The Palliative Approach Toolkit

Module 3: Clinical care
The Palliative Approach Toolkit was developed as part of the Implementation of a comprehensive evidence based palliative approach in Residential Aged Care (cebparac) project funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPRAC) program.

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The Palliative Approach Toolkit

The Palliative Approach (PA) Toolkit is designed to assist residential aged care facilities to implement a comprehensive, evidence-based palliative approach of care for residents. The PA Toolkit contains:

**Module 1: Integrating a palliative approach**
Module 1 focuses on policies, systems and resources to support a palliative approach in a residential aged care setting.

**Module 2: Key processes**
Module 2 focuses on three key processes essential in implementing a palliative approach:
- Advance care planning
- Palliative care case conferences
- End of life care pathway

**Education resources**
- Three self-directed learning packages
  1. Nurse (Introduction)
  2. Nurse (Advanced)
  3. Careworker (Introduction)
- Two educational DVDs
  1. “A palliative approach in residential aged care: Suiting the needs”
  2. “All on the same page: Palliative care case conferences in residential aged care”
- Five educational flipcharts
  The flipcharts are for short sessional in-service education targeting careworkers and are mapped to the clinical care domains.

**Resource materials**
The PA Toolkit includes several important reference publications:
- “Guidelines for a Palliative Approach in Residential Aged Care – Enhanced Version” 14
- “Therapeutic Guidelines: Palliative Care, Version 3” 49
- “Now What? Understanding Grief” brochure 37
- “Understanding the Dying Process” brochure
- “Invitation and family questionnaire - Palliative care case conference”

**Module 3: Clinical care**
Module 3 focuses on the assessment and management of five clinical care domains:
- Pain
- Dyspnoea
- Nutrition and hydration
- Oral care
- Delirium

For the purposes of this toolkit, nurse will refer to registered and enrolled nurse and careworker will refer to personal careworker, health careworker and assistant-in-nursing.
Throughout the module, we provide examples of assessment tools and forms. Printable versions can be downloaded from “PA Toolkit: Forms CD”.

MODULE 3

What is a palliative approach?

A palliative approach aims to improve the quality-of-life for individuals with a life-limiting illness and their families by reducing their suffering through early identification, assessment and treatment of pain, physical, cultural, psychological, social and spiritual needs.¹⁴

A palliative approach is not restricted to the last days or weeks of life.

A palliative approach offers many benefits to residents, their families and the residential aged care facility (RACF) team including:

• reducing potential distress to residents and their families caused by a transfer to an acute care setting
• reducing the admission and/or transfer of residents to acute care facilities as RACF staff develop the skills to manage the palliative care of residents
• increasing the involvement of the resident and their family in decision making about their care
• encouraging open and early discussion on death and dying
• facilitating advance care planning
• providing opportunities, especially for improved control of pain and other symptoms, in a setting that is familiar to the resident
• offering the resident and family consistent and continuous care by staff with whom they have developed a rapport and positive therapeutic relationship.⁶

Why a palliative approach in residential aged care?

In Australia, the proportion of people dying in residential aged care facilities has steadily increased over the last two decades.³⁹ In addition, residents entering residential care are increasingly frail, often highly dependent and with multiple co-morbidities.³⁹ The complex needs of residents and their families have prompted recognition of the need for a palliative approach.

When should a palliative approach be implemented?

Estimated prognosis is used as a trigger for the key processes in a palliative approach. Three trajectories can be applied to all new and existing residents based on their estimated prognosis (Figure 1).

Residents in trajectory B have a prognosis of six months or less. They are in the palliative phase and require a palliative approach.

Residents in trajectory C have a prognosis of less than one week. They are in the final stages of their illness and require terminal care.

