dementia and can be missed if not actively addressed by staff, such as delirium and depression.



- Adapt the hospital environment to suit the needs of the person with dementia (for example, have familiar personal belongings around them and familiar routines).



- Engage and involve family and carers of people with dementia. If carers are informed about what can be expected during an admission, or how they may work with the hospital staff, care of the patient with dementia can be improved.



***Information for carers of people with memory and thinking difficulties: a guide to coming to hospital*** is designed to complement the generic coming to hospital information usually provided on admission.



The ***Information about 'me' for planning care in hospital*** form provides a way for family and carers to provide hospital staff with specific information about how they usually respond to the patient and any behavioural and psychological symptoms at home.

Refer for follow-up and formal diagnosis as appropriate.

## How should I respond to a patient who has dementia?



A key way of improving care for a patient with cognitive impairment is proactive involvement of the family and carers in assessment and care planning. This could be considered a partnership between expert healthcare staff and the carer who has expert knowledge of the patient requiring care. The carer could be a member of the patient's family, staff from residential care or a community-based case manager someone who knows the person well.



A **carer charter** is included that can assist an organisation to demonstrate commitment to engaging carers in patient care.



**Information for carers of people with memory and thinking difficulties: a guide to coming to hospital** is designed to complement the generic 'coming to hospital' information usually provided on admission.



To assist in involving the carer in the assessment process, the **Information about me** form has been developed. This provides an opportunity for the family or carer to provide specific information about key domains of care that the patient with dementia may be unable to reliably provide. For example, how to best manage medication administration or toileting needs. While developing a care plan or tailoring a care pathway for the patient with dementia, this information is used to ensure the patient's needs are met and potential problems or barriers are avoided where possible.



The **Information about 'me' for planning care in hospital** form provides a way for family and carers to provide hospital staff with specific information about how they usually respond to the patient and any behavioural and psychological symptoms at home.

## What are the care or management principles I should follow if someone has dementia?

 Once patients with memory and thinking difficulties have been identified, all hospital staff coming into contact with them should be alerted to their condition. Use of the **Cognitive Impairment Identifier (CII)**, a tool designed to be used as a discreet bed-based flag of cognitive impairment, has been found to be useful.

In organisations using the CII, a hospital-wide education program trains staff to respond appropriately to the needs of a patient with cognitive impairment and dementia. Please refer to [www.health.vic.gov.au/agedcare/publications/dementia.htm](http://www.health.vic.gov.au/agedcare/publications/dementia.htm) for more information about the identifier and how to use it effectively.



### Keys for effective communication

 People with dementia and their family and carers consider the following points to be most important when speaking to someone with dementia, delirium or cognitive impairment:

- Introduce yourself.
-  • Involve family and carers.
- Make sure you have eye contact at all times.
- Remain calm and talk in a matter-of-fact way.
- Keep sentences short and simple.
- Focus on one instruction at a time.
- Give time for a response.
- Repeat yourself – don't assume you have been understood.
- Do not give too many choices.

### Further information

 For further information on effective communication, refer to *Understanding dementia: a guide for hospital staff*.

### Behavioural and psychological symptoms of dementia (BPSD)

The early signs of dementia are very subtle, vague and may not be immediately obvious.

Common symptoms of dementia are:

- progressive and frequent memory loss
- confusion
- personality change
- apathy
- withdrawal
- loss of ability to do everyday tasks.

Dementia affects people differently. As well as the common symptoms already listed, a patient's behaviour can change. This can include wandering, pacing, agitation, depression, aggression and hallucinations. These are known as the **behavioural and psychological symptoms of dementia (BPSD)**. Each patient diagnosed with dementia will have different symptoms, be affected differently and have different care needs.

### Why is understanding BPSD important?

Changes in behaviour are very common in patients with dementia admitted to hospital. These behaviours may impact on family, carers and hospital staff. The disease process can alter how the patient reacts to the hospital environment, while having a disinhibiting effect on their social behaviour.

BPSD affects patient behaviours and responses. Patients may be perceived to be difficult when their behaviour is actually a symptom of dementia. BPSD can impact on many areas of care and, in order to provide optimal care in hospital, dementia must be identified and considered in planning and delivering care.

Importantly, BPSD are recognisable, understandable and treatable. The recognition and appropriate management of BPSD are vital factors in improving care for people with dementia.

Caring for a patient with BPSD can affect staff and cause stress. Conversely, staff management practices and responses can influence patients with BPSD. The way hospital staff respond to a patient with dementia can greatly improve or worsen the situation. Responding appropriately can reduce the BPSD, while responding rigidly can exacerbate the behaviours [7].

The attitude and manner of hospital staff is extremely important, as patients with dementia are very sensitive to non-verbal cues and mirror the affective behaviour of those around them. A calm and gentle manner has a positive effect. It is important to be aware that your body language may contradict the words you are using.

If not effectively treated, BPSD can contribute to:



- compromised patient safety (for example, falls, the potentially harmful use of sedation, physical restraint)
- worsening patient outcomes
- functional decline of the patient
- diminished quality of life for the patient and their family or carers
- premature residential placement [7]
- significant financial cost (constant patient observation costs and increased length of stay)
- a perception by the patient and family of substandard hospital care and increased risk of complaints
- substantial work-related stress and decreased job satisfaction for staff.

## Assessment of BPSD

Close observation of patient symptoms can assist in determining which BPSD are present, and help identify triggers, antecedents or activating events.



An accurate history from a family member or carer can help manage and prevent the exacerbation of BPSD during a hospital stay. Observation and clear documentation of the behaviour is important.



The ***Information about 'me' for planning care in hospital*** form provides a way for family and carers to provide hospital staff with specific information about how they usually respond to the patient and any behavioural and psychological symptoms at home.

## Further information

For further information, tools and resources refer to the following:



For a table outlining some of the most commonly encountered care issues in a hospital setting and some strategies to try, refer to *Understanding dementia: a guide for hospital staff*



*Dementia resource guide* [5]



*Regional dementia management strategy* [8].

## What care or management principles should I follow if a patient's behaviour becomes unsettled?

Refer to the following sections on some commonly encountered BPSD and strategies for responding to these symptoms:

- wandering
- sundowning
- anxiety or agitation
- aggression (physical or verbal)
- hallucinations or false ideas
- disinhibited behaviour
- pharmacological treatment options.



For a table outlining some of the most commonly encountered care issues in a hospital setting and some strategies to try, refer to ***Understanding dementia: a guide for hospital staff***.



Alzheimer's Australia has information for patients, families and carers. Refer to Alzheimer's Australia **help sheets and update sheets** for further information on BPSD.

It is unrealistic to assume that a patient with dementia will be capable of independently attending to their personal care needs within the unfamiliar hospital environment.

### Wandering

Wandering behaviour is regarded by nurses, family and carers as one of the most troubling behavioural symptoms likely to cause stress to the caregiver [9]. There is no one type of wandering behaviour. It has different patterns and, therefore, creates different management issues and levels of risk [10]. Screening and measurement tools can assist in differentiating between different types of wandering and assist in developing an individualised person-centred intervention [10, 11].

Some strategies to try:

- Keep objects that might encourage wandering out of sight (for example a coat or handbag).
- Ensure a patient's room is convenient for observation and is away from stairs or elevators, or located so the patient has to pass the nursing station to reach an exit.
- Make sure all staff are alerted to the possibility of wandering.
- Provide opportunities for exercise and activity as appropriate. The family or carer can be involved by taking the patient for a walk within the hospital grounds at appropriate times. Allied health assistants or trained volunteers may be available to assist.
- Designate a safe place for the patient to wander.
- Ensure the patient has identification intact at all times. Keep a description of what the patient is wearing on a daily basis and ensure a current photo is available.

## Sundowning

Sundowning is restlessness, increasing confusion or changed behaviours in a patient with dementia that can occur late in the afternoon or early evening.

Some strategies to try:



- Use early evening routines that might be familiar for the patient. Check with their family or carer.



- The **Information about 'me' for planning care in hospital** form provides a way for family and carers to provide hospital staff with specific information about how they usually respond to the patient and any behavioural and psychological symptoms at home.



- Find out what activities or strategies calm the patient (for example, warm milk, back rubs, calming music).

- Allow the patient to mobilise in a safe environment.
- An afternoon rest, if fatigue is making sundowning worse.
- Consider environmental factors (for example, is the lighting too dim or bright or are sounds too loud?).
- Avoid activities in the late afternoon that may be unsettling (for example, showers, dressings).

## Anxiety or agitation

Anxiety and agitation require an understanding of the reality the person with dementia is experiencing, and validating this may help settle the patient.

Some strategies to try:

- talking about the anxiety-producing thoughts
- reassurance
- identifying, and relieving, the cause of the anxiety, where possible.

## Aggression (physical or verbal)

Consider possible causes of aggressive behaviour:

- fatigue
- over-stimulating environment
- asking the patient too many questions at one time
- too many strangers in a noisy, crowded atmosphere
- asking the patient to perform tasks beyond their abilities
- failure at simple tasks
- encounters with irritable staff.

Some strategies to try:

- Identify and address the triggers and underlying emotion or feelings if possible.
- Simplify the task and communication.
- Ask a 'why?' question to get to the reasons for repetitive questioning and reduce its occurrence.
- If an explanation doesn't help, a distraction or some type of activity may diffuse the situation.
- Remain calm and use a low tone of voice.
- State things in positive terms, the constant use of 'no' or use of commands increases resistance.
- Refrain from forcing or restraining a patient.

## Hallucinations or false ideas

Hallucinations are often present in later stages of dementia and can often cause great distress.

Seeing or hearing things that are not there is often frightening. Voices or sounds may be heard, or people or objects are seen, and these can cause severe reactions. Hallucinations of false ideas can cause extreme anxiety and agitation.

Some strategies to try:

- Don't argue and don't take any accusations personally.
- Maintain a familiar environment, with consistent staff and routine, as much as possible.
- Ignore some hallucinations or false ideas if they are harmless and aren't causing agitation.
- Avoid triggers.



Pharmacological treatment may be part of a coordinated response (some patients benefit from treatment with anti psychotics). For further information, refer to ***Pharmacological treatment options***.

## Disinhibited behaviour

Disinhibited behaviours may occur because a patient has forgotten where they are, how to dress or the importance of being dressed. It is important to understand why a patient may be behaving in this way so that triggers can be avoided where possible.

Some frequent causes include:

- confusing the identity of a person
- discomfort (too hot or cold, clothes too tight or itchy)
- loss of memory or disorientation (forgetting where the bathroom is and how to use it, confusing the time of day and what they should be doing).

Some strategies to try:

- Respond with patience and in a gentle, matter-of-fact manner.
- Don't over-react; remember it is part of the condition.
- Reassure and comfort the person who may be anxious.
- Gently remind the patient that the behaviour may be inappropriate.
- Lead them gently to a private place.
- Provide clothing that is more comfortable.
- Distract the patient by providing something else to do.

## Pharmacological treatment options

Pharmacological treatment should always be used in conjunction with a consistent, non-pharmacological management plan.

Due to the potential side effects, the introduction of pharmacological treatment of BPSD should be avoided where possible. If a patient is medicated it is recommended that a geriatrician or specialist be involved. Using the expertise of a pharmacist as part of the care team is also advisable. Ideally, medications should be administered orally, in low doses and monitored and adjusted accordingly.

## Further resources

For further information, tools and resources refer to:



***Understanding dementia: a guide for hospital staff***



***Best practice approaches to minimizing functional decline in the older person across the acute, subacute and residential aged care settings [1, 11]***



***Clinical practice guidelines for the management of delirium in older people [13]***



***Behavioural and psychological symptoms of dementia (BPSD): education pack (Module 1) [7].***

## What needs to be considered when planning discharge for a person with dementia?

For people with dementia, early discharge planning is of particular importance because their needs are complex.

Discharge planning needs to start soon after admission in order to prevent lengthy stays that may result in diminished independence and early admission to residential care. Discharge planning extends beyond the hospital environment and makes optimal use of GPs, other healthcare providers or social services. It involves arrangements for medical follow-up of acute illness and other care and support services.



Discharge planning is always undertaken in consultation with the patient and family or carers.

## Case study

Mrs Wright's husband was admitted to hospital for a minor surgical procedure. On admission, Mrs Wright mentioned that her husband had been diagnosed with Alzheimer's disease and asked the nurse to highlight this by circling and underlining it on the admission notes. Mrs Wright explained that her husband presents well so staff needed to be aware that he does actually have dementia and needs extra supervision. After his surgical procedure Mr Wright was very disorientated and agitated, pulling at his intravenous lines and trying to remove his identification band.

### Scenario 1

Mrs Wright visited the day after his surgery and found her husband sitting in the chair with his clothes over his pyjamas, looking like he was ready to come home. When questioned, the nurse explained that Mr Wright had put his clothes on himself and that they had left him like that. Mrs Wright felt that he should have had the clothes taken off and been kept in his pyjamas so he would better identify he was to stay in bed. As he was now disorientated and agitated, Mrs Wright felt that she would have to stay in the ward all day to watch him. She was worried that the nurses were not concerned about her husband's state of mind.

During the course of the day, a nurse asked Mr Wright to drink a lot of water because it would be good for him but didn't stay and offer any help or supervision, confirming for Mrs Wright that she really would have to stay all day. Mrs Wright knew there was no way her husband could follow the instructions from the nurse or remember what he had been asked to do. Mr Wright would need assistance and direction to drink the water. A little later the nurse returned and asked Mr Wright to use the urinal bottle rather than the toilet. This was another request he would not be able to remember. Mrs Wright made sure that when her husband went to the toilet she followed him to remind him to use the bottle.

Later that evening, Mrs Wright found her husband's tablets in his pocket, indicating the nurse hadn't watched him take them before she had left the room. During the course of the day, Mrs Wright had to leave the ward every two hours due to parking restrictions. Each time she left the ward, she made a point of asking the nurse to watch Mr Wright while she went out so that he didn't follow her. Mrs Wright knew that he was normally only a step behind her and in his current agitated state he was even more 'clingy'. When her son and grandson visited later in the evening Mrs Wright took the opportunity to leave and go home for a while, knowing that her husband had company.

At about 7.30 pm, her son rang to tell her he had noticed his father was not wearing an identification band and he was concerned that if he wandered off he could not be identified. Mrs Wright rang the ward and notified the staff, who said they would put a new band on straight away. Alarming when the nurse went to Mr Wright's room to replace the identification band he was not there. At 9.00 pm, Mrs Wright received a phone call from a nurse on her husband's ward informing her that he was missing. Staff were looking for him and the police had been notified. The nurse asked if Mr Wright had arrived at home, which was about four kilometres from the hospital. Mrs Wright rang her son to tell him that his dad was missing, 'I know', he replied, 'He is here at my house'. Mr Wright had walked about three kilometres, crossed a bridge over a river and walked over numerous hills to get to his son's home.

The hospital was very apologetic. Mrs Wright told them that she did not think the hospital was equipped to look after patients with dementia and that from the beginning of the hospital stay, things had not gone well. Mrs Wright informed hospital staff that her husband needed to be in a room

close to the nurses' desk so that if he wandered he would be noticed. Mrs Wright also reported her concerns in relation to her husband's toileting, fluid intake and medication administration. Mrs Wright felt strongly that staff needed to learn more about how to effectively care for patients with dementia in the hospital setting.

## Scenario 2

Utilising the following strategies from *The toolkit*:



Family and carers play a vital role in a hospital admission. They have a unique knowledge and experience in caring for the person to be admitted and the hospital staff will benefit from their input into planning care.

The **Cognitive Impairment Identifier (CII)** is a bedside alert sign that shows all hospital staff that the patient has a cognitive impairment. Hospital staff are required to undertake an education program that includes the use of the CII sign and how to approach and assist the patient with cognitive impairment.

Use of the ***Information for carers of people with memory and thinking difficulties: a guide to coming to hospital*** brochure, designed for family or carers, is aimed at improving the hospital experience and quality of care received. This guide will support the family or carers in their caring role, which continues during the hospital admission. The guide outlines how family or carers can work in partnership with hospital staff to make the hospital experience as stress free as possible.

***Information about 'me' for planning care in hospital*** is designed to be completed by family or carers of people with memory or thinking difficulties who at times may not be able to communicate their needs and problems. It will assist hospital staff with planning individualised care for the patient.

The book ***Understanding dementia: a guide for hospital staff*** is designed to be a quick reference for staff caring for patients with dementia. It has three parts:

1. Understanding dementia
2. Responding appropriately to the patient with dementia
3. Behavioural and psychological symptoms of dementia.

Mrs Wright's husband was admitted to hospital for a minor surgical procedure. On admission Mrs Wright mentioned that he has Alzheimer's disease. Mrs Wright asked the nurse to highlight this in the admission notes.

Now that Mrs Wright had highlighted her husband had been diagnosed with dementia, the nurse provided Mrs Wright with a *Dementia care in hospital* support pack. This included the ***Information for carers of people with memory and thinking difficulties: a guide to coming to hospital*** brochure and ***Information about 'me' for planning care in hospital*** form for use in planning Mr Wright's hospital care. The nurse asked Mrs Wright if she could fill out the form so hospital staff would have an idea of what is usual behaviour for her husband and how he manages activities of daily living in relation to his Alzheimer's disease.

The completed form showed that Mr Wright was only ever a few steps behind his wife during the day, 'shadowing' her and that he generally could perform activities of daily living himself with instruction and supervision, for example, taking medications and dressing himself. From this information the nurse was then aware that if Mr Wright was not observed closely he may wander. The nurse was also mindful that Mr Wright had to be reminded and assisted to eat and drink and directed and assisted with toileting. The nurse allocated Mr Wright to a room close to the nurses' station to ensure close

observation at all times. If Mr Wright attempted to leave the ward he would be seen by staff at the desk. The nurse asked Mrs Wright for a recent photo of her husband, checked his identification band regularly to ensure he had not removed it and documented what Mr Wright was wearing on each shift, so that he could be easily identified if found wandering in the hospital area.

