

FACULTY GUIDE

Core Module 14:

The Role of Acute Care Staff in Emergency Departments (EDs) and Hospitals for Persons Living with Dementia

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Slide 1:

- This module will provide health care professionals with the information needed to discuss the prevalence of dementia in the general population, common reasons why a person living with dementia (PLwD) presents to the emergency department (ED), and individual challenges a PLwD may face through the trajectory of his/her disease while receiving emergency care. This module will further detail the risks, problem behaviors and potential adverse events that can occur for the PLwD in acute care settings. Finally, this module will identify guidelines, strategies, models of care and other resources that acute care providers and health systems can implement for the PLwD to minimize negative events that can be experienced in EDs and hospitals—events which often have significant impact on outcomes.

Slide 3:

- Module 14 will provide an overview of best practices for acute care within the ED or hospital. You will gain an understanding of the prevalence of Alzheimer's disease in the acute care setting, and the common co-existing disorders, risk factors, and adverse events related to PLwD in the acute care setting. The module will provide you with appropriate guidelines and tips for a smooth transition into the ED or hospital setting by understanding the concept of the Geriatric ED and learning how to create a safe and secure environment. You will learn the appropriate clinical assessment tools to use, as well as best practices for the successful management of acute care, best practices for assessing and managing common behavioral challenges and delirium. Finally, you will understand the elements of a successful transition from ED.

Slide 4:

- Our goal is for you to become more familiar with the specific needs and issues related to a PLwD needing acute care within the ED or hospital. By the end of this module, you will be able to:
- Recognize the prevalence of PLwD coming into the ED or hospital, the potential reasons a PLwD may require acute care, and challenges that may arise.
- Understand common risks, behaviors, and other concerns that may occur for the PLwD while in an acute care setting.
- Identify the guidelines, strategies, models of care and other resources available to acute care staff that may minimize the negative events that may occur in the acute care setting.

Slide 5:

- These are the important take home messages to keep in mind as we review the details of each section. Remember that, although there are significant challenges in caring for a PLwD in an acute care setting, there are guidelines and practices that an interprofessional team can leverage to coordinate efforts and minimize these challenges.

Slide 7:

- Alzheimer's disease (AD) is the most common form of dementia in people over age 65.
- An estimated 5.4 million Americans are living with Alzheimer's disease.
- 15% of people aged 65-74 and one third of persons aged 75 and older have Alzheimer's disease.

- More women than men present with AD or other dementias. Nearly two-thirds of PLwD are women.
- Despite the fact that most people diagnosed with AD are non-Hispanic whites, data indicates older Africa-Americans are approximately twice as likely to have AD, and Hispanics are approximately 1.5 times as likely to have AD.
- Alzheimer’s disease is the sixth leading cause of death in the United States. In people over 65, AD is the fifth leading cause of death.
- Between 2000 and 2013, the proportion of deaths caused by heart disease, stroke and prostate cancer all decreased, while the proportion resulting from AD increased 71%.
- Alzheimer’s disease and other dementias present a significant burden to health care in the United States.
- A significant part of this burden includes frequent and potentially avoidable hospitalizations and ED visits.
- Potentially avoidable hospitalizations may occur more frequently in individuals with AD and diabetes or hypertension.

Slide 8:

- Due to the aging population, the incidence of AD is expected to increase drastically in the coming decades.
- Individuals with Alzheimer’s disease and other dementias are more likely to be hospitalized for acute care than individuals without these conditions.
- These numbers underscore the importance of AD education for ED staff.

Slide 9:

- The incidence of hospital admissions for PLwD is significant, and so is the burden of time and resources on the acute care staff. The ED is therefore an important point-of-care for the PLwD.

