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HOSPITALISATIONS IN PEOPLE WITH DEMENTIA APPROACHING END OF LIFE – WHAT CAN WE IMPROVE?

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Data obtained from the Western Australian Data Linkage Branch and the custodians of the Hospital Morbidity Data Collections; the Births, Deaths and Marriages Register and the Silver Chain Community Care Group

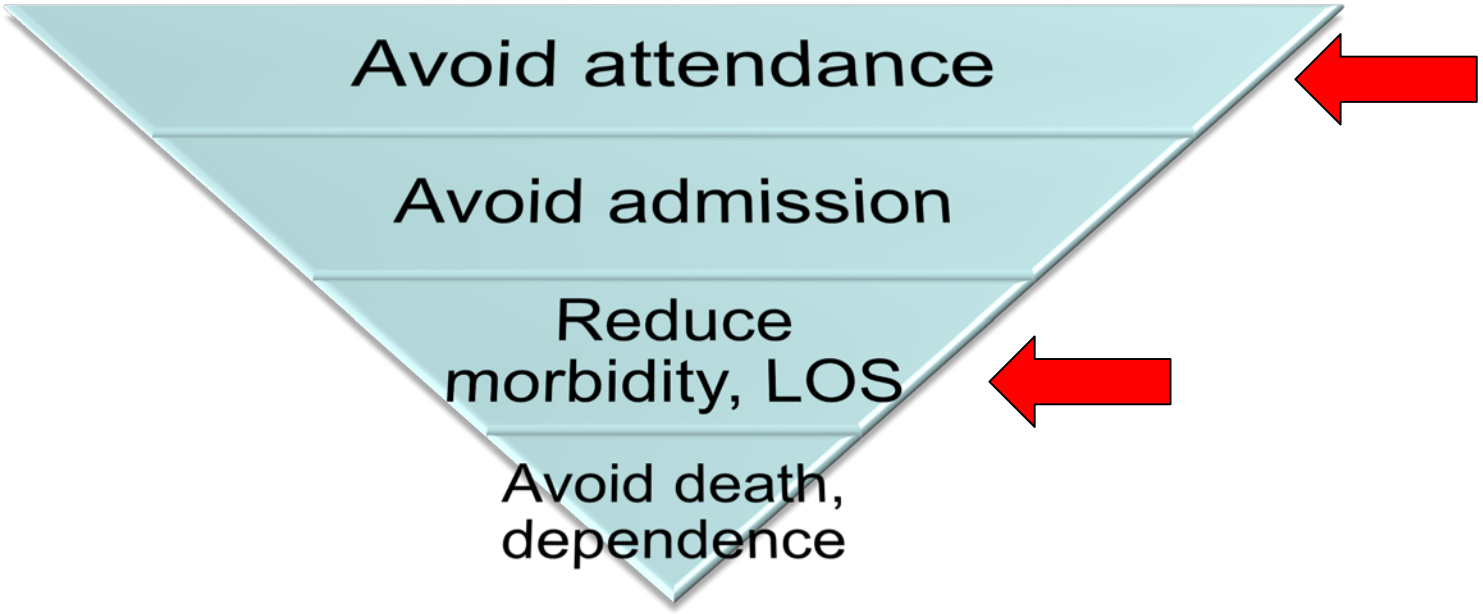

FIONA STANLEY
hospital


Royal Perth Hospital
Emergency Department

The two key topics for today

People dying of and with dementia: can we reduce ED attendance through the use of palliative care principles ?

When admissions occur, can we improve care from the front door to reduce incident delirium?


Avoid attendance
Avoid admission
Reduce morbidity, LOS
Avoid death, dependence

LIVING WELL WITH CHRONIC ILLNESS

22–28 May
National Palliative Care Week 2016

75% of older adults have at least one ED visit in the last year of life, heavily weighted towards the last 3 months

Conservatively, more than 50% of deaths are anticipated

Less than 30% of these >50% receive any form of palliative care

For patients dying with cancer, it has long been known that palliative care reduces hospital use in the last year of life

Emergency Medicine Australasia (2014) ••, ••–••

doi: 10.1111/1742-6723.12215

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ORIGINAL RESEARCH

Understanding emergency department staff needs and perceptions in the provision of palliative care

