These educational flip charts are not a stand-alone resource. Please consult the PA Toolkit Modules for further information and references.
Delirium
Dyspnoea
Nutrition and hydration
Oral care
Delirium
Pain
Pain

Pain is a subjective experience, occurring when and where the resident says it does.

“Pain is a more terrible lord of mankind than even death itself.”

Albert Schweitzer
Facilitators notes:

**Pain**

**Scope:**
This module is appropriate for:
Careworkers (assistants-in-nursing)

**Materials needed:**
Abbey pain scale form (from PA Toolkit)
Visual analogue (0-10) pain scale ruler

**Learning Objectives**
By the completion of the session participants will be able to:
• define pain
• understand how to identify pain in residents who can and cannot communicate
• identify appropriate non-pharmacological approaches to treating pain
• understand, on a basic level, the interventions that nursing and medical staff may utilise.

**Key Points**
• Pain is a subjective experience occurring when and where the resident says it does.
• Older people may deny ‘pain’, instead using words like ‘ache’, ‘soreness’ and ‘stabbing’.
• Pain is more than just a physical symptom.
• The experience and perception of pain is strongly influenced by a resident’s previous pain experiences, culture, spiritual beliefs, social relationships and other physical symptoms they may be experiencing.
• In 1931, the French medical missionary Dr. Albert Schweitzer wrote: ‘Pain is a more terrible lord of mankind than even death itself’.

*Ask the group what he meant by that.*
See: Recognise and assess pain

Ask

“How bad is your pain?
Give me a score out of ten”

or

‘Which of these words describes how bad your pain is?’
Facilitators notes:

See: Recognise and assess pain

If the resident can communicate
Ask the resident if they have any pain.

Tips

- Older people may deny ‘pain’, instead try words like ‘ache’, ‘soreness’ and ‘stabbing’.
- Most pain in older people is related to activity. Ask them when they are moving, transferring, being turned in bed; not when they are at rest.
- Allow enough time for the resident to think about the question and reply.
- Ask more than one question, such as “Does it hurt anywhere?” or “Do you have any aching or soreness?” or “Do you have any pain or discomfort?”

Severity of pain
Ask the resident
‘How bad is your pain? Give me a score out of ten’

Or

Get the resident to look at a visual scale which should use large clear letters/numbers and be presented under good lighting.

Everyone has their own pain threshold
It is unfair and of no use to compare the scores of different residents.

What is most important is whether the score changes over time for each resident.

Important
If a resident rates their pain as severe or they report chest pains or have difficulty breathing: Treat it as an emergency and call a nurse immediately.
See: Recognise and assess pain

Resident who cannot communicate

What is important?

• behaviours
• facial expressions

Especially important when they change over time
Facilitators notes:

**See: Recognise and assess pain**

**Resident who cannot communicate**

One of the most difficult aspects of caring for the resident who cannot communicate (or has cognitive deficits such as advanced dementia) is identifying whether they are experiencing pain.

The most effective method is to observe their behaviours and facial expressions.

*Discuss the differences in facial expressions.*
**Abbey Pain Scale**

<table>
<thead>
<tr>
<th>Vocalisation</th>
<th>Physiological changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• whimpering, groaning, crying</td>
<td>• perspiring, flushed or pale skin, abnormal temperature, pulse or blood pressure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facial expression</th>
<th>Physical changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• looking tense, frowning, grimacing, looking frightened</td>
<td>• skin tears, pressure areas, arthritis, contractures, previous injuries</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in body language</th>
<th>Scored absent, mild, moderate or severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>• fidgeting, rocking, guarding part of the body, withdrawn</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Behaviour changes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• increased confusion, refusing to eat, alteration in usual patterns</td>
<td></td>
</tr>
</tbody>
</table>
Facilitators notes:

See: Recognise and assess pain

Abbey Pain Scale

A common assessment tool for residents with cognitive impairment is the Abbey Pain Scale. It gives a score out of 18 that can be compared over time.

If careworkers document pain levels in your facility hand out the assessment form as an example.

Most pain in older people is related to activity. The assessment is best undertaken when they are moving, transferring, being turned in bed; not when they are at rest.

Vocalisation
Whimpering, groaning, crying

Facial expression
Looking tense, frowning, grimacing, looking frightened

Changes in body language
Fidgeting, rocking, guarding part of the body, withdrawn

Behaviour changes
Increased confusion, refusing to eat, alteration in usual patterns

Physiological changes
Perspiring, flushed or pale skin, abnormal temperature, pulse or blood pressure

Physical changes
Skin tears, pressure areas, arthritis, contractures, previous injuries

Scored absent, mild, moderate or severe
Say: Report your assessment

- Be SPECIFIC when reporting pain to a nurse
- Immediately report ANY severe or worsening pain to the nurse
- Do NOT wait to see if it gets better
Facilitators notes:

**Say: Report your assessment**

*Emphasise:* Provide clear appropriate information when discussing or documenting the incidence or assessment of pain.