Mrs Wright observed the care the nurse had given her husband and felt confident leaving him in the care of the hospital and would not have to worry about his wellbeing and safety. Mr Wright had his minor surgical procedure and was discharged home with his wife the next day. A week later Mrs Wright sent a letter to the surgical ward to thank them for her peace of mind when leaving her husband at the hospital and providing she and her family with the ***Information for carers of people with memory and thinking difficulties: a guide to coming to hospital*** brochure, which outlined what they should expect in relation to Mr Wright's care while in hospital. She was also impressed that an assessment had taken place prior to discharge, which had addressed both her and her husband's need for assistance and services when he went home from hospital.

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# Depression



## Five facts everyone should know about depression

1. Depression is not a normal part of ageing. Depression is not general sadness or grief following bereavement.
2. Older people do not commonly let others know they may have depression and may tend to focus on physical problems.
3. Some less typical behaviours (for example, being irritable, angry or demanding) are as likely to be part of a depressive illness as tearfulness or lack of motivation.
-  4. Acute and chronic illness (for example, dementia) can mask depression. Assessment by a mental health specialist is recommended; however, early screening can assist in identification.
5. Effective treatments, including both medication and psychological therapies, are available.

## Why is recognising depression important in working with older people in hospitals?

Depression is not a normal part of ageing.

Depression is under-recognised and inadequately treated in many older people. Misdiagnosis of depression delays treatment, increases the risk of functional decline and slows the rate of recovery [54].

Depression is a serious condition that can be life threatening. During a hospital admission, depression is associated with:

- increased risk of death
- loss of independent function
- poor response to rehabilitation and diminished recovery
- poor post-operative recovery
- increased length of stay
- increased healthcare use after discharge
- increased re-admission rates
- cognitive impairment [1].

Major depression occurs in one to three per cent of the general older population, with a further eight to 16 per cent having clinically significant depressive symptoms. The incidence of depression in long-term care settings is three to four times higher than in the general population. Sleep disturbances can result in cognitive impairment and depression, with prevalence rates of insomnia in people over 65 years of age reaching 12 to 30 per cent.

Depression can be effectively treated in older people, resulting in improved mood, improved function and an increased quality of life [1].

## What is depression?

Clinical depression is characterised by at least two weeks of depressed mood or loss of interest or pleasure, accompanied by at least four additional symptoms of depression:



- a significant change in appetite or weight



- fatigue or loss of energy

- disturbed sleep
- psychomotor agitation/retardation (psychomotor agitation refers to a series of unintentional and purposeless movements due to an individual's mental tension, such as pacing or hand wringing; psychomotor retardation refers to a slowing of thought, coordination and speech, and presents as sluggishness or confusion in speech)
- feelings of worthlessness
- recurrent thoughts of death or suicidal ideation.

Depression presents as a complex combination of behaviours, thoughts, feelings and physical symptoms that are severe and lasting (such as withdrawing from people and activities, neglecting personal appearance and commitments, moodiness, indecisiveness, lack of energy).

In the most severe form (psychotic) a person has delusions (false beliefs, typically of being a bad person, deserving punishment or that bad things will happen) and hallucinations that may involve hearing voices, smelling bad smells or other physical sensations [1].

Depression can be an acute or chronic condition. It can occur for the first time in an older person, or could be a recurrence or relapse of a previous episode of depression.

### Further information



For a fact sheet, refer to *Depression in older people*.



For further information, refer to beyondblue: the national depression initiative:  
<[www.beyondblue.org.au](http://www.beyondblue.org.au)>



For information about peer education that is available to older people to create awareness about depression, refer to *Beyond maturity blues* [2].

## Can I help prevent depression?

Early identification and treatment of depression is critical in minimising functional decline and can contribute to a quicker recovery.

To prevent a recurrence of depression or to keep symptoms from getting worse, individuals should try the following:

- Seek treatment immediately at the first sign of symptoms of depression.
-  • Take medications as prescribed. It may take some time for the clinical benefits of anti-depressants and other psychotropic medications to become evident. Regular review of medications by a doctor is necessary.
-  • Continue to take medications as prescribed even after the symptoms improve. Medication may be required for several months after symptoms resolve to prevent relapse.
-  • Promote daily and weekly activities.
-   • Eat a balanced diet, get regular exercise and maintain a regular sleep pattern.
-   • Be aware of the impact of depression on other domains of functioning.
- Continue with cognitive behaviour therapy or interpersonal therapy, even after medications have been stopped.
- Avoid drugs and alcohol.
- Maintain strong connections with family and friends.
- Others (for example, family, clinicians) should:
  - Increase awareness of depression.
  - Provide realistic hope.
  - Promote gradual re-engagement.
  - Facilitate a sense of achievement (for example, provide a role or responsibility within the person's capacity).
  - Avoid isolation (for example, a single room in hospital).
  - Make time to listen, encourage recall of positive memories.

Although research on preventing the onset of depression in older people is limited, the main focus has been on public education and regular physical activity.

## How can I recognise depression?

It is important to be alert to the following risk factors:

- a past history of depression
- chronic and acute stress
- cardiovascular disease – there is now strong evidence of an association between heart disease and depression [3]
- drug and alcohol abuse
- lack of material support or emotional support from others
- physical disability (for example, associated with a stroke)
- chronic medical illness (for example, chronic pain)
- cognitive decline
- grief in response to the loss of a loved one, especially the death of a wife, husband or life partner, or loss of opportunities or abilities
- people caring for a family member with chronic illness — particularly dementia.



In some older people, depression and dementia may occur at the same time. Refer to the ***Depression and dementia factsheet*** for information about recognition of these conditions [2].

Families or carers are often best placed to recognise a change in the older person's normal ways of thinking and reacting to situations.

### Depression screening tools

Screening is a rapid and simple process that can be undertaken by staff other than mental health specialists. The choice of tool should be made based on the healthcare setting, who will be conducting the screening, training requirements, likely compliance and follow-up care available.



The short form of the **Geriatric Depression Scale** (GDS-15 or GDS 5/15) is a widely used tool for screening or assessing depression in cognitively intact older people.



The **Cornell Scale for Depression in Dementia** (CSDD) is also commonly administered and is designed for people with dementia.

## Differential diagnosis



A common difficulty is determining whether a person has depression, dementia, delirium or a combination of these, because the conditions can have similar presenting features.

In order to provide appropriate care to an older person, clinicians must be able to differentiate between changes in mental status due to dementia and those due to an acute health condition.

### Further information



Refer to *Differentiating the three D's – dementia, delirium, and depression* for a comparison of characteristic features.



Milisen K, Braes T, Fick DM and Foreman MD 2006, 'Cognitive assessment and differentiating the 3 Ds (dementia, depression, delirium)', *Nursing Clinics of North America*, vol. 41, pages 1–22.



Screening for delirium, dementia and depression in older adults.



The 3-D's: Depression, delirium and dementia: Resource guide.



Recognizing delirium, depression and dementia (3D's).

## What can I do if I recognise that an older person has depression?

Refer the older person to a mental health specialist (for example, a psychiatrist, clinical psychologist, psychiatric nurse) for a diagnostic assessment. In rural and regional centres, where specialists are not available or access is limited, an assessment can typically be conducted by a GP.

If an older person is diagnosed with depression, ensure appropriate treatment starts quickly.



**Refer to *Treatment in the community*.**



Help the older person maintain their sense of self and ensure they are included in the decision making process.

## What are the care or management principles I should follow if an older person has depression?

When an older person is diagnosed with depression, and treatment has commenced, focus on the following areas of care:



- Ensure food intake and hydration are adequate.



- Monitor gastrointestinal function.



- Assist with personal care when there is low motivation.

- Use gentle but persistent encouragement to engage the person in tasks. Have the whole healthcare team adopt a consistent approach.
- Emphasise even small progress and avoid criticism.
- Encourage achievable tasks to enhance self-esteem and avoid failure.
- Encourage regular contact with family, friends and carers, by telephone if they are unable to visit.
- Provide a level of stimulation and interaction appropriate to the person's abilities [1].

Assist patients to:

- mobilise for personal care activities as much as possible
- practice mobilisation (under prescription, direction or instruction by physiotherapist)
- undertake Thera-Band strengthening exercises (under prescription, direction or instruction by a physiotherapist).

### In different settings of care

#### Emergency department (ED)

Identification is a priority and screening is recommended.

If depression is likely, contact their usual GP and assist with making an appointment, as necessary.

Refer to a mental health specialist for risk assessment if suicidal ideas are expressed.

#### Acute

If not conducted in ED, an admission screen is recommended in general medical wards.

If possible, liaise with a Psychiatrist if a diagnostic assessment is required or an older person's condition deteriorates.

Mood should be observed and monitored daily.

Medication and psychological treatment may be commenced.

A patient's usual GP should be contacted prior to discharge.



- Activity participation should be maximised.

### Subacute (inpatient)

Admission and discharge screening is recommended.

If possible, refer to a psychiatrist or clinical psychologist for a diagnostic assessment if required.

A treatment plan of medication and psychological intervention is usually recommended. Every person is different and has different needs for their specific treatment plan to address.

Consider day, overnight or weekend leave to promote the patient's engagement in their usual activities and social supports. This may be contraindicated if the patient is suicidal, unless a careful risk management plan with supervision is available.



Maximise activity participation.

### Subacute (ambulatory)

Screen on admission.

Contact the person's GP and assist with making an appointment, as necessary.



Maximise activity participation.



For an education package designed to increase staff awareness of depression in older people, refer to ***Navigating depression: a road map for health professionals***.



For questionnaires for pre and post training and evaluation, refer to ***Navigating depression: pre and post feedback and evaluation***.



For further information, refer to ***Recommendations for navigating depression care***, and ***Recommendations for navigating depression care (flowchart)***.

### At night

Night-time can be particularly challenging for older people with depression. Difficulty getting to sleep, restlessness, nightmares or waking early are common. Night-time and darkness is lonely and the lack of distractions can lead to pondering over fears or feelings of hopelessness.

If the older person's suicidal risk is high, an additional nurse may need to be allocated to observe and monitor the patient. Removing any means to act on suicidal ideas is critical.

An evening shower, clean sheets and a warm drink at night may be helpful. The reassurance of a familiar staff member who is willing to listen can be comforting. It may also be easier for some people to express their thoughts and feelings when the ward is quieter [1].

## What needs to be considered when planning discharge for an older person with depression?



Understanding the degree of progress in treatment and the nature and severity of symptoms is integral to an effective discharge plan. Most older people will not recover from depression prior to discharge, but the degree of progress may have been sufficient to allow them to be safely discharged. If an older person has not fully recovered, implications for treatment and supports in the community must be considered. A discharge plan must address risk of self-harm and self-neglect. A discharge plan may include referral to (or consultation with) an older persons' mental health service or the local GP regarding ongoing treatment and monitoring after discharge. Setting up appropriate social supports through a social worker is essential. It is important to include the older person and family or carers in discussions about a discharge plan [1].

The main emphasis of the discharge plan is promoting continued improvement in mental health through:

- psychological intervention
-  • medication
-  • physical activity
- social connectedness
- regular contact with the patient's GP.

## What can patients, families or carers do to help someone with depression in hospital and at home?

### In hospital

Bring familiar and comforting items from home (for example, photos, favourite doona).

Match the depressed older person's pace in conversation (in other words, speak slower) and activities (anticipate that it will take longer to finish a task).

Talk about usual family events and activities and reminisce about positive memories.

If a depressed person has a large number of family and friends, develop a schedule for visiting that is evenly spread throughout the week.

### At home

Assist with maintaining a daily routine and weekly activities.

Engage them in low-demand tasks (for example, wiping the dishes).

Reinforce hope. The likelihood of improvement is high.

Support treatment, including medication adherence and attending appointments with their GP, psychiatrist or psychologist.

Encourage participation in previously enjoyed activities.

Promote manageable social contact (for example, arrange dinner with one or two friends).



Promote regular physical activity (for example, walking).



For information for families or carers, refer to the factsheet ***Living with and caring for a person with depression***.

## Case study

Mrs Phillips is a 77-year-old woman. She was living at home independently until her admission into an acute hospital with a suspected stroke and confusion. No abnormalities were noted on brain imaging. Poor balance and recent weight loss have been noted.

Her husband died 15 months ago and she has become isolated. More recently, Mrs Phillips had noticed forgetfulness, such as forgetting to pay bills or attend appointments.

Information from the local GP is limited as Mrs Phillips' last visit was two years ago. Her daughter, who lives interstate but calls her twice a week, has noted conversations have become one-sided and effortful. She feels that Mrs Phillips has no motivation to engage in social activities.

### Scenario 1

During a six day admission in an acute stroke unit, Mrs Phillips does not initiate showering or dressing and is very slow. She prefers to remain in bed during the day and sleeps often throughout the day. She is very quiet and tearful and does not speak to staff. She refuses to participate in physiotherapy. Her balance has not improved and she has made minimal progress in her mobility. She has developed a stage 2 pressure ulcer on her heel. She is transferred to a subacute stroke rehabilitation unit.

A morning rehabilitation program, which includes physiotherapy and occupational therapy, is provided to Mrs Phillips. During the first week, she attends physiotherapy twice but does not participate. For the next two weeks, she does not attend her program despite encouragement from therapists. It is noted that she is not sleeping well at night and wakes early. After a three-week admission, she has not improved and has experienced further functional decline. A discharge plan to residential accommodation is discussed with her.

Three days later it is noted that Mrs Phillips has not eaten since the discussion about discharge, and referrals to dietetics and speech pathology are made. Respectively, the assessments indicate a low body mass index (BMI) and no swallowing difficulties. A social worker rings Mrs Phillips' daughter and discusses her condition. Her daughter suggests that her mother may be depressed. She indicates that Mrs Phillips' husband died 15 months ago and she has become socially isolated. A medical mood screen indicates features consistent with a depressive illness and medication is commenced. Food intake is encouraged by all staff and, after four days, Mrs Phillips begins eating again. Three days later, due to her poor mobility and de-conditioning, she is discharged to a residential care facility.

## Scenario 2

Utilising the following strategies from *The toolkit*:

- early identification of possible factors contributing to presentation
- use of a validated depression screening tool to identify risk of depression in first 24 hours of admission
- activity participation is maximised by teams during acute and subacute admission through a structured daily activity program
- persistent and consistent encouragement by team members to engage in tasks, and enhancing self-esteem through adapting program to be achievable (for example, morning only)
- assessment by a mental health specialist
- a treatment plan of medication and psychological intervention
- comprehensive discharge planning for ongoing treatment of depression



- use of education material for patients and family members



- ensuring food intake and hydration are adequate.



On admission to an acute stroke unit, cognitive and mood issues are identified on a global admission screen. The **Geriatric Depression Scale** is conducted and Mrs Phillips scores 11/15. A referral is made to psychiatrist and medication is commenced.



Verbal and written education on depression is provided to Mrs Phillips. Activity participation is maximised through a functional maintenance program for physical, cognitive and social needs.



This occurs in addition to supervision when walking (with nursing staff in the morning and a volunteer in the afternoon) and having a volunteer read her the newspaper and her favourite novel daily. The social worker speaks with her daughter and arranges for the daughter to phone at a set time each day. She also participates in physiotherapy every second day.

A dietitian provides a plan to ensure optimal nutrition and nursing staff encourage fluid intake. Monitoring of pressure areas is undertaken and assistance with personal care is provided by nursing staff. Mrs Phillips makes slow progress over a six-day admission. Discharge planning is undertaken with Mrs Phillips and her daughter (by speaker phone) and the reasons for a possible transfer to a rehabilitation unit are discussed. Mrs Phillips is hopeful she can continue to improve and agrees to be transferred to a stroke rehabilitation unit.



Mrs Phillips is screened with the **Geriatric Depression Scale** on admission to the unit and she scores 9/15. A clinical psychology referral is made, and it is found that her admission to hospital was precipitated by a suicide attempt. (Her diagnosis is revised to hypoxic brain injury.)



She expresses concern about being a burden to everyone and had not seen any point in living. She wants to be with her husband. A suicide risk assessment indicates low risk. A team-based management plan to minimise functional decline and maximise activity is directed by the clinical psychologist, who also provides individual therapy and further education to Mrs Phillips and her daughter (with Mrs Phillips' permission) on depression and suicide.

The multidisciplinary team, in discussion with Mrs Phillips, sets up a structured daily (written) program that includes: physiotherapy, occupational therapy, music therapy, clinical psychology, reminiscence group, indoor walking group and afternoon bingo (run by an allied health assistant and volunteer). In addition to monitoring pressure areas, nursing staff in particular focus on encouraging progress, listening to her concerns, and being present at night when sleeping is a problem. The ward social worker contacts her daughter and, with Mrs Phillips' permission, also provides information on depression and suicide. She arranges a meeting with Mrs Phillips and her daughter to explore discharge options.

Initially Mrs Phillips does not attend her program. The team conduct a treatment planning meeting with Mrs Phillips. She is provided with verbal and written information about her potential progress and, after significant encouragement from the team, agrees to attend the morning program. After three weeks, Mrs Phillips' depressive symptoms are improving and she agrees to participate in her entire program. Her balance has improved and she is attending an outdoor walking group. Her food intake and hydration have improved and she is not as tearful. She is still slow with showering and dressing but does not require assistance. She does, however, require reminders about her daily program.

After another three weeks, Mrs Phillips is attending her program independently, has gained weight, and is sleeping better. She smiles and engages in social conversation. Her discharge is arranged for later in the week and she is moving interstate to live with her daughter. Her daughter has discussed a role for Mrs Phillips in minding her grandchildren one afternoon a week, when she is feeling well. She is not as concerned about being a burden and is looking forward to living with her family. Two of Mrs Phillips' old friends live close to her daughter and she is looking forward to this social contact. Her daughter is aware that she will need to assist her mother with establishing a routine and weekly activity program, based on her interests. A treatment program will be set up with the assistance of a GP and both Mrs Phillips and her daughter are aware that full recovery could take approximately six months.