Slide 11:

- Take time to imagine the ED from the point of view of a PLwD. The lighting, the noise, and the strange faces, all have the potential to contribute to heightened emotions, especially fear. If a familiar care partner is not present, heightened emotions can quickly translate into agitation. Maintain a routine and structure—family and care partners can alert you to previous routines that may be recreated. If possible, ensure that any recurring visits are with the same members of the dementia care team, to help familiarize the PLwD with staff. Regular rest periods are extremely important—try to schedule assessments and visits after the PLwD has adequate rest. Be alerted to any changes in behaviors that may be related to new medications. Creating a simple, structured, and secure environment will help minimize any negative reactions, and will also help reduce the need for stressful interventions.

Slide 12:

- The Delirium Room provides 24-hour nursing care, emphasizes non-pharmacological approaches, and is completely free of physical restraints.

- Delirium prevention programs: Use of multiprofessional (vs. interprofessional), rounds to improve care coordination, protocols for early mobilization, volume repletion (for hydration and electrolyte balance), addressing visual or hearing deficits, and medication review.
- The ABCDE or Delirium Bundle by SCCM and AACN is a tool kit that provides validated, evidence-based clinical knowledge, resources and guidelines regarding prevention of delirium.
- Companion care or sitters is constant supervision, may be a more costly option for EDs.
- Communication training for ED staff refines interactions with a PLWD. It encourages PLWD involvement in decisions and increasing patience. Specific phrase swaps such as “Let’s try this way” instead of pointing out mistakes, “Please do this” instead of “Don’t do this” and “Thanks for helping” are recommended.
- ACE Units have been shown to improve processes of care, prescribing practices, physical functioning, as well as patient and provider satisfaction. These analyses have also suggested that ACE units help reduce rates of restraint use and institutionalization.
- References: AHRQ, 2013; AACCN, 2016; NIAH, 2015; Flood, 2013)

Slide 13:

- Geriatric EDs are specifically designed for an older adult population in terms of staffing and environmental design. They are uniquely positioned to improve the trajectory of care of a PLWD by including special programs and care pathways. A Geriatric ED can also be implemented as a concept, through the development of person-centered, collaborative care.

Slide 14:

- The ED is an important point-of-care for PLWD, and there is an opportunity to expedite and improve this care. By following the concept of a specialized geriatric ED, acute care staff can set the stage for more effective care and a safe environment.
- Although the geriatric population uses more resources, they often end up dissatisfied with their care.
- Reimagine the ED from the point of view of an older adult and their specific needs. Redesign of the physical environment, specialized training for staff, and specialized models of care will improve health outcomes, reduce health system costs, and improve the experience of care.
- These endeavors can not only expedite and improve patient care and outcomes, but can guide the distribution of resources more efficiently.

Slide 15:

- The concept of a Geriatric ED includes a specifically designed physical environment. The physical environment of a Geriatric ED should focus on improvements in safety, comfort, mobility, memory cues and sensorial perception with vision and hearing. These improvements can be implemented with lighting, color, and signage enhancement which are better not only for PLWD, but for everyone.
- This list is a suggested starting point for any ED to create a physical environment that is more comfortable and safe for the PLWD.
- Visual orientation includes soft lighting, though the benefits of exposure to natural light cannot be understated as research shows it can help improve recovery times and decrease delirium; as

well as control over the lighting in their space if the PLWD wishes to sleep at a time when the other lights are on.

- Acoustic orientation includes using sound-absorbing materials (i.e., curtains, carpet, or ceiling tiles) to reduce background noise and increase privacy as well as using portable hearing assist devices to enhance communication and comprehension.
- Furnishings considerations include having sturdy armrests and beds to allow older adults to rise easily for safe transferring; gurney and bed mattresses should be extra thick and soft to decrease skin breakdown and ulcer formation; furniture surfaces should be easily cleaned with no joints or seams to reduce surface contamination; body warming devices, warm blankets, a fluid warmer, non-slip fall mats, bedside commodes when necessary, walking aids and hearing aids keep the PLWD comfortable and safe; and doors should be fitted with handles (not round knobs) for ease of use.