*What to say*

‘Mrs S appears to have pain. She grimaces when we transfer her from sit to stand. This is not her normal behaviour. It has happened three times today so far. She says it is a new pain’.

*Is much better than:*

‘Mrs S has got pain. You need to see her to sort it out’.

*Sometimes it is an emergency*

If a resident rates their pain as severe, or they report chest pains and difficulty breathing: treat it as an emergency and call a nurse immediately.
Do: Manage the pain

Manual handling
- comfortable positioning
- take time to position lifters and other equipment to prevent pain
- prevent twisting or stretching of joints or muscles

Massage and other therapies

Always provide care as directed in the resident’s care plan.

If unsure, speak to the nurse.
**Facilitators notes:**

**Do: Manage the pain**

<table>
<thead>
<tr>
<th>Manual handling</th>
<th>Emphasise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• comfortable positioning</td>
<td>Always provide care as directed in the resident’s care plan.</td>
</tr>
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<td>• take time to position lifters and other equipment to prevent pain</td>
<td>If unsure about any aspect, speak to the nurse.</td>
</tr>
<tr>
<td>• prevent twisting or stretching of joints or muscles</td>
<td></td>
</tr>
<tr>
<td>Massage and other therapies</td>
<td></td>
</tr>
</tbody>
</table>

**Non-pharmacological**

Careworkers have the ability to help manage a resident’s pain with some simple yet very effective activities.

Be sure to think about the following when you next provide care to a resident:

- Is the resident lying or sitting in a comfortable position?
- Do you take the time to position lifters and other equipment to prevent pain?
- Does the resident have to twist or stretch their joints or muscles abnormally when being transferred?
- Can you think of any other interventions?

Massage and other therapies can provide relief for residents.
Do: Manage the pain

What will the nurse or doctor do?

<table>
<thead>
<tr>
<th>Analgesic medications</th>
<th>Superficial heat (NOT cold)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple</td>
<td>Education (resident and family)</td>
</tr>
<tr>
<td>• paracetamol</td>
<td>TENS machine</td>
</tr>
<tr>
<td>Strong</td>
<td>Referral to other health professionals</td>
</tr>
</tbody>
</table>
| • Morphine, fentanyl, oxycodone, buprenorphine (Norspan) | Consider waiting > 30 minutes after analgesic medication before providing any care that is known to cause pain or discomfort.
Do: Manage the pain
What will the nurse or doctor do?

Medications have an important role in managing many types of pain

Opioids (e.g. morphine, oxycodone, narspan or fentanyl) are a type of strong analgesic. Sometimes residents, family members and even aged care staff may have concerns about these medications. It is important to know that, when used correctly, opioid medicines:

• **do not lead to addiction or dependence**
  Opioid medicines are not addictive when used for pain. Addiction only occurs when people have no pain and they abuse opioid medicines.

• **do not hasten death**
  Morphine and other opioid medicines are for improving life — not hastening death. Some people fear that being prescribed opioid medicines means that they’re closer to the end. However, relieving pain changes the quality of life — not its length.

• **do not cause terrible side-effects**
  All medicines can have side effects. The side effects of opioid medicines (constipation, drowsiness, nausea, dry mouth) are usually manageable.

**Emphasise**
Consider waiting at least 30 minutes after a resident has been given analgesic medication before providing any care that is known to cause them pain or discomfort.

**Referral to other health professionals**
• physiotherapist
• occupational therapist
• pain clinic
• specialist palliative care.

Superficial heat (NOT cold)
Education (resident and family)
TENS machine
Referral to other health professionals
Write: Document your actions

If you write in clinical notes or on assessment charts
Avoid general statements!
Be specific

Review: Evaluate and reassess as necessary

Evaluate your care
Q: Did it help?
Yes: keep doing it
No: tell the nurse

*Insanity = doing the same thing over and over again and expecting different results.*
Albert Einstein
Facilitators notes:

Write: Document your actions

Documentation
If careworkers document in the clinical record or handover sheets, emphasise that they should be as detailed as possible, avoiding generalised statements.

Example
Instead of ‘with effect’ or ‘effective’, write:
‘Resident states pain has reduced to 2/10 score (was 5/10)’.

Review: Evaluate and reassess as necessary

After helping to relieve or prevent pain, consider:
• Did it help?
• If Yes: keep doing it, regularly!
• If No: tell the nurse

Insanity = doing the same thing over and over again and expecting different results. Albert Einstein
Dyspnoea
Dyspnoea

Dyspnoea  =  breathlessness or shortness of breath
an awareness of uncomfortable breathing

‘It’s funny, but you never really think much about breathing, until it’s all you ever think about.’

Tim Winton (Breath)
Facilitators notes:

**Dyspnoea**

**Scope:**
This module is appropriate for:
Careworkers (assistants-in-nursing)

**Materials Needed:**
Oxygen nasal specs

**Learning Objectives**
By the completion of the session participants will be able to:
• define dyspnoea as an awareness of uncomfortable breathing
• identify dyspnoea in a resident
• implement non-pharmacological strategies within a careworkers scope of practice for a resident with dyspnoea
• have a basic understanding of which medications are used to treat dyspnoea
• understand, on a basic level, the interventions that nursing and medical staff may utilise including medications.