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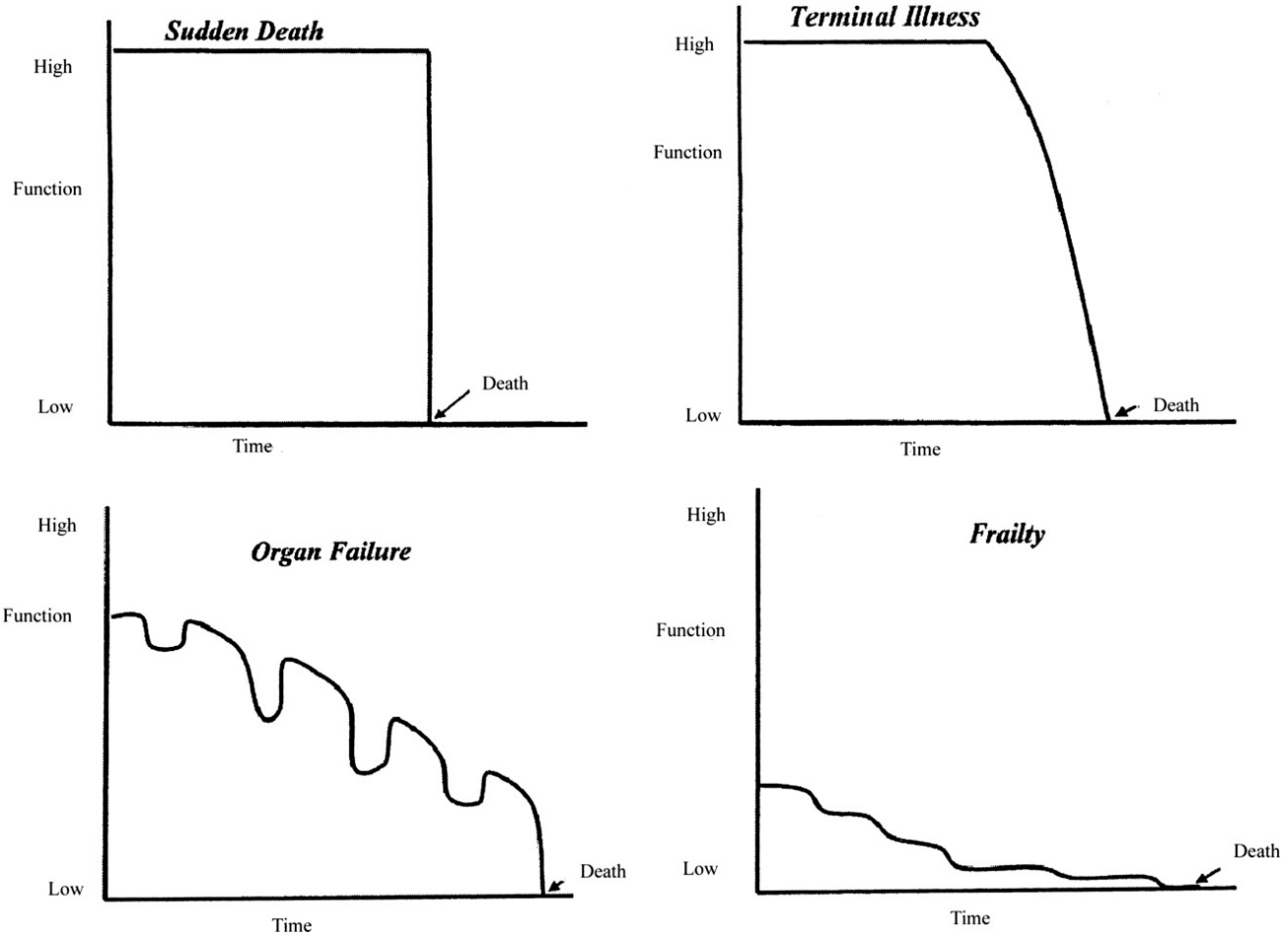
Ischaemic heart disease
Cerebrovascular diseases
Dementia and Alzheimer's disease
Trachea, bronchus and lung cancer
Chronic lower respiratory diseases
Diabetes
Colon, sigmoid, rectum and anus cancer
Blood and lymph cancer
Heart failure
Diseases of the urinary system
Prostate cancer
Breast cancer
Influenza and pneumonia
Pancreatic cancer
Intentional self-harm
Skin cancers
Accidental falls
Hypertensive diseases
Cardiac arrhythmias
Cirrhosis and other diseases of liver

Causes	Amenable
IHD	Lung cancer
CVD	Colon cancer
Lung cancer	Pancreatic cancer
Colon cancer	Breast cancer
Heart failure	Haem cancer

Proposed Trajectories of Dying



Original Article

PALLIATIVE MEDICINE

Community-based palliative care is associated with reduced emergency department use by people with dementia in their last year of life: A retrospective cohort study

Palliative Medicine
2015, Vol. 29(8) 727–736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To describe patterns in the use of ED by people who had dementia in their last year of life and determine whether this was modified by the use of community-based palliative care services.