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# Continence



## Five facts everyone should know about continence

-  1. Promoting and encouraging continence in hospital can have a positive impact on an individual's dignity, self-esteem and wellbeing, often without time-consuming or costly measures.
-   
 2. Targeted continence screening, assessment and documentation are required to identify, manage and prevent continence problems from occurring, or getting worse, while a patient is in acute or subacute care.
-   
 3. Reduced mobility is the single most predictive factor of incontinence [1] and urge incontinence has been identified as a major contributing factor for hip fractures and a high falls risk in older women [2].
4. Incontinence is not, and should not be, an expected outcome of older age.
-   
  
 5. Constipation does not resolve with one bowel action [3] and constipation can contribute to urinary retention.

## Why is continence important for older people in hospital?

Thirty per cent of women and 20 per cent of men aged 60 years or over suffer urinary incontinence [4].

About 42 per cent of women and 44 per cent of men aged 75 years or over experience urinary incontinence [4].

In the community-dwelling population aged over 65 years, faecal incontinence occurs at least once a week in 3.7 per cent of people and the rate is substantially greater for residents of aged care facilities (10.3 per cent) [4].

Urinary and faecal incontinence may already be present in patients on admission to acute and subacute care and, in association with other issues, is a significant contributing factor to the decision to admit to residential aged care.

Promoting and encouraging continence in hospital can have a positive impact on an individual's dignity, self-esteem and wellbeing, often without time-consuming or costly measures.

Continence issues can often be prevented with appropriate screening, assessment, prevention and management strategies, resulting in better quality of care and life for the older person in an acute or subacute environment.

At present, continence is not well promoted and incontinence is not well managed in hospitals. It usually forms part of a patient's past history, or is a complication during admission, but is rarely the reason a patient is admitted to hospital.

## What is continence?



Continence is the capacity to pass urine or faeces in socially and hygienically acceptable circumstances [5].



Incontinence is the accidental or involuntary loss of urine from the bladder (urinary incontinence) or bowel motion, faeces or wind from the bowel (faecal or bowel incontinence) [4].



A normal bladder:

- empties four to eight times each day (every three to four hours)
- can hold up to 400–600 mL of urine (the sensation of needing to empty occurs at 200–300 mL)
- may wake you up once at night to pass urine and twice if you are older
- tells you when it is full, but gives you enough time to find a toilet
- empties completely each time you pass urine and does not leak urine [4]



A normal bowel:

- Normal frequency for bowel motions varies greatly and can be within the range of three times a day, to once every three days.
- Bowel motions are soft and formed.
- You should not have to strain to empty your bowel.
- You should not experience any accidental loss of faeces.
- Bowel motions should not take more than a minute to completely evacuate.
- You should not experience pain when emptying your bowel [4].

## How can I help older people to maintain continence in hospital?

Helping older people maintain continence in hospital is the responsibility of all clinicians.

When a patient is admitted:



- Treat underlying causes or contributing factors (such as urinary tract infections, constipation, medications, delirium and lack of toilet access) [1].



- Promote adequate oral hydration and fibre intake.



- Document bowel actions using a bowel chart such as the Bristol Stool Chart® [1].



- Monitor the use of medications that may cause constipation, such as opiates.

- Orientate the person to their new physical environment, with special attention to locating the call bell and where the bathroom is.
- Provide clear signage for toilets.
- Ensure the patient can access the toilet (if unable to independently access the toilet, ensure access to their call bell).
- Provide adequate lighting and luminous signage to toilets at night.
- Provide optimal privacy for urinary and faecal elimination.
- Discourage the use of known bladder irritants (such as coffee, alcohol and soft drinks).
- Minimise the use of indwelling catheters where possible.
- Minimise the use of restraints (including bed rails) when possible.
- Ensure gait aids are within reach at all times when the person is cognitively intact and independent with mobility.
- Limit the use of continence pads 'just in case', especially large ones that may reduce a patient's ability to self-toilet.

## How can I recognise problems with incontinence?

There are four important steps to remember:

1. Screen to see if there is a problem.
2. Assess what the problem is.
3. Create, document and implement a management plan.
4. Put strategies in place to prevent problems.

These steps should be simple and effective, and done in consultation with the patient and their family or carers.

A discussion with the patient about continence should be conducted as soon as possible after the patient has arrived. This will assist to identify the actual or potential risk of having episodes of incontinence during their stay.

Any person with a positive screen should have a further assessment completed.

Using an appropriate screening and assessment tool in conjunction with appropriate supporting resources can help inform practice. No validated screening tools currently exist, although many organisations have developed ways of screening that may be effective.

### Recommended screening questions

If a patient answers YES to any of the following questions, an assessment should be conducted:

- Do you leak urine before you get to the toilet?
- Do you suffer from constipation or diarrhoea?
-  • Do your bowels or bladder ever cause you embarrassment, pain or concern [3]?

### Further information



Refer to *A guide to continence assessment*.



## What can I do if I recognise an older person has problems with incontinence?

If someone has a problem with incontinence, an assessment or referral to an appropriate person, such as a continence nurse or specialist who can conduct an assessment, should be undertaken to establish the nature of the problem.

Assessment tools should be appropriate to the setting. For example, it may not be appropriate to complete a continence assessment on a patient who presents to the emergency department with a complaint that requires major surgery (like a fractured neck of femur), when they will likely have an indwelling catheter inserted. It may, however, be appropriate for the assessment process to be started and documented so that it can be completed in another setting.



Encourage the patient to get out of bed and use a commode next to the bed or walk to the toilet if possible.



Monitor and protect the patient's skin integrity (with particular attention to the perineum, inner thighs and buttocks).



Ensure adequate hydration and fibre intake to maintain optimal bladder and bowel function.



**Refer to *A guide to continence assessment* for further information.**

Be aware that continence is a sensitive issue to most people, even though a healthcare worker might face it every day.

Focus on the person with the problem.

Respect the patient's right to choose the most appropriate treatment option.

Actively listen to the patient and avoid making judgements.

Value the therapeutic patient–health practitioner relationship.

Implement an individualised management plan (such as a regular toileting program).

Encourage the patient to completely empty their bladder with each void.

Discourage the use of bedpans and urinals in the bed if possible, unless they are part of a management plan.

Provide education about bladder function.

Select appropriate continence products if required.

Check disposable pads after each episode of incontinence.

Change disposable pads after each episode of incontinence as per the manufacturer's guidelines.



Offer the patient and their family or carer a referral to a continence service or specialist to provide advice on continence products, behavioural therapy, medication or surgery [1, 6].



**Refer to *Steps included in a continence assessment*.**

## What care or management principles should I follow if an older person has an incontinence problem?



The key principles in managing continence issues are **person-centred practice** and documentation as a means of communication. It is important to respect the dignity and privacy of the older person and to involve them in every aspect of care. Communicating the care plan with the rest of the healthcare team, including the patient and family or carer, is also vital in providing a consistent person-centred approach to continence management.



It is also important to consider other functional maintenance domains. These may include Mobility (including a high falls risk), self-care, cognition (including delirium, dementia and depression), nutrition (hydration and fibre), medication (particularly diuretics, sedatives, caffeine and alcohol), and skin integrity. Reduced mobility is the single most predictive factor for incontinence [1], and urge incontinence has been identified as a major contributing factor for hip fractures and is a high falls risk in older women [2].

A management plan will depend on bladder and bowel symptoms and the type of incontinence.

The most common symptoms and types of incontinence are:

- stress incontinence: an involuntary loss of urine that occurs during activities that increase intra-abdominal pressure, such as coughing, sneezing, laughing or exercise
  - urge incontinence: a strong, sudden need to urinate, followed by a bladder contraction, which results in leakage
  - frequency of urination
  - incomplete emptying: when some urine or faeces remains in the bladder or bowel after emptying
  - overflow incontinence: when urine leaks from a full bladder that cannot empty properly
  - nocturia: an increased need to urinate at night
  - dysuria: painful urination
  - haematuria: blood in the urine
-  • **functional incontinence:** when a person cannot perform toileting tasks such as getting to the toilet or removing their clothes [1, 7, 8].

A person may have more than one type or symptom of incontinence.

## Continence in different settings of care

The setting may determine the extent to which a management plan can be developed, but the principles should be the same. An appropriate management plan should be individualised for each patient, developed in consultation with the patient and family or carer, and be tailored to the type of problem that exists.

A management plan may include:

- bladder or bowel re-training
- prompted toileting
- timed toileting
- pelvic floor muscle exercises
- indwelling catheter
-  • containment [3]
-  • dietitian involvement for fibre and fluid advice
-  • physiotherapy involvement for functional mobility and strengthening advice, or the provision of a gait aid.

It is important in all settings to eliminate as many contributing factors to incontinence as possible. These may include:

- urinary tract infections
- decreased fluid intake
- constipation
- urinary retention
- lack of toilet access
-  • medication.

### At night

 Assessment of nocturia (voiding more than twice a night) should aim to determine what impact the problem has on the patient and determine why nocturia is being experienced. The type of nocturia will determine the strategy required [7].

Patients should be encouraged to get out of bed, if possible, to use the toilet or a commode next to the bed. This encourages proper emptying of the bladder. This may not be practical for medical reasons; however, it should not be discouraged due to staffing reasons.

Patients should not void into an incontinence pad overnight instead of going to the toilet or using a bedpan, urinal or commode.

Patients may need bladder retraining, fluid management and catheter management.

## What should I consider when planning discharge to help an older person maintain continence?

The person's ongoing need for continence management should be considered:

- Do they need a referral to a continence clinic?
- Should their general practitioner be made aware of continence issues identified in hospital?
- Do they need written materials to help manage continence?
- Do they need referrals for aids and specialist services?

Resources available to assist in managing continence should be considered:

Where is the person going upon discharge (their own residence, supported accommodation (with or without stand-up staff overnight) or residential care (low or high care)?

If they are going home, will they be alone or have help? Does the person have a carer who is willing and able to provide assistance?

Can they afford the cost of aperients (mild laxatives) and continence appliances?



Are they eligible for an aids assistance scheme (for example, from the Department of Veterans' Affairs (DVA), Continence Aids Assistance Scheme (CAAS) or the Department of Human Services' Aids and Equipment Program (A&EP)) [9].

### Further information



For a brochure for patients, families or carers, refer to *Disability Services: The Victorian Aids and Equipment Program (A&EP)*.

## What can patients, families or carers do to help an older person maintain continence in hospital and at home?

Ask the patient and family or carer about their routine at home and try to maintain it in hospital as much as possible.

Encourage the patient to go to the toilet or use the call bell for assistance if they need to use the toilet.

Encourage normal patterns of continence. Don't get into the habit of going to the toilet 'just in case'.



Encourage the patient to drink plenty of fluids and eat a high-fibre diet. Carers and family members may be able to bring in fruit or fluids preferred by the patient.



Find out when they normally use their bowels. Encourage the patient to go to the toilet when they get the urge because this is the most effective time to completely empty their bowels. For most people, it is usually first thing in the morning after breakfast [4, 7].

## Case study

Mrs Nash is an 83-year-old woman who presented to the emergency department with a fever and red area on her right shin. She reported 'catching her leg' on a rose bush in the garden. She lives at home with her husband, Jack.

Mrs Nash's history includes working as an accountant, marrying Jack, raising three children, playing tennis and, in her later life, playing the piano, gardening and talking to her grandchildren by phone. Her medical history includes a mild stroke, mild congestive cardiac failure, mild cognitive impairment and gastric oesophageal reflux. Prior to admission, Mrs Nash was able to walk safely with a single-point stick (SPS) and had mild memory problems. She also had some urinary urge incontinence as a result of not being able to get to the toilet on time, and consequently wears pads. Mr and Mrs Nash received home help once a fortnight.

Mrs Nash had considerable pain in her right leg and was diagnosed with cellulitis requiring intravenous antibiotics. As a result, she was admitted to an acute ward.

### Scenario 1

On admission to the acute ward, Mrs Nash was transferred into a bed near the window, some distance from the bathroom, and shown the location of the bathroom.

On her first night in hospital, desperate for the toilet but unable to reach her buzzer, Mrs Nash was incontinent, wetting her pants. The nurses attended to her hygiene and placed a large pad between her legs. This was humiliating for Mrs Nash because she very rarely had 'accidents'. She was unable to go back to sleep, because she was uncomfortable with the pad.

The next morning Mrs Nash was tired, in pain and feeling a bit confused. The nurses transferred her onto a commode chair and wheeled her to the shower where they washed and dried her. The nurses did not provide Mrs Nash with an opportunity to help because they thought it quicker if they did it for her.

On the second night, Mrs Nash again wanted to go to the toilet but, being sleep deprived from the previous day, she forgot she had a drip in and needed to call for help. Mrs Nash got up by herself and tried to make it to the toilet. She fell and sustained a skin tear on her forearm that required immediate attention, and pulled her drip out. The nursing staff found her and put her back to bed with the cot sides up. Mrs Nash was then woken up half an hour later by a doctor who tried twice to put a drip in, unsuccessfully, before calling another doctor to assist. This took another hour, by which time Mrs Nash was exhausted.

The next day all she wanted to do was sleep, but she was assisted out of bed, showered, again with little opportunity to help, and put back to bed before being sent for an X-ray of the hip she had landed on the previous night. She was so tired that afternoon that she fell asleep for a few hours. That night she couldn't sleep even though it was dark. She had periods during the night when she thought she was at home and called out for her husband. Due to her hip pain, she was now wearing a large pad and was encouraged to use a bed pan.

Mrs Nash developed a urinary tract infection (UTI), a pressure ulcer on her heel and delirium. She went off her food and had to start using a four-wheel frame when mobilising. Even though Mrs Nash was on medication for pain that increased her chance of constipation, aperients were not ordered and, after four days with no bowel actions, she required an enema. An abdominal X-ray showed she remained faecally loaded and required further enemas. Mrs Nash became mildly dehydrated because she doesn't like water and no alternative was offered. As a result, her drip rate was increased to improve her hydration. Mrs Nash had blood tests every day to monitor her electrolytes.

Eventually, after eight days (four days after the IV antibiotics ceased) Mrs Nash was sent to a subacute geriatric evaluation and management (GEM) unit, where it was decided that low-level care at a hostel was the most appropriate place for Mrs Nash on discharge. Mrs Nash and her husband were devastated but had to accept her level of functioning meant that Mr Nash could no longer support her at home. She was discharged 20 days after arriving with district nursing providing follow-up management for her heel ulcer and skin tear.

## Scenario 2

Utilising the following strategies from *The toolkit*:



Use of comprehensive risk screening and assessment to identify any risks.



Identification of interacting domains, with appropriate multidisciplinary referrals completed. Flow chart for assessment and management and referral of continence issues followed.



Care plan to maintain continence principles while in hospital, including night-time care.

Environmental cues for maintaining a safe environment.

Benefits of multidisciplinary involvement.



Use of patient education materials and information on equipment.



On admission to the acute ward, Mrs Nash was orientated to the ward layout and routine.



Mrs Nash, her husband and her admitting nurse met to discuss how best to minimise any functional decline she may have when in hospital and what they could all do to help achieve this.



Mrs Nash was comprehensively screened and assessed using a multidisciplinary tool. The screening indicated she was at risk of developing a pressure ulcer, incontinence and falls. She had a continence assessment that indicated she had some mild urge incontinence when unable to get to the toilet in a hurry. She was therefore at further risk of falls, and at risk of having episodes of incontinence in hospital because her mobility was decreased and she was limited by her drip. She had a falls risk assessment completed and a referral to physiotherapy, where she was assessed as requiring a two-wheel walking frame to support her when walking.

 A management plan was completed and documented, and a referral to dietetics was made to ensure her menu consisted of high-fibre foods. She doesn't like drinking water, so her family was encouraged to bring in her favourite fruit juice to ensure her fluid intake was adequate (but not too much due to her cardiac failure). Due to her pain medication she was identified as being at risk of constipation, therefore aperients were prescribed and her bowels were regularly monitored.

 Mrs Nash's call bell was to be within reach at all times and she was moved to a bed closest to the toilet to ensure she had a minimal distance to walk to get to the toilet. This was important because she required assistance walking to the toilet, as she couldn't manoeuvre a walking frame and an intravenous pole. She was also encouraged to shower herself, with assistance if required, to increase her activity.

 During the day the blinds were never closed and she had the opportunity to do things to keep her mind busy. If tired, an afternoon nap was recommended, but not a big sleep. She had access to a clock in the room so she knew what time of day it was. At night, a commode chair was left by the bedside and a bed stick was fitted to assist her in getting up and out of bed.  A night-light was left on, at her request, so she could see the commode chair. This encouraged her to remain orientated to her environment and mobilise, which had a positive outcome on her skin integrity, mobility and continence.

Her family brought in the incontinence pads she used at home because the ones the hospital supplied were too big and cumbersome to manage. After her drip was removed and she was able to mobilise independently, a large 'toilet' sign was placed on the bathroom door to assist Mrs Nash to easily locate the toilet.

After four days in hospital Mrs Nash was discharged home having experienced only three episodes of urinary incontinence. She and her family were provided with information regarding where to purchase equipment and tips on maintaining continence utilising information from all the interacting domain areas, including mobility, self-care and vigour, nutrition and skin integrity. Mrs Nash was pleased with this outcome, as were the rest of the healthcare team. She progressed from her two-wheel frame back to her SPS following a visit to the house by a physiotherapist. A few weeks later, Mrs Nash had an appointment with her local memory clinic for follow-up on her mild cognitive issues.