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_Read the quote by Tim Winton out loud._

'It's funny, but you never really think much about breathing, until it's all you ever think about.'

Tim Winton (Breath)

Quote is from Australian author Tim Winton's book Breath published in 2008 by Penguin books

_Ask participants if they have ever been severely short of breath._

_What did it feel like?_  

_Can they identify with the quote?_
See: Recognise and assess dyspnoea

Rapid and/or laboured breathing
Cough
Increased sputum
Wheeze
Chest pain
Fatigue
Panic

• often worsens as death approaches
• impairs ADLs, mobility & social isolation
• is frightening for resident and family
See: Recognise and assess dyspnoea

Ask:

What might you notice in a resident that could be related to dyspnoea?
- rapid and/or laboured breathing
- cough
- sputum
- wheeze
- chest pain
- fatigue
- panic.

Often anxiety is a major component of dyspnoea.
Dyspnoea triggers panic, and panic exacerbates dyspnoea, so the pattern becomes cyclical.
Dyspnoea can impair a resident's activities of daily living, limit mobility, increase anxiety, and can leave them feeling fearful and socially isolated.
- It can also be a sign of a deteriorating condition in residents receiving a palliative approach.
- Dyspnoea may also be a distressing and frightening symptom for the family. This can lead to increased anxiety for the resident which may increase their dyspnoea.
Ask

“How bad is your shortness of breath?
Give me a score out of ten”

or

‘Which of these words describes how bad your shortness of breath is?’
Facilitators notes:

See: Recognise and assess dyspnoea severity

Severity
Use a Rating Scale

ASK
‘On a scale of zero to 10, with zero meaning no shortness of breath, and 10 meaning the worst shortness of breath possible, how much shortness of breath do you have right now?’

OR:
Get the resident to look at a visual scale which should use large clear letters/numbers and be presented under good lighting.

Please note: while dyspnoea is the term health professionals use, it is better to refer to it as breathlessness when talking to residents or family members.

Note: Some residents may not be able to understand these questions due to cognitive impairment or difficulty communicating. Instead, take time to observe their breathing rate and any resulting impact on their mood, sleep or function.
Say: Report your assessment

Be SPECIFIC when reporting information to a nurse

Immediately report ANY severe or worsening breathing problems to the nurse

Do NOT wait to see if it gets better
Say: Report your assessment

*Emphasise:*
Provide clear appropriate information when discussing or documenting anything about the residents abnormal breathing to a nurse. This will allow them to decide how urgently they need to review the resident.

*Ask*
“Which of the following would be most effective?”

**Careworker to Nurse:**
‘Bob appears to be short of breath. He cannot walk to the dining room without having to stop twice to catch his breath. He says it has been a problem for a few days now.’

*Is much better than:*
‘Bob can’t breathe properly, please come and review him.’

Just because a resident requires a palliative approach does not mean that dyspnoea is normal or that nothing can be done. Problems like asthma or cardiac chest pain can become worse very quickly and early detection of an episode is very important.
Do: Manage the dyspnoea

Increase air movement
• open doors and windows
• fans

Prevent overheating and claustrophobia
• exhaust fan in bathroom
• deflect the shower water away from the face

Reduce exertion
• frequent rest breaks
• don’t rush

Position resident appropriately

Always provide care as directed in the resident’s care plan.
If unsure, speak to the nurse.
**Do: Manage the dyspnoea**

*Emphasise*

Focusing on these management strategies can often help the resident decrease the need for medication and oxygen.

- Increase air movement around the resident – open doors and windows, use bedside fans.
- Prevent overheating – exhaust fan in bathroom, cool face cloths.
- Deflect the shower stream away from the face.
- Use strategies to adapt physical activity to reduce the need for exertion.
- Position appropriately – propping up the resident with pillows.

*Demonstrate sitting forward over a pillow or table to expand chest cavity.*
Do: Manage the dyspnoea

- reassurance
- calm presence
- listen empathically
- slow down!
**Do: Manage the dyspnoea**

- Fear and anxiety about not being able to breathe is very real and can actually increase shortness of breath.
- Listen empathically to the resident’s concerns.
- Try not to rush activities (as hard as that is when you are busy!)

*Emphasise Again*

Focusing on these management strategies can often help the resident avoid medication and oxygen.
Do: Manage the dyspnoea

What will the nurse or doctor do?

**Opioids**
- decrease the feeling of dyspnoea

**Benzodiazepines**
- can help with the severe anxiety

**Oxygen**
- few residents benefit from oxygen
- only nurses start oxygen or changes flow rate
- mouth/ nasal / skin care becomes more important
**Do: Manage the dyspnoea**

**What will the nurse or doctor do?**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>• Decrease the feeling of dyspnoea</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>• Mouth/nasal/skin care becomes more important</td>
</tr>
</tbody>
</table>

*Facilitators notes:*

Careworkers do not need to know about medications in any detail. They can however observe the effects and side effects of medications.