We compared those dying of or with dementia to a cohort without dementia but dying of other expected causes amenable to palliative care (e.g. cancer, renal failure, heart failure, COPD)

5261 decedents with dementia and 2865 age and gender matched decedents without dementia (median age 87 years, 60% F)

Dementia Cohort	Comparator
63% live in RACF	28% live in RACF
30% die in hospital	50% die in hospital
6% receive any palliative care in last year of life	26% receive any palliative care in last year of life

In last year of life	Dementia cohort, *N* = 5261		Comparative cohort, *N* = 2865	
	n	%	*n*	%
Any ED visit				
No	1421	27.0	679	23.7
Yes	3840	73.0	2186	76.3
Median number of ED visits (IQR)	1	0–3	1	1–3
Mean number of ED visits (SD)	1.9	2.1	2.0	2.3
Range of number of ED visits; min. and max.	0	43	0	29

10 most frequent ED presenting symptoms[a] for dementia cohort

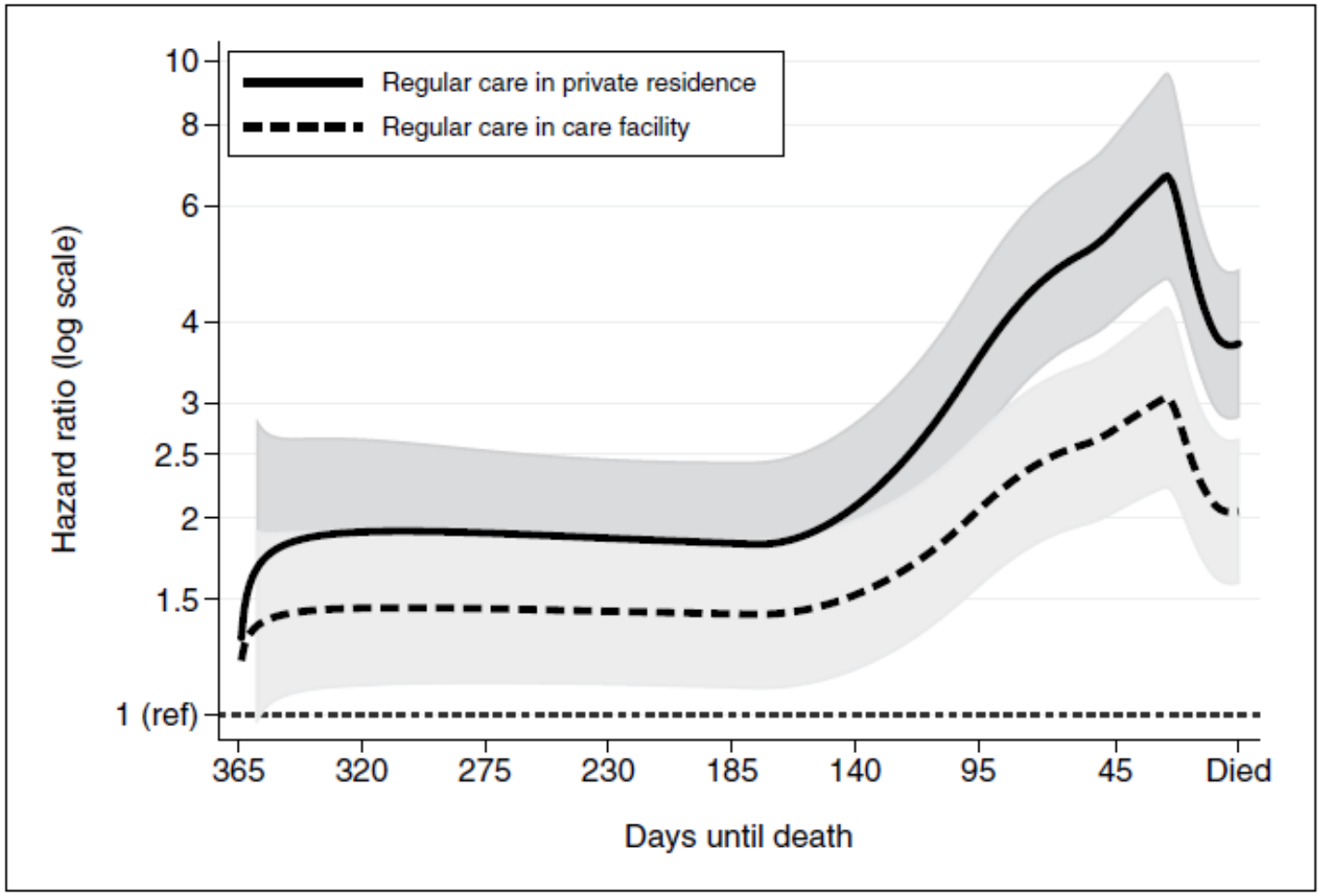
Shortness of breath	711	9.0	707	16.4
Lower leg injury	526	6.7	134	3.1
Altered conscious state	410	5.2	67	1.6
Chest pain	375	4.8	393	9.1
Head injury (includes closed)	305	3.9	62	1.4
Confusion/altered mental state	299	3.8	74	1.7
Abdominal pain	259	3.3	277	6.4
Collapse	247	3.1	116	2.7
Fall	234	3.0	72	1.7
Nausea/vomiting	134	1.7	99	2.3