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# Medication



## Five facts everyone should know about medication

1. Medication reconciliation should be performed on admission for every inpatient.
2. High-risk patients should be reconciled as a priority. They include those aged over 75 who have been prescribed medications that require close monitoring, are on five or more medications, have cognitive or sensory impairment, manage their own medications and have been recently discharged from hospital.
3. Prescribing medications to older people must be carefully planned and monitored because age-related changes, as well as the risks of polypharmacy, predispose older people to adverse drug reactions.
4. Non-adherence to medication instructions is common among older people and may be related to several factors.
5. Medications may be implicated in older patients presenting with falls, confusion and incontinence.



## Why is medication important for older people in hospital?

- Medication errors are implicated in 15–22 per cent of unplanned hospital admissions [1].
- Medication errors are a leading factor in injuries sustained by hospitalised patients [2].
- Medications may be implicated in older patients presenting with falls, confusion and incontinence [3].
- Experience from organisations has shown that poor communication of medical information at transition points (interfaces) is responsible for more than 50 per cent of all medication errors in hospital [2] and up to 20 per cent of all adverse drug events [4].
- Australian studies have reported that an average of five to seven medication changes are made during the hospitalisation of an older person [3].
- Medication may impact on, or relate to, other functional domains.

General practitioners (GPs) frequently fail to receive timely information, and discharge summaries may contain errors in up to 73 per cent of cases [3].

An up-to-date and accurate medication list is essential to facilitate safe prescribing in any setting [5]. This results in a number of organisational challenges including the:

- need for clear ownership of the process
- need for standardised processes.

To minimise functional decline in hospital, clinical decision making regarding medication must be communicated to all members of the patient's healthcare team, including the patient and their family or carers at every transition point (interface) of care [3].

## What do I need to consider about an older person's medication?

Prescribing medications to older people must be carefully planned and monitored because age-related changes in pharmacokinetics (the way by which a drug is absorbed, distributed, metabolised and eliminated by the body), as well as the risks of polypharmacy (combining medications), predispose older people to adverse drug reactions.



### **Important factors that affect medication metabolism in older people.**

Factors to consider:

- potentially inappropriate medications
- polypharmacy
- adherence
- under-prescribing.

### **Potentially inappropriate medications**

In an attempt to reduce the frequency of adverse drug events, several methods have been developed to assess the appropriateness of medications for older people. The **Beers Criteria** includes a consensus-based list of medications identified as potentially inappropriate for use in older adults. The list was developed through an extensive literature review and evaluated by recognised experts in geriatric medicine, clinical pharmacology and psychopharmacology in the United States (US). In the US, the application of the criteria has become a widely used measure of quality of medication care for older people [6].

Although it is important to prevent harm, the Beers Criteria list is extensive and includes many commonly prescribed medications. Further work has been completed targeting 'high alert' medications. These are medications with the highest risk of causing injury, and it is predicted that targeting these medications could prevent more adverse drug events and emergency department visits. These medications include warfarin, insulin, digoxin, narcotics, opiates and sedatives [6–8].

### **Further information**



#### ***Beers Criteria for potentially inappropriate medication use in the elderly.***



#### ***Prevent harm from high-alert medications: getting started kit.***

### **Polypharmacy**

Given the higher prevalence of disease in older people, it is not uncommon for older people to be taking several medications. As a result, the risk of adverse medication effects and interactions is higher.

Be aware that patients may be taking medications from a number of sources:

- different doctors and hospitals
- self-prescribed, over-the-counter medications
- medications for a previous illness
- medications prescribed for another person.

A domiciliary medication review may be necessary to confirm exactly what is being taken.

## Adherence

Non-adherence to medication instructions is common among older people and may be related to several factors. Estimates of non-adherence in international literature range from 44 to 95 per cent [3].

Reasons provided by older people for non-adherence include the following [3]:

### Intentional non-adherence

Side effects.

No perceived need for medication or dose prescribed.

Taking too many medications.

Concerns about dependence.

The medication is ineffective.

Stopping medication to see if it is still needed.

Going out for the day (especially diuretics).

Cost/affordability.

### Unintentional non-adherence

Forgetfulness.

Running out.

Difficulty reading labels, opening containers, halving tablets, or using medication devices.

Confusion about medication regimes.

### Communication problems

Lack of information about the medication and side effects from the prescriber.

Failure to discuss non-medication treatment options.

Lack of explanation about the reasons for the dosing regimen and special instructions.

Lack of time spent with health professionals.

Failure by health professionals to communicate instructions in a way the patient understands.

Conflicting information from the prescriber and pharmacist.

Antagonism between the prescriber and pharmacist.

### Under-prescribing

Under-use of medications is also common [3], and under-prescribing can be difficult to identify. For example, one of the most common chronic conditions associated with emergency department visits is chronic obstructive pulmonary disease; however, it has been identified that optimal treatment is prescribed in only 30 per cent of older people [7].

## How can I recognise problems with medication?

A medication risk screen (MRS) can assist in identifying factors that put older people at risk of adverse events relating to medications. In the absence of validated screening tools, MRS was developed using the best available evidence and pre-existing risk screen tools as guides [8–10].

The MRS is a self-administered medication risk screening tool comprising 10 'yes/no' questions, with simple and relevant patient information on the back.

The MRS aims to:

- encourage dialogue with health professionals regarding medications
- encourage patients and family or carers to be recognised partners in decision making and communication relating to medications
- not require assistance from health professionals to be completed.

### Further information



**Medication risk screen**



## How can I help with medication management for older people in hospital?

An up-to-date and accurate medication list is essential to facilitate safe prescribing in any setting [5].



### ***Preventing adverse drug events: toolkit***



### **Medication history and reconciliation**

Medication history and reconciliation is the formal process of obtaining a complete and accurate list of each patient's medications. The Society of Hospital Pharmacists of Australia (SHPA) recommends processes be in place to ensure medication reconciliation is performed on admission for every inpatient [11].

This involves four steps:

1. Medication history – which includes recording all medications being taken at the time of presentation, GP and pharmacy details, the source of the information, any adherence issues and any other relevant information.
2. Confirmation – the process of ensuring the accuracy of the information.
3. Reconciliation – the process of comparing various medication lists to avoid errors in transcription.
4. Medication liaison – the process of ensuring continuity of care by establishing effective communication lines between care providers and sites.



**Safer Systems Saving Lives (SSSL)** recommends that participating hospitals utilise the *National inpatient medication chart (NIMC)* to support this process [5].

### **Further information**



***National Inpatient Medication Chart (NIMC)*** [12].



***Refer to Medication safety: improvement toolkit.***

The NIMC was developed by the Australian Council for Safety and Quality in Healthcare as part of the National Medication Safety Breakthrough Collaborative [13].

## Medication changes tool

This enables clinical staff (medical, pharmacy and nursing) to record all medication changes in a single place, collocated with other medication-related forms such as the NIMC.

Is a partner document to the medication history and reconciliation (MHR) form.



### Medication changes tool

As part of the medication reconciliation process, it is important to establish formal mechanisms that support information sharing between health professionals both within the hospital and in the community [5]. When medication liaison occurs it is important for it to be clearly documented. Pharmacists, doctors or nurses can complete this documentation. As pharmacists are usually the most prepared to complete medication reconciliation, it is recommended they also complete the **medication changes tool**. This can greatly enhance the clarity of communication, especially for patients with complex medications and where multiple changes have been made.

The National Institute for Health and Clinical Excellence (NICE) [14] recommends that:

- all healthcare organisations put policies in place for medication reconciliation on admission and at transfer points
- systems for medications reconciliation be standardised
- pharmacists complete the most accurate history and medication reconciliation.

There is insufficient evidence to make recommendations on specific packages for medication reconciliation or IT-based information transfer initiatives. There are, however, many examples of MHR tools from both Australia and overseas.

## Further information

Examples of medication history and reconciliation tools:



***Medication reconciliation tool: on admission definitions*** [15]



***Medication safety reconciliation tool kit*** [16]



***Prevention of adverse drug events (medication reconciliation):updated how-to guide*** [4]



***Medication history and reconciliation***



For organisations that wish to develop their own document, the Society of Hospital Pharmacists of Australia recommends minimum details to be included on the form [11].



***Technical patient safety solutions for medicines reconciliation on admission of adults to hospital***

## What should I consider when planning discharge to help an older person manage their medication?

- Will the patient be able to manage his or her own medications?
- Will there be adherence issues?
- Provide the patient, and family or carers, with an accurate list of medications.
- Provide education to patients prior to discharge.
- Where possible, include the family or carer in education.
- Ensure the patient has a sufficient supply of medications until their next GP visit.
- Ensure discharge information is accurate and reaches the GP in a timely manner.
- Consider a home medication review.

### Further information



For information on home medication review, refer to the *Medication Management Review Program*.

## What can patients, families or carers do to help an older person manage their medication in hospital and at home?

The back of the **MRS** provides simple messages that assist patients and carers to manage medications at home and encourage self-determination and partnership with their healthcare providers.

The most important messages to convey to patients and carers are:

- Always carry an up-to-date list of medications.
- Wherever possible, use only one pharmacy and visit only one GP.

These actions encourage continuity of care through partnerships with everyone involved in the care of the older person.

The National Prescribing Service (NPS) is an Australian member-based organisation that provides accurate, balanced, evidence-based information and services to health professionals and the community on quality use of medicines (QUM). The NPS works in partnership with GPs, pharmacists, specialists, other health professionals, government, the pharmaceutical industry, consumer organisations and the community. It is independent, non-profit and funded by the Australian Government Department of Health and Ageing. Free information on QUM is available online or in hard copy by contacting the NPS. A medicines list can be downloaded from the site or sent to consumers.

### Further information



The National Prescribing Service



## Case study

Mrs Hayden is an 80-year-old woman presenting with a new onset of falls, unsteadiness, dysarthria, and tremor. Following a recent fall, she sustained a distal radius fracture. She has a past history of long-standing depression, anxiety and panic disorder, as well as chronic lower back pain.

Mrs Hayden was widowed 15 years ago, has no children or close relatives and lives alone. She is a self-funded retiree and uses no services. She attends church every Sunday but rarely goes out apart from shopping.

On a previous admission Mrs Hayden had been described as 'non-compliant' with medication. She had been visiting several doctors and had not always followed instructions. Medication changes had been made by different doctors without consultation with the original prescribers.

On admission her medications were:

- alprazolam – increased from 1 mg three times daily (TDS) to 3 mg TDS in the past three months
- tramadol – increased from 100 mg slow release (SR) twice daily (BD) to 200 mg BD in the past two months
- dothiepin – commenced 'years ago' but recently increased to 150 mg nocte
- olanzapine – 7.5 nocte (should have ceased when dothiepin commenced but patient may still be taking some)
- nitrazepam – 5 mg at night (nocte) as necessary (PRN)
- fluoxetine – 20 mg BD and 10 mg midday.

### Scenario 1

Mrs Hayden was admitted to the orthopaedic unit for a general anaesthetic manipulation and plaster (GAMP) to repair her fractured radius. Her anticipated length of stay was two to three days.

Mrs Hayden complained of severe pain post-operatively. Her analgesics were increased by adding Oxycontin 10 mg BD to the tramadol. Her pain did not improve and the dose was increased to 20 mg BD. On day two of her admission, she developed acute urinary retention, for which a urinary catheter was inserted. By day four, she had developed abdominal pain. An X-ray confirmed faecal impaction, which was managed with a series of enemas and lactulose BD. She found the lactulose unpalatable, so Coloxyl with Senna was added as a PRN order. On day five she complained of dysuria. A urine sample was collected for microscopy and culture, which showed an infection. Her urinary catheter was removed, and she was commenced on cephalexin 500 mg four times a day (QID). During the admission, Mrs Hayden was referred to several units for consultation, resulting in multiple medication changes.

Mrs Hayden was discharged home on day six, with home help and Meals on Wheels arranged to support her. Her discharge medications included changes to some of her admission medications, and the addition of three new medications (Coloxyl with Senna PRN, Oxycontin 20 mg BD, and cephalexin 500 mg QID).

Mrs Hayden was readmitted two days later with a fractured neck of femur. She had been found, by Meals on Wheels staff, after having spent 24 hours on the floor unable to reach the phone. She had developed serotonin syndrome and had become severely constipated again. She had an extended length of stay and suffered significant functional decline, resulting in decreased mobility and increasing episodes of incontinence. She was eventually discharged to residential care.

## Scenario 2

Utilising the following strategies from *The toolkit*:

- identifying and managing risk factors contributing to medication issues
- using **medication history and reconciliation process** within one working day of admission to ensure that prescribed medications are accurate and identify any potential issues with other key stakeholders
- using a clear hospital policy that guides management of medication
- interdisciplinary assessment and management of medication issues
- medication changes and reasons for same communicated to the GP and all other prescribing medical practitioners
- referral for home medication review
-  • using patient education materials
-  • comprehensive discharge education to the patient concerning medications and the reasons for their use, including information concerning medications that have been newly prescribed, dosage changed or ceased.



Mrs Hayden was admitted to the orthopaedic unit for a GAMP to repair her fractured radius.



The admitting intern assessed possible causes for her fall and suspected they could be related to her medications. The intern referred her to the ward pharmacist as a priority for



a **medication history and reconciliation (MHR)**. Her anticipated length of stay was two to three days.



The MHR was completed and documented as per hospital policy. The pharmacist identified Mrs Hayden had the following risk factors:

- older than 75 years.
- taking multiple medications.
- more than one treating doctor.
- multiple medication changes over recent months.
- high-risk medications with potential adverse interactions with other prescribed drugs.
- non-adherence with medications.



While Mrs Hayden was in theatre, the ward pharmacist contacted the community pharmacist and her GP. The community pharmacist confirmed that Mrs Hayden had multiple prescribers and specialists who often gave conflicting advice. The GP agreed with the suspected non-adherence with medications, and stated that Mrs Hayden has been become increasingly withdrawn over the past several years since she has been widowed.



The pharmacist alerted the medical team to the medication issues. Following consultation with medical staff, fluoxetine, dothiapien and tramadol were all ceased due to the risk of serotonin syndrome and the perceived lack of efficacy. It was arranged that Mrs Hayden would have a washout period of 14 days and then commence on mirtazepine 15 mg at night, with a view of increasing the dosage to 30 mg if required. The nitrazepam was ceased and other sleep hygiene measures discussed. Alprazolam was decreased due to a risk of drowsiness contributing to falls. The olanzapine was also ceased because it was not indicated for Mrs Hayden. Paracetamol was introduced as baseline pain relief with Oxycontin 10 mg BD. Endone was prescribed for breakthrough pain and a regular dose of Coloxyl with Senna established. Nursing staff were alerted to asses and manage her bowel function and use lactulose PRN. Calcium was commenced to manage her risk of osteoporosis.



As she recovered from surgery, Mrs Hayden's pain was monitored closely. The pharmacist and doctor made a time to discuss medication with her once she had recovered from the anaesthetic. It was considered extremely important to involve Mrs Hayden in her medication management, especially because there had been so many changes to her regimen.



Mrs Hayden recovered well with careful monitoring and reassurance. She was discharged home on day three with home help and Meals on Wheels arranged to provide support at home.



On discharge, the pharmacist counselled Mrs Hayden concerning her medications and decided to refer her for an outreach medication review.



Mrs Hayden was provided with an up-to-date list of her medications and arrangements were made for her medications to be delivered in a Webster pack. Hospital staff discussed ongoing plans with her GP and local pharmacist, and the medication changes and rationale for these changes were clearly documented on her discharge letter.

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# Skin integrity



## Five facts everyone should know about skin integrity

1. Older skin is thinner, sometimes very frail. It will sustain injury easily and take longer to heal.
2. Skin integrity in hospital is not just about pressure ulcers (refer point 5).
3. Skin must be clean and dry. Three proactive steps should be taken to protect skin: avoid using 'drying' soaps; apply protective moisturisers; and use skin protection devices to avoid both skin tears *and* pressure injuries.
4. To choose an appropriate wound dressing, assess the whole person and then decide what can be achieved for each wound. For more information refer to the ***Skin integrity booklet: its maintenance and support.***



5. Maintenance of other functional areas, such as nutrition, mobility, cognition, falls prevention, pain management and continence, is integral to managing skin integrity. Do not allow older patients to experience functional decline. Refer to other sections of *The toolkit* for guidance and refer older patients early to all appropriate members of the interdisciplinary healthcare team.

## Why is it important to consider skin integrity when working with older people in hospital?

 Maintaining skin integrity is important because hospital-acquired pressure areas, skin tears and infections are associated with pain, reduced mobility, increased risk of in-hospital complications and increased healthcare costs due to a prolonged length of stay [1].

 Wound prevalence increases with age [2].

Intact, healthy skin protects all our other body organs and their functions.

Ageing changes the ability of the skin to perform its important functions.

Older people's skin is more vulnerable to damage and stress, and slower to heal.

Any breakdown in skin integrity makes the body susceptible to infection.

## What is skin integrity?

Skin is the largest body organ.

Having integrity means the skin is whole, intact and undamaged.

When skin has integrity, it performs these very important functions:

- It shields the body's vital metabolic functions from harmful temperatures, chemicals, radiation and pathogens.
- It helps maintain fluid and electrolyte balance and optimal inner body temperature.
- It conveys pleasant and unpleasant sensations.
- It communicates our individuality by its texture, colour and characteristics.

The integrity of our skin is vital to our physical and psychological health.

Skin integrity is something we usually take for granted, until it is damaged.



As skin ages it:

- becomes thinner
- loses elasticity and moisture
- develops folds and wrinkles
- loses its cushioning layer of subcutaneous fat
- is more easily injured (prone to tearing and bruising)
- is slower to heal [3, 4].

Healthcare workers, aware of these changes, can be proactive in protecting the skin and preventing hospital-acquired damage. Healthcare workers can also educate patients and their families or carers to help maintain skin integrity.

## How can I help older people maintain skin integrity while in hospital?

### On admission to hospital

Screen for the risk of skin damage.

To assess pressure injury risk, use a validated tool:



**Braden Scale for Predicting Pressure Sore Risk** [5]



**The Norton Scale** [6]



**Waterlow Scale** [7].



Do not just consider pressure injury. Look for other risk factors affecting skin function and integrity (for example, potential for the skin to tear, under-nutrition, use of medications that affect skin integrity, past history of chronic wounds, compromised circulation or neuropathy).