**Opioids (like morphine)**
- Are not just for treating pain.
- Some residents may require them regularly or only when breathing worsens.
- Opioids decrease the feeling of dyspnoea and decrease oxygen consumption.

**Benzodiazepines (like diazepam)**
- Can help with the anxiety and panic but do not by themselves help the dyspnoea.

**Oxygen**
- Few residents with dyspnoea will benefit from oxygen.
- Being short of breath does not mean that a resident needs oxygen.
- Do NOT start oxygen yourself or change the flow rate.
Write: Document your actions

If you write in clinical notes or on assessment charts
Avoid general statements!
Be specific

Review: Evaluate and reassess as necessary

Evaluate your care
Q: Did it help?
Yes: keep doing it
No: tell the nurse

*Insanity = doing the same thing over and over again and expecting different results.*

Albert Einstein
Facilitators notes:

**Write: Document your actions**

**Documentation**
If careworkers document in the clinical record or handover sheets, emphasise that they should be as detailed as possible, avoiding generalised statements.

**Example**
Instead of ‘with effect’ or ‘effective’, write:
‘Resident states dyspnoea has reduced to 2/10 score (was 5/10).’

**Review: Evaluate and reassess as necessary**

After helping to relieve or prevent dyspnoea, consider:
• Did it help?
• If Yes: keep doing it, regularly!
• If No: tell the nurse

Insanity = doing the same thing over and over again and expecting different results. Albert Einstein
Nutrition and hydration
Nutrition and hydration

Towards the end of life the body begins to shut down because of disease and the dying process not because of a lack of food and liquid.

‘Not eating/drinking’ does not cause the dying process

‘Not eating/drinking’ is part of the dying process
Nutrition and hydration

Facilitators notes:

Scope:
This module is appropriate for:
Careworkers (Assistants-in-nursing)

Materials needed
Subcutaneous cannula (intima or similar)

Learning Objectives
By the completion of the session participants will be able to:
• Appreciate that not eating or drinking is part of the dying process rather than the cause.
• Report and document common problems relating to nutrition and hydration at the end-of-life.
• Describe the positive and negative aspects of artificial nutrition and hydration.
• Understand, on a basic level, the interventions that nursing and medical staff may utilise.

Key Points
• Artificial nutrition or hydration is generally considered to be a life sustaining measure or medical treatment.
• At the end-of-life, it is important to remember that the person’s body is beginning to shut down because of the disease and dying process, not because of the absence of food and liquid.
• Family members may find it difficult to distinguish between ‘not eating’ as part of the dying process and ‘not eating’ as bringing about the dying process.
• Just because something is reversible does not mean it should be reversed. Decisions need to be made considering the residents prognosis and any previous decisions/wishes about life sustaining care.

Towards the end of life the body begins to shut down because of disease and the dying process not because of a lack of food and liquid.
‘Not eating/drinking’ does not cause the dying process
‘Not eating/drinking’ is part of the dying process
See: Recognise and assess nutrition issues

- decreased need for “energy”
- poor appetite
- difficulty swallowing
- oral/mouth problems
Facilitators notes:

**See: Recognise and assess nutrition issues**

Residents requiring a palliative approach frequently lose interest in eating.
Their poor appetite may simply be because they have a decreased need for energy.
Functional issues can also be present:
- difficulty swallowing
- inability to manage cutlery, cups etc.

**Other potential problems:**
- medication side effects
e.g. nausea, constipation
- emotional problems; depression, anxiety
- swallowing disorders
- oral factors
- not culturally appropriate food
- wandering and other dementia-related behaviours
- metabolic problems
- enteric problems (bowel does not absorb nutrients)
- socially inappropriate food or environment, lack of interaction, inappropriate positioning of resident.
See: Recognise and assess hydration issues

Dehydration?
Not drinking enough?
• dry mouth
• sunken eyes
• dizziness
• headaches
• decreased urination
• weakness

OR
• mouth breathing
• medication side effects
• prolonged bed rest
• oxygen therapy
• oral supplements
See: Recognise and assess hydration issues

As the resident approaches the end of life, these may also be caused by:
• prolonged bed rest
• side effects of medications
• mouth breathing
• supplemental oxygen administration
• the use of oral supplements.

Emphasise
These do not respond to simply increasing the intake of fluids either orally or by artificial means.
Say: Report your assessment

- Be SPECIFIC when reporting information to a nurse
- Immediately report ANY choking or new swallowing problems
- Do NOT wait to see if it gets better
Facilitators notes:

**Say: Report your assessment**

*Emphasise:*
Residents get the best outcomes when you provide clear information when discussing or documenting nutrition or hydration issues.

Provide clear appropriate information when discussing or documenting nutrition / hydration issues.

*What to say*

**Careworker to RN.**
‘Mrs S appears to be having trouble with her breakfast this morning. She was coughing. She says she has had some trouble swallowing for a few days.’

*Is much better than:*
‘Mrs S couldn’t eat her breakfast. You need to see her to sort it out.’
Do: Manage nutrition issues

Oral nutrition is preferable
- requires diligent hand feeding
- offer smaller more frequent meals
- don’t rush or force feed
- oral care becomes a priority
Do: Manage nutrition issues

Oral nutrition is preferable
• This requires diligent hand feeding to remain effective as the resident deteriorates.
• Smaller more frequent meals are more appropriate than three larger more traditional offerings.
• Select a diet based on resident preferences, lifelong food habits and identification of swallowing problems.
• Consulting a dietician versed in the palliative approach may be of benefit.
• When feeding causes choking, nutrition can be provided in liquid form that has been thickened with proprietary agents.
**Do: Manage nutrition issues**

**Artificial nutrition**

<table>
<thead>
<tr>
<th>Positives / Benefits</th>
<th>Negatives / Burdens</th>
</tr>
</thead>
<tbody>
<tr>
<td>• being seen to be doing something</td>
<td><strong>Does not:</strong></td>
</tr>
<tr>
<td></td>
<td>• prolong life</td>
</tr>
<tr>
<td></td>
<td>• improve comfort</td>
</tr>
<tr>
<td></td>
<td>• improve quality of life</td>
</tr>
<tr>
<td></td>
<td>• prevent pneumonia</td>
</tr>
<tr>
<td></td>
<td>• improve nutrition</td>
</tr>
<tr>
<td></td>
<td>• decrease pressure sores</td>
</tr>
</tbody>
</table>
**Facilitators notes:**

**Do: Manage nutrition issues**

**Artificial nutrition**

Artificial nutrition is usually administered through an enteric gastrostomy (PEG) tube.

**There is no evidence that enteral tube feeding:**
- prolongs life
- improves comfort or quality of life
- prevents aspiration pneumonia
- leads to better nourishment
- decreases the risk of pressure sores.

A swallowing assessment is mandatory if there is any sign of dysphagia. Registered speech pathologists should be consulted as necessary.

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</tbody>
</table>

**Does not:**
- prolong life
- improve comfort
- improve quality of life
- prevent pneumonia
- improve nutrition
- decrease pressure sores
Do: Manage hydration issues

Artificial hydration

Positives / Benefits
• can help some reversible problems
• seen to be doing something

Negatives / Burdens
• does not help dry mouth

Can worsen:
• vomiting
• dyspnoea
• respiratory secretions
• oedema / swelling
• ascites
Facilitators notes:

**Do: Manage hydration issues**

**Artificial hydration**

Not normally used in the terminal phase when a resident is expected to die within 48 – 72 hours. May be useful for time limited use when dehydration is caused by a potentially reversible cause:
- over treatment of diuretics
- unintended sedation from medications (opioids etc)
- recurrent vomiting or diarrhoea.

Most appropriately administered via the subcutaneous route (hypodermoclysis).

If you have a subcutaneous cannula such as an intima, show participants.

**Fluid accumulation may be an adverse effect of artificial hydration at end-of-life**
- increased urinary output
- increased fluid in GI tract – vomiting
- pulmonary oedema, pneumonia
- respiratory tract secretions
- ascites.

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**Positives / Benefits**
- can help some reversible problems
- seen to be doing something

**Negatives / Burdens**
- does not help dry mouth
  - Can worsen:
    - vomiting
    - dyspnoea
    - respiratory secretions
    - oedema / swelling
    - ascites
Write: Document your actions

If you write in clinical notes or on assessment charts
Avoid general statements!
Be specific

Review: Evaluate and reassess as necessary

Evaluate your care
Q: Did it help?
Yes: keep doing it
No: tell the nurse

*Insanity = doing the same thing over and over again and expecting different results.*

Albert Einstein
Facilitators notes:

**Write: Document your actions**

**Documentation**
If careworkers document in the clinical record or handover sheets, emphasise that they should be as detailed as possible, avoiding generalised statements.

**Example**
Instead of ‘ate well’ or ‘well hydrated’, write:
‘Resident ate 3 spoonfuls of soft custard and did not have any swallowing problems.’ or:
‘Resident accepting sips of fluid. Says she still feels thirsty. Tongue not as dry as this morning’.

**Review: Evaluate and reassess as necessary**

For any interventions related to nutrition or hydration, consider:
• Did it help?
• If Yes: keep doing it
• If No: tell the nurse

Insanity = doing the same thing over and over again and expecting different results. Albert Einstein
Oral Care
A healthy mouth is...

- clean
- intact
- moist
- not infected
- not painful
Oral Care

Scope:
This module is appropriate for:
Careworkers (assistants in Nursing)

Materials Needed:
• torch
• tongue depressor and toothbrush
• disposable gloves
• mouth swabs.

Learning Objectives
By the completion of the session participants will be able to:
• describe what is required for a healthy mouth
• be able to simply assess the oral health of a resident
• know what to do if you find something abnormal
• provide standard protective care for residents with their own teeth or dentures
• provide oral care for a resident in the terminal phase of their life who cannot swallow.

Ask
What do we need a mouth for?

Answer:
• communicating: talking, smiling etc.
• chewing
• swallowing
• tasting
• kissing!

In order to do these we need a healthy oral cavity that is:
• clean
• intact
• moist
• not infected
• not painful.

Careworkers have a key role in helping residents who require a palliative approach to maintain their oral health.
See: Recognise and assess

Look:

- every meal time
- when cleaning teeth/dentures
- performing mouth care.

- Lips
- Tongue
- Gums and tissues
- Saliva
- Teeth/ Dentures
- Cleanliness
Facilitators notes:

**See: Recognise and assess**

Careworkers are most likely to notice problems as they:
- are the ones that provide mouth care
- feed the resident
- spend most time with the resident.

**Look at the:**
- lips
- tongue
- gums and tissues
- saliva
- teeth / dentures
- cleanliness.

**Look:**
- every meal time
- when cleaning teeth/dentures
- performing mouth care.
Say: Report your assessment

- bad breath
- sore mouth and gums
- lip blisters/sores/cracks
- difficulty eating
- broken teeth
- bleeding gums
- pain in mouth/lips
- tongue coated or abnormal colour
- excessive food left in mouth
- mouth ulcer
- refusing oral care
- swelling of face/mouth
- denture broken/lost
Facilitators notes:

**Say: Report your assessment**

Careworkers are ideally suited to noticing problems during feeding or oral care.

Need to report problems to nursing staff if they are even slightly worried.

**Don’t assume someone else has already reported it.**

*Emphasise*

Some of these issues can begin as minor problems but have the potential to develop into significant ones resulting in decreased quality of life for the resident.

- bad breath
- sore mouth and gums
- lip blisters/sores/cracks
- difficulty eating
- broken teeth
- bleeding gums
- pain in mouth/lips
- tongue coated or abnormal colour
- excessive food left in mouth
- mouth ulcer
- refusing oral care
- swelling of face/mouth
- denture broken/lost
## Do: Manage oral care

### Standard protective care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brush Morning and Night</td>
<td>High Fluoride Toothpaste on Teeth</td>
</tr>
<tr>
<td>Soft Toothbrush on Gums, Tongue and Teeth</td>
<td>Antibacterial Product After Lunch</td>
</tr>
<tr>
<td>Keep the Mouth Moist</td>
<td>Cut Down on Sugar</td>
</tr>
</tbody>
</table>
Facilitators notes:

Do: Manage oral care

Standard protective care

Standard protective care should be provided for all residents requiring a palliative approach who can still eat and drink.

Own Teeth
- high fluoride toothpaste (5000ppm) morning and night
- soft toothbrush to brush teeth, gums and tongue morning & night
- antibacterial product after lunch
- keep mouth moist – drink water after meals, medications & other drinks and snacks.

Dentures
- label dentures
- brush dentures morning and night using mild soap
- rinse well under running water
- brush gums and tongue with soft toothbrush morning and night
- remove dentures overnight, clean and soak in water
- disinfect dentures weekly
- encourage resident to drink water after meals, medications & other drinks and snacks.
**Do: Manage oral care**

**Specific problems**

<table>
<thead>
<tr>
<th>Dry Mouth</th>
<th>Pain or Ulceration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moisten oral cavity</td>
<td>Rinse or swab mouth with warm saline</td>
</tr>
<tr>
<td>Water-based moisturiser to lips</td>
<td>Check denture fitment</td>
</tr>
<tr>
<td>Discourage strong drinks</td>
<td>Avoid spicy or acidic foods or food with sharp edges</td>
</tr>
<tr>
<td>Reduce caffeine</td>
<td>Offer cold, soft food</td>
</tr>
<tr>
<td>Stimulate saliva</td>
<td>Local or systemic analgesics as required</td>
</tr>
<tr>
<td>Encourage resident to drink water</td>
<td>Medical review if not resolved within 7 days</td>
</tr>
<tr>
<td>Saliva substitutes</td>
<td></td>
</tr>
</tbody>
</table>
Do: Manage oral care

Specific Problems

Dry Mouth (Xerostomia)
- moisten oral cavity with frequent rinsing and sipping of water
- water based moisturiser to lips
- discourage strong cordial, juices or sugary drinks
- reduce caffeine
- stimulate saliva with tooth friendly lollies
- encourage resident to drink water after meals, medications and other drinks and snacks
- saliva substitutes: water spray, oral balance gel or liquid.

Pain or Ulceration
- rinse or swab mouth with warm saline three to four times/day until resolved
- check denture fitment
- avoid spicy or acidic foods or food with sharp edges
- offer cold, soft food
- local or systemic analgesics as required
- medical review if not resolved within 7 days.

Emphasise
Follow the residents care plan.
| Specific Problems | | |
|-------------------|------------------|
| **Coated / Dirty** | **Infection** |
| tongue, mucosa or teeth | Treat the cause |
| Remove debris | Replace toothbrush |
| Mouth rinses | Disinfect dentures daily |
| Brush tongue | |
Facilitators notes:

**Do: Manage oral care**

**Specific Problems**

**Coated tongue, mucosa or teeth**
- remove debris with soft toothbrush or mouth swab
- mouth rinses with water or warm saline 4 times/day
- brush tongue with soft toothbrush

**Infection**
- treat the cause as prescribed by GP or dentist
- replace toothbrush before treatment commences and again when complete
- disinfect dentures daily until resolved

*Emphasise*

Follow the residents care plan
Do: Manage oral care

End of life (terminal) phase

As a resident approaches death they lose the ability to feed themselves or have a drink.
Facilitators notes:

**Do: Manage oral care**

**End of life (terminal) phase**

As a resident approaches death they lose the ability to feed themselves or have a drink. Eventually swallowing becomes difficult and unsafe. Functionally they cannot clean their teeth or oral cavity by themselves. Often this is when a 'mouth care' trolley or tray is seen in the resident’s room.

*Emphasis*

Careworkers should provide oral care every time they enter the residents room

- clean and/or moisten the mouth with a swab
- check the lips, apply moisturiser
- look for any problems as described earlier in this talk.

*When a resident can no longer eat or drink safely at the end of life:*

- apply dry mouth products e.g. water spray, oral balance gel or liquid via mouth swabs
- use a spray bottle for products such as chlorhexidine (alcohol free) mouthwash
- apply water based lip moisturisers
- petroleum based products can increase risk of inflammation and aspiration pneumonia. Also contraindicated during oxygen therapy.

**DO NOT USE MOUTHWASHES AND SWABS CONTAINING:**

- lemon and glycerine
- sodium bicarbonate (high strength)
- preparations containing alcohol or hydrogen peroxide
- pineapple or other juices.

May damage oral tissues and increase risk of infection.
Write: Document your actions

If you write in clinical notes or on assessment charts

Avoid general statements!
Be specific

Review: Evaluate and reassess as necessary

Evaluate your care

Q: Did it help?
Yes: keep doing it
No: tell the nurse

*Insanity = doing the same thing over and over again and expecting different results.*

Albert Einstein
Facilitators notes:

**Write: Document your actions**

**Documentation**
If careworkers document in the clinical record or handover sheets, emphasise that they should be as detailed as possible, avoiding generalised statements.

**Example**
‘Mrs S appears to have a very dry mouth. Swallowing anything more than water is difficult. Her tongue is dry and has white spots and there are some cracks in the corners of her lips. She says it got much worse when the strong pain medications began.’

**Review: Evaluate and reassess as necessary**

**Evaluation**
After delivering oral care to a resident, consider:

- Did it help?
- If Yes: keep doing it
- If No: tell the nurse

Insanity = doing the same thing over and over again and expecting different results. Albert Einstein
Delirium
Delirium

Disorganised
- thinking
- behaviour

Poor attention
- focusing
- sustaining
- shifting

Hallucinations and delusions (possible)
**Delirium**

**Scope**
This module is appropriate for:
- careworkers (assistants-in-nursing).

**Learning Objectives**
By the completion of the session participants will be able to:
- define delirium in terms of its effect on behaviour, thinking and attention
- identify differences between delirium and dementia
- identify clinical signs of delirium
- implement non-pharmacological management strategies within a careworker’s scope of practice
- understand, on a basic level, the interventions that nursing and medical staff may utilise including medications.

**Key Points**
Delirium is a condition where the resident’s behaviour and thinking is disorganised.
They struggle to focus, sustain or shift their attention.
Sometimes hallucinations or delusions are present.
Delirium is distressing not only for the resident but for family and health care workers.
Delirium in older people is often overlooked and misdiagnosed, especially at the end-of-life.
See: Recognise and assess delirium

**Develops** over short period of time

**Fluctuates** during the course of the day

**Lasts** usually for a few days but may be weeks

**Causes:**
- dehydration
- medication side effects
- uncontrolled pain
- infections

**Dementia is different**
See: Recognise and assess delirium

Timeframe:
Delirium develops over a short period of time. Generally fluctuates during the course of the day. Delirium usually only lasts for a few days but may persist for weeks or even months.

Causes:
Delirium is often caused by a combination of factors including dehydration, medication side effects, uncontrolled pain and infections. Dementia on the other hand is a long term impairment of thought processes (cognition) with clear consciousness that develops over a longer period of time than delirium.

Read this aloud to the group:
Alfred who you see here has always been alert with only minor memory impairment.
This afternoon he is very drowsy. He mumbles that he needs help to “catch the chickens” and keeps trying to get out of bed.
He cannot tell you where he is or identify significant family members.
Three days ago he was diagnosed with a urinary tract infection.

Ask:
Do you think Alfred might have a delirium?
Say: Report your assessment

Be SPECIFIC when reporting information to a nurse

Immediately report ANY changes in mental state or altered level of consciousness

Do NOT wait to see if it gets better
Emphasise:

Any new or worsening signs of thought or behaviour always need to be reported to a nurse. Be as clear and detailed as possible.

Ask:

Which do you think is better?

‘Alfred appears to be confused and drowsy. He says he wants to catch “the chickens” and keeps trying to get out of bed. He wasn’t sure who his daughter was when she visited. I noticed the urine in his urinal bottle is very smelly’.

OR

‘Alfred is confused. You need to see him to sort it out’.
Do: Manage the delirium

Remove hazards

Bed
- lowest position
- cot sides down
- against wall

Familiar objects and people

Lighting

Noise

Clock

Avoid room changes
Do: Manage the delirium

Sometimes it may be appropriate to treat the cause (if it is known).

At the end-of-life, non-pharmacological strategies are often better.
• appropriate lighting
• minimise noise especially at night
• provide a clock that the resident can see
• avoid room changes and keep personal and familiar objects in view.

Modify environment to minimise risk of injury e.g. low bed in the lowest position with cot sides down, bed against the wall, potential hazards such as bedside tables removed.

Ask:
Imagine you are Alfred lying in bed at night. It is dark, no one is around and you are confused, frightened and not sure where you are. You hear loud noises in the corridor that sometimes disturb you. Perhaps you want to get out of bed to find somewhere better to be.

Ask:
Which of these measures could they do to decrease Alfred’s distress and even prevent the delirium getting worse.
None of them will cure Alfred’s delirium but many would decrease his fear and anxiety.

Ask:
What else apart from environmental strategies might help? (turn the page to answer this)
**Do: Manage the delirium**

<table>
<thead>
<tr>
<th>Resident Distress</th>
<th>Family Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVOID physical restraint</td>
<td>Explanation</td>
</tr>
<tr>
<td>Reassurance</td>
<td>Reassurance</td>
</tr>
<tr>
<td>Reorientation</td>
<td></td>
</tr>
<tr>
<td>Relaxation</td>
<td></td>
</tr>
<tr>
<td>Sufficient sleep</td>
<td></td>
</tr>
<tr>
<td>Manage pain</td>
<td></td>
</tr>
<tr>
<td>Spectacles and hearing aids</td>
<td></td>
</tr>
<tr>
<td>Interpreters</td>
<td></td>
</tr>
</tbody>
</table>
Do: Manage the delirium

Resident Distress

- address anxiety
  - residents with delirium are often very frightened
- manage discomfort or pain
- minimise sensory deficits by providing & assisting with hearing and visual aids
  n.b. clean spectacles and remove wax deposits in hearing aids. Check batteries are fresh.
- encourage presence of people known to the resident – e.g. family and friends and regular staff members
- reassure and reorientate the resident
- explain and reassure regarding the possible causes and management plan to the resident and their family
- AVOID physical restraint
- use interpreters and communication aids for residents with culturally & linguistically diverse needs
- promote relaxation and sufficient sleep
  e.g. assisted by, massage and/or encouraging wakefulness during the day.

Family Distress

- explanation of the cause if known
- reassurance.

Emphasise
Focusing on these measures can sometimes help the resident avoid medication.

Facilitators notes:
Do: Manage the delirium

What will the nurse or doctor do?

Treat the cause if appropriate

Minimise use of urinary catheters

Review medications

When nothing else works
Do: Manage the delirium

What will the nurse or doctor do?

- Treat the cause if appropriate
  (often not appropriate in the terminal phase)
- Minimise use of urinary catheters (discuss why)
- Medications
  - stop unnecessary medications
  - sometimes medications are needed to reduce the resident’s distress if they are very agitated or having hallucinations
    - Alfred became very agitated despite care workers trying many of the simple measures in the above list. His daughter Sarah was also very upset seeing her father yelling at her and the staff.
    - The nurse administered an injection of haloperidol which was effective in reducing his distress and confusion. He received a number of doses which continued to help without any side effects.

When nothing else works

Unfortunately, sometimes agitation and delirium in the terminal phase causes such severe distress that strong sedative medication is the only appropriate intervention.
Write: Document your actions

If you write in clinical notes or on assessment charts
Avoid general statements!
Be specific

Review: Evaluate and reassess as necessary

Evaluate your care
Q: Did it help?
Yes: keep doing it
No: tell the nurse

Insanity = doing the same thing over and over again and expecting different results.
Albert Einstein
Facilitators notes:

**Write: Document your actions**

**Documentation**
If careworkers document in the clinical record or handover sheets, emphasise that they should be as detailed as possible, avoiding generalised statements.

**Example**
Instead of 'with effect' or 'effective', write: “Resident has not hallucinated in the last two hours and has stopped physically plucking at the bed sheets’.

**Review: Evaluate and reassess as necessary**

After helping to improve safety or relieve distress of delirium, consider:
- Did it help?
- If Yes: keep doing it, regularly!
- If No: tell the nurse

*Insanity = doing the same thing over and over again and expecting different results.*
Albert Einstein