ED use in last year of life is the norm for both populations

Problem list for dementia sufferers differs significantly

A much higher proportion of people with dementia live and die in RACF

People with dementia are much less likely to receive palliative care


Regular care in private residence
Regular care in care facility
Hazard ratio (log scale)
10
8
6
4
3
2.5
2
1.5
1 (ref)
365
320
275
230
185
140
95
45
Died
Days until death

Palliative care is a highly protective factor against ED visitation for people with dementia in last year of life

People with dementia are much less likely to receive palliative care

What is palliative care?

Care to improve the quality of life by relief of suffering for patients and families facing life-threatening illness. It utilises symptom relief, spiritual and psychosocial support, from diagnosis through death and bereavement.

What does palliative care in dementia look like?

Consider reasons for low uptake of a beneficial intervention:

- ?lack of understanding of dementia as a life-limiting condition
- ?lack of validated symptom scales
- ?resource restraints

Some key general messages

Palliative care ≠ care for cancer. The dying trajectory and care needs of patients dying of other means are frequently unrecognised

Palliative care ≠ withholding care. It is active care with it's own goals.

Palliative care ≠ someone else's business.

Ask family members "Is this a change?"

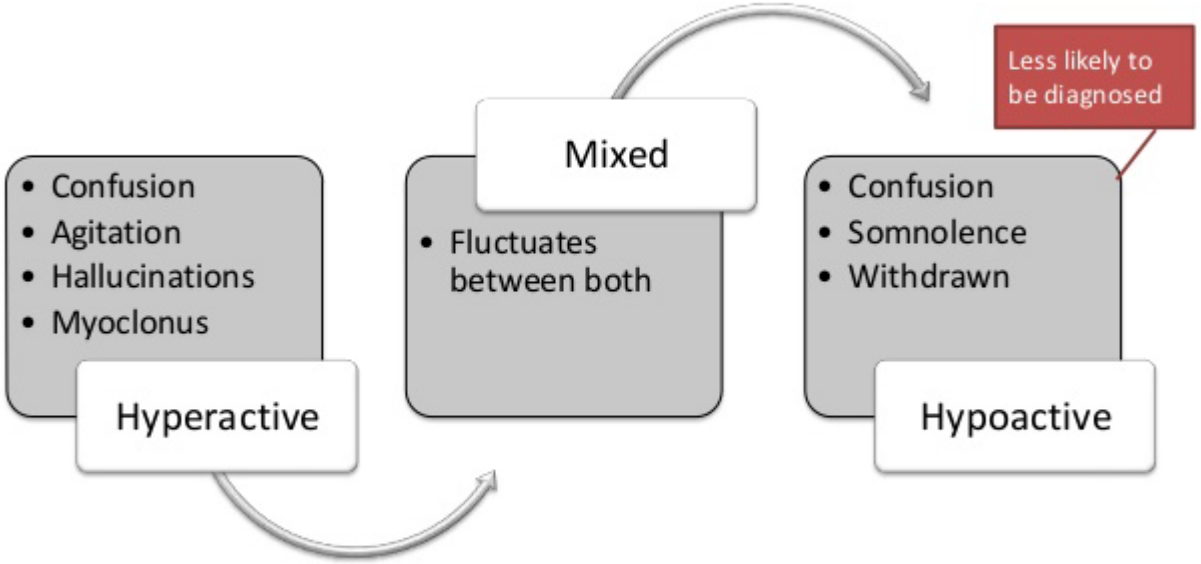
Clinical definition

Short-term disturbance of consciousness (confusion)

characterised by all of

1. Acute onset PLUS
2. Fluctuating course PLUS
3. Inattention PLUS
4. At least one of altered (↑ or ↓) alertness, disorganised thinking or perceptual disturbance