### While in hospital and during transfers between wards, departments or hospitals

Actively prevent injury.

Take these important actions every day:

- Assess skin integrity. This is easily done while assisting patients with personal hygiene. Documenting observations will help identify any changes.
-  • Refer patients at risk or with existing skin, nutrition, swallowing, balance or mobility problems to appropriate interdisciplinary expertise, for example, podiatry, nutrition, nursing, speech, medical, physiotherapy.
-  • Orient patients to their environment and keep the environment free of clutter, well signed and easy to navigate.
- Carefully avoid any collision with environmental hazards such as bed rails, lifting machine parts and wheelchair footplates.
-  • Any falls risk is also a skin integrity risk [8].
- Employ protective mattresses, seat cushions, heel wedges and limb protection as appropriate [9, 10].
-  • For guidelines, refer to the ***Clinical practice guidelines for the prediction and prevention of pressure ulcers***.
- Do not use drying soaps on the skin. They alter the pH balance and make the skin drier and more susceptible to breaks and infections.
- Never use aggressive tapes or adhesives.
-  • Keep frail skin on limbs moisturised and covered for protection [11].

Educate patients and carers about their risks in hospital and the importance of preventative actions.



For information for patients, families or carers, refer to **Move Move Move**.



Ensure meals are not interrupted by unnecessary, non-urgent activities.



Nutrition is vital to skin integrity. Ensure patients' hydration is constantly optimal and they eat their meals.



Sit patients out of bed for meals so they can see their meals properly and be in a good position to swallow and digest their food. Assist with meals as needed. Fill out menus, open packets, encourage consumption of any prescribed nutritional supplements, as well as meals, providing feeding assistance when required.

Document interventions in order to communicate and progress them as necessary.

### Further information



For more information, refer to the *Skin Integrity Booklet: Its maintenance and support (pages 3-4)*.

## How can I recognise a potential problem with skin integrity?

If patients have one or more of the following risk factors, they are at a high risk of developing problems with skin integrity. Patients' skin should be assessed during every shift if they are at significant risk of problems.

*Note:* You must remove and replace anti-embolic stockings to see the heels and toes properly.

Document your observations of the skin condition to assist other clinicians in identifying any changes.

Skin integrity is at significant risk for patients with any of the following characteristics:

- losing protective layers of skin due to ageing
- underweight or overweight
- having difficulties washing or drying any part of their skin (for example, contractures, folds beneath abdominal aprons or hard to reach areas between toes)
- presenting with, or at risk of, developing problems with:
  - » sensation
  - » blood circulation (for example, diabetes)
  - » quality of circulating blood (for example, anaemia)
- having radiation therapy
- fasting for theatre



- under-nourished



- dehydrated



- immobile



- incontinent



- at high risk of falls



- taking medications such as warfarin, prednisolone or chemotherapy



- confused or disoriented.

## What can I do if I recognise that someone has a potential problem with skin integrity?



Discuss the problem with the patient, their family or carer and with the interdisciplinary healthcare team as appropriate.

Develop a person-centred care plan to manage the problems using the actions outlined in ***What do I need to do to help older people maintain skin integrity while in hospital?***

Document and report what has been done to effectively communicate the patient's care plan to others.



For specific prevention strategies for skin tears (page 10), and important actions to take to prevent pressure ulcers (page 7), refer to ***Skin integrity booklet: its maintenance and support.***

## What are the care or management principles I should follow if an older person has a wound, skin tear, pressure ulcer or other skin problem?



The important thing to remember is to assess the whole person, not just the wound.

Plan the dressing and management regime to suit the person's needs. Consider what the goal is for the wound (for instance, will it heal or is that not possible? Does discharge need to be contained and odours managed to improve the person's comfort level?) and consider who will change the dressings and how often.

Consider cost and availability of dressings. Also consider costs for the person after discharge.



Refer to the **Australian Wound Management Association**: <[www.awma.com.au](http://www.awma.com.au)>



For more information and references, refer to *Skin integrity booklet: its maintenance and support (pages 3–4)*.

Use clinical practice guidelines to plan specific care.



For simple strategies supporting clinical best practice, refer to **Long Stay Older Patients: Skin integrity domain**.

In different settings of care consider:

- the goals for the wound
- who will be there
- what resources and supplies they have?

### At night

For nearly all wounds it should be possible to choose a dressing regime that does not require overnight changes and supports sleep and comfort throughout the night.

If the patient is at risk of pressure ulcers, recommend pressure-reducing mattresses and overnight repositioning.



If the patient is incontinent and cannot get up to the toilet at night, develop a plan to keep the skin dry overnight.

## What can patients, families or carers do to maintain skin integrity in hospital and at home?



Educate patients and carers about how they can:

- use only moisturising, pH balanced lotions or skin cleansing bars instead of drying soaps
- perform a daily skin inspection to pick up any problems and address them immediately
- use moisturisers regularly to protect dry skin
- use skin tear protection strategies and equipment, and provide advice about obtaining these.
- avoid pressure and teach about the positioning and availability of pressure offloading equipment (refer to occupational therapy, podiatry, physiotherapy or specialist local suppliers as appropriate)
- ask questions of their general practitioner or practice nurses
- educate patients about pressure risk in hospitals



- maintain optimal hydration



- maintain optimal nutrition, refer to a dietitian for advice and follow up and ensure patients are supported to optimise food intake



- maintain good balance and mobility, encourage regular exercise and refer to a physiotherapist or podiatrist if appropriate



- avoid falls



For information for patients, families, or carers, refer to **Move Move Move**.

## What should I consider when planning discharge to help an older person maintain skin integrity at home?

If a patient is ready to go home with a continued need for wound dressings, involve the patient and family or carers early in discussions and decisions about the type of dressing regime that will work for them.

Involve support services such as home nursing services as appropriate, and communicate the person-centred care plan to ongoing care providers. Refer as soon as possible.

Discuss the need for any further referrals with patients and carers.



Refer to a dietitian if under-nutrition is suspected, to ensure optimal nutrient intake to maximise wound healing.

### Further information

Refer to a podiatrist if foot care or footwear advice is needed.



For more information, refer to ***Skin integrity booklet: its maintenance and support***.

## Case study

Mr Jackson, 70, is a retired engineer living in his own home with his wife. He has diagnosed dementia. He does not initiate daily tasks but is able to walk, shower, dress and toilet himself once prompted. Mrs Jackson understands that unless she prompts her husband regularly to drink and eat the food she prepares he will become dehydrated and under-nourished, placing him at risk of decline in other areas, such as his ability to walk safely and independently and complete tasks of daily living.

### Scenario 1

Mr Jackson was admitted to an acute surgical ward for pre-operative bowel preparation three days prior to a colonoscopy, scheduled to diagnose the cause of chronic constipation with recent bleeding and anaemia. A previous colonoscopy was unsuccessful due to inadequate bowel preparation at home.

In hospital, Mr Jackson was quiet and uncomplaining. The nurses wheeled him into the toilet on a commode chair and helped him shower and dress. The colonoscopy failed again due to inadequate preparation, and the surgeon directed a repeat preparation in hospital.

The day after the second colonoscopy, Mr Jackson collapsed due to hypotension. Investigations revealed anaemia, dehydration and hypokalaemia. Treatment involved intravenous fluids and electrolytes and bed rest. Mrs Jackson reported that her husband had complained of sore heels.

Dressings were applied to stage 2 pressure ulcers on both heels. The next day Mr Jackson's blood pressure was normal and he was feeling better. The doctors said he could go home.

However, Mr Jackson was unable to walk due to pain, weakness and the heel dressings. He had lost strength in his legs after not walking and not eating much for the past six days, and his wife said she would be unable to care for him at home until he could walk and toilet by himself.

He waited another two days in acute care for a rehabilitation bed.

On admission to rehabilitation he was noted to have lost five kilograms since his acute admission and developed stage 3 pressure ulcers. He was provided with specially made boots to enable walking while the pressure sores were healing; however, due to his dementia, he had trouble adjusting to the new boots. He only regained his confidence in walking once the ulcers had healed and he was able to wear his own shoes.

Mr Jackson was admitted for a minor procedure yet ended up spending seven days in acute care and 28 days in subacute care to get back to regain his premorbid level of function. What went wrong?

## Scenario 2

The following strategies from *The toolkit* were utilised:



- **Information about 'me' for planning care in hospital.**



- Engage the family and carers of people with dementia.



- Ensure the patient is sitting out of bed for all meals.

- Adapt the hospital environment to suit the patient's needs.
- Use the Braden skin integrity risk screening tool.
- Use the nutrition risk screening tool MNA-SF.
- Complete the interdisciplinary assessment of mobility and nutrition issues.
- Maintain the patient's own continence routine.

When Mr Jackson was admitted for the pre-operative preparation, the nurses consulted with Mrs Jackson about his care. Risk screens were performed and discussed with Mr and Mrs Jackson. Together, the staff, patient and carer made a care plan that would enable Mr Jackson to retain his functional independence in hospital. The nurses knew they needed to prompt Mr Jackson regularly to drink enough fluid to keep him well hydrated. Referrals were made to physiotherapy and dietetics for further professional assessment and to ensure his mobility and optimal nutrition were maintained.

Mrs Jackson was encouraged to spend time with her husband in hospital outside visiting hours, and was able to continue looking after him and maintain his daily routine as much as possible throughout his stay. Mr Jackson's admission was uncomplicated.



- The difference was the person-centred care plan.

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# Pain



## Five facts everyone should know about pain

1. Pain is not an inevitable part of ageing. Effective treatments are available for many people with pain.
2. Older people are often reluctant to acknowledge and report pain [1]. All healthcare professionals should be alert to the possibility of pain in older people.
3. Pain is highly damaging to quality of life, and costly for society as a whole. Effective assessment and treatment of pain is crucial in preventing disability and improving quality of life in older adults [2].
4. **Self-report is the most reliable source of information on pain.** Mild to moderate cognitive impairment is not usually a barrier to completing simple pain tools. More profound cognitive impairment may affect a patient's ability to complete pain tools; nevertheless these individuals may still be able to self-report pain. Pain instruments are available for non-verbal patients.
5. It is important to treat the cause of the pain, but it is also vital to treat the pain itself. This can help to reduce the effect of the injury or disease and decrease the chance that the pain will become chronic.

## What is pain?

Pain is a subjective, unpleasant sensory and emotional experience of actual or potential tissue damage [1, 3].

Pain is whatever a person says it is, existing wherever a person says it does [4].

An older person may describe pain by:

- the sensory experience – intensity, nature and location
- an emotional response (such as unpleasantness, fear, exhaustion, frustration or anxiety)
- the impact on physical, psychosocial and functional aspects of daily life (such as dressing, mood disturbance, social relationships and leisure activities) [1, 5].

Pain can be an acute episode resulting from tissue damage, which typically resolves following healing.

Chronic pain is defined as pain that extends beyond normal healing (traditionally beyond three months) or occurs with a disease where healing will not occur [5]. Chronic pain is also recognised as a disease entity in its own right and not only a symptom.

Identifying the underlying cause(s) of pain is important to assist with treatment and management. Treatment approaches vary according to the type of pain but all involve a combination of pharmacological and non-pharmacological approaches. Coordinated, multidisciplinary treatment strategies are sometimes required.

Pain can be divided into the following five categories.

### **Nociceptive pain [2, 3]**

Somatic pain

- Receptors located in skin, muscles and bone and associated with skin ulcers, fractures, arthritis and musculoskeletal conditions
- Described as a sharp, aching or gnawing sensation and well localised.

Visceral pain

- Receptors located in body organs and associated with pulmonary, liver, gastrointestinal, cardiac or intra-abdominal conditions
- Described as a dull ache, deep or squeezing sensation and often poorly localised.

### **Neuropathic pain [2, 3]**

- Pain caused by a primary lesion or dysfunction in the nervous system (peripheral neuropathic pain or central nervous system neuropathic pain)
- Described as shooting, burning or tingling sensation
- Associated with conditions such as postherpetic neuralgia, phantom limb pain following amputation, sciatica, diabetic neuropathy, stroke.

### **Cancer pain**

- Pain caused by the cancer itself or related to cancer treatment
- Can be nociceptive or neuropathic in nature.

### **Psychological [2]**

- Psychological and/or psychiatric factors play a major role in the onset and/or severity of pain and therefore any underlying psychopathology must be identified and treated [2]
- Psychological/psychiatric factors are rarely the sole cause of pain but may play a major role in the way that pain is reported and the impact of pain on the individual.

### **Mixed or unspecified pain [3]**

- Pain that has a mixed or unknown mechanism such as recurrent headache, fibromyalgia.

### **Further reading:**

Macintyre PE, Schug SA, Scott DA, Visser EJ, Walker SM, APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine 2010, *Acute Pain management: scientific evidence*, (3rd edn), ANZCA and FPM, Melbourne, <[http://www.anzca.edu.au/resources/books-and-publications/Acute\\_pain\\_management\\_-\\_scientific\\_evidence\\_-\\_third\\_edition.pdf](http://www.anzca.edu.au/resources/books-and-publications/Acute_pain_management_-_scientific_evidence_-_third_edition.pdf)>.

British Pain Society and British Geriatric Society 2007, *Guidance on: The assessment of pain in older people*, British Pain Society and British Geriatric Society, <[http://www.bgs.org.uk/Publications/Publication\\_Downloads/Sep2007PainAssessment.pdf](http://www.bgs.org.uk/Publications/Publication_Downloads/Sep2007PainAssessment.pdf)>.

Hadjistavropoulos T, Herr K, Turk DC, Fine PG, Dworkin RH, Helme R, Jackson K, Parmelee PA, Rudy TE, Lynn Beattie B, Chibnall JT, Craig KD, Ferrell B, Fillingim RB, Gagliese L, Gallagher R, Gibson SJ, Harrison EL, Katz B, Keefe FJ, Lieber SJ, Lussier D, Schmader KE, Tait RC, Weiner DK, Williams J 2007, 'An interdisciplinary expert consensus statement on assessment of pain in older persons', *Clinical Journal of Pain*, vol. 23, Supplement 1, pp. S1–S43.

The American Geriatrics Society 2002, 'The management of persistent pain in older persons: American Geriatrics Society panel on persistent pain in older persons', *Journal of the American Geriatrics Society*, vol. 50, pp. S205–S224.

Therapeutic Guidelines Limited 2007, *Therapeutic guidelines – analgesic*, version 5, North Melbourne, <www.tg.org.au>.

## Why is recognising pain important when working with older people in hospital?

Pain is often prevalent in older people and is frequently under-recognised and under-treated [1].

Of hospitalised patients aged 80 years old or older almost 46 per cent report experiencing pain with almost 13 per cent dissatisfied with the pain control provided [6].

Effective assessment and management of pain in hospital is critical in reducing hospital length of stay, preventing disability and improving quality of life for older people.

Identifying and treating pain in older people is important because pain can cause [3, 7, 8]:



- impaired mobility or immobility



- depression and anxiety

- social isolation
- sleep disturbances
- reduced participation in everyday activities



- post-operative confusion and delirium



- muscle wastage due to immobility

- fatigue
- delayed healing and recovery
- pulmonary complications
- increased hospital length of stay, health care utilisation and costs
- increased mortality.

The presence of pain in older people is also thought to worsen [3, 7]:



- gait disturbances



- polypharmacy



- physical deconditioning



- falls



- cognitive dysfunction



- malnutrition

- attempts at rehabilitation.

Benefits of effective pain assessment and management in hospital to older people include improvements in [3, 6, 9]:

- healing and rehabilitation



- muscle strength



- mobility and physical performance



- positive mood

- sleep

- socialisation



- cognitive functioning



- nutrition

- quality of life

- mortality rates.

## How do I recognise that an older person is in pain (including those with limited verbal communication)?

There are two main methods for pain identification in older people:

### 1. Self-report

**Self-report should be the first pain assessment undertaken with all older people, including those with a cognitive or communication impairment [3, 5].**

Staff should regularly ask older people about their pain with concern and carefully phrased questions. Note that older people may not admit to 'pain' but may acknowledge terms such as 'hurting', 'aching' and 'soreness'.

Self-report of pain may be obtained by asking an older person questions regarding the presence of pain, or using a pain intensity scale or multidimensional self-report tool. Any terms used by an older person to describe their pain should also be documented and used during subsequent pain assessments [1].

All self-reports should be taken seriously including those from older people with a cognitive impairment [3, 5, 10].

Self-reported pain from those with a severe cognitive impairment or non-communicative patients should be cross-validated with an observational pain assessment [11] and, where appropriate, discussed with family or carers involved with the older person.

Healthcare professionals tend to under-estimate patient pain levels. However, caution needs to be taken when using family or carer reports of pain in an older person, as pain intensity may be over-estimated (or sometimes under-estimated) [5, 12].

Pain is more than an unpleasant sensory experience. Unidimensional pain assessment tools are used to evaluate the sensory component of pain. Multidimensional pain assessment tools also evaluate the emotional response, which is the impact the pain is having on the individual's function and interpersonal relationships, and the meaning of the pain to the individual.

A multidimensional tool should be used for an initial comprehensive pain assessment. Examples include:



***Short-form McGill questionnaire***



***Brief pain inventory – short and long version***



***Geriatric pain measure***



***Pain disability index***



***Multidimensional pain inventory.***

Unidimensional pain assessment tools should be used for ongoing evaluation of pain intensity and response to treatment. Examples include:



***Numeric Rating Scale (NRS)***



***Verbal Descriptor Scale (VDS)***

 **pain thermometer**

 **Visual Analogue Scale (VAS)**

 **a pictorial pain scale, (FACES pain scale).**

If you are not successful in using one self-report tool with an older person, try a different tool.

## 2. Observational

Identifying pain using behavioural signs is important for older people with severe cognitive impairments and/or communication difficulties where behavioural signs may be the only external indicators of pain [5].

Pain behaviours are individual and therefore require clinical judgement and familiarity with the older person to best identify pain. Pain at rest should be assessed in conjunction with pain seen on activity such as movement or transfer.

Involving family and/or carers who know the patient well may assist with identifying and confirming observational pain [5].

Autonomic signs of pain such as pallor, sweating and rapid heartbeat are only observable during a severe acute pain episode [5]. They may assist with pain identification in older people who are intubated or unconscious following surgery but need to be used carefully because the absence of autonomic signs does not indicate the absence of pain.

For older people with severe cognitive impairment and/or communication difficulties a number of observation scales are recommended [13–15]:

 ***Pain assessment checklist for seniors with limited ability to communicate (PACSLAC)***

 **Pain Assessment in Advanced Dementia (PAINAD)**

 **Abbey pain scale**

 **Non-Communicating Patient's Pain Assessment Instrument (NOPPAIN).**

Caution must be taken when using behavioural and autonomic signs of pain because the behaviour or autonomic response may have other underlying causes such as a dislike to having a shower or previous high blood pressure. The following table outlines examples of possible behavioural and autonomic signs of pain.

## Observational signs of pain [1, 3]

### Behavioural and autonomic signs of pain

#### Facial expressions:

- Frowning, sad or frightened face
- Grimacing, wincing, eye tightening or closing
- Distorted facial expressions - brow raising/lowering, cheek raising, nose wrinkling, lip corner pulling
- Rapid blinking

#### Vocalisation:

- Sighing, groaning, moaning
- Grunting, screaming, calling out
- Aggressive/offensive speech
- Noisy breathing
- Asking for assistance

#### Body movement:

- Tense posture, guarding, rigid
- Fidgeting
- Pacing, rocking or repetitive movements
- Reduced or restricted movement
- Altered gait

#### Changes in social interaction:

- Aggressive or disruptive behaviour
- Socially inappropriate behaviour
- Decreased social interactions
- Withdrawn

#### Changes in activities:

- Appetite change, refusing food
- Increase in rest periods
- Sleep or rest pattern changes
- Increased wandering

#### Changes in mental status:

- Cognitive decline, increased confusion
- Crying/tears
- Irritability or distress

#### Autonomic:

- Pallor, sweating, tachypnoea, altered breathing, tachycardia, hypertension

Healthcare professionals must be aware of the numerous factors that may obstruct pain identification [3, 5]:

- terminology used by the healthcare professional or pain scale
- fears, beliefs and misconceptions about pain
- literacy skills, numeracy skills, language and cultural needs (need for and use of an interpreter should be considered)
- communication impairments
- cognitive impairments
- sensory impairments – ensure the older person is wearing all appropriate aids (glasses/hearing aids), that lighting is adequate and that the font size of printed pain assessment questions is appropriate.

#### Further reading:

Gibson S, Weiner D (eds) 2005, *Pain in older persons*, IASP Press, Seattle.

Royal College of Physicians, British Geriatrics Society, British Pain Society 2007, 'The assessment of pain in older people: national guidelines', Concise guidance to good practice series, No. 8, RCP, London. Includes algorithm of the assessment of pain in older people, <<http://www.rcplondon.ac.uk/pubs/contents/497d5548-ee0e-46ca-aa4b-4eaddf9724cb.pdf>>.

The Victorian Quality Council 2007, *Acute pain management measurement toolkit*, Rural and Regional Health and Aged Care Services Division, Department of Human Services, State Government of Victoria, Melbourne.

Gibson SJ, Scherer S, Katz B, Nay R 2009, 'Persistent pain in the older person'. In: Nay R, Garrett S (eds), *Older people: issues and innovations in care* (3rd edn), Churchill Livingstone, Sydney, pp. 261–291.

Herr K, Garand L 2001, 'Assessment and management of pain in older adults', *Clinics in Geriatric Medicine*, vol. 17, no. 3, pp. 1–18.

## How can I help prevent pain in a person identified as being at risk of pain?

Once an older person is identified as being at risk of pain, a comprehensive geriatric-focused pain assessment should be conducted and a pain management plan developed.

A pain assessment should include the following areas [3, 7, 10].

## Outline of a comprehensive pain assessment

### General medical history

- Include questions regarding conditions and illnesses that are common in older people, as these may contribute to acute or chronic pain conditions

### Pain history

- Commencement of pain
- Intensity – at rest and on movement, duration, current, during last week, highest level
- Aggravating and relieving factors
- Location – point to pain site on body or body map
- Radiation or referred sites of pain
- Quality – sharp, throbbing, aching
- Determine if the pain is acute or chronic, including acute exacerbations of chronic pain

### Physical examination

- Examine reported and referred pain and common pain sites in older people
- Musculoskeletal and neurological systems
- Signs of arthritis
- Sensitisation of pain responses – hyperalgesia or allodynia

### Functional assessment

- Physical function
- Amount of assistance required to perform personal, domestic and community activities of daily living
- Changes in mobility/activity level
- Sleep – difficulty falling asleep or waking due to pain
- Changes in appetite
- Pain intensity
- Range of movement

### Psychosocial function

- Mood – anxiety and/or depression may worsen with pain
- Social relationships, coping skills and social supports, pain-related fears

### Cognitive function

- Mental status including acute or subacute confusion or delirium associated with pain
- Pain beliefs and fears

### Previous pain treatments:

- Effectiveness and side effects of all past and present pharmacological and non-pharmacological pain management strategies
- Older person's satisfaction with past and present pain management strategies
- Older person's expectation of and goals for pain management

Adapted from The Australian Pain Society 2005, Pain in residential aged care facilities: Management strategies and American Geriatric Society 2002, The management of persistent pain in older persons: AGS panel on persistent pain in older persons.

### Further reading:

The American Geriatrics Society 2002, 'The management of persistent pain in older persons: American Geriatrics Society panel on persistent pain in older persons', *Journal of the American Geriatrics Society*, vol. 50, pp. S205–S224.

Herr K 2005, 'Pain assessment in the older adults with verbal communication skills'. In: Gibson S, Weiner D (eds), *Pain in older persons*, IASP Press, Seattle, pp. 111–133.

## What can I do if an older person complains of pain or I notice that they are in pain?

If an older person complains of pain or you notice they are in pain, health professionals should do the following.

- Initiate a discussion and question the older person regarding his or her current pain experience including
  - » whether the current pain complaint is new or old
  - » the location, duration, intensity, frequency, and quality of the pain
  - » exacerbating and relieving factors [10].
- Pain treatment should occur without a pain score when an older person is not able to focus, able to use a pain rating scale, or is visibly in pain [16].
- Assess and document the pain assessment outcome including current pain score, terms used by the older person to describe his or her pain, and pain management treatment provided [10, 16]. It is important to re-assess pain regularly. Think of pain as the fifth vital sign.
-  • Monitor and reassess the older person's pain levels and effectiveness of the treatment provided at least every one to two hours until the pain episode is controlled. More frequent monitoring may be required depending on the severity of the pain, the pain management strategy used and potential for adverse effects [8, 16].
-  • If pain is poorly controlled, that is, the patient has a pain rating greater than 3/10 or the pain stimulus or intervention alters, more frequent pain assessments should be conducted and a revision of the treatment plan is required [16].

### Further reading:

The Victorian Quality Council 2007, *Acute pain management measurement toolkit*, Rural and Regional Health and Aged Care Services Division, Department of Human Services, State Government of Victoria, Melbourne, <[http://www.health.vic.gov.au/qualitycouncil/downloads/apmm\\_toolkit.pdf](http://www.health.vic.gov.au/qualitycouncil/downloads/apmm_toolkit.pdf)> and includes the Victorian Quality Council patient brochure, *Managing your pain*, available in multiple languages including English, Arabic, Chinese, Croatian, Greek, Italian, Macedonian, Somali, Spanish, Turkish and Vietnamese, <[http://www.health.vic.gov.au/qualitycouncil/activities/acute/patient\\_information.htm](http://www.health.vic.gov.au/qualitycouncil/activities/acute/patient_information.htm)>.

Pasero C, Rakel B, McCaffery M 2005, 'Postoperative pain management in the older adult'. In: Gibson S, Weiner D (eds), *Pain in older persons*, IASP Press, Seattle, pp. 377–401.

## What care management principles should I follow with all older people to ensure pain is minimised and/or managed?

### Rights and responsibilities

All healthcare professionals should:

- consider the possibility of pain in all contacts with older people
- ask about pain routinely
- be aware of behaviours that might indicate underlying pain
- have pathways for pain management.

Patient rights include:

- education about effective pain management options
- appropriate assessment and management of pain
- regularly recorded assessment results to facilitate ongoing care
- care by health professionals with appropriate training and experience
- effective pain management strategies supported by appropriate policies and procedures.

### Assessment

The use of a pain measurement tool enables staff to identify an older person's current level of pain.

This helps to:

- decide on appropriate intervention
- enable prioritisation.

The initial pain assessment should be conducted at the pre-admission clinic or at time of admission if possible.

### **Self-report is accepted as the most reliable source of information on pain and is the current gold standard.**

Thorough and regular documentation of the pain experience is necessary.

The frequency of assessment should be determined by the older person's status:

- If the older person has no pain on admission, 0 is recorded as the pain score and the older person should be instructed and regularly reminded to inform staff if pain develops. A pain score may only need to be recorded once a day.
- The frequency of assessment should be increased if the pain is poorly controlled or if the pain stimulus or treatment interventions are changing.
- Pain assessment may need to occur one- to two-hourly until the pain episode is under control (for example, post-procedural pain).
- If a patient has an analgesic infusion in progress, pain scoring will be more frequent because
  - » this indicates a higher intensity of pain needing to be controlled
  - » there is a need to ensure appropriate safety monitoring occurs.
- Older people should be reassessed after any analgesic treatment to see if the treatment was effective, whether further treatment is necessary, and whether any side effects have occurred as a consequence of the treatment (for example, nausea, vomiting, constipation and sedation).
- Pain should be assessed as part of final hospital discharge.

Badges worn by staff and stickers on care plans can be used as visual reminders to regularly assess and report pain.

## Management



Treatment should be based on the assessment findings regarding the pain, barriers, strengths and goals of the older person.

Coordinated, multidisciplinary management strategies are sometimes required.

Proper classification of the pain – acute, post-operative or chronic – is essential for the treatment planning process.



Medication dose, administration, monitoring and adjustment must be carefully considered.



Analgesic treatments should be tailored to individual needs. Regular monitoring for any side effects following pain treatment (such as nausea, vomiting, sedation, constipation or dizziness) is required [16].



Pre-emptive analgesia should be considered prior to any medical procedure (IV cannulation, dressing change) or rehabilitation procedure (physiotherapy exercises) likely to cause significant pain.



Patient-controlled analgesia should be considered post-operatively.

Chronic pain is best managed with around-the-clock analgesia. Medications should be given, even if the person doesn't have pain at the time the medication is due.

Avoid opiophobia.

- Many older people with pain respond well to opioid therapy. This should not be denied because of fears of addiction.
- It is reasonable for a person with severe pain to seek analgesia.
- Addiction, also known as psychological dependency, is manifested by opioid-seeking behaviours for reasons other than pain relief. Psychological dependency should be differentiated from physical dependency.
- Physical dependency occurs after a person has been on certain medications for some time, including opioid analgesics. Addiction is manifested in withdrawal symptoms if the drug is suddenly stopped. Chronic opioid therapy should therefore not be abruptly stopped.
- Opiophobia may contribute to persistent unrelieved pain.

Non-pharmacological treatments may have an important role in pain management. Combining pharmacological approaches with non-pharmacological approaches may allow lower doses of drugs to be used. Non-pharmacological treatments include [17]:

- psychological approaches (cognitive behavioural therapy, relaxation, education)
- physical therapies (superficial heat and cold, TENS, gentle exercise, hydrotherapy)
- complementary and alternative therapies (acupuncture, glucosamine).



For older people with chronic pain, healthcare professionals and the older person must share in treatment planning and implementation, with the older person taking an active role whenever possible.

For many older people, especially those in alternative care settings, treatment planning should involve caregivers and significant others who require education or behavioural training.

Referral for multidisciplinary pain management should not prevent efforts to treat the underlying cause of the pain.

Including specialists on the multidisciplinary team to advise about adapting the older person's environment may be necessary.



The very useful *Algorithm for the assessment of pain in older people* is available from the Royal College of Physicians, British Geriatrics Society, and British Pain Society [1].

### Further reading:



Royal College of Physicians, British Geriatrics Society, British Pain Society 2007, *The assessment of pain in older people: national guidelines*, Concise guidance to good practice series, No. 8, RCP, London. Includes algorithm of the assessment of pain in older people, <<http://www.rcplondon.ac.uk/pubs/contents/497d5548-ee0e-46ca-aa4b-4eaddf9724cb.pdf>>.



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The Australian Pain Society 2005, *Guidelines for pain in residential aged care facilities: management strategies*, The Australian Pain Society, Sydney, <<http://www.apsoc.org.au/owner/files/9e2c2n.pdf>>.

## What can older people and their carers do for themselves to minimise pain in hospital and at home?

Patient education and self-management interventions reduce pain-related suffering [2].



It is important to have older people participate in treatment planning and the goal-setting process so they have an active role in their pain management.

Older people should be encouraged and regularly reminded to tell healthcare professionals about:

- any pain they feel
- the location of any pain
- the intensity of any pain
- characteristics of any pain (such as aching, throbbing, stabbing)
- activities that make any pain better or worse
- how pain impacts on their daily routine (appetite, sleep, mood, mobility).

Encourage older people to request pain relief at the onset of pain. Consider using relaxation strategies or anxiety reduction as a component of pain self-management.

An easy-to-understand information brochure for older people and their carers is available in Appendix 2 of the Victorian Quality Council *Acute pain management measurement toolkit*:



**Managing your pain information brochure [16].**

### Chronic pain

Sometimes chronic pain cannot be relieved; however, the negative impact can be reduced.

Advice to older people on how to deal with chronic pain includes:

Find out as much as possible about the condition so you understand what is happening and don't worry unnecessarily about the pain.



Exercise gently, eat healthy foods and ensure you get all the rest you need.



Take steps to prevent or reduce depression by any means that work for you, including talking to friends or health professionals.

Think positively. Identify negative thoughts you have in response to pain and practise challenging these negative thoughts with positive thoughts.

Don't let pain interfere with your life more than necessary – if you miss activities you used to do before the pain, try reintroducing them gradually and remember to pace yourself. Taking pain medication prior to an activity you know will aggravate your pain is advised. You may need to cut back on these activities if pain flare-ups occur, but you will be able to increase slowly again as you did before. Remember: pacing, planning and pre-emptive pain medication.

Focus your efforts on finding enjoyable and fulfilling activities that don't aggravate your pain.

Seek advice on different types of coping strategies.

Seek a referral to a pain clinic or chronic pain specialist or team if pain is ongoing.

Further information and specific examples for tackling negative thoughts and different coping strategies are available in the following publications:

 **The Australian Pain Society 2005, *Pain in residential aged care facilities – management strategies*: <<http://www.apsoc.org.au/owner/files/9e2c2n.pdf>>. These guidelines are written for use in residential care but have a great deal of useful information for managing pain in any setting.**

 **Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine 2010, *Managing acute pain: a guide for patients*, Australian Government National Health and Medical Research Council: <[http://www.nhmrc.gov.au/\\_files\\_nhmrc/file/publications/synopses/managingacutepain.pdf](http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/managingacutepain.pdf)>.**

 **Hadjistavropoulos T, Hadjistavropoulos H 2008, *Pain management in older adults: a self-help guide*, IASP Press, Seattle.**

 **Nicholas M, Molloy A, Tonkin L, Beeston L, 2007, *Manage your pain: practical and positive ways of adapting to chronic pain*, ABC Books, Pymble.**

## What pain related strategies should be considered when planning discharge?

Pain should be assessed as part of final hospital discharge.

### Developing a person-centred pain management discharge plan

 Pain management discharge planning should start on admission to provide sufficient time to develop an appropriate plan in collaboration with the older person and/or his or her family or carer.

Ensure the GP and other healthcare professionals who will provide services to the patient during the initial post-discharge period are informed of the care plan and involved in its development (where possible).

The older person and/or family or carers should be provided with a written copy of the person-centred pain management discharge plan. The following information should be considered for inclusion:

The older person's functional goals following discharge.

-  A list of prescribed medication including the dose, frequency and expected duration medication is to be taken.
-  Prevention and management strategies for potential medication side effects.
-  Restrictions and/or precautions associated with prescribed medication such as driving limitations, work.
-  Potential drug interactions between pre-hospital prescribed medication, over-the-counter medication and medications prescribed on discharge.

The contact details of the person the older person and/or family or carer should contact, and when, in the event of inadequate pain relief on discharge.

Details of follow-up appointments or referrals for outpatient or community-based rehabilitation.

Depending on the older person's functional status and his or her family or carer's ability to safely and effectively implement the discharge plan, a period of rehabilitation before returning home, or community services support upon discharge to home, may be required. With the older person's consent, and where appropriate, provide a copy of the pain management discharge plan to, and liaise with:

- the older person's GP
- the residential aged care facility
- the rehabilitation service
- community services.

### **Discharge education**

Older people and/or family or carers should be properly educated about implementing the pain management discharge plan and the importance of maintaining adequate pain control on discharge.



Prior to discharge, ongoing pain control should be discussed with the older person and/or carers. Information should be provided on the pain medicines prescribed including:

- advice about doses
- how often the older person will need to take the pain medicines
- how long the older person should take the pain medicines
- how to deal with any side effects.

The older person should be provided with education on energy conservation, pacing activity and work simplification techniques to assist with pain management. Proper education must also be provided if a home exercise program (HEP) is prescribed, including information about managing pain in relation to completing a HEP.

