Personal Support Worker Community of Practice Series

End of Life Delirium

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Presenters: Tracey Human and Diane Roscoe

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The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

Stay connected: www.echopalliative.com

Thank you!

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Welcome and Reminders

- Please introduce yourselves in the chat!
- Your microphones are muted for background noise, but we do want dynamic sharing, so please raise your hand to unmute to talk. Sharing or asking questions in the chat is also welcome.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session
- Terminology (Personal Support Worker)

Series Objectives

Our PSW Palliative Care Community of Practice

- **PSWs with a passion to become PSW experts in palliative care**
- A place for Peer-to-Peer practice support
- Facilitated and coached by palliative care experts
- Shared skill building in the Palliative Approach to Care
  - We engage in topic-based discussions, share knowledge and experiences to learn from each other, used cases to practice applying our skill caring for individuals/ families living with life-limiting illness
  - We share resources, tools, best-practice approaches
- Build on foundational knowledge acquired through LEAP PSW

Overview of Topics

Session #	Session Title	Date/ Time
Session 1	Introductory Session	Nov 16th, 2021 from 5-6pm
Session 2	Essential Communication Skills Part 1	Nov. 30th, 2021 from 5-6pm ET
Session 3	Essential Communication Skills Part 2	Dec. 14th, 2021 from 5-6pm ET
Session 4	Tools Practicum Part 1	Jan. 11th, 2022 from 5-6pm
Session 5	Tools Practicum Part 2	Jan. 25th, 2022 from 5-6pm ET
Session 6	Pain and Shortness of Breath Management	Feb. 8th, 2022 from 5-6pm ET
Session 7	The PSWs Role in the Last Days and Hours	Mar. 8th, 2022 from 5-6pm ET
Session 8	End of Life Medications and Side Effects	Mar. 22nd, 2022 from 5-6pm ET
Session 9	End of Life Delirium	Apr. 5th, 2022 from 5-6pm ET
Session 10	Post-mortem Care: Cultural Considerations and what happens at the funeral Home	Apr. 19th, 2022 from 5-6pm ET
Session 11	Culturally Relevant Care	May 3rd, 2022 from 5-6pm ET
Session 12	Trauma Informed Care and Cultural Safety	May 17th, 2022 from 5-6pm ET
Session 13	Indigenous End of Life Care	May 31st, 2022 from 5-6pm ET
Session 14	Understanding Tubes, Pumps, Bags and Lines	Jun. 14th, 2022 from 5-6pm ET

TOPIC: End of Life Delirium

What is your role as a PSW?

Palliative Performance Scale (PPSv2)

version 2

	PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
STABLE	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
	80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
	70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
TRANSITIONING	60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
	50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
	40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
END OF LIFE	30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
	20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
	10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
	0%	Death	-	-	-	-

Delirium - Definition

Sudden change in brain function characterized by disturbances in

- **in attention & awareness (inability to focus; decreased level of consciousness)**
- **orientation and cognition (disoriented; confusion; sudden memory deficit)**
- **develops over a short period of time (sudden onset)**
- **fluctuates in intensity (over hours or a few days)**
- **accompanied by behavioral changes (restlessness; agitation; or hypoactivity)**

Delirium Prevalence

Common symptom:

- 28 - 48% of patients on admission to hospital or Palliative Care Unit experience delirium
- Up to 88% of individuals at end of life will experience delirium (PPS less than 30%)

Impact of Delirium

- Distressing to patients, families & caregivers
- Alters symptom perception & expression
- Complicates symptom assessment and control
- **Under-diagnosed and under-treated**
- **Is considered a medical emergency in palliative care**

Causes of Delirium

Causes of Delirium Acronym (adapted from Capital Health)	
D	Drugs, drugs, drugs, dehydration, depression
E	Electrolyte, endocrine dysfunction (thyroid, adrenal), ETOH (alcohol) and/or drug use, abuse or withdrawal
L	Liver failure
I	Infection (urinary tract infection, pneumonia, sepsis)
R	Respiratory problems (hypoxia), retention of urine or stool (constipation)
I	Increased intracranial pressure;
U	Uremia (renal failure), under treated pain
M	Metabolic disease, metastasis to brain, medication errors/omissions, malnutrition (thiamine, folate or B12 deficiency)

Screening Tool

The Confusion Assessment Method

Delirium should be suspected with the presence of Features 1 and 2 and either 3 or 4

Feature 1: **Acute Onset and Fluctuating Course**	This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Does the (abnormal) behaviour fluctuate during the day; that is, does it tend to come and go, or increase and decrease in severity?
Feature 2: **Inattention**	This feature is shown by a positive response to the following question: Does the patient have difficulty focusing attention; for example, is the patient easily distractible, or having difficulty keeping track of what's being said?
Feature 3: **Disorganized Thinking**	This feature is shown by a positive response to the following question: Is the patient's thinking disorganized or incoherent, as evidenced by rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
Feature 4: **Altered Level of Consciousness**	This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stuporous [difficult to arouse], or comatose [unarousable])?

Inouye, S.K. (1990). Clarifying confusion; the confusion assessment method. A new method for detection of delirium. Ann Intern Med, 113 (12): 941-8.

"The other features of delirium are not included in the algorithm because Inouye et al. (1990) reported that they add nothing to the sensitivity and specificity of the instrument.

Delirium vs Dementia

Dementia

Delirium

Are there differences between Delirium and Dementia?

What observations help us tell them apart?