Slide 16:

- The staffing of a Geriatric ED consists of a coordinated framework of staffing and administration:
- The Geriatric ED staff and administration provides an interprofessional team of care providers focused on the varying needs of the geriatric population.
- By providing trained staff in the ED, as well as readily available staff for inpatient care and outpatient follow-up, the Geriatric ED can:
 - Optimize ED visits,
 - Effectively deliver and/or coordinate care in a less costly and more comfortable outpatient setting,
 - Coordinate inpatient resources for high risk patients.
- *An effective program will involve hospital site-specific staff as well as an overall coordination of local resources.

Slide 17:

- The Geriatric ED policies in this slide are specifically relevant for a PLWD, and are oriented toward a goal of reducing hospital admissions. A more comprehensive list of policies may also include: Triage and initial evaluation, initial screening tool to recognize and evaluate at-risk seniors, patient safety, suspected elder/dependent adult abuse and neglect, sedation/analgesia in the geriatric PLWD, Do Not Resuscitate (DNR) and Physicians Orders for Life-Sustaining Treatment (POLST) forms, palliative care, fall risk assessment guidelines, wound assessment and care, transition of care and follow-up, medication reconciliation and pharmacy review.

Slide 18:

- The Geriatric ED is focused on person-centered care. Some tips to be aware of when caring for PLWD in the ED are listed on the slide. In general, simplifying the environment and using reassuring, simple communications can reduce confusion and stress and will help develop a sense of safety and security. Take the time to observe small changes and non-verbal cues that will help alert the dementia care team of issues or progression of the dementia. Consider all the elements of daily living that would be affected by cognitive impairment. There are many ways to approach the cognitively impaired person. Always plan your approach and words before

entering the room. Do not startle the PLwD, but alert them to your presence and introduce yourself again if necessary. If the PLwD is not attentive, gently touch their arm to get attention.

Slide 19:

- Loud, distracting noises and a busy environment can disorient and upset the PLwD. Always orient the PLwD to your presence. Do not let more than one person talk at a time, and try and minimize the amount of activity in the room. Attempting to engage the PLwD in a debate or correction may result in agitation. Instead, use neutral language and topics that will redirect or distract the PLwD. Use simple, respectful communication and speak directly to the PLwD.

Slide 21:

- PLwD may present with any combination of these issues, and the dementia may be only one part of the whole story. Training and increased awareness by the care team will improve recognition of dementia and increase effectiveness of care.

Slide 22:

- Specific risk factors increase the likelihood that a PLwD will be admitted to the hospital. These risk factors can further complicate presentation to ED staff.

Slide 23:

- Co-existing medical conditions can complicate and sometimes overlap with effects of Alzheimer's disease or other dementias. These co-existing medical conditions may also present a challenge as PLwD struggle to manage the different dosages and schedules of multiple medications.

Slide 24:

- For people with AD and for their care partners, ED visits can be disruptive, costly, and particularly challenging as the PLwD may be disoriented and traumatized by the dramatic shift in environment.
- PLwD are particularly vulnerable to a host of adverse health outcomes while under the care of the dementia care team. Co-existing conditions such as anemia, asthma, cancer, COPD, and stroke can contribute to adverse outcomes such as delirium, falls, agitation, and behavioral issues. This can be further exacerbated by poor communication from the PLwD stemming from cognitive impairments or cognitive decline. For these reasons, the quality of care in ED visits for PLwD is particularly critical.

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- Since the diagnosis is often based on reported symptoms, it is possible that many diseases, potentially treatable, may not be diagnosed in the person living with cognitive impairment. It is of critical importance that ED staff interview, and take seriously, the person accompanying the person living with dementia. Always conduct a detailed history with care partner input as well as frequently re-affirming if changes in behavior are new or acutely different from the person's

“normal” dementia behavior and potentially indicating delirium. Be aware of red flags for elder abuse, which have the potential to affect the credibility of the accompanying person.

Slide 27:

- This is another area to possibly address delirium and or dementia screening tools, fall risk tools, etc. to be used during the clinical assessment period of the emergency department. Collecting information from these difference sources will inform one of the targets of care of PLwD– the prevention of complications (infection, malnutrition, incontinence, or delirium) which result in an increased risk of hospitalization and increased mortality in short and medium term. A careful management of possible comorbidity can also slow the functional decline and limit complications for this population.

Slide 28:

- Family members and other care partners play an important role in a successful encounter with the ED. Work with them to obtain a full history, medications, routines and schedules, and preferences. Perform a comprehensive examination, taking note of non-verbal cues and signs of pain. Remember that the PLwD may not be able to communicate effectively—patience, coordination with family members, and simple communications will ensure an accurate assessment.

Slide 29:

- These tips will help orient the dementia care team to deliver person-centered care. By careful observation, respect for the individual, and patience in the delivery of assessment and care, the PLwD will be much more comfortable and willing to engage.

Slide 30:

- Communication and observation is key for providing a comfortable environment for the PLwD. A close family member or friend is usually the best resource for ED staff to understand the specific needs of the individual. However, this is not always possible and, as ED staffs encounter PLwD, they will need to be creative and develop strategies to increase the comfort and safety of this vulnerable population. Communication isn't always verbal, and this is especially important in terms of understanding the needs of the PLwD. A behavior may be the result of an unmet need—ask yourself what the individual may be missing or experiencing.
- From the point of view of a PLwD, a visit to the ED is a new environment filled with strange sights, odors and sounds. This change to the daily routines, on top of a potential illness or injury, can drastically increase confusion, agitation and anxiety. Use family coordination, observation, and other communications to guide your strategies and interactions.

Slide 31:

- The ED, noisy and brightly lit, can agitate or confuse the PLwD. Place the individual in an area where noise can be reduced and lighting can be adjusted. Make changes to the environment that are deliberate and structured, and adjust only as needed. Provide the PLwD with consistent staff members. If possible, place the PLwD near the nursing station for better observation. Provide low risk slip/fall walking surfaces, strategically placed handrails, uncluttered areas/halls, large clocks and calendars.

Slide 32:

- Consistent personal care is important for the well-being of the PLWD. However, PLWD may exhibit care-resistant behaviors during personal care. A successful person-centered approach to personal care can ensure success, and is based on
- Understanding that communication is possible throughout the stages of the disease.
- Maintaining the person's privacy and dignity.
- Giving the person choices and putting their preferences first wherever possible.
- Promoting the person's independence and self-sufficiency.
- Being as attentive and flexible as possible.
- Ensuring that the environment is safe, comfortable, and meets the needs of the PLWD.

Slide 34:

- Almost all PLWD are expected to develop significant behavioral problems at some point in the course of dementia.
- Behavioral disturbances occur throughout the course of dementia, regardless of level of cognitive impairment.
- The more cognitively impaired the individual, the greater the likelihood of agitated behavior.
- Behavior disturbances in PLWD are most commonly referred to as behavioral and psychological symptoms of dementia. They are frequently seen at some point in the trajectory of the disease, and can cause suffering and caregiver stress. When a care partner brings a PLWD to the ED, they may complain of personality changes such as irritability, hiding objects, imagining things that aren't there, wandering, aggression, pacing, or disinhibition of sexuality. The PLWD may have stopped bathing or become resistant to changing clothes or regular grooming.
- Because of this, it is very important to identify predisposing and precipitating factors for behavioral disturbances in the ED. It is important for the dementia care team to recognize the type and severity of the behavioral problem early so that the behaviors are more likely to be successfully treated in a dignified manner for the PLWD.
- References: (NIA, 2015h; Desai et al., 2012)

Slide 35:

- Behavioral disturbances can be treated and prevented, but this requires early identification and management. There are several assessment tools to help identify behavioral challenges in PLWD. These include the Neuropsychiatric Inventory Questionnaire for People with Clinical Dementia (a tool administered to care partners of PLWD to identify behavioral symptoms), the Cohen-Mansfield Agitation Inventory (a 29-item scale to assess agitation), and the Behavioral Pathology in Alzheimer's Disease Rating Scale (a 25-item scale to assess behaviors across all types).

Slide 36:

- Many behavioral disturbances can be prevented by educating the PLWD, and their family, care partners, and health care providers on non-pharmacological interventions. It is important for the dementia care team to emphasize to families that they may have to cycle through non-

pharmacological treatment options as the needs of a PLWD can change rapidly. Observe the PLWD for non-verbal communications and adjust strategies as needed. Common unmet needs include medication issues, discomfort, unfamiliar routines and environment, or pain.

Slide 37:

- There is currently no FDA-approved pharmacologic treatment for behavioral disturbances for dementia. If pharmacology is deemed necessary, safe pharmacologic options may include:
- Antipsychotic medications, which are favored when compared to benzodiazepines in agitated PLWD.
- Haloperidol, which has shown to be effective in improving symptom severity in delirium compared to placebo.
- Atypical antipsychotics have also been shown to be effective, with a lower incidence of extrapyramidal side effects.
- Some pharmacological treatments, such as benzodiazepines, have a significant side effect profile to include falls, worsening of delirium, and over-sedation, and are therefore best avoided. The rule for pharmacological treatment for behavioral problems in dementia is “start low; go slow.”
- The success of pharmacologic interventions will depend on accurate identification of specific syndromes, e.g., depression-anxiety and psychosis and severity of symptoms. Response to pharmacologic interventions is usually modest and may be associated with significant symptom resolution. It is important to note many behavioral disturbances such as wandering and hoarding are not amenable to pharmacotherapy and can best be addressed through environmental modification.
- Module 8 addresses the special concerns of using pharmacologic management in persons living with Lewy Body Disease (LBD).

Slide 38:

- Coordinate with the dementia care team to ensure that all observations of behavioral changes are recorded and communicated within the team. Remember that the primary goals of managing behavioral issues is to keep the PLWD safe and secure, maintain dignity of the PLWD, and understand the underlying cause of the disturbance. Watch for non-verbal communications that indicate unmet needs, such as discomfort, too much noise, or tasks that are too difficult. Share these observations with the dementia care team and work collaboratively to ensure that strategies are coordinated and consistent.

Slide 39:

- Sleep is very important for the well-being of the PLWD, but it is commonly disrupted in the ED and hospital. In addition to reducing noise and lights, ensure that the PLWD is not waking from pain or hunger. Provide an environment with the best possible sleep hygiene—a comfortable temperature, low light, structured nightly activity. Provide the PLWD an opportunity to use the bathroom before sleep.
- References: (ADEAR, 2015a, b; Vista Continuing Education, 2016; NIA 2015a)

Slide 43:

- Delirium is an acute disturbance of consciousness (i.e., attention) that is accompanied by an acute loss in cognition that is not better explained by a preexisting dementia. It can be further subcategorized as hypoactive or hyperactive delirium. Hypoactive delirium is described as “quiet” delirium, with hallmark signs including psychomotor retardation, marked levels of drowsiness, somnolence and lethargy. As these are subtle symptoms, hypoactive delirium is frequently overlooked and mislabeled as depression or fatigue. Hyperactive delirium results in increased psychomotor activity and signs of agitation, anxiety or restlessness.
- Despite the fact that delirium and its negative consequences have been well established, it is frequently overlooked in an ED setting.
- Research evaluating the attitudes of doctors reveals that while the majority of ED doctors feel screening for cognition was important, almost one-third felt they lacked the expertise to perform a cognitive screening.
- Other barriers to assessing cognition in the ED include lack of privacy, too much noise, and time constraints.
- The consequences of failing to recognize delirium can have major prognostic implications, with higher 3-month mortality rates in those in whom the diagnosis was missed compared to those in whom delirium was identified. Furthermore, the Society for Academic Emergency Medicine Geriatrics Task Force recommended that screening for delirium be one of the key quality indicators in the delivery of acute geriatric care.
- Delirium is a common issue with PLwD who are in the ED or hospital. Delirium needs to be recognized and managed quickly, so it is important that the dementia care team should be aware of the different ways delirium can present.
- Delirium is an acute, abrupt change in the PLwD.
- Disorganized thinking—may ramble, seem incoherent, or become more than usually confused
- Perceptual disturbances—may hallucinate, picking at things that aren’t really there
- Disorientation—likely to not know time, date, place
- Delirium has several types.
- Hypoactive delirium:
 - Drowsy, lethargic
 - Slow movements
 - Often overlooked, or misdiagnosed as depression or fatigue
- Hyperactive delirium:
 - Agitation, restlessness
 - Increased movement
- Mixed delirium:
 - Cycles between hypoactive and hyperactive delirium states
 - Fluctuation can be rapid, within minutes or seconds

Slide 44:

- Delirium is frequently overlooked in an ED setting.
- ED doctors recognize the need for screening, but may feel they lack the expertise.

- Other barriers to assessing cognition in the ED include lack of privacy, too much noise, and time constraints.
- The CAM-ICU has been modified from the Confusion Assessment Method and has been validated in both the ICU and ED setting.

Slide 45:

- The CAM-ICU has been modified from the Confusion Assessment Method and has been validated in both the ICU and ED setting. It assesses four features: 1) acute change or fluctuation in mental status from baseline, 2) inattention, 3) altered level of consciousness, and 4) disorganized thinking.

Slide 46:

- Dementia and delirium can manifest in very similar ways, but it's important to know the difference. Delirium is common in the ED or hospital and it needs to be identified and treated quickly. In dementia, the changes in memory and cognition slowly evolved over the course of years. In delirium, the change is abrupt—confusion that emerges over the course of a few days or weeks. But in a person who is experiencing both, it can be easy to overlook delirium. Look for mild, but sudden disorientation and changes in movement and consciousness. Careful observation and early assessment is important.

Slide 47:

- The Geriatric ED is dedicated to providing a thorough and thoughtful evaluation of PLWD presenting with delirium. Routine cognitive screening is rigorously practiced in order to complete a formal assessment of mental status, and provide a baseline for future ED visits.

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- The Delirium Triage Screen (DTS) was developed to rapidly rule-out delirium and reduce the need for formal delirium assessments. It takes less than 20 seconds to perform and consists of two components:
- Level of consciousness as measured by the Richmond Agitation Sedation Scale (RASS).
 - Inattention by spelling the word "LUNCH" backwards.
 - If the patient has a RASS of 0 (normal level of consciousness) or makes 0 or 1 error on "LUNCH" backwards spelling test, then the DTS is considered negative. Because the DTS is 98% sensitive, delirium is ruled out in this case and no additional delirium testing is needed. If the individual has a RASS other than 0 (altered level of consciousness) or makes 1 error on the "LUNCH" backwards spelling test, then the DTS is considered positive. Because the DTS is 55% specific, confirmatory testing is needed using the bCAM or CAM to rule in delirium.

Slide 49:

- The Brief Confusion Assessment Method (bCAM) is a delirium assessment that takes less than 2 minutes to perform. The bCAM is a modified CAM-ICU to quickly determine the presence of inattention and disorganized thinking. Inattention is measured by asking the PLWD to recite the

months backward from December to July. The individual must be considered inattentive to receive a positive result for delirium. The Richmond Agitation Sedation Scale (RASS) is given, and any score greater than 0 is positive for delirium. Finally, PLWD are asked 4 common sense questions. Presence of any error is considered positive for delirium.

- The DTS and bCAM have been validated as efficient and effective screening tools for delirium in the ED.

Slide 50:

- Geriatric ED guidelines recommend that the evaluation of a mental status change begin with an understanding of the difference between a delirium and a progression of an underlying dementia. ED staff should also keep in mind that as mental status changes may wax and wane, delirium screening should be reevaluated on a regular basis.
- Reference: (American College of Emergency Physicians, 2013)

Slide 51:

- Once delirium has been identified it is necessary to establish the etiology. A detailed history and physical examination is crucial. ED staff should focus on particular signs and symptoms of infection, which is one of the common precipitants of delirium, but also carefully review the PLWD's medications, as well as taking care to identify a history of alcohol and benzodiazepine misuse. Other commonly missed precipitants for delirium in older PLWD are urinary retention, constipation, and pain in an individual who is unable to articulate it clearly.

Slide 52:

- The approach to the management of behavioral disturbances in PLWD should be structured and thorough, with the safety of the individual and caregivers as paramount. ED staff should take care in identifying what tests and tools will be used with PLWD. All procedures should be explained fully and patiently to PLWD and their families. Remember to emphasize the importance of pursuing accurate diagnoses in order to maximize positive outcomes and minimize negative outcomes for PLWD.

Slide 54:

- The presence of delirium results in poor outcomes, regardless of its cause (Fong et al., 2009).
- Non-pharmacological strategies include reorientation and behavioral intervention, reducing sensory impairments by providing glasses, hearing aides, and dentures, NEVER using physical restraints (such as a catheter or a saline drip); and providing a quiet, low-light environment to promote undisturbed sleep.
- The different subtypes of delirium (hyperactive, hypoactive and mixed) may require different pharmacological interventions (if they are deemed appropriate) but further study is required before recommendations can be made. Persons living with dementia who experience delirium have worse cognitive function and higher rates of hospitalization, institutionalization and death.

Slide 55:

- The presence of a cognitive impairment contributes to the possibility of discharge failure. People with a cognitive impairment may have difficulty understanding their diagnosis, prognosis, and treatment plan. They may have difficulty coordinating and following medication schedules, using new medical equipment, and following through on future health care provider appointments. Discharge failure is a discharge that does not meet one of these three main criteria.

Slide 56:

- Depending on the perspective of the clinician, discharge failure can be defined in a variety of ways. All of these descriptions can result in significant impact on the individual and the health care system as a whole, increasing the likelihood of negative outcomes for the individual, and increasing overall cost for the system.

Slide 57:

- Cognitive impairment is an important risk factor for ED staff to consider when treating a PLWD. Undoubtedly, these risk factors are correlated, and it is challenging to determine the independent contribution of each risk. The presence of a cognitive impairment can put a PLWD at increased risk for a variety of poor outcomes, including ED revisits, poor prescription compliance, poor PCP follow-up, and poor comprehension of discharge instructions. As noted earlier, frequency of previous ED visits also is a strong predictor of discharge failure. People with cognitive impairments were more likely to revisit the ED at three, six, and 12-months post-discharge.
- Reference: (Johns Hopkins University, Armstrong Institute for Patient Safety and Quality, 2014)

Slide 58:

- The Geriatric ED will have discharge protocols in place that facilitate the communication of clinically relevant information to the PLWD/family and outpatient care providers, including nursing homes. This information should always be presented in a way that is suited for elder adults, including large font discharge instructions and HIPAA compliant copied discharge instructions for the individual and family or caretakers as needed. Note these guidelines address the criteria for a quality discharge (as opposed to a discharge failure) as discussed earlier.

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- A clear process for follow-up is essential to an effective, quality discharge from the Emergency Department. The PLWD, and their care partner if appropriate, should know what the process and the plans are. Communicate this both verbally and in writing at the time of discharge. The follow up may involve communication with the PLWD, their care partners, and their providers; as well as any plans for further evaluation or care.

Slide 60:

- When all these discharge guidelines are implemented collectively, a geriatric ED can expect to see improvements in patient care, customer service, and staff satisfaction. Note these guidelines

address the criteria for a quality discharge (as opposed to a discharge failure) as discussed earlier.

Slide 61:

- Keep in mind that even persons with early stage dementia or mild cognitive impairment are able to participate in treatment planning, and there are tools to assess their capacity for decision making. Recognize the care partner is a part of the dementia support system and acute care providers should engage care partners AND PLWD as much as possible in the discharge planning process. Utilize social services when appropriate and discuss the importance of advance directives and power of attorney options.
- The care partner (s) is/are a part of the client support system and acute care providers should engage care partners and PLWD—as much as realistically possible—in the discharge planning process.

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- For a PLWD, it is always best to have a familiar face nearby. Obviously, this is not always possible as caregivers need rest and respite from the great toll caregiving can extend. Therefore, it is important for hospitals and EDs to have other options such as sitters, dementia rooms available, and follow a variety of preventative protocols meant to prevent negative events such as falls or escalation of agitation, aggression, or other potentially injurious behavior.

Slide 63:

- The comfort and safety of a PLWD should always be paramount. Environmental and schedule modifications should be utilized when appropriate to improve well-being and decrease the risk of adverse events related to challenging or problem behaviors.
- Provide a consistent, predictable routine. Ask the primary caregiver for the person's usual routine and follow it as closely as possible.
- Encourage the use of favorite objects from home (i.e., favorite pillow or quilt or photo).
- Provide care by the same nurses and nursing assistants as much as possible.
- Avoid surrounding the PLWD with several doctors and medical students at one time.
- Evaluate the PLWD for sources of potential pain and discomfort. Even though he/she may be experiencing pain, the PLWD will probably not verbally complain.
- When possible, schedule tests at a time of day when the PLWD is at his best and not fatigued.
- Discontinue asking orientation questions once the PLWD's level of comprehension is established.
- Limit visitors to one or two at a time.
- Cue the PLWD for sleep by darkening and quieting the room.
- No daytime napping
- Avoid using physical restraints. They do not prevent falls and injuries from falls while the PLWD is restrained are often more serious.

Slide 64:

Resources:

- [Integrated Medicine/Comprehensive Care Practice Redesign for Dementia: The UCLA Alzheimer's and Dementia Care Program Retrieved](#)
- [Dementia Friendly Hospitals—Care Not Crisis Retrieved](#)
- Partner with Me Project-- [Video Partnering with Family Caregivers: A Guide for Hospitalization When Your Loved One has Dementia Retrieved from USCF - Surgery and Hospitalization](#)
- P.A.C.E.—Program for All Inclusive Care for the Elderly Retrieved from www.cms.gov
- [New resource-14th Annual Report to the Secretary of Health and Human Services and the U.S. Congress, Rethinking Complex Care: Preparing the Healthcare Workforce to Foster Person Centered Care. Retrieved](#)
- [The SHARE Approach—Achieving Patient-Centered Care with Shared Decision Making: A Brief for Administrators and Practice Leaders](#)

Slide 65:

Resources:

- [Alzheimer's Disease Research Centers Retrieved](#)
- [Integrated Medicine/Comprehensive Care Practice Redesign for Dementia: The UCLA Alzheimer's and Dementia Care Program Retrieved](#)
- [Dementia Friendly Hospitals—Care Not Crisis](#)
- Partner with Me Project-- [Video Partnering with Family Caregivers: A Guide for Hospitalization When Your Loved One has Dementia](#)
- P.A.C.E.—Program for All Inclusive Care for the Elderly Retrieved from www.cms.gov
- New resource-14th Annual Report to the Secretary of Health and Human Services and the U.S. Congress, [Rethinking Complex Care: Preparing the Healthcare Workforce to Foster Person Centered Care.](#)
- [The SHARE Approach—Achieving Patient-Centered Care with Shared Decision Making: A Brief for Administrators and Practice Leaders.](#)

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- These items are provided to allow faculty to evaluate what students have learned. The items can be used in several ways including given at the end of the lecture to assess knowledge or as a pre-post test to assess knowledge gain. These items have face validity. Psychometric testing was not conducted on these items.

Answers:

1. c. Adults with Down syndrome have a low risk of developing Alzheimer's disease.
2. b. Sudden onset of increased agitation towards people who are not really there

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Answer

3. a. Leave the PLWD alone until he/she calms down

4. c. Hyperactive, Mixed, Hypoactive