## Case study

Mr Smylie is a 75-year-old retired lawyer who recently began living in a retirement community which offers building maintenance and upkeep, but no additional services. He is an extremely clever man who prides himself on his intellect and independence. His wife passed away 10 years ago. He has one son and one daughter, who live in the same city but are 'busy with their own lives.' Mr Smylie is very good at 'coping' and hiding his pain from others. As such, he chose to sell his home six months ago and move to a retirement community because chronic back pain and poor eyesight meant he was having difficulties managing a large family home. He also knew he would soon require a knee replacement as his orthopaedic specialist had mentioned this during his last appointment. He did not want to be a burden to his children, and did not want to see the family home go into disrepair.

Mr Smylie's daughter took the morning off work to drive him to hospital and sit with him during the day of his knee replacement surgery.

### Scenario 1

Mr Smylie was grumpy the morning of his surgery because he was hungry from fasting and his back was painful. He was further angered when the admissions personnel gave his forms to his daughter and implied he required her help to fill them out.

Mr Smylie's surgery went well and from recovery he was admitted to an orthopaedic ward. He was given regular analgesia for his knee and was told, 'If your knee is painful please press the call bell and let a nurse know'. He had also brought his usual analgesic medication and heated wheat pack for his back pain but was unsure if he was allowed to use them, and didn't want to bother anyone to ask.

Over the next two days Mr Smylie grew increasingly withdrawn and was quick to anger with staff. He eventually refused to get out of bed for therapy and threatened to press assault charges if anyone touched him. He demanded to go home. He did not want to go to a rehabilitation ward or spend another day in hospital. He thought if he could just get home he'd be able to cope like he always did. Staff convinced him to stay one more night because it was already getting late in the day and there was no one to drive him home.

Upon waking on the third day he struggled to get himself out of bed to use the toilet. He did not want any of the staff helping him. On the way to the toilet he fell to the floor and fractured his wrist. The pain in his back became unbearable.

Later his daughter asked why he had not told staff about his back pain. He told her he was in hospital to fix his knee, not his back. His knee was not painful. It was a little achy, but compared with the sharp stabbing pain he'd been enduring in his back it was nothing.

## Scenario 2

Utilising the following strategies from *The toolkit*:



**Using a multidimensional tool for an initial comprehensive pain assessment**



**Using a unidimensional pain assessment tool for ongoing evaluation**



**Creating a person-centred pain management plan**



**Education**



**Creating a person-centred pain management discharge plan.**

During admission a multidimensional tool was used to conduct a comprehensive pain assessment with Mr Smylie. It allowed the admissions staff to highlight Mr Smylie's chronic back pain as a possible barrier to his recovery.

After surgery the numeric rating scale was initially used with Mr Smylie every hour until his pain was controlled. Staff asked directly about his back pain and his knee pain, and regularly encouraged him to report any discomfort he experienced.

The staff explained to Mr Smylie how important it was to his recovery to report any changes or pain in his knee, his back or anywhere else he might experience it. They also explained that, although he was in hospital for a knee replacement, his recovery depended on his overall wellbeing. When questioned Mr Smylie told staff about many of the strategies he regularly used when his back was painful. Together they formed a pain management plan for his recovery.

Four days after surgery Mr Smylie was consulted and then transferred to a rehabilitation ward, where he continued his rehabilitation before returning home. As they were preparing for discharge Mr Smylie indicated a few home modifications would be useful, and the proper referrals were made. With his consultation, he was also provided with pain medication and a home exercise program to further his rehabilitation. Clear written instructions and follow-up information was provided for Mr Smylie to take home.

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# Palliative approach to care



## Five facts everyone should know about palliative approach care

1. Palliative care is for anyone facing a life-threatening illness. It is not just for people with cancer.
2. Palliative care is applicable throughout the course of any life-threatening illness, from diagnosis and active treatment through end-of-life and including a period of bereavement.
3. Palliative care aims to improve quality of life; it is more than just pain management.
4. The inclusion and consideration of families and carers is important for palliative care.
5. Palliative care takes place in hospitals, in other care facilities, and in the community.

## What is palliative care?

The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” [1].

## Why is palliative care important when working with older people in hospital?

- Research has demonstrated that when palliative care is introduced in conjunction with other active treatment, both life-expectancy and quality of life can be improved in patients with life-limiting conditions [2].
- A preponderance of literature supports the effectiveness of palliative care for improving both patient and caregiver satisfaction [3]. For example, bereaved family members of people who died from dementia reported fewer unmet needs and concerns with quality of care, as well as better quality of dying [4].

## What are the principles of palliative care?

According to WHO, palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications [1].

## What should I consider when care planning for an older person in hospital?

When care planning for an older person in hospital, it may be important to distinguish between:

- a palliative approach to care
- specialised palliative care services
- end-of-life (terminal) care [5].

### A palliative approach

The primary focus of a palliative approach to care is to:

- improve patients' comfort and function
- reduce symptoms and distress
- address psychological, spiritual and social needs [5].

A palliative approach is applicable at any stage of illness, not just the end stage of life [6].

A palliative approach to care is appropriate when a patient has a life-threatening condition, not amenable to cure, with symptoms requiring effective symptom management [5]. Examples include patients with dementia and frail older patients. For these patients, active treatment may still be important and can be provided concurrently with a palliative approach. Implementing a palliative approach should not be based on a clinical stage or diagnosis, but offered according to individual needs [7]. A palliative approach well before the final months of life gives patients and their families an opportunity to plan and enjoy the remaining time they have, and prepare for death [2].

Useful resources to help guide decision making include:

 **'The clinical course of advanced dementia' in The New England Journal of Medicine [8].**

 ***An ethical framework for integrating palliative care principles into management of advanced chronic or terminal conditions* [2]: <[www.nhmrc.gov.au/\\_files\\_nhmrc/publications/attachments/rec31\\_ethical\\_framework\\_palliative\\_care\\_terminal\\_110908.pdf](http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/rec31_ethical_framework_palliative_care_terminal_110908.pdf)>**

To enhance quality of life, it is important to address psychological, spiritual and social needs in a palliative approach care plan. The *Quality of life and palliative care* section of this domain contains relevant resources that may be useful in this regard.

Screening, assessment and intervention resources that may be relevant for a palliative approach to care are available throughout this toolkit. Importantly, sound clinical judgement in using tools appropriately is required, as much of this toolkit is focused on maximising function and there are often other aims to consider within a palliative approach to care. This toolkit contains screening, assessment and intervention resources for:

- mobility/vigour/self-care
- nutrition and swallowing
- delirium
- dementia
- depression
- continence

- medication
- skin integrity
- pain
- communication - vision, hearing and speech impairments.

### Specialised palliative care services

Referral to a specialised palliative care team, service or healthcare practitioner does not replace a palliative approach to care planning in hospital.

Referral to specialised palliative care services should be considered for:

- assessing and treating complex symptoms
- information and advice on complex issues such as ethical dilemmas, family issues, or psychological, social or spiritual distress [5].

Input from a specialised palliative care service may be focused, intermittent and specific [5]. It does not replace a palliative approach in hospital. An ongoing collaborative relationship with specialist palliative care services can improve the quality of a palliative approach [9].

As a guide, some experts suggest if a health professional would not be surprised if a patient were to die in the next year or so of an advanced chronic or terminal condition, then the expertise of a specialist palliative care practitioner should be sought to manage symptoms inhibiting quality of life [2].

Individual health services often have advice or guidelines for referrals to specialist palliative care services. General information about referrals, including when to refer to a specialist palliative care service, can be found at:



[www.pallcarevic.asn.au/health-professionals](http://www.pallcarevic.asn.au/health-professionals)

For information about finding palliative care services in Victoria:



[www.pallcarevic.asn.au/resources-links](http://www.pallcarevic.asn.au/resources-links)



[www.caresearch.com.au/caresearch/FindingServices/tabid/66/Default.aspx](http://www.caresearch.com.au/caresearch/FindingServices/tabid/66/Default.aspx)

### End-of-life (terminal) care

Identifying when a patient is entering a terminal phase of life will assist the healthcare team to provide appropriate care and communication [5]. A terminal phase of life refers to a patient's final days or weeks of life, when death is expected. The following symptoms are considered to be indicators of a terminal phase of life; however, these indicators are not prescriptive and should not replace individualised assessment and clinical judgement [10].

Indicators of a terminal phase of life include:

- requiring frequent interventions
- being bed-bound
- loss of appetite
- profound weakness
- trouble swallowing
- a dry mouth
- weight loss

- becoming semiconscious, with lapses into unconsciousness
- experiencing day-to-day deterioration that is not reversible [5].

As the terminal phase of life approaches death, the following symptoms may be indicative that death is imminent (within hours to days):

- peripheral shutdown and cyanosis
- changes in respiratory patterns (such as 'Cheyne-Stokes' breathing)
- drowsiness or reduced cognition (such as not responding to verbal and/or physical stimuli)
- uncharacteristic or recent restlessness and agitation
- retained upper airway secretions
- cardiac signs – hypotension, tachycardia [5].

Unless the terminal phase of life occurs suddenly and unexpectedly, patients should not normally find themselves abruptly transferred to palliative care in the last days of life [2]. Ideally, palliative care should be discussed and appropriate care planned and provided well before end-of-life care is required.

In the final days or weeks of life, goals may be more sharply focused on physical, emotional and spiritual comfort, and supporting the family. Care decisions may also need to be reviewed more frequently [5].



**End-of-life care pathways page from Care Search: <[www.caresearch.com.au/caresearch/ProfessionalGroups/NursesHubHome/Clinical/EndofLifeCare/EOLCarePathways/tabid/1469/Default.aspx](http://www.caresearch.com.au/caresearch/ProfessionalGroups/NursesHubHome/Clinical/EndofLifeCare/EOLCarePathways/tabid/1469/Default.aspx)>**



### Using advance care plans

Healthcare professionals should respect current and valid advance care plans as indicative of patients' wishes [9].

Healthcare professionals should document the existence of a valid and current advance care plan and communicate this information to all members of the healthcare team. This information must also be passed on in the event an older patient is transferred into the care of another healthcare team [9]. This communication is critical for providing the best possible care.

If the use or interpretation of an advance care plan is challenged, the healthcare team should first attempt to resolve the issue in a direct and appropriate manner, in accordance with their health service's policies or guidelines. Effective communication between the interested parties may be all that is needed to resolve such disputes. An appropriately resourced family and/or team meeting can help facilitate effective communication. If the dispute cannot be resolved by the disagreeing parties, in Victoria the Office of the Public Advocate can provide advice and/or help to resolve conflict should the use or interpretation of an advance care plan be challenged.



**<[www.publicadvocate.vic.gov.au](http://www.publicadvocate.vic.gov.au)>**

### Teamwork and communication

Using a team approach to address the needs of patients and their families is a principle of palliative care [1]. Effective multidisciplinary teams are important to the success of palliative care planning in hospitals as patients and families may require a range of skills and expertise.

Effective communication is essential. This includes communication between members of the multidisciplinary healthcare team, and between health professionals, patients and families. Effective communication should occur early and throughout the illness trajectory, or as an older person becomes progressively more frail. Early communication about palliative care is critical so that care transitions can be gradual and appropriate.

The person-centred practice domain of this toolkit offers useful resources to improve communication among the healthcare team. Resources include good practice guidelines for:

- case conferences
- care planning and decision making
- charting and documentation.

### Culturally safe palliative care planning

Health professionals should demonstrate cultural sensitivity and undertake culturally safe practices in care planning [9]. The following resources offer some useful guidance:

 **Multicultural palliative care guidelines from Palliative Care Australia [11]:**  
<[www.palliativecare.org.au/Portals/46/Multicultural%20palliative%20care%20guidelines.pdf](http://www.palliativecare.org.au/Portals/46/Multicultural%20palliative%20care%20guidelines.pdf)>

 Chapters 9, 10 and 11 of the *Guidelines for a palliative approach for aged care in the community setting* outline good practice points for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups and other communities with special needs or perspectives [9]: <[www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/\\$File/COMPAC-30Jun11.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/$File/COMPAC-30Jun11.pdf)>

 **Multicultural clinical practice page from Care Search:**  
<[www.caresearch.com.au/caresearch/tabid/234/Default.aspx](http://www.caresearch.com.au/caresearch/tabid/234/Default.aspx)>

### Palliative care education, training and quality improvement resources

Health professional resources:

 **Program of Experience in a Palliative Approach (PEPA) – education and training for health professionals in a palliative approach to care that offers many models of education including workshops, supervised clinical placements and workplace activities:**  
<[www.pepaeducation.com](http://www.pepaeducation.com)>

 **PCC4U Palliative Care Curriculum for Undergraduates:**  
<[www.caresearch.com.au/caresearch/pcc4u/tabid/2083/Default.aspx](http://www.caresearch.com.au/caresearch/pcc4u/tabid/2083/Default.aspx)>

 **Palliative Care Australia glossary:** <[www.palliativecare.org.au/Portals/46/PCA%20glossary.pdf](http://www.palliativecare.org.au/Portals/46/PCA%20glossary.pdf)>

Service level resources:

 **National Standards Assessment Program (NSAP) – a quality improvement program for palliative care services. Information available:**  
<[www.standards.palliativecare.org.au/Default.aspx](http://www.standards.palliativecare.org.au/Default.aspx)>

 **Palliative Care Outcomes Collaboration (PCOC) – a voluntary program for palliative care services utilising standardised validated clinical assessment tools to benchmark and measure outcomes in palliative care:** <[www.pcoc.org.au](http://www.pcoc.org.au)>

## Talking about palliative care

It is important to talk about the transition from a primarily curative approach to a palliative approach with patients, families, carers, and within the healthcare team. These discussions need to happen early and often during a life-threatening illness or when an older person is starting to become progressively more frail. These may be difficult conversations but they are important conversations. Early communication about palliative care is critical so that care transitions can be gradual and appropriate [2].

Talking to patients, families and carers openly and regularly will help the healthcare team understand their needs and wishes and reduce the possibility of conflict or confusion about care goals [5, 12]. If family members perceive that either they or their relative have control of care decisions, they tend to report great satisfaction with the care received [13].

The following guidelines may add to the quality of these important discussions:

 **Family meetings in palliative care: multidisciplinary clinical practice guidelines [14].**

 **Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers [15]:**  
<[www.mja.com.au/public/issues/186\\_12\\_180607/cla11246\\_fm.html](http://www.mja.com.au/public/issues/186_12_180607/cla11246_fm.html)>

There will be a range of reactions from patients and families when talking about a palliative approach to care. Patients and families are likely to have preconceived ideas about what palliative care means and may therefore have strong initial reactions and assume death is imminent. Other common misunderstandings in the community include equating palliative care with euthanasia or 'giving up'.

Cultural and religious beliefs may play an important role in one's understanding and acceptance of a palliative approach to care, and health professionals should be sensitive to such beliefs. They should show cultural sensitivity and undertake culturally safe practices [9].

 **Multicultural palliative care guidelines from Palliative Care Australia [11]:**  
<[www.palliativecare.org.au/Portals/46/Multicultural%20palliative%20care%20guidelines.pdf](http://www.palliativecare.org.au/Portals/46/Multicultural%20palliative%20care%20guidelines.pdf)>

Some patients and families will accept a primarily palliative approach to care much earlier in the illness and ageing process than others. Some patients and families may never accept a primarily palliative approach. Regardless of their beliefs, wherever relevant, patients and their families should be involved in treatment and care decisions [16]. Therefore, information about palliative care should be presented and talked about in a manner that promotes understanding by patients and families [5].

Families are often concerned about pain control and would like information about prognosis, the trajectory of the illness and care decisions that need to be made [17]. It is important that all patients and families are assured that symptoms such as pain and nausea can usually be controlled and that a combination of active treatment to manage difficult symptoms while following a palliative approach is considered best practice [12].

Education resources for families and carers explaining what palliative care is and why it is appropriate care include:



<[www.caresearch.com.au/caresearch/ForPatientsFamilies/tabid/64/Default.aspx](http://www.caresearch.com.au/caresearch/ForPatientsFamilies/tabid/64/Default.aspx)>



<[www.palliativecare.org.au/portals/46/resources/WhatIsPalliativeCare.pdf](http://www.palliativecare.org.au/portals/46/resources/WhatIsPalliativeCare.pdf)>



<[www.pallcarevic.asn.au/media/1188277472875-9740.pdf](http://www.pallcarevic.asn.au/media/1188277472875-9740.pdf)>

See the following website for multilingual resources for families and carers explaining what palliative care is and why it is appropriate care:



<[www.palliativecare.org.au/Default.aspx?tabid=2116](http://www.palliativecare.org.au/Default.aspx?tabid=2116)>

Resources for clinicians to improve or practice skills in talking about palliative care include:



**Victorian Cancer Clinicians Communication Program – training programs for clinicians on how to deliver bad news and transition to palliative care for cancer patients:**

<[www.cancervic.org.au/for-health-professionals/training\\_courses\\_and\\_education/vcccp](http://www.cancervic.org.au/for-health-professionals/training_courses_and_education/vcccp)>



**Balint Society of Australia and New Zealand offers small experiential group education activities focusing on the doctor–patient relationship:**

<[www.balintaustralia.org/index.htm](http://www.balintaustralia.org/index.htm)>



***Tough talk: helping doctors approach difficult conversations toolbox:***

<<http://depts.washington.edu/toolbox/toc.html>>



**'A physician's guide to talking about end-of-life care' in *Journal of General Internal Medicine* [18].**

## Death and dying

A positive and open attitude towards death and dying underpins palliative care [5]. By recognising and talking about death and dying, healthcare professionals can help patients and families prepare for the terminal phase of life.

Initiating a conversation about death and dying with a patient or family may be difficult. Healthcare professionals should be open and honest about prognosis and the expected trajectory of an illness from the time of diagnosis or when an older person is starting to become progressively more frail. Early communication about death and dying is important because it allows patients and families to plan for the remaining time they have, and prepare for death [2].

The following guidelines may add to the quality of these important discussions:



***Family meetings in palliative care: multidisciplinary clinical practice guidelines*** [14].



***Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers*** [15]:  
<[www.mja.com.au/public/issues/186\\_12\\_180607/cla11246\\_fm.html](http://www.mja.com.au/public/issues/186_12_180607/cla11246_fm.html)>



***Clinical practice guidelines for the psychosocial and bereavement support of family caregivers of palliative care patients*** [19]:  
<[www.centreforpallcare.org/assets/uploads/CP-Guidelines\\_web.pdf](http://www.centreforpallcare.org/assets/uploads/CP-Guidelines_web.pdf)>



**A useful fact sheet for teaching families what to expect when a patient is dying:**  
<[www.eperc.mcw.edu/fastFact/ff\\_149.htm](http://www.eperc.mcw.edu/fastFact/ff_149.htm) [20]>.



***Ten steps to better prognostication*** – PDF from M Downing at Victoria Hospice Society, Victoria, BC, Canada [21].



**Prognosis literature search from CareSearch:**  
<[www.caresearch.com.au/caresearch/tabid/1218/Default.aspx](http://www.caresearch.com.au/caresearch/tabid/1218/Default.aspx)>

If patients ask about euthanasia or say they ‘want to die’, it is important to explore their reasons. Appropriate consultations and/or referrals should be made if, upon hearing such requests, hospital staff are unable to address this issue.

For any patient expressing a wish to die, an appropriately trained professional should investigate:

- if the patient is experiencing distressing symptoms
- how serious the request is
- how long the patient has had thoughts of wanting to die
- whether the request is known to family [2].

Further information about the patient’s experiences and beliefs can help inform an appropriate care plan. Loss of purpose, not wanting to be a burden and concerns about one’s legacy are examples of patient beliefs that may lead to expressions of wanting to die. Appropriate and individualised spiritual and psychosocial interventions can help resolve spiritual and psychosocial distress.



***Responding to desire to die statements from patients with advanced disease: recommendations for health professionals*** [22].

## Care for health professionals

Healthcare professionals should also consider their own health and wellbeing in dealing with death and dying. Talking about and witnessing death and dying in a professional capacity has the potential to highlight distressing personal issues. Counselling or a safe environment to debrief with colleagues should be sought and made available when required.

Resources for clinicians to improve or practise skills in talking about death and dying:



**Grief and Bereavement Practitioner Consultancy Service 1300 858 113. Telephone the service for professionals providing grief or bereavement support or counselling (offers information to help clients and support for the professional).**



***Communication phrases near end-of-life* – PDF adapted by Matthew Ellman MD [23].**

Grief and bereavement resources to help families, carers and health professionals:



**Grief line (03) 9935 7400 – grief telephone counselling available from midday to 3 am daily.**



**Australian Centre for Grief and Bereavement website: <[www.grief.org.au](http://www.grief.org.au)>**



**Beyondblue: the national depression initiative website:  
<[www.beyondblue.org.au](http://www.beyondblue.org.au)>**

## Quality of life and palliative care

Palliative care aims to improve the quality of life of patients and families [1]. Research into what quality of life means to people as the terminal phase of life nears has uncovered the following themes:

- adequate pain and symptom management
- avoiding inappropriate prolongation of dying
- relieving burden
- achieving a sense of control
- strengthening relationships with loved ones [24].

However, defining and measuring quality of life is difficult because patients, families and healthcare providers may have differing perceptions of what contributes to quality of life. What is important to one person may be of no concern to another. These perceptions define quality of life for each individual. Frequent and effective communication with patients and their families is therefore important to understand individual perceptions of quality of life.

The most important definition of quality of life is that which is provided by each patient [5]. Care decisions and perceptions of quality of life in many cases will change during the course of an illness or as an older person becomes progressively more frail, therefore frequent and effective communication with patients is important.

Family and carer opinions are important in palliative care, but the most important person is the patient [5].

### Futile or overly burdensome care

Treatments and care plans may be described as futile if they bring no benefit to the patient [25]. Treatments that bring benefits may also be quite burdensome. Burden of care or burden of treatment considers the patient's distress and suffering [2].

Care and treatment may be overly burdensome when the burden of that care or treatment is disproportionate to the likely benefits for a patient [2]. Treatment that prolongs a life may in principle be beneficial, but it may not be so for a particular patient if it merely prolongs the dying process, is overly burdensome and undermines quality of life [2].

Expert knowledge of a patient's diagnosis, comorbidities and likely impact of proposed care and treatment will help guide decision making in determining if care or treatment will be overly burdensome. These decisions should also be informed by the patient's (and often family's) wishes, culture, beliefs and preferences [2].

### Psychosocial care

Appropriate screening and assessment can help identify needs that may be improved with psychological and/or social care [9].

Consideration of psychological and social reasons for symptoms is appropriate in palliative care [9].



Depression, dementia and delirium impact on quality of life and should be assessed and treated appropriately. The depression, dementia and delirium domains of this toolkit contain information and screening, assessment and treatment resources for diagnosing and treating these conditions. Sound clinical judgement in appropriately using these tools is required because the aim of much of this toolkit is on maximising function; there are often other aims to consider when using a palliative approach to care.

Each health service will have a variety of psychosocial care options available. Psychosocial interventions should be tailored to the preferences and needs of each patient and delivered by a multidisciplinary team. These may include [9]:

- reminiscence and life review
- music therapy
- health promotion programs
- relaxation therapy
- mind–body therapies (such as yoga, tai chi, qigong)
- animal-assisted therapy
- environmental modifications.



***Complementary therapy*** clinical practice page from CareSearch:  
<[www.caresearch.com.au/caresearch/tabid/1258/Default.aspx](http://www.caresearch.com.au/caresearch/tabid/1258/Default.aspx)>



***Psychological, social, spiritual*** clinical practice page from CareSearch:  
<[www.caresearch.com.au/caresearch/tabid/131/Default.aspx](http://www.caresearch.com.au/caresearch/tabid/131/Default.aspx)>



***Clinical practice guidelines for the psychosocial and bereavement support of family caregivers of palliative care patients*** [19]:  
<[www.centreforpallcare.org/assets/uploads/CP-Guidelines\\_web.pdf](http://www.centreforpallcare.org/assets/uploads/CP-Guidelines_web.pdf)>



**Grief line (03) 9935 7400** – grief telephone counselling available from midday to 3 am daily.



**Grief and Bereavement Practitioner Consultancy Service 1300 858 113.** Telephone the service for professionals providing grief or bereavement support or counselling (offers information to help clients and support for the professional).

## Spiritual support

Recognising spiritual needs and incorporating each patient's spiritual beliefs into an individualised palliative care plan can improve quality of life [9].

Spirituality is difficult to define [26]. Some authors suggest a person's spirituality can be thought of as that which provides meaning, purpose and fulfilment in life [9]. Spirituality may also determine how each patient can come to feel a sense of peace [26]. Spirituality may be reflected in beliefs, attitudes and behaviours. Personal spirituality can be expressed and experienced within or without participation in an organised religion [9].

For a model of spirituality as 'ultimate meaning mediated through relationship, religion, environment, the arts' see [27]:



<[www.centreforageing.org.au/html/pdfs/Spirituality\\_UltimateMeaning.pdf](http://www.centreforageing.org.au/html/pdfs/Spirituality_UltimateMeaning.pdf)>

All healthcare professionals should recognise the importance of and support patients' spirituality. Chaplains, pastoral care workers and/or traditional healers, working as part of a healthcare team, can help deliver spiritual care to patients and their families. Where necessary they can also educate and support the rest of the healthcare team in providing culturally sensitive spiritual care [9].

Asking open-ended questions about a patient's spiritual history is recognised as an effective form of spiritual assessment [9, 26, 28].

A patient often receives spiritual support from family, friends, carers and from elsewhere in their community. The importance of these relationships should be recognised [26]. Patient and family religious beliefs and practices should be respected and affiliation with religious and other organisations that help address spiritual issues should be encouraged [9]. Spiritual care is an integral part of palliative care, but it must be individualised care according to each person's needs [26].

Possible spiritual interventions include:

- visits from or referral to chaplains, pastoral care workers, traditional healers
- spiritual or religious counselling
- taking part in religious services
- life review
- support groups
- listening to music
- artwork
- enjoying nature
- enjoying other leisure activities [9].

 **The *Multidisciplinary training program for spiritual care in palliative care* is a web-based module developed by a team from the University of Queensland and presented in partnership with Palliative Care Australia: <[www.palliativecare.org.au/Spiritualcare.aspx](http://www.palliativecare.org.au/Spiritualcare.aspx)>**

Worship, rituals, customs, relationships and life review may improve spiritual distress [26].

Respecting a patient's spirituality may mean timing other screenings, assessments and interventions around spiritual practices. Medication does not fix emotional or spiritual pain [8].

The purpose of spiritual interventions is not necessarily to resolve a patient's spiritual or religious issues, but to create an environment that enables and promotes spiritual expression and allows patients to discover their own answers [26].

 ***Complementary therapy* clinical practice page from CareSearch: <[www.caresearch.com.au/caresearch/tabid/1258/Default.aspx](http://www.caresearch.com.au/caresearch/tabid/1258/Default.aspx)>**

 ***Psychological, social, spiritual* clinical practice page from CareSearch: <[www.caresearch.com.au/caresearch/tabid/131/Default.aspx](http://www.caresearch.com.au/caresearch/tabid/131/Default.aspx)>**

 **Centre for Ageing and Pastoral Studies (CAPS): <[www.centreforageing.org.au](http://www.centreforageing.org.au)>**

 **George Washington Institute for Spirituality and Health Resources, online education and resource centre: <[www.gwumc.edu/gwish/soerce/index.cfm](http://www.gwumc.edu/gwish/soerce/index.cfm)>**

## What can patients, families or carers do to help an older person in hospital and at home?

Patients, families, carers, GPs and other community aged care providers are important members of a palliative care team. Patients, and the people who regularly provide them with care, often have knowledge and insights that are beneficial to the healthcare team and the overall quality of life of the patient.

In hospital and at home, patients and their families or carers should be encouraged to:

- communicate openly and honestly with all health professionals
- be valuable members of the healthcare team
- have a plan for what to do in a crisis
-  • undertake advance care planning
- discuss advance care plans with family, carers and health professionals
- use and review advance care plans as necessary while communicating with their healthcare providers about any changes
-  • use a medication chart
- record relevant health-related events
-  • tell the healthcare team about any complementary or alternative therapies used medication domain symbol
- seek and/or maintain psychological and spiritual support [9].

Additionally, families and carers should be encouraged to:

- undertake disease-specific education and skills training (where appropriate)
- consider their own health and wellbeing and seek appropriate resources as required [9].



**Links to disease-specific organisations can be found from CareSearch:**

[<www.caresearch.com.au/caresearch/tabid/310/Default.aspx>](http://www.caresearch.com.au/caresearch/tabid/310/Default.aspx)



***Living well with an advanced chronic or terminal condition: how ethics helps: a guide for patients, family and carers:*** [<www.nhmrc.gov.au/\\_files\\_nhmrc/publications/attachments/rec31a\\_advanced\\_chronic\\_terminal\\_ethics\\_guide\\_110908.pdf>](http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/rec31a_advanced_chronic_terminal_ethics_guide_110908.pdf)



***Getting the best healthcare*** from Palliative Care Victoria:

[<www.pallcarevic.asn.au/general-public/getting-the-best-health-care>](http://www.pallcarevic.asn.au/general-public/getting-the-best-health-care)



***How a palliative approach can help older people being cared for at home: a booklet for older people and their families:*** [<www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/\\$File/COMPAC%20Older%20people%20booklet%20RTF%20accessible%20WEB.pdf>](http://www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/$File/COMPAC%20Older%20people%20booklet%20RTF%20accessible%20WEB.pdf)



***For patients and families*** page from CareSearch:

[<www.caresearch.com.au/caresearch/ForPatientsFamilies/tabid/64/Default.aspx>](http://www.caresearch.com.au/caresearch/ForPatientsFamilies/tabid/64/Default.aspx)



*How a palliative approach can help older people being cared for at home:* <[www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/\\$File/COMPAC%20Older%20people%20booklet%20RTF%20accessible%20WEB.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/$File/COMPAC%20Older%20people%20booklet%20RTF%20accessible%20WEB.pdf)>



*Clinical practice guidelines for the psychosocial and bereavement support of family caregivers of palliative care patients* [19]:  
<[www.centreforpallcare.org/assets/uploads/CP-Guidelines\\_web.pdf](http://www.centreforpallcare.org/assets/uploads/CP-Guidelines_web.pdf)>

Ideally, assistance with planning, education and training should be provided by a health professional who knows the older person well, so that planning, care and treatment options can be explained in a way that is specific to each unique patient [9].



*An ethical framework for integrating palliative care principles into management of advanced chronic or terminal conditions* [2]:  
<[www.nhmrc.gov.au/\\_files\\_nhmrc/publications/attachments/rec31\\_ethical\\_framework\\_palliative\\_care\\_terminal\\_110908.pdf](http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/rec31_ethical_framework_palliative_care_terminal_110908.pdf)>



*Guidelines for a palliative approach for aged care in the community setting* [9]:  
<[www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/\\$File/COMPAC-30Jun11.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/400BE269B92A6D73CA2578BF00010BB0/$File/COMPAC-30Jun11.pdf)>



*Guidelines for a palliative approach in residential aged care* [5]:  
<[www.nhmrc.gov.au/\\_files\\_nhmrc/publications/attachments/pc29.pdf?q=publications/synopses/\\_files/pc29.pdf](http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/pc29.pdf?q=publications/synopses/_files/pc29.pdf)>

## Case study

Mrs Loukomitis was an 85-year-old widow with advanced dementia who had lived in a high-care residential facility for three years. She presented to the emergency department (ED) with pneumonia and dehydration from the residential facility, via ambulance and accompanied by her son. Mrs Loukomitis vocalised but had lost her use of language. She'd had other febrile episodes and documented weight loss in recent months. During her recent febrile episodes comfort care was provided for Mrs Loukomitis at her place of residence. She had a son and two daughters. Her son lived interstate but was in town to visit his mother. Her daughters lived nearby and mostly shared responsibility for her care decisions on an as-needed and as-available basis.

### Scenario 1

Mrs Loukomitis was initially quiet, appearing only semiconscious with lapses into unconsciousness. She was given intravenous hydration and antibiotics and admitted to a general medical ward from the ED. Her son was very vocal about his displeasure with the care his mother had been receiving. He had an aggressive manner with the hospital staff and yelled at his sisters when they arrived at hospital. He was particularly focused on his mother's weight loss and insisted that she would 'get better' if the nurses fed her. A staff member tried to explain to him that feeding his mother by mouth would likely make her pneumonia worse and it is 'not best practice' to insert a feeding tube. Unfortunately her son didn't really hear anything beyond 'feeding tube' and from that point on campaigned aggressively to get his mother a feeding tube. A PEG tube was inserted on her second day in hospital and the medical staff suggested she be discharged back to the residential facility. Her son refused. He did not want her to leave hospital until she was 'better' and he did not want her to go back to the residential facility because they were not helping her to get better. On day three Mrs Loukomitis became very agitated. She pulled at the PEG tube. It was reinserted after she was physically restrained. On day four pressure ulcers began to appear on Mrs Loukomitis' buttocks; she again attempted to pull out her PEG tube and she was again physically restrained. On day five her son told a nurse that he needed to go home to look after his business, but his mother was not to leave hospital until she was better. On day six her daughters asked for the PEG tube to be removed and for Mrs Loukomitis to be discharged to the residential facility. They apologised to staff for their brother's behaviour and explained that he was refusing to accept that their mother was dying.

One week later Mrs Loukomitis again presented to the ED from the residential facility accompanied by her son. She had another PEG tube inserted and was admitted to a general medical ward. Mrs Loukomitis died in hospital the following morning.

### Scenario 2

Mrs Loukomitis was initially quiet, appearing only semiconscious with lapses into unconsciousness. She was given intravenous hydration and antibiotics and admitted to a general medical ward from the ED. Her son was very vocal about his displeasure with the care his mother had been receiving. He had an aggressive manner with the hospital staff and yelled at his sisters when they arrived at hospital. Upon expressing his belief that his mother would 'get better' if the nurses would feed her, a nurse asked him if he understood that his mother had dementia and was dying and that force feeding her would not change that nor would it provide her with comfort. When her son told the nurse he didn't believe what she was telling him, the nurse reported this to the medical staff and a family meeting was scheduled. The meeting was arranged so Mrs Loukomitis' son and her two

daughters could attend, as well as a clinical nurse consultant and psychologist from the hospital's palliative care department. The GP who regularly visited Mrs Loukomitis at the residential facility was also asked to attend and she joined the meeting via telephone.

During the meeting the GP was asked about Mrs Loukomitis' advance care planning. The GP said she was not aware of any signed documents, and when she started seeing her in residential care she was already very cognitively impaired. However, in her conversations with her daughters they'd always agreed that as her dementia reached an advanced stage comfort care at the residential facility was in Mrs Loukomitis' best interests. Mrs Loukomitis' daughters agreed and described how their mother had told them when she was first diagnosed with dementia that she didn't want to die in a hospital, and they believed that although residential care wasn't home she had always been content there and that they knew her and cared well for her there. The palliative care clinical nurse consultant then explained to her son that dementia is a terminal illness. She detailed what the family should expect now that she was in the terminal phase of her life. She also explained how inserting a PEG tube and moving her back and forth to hospital would be futile and overly burdensome to Mrs Loukomitis. The psychologist offered to speak to her son privately or suggest someone close to his home he could contact to help him come to terms with his mother's illness and death. Her son told the psychologist he would like time to consider her offer. He then explained that he was only trying to do what he thought was best.

With clear palliative care goals established at the family meeting Mrs Loukomitis was discharged to her home at the residential facility to receive comfort in her final days. Mrs Loukomitis died 10 days later.

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