Geriatric Emergency Network Initiative: GENI 4 hour

January 31,2007

Embedding Care of Acutely Ill Older Adults into Emergency Departments' Orientation

Developed by:

- Adapted from work done for GENI 2-day workshop and the Acute Care Geriatric Nurse Network (ACGNN)
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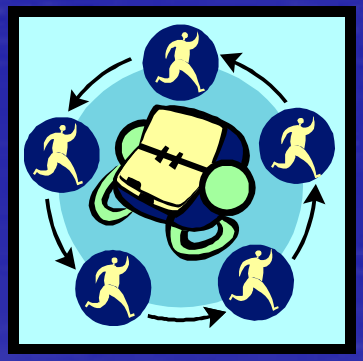
- Marcia Carr – CNS, FH

Train-the-Trainer: Goals

- To improve the care of acutely ill older adults coming into the ER by embedding geriatric/geropsychiatric care principles into all ER nurses' practices
- To assist the nurses who are responsible for orientating, educating and assuring best practice nursing care with GENI 4-hr to lay a beginning knowledge and skills' foundation for care

Today

- Demonstrate and discuss practical ways to implement GENI 4-hr.
- The focus will *not* be on content; rather on suggested ways to do
- Content is provided on CD for you to use as you wish



Time

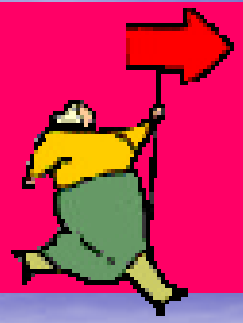
- All in blocked 4 hour time period
- 2, 2-hr blocks
- 4, 1-hr blocks
- Weekly or monthly
- Will be dependent on who can attend and how many times you may need to repeat
- May want to do a “post-test” 3 months later

An Overview (morning session)

- 0800-0845: Introduction; your views
- 0845-1015: Aging, Geri Giants
- 1015-1035: Refreshment Break
- 1035-1120: Strategies to address effects of hospital on vulnerable elders
- 1120-1150: What you can do
- 1150-1200: Evaluation, certificates

An Overview (afternoon session)

- 1230-1315: Introduction; your views
- 1315-1445: Aging, Geri Giants
- 1445-1505: Refreshment Break
- 1505-1550: Strategies to address effects of hospital on vulnerable elders
- 1550-1620: What you can do
- 1620-1630: Evaluation, certificates



Goals

- Recognize the significant differences in presentation between an older adult & a younger adult when they are acutely ill in ER
- Use the M.A.C. Model to analyze the geriatric giants in terms of prediction, prevention, detection and management.
- Describe the inter-relationship of the GERIATRIC GIANTS and their impact on the older adult
- Working towards an Elder-friendly ER

WHY are they different?

- ***Normal Aging plus one or more chronic diseases superimposed upon an acute illness = COMPLEXITY and potential for multiple system adverse effects or failure***

Geriatric Giants

- Predictable problems for the older adult; therefore, often preventable
- Are interrelated and interdependent on each other.
- Require proactive care as one giant will ultimately have impact and effects on all of the other giants.

Food for Thought…

- DNR does not mean DNC (DO NOT Care)
- Nor do any of the other advanced directives infer that we do not treat or do not provide care; especially for acute, reversible conditions

Targeting The Way You Care

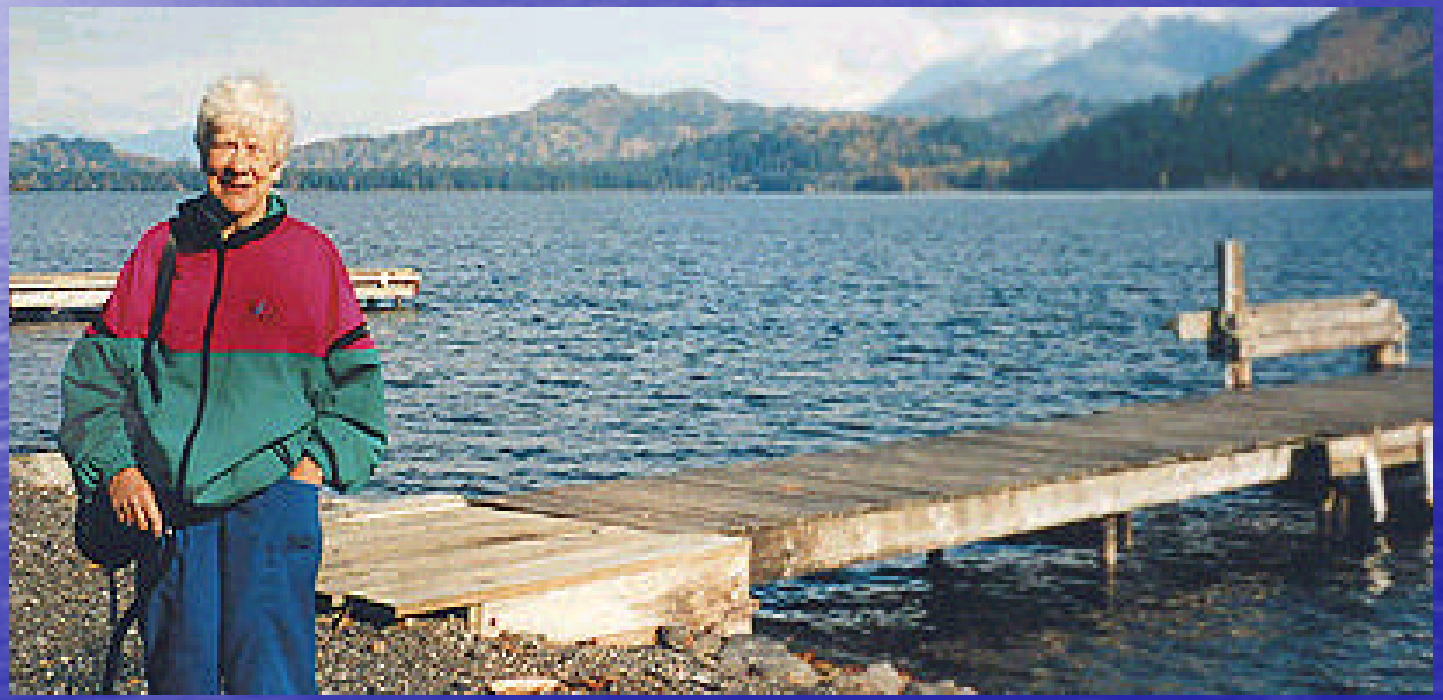
- The MAC Model is a tool to help ER nurses become proactive in their care of acutely ill older adults
- Delirium is a Geriatric Giant that provides a very good example of how the MAC Model can be used to provide proactive care.

Hmmm...

Is this simply nice to know or a need to know?

A Preventable Tragedy?

- Esther Winckler: esthersvoice.com



Caring for Acutely Ill Older Adults

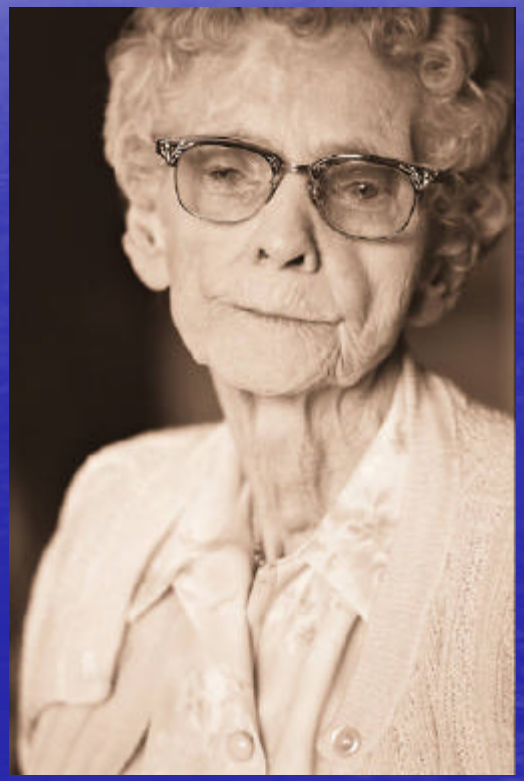
- Ministry of Health, Nursing Directorate
- Acute Care Geriatric Nurse Network (ACGNN) and CNS Collaborative – now in phase 5: HF/CVA and geriatric giants
- GENI 2-day workshop
- Geriatric Emergency Nurse (GEN)
- GENI 4-hour: introduction overview

A “common” scenario

- BCAS arrives with George; 85 yrs; fell off his ladder while cleaning his eaves troughs; suspect he has #’d right arm and ankle. Bruise on forehead.

An accompanying scenario

- Evelyn, 82 yrs; called 911 for George as she saw him fall. She arrives in the second ambulance SOB and nauseated after collapsing.

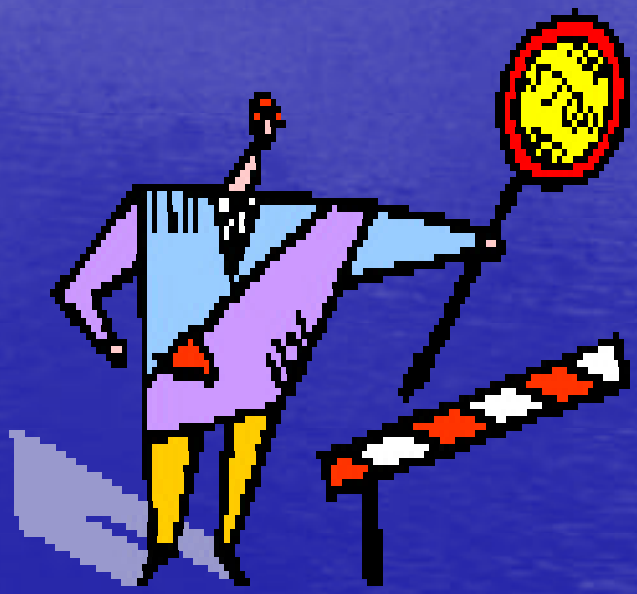


What do you currently do?

- Triage?
- Assessment?
- Plan?
- Are there any RED FLAGS that come to mind when caring for these older adults?

Challenges and Barriers

- What bothers you the most about caring for older adults in the ER?
- What do you think are your current challenges and barriers to caring for older adults in the ER?



What is your thought on...

- Residents transferred from a nursing home to acute care?
- Palliative Care patient coming into ER?
- Making the ER elder-friendly?
- Advanced care directives, DNR? DNR and Advanced Directives are not equal to DNC

Section completed

- Should take about an hour to complete

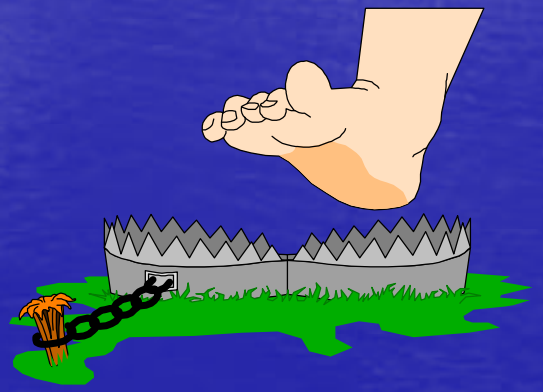
Where do you start?

A conceptual model of care for acutely ill older adults

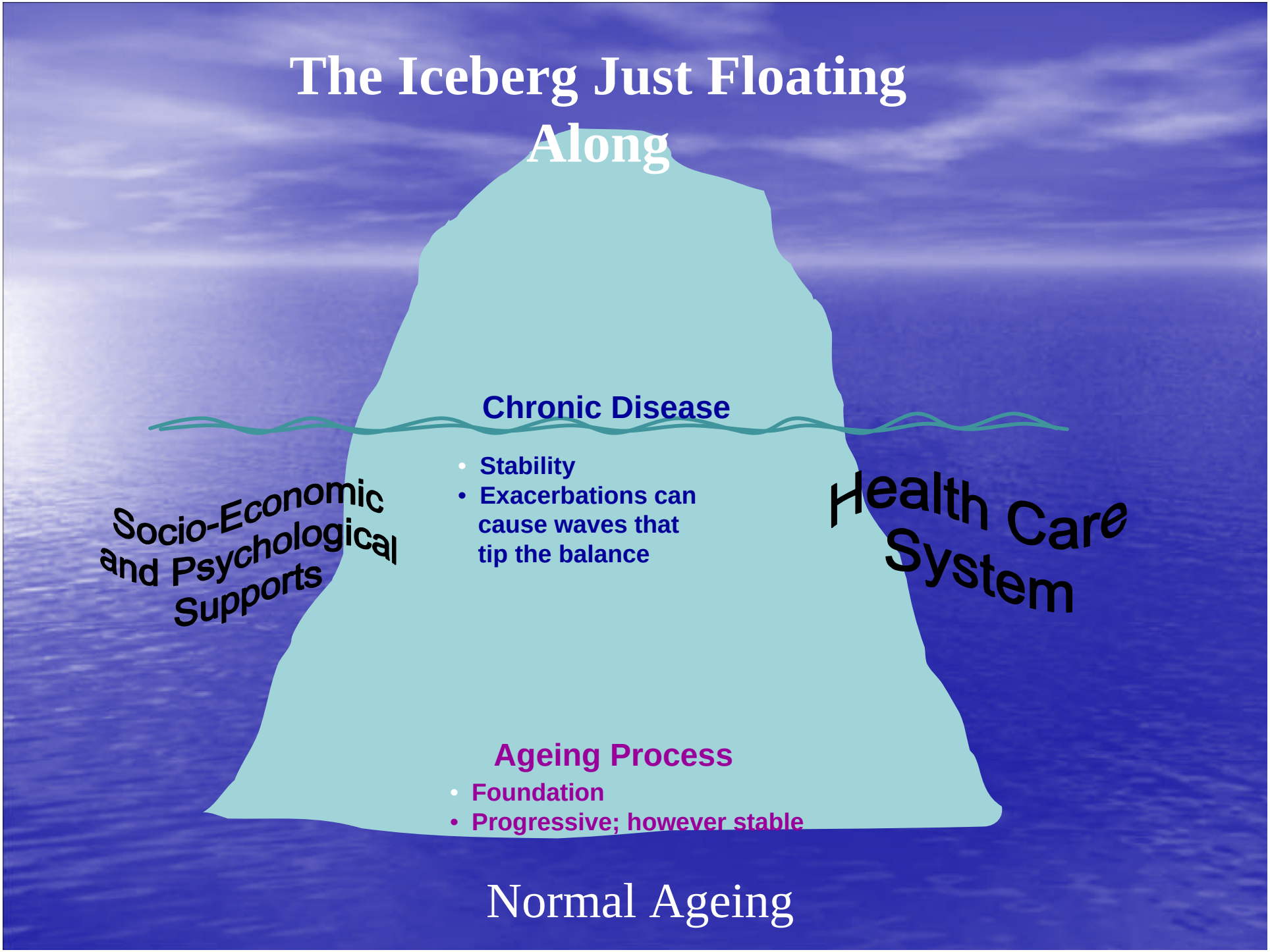
Geriatric Giants!!!

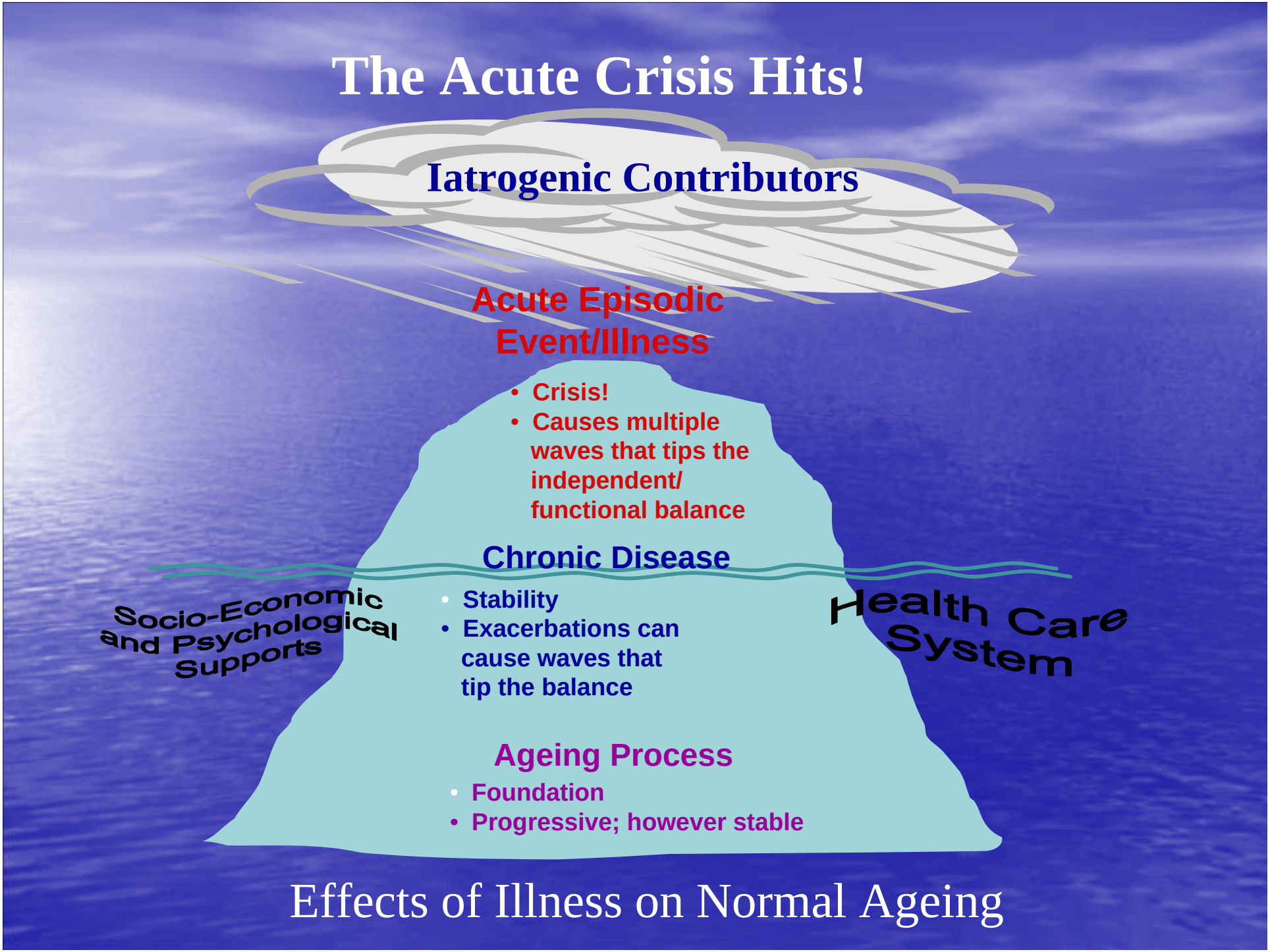
The Foundations

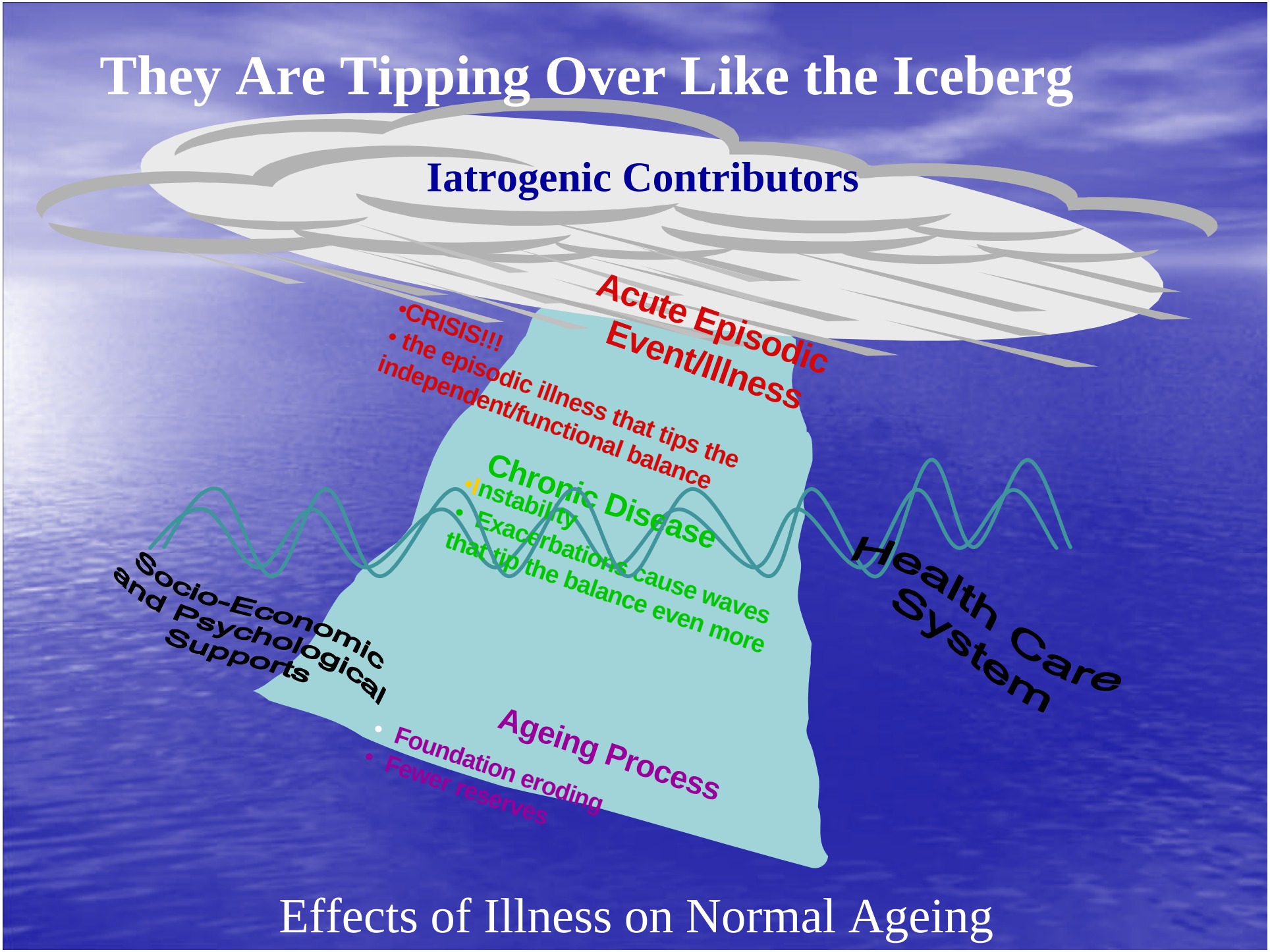
- **The ICEBERG or TRIANGLE and the Geriatric Giants**