It is important that residents are assessed and identified early and that strategies are developed to address issues of pain management, symptom relief and spiritual and cultural needs.⁵
Figure 1
Palliative approach trajectories

All new and existing residents

Trajectory A
Expected prognosis of greater than 6 months
Annual nurse led case conference including advance care planning
Review 6 monthly
Prognosis 6 months or less

Trajectory B
Expected prognosis of 6 months or less
Palliative care case conference including review of advance care planning
Assessment and management of palliative clinical symptoms
Review monthly
Prognosis less than 1 week

Trajectory C
Expected prognosis of less than 1 week
Commence Residential Aged Care End of Life Care Pathway
Review daily
If prognosis is greater than 1 week

Terminal phase
Trajectory A—Estimated prognosis greater than six months:
All new and existing residents should have the opportunity to express their wishes about advance care planning (see Module 2 for further information) and have these clearly documented in their clinical notes. We recommend that this involves a discussion between the resident, family and the general practitioner (GP) and may result in the completion of a legal advance health directive.

For new residents it can be undertaken as part of the care-planning process. One option is a nurse-led care-planning conference involving the resident (where possible) and appropriate family or the legal representative. We suggest that the resident’s GP be invited to attend (or at least be made aware of any wishes or decisions regarding advance care planning).

For existing residents that have not had an advance care planning discussion on admission this should be undertaken at the next scheduled review of care.

Residents on this trajectory of care should be reviewed every six months or sooner if there is a significant change that suggests a prognosis of six months or less. Nurses should review the five palliative care clinical care domains (see Module 3) and include any aspects that are relevant in the resident’s care plan.

Trajectory B—Estimated prognosis six months or less
For all new or existing residents where a prognosis of six months or less is expected we recommend a palliative care case conference (see Module 2) be convened. We recognise estimating a prognosis is difficult and imprecise. However, we provide some key questions or markers that may assist members of the multidisciplinary team:

Markers for a prognosis of six months or less
14,31
- A positive response to the question: “Would you be surprised if the resident died within the next six months?”
- If there has been a significant functional or medical decline.
- If problems are perceived concerning goals of care around futile treatment (perhaps after an acute event).
- If the resident is transferred or admitted to the RACF specifically for comfort or palliative care.

The aim of a palliative care case conference is to identify clear goals of care for the resident including a review of advance care plans.

A palliative care case conference provides the opportunity to claim for the palliative care component of the Aged Care Funding Instrument (ACFI) if at this conference it is deemed that a “palliative care program involving end of life care where ongoing care will involve very intensive clinical nursing and/or complex pain management in the residential aged care setting is required”.13

If the palliative care case conference is attended by either the resident’s GP or a specialist palliative care nurse and all requirements for claiming ACFI are met then either of these health professionals can provide this directive. The five clinical care domains of palliative care (see Module 3) provide a template for care planning, recognising that all residents have individual needs and not all domains may be appropriate at any one time.

The care plan should be reviewed monthly and adjusted as the resident’s care needs change utilising the domains of care as appropriate. If the resident has signs and symptoms that they may die within the next week (requires terminal care) their care plans can be replaced by an end of life care pathway.
Criteria for commencing a resident on the Residential Aged Care End of Life Care Pathway

The existence of three or more of the following signs and symptoms:

• experiencing rapid day-to-day deterioration that is not reversible
• requiring more frequent interventions
• becoming semi-conscious with lapses into unconsciousness
• increasing loss of ability to swallow
• refusing or unable to take food, fluids or oral medications
• irreversible weight loss
• an acute event has occurred requiring revision of treatment goals
• profound weakness
• changes in breathing patterns.

For residents who have not previously had a palliative care case conference this may be useful (if time permits) to inform and support the family and clarify the goals of care. Where a palliative care case conference is not possible the GP or the nursing staff should review the resident’s care needs and goals and explain the pathway to the resident and family.

Commencing a resident on the RAC EoLCP provides another opportunity to claim for the palliative care component of ACFI if your facility has not already done so.

Trajectory C-Estimated prognosis less than one week:

All new residents or existing residents with a prognosis of less than one week should be commenced on an end of life care pathway. We recommend the Residential Aged Care End of Life Care Pathway (RAC EoLCP) (see Module 2).
This module follows a step-by-step approach to clinical care using 5 key actions.

See – Recognise and assess
Say – Report your assessment
Do – Manage the symptom
Write – Document your actions
Review – Evaluate and reassess as necessary

In this module, we provide information on the assessment and management of:
- pain
- dyspnoea
- nutrition and hydration
- oral care
- delirium.