Clinical subtypes

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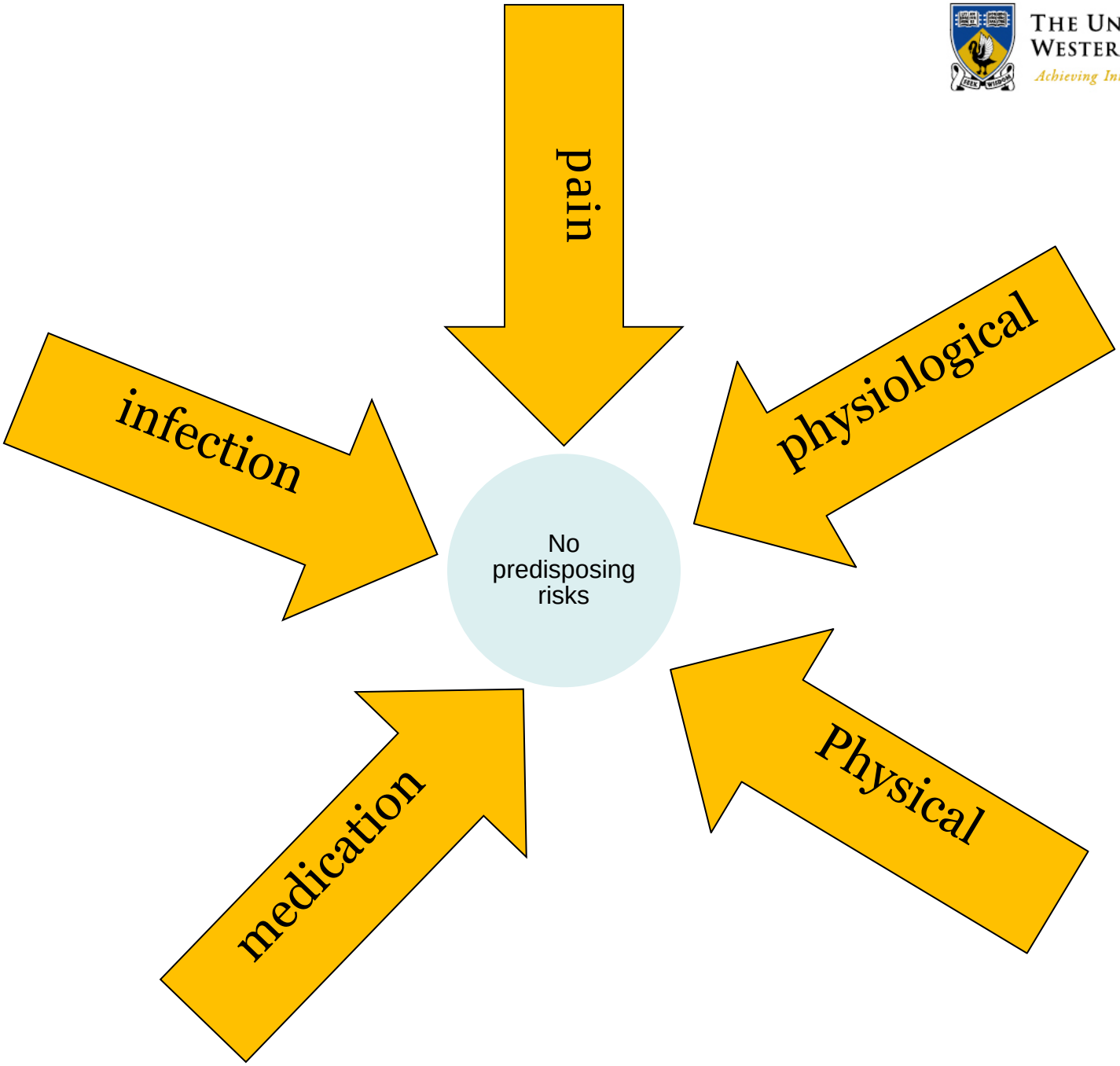
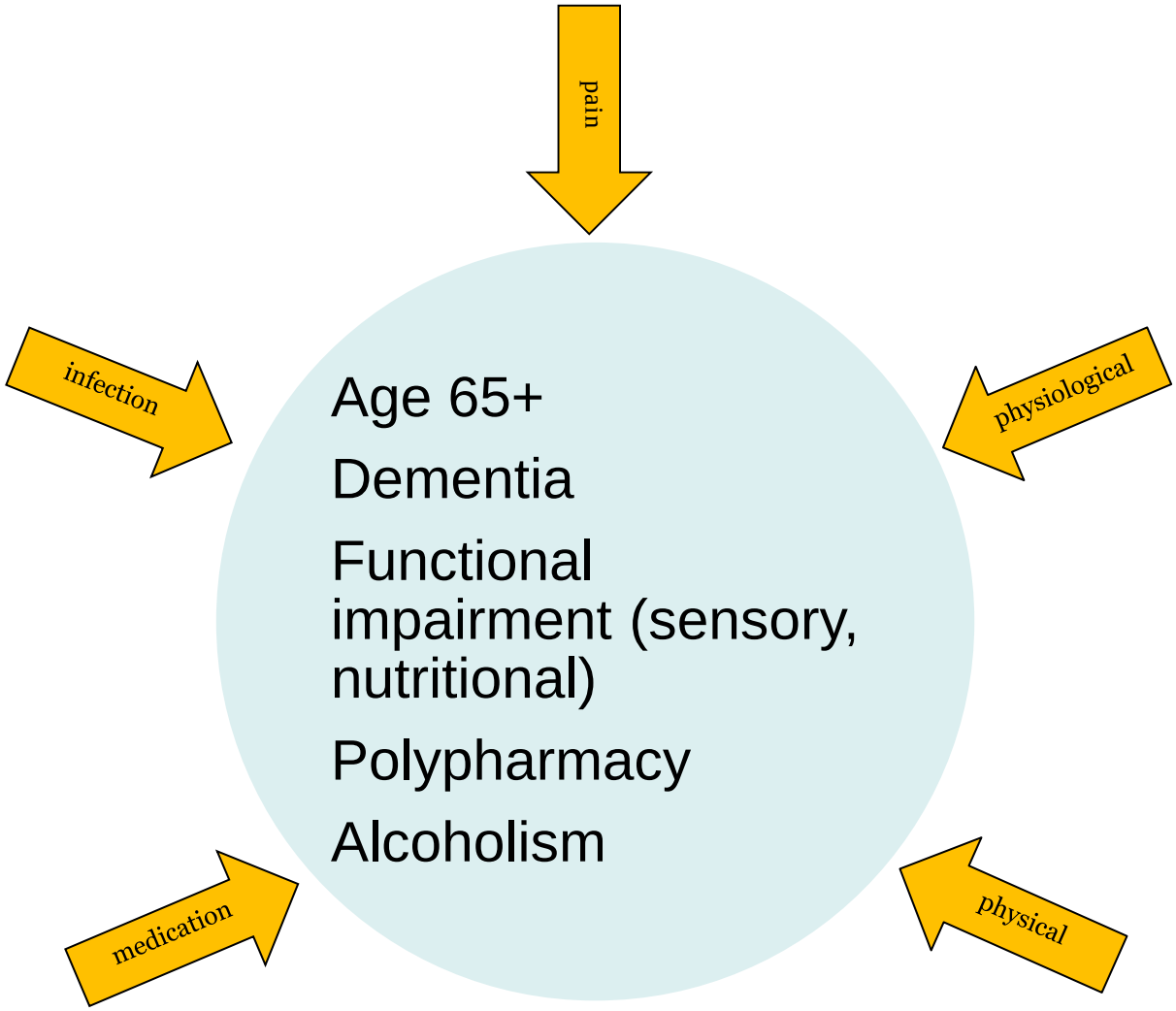
What causes delirium?


pain
infection
physiological
No predisposing risks
medication
Physical


pain
infection
physiological
Age 65+
Dementia
Functional impairment (sensory, nutritional)
Polypharmacy
Alcoholism
medication
physical

What “causes” delirium?