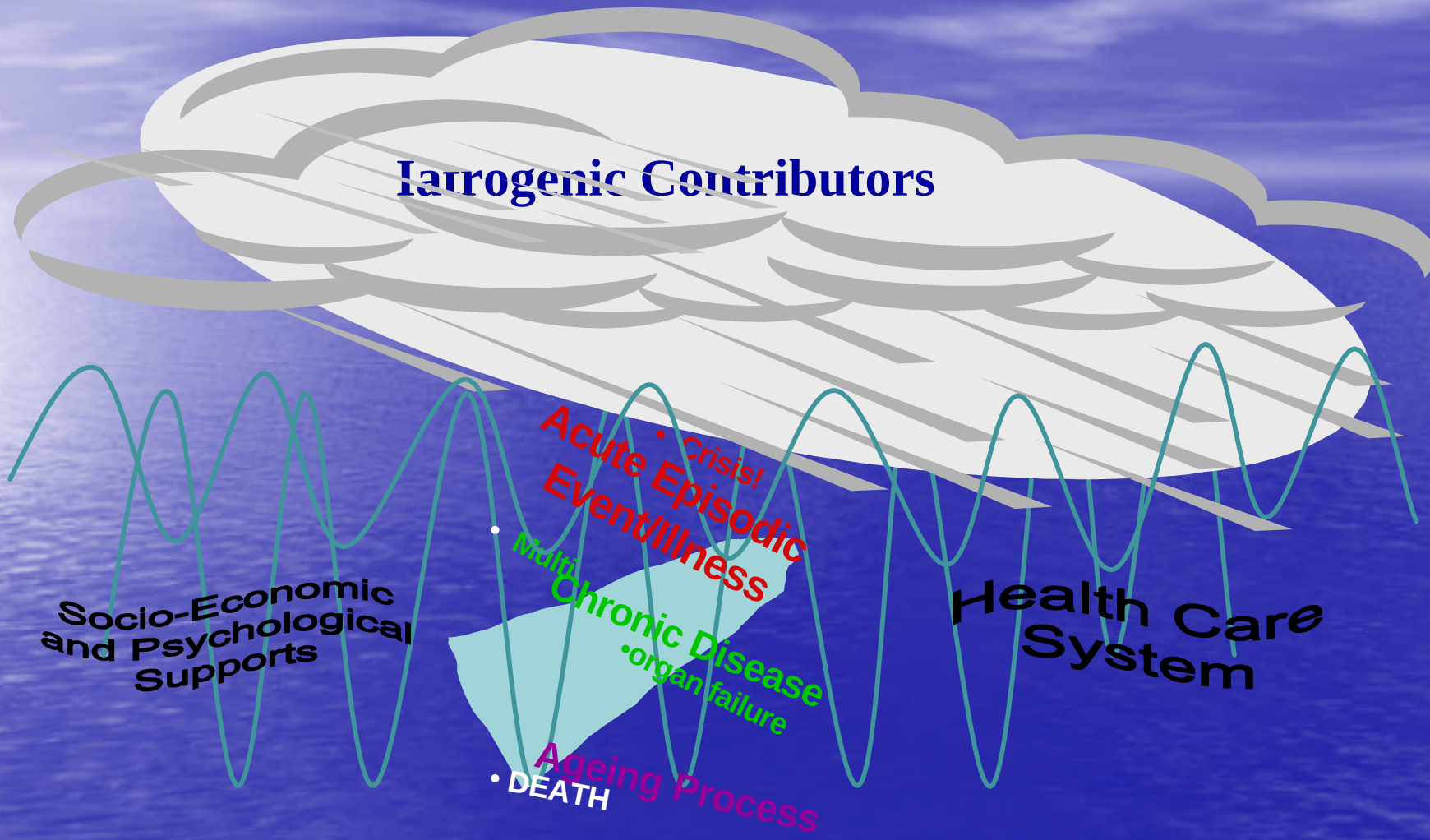
The Iceberg Just Floating Along




The Acute Crisis Hits!
Iatrogenic Contributors
Acute Episodic Event/Illness
• Crisis!
• Causes multiple waves that tips the independent/ functional balance
Chronic Disease
• Stability
• Exacerbations can cause waves that tip the balance
Ageing Process
• Foundation
• Progressive; however stable
Socio-Economic and Psychological Supports
Health Care System
Effects of Illness on Normal Ageing


They Are Tipping Over Like the Iceberg
Iatrogenic Contributors
Acute Episodic Event/Illness
•CRISIS!!!
• the episodic illness that tips the independent/functional balance
Chronic Disease
•Instability
• Exacerbations cause waves that tip the balance even more
Ageing Process
• Foundation eroding
• Fewer reserves
Socio-Economic and Psychological Supports
Health Care System
Effects of Illness on Normal Ageing