Feature	Delirium/Acute Confusion	Dementia	Depression
Onset	• Acute/subacute depends on cause, often at twilight	• Chronic, generally insidious, depends on cause	• Coincides with life changes, often abrupt
Course	• Short, diurnal fluctuations in symptoms; worse at night in the dark and on awakening	• Long, no diurnal effects, symptoms progressive yet relatively stable over time	• Diurnal effects, typically worse in the morning; situational fluctuations but less than acute confusion
Progression	• Abrupt	• Slow but even	• Variable, rapid-slow but uneven
Duration	• Hours to less than 1 month, seldom longer	• Months to years	• At least 2 weeks, but can be several months to years
Awareness	• Reduced	• Clear	• Clear
Alertness	• Fluctuates; lethargic or hypervigilant	• Generally normal	• Normal
Attention	• Impaired, fluctuates	• Generally normal	• Minimal impairment but is distractible
Orientation	• Fluctuates in severity, generally impaired	• May be impaired	• Selective disorientation
Memory	• Recent and immediate impaired	• Recent and remote impaired	• Selective or patchy impairment, "islands" of intact memory
Thinking	• Disorganized, distorted, fragmented, slow or accelerated incoherent	• Difficulty with abstraction, thoughts impoverished, make poor judgments, words difficult to find	• Intact but with themes of hopelessness, helplessness or self-deprecation
Perception	• Distorted; illusions, delusions and hallucinations, difficulty distinguishing between reality and misperceptions	• Misperceptions often absent	• Intact; delusions and hallucinations absent except in severe cases

Reprinted with permission. Adapted from: New Zealand Guidelines Group (1998). *Guideline for the Support and Management of People with Dementia.* New Zealand: Enigma Publishing.

What does it look like?

Quiet Delirium (Hypoactive delirium)

https://youtu.be/M4wsPTtGeIc

Excited Delirium (Hyperactive delirium)

https://youtu.be/hwz9M2jZi_o

Mixed Delirium
(fluctuates between Quiet & Excited Types)

Poll Number 1

Following this review I realize that I have cared for a individual with a delirium:

1. Yes

1. No

Do you feel equipped to know what it looks like; what to watch for and what to do as the PSW?

How Delirium is managed by the Team

Treat the underlying cause, if reversible, for example:

Undertreated pain

- managed pain

Infection example UTI

- antibiotics

Opioid Neurotoxicity

- switch the Opioid; IV/SC hydration; a dose change may be needed

Brain tumour/metastases

- corticosteroids like Dexamethasone (decadron)

Medications

- Haldol
- Methotrimeprazine (Nozinan)
- Quetiapine (Seroquel)
- Risperidone
- Olanzapine

Terminal Delirium (severe, last hours of life)

- Haldol + sedation using Midazolam

PSW Role - Delirium Care
Identify; Screen; Observe For:

- Attention deficit (unable to focus)
- Altered sleep-wake cycle (sleep disturbance; sundowning)
- Disorientation/Sudden confusion
- Restlessness; agitation; or reduced activity
- Altered awareness or level of consciousness
- Disorganized thoughts
- Sudden memory changes
- Hallucinations
- Delusions or paranoia

PSW Role: Non Pharmacological Management

What is in your Tool Box?

Non Pharmacological Approaches

- If mildly restless try relaxation techniques (massage, tub baths, favorite gentle music)
- Prevent over-stimulation
- Keep visitors to a minimum
- Minimize staff changes and room changes
- Ensure glasses are on, hearing aids in/ working
- Watch for and report sleep deprivation
- No physical restraints and ensure safe environment (no tripping hazards)
- Avoid catheterization unless urinary retention is present (risk of pulling out)

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End of Life Delirium - Terminal Delirium

- Occurs in last hours/last day
- Crisis severity delirium, We consider it a palliative emergency!
- Sudden and extremely dramatic
- Due to organs and body systems final shut down
- Needs to be brought under control quickly (Physician/NP/RN will use Haldol with Midazolam and Nozinan)

Does anyone have a example to share? Put up your hand!!

Case-Based Discussion

Case Study: Lena

Lena is a 55 year old female with stage 4 ovarian cancer with PPS 20%. She is taking sips of fluid only. She is being cared for in her home with a support team of a visiting palliative MD, a visiting nurse, daily shift PSW overnight for family respite for sleep.

Lena has a foley catheter. Her medications are being given via SC butterfly on a infusion pump (Morphine for pain and shortness of breath; Maxeran for nausea)

Your PSW overnight duties include watching for any changes; assisting with oral intake and oral care, skin care/pericare, repositioning; waking the family if any changes, if any increase in pain or symptoms; empty the foley bag at end of your shift.

You observe that there is minimal urine output in the foley bag overnight.

Lena continued

At about 0100 hrs Lena is awake. She becomes restless, picking at the bed linens, is frightened by “the man in the corner of the room”, and repeatedly asks you can’t you see him? She is becoming agitated and trying to get out of bed.

What is happening?

What Tool could you use?

What actions will you take?

What other observations would be important to share?

Wrap Up

Wrap Up

- Please fill out our feedback survey! A link has been shared in the chat
- A recording of this session will be emailed to you within the next week
- Make sure you have the next session marked in your calendar!
  - Post-mortem Care: Cultural Considerations and what happens at the funeral home
  - April 19th, 2022 from 5-6pm ET

LEAP Personal Support Worker

- LEAP Personal Support Worker is an online, self-learning course that provides personal support workers and care aides with the essential competencies to provide a palliative care approach
- Register at: https://www.pallium.ca/course/leap-personal-support-worker/?enroll=enroll

"I feel this course was great, and straight forward. It was easy to navigate, and had very good information, and knowledge"

"A great course, lots of information just for the PSW role. Information very informative and easily learned."

"This course is really amazing, well made and really helped me understand palliative care"

"I feel this course was absolutely fantastic! I enjoyed it very much."

"Wonderful journey, thank you"

Thank You

See you on April 19th!

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