Does delirium matter – EDDI trial results

Characteristic	Delirium negative (n=3477)	Delirium positive (n=414)
Median (IQR) length of stay	3 (1-6) days	7 (3-13) days
% mortality	3%	7%
% newly discharged to RACF	3%	18%
Injurious falls / 1000 patient days	0.8	2.2
In-hosp aspiration pneumonia rate	1%	1%
Sedation usage	4%	17%

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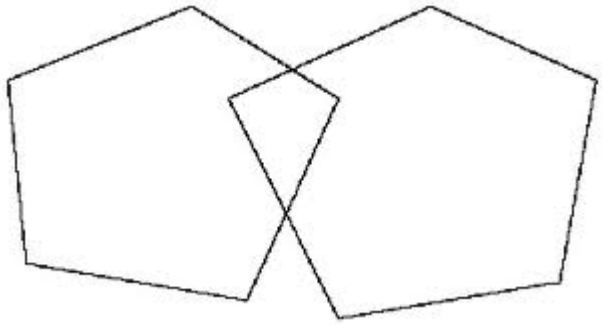
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TRIM D14-43308

Consultation Draft Delirium Clinical Care Standard

STANDARD ONE

A patient presenting to hospital with one or more risk factors for delirium is screened for cognitive impairment using a validated test.



STANDARD TWO

A patient with cognitive impairment on presentation to hospital, or who has a change in cognitive function or behaviour during a hospital stay, is promptly assessed for delirium by a clinician trained and competent in the use of a validated diagnostic tool.

CAM-ICU

stands for

Confusion Assessment Method for the Intensive Care Unit

...

by allacronyms.com

STANDARD THREE

A patient at risk of delirium is offered a set of interventions to prevent delirium.

STANDARD FOUR

A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment

D rugs, drugs, drugs, dehydration
E motion, encephalopathy, environmental change
L ow oxygen, low hearing/seeing
I nfection, intracerebral event or metastasis
R etention (urine or stool)
I ntake changes (malnutrition, dehydration), Immobility
U remia, under treated pain
M etabolic disease

WHAT CAUSES IT?

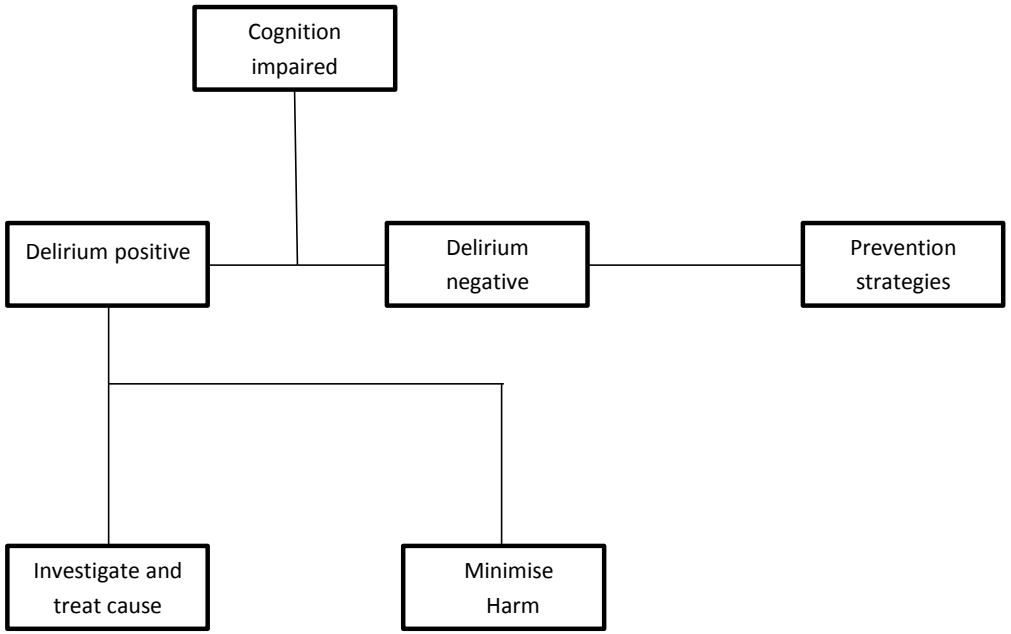
STANDARDS FIVE TO SEVEN

STANDARD FIVE:
Falls and pressure risks

STANDARD SIX:
Minimise use of antipsychotics

STANDARD SEVEN:
Communicate a plan at discharge

Ask family members "Is this a change?"


Cognition impaired
Delirium positive
Delirium negative
Prevention strategies
Investigate and treat cause
Minimise Harm

Remember Delirium Risk

- Reorientation at each contact
- Minimise bed movements
- Falls prevention strategies
- Refer to delirium management guideline

Delirium prevention for all at risk patients

Encourage independence with activities of daily living

Maintain orientation

Lighting that is appropriate for the time of day.

Avoid room/bed changes

Encourage family members to be involved in patient care

Provide clocks and calendars that the patient can see

Provide simple, clear single step instructions

Ensure that spectacles/hearing aids are in place

Avoid/minimise use of bed rails and restraints

Sleep hygiene

Delirium rate by screen result

	Delirium positive	Delirium negative	Total
ED screen +ve	273	702	975
ED screen -ve	135	2748	2883
Total	408	3450	3858

OR 8
LR+ 3.4, LR- 0.4

	Phase 1	Phase 3
Delirium diagnosis rate	**10.1%**	**12.1%**
Screen +ve delirium Dx	26.9%	30.8%
Screen –ve delirium Dx	4.4%	5.7%

Therefore, though delirium detection rate in phase 3 was higher (2% absolute and 17% relative increase) this was not statistically significant (p=0.12) and the relative change in both screen +ve and –ve patients was similar, suggesting some other process change rather than ED identification of the at risk patient was more likely responsible.

Delirium is associated with multiple negative outcomes

¼ ED patients aged 65+ screen positive for delirium risk

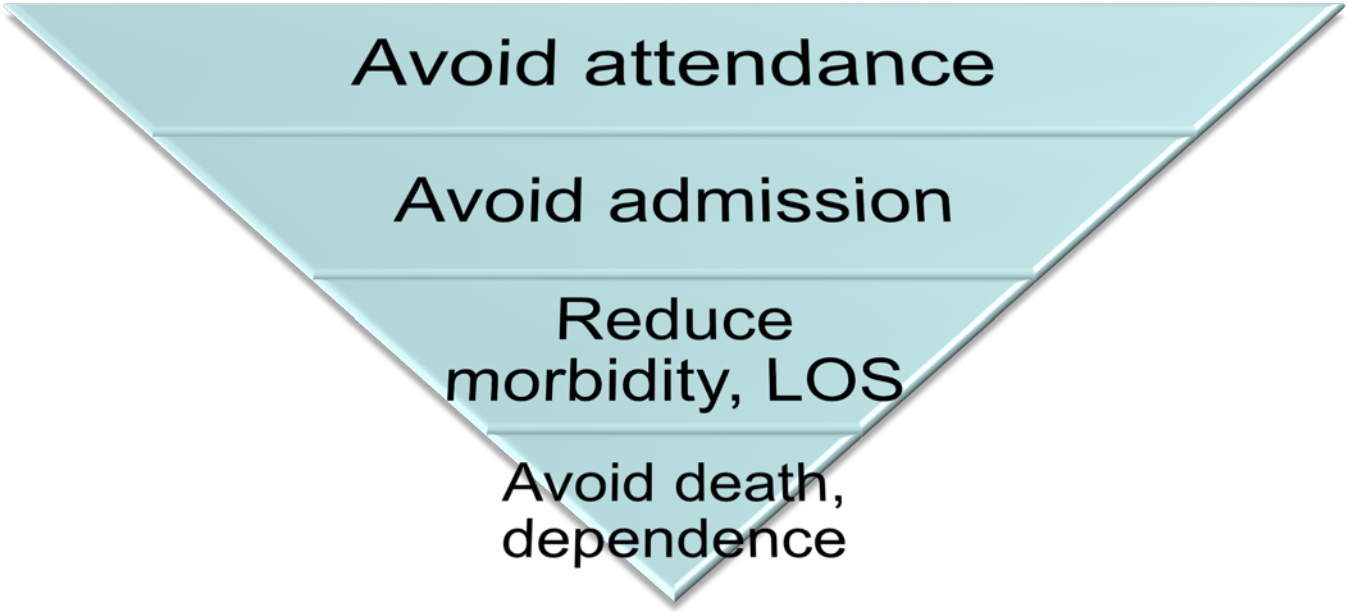
The odds of delirium if you do screen positive are 8 times higher than if you screen negative

Action cards for delirium risk in itself had minimal if any impact

Standardised cognitive screen (standard 1) and delirium assessment (standard 2)

Agree on delirium sensitive measures for patient flow

Commit to caring for cognitive impairment



THANK YOU

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https://www.perkins.org.au/ccrem/team/glenn-arendts/