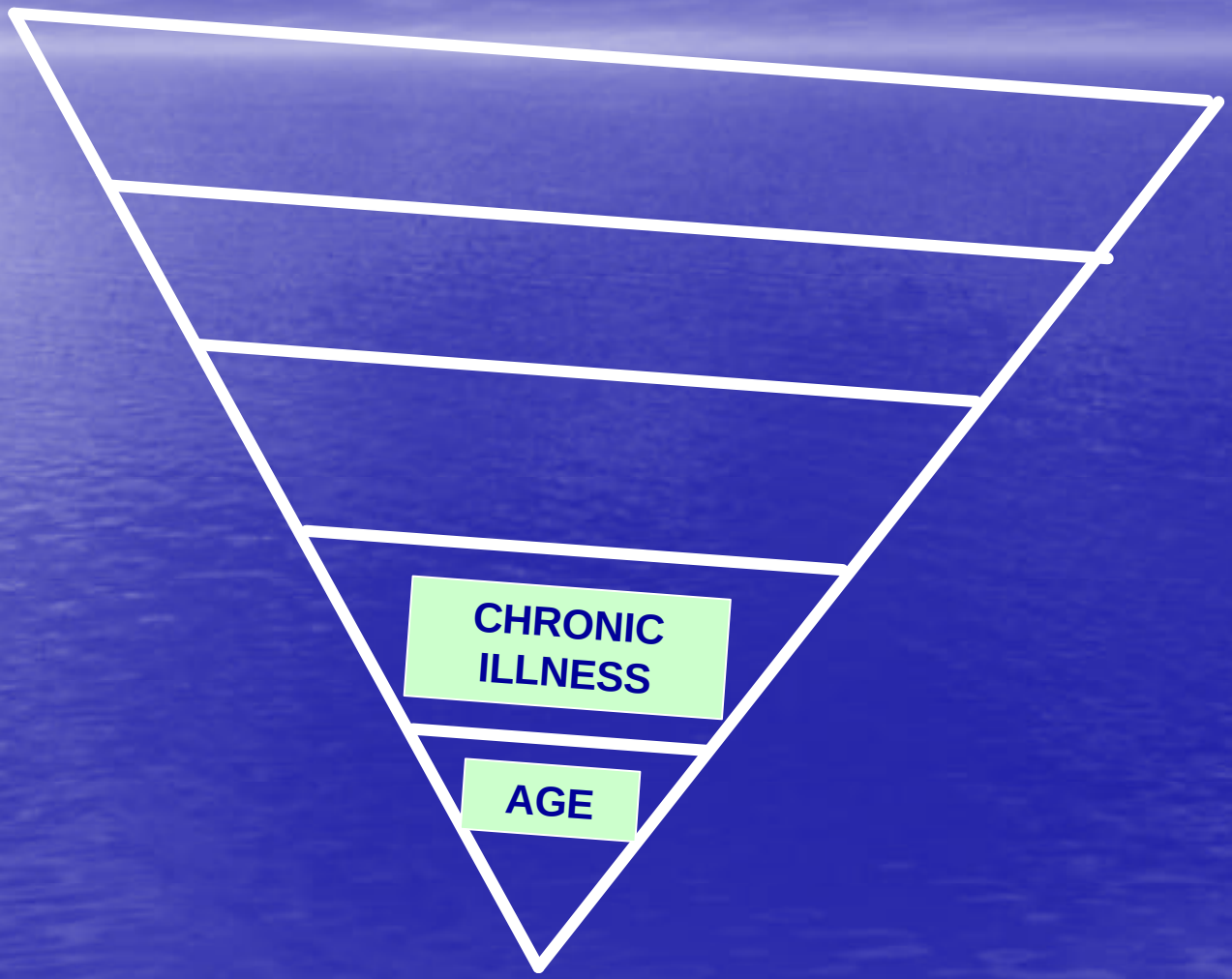
The Iceberg Has Tipped Over and Melted



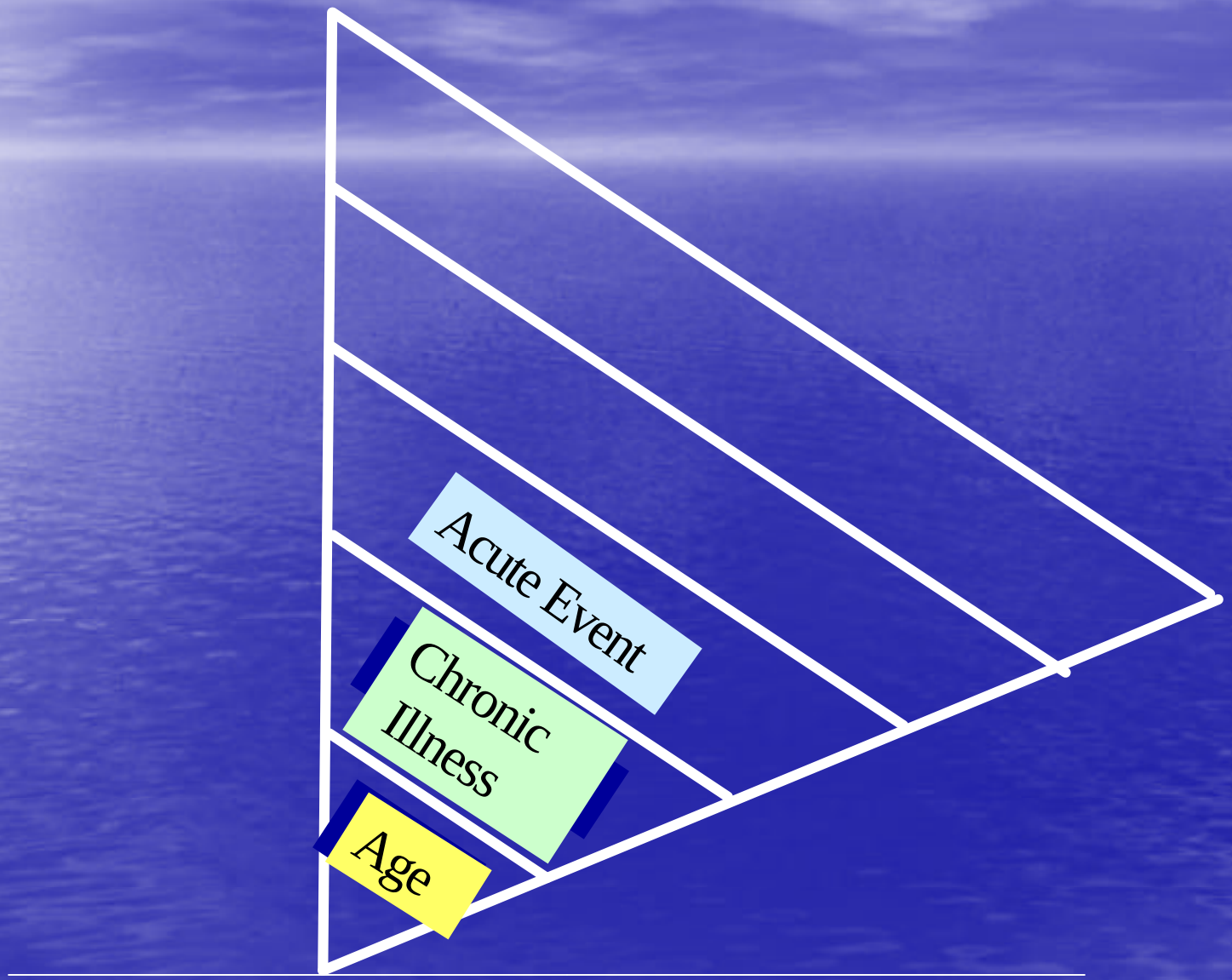
Effects of Illness on Older Adults

The Elderly Person in Balance

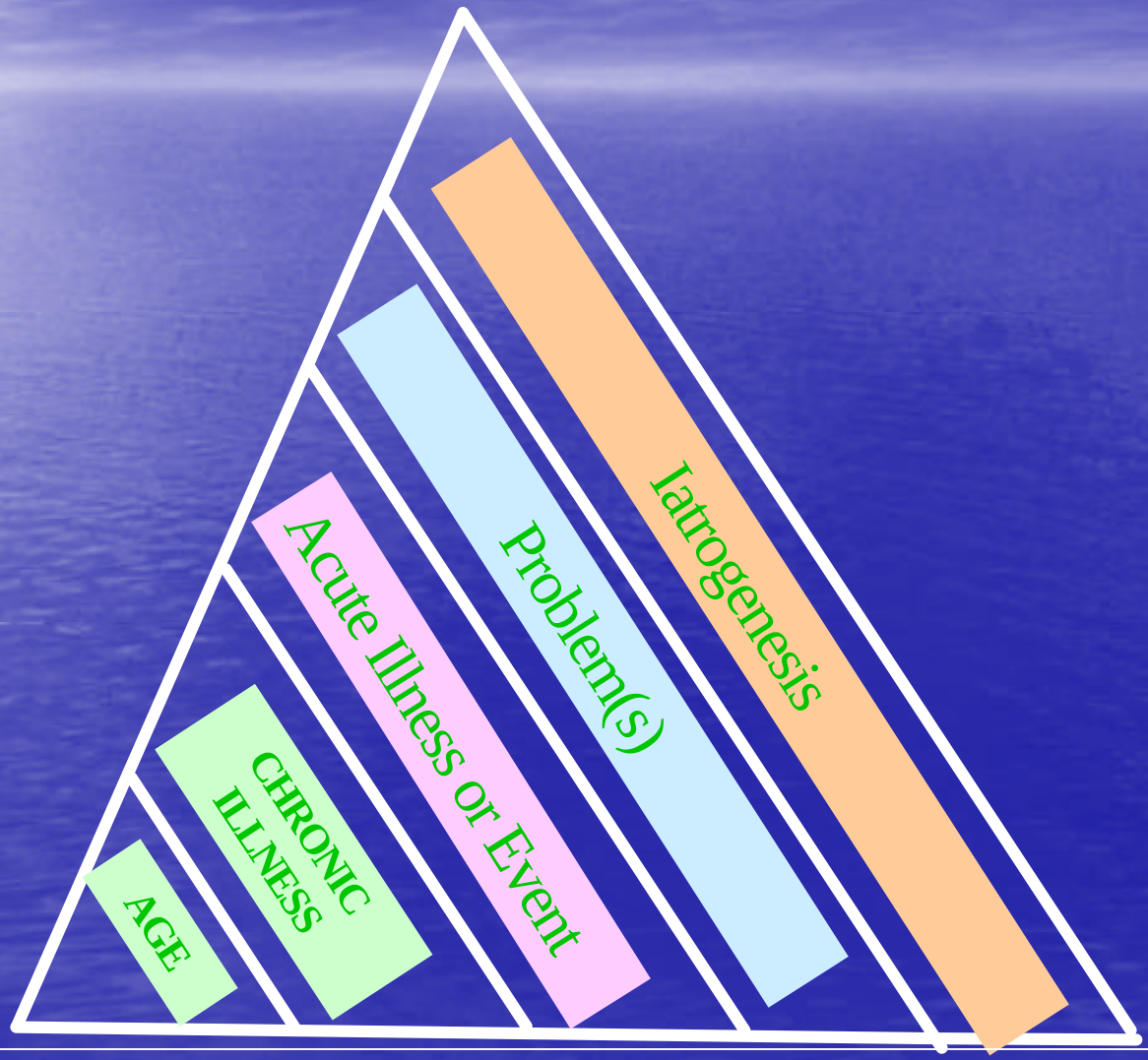
but teetering on the tip of the triangle



Aging + Chronic Illness + Acute Event = Danger



Balance is lost when the triangle is over-burdened



Do you know what is aging and what is not?

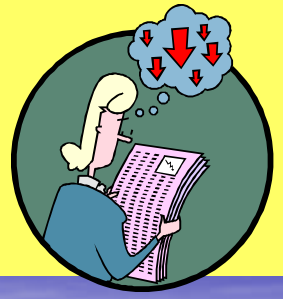
* Assumptions can lead to incorrect diagnosis and treatments

The significance of aging

- Differentiating "*normal" aging from pathology* increases the complexity of assessment and care

- Underlying pre-existing co-morbidities add another layer to the inter-relationships of aging and acute illness r/t stability/instability of multiple disease process and medications

General Aging Changes



- less reserve in all systems;
- presenting symptom may be in the system with the least reserve rather where the pathology lies; eg. delirium may be symptom of heart attack
- System with least reserve – CNS
- Lifestyle or environment affects aging
- Aging begins at 25? OR When we are born??? (cellular level)

Implications for Care:

- Looking closer
- Not assuming “just old” so…must be because of age
- Ask what their weakest “system” is

Nervous System Changes:

- loss of brain/nerve cells; mild memory changes (benign forgetfulness)

- Increased sensitivity to change
- decreased seratonin and dopamine; increased white matter and ventricles
- decreased response time
- difficulty adjusting to temperature changes
- sleep pattern changes: awake early, not as deep

Implications for Care:

- Being patient by waiting for them to think about what you have asked them to do or say
- Warm blankets go a long way!

Genitourinary Changes

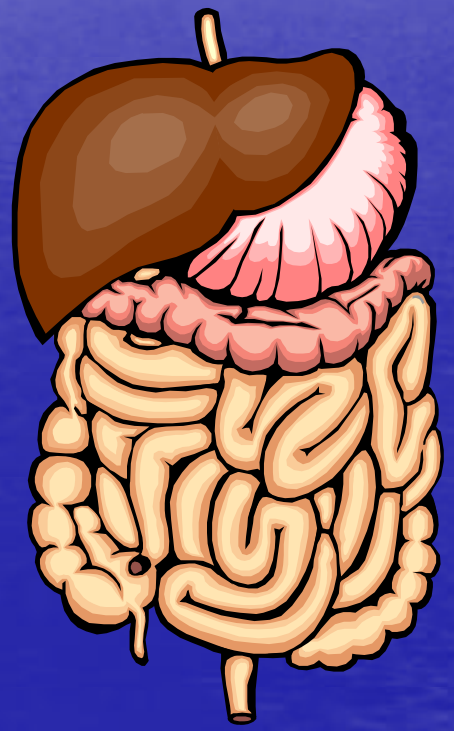
- kidneys less able to concentrate urine
- urine output at night equal or more than day
- Detrusor instability
- reduced production of male/female hormones
- Prostate enlargement

Implications for Care:

- Asking on a regular basis if they need to use the toilet
- Do not assume that they are incontinent

Gastrointestinal Changes

- reduced saliva;
- reduced taste buds
- reduced thirst mechanism
- reduced motility throughout GI system (e,g, GERD, constipation, bowel obstructions)



Implications for care:

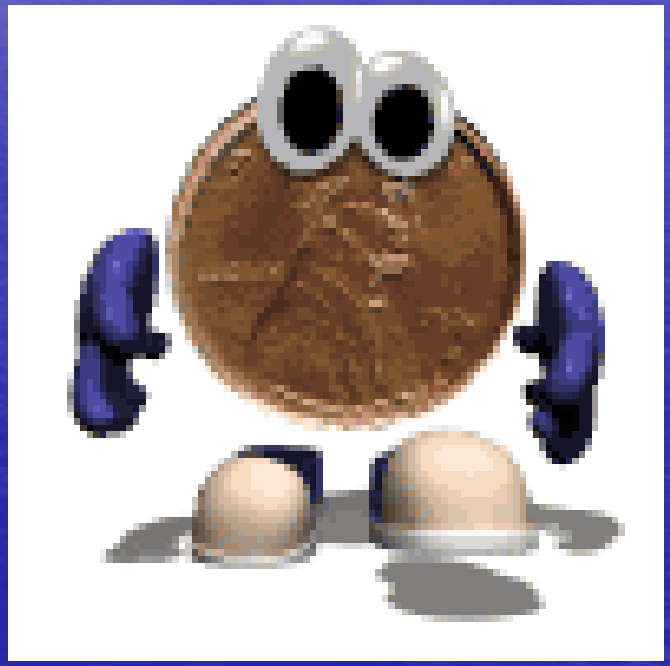
- Balance hydration needs
- Feed them
- ORAL hygiene: teeth and gums
- Check that they are swallowing okay
- Constipation: r/o acute abdomen
- Look for GI bleed!

Musculoskeletal Changes

- Reduced muscular strength and tone.
- Joints stiffer
- Loss of strength, endurance
- Decalcification of bones

Implications for Care:

- Need to keep them moving
- Quick Mobility Test
- Safe mobility and FUNCTION will determine discharge home ability



Skin Changes

– loss of underlying subcutaneous fat tissue

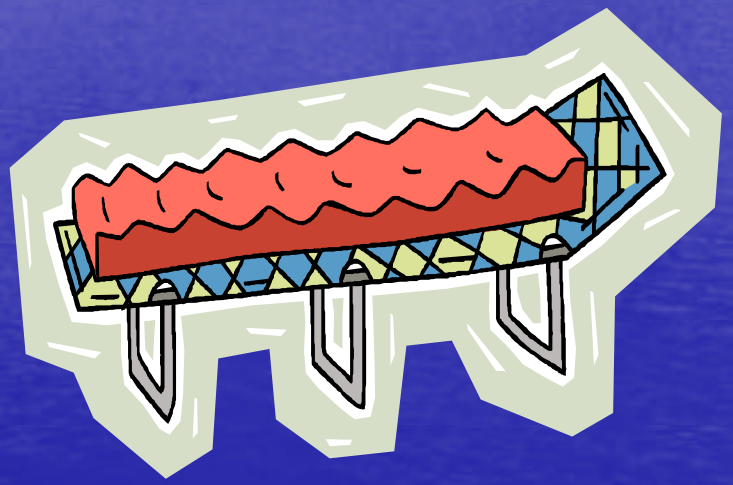
- reduction in oil production

- thinner and dryer

- Poorer thermo-regulation

Implications for Care:

- Pressure relief mattress
- Prevent shearing or friction when moving them
- Pressure ulcer can start within 20 minutes on inappropriate surface



Cardiovascular System

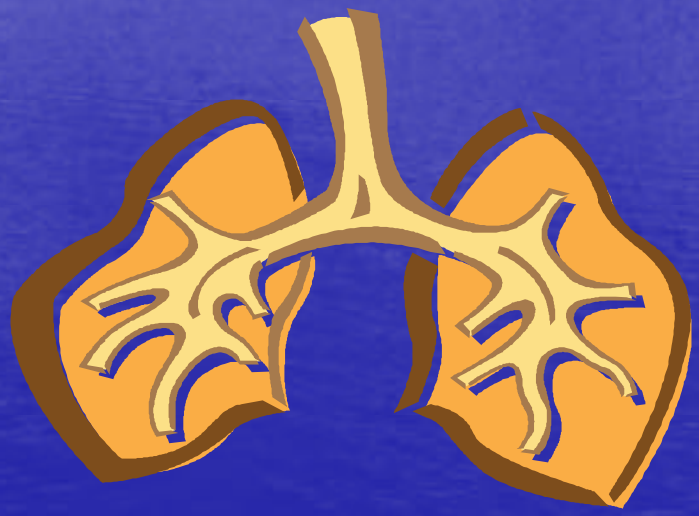
- Increase HR, Decreased pacer cells in SA node
- Baro-receptors less sensitive, Arterial stiffening,
- Venous wall less elastic/ thicker - Venous stasis
- ↑ susceptibility to arrhythmias
- ↑ BP affects ↓ cerebral blood flow
- Hypo or hypervolemia will contribute to cardiac decompensation,
- ↓ ability to mount compensatory tachy

Implications for Care:

- Looking for the atypical presentation of MI (e.g. delirium, SOB, indigestion)
- Suspect and look for TIA as warning sign for CVA

Respiratory Changes

- rib cage less flexible
- lungs less elastic
- less air enters and leave
- tend to be shallow breathers

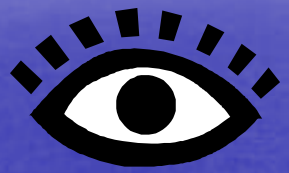


Implications for Care:

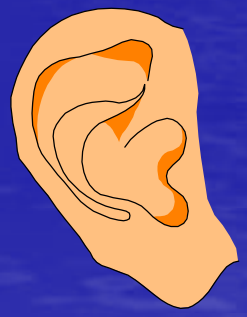
- Doing O2 sats
- Try to care for in 30-45 degree angle in bed to decrease potential for positional de-saturation

Sensory Changes

- **Visual**:
  - lens becomes rigid (far sighted, reduced adaptation to changes in light)
  - pupil smaller, rigid iris - increased darkness adaptation time

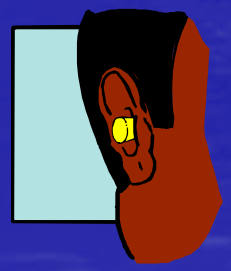


- **Auditory**
  - most severe changes in inner ear - reduced sensitivity to sound, and understanding of speech, deficits in equilibrium
  - wax becomes thick & dry



Implications for Care:

- Speak slowly at level of hearing that patient indicates is audible
- PLEASE clean and put on glasses
- PLEASE put in “working” hearing aides. (batteries/clean; *pocket talker*)



Immune System Changes

- ↓ helper T cell response & antibody prod
- ↓ antibody response to new antigens
- Involution of thymus - ↓ cell-mediated immunity
- More susceptible to infection
- ↓ febrile response to infection
- Infection leads to delirium
- Determine baseline temp

Implications for Care:

- Check for Flu and pneumonia vaccination status
- Hydrate
- May not have a fever so check baseline

Psycho-Social Changes

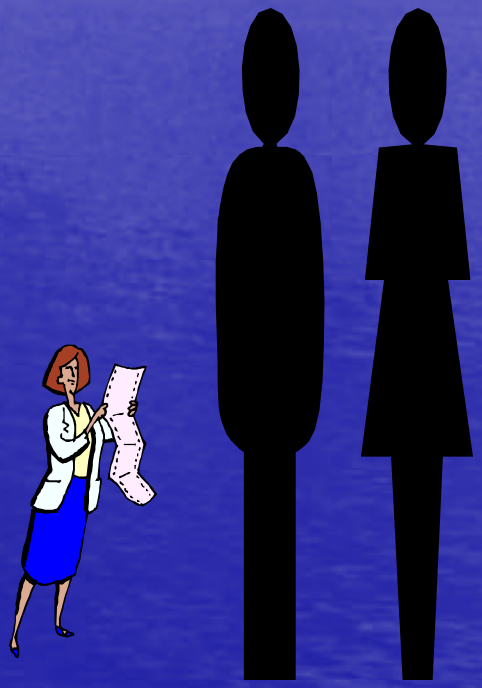
- Increased stressors from multiple losses (e.g. spouse, friends, family, income, health, independence)
- Spirituality
- Examining one's own mortality
- Valuing quality of living and life goals

Implications for Care

- Do not make assumptions of person's life or death choices; especially based upon age or health/illness status
- Individually personal decisions and choices that warrant respect
- Ask the patient FIRST and do not assume that somebody else should or would speak for them.

The Geriatric Giants

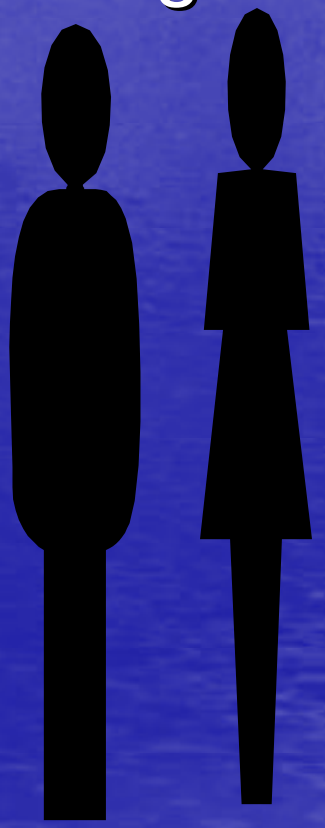
- **The major conditions/disorders/syndromes that can contribute to acceleration of biopsychosocial decline in older adults**
- **Factors which produce tiers of disability in the cascade toward dysfunction and the pathway to dependency**



(Creditor, M. (1993). Hazards of Hospitalization of the Elderly. Annals of Internal medicine, 118(3), 219 – 223)

Geriatric Giants

- Delirium, Depression, Dementia, Drugs
- De-Conditioning
- Falls
- Pain
- Incontinence
- Malnutrition/Dehydration



Geriatric Giants: Put Seniors at Risk for…

- Dependence/ Decreased Quality of Life
- Pain/Suffering
- Altered Cognition
- Restraints/Falls
- Skin Breakdown
- Increased Chronicity
- Excess disability
- DEATH

The Model for Accountable Care
"The MAC"
Proactive NOT Reactive Care

Prevention, Early Detection,

Evidenced Based Management,
Monitoring/Evaluation

Model for Accountable Care (M.A.C. Model)

- Predictable problems (the Geriatric giants) delay recovery from acute illness and result in added morbidity, mortality and functional decline

- The Geriatric Giants are, to a very large extent, predictable problems

MAC Model: Underlying Beliefs

- Predictable Problems for the elderly must be:
  - **Prevented**
  - **Detected**
  - **Managed in an evidence-based and timely way**
- ***Ask:*** Can we predict this? Can we prevent, detect and manage this problem in an evidence-based and timely way?

MAC Worksheet

Giant (issue) Is this a predictable problem?	**Prevention – how can you prevent or minimize before it take hold**	**Detection – how will you know it is manifesting.**	**Evidence Based Management**	**Evaluation** What are the desired outcomes you will measure against.

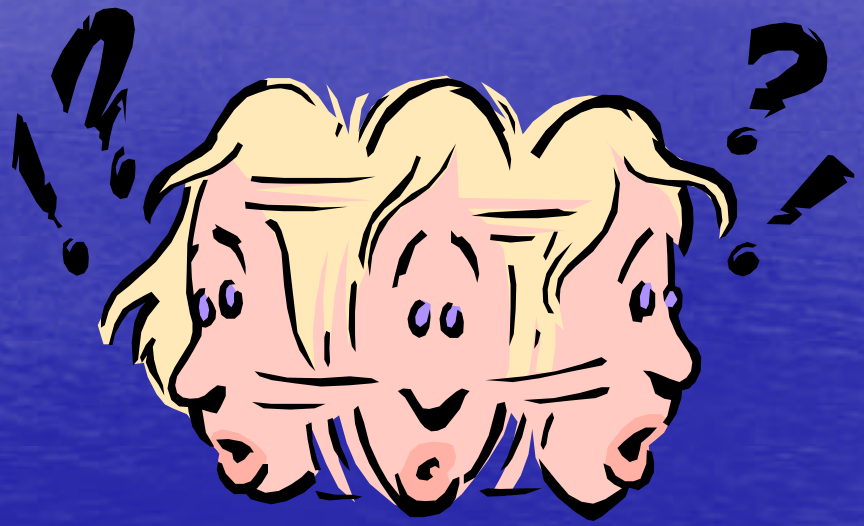
Applying the MAC Model

Geriatric Giant:

DELIRIUM

Delirium

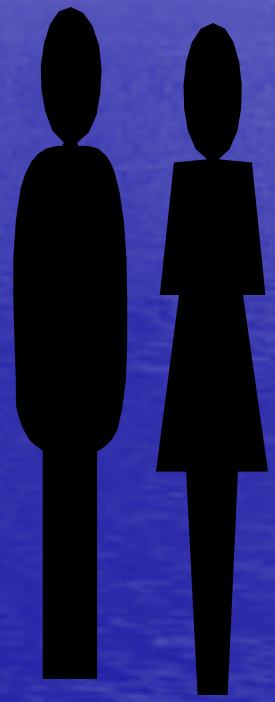
- A common and often predictable problem for the elderly
- A MEDICAL EMERGENCY!
- Provides an excellent example of how we can use the MAC Model to help us be pro-active about care of the acutely ill older adult



Delirium: What is it?

- transient organic or mental syndrome; differentiate from dementia
- characterized by:
  - a global disorder of cognition and attention, a altered level of consciousness
  - abnormally increased or reduced psychomotor activity
  - disturbed sleep-wake cycle

(Lipowski, 1989)



Delirium: Two types

- **Hyperactive:** agitated, restless or combative

- **Hypoactive:** lethargic, difficult to rouse (Note: higher mortality rate)

May alternate between agitation & lethargy

Is Delirium a Predictable Problem?

Delirium: Predictable?

- 15% over 60yrs of age are delirious at any time in acute care
- 80% have symptoms 6 months after initial onset
- If is delirium present, the older adult has a 22% - 76% chance of dying during hospitalization
- Delirium is the most common complication of surgery - incidence 36.8%

Delirium: Most Common Predictors

- cognitive impairment
- Age >80
- co-morbidities
- physical restraints
- catheter
- malnutrition
- psychoactive medications
- >3 medication in 24 hours
- immobility

Can Delirium be Prevented?

Avoid the Most Common Causes When Possible

- uncontrolled pain
- hypoxia
- severe illness
- infection
- electrolyte imbalance
- fluid & electrolyte imbalance
- surgery
- visual/hearing impairment
- constipation

Can Delirium be Detected?

Delirium Screen: The CAM (Confusion Assessment Method)

Diagnosis of delirium requires the presence of features 1 and 2 & either 3 or 4:

1. Acute Onset and Fluctuating Course
2. Inattention
3. Disorganized Thinking
4. Altered Level of Consciousness

(Inouye et al, 1990)

1. Acute Onset and Fluctuating Course

- Is there evidence of an acute change in mental status from the patient's baseline?
- Does the behaviour fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?
  - **Best if you can obtain information from a family member.**
  - **Need comparison from previous time (another staff member? Has he changed?**

2. Inattention

- Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

3. Disorganised Thinking

- Was the patient's thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

4. Altered Level of Consciousness

- Overall, how would you rate this patient's level of consciousness? Alert (normal); vigilant (hyper-alert), lethargic, (drowsy, easily aroused; stupor (difficult to arouse), or coma (not arousable).
- Anything but alert is not normal

Waszynski, C. (2002). Confusion assessment method (CAM). Journal of Gerontological Nursing, April, 4-5.

Delirium: The rest of the screen for cognitive impairment

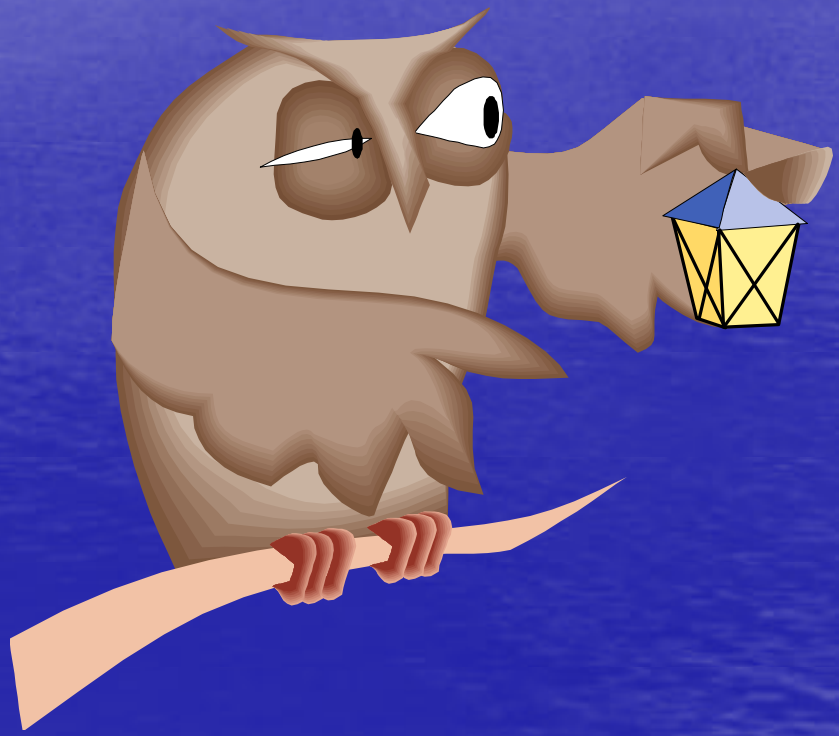
- disorientation: location, time of day
- memory impairment?
- perceptual disturbances? hallucinations, illusions
- psychomotor agitation: restlessness, picking?
- psychomotor retardation: sluggishness, staring into space?
- altered sleep-wake cycle: sleep in day, insomnia at night?

Identifying Delirium

- Requires establishment of a baseline cognition and full physical work-up
- Preferable on admission; however, do screen if sudden change in cognition.
- MMSE - helpful or not?
- If your patient has dementia, will have a *greater* likelihood of developing a delirium

Delirium Watch!

- Screen all older adults for potential for delirium
- Identify through use of CAM tool



Can Delirium be Managed?

Look for Common Causes and Treat

PRISM -E

Pain

Retention, urinary

Infection, **I**mpaction, & **I**mmobility

Sensory impairment, **S**leep deprivation

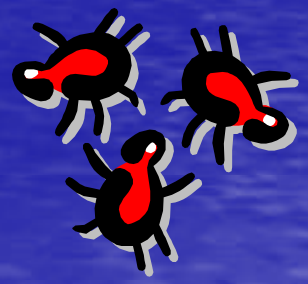
Medications, **M**etabolic imbalance (hypoxia, Na, K, Ca; dehydration- vomiting, diarrhea, poor fluid intake)

Environment

Common Causes: Drugs or Bugs

Examples of common causes:

- medications: (Beer's List)
  - Most common cause (especially sedatives, anticholinergics, narcotics, cimetidine, cipro., NSAIDS,)
  - withdrawal - alcohol, benzos, nicotine
- urinary tract infection, pneumonia



Managing Delirium

- correct any of the contributing factors found
- correct visual & hearing defects
- adequate lighting at night
- environment: not too hot/cold/noisy
- identify triggers: routines, personal care, other behaviours, boredom
- increase environmental stimulation
- reorientation with clocks, calendars
- plan for correcting sleep disturbance

Delirium Management:Drugs

- Used when the safety of the patient or others is at risk
- Used to correct sleep disturbance, hallucinations, delusions
- No ideal medication
- Use lowest dose possible for shortest time possible
- Benzodiazepines not recommended except for alcohol withdrawal

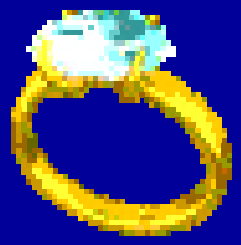
Pharmacological Management

- Loxapine 2.5mg - 5mg PO q 1 - 4 hours or once daily: titrating up to 20 mg /day (for frail, small) in bid - qid as tolerated. Can be used as PRN q2h with same maximum.
- Loxapine for correction of sleep disturbance - 1600 dose of 2.5 mg and a similar or slightly higher dose at 2000 plus PRNs
- check for orthostatic hypotension, watch for unsteadiness & falls

Delirium: other medications that can be used

- Risperidone: Not as effective as PRN
- Olanzepine 1.25–2.5 mg; max. 7.5 mg qhs
- Quetiapine☹more sedating) 25 mg to max. 200 mg bid
- haloperidol : not used often due to high incidence of extrapyramidal symptoms
- methotrimeprazine (Nozinan) very sedating, very anticholinergic

GEMS!!!



- If the patient has Lewy Body dementia DO NOT use antipsychotic medications as they will make the behaviour worse.
- Sleep improvement is essential so the use of Trazadone at low dose can help
- Cautious use of anti-psychotics in patients with known seizures, CVD (e.g. stroke)
- R/O PAIN as the underlying cause of the unsettled behaviour

Delirium: Key Points

- common and deadly: a medical emergency
- preventable
- use CAM for early recognition
- search for common causes
- use non-pharmacological management
- use pharmacological strategies only if dangerous to self or others or to correct sleep disturbance

Delirium Summary

Delirium is:

- Predictable problem – Be on “Delirium Watch”
- Preventable: Avoid common causes
- Detectable: Use the CAM
- Manageable: Identify & treat common causes

Presenter note

- The next slides are BRIEF summaries of common Geri Giants
- This may take an additional amount of time depending on questions that may arise
- Remember that this is just a VERY SHORT OVERVIEW!

Slaying the Geriatric Giants!

The “D’s”

- Delirium, dementia, depression, delusions, de-conditioning, drugs...
- Underlying heavy-weight “giants” to most geriatric cascades of decline
- 3 D’s are labeled and perceived as unsettled, difficult or challenging “acting out” behaviours that distressing to the patient and interferes with staff’s ability to care

Differentiating Delirium and Dementia

	Delirium	Dementia
Onset	Rapid (hours, days)	Slow (months, years
Symptoms	Fluctuate over course of day	Relatively stable
Duration	Days to weeks	Years
Level of consciousness	Fluctuates with inability to concentrate	Sleep may be fragmented
Sleep/wake cycle	May be reversed	Sleep may be fragmented

Look for Delirium first: Why?

- predictable problem for acutely ill elderly
- 15% over 60 are delirious at any time on acute care;
- higher if pre-existing dementia
- any infection, (eg. UTI, pneumonia) can trigger delirium in the elderly
- under-recognized/diagnosed (physicians 50%; nurses 70%)
- delirium is MEDICAL EMERGENCY – don't want to miss it

Geriatric Giant: Dementia

Dementia means:

- **brain failure**, the inability of the brain to function normally
- refers to a loss of intellectual ability sufficient to interfere with the person's daily activities and social or occupational life

Molloy & Caldwell, 1998

Dementia is a **syndrome:** (cluster of symptoms) including:

- chronic progressive memory loss
- problems with higher cognitive (thinking) function
- personality changes
- behavioural symptoms

Drance, 2000

Can Unsettled Behaviour Be Prevented?

Use principles of care

- Decrease threats, promote the familiar
- Provide structure, promote predictability
- Enhance existing abilities
- Compensate for existing abilities

Karen Kline, CNS/Gerontolgy

Use standards of care that have been developed

- Management of Unsettled/Challenging Behaviours: Least Restraint Approach

Some Medication Strategies for Specific Challenging Behaviour in Dementia

- psychosis (delusions/hallucinations) - antipsychotic; atypical antipsychotic may be used long term

  NB: Not in Lewy Body dementia
- aggression, anger - antipsychotic (short-term); Divalproex or antipsychotic long-term
- sundowning - trazadone; sometimes antipsychotic
- insomnia - trazadone
- anxiety - Buspirone for long-term use; benzodiazepine for short-term only

Alexopoulos, G. et. Al. (1998)

Geriatric Giant: Depression

	Depression
Onset	Relatively rapid, progressing from weeks to months
Symptoms	Worse I morning, improve during the day
Duration	Months or years, resolves with treatment
Orientation	Selective disorientation
Level of consciousness	Clear, normal, may have selective attention, difficulty concentrating
Sleep/wake cycle	Disturbed, early morning wakening, hypersomnia during day

Signs & Symptoms of Depression

S = Sleep disturbance
I = Interest, lack of
G = Guilt
: = colon - constipation
E = Energy
C = Concentration
A = Appetite
P = Psychomotor (retardation)
S = Suicide ideation

A = anxious
C = cognitive impairment
I = irritable
D = denies despite looking depressed
S = somatic complaints, sleep

Depression

Under-recognized and TREATABLE

Non-pharm. Interventions for Depressed Older Adult

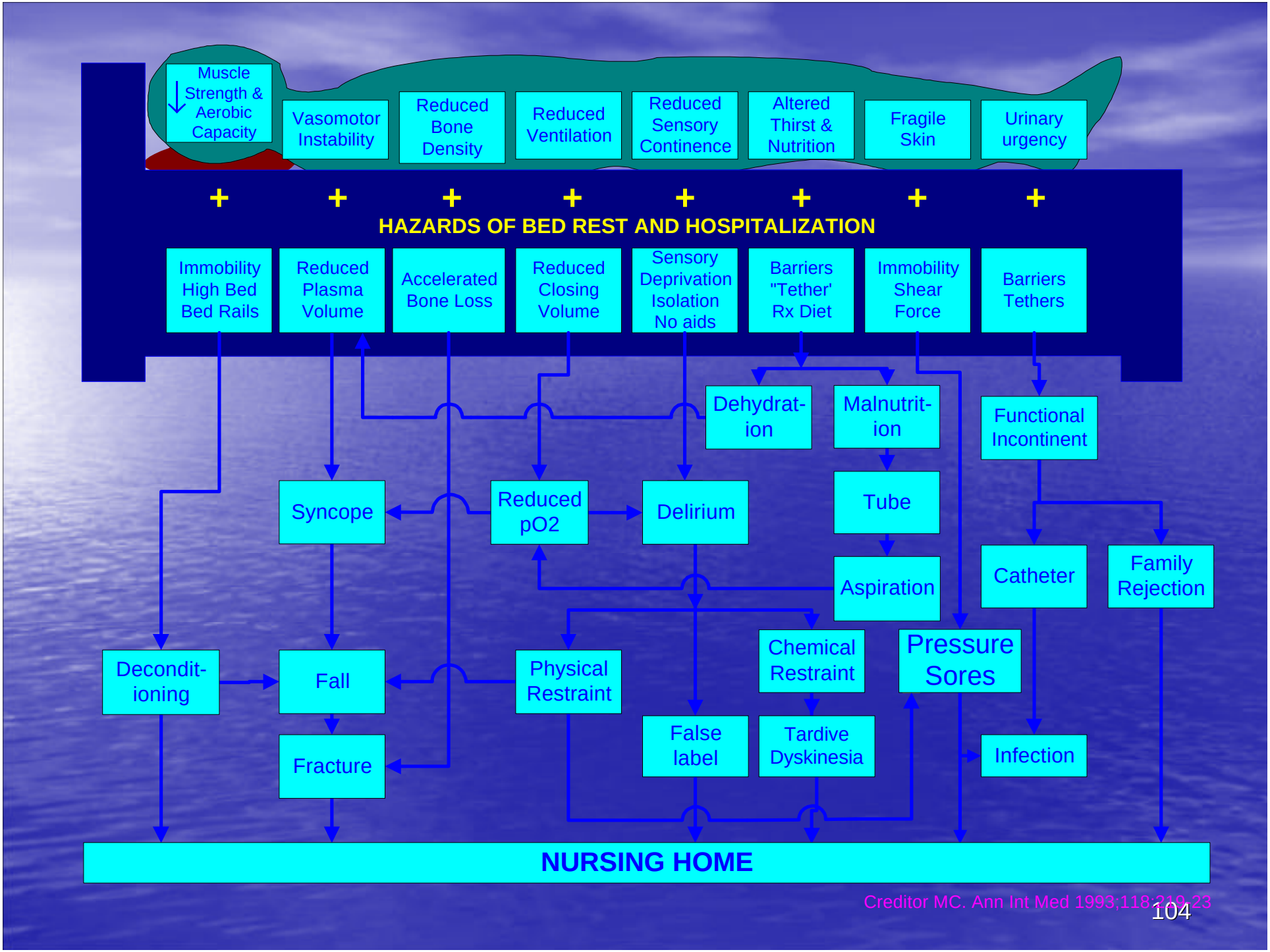
- Safety. Attend to suicidal thoughts, ask: "Have you ever thought of hurting yourself". Do you have a plan?" Report immediately.
- Provide support to patient & family
- Encourage hope, self-esteem
- Address physical complaints (e.g. pain!)
- Encourage & facilitate family spending time
- Implement plan for sleep
- Support hydration/nutrition

Tool: Geriatric Giants Binder

- Quick reference cards to help prompt your knowledge in caring for acutely ill older adults wherever they be
- Evaluation card – PLEASE complete and send back

Geri Giant: De-Conditioning

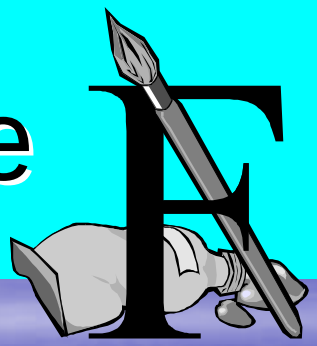
- One day in bed leads to loss of muscle strength (1-5.5%) or 7-20% per week!
- Loss of joint articulation flexibility = 1 day in bed requires 1 week to regain
- ***Keep old people in bed and you are assured that you will debilitate them and may lead them to an early death!***



Creditor MC. Ann Int Med 1993;118:219-23

Geri Giant: De-Conditioning

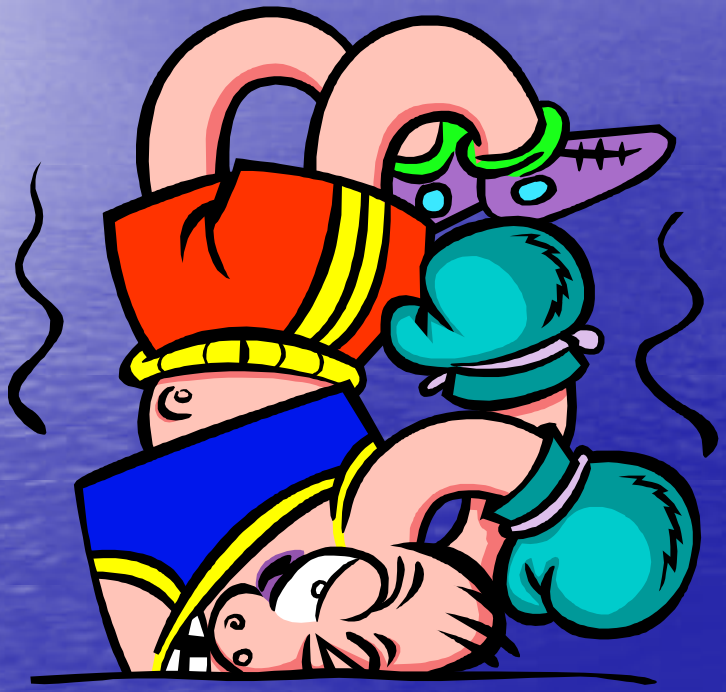
- ***Mobilize, mobilize, mobilize!!!***
- ***Assess safety risks and balance with least restraints***

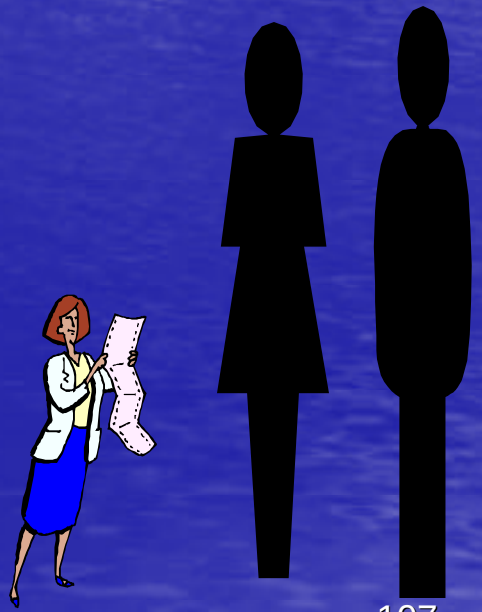
It is all about the  word

- ***FUNCTION, FUNCTION, FUNCTION…***

  - level of mobility, ADLs and IADLs
- Must know their functional level prior to this acute event in order to determine where to even start your assessment
- Impacts on discharge planning

Geriatric Giant: FALL and Injury





Screen for Falls

Have you had a fall in the last 6 months?
If YES, then refer for assessment (e.g. physiotherapist, occupational therapist, specialized clinic, GP)
*** Acutely ill older adults at ***ALL*** at high risk for a fall and injury.

Contributing Factors

- Orthostatic hypotension (BP drop: lying to standing): systolic, drop of >20 or diastolic, any drop, in up to 3 minutes
- Medications: diuretics, anti-hypertensives, sedatives, neuroleptics benzodiazepines, narcotics
- Cerebrovascular disease
- Lower limb weakness, gait problems, numbness .....etc. .....etc.
- impaired judgement/altered mental status
- sensory impairment (vision, hearing, proprioception, balance)

ALERT!
Osteoporosis/Osteopenia

- Loss of cross struts inside of bone leads to fragility fractures
- Vertebral #'s predict future hip #
- TREAT early! Calcium & Vit.D
- Bisphosphanates, calcitonin, estrogen modulators, parathyroid hormone
- Weight-bearing, resistant exercises!

Universal Falls Precautions

- ✓ ***all*** patients are at risk for falls
- ✓ ***everyone*** has a role in fall prevention

Safe environment

- Bed rails down unless assessed otherwise
- Pathways clear of clutter
- Bed and chairs in locked position
- Adequate and appropriate lighting

Assist with mobility

- Safe and regular toileting
- Mobility assist **documented**
- Assistive devices within patient reach

Fall risk reduction

- Call bell in patient's reach
- Bed lowered to patients knee height
- Personal items reachable
- Proper footwear available and in use

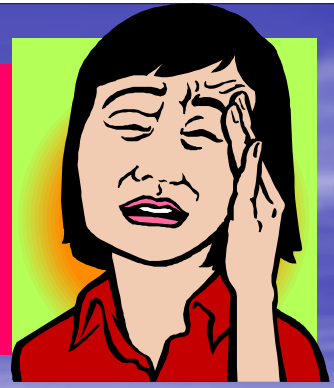
Engage patient and family

- Discuss risk factors with patient and family
- Communicate mutual plan

fraserhealth Better health. Best in health care.

Keeping SAFE from falls

Geriatric Giant: PAIN!



"Pain is whatever the experiencing person says it is, existing whenever he says it does." McCaffery, 1968

"Pain may also be what the person doesn't say it is." Black, 2005

Consequences of Untreated Pain

- Gait disturbance
- Falls
- Cognitive dysfunction
- Agitation & restlessness
- Malnutrition
- Sleep disturbance
- Impaired ambulation
- Decreased ADLs & IADLs
- De-conditioning
- Decreased Socialization
- Depression & Suicide

Principles of Pain Management

Keep the patient in control
- Informed decision-making
- Focus on realistic goals
- Use appropriate pain scale!

Involve the family as part of the team

Use an interdisciplinary team approach

Use a multi-modal approach
- Treat underlying disease; modify pathology
- Interrupt pain pathway: Analgesic; Adjuvant
- Elevate pain threshold: Modify lifestyle
- Non-pharmaceutical; Complementary Therapies

Always remember .....

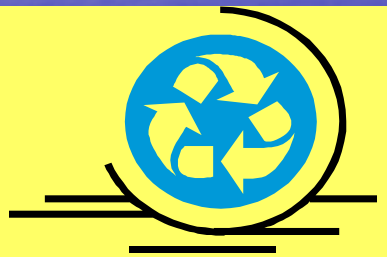
- Untreated pain has harmful consequences
- Acute pain is often superimposed on chronic pain
- Pain can be safely and effectively managed
- Assess and assume pain is present until otherwise is ruled out

Geri Giant: Urinary Incontinence

- A Geriatric Giant because
  - Risk of undetected underlying causes
    - Retention, infection, impaction, diabetes
  - Demoralizing and socially isolating
  - Depression
  - Risk of falls
  - Most often issue leading to nursing home placement

Transient Causes of Urinary Incontinence

- **D** – Delirium (Drugs and/or Bugs)
- **I** – Infection & Intake
- **S** – Stool impaction/constipation
- **A** – Atrophic vaginitis or urethritis
- **P** – Pharmaceuticals
- **P** – Psychological (depression, psychosis)
- **E** – Excess urine (endocrine)
- **A** – Abnormal lab values
- **R** – Restricted mobility



Assessment: ASK

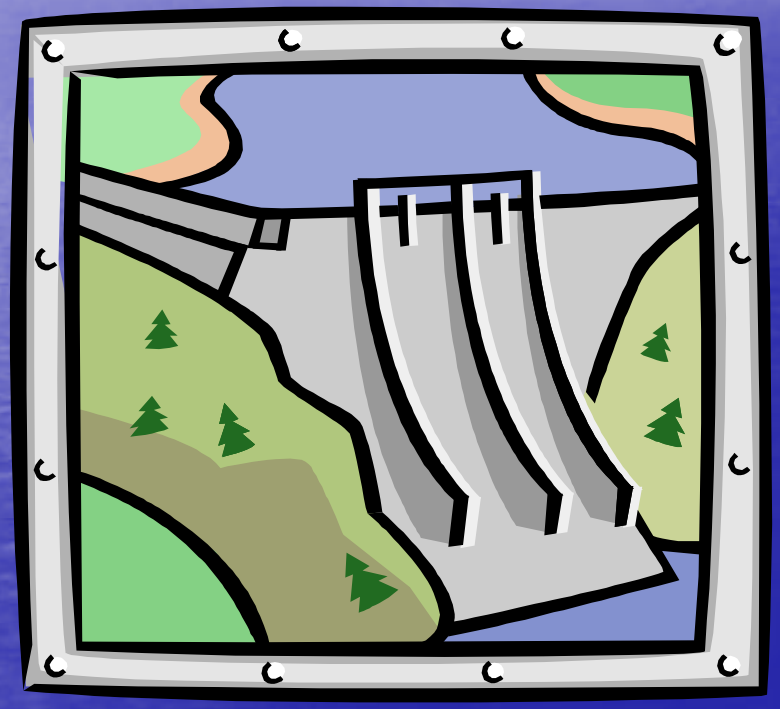
- "Have you ever had trouble making it to the toilet in time?" (mobility? Ability to control urination?)
- "Do you know when you have to void? (sensation of urge)
- Do you feel that you have completely emptied your bladder (retention? Overflow?)
- Do you ever loose urine when you sneeze, cough or laugh? (stress UI?)

Managing Urinary Incontinence

- Detect and treat underlying causes
  - UTI, retention, constipation, functional causes
- Promote function – commode or BR.
- Cueing for forgetfulness – toileting
- Ensure bladder emptying

  - bladder scan
  - Comfortable position, privacy, water running
  - I & O catheter if necessary
  - ***Last resort is indwelling catheter***

No “HOOVER DAM” when smaller product will do.



Geri Giant: Fecal Incontinence

- Fecal impaction (immobility, opioid side effect!)
- Mental or physical impairment (advanced dementia)
- Decreased rectal reservoir capacity (aging,radiation, tumour, ischemia, surg.)
- Decreased rectal sensation (diabetes, megarectum, fecal impaction)
- Impaired anal sphincter and puborectal muscle function (trauma, surg.,spinal cord or pudendal lesions, or unknown)

Constipation?Abdominal Pain?

- Constipation is serious!
- If abdominal pain present, GO LOOKING for underlying cause!
- Is it indicating a bowel obstruction, appendicitis, abdominal aortic aneurysm…
- DO a thorough assessment!

Diarrhea

- Could also be constipation (by-passing) or IBD or IBS
- Could be S/E of too many laxatives
- Inquire if recent hx of antibiotics as could be C. difficille
- Abdominal assessment
- Fluid and electrolytes, WCB, CBC
- May require CT or ultra sound

Dehydration & Malnutrition

- Common and chronic problems
- Assessment: infections in the mouth, ill-fitting dentures, dysphagia, dry oral mucosa, urine colour and amount, serum Na+, serum creatinine
- Ability to obtain food and feed self. Time taken to eat/drink.
- Watch for drug toxicities d/t free floating metabolites when there is not enough protein for the protein-bound drugs to bind with.

Malnutrition

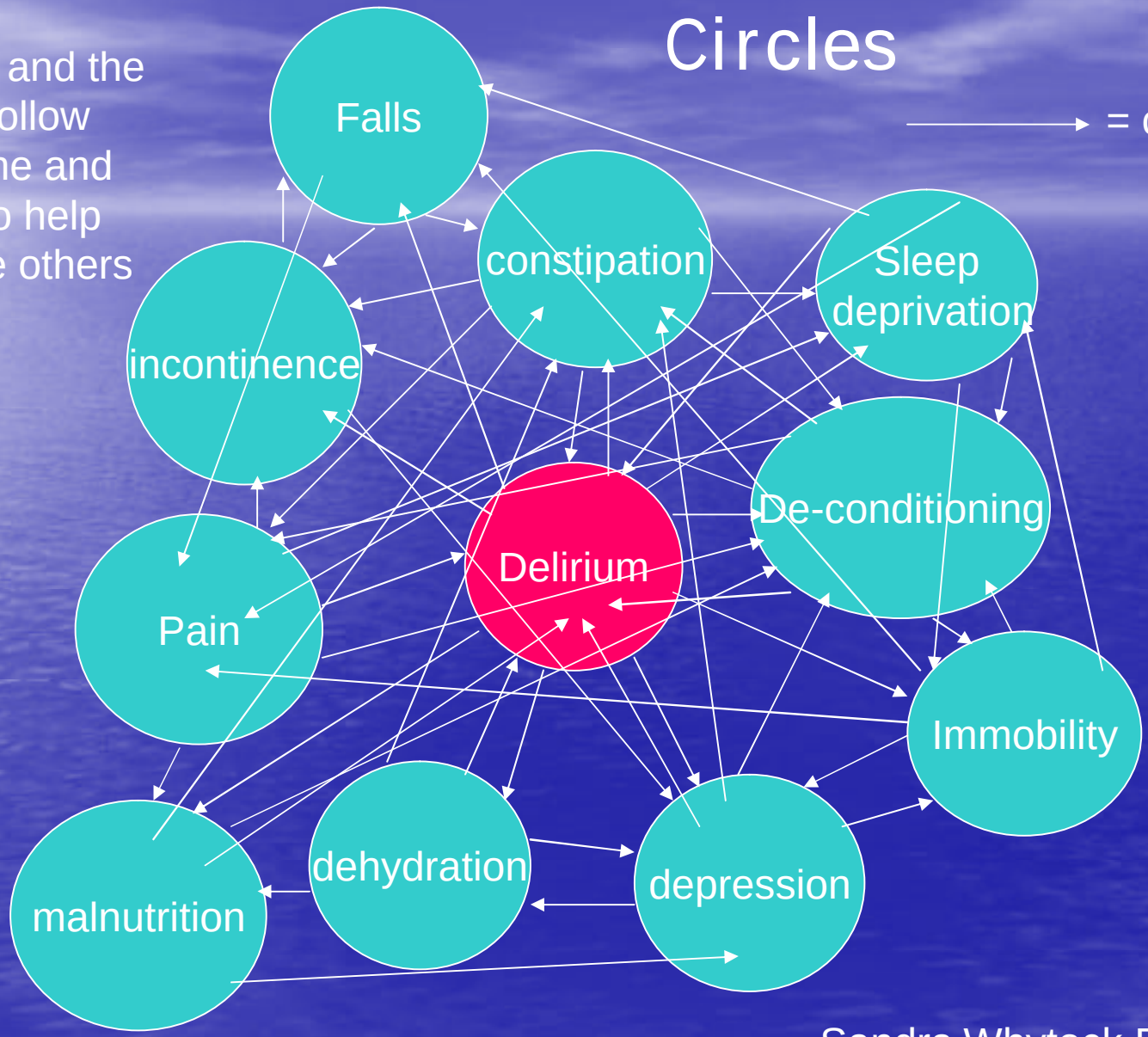
- Contributing factors: Constipation – appetite suppression, drugs with SE, living alone, under or over weight, depression, acute or chronic illness – N&V, reduced capacity to eat.
- Watch for: weight loss, dependent edema, poor wound healing, difficulty chewing or swallowing, skin sores, dull, brittle hair.

Malnutrition and dehydration

- Ensure don't lie down after meals
- Consult dietitian
- Blood Work investigations – anemia, infections, drug effects
- Ensure fluids and food offered – small amounts frequently. Supplement drinks.
- Often lack appetite and thirst.

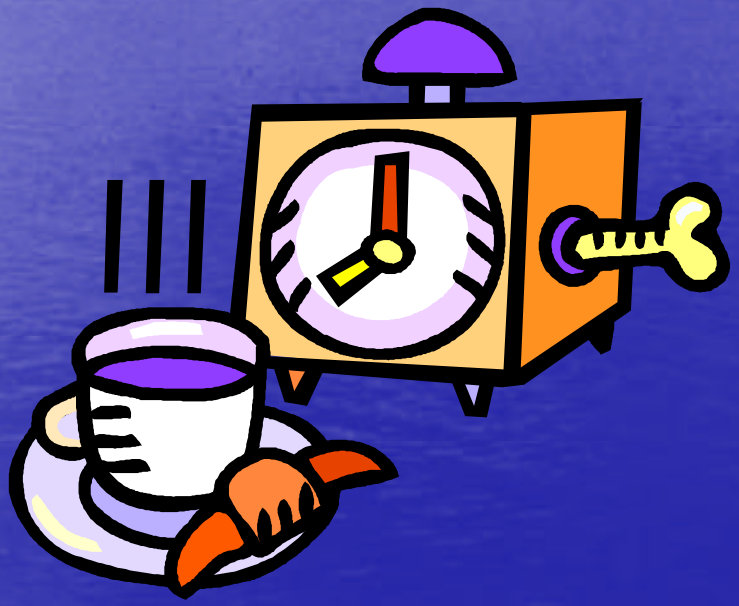
Geriatric Vicious Circles

Principles of care:
- Leave one unattended and the others will follow
- Manage one and you will also help manage the others



Sandra Whytock RN MSN

Coffee Break



EMERGENCY!

- Usually the access point to acute care for older adults
- Many older adults perceive hospital as the highest level of care required to help them with their problem
- Fear and anxiety are frequent feelings that they bring with them
- Many wait until they believe that they are very ill before coming; therefore, be aware that they may have been sick longer than what you may think

Hospital Environment

- George and Evelyn are admitted and there are lights, noise, strange people rushing around, paging overhead, procedures, confusion, delay....
- Fear, pain, distress at being separated from each other, worry about what is happening to the person, cat at home, etc.
- Add the illness or injury and the meaning of it!!!
- Reserve is taxed to the point of breaking.

Relocation Stress

- Evelyn has mild cognitive loss (may not be apparent) and frailty, relocation away from normal familiar environment can cause delirium without other problems.
- Relocation major cause of decline in older persons
- Fear and worry - feelings of abandonment

Relocation Management

- Link to the familiar
- Calm fears
- Personalize care
- The most important thing for them is to know they will be cared for, by a real person who takes an interest in them personally.
- **TLC**.

The ER

- What is going on around the older person?
- What do they need but either cannot say or will not ...?
- Do they know who is taking care of them?
- Do they have a supportive person that could come and be with them?

Most experienced nurses have seen this played out before……

- When the giants hit, can we spring into action?
- Not about bad people or wrong care
- Its about recognizing the significance of the giants and having the supports to assure safe care

We can feel helpless in the face of the what we think is ‘inevitable’ decline.

But with the power of our knowledge, compassion and courage, we can make a tremendous difference; especially if we act proactively rather than reactively

We need to restructure our care to …

- Prevent/minimize problems
- Early detection
- Evidenced based management
- Monitor and evaluate our progress

Why?

Because each system is perfectly designed to achieve the results it does.

Donald Berwick

So, how do we do this?

How can WE change the care and the system?

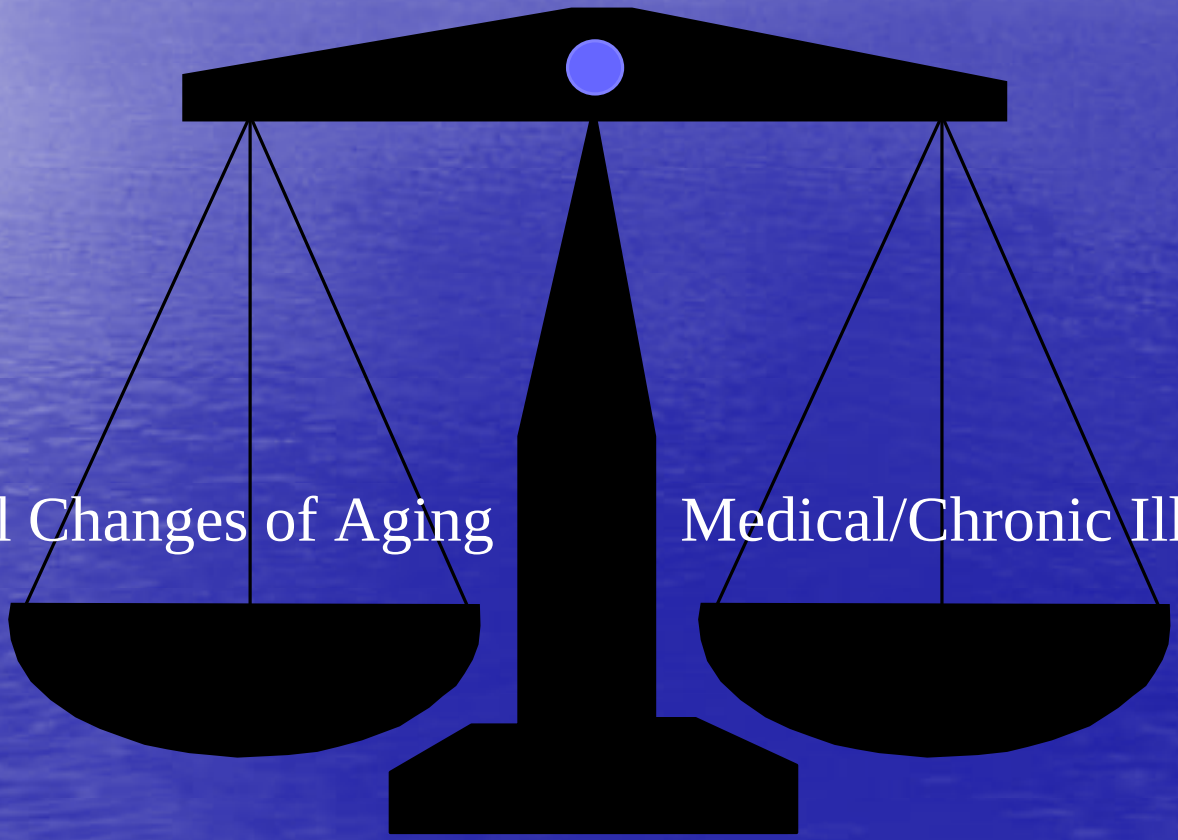
RAPID CYCLE IMPROVEMENT for Clinical Staff

PDSA = Plan, Do, Study, Act

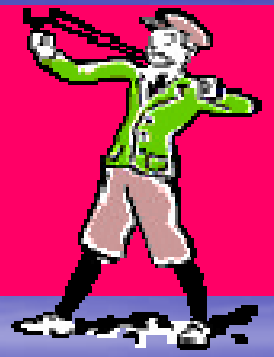
What can you do now?

- Commit to do one small care improvement
- Write it down on the provided card
- Will be sent back to you in about a month to see how you have done
- Let us know so we can celebrate!!!

Aging: Restoring Balance



“Slaying the Giants”



- Know what is related to *aging* and what is *not* before making decisions.
- Factor in known Chronic illness and medical problems
- Take into account the effects of the acute event in view of aging and chronic illness
- Prevent or manage problems that occur
- Prevent the effects of hospitalization

The time has come to slay the geriatric giants

- Remember Esther
- Prevent the giants from rising up through anticipation, detection, timely management

Please complete evaluation and pick up your certificate