We have selected five core clinical care domains, which will support your work with the resident requiring a palliative approach. This list is not exhaustive and we encourage you to read “Guidelines for a Palliative Approach in Residential Aged Care – Enhanced Version” for more information and further learning opportunities.
Pain
Pain

Key points

- Pain is a subjective experience, occurring when and where the resident says it does.
- Older people may deny that they are experiencing ‘pain’. Try using other terms like ‘ache’, ‘soreness’ or ‘stabbing’.
- Pain is not always well managed with ‘as required’ (PRN) analgesics, as older people may be reluctant to report unrelieved pain.
- Pain is more than just a physical symptom. A resident’s previous pain experiences, culture, spiritual beliefs, social relationships, and other physical symptoms, strongly influence their perception of pain.

See

Recognise and assess

Identification and ongoing assessment of pain can be done by nurses and carers but the initial assessment should be completed by a nurse.

Pain assessment for residents who can communicate

Recognising pain

Self-reporting provides the most accurate and reliable evidence of pain in residents who can communicate (even for those with mild to moderate dementia).3,4,2

These strategies may help the self-report process:

- Sit down with the resident, make eye contact and demonstrate a willingness to discuss their symptoms.
- Allow sufficient time for the resident to process the question and formulate a response.
- Ask about pain in a broad and open-ended way.
- Use at least two questions, phrased in different ways, such as:
  - Does it hurt anywhere?
  - Do you have any aching or soreness?
  - Do you have any pain or discomfort?
  - Is your pain a big problem, a medium-sized problem or a small problem?
  - From time to time, most of us have had pain, such as minor headaches, sprains and toothaches. Have you had pain other than these everyday kinds of pain during the past 24 hours?2

Initial assessment

If pain is identified, undertake a comprehensive overview of the resident’s pain using the Modified Resident’s Verbal Brief Pain Inventory (M-RVBPI) which has been developed specifically for use in RACFs (see Form 1).3,4,7
Form 1: Modified Resident’s Verbal Pain Inventory (M-RVBI) 3,12,17,50

Note: This questionnaire is to be answered at interview

Date: ___________________________ Time: ___________________________

Name: ____________________________

1. Have you had any pain in the last 24 hours?
Prompts: An ache; feeling tender; hurting; feeling stiff and sore; headache.
Please tick: ☐ Yes ☐ No

2. (a) Did you have any pain when you were moving just now?
Please tick: ☐ Yes ☐ No

(b) Where was the pain when you were moving?
Show body map.
Location(s)

(c) And how bad was your pain when you were moving, just now?
Please tick:
☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

Note: use the chart showing these response options in large font, if the individual is able to see them. If the individual reports no pain using either of these two items, this is the end of the pain check. Otherwise, please continue

3. Please tell me more about all the pain or pains you have had in the past 24 hours (show body map). Show me all the places where the pain is or has been.
List pain sites

4. In the past 24 hours, how bad has the pain been as its worst?
Prompts: most troublesome, when it was as bad as it got.
Please tick:
☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

5. In the past 24 hours, how bad has the pain been at its least?
Prompts: least troublesome or not there at all, when it was as good as it got.
Please tick:
☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

6. How bad is your pain now?
Please tick:
☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

7. In the past 24 hours, please tell me how much pain has had an effect on your walking ability (if applicable)?
PLEASE TICK here if the person is unable to walk (regardless of pain)
Otherwise, please tick below:
☐ No effect ☐ Mild effect ☐ Moderate effect ☐ Severe effect

8. Please tell me how much pain has had an effect on your general activity in the past 24 hours?
Prompts: the things that you do each day (give appropriate examples such as eating breakfast, selecting clothing for the day, combing hair)
Please tick:
☐ No effect ☐ Mild effect ☐ Moderate effect ☐ Severe effect

9. In the past 24 hours, how much has pain had an effect on your interactions with other people?
Prompts: chatting, saying hello, answering when others speak to you, smiling at other people.
Please tick:
☐ No effect ☐ Mild effect ☐ Moderate effect ☐ Severe effect

Now please think about your pain overall, whether it is in one place or in more than one place.

Note: continue to use the chart showing No Pain/Mild/Moderate/Severe if the resident is able to read the font.

THANK YOU
Form 1: Modified Resident’s Verbal Pain Inventory (M-RVBPI) (continued)

Scoring the M-RVBPI

Items 2c, 4, 5, and 6 assess the intensity of pain as reported by the resident. These items are best used to obtain a picture of the level of the resident’s pain experience that can be summarised in the Pain Intensity Summary.

### Pain Intensity Summary

<table>
<thead>
<tr>
<th>Item</th>
<th>Pain Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Pain initially recalled in past 24 hours</td>
</tr>
<tr>
<td></td>
<td>Please tick: Yes</td>
</tr>
<tr>
<td>2c.</td>
<td>Pain on movement</td>
</tr>
<tr>
<td></td>
<td>No Pain</td>
</tr>
<tr>
<td>4.</td>
<td>Pain worst in past 24 hours</td>
</tr>
<tr>
<td></td>
<td>No Pain</td>
</tr>
<tr>
<td>5.</td>
<td>Pain least in past 24 hours</td>
</tr>
<tr>
<td></td>
<td>No Pain</td>
</tr>
<tr>
<td>6.</td>
<td>Pain now</td>
</tr>
<tr>
<td></td>
<td>No Pain</td>
</tr>
</tbody>
</table>

Responses to items 7, 8 and 9 can be scored using the scale of 0 (no pain) to 3 (severe pain) and these scores can be summed to give an overall score for pain interference. This score can be documented in the Pain Interference Summary.

### Pain Interference Summary

<table>
<thead>
<tr>
<th>Item</th>
<th>Area of interference</th>
<th>Circle and transfer score to total.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Walking</td>
<td>0 No Pain 1 Mild 2 Moderate 3 Severe Not Applicable</td>
</tr>
<tr>
<td>8.</td>
<td>General activity</td>
<td>0 No Pain 1 Mild 2 Moderate 3 Severe Not Applicable</td>
</tr>
<tr>
<td>9.</td>
<td>Interactions</td>
<td>0 No Pain 1 Mild 2 Moderate 3 Severe Not Applicable</td>
</tr>
</tbody>
</table>

**TOTAL PAIN SCORE** /9

**Recommended Uses of Scores**

Obviously, responses for pain intensity and scores for pain interference can be used for comparison purposes. This is especially important when trialling an intervention to reduce pain. However, responses and scores should also serve to alert staff to the need to implement such an intervention.

**Some key principles are that:**

- Pain of moderate or severe intensity that cannot be controlled by existing measures needs urgent review.
- Scores of 6 and over for pain interference, or four and over when the resident cannot walk, also mean that urgent review is required.
- Pain of any level of intensity that recurs, lasts for long periods, and/or causes interference with walking, general activity, or interactions must prompt the implementation or review of pain management strategies.

This form can be downloaded from “PA Toolkit: Forms CD”.

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- Scores of 6 and over for pain interference, or four and over when the resident cannot walk, also mean that urgent review is required.
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Ongoing assessment \textsuperscript{3,5}

Use a pain rating scale for ongoing assessment. Record these ratings:

- at least once daily
- preferably during an activity known to trigger the pain
- whenever pain is reported
- after interventions to evaluate effectiveness.

A pain rating scale can be presented verbally or visually.

**Verbal**

Ask: ‘On a scale of zero to 10, (with zero meaning no pain, and 10 meaning the worst pain possible) how much pain do you have right now?’

**Visual**

A visual scale needs to have large clear letters/numbers. Present it to the resident under good lighting. Make sure the resident has their reading glasses on if required.

1. Try a horizontal numeric scale first:

   10 - point Numeric Rating Scale (NRS) Horizontal

   \[
   \begin{array}{cccccccccc}
   & 0 & 1 & 2 & 3 & 4 & 5 & 6 & 7 & 8 & 9 & 10 \\
   \hline
   & \text{No pain} & \text{Mild pain} & \text{Moderate pain} & \text{Severe pain} & \text{Very Severe pain} & \text{Worst possible pain} \\
   \end{array}
   \]

2. A vertical scale is another option:

   10 - point Numeric Rating Scale (NRS) Vertical

   \[
   \begin{array}{cccccccccc}
   & 10 & 9 & 8 & 7 & 6 & 5 & 4 & 3 & 2 & 1 & 0 \\
   \hline
   & \text{No pain} & \text{Mild pain} & \text{Moderate pain} & \text{Severe pain} & \text{Very Severe pain} & \text{Worst possible pain} \\
   \end{array}
   \]

3. With verbal descriptors:

   Six-category Verbal Descriptor Scale (VDS)

   \[
   \begin{array}{cccccccccc}
   & \text{No pain} & \text{Mild pain} & \text{Moderate pain} & \text{Severe pain} & \text{Very Severe pain} & \text{Worst possible pain} \\
   \end{array}
   \]

**Please note**

Most residents with moderate degrees of dementia prefer verbal descriptors of pain intensity, rather than numeric rating scales. \textsuperscript{3,5}

Full-sized copies of these scales for clinical use can be downloaded from “PA Toolkit: Forms CD”. 

**Pain assessment for residents with severe cognitive impairment or difficulty communicating**

**Initial and ongoing assessment**

If the resident has severe cognitive impairment or difficulty communicating, use the Abbey Pain Scale\textsuperscript{1} to assess pain\textsuperscript{2,3} (see Form 2).

The scale is based on:

- observation of the resident
- knowledge of the resident’s usual functioning and medical history.

Scores from six questions provide a severity rating (0–18). Compare the scores over time to provide an ongoing assessment.

Remember that some residents demonstrate little or no specific behaviour associated with severe pain. Behaviours listed in the Abbey Pain Scale may also be exhibited by residents who are distressed for reasons other than pain. \textsuperscript{3,5}
Form 2: Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

Name of Resident: ________________________________

Name and designation of person completing the scale: ________________________________

Date: __________ Time: __________

Latest pain relief given was: ________________________________

at __________ hours

How to use scale:
While observing the resident, score questions 1 to 6

1. Vocalisation
e.g. whimpering, groaning, crying

0 Absent 1 Mild 2 Moderate 3 Severe

2. Facial Expression
e.g. looking tense, frowning, grimacing, looking frightened

0 Absent 1 Mild 2 Moderate 3 Severe

3. Change in Body Language
e.g. fidgeting, rocking, guarding part of the body, withdrawn

0 Absent 1 Mild 2 Moderate 3 Severe

4. Behavioural Change
e.g. increased confusion, refusing to eat, alteration in usual patterns

0 Absent 1 Mild 2 Moderate 3 Severe

5. Physiological Change
e.g. temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor

0 Absent 1 Mild 2 Moderate 3 Severe

6. Physical Changes
e.g. skin tears, pressure areas, arthritis, contractures, previous injuries

0 Absent 1 Mild 2 Moderate 3 Severe

TOTAL PAIN SCORE __________/18

Now tick the circle that matches the Total Pain Score

0-2 No Pain 3-7 Mild 8-13 Moderate 14+ Severe

Finally, tick the circle which matches the type of pain

Chronic Acute Acute on Chronic

This form can be downloaded from “PA Toolkit: Forms CD”.

For measurement of pain in people with dementia who cannot verbalise.
Do

Manage the symptom

Combining pharmacological and non-pharmacological treatment strategies is more effective than a single approach. 10

Non-pharmacological therapies 3,10,14

Consider the following before selecting non-pharmacological therapies:

- resident’s cognitive and communicative abilities
- resident and families’ cultural background and financial resources
- availability of the treatment approach at your facility.

Superficial heat

- Use only to manage acute pain 48 hours after onset or before painful procedures.
- Residents must have intact thermal sensation and be able to provide accurate feedback.

Transcutaneous Electrical Nerve Stimulation (TENS)

- Consider for residents with persistent pain who can provide accurate feedback on sensations produced by the stimulator.

Appropriate manual handling techniques and equipment

Use appropriate assessments and adapt transfer and mobility procedures to reduce the risk of exacerbating pain from:

- stimulation of tissue that has increased sensitivity to pain
- movements that exceed the impaired range of joints and muscles.

Input from the multidisciplinary team to plan careful manual handling techniques leads to more efficient and comfortable procedures.10

Say

Report your assessment

Sometimes it is an Emergency

Do not wait to report pain that is severe and not controlled by existing measures.

GPs and specialist palliative care services often have after-hours services that can provide reviews or telephone-based advice.

What to say when reporting your pain assessment

Careworker to nurse

‘Mrs Smith 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’.

Nurse to GP

‘Mrs Smith is reporting a new pain in her right hip. She says it is severe, usually 5/10 but walking increases this to 8/10. It wakes her at night if she rolls over in bed. We have tried hot packs, massage and regular simple analgesia but it is no better’.

Is much better than

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

Unsure about cognitive or communication capacity?

Use the Abbey Pain Scale to verify the Modified Resident’s Verbal Brief Pain Inventory (M-RVBPI) until you can ascertain which is the most effective.3
Complementary and alternative medicine (CAM) therapies

• Understand the length of time required before an effect may be noticed.

• Understand the safety and effectiveness of any CAM treatment.

• Inform all relevant health care providers before a CAM therapy is undertaken.

• Obtain clear approval and consent from the resident or their legal representative if cognitively or communicatively impaired before commencing any CAM therapy on the recommendation of family, friends, staff or doctors.

• Choose CAM practitioners carefully so the resident has confidence in their credentials and qualifications.

• Check with private health insurers to see whether a CAM therapy is covered.

Alternative medical systems

• homeopathic and naturopathic medicines

• traditional Chinese medicine

• Indian practice (Ayurveda).

Mind body interventions

• meditation or prayer

• mental healing

• art, music or dance.

Biologically-based

• dietary supplements, herbal and aromatherapy products.

Manipulative and movement-based

• chiropractic or osteopathic manipulation

• massage.

Energy therapies

• bio-field therapies: qi gong, reiki and therapeutic touch

• bio-electromagnetic-based therapies.

Not recommended for older persons requiring a palliative approach in RACFs

• strengthening, stretching or aerobic exercise
  (long term adherence is required for sustained results)

• cognitive behavioural therapy
  (possible but requires cognitive capacity, active participation by the resident, a trained therapist, and 6-10 weekly sessions)

• superficial cold
  (transient effect only and potential for tissue damage)

• vibration
  (little or no evidence of efficacy).
Pharmacological therapies

Consult “Therapeutic Guidelines: Palliative Care” for additional and comprehensive prescribing recommendations. Version 3 of these guidelines is included in the PA Toolkit.

Basic principles

By mouth
Prescribe and administer analgesia by the oral route unless the resident has a pre-existing condition that makes this impractical e.g. persistent nausea, vomiting, bowel obstruction, dysphagia, or general functional decline.

By the clock
• Administer analgesia regularly (around the clock) for chronic pain rather than wait for a resident or staff request.
• Short-acting, ‘as required’ (PRN) analgesics should be reserved for breakthrough dosing or intermittent and predictable pain (incident pain).
• Administer analgesia 30 minutes before activities that may provoke or worsen pain e.g. pressure area care, wound dressings, physiotherapy, and hygiene procedures.

It is not necessary to start at the bottom of the ladder. Consider the presenting pain severity reported by the resident as detailed in Table 1.

By the ladder
Proceed from a non-opioid, to a weak opioid, and then to a strong opioid, with adjuvant medications added as needed at any stage (see Figure 1).

Figure 1
The World Health Organisation (WHO) analgesic ladder for pharmaceutical treatment of pain

Pain under control
Strong pain - strong opioids for moderate to severe pain, non-opioid adjuvant

Increase in pain
Moderate pain - weak opioids for mild to moderate pain, non-opioid adjuvant

Increase in pain
Mild pain - non-opioid adjuvant
Table 1
Analgesic of choice for WHO ladder 46

<table>
<thead>
<tr>
<th>WHO Ladder step</th>
<th>Score on pain scale (Visual scale)</th>
<th>Analgesics of choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mild pain</td>
<td>&lt;3 out of 10</td>
<td>Paracetamol and/or NSAIDS (aspirin is not recommended for older people due to a high risk of GI bleeding)</td>
</tr>
<tr>
<td>2. Mild to moderate pain</td>
<td>3 to 6 out of 10</td>
<td>Weak opioids (codeine, tramadol*) +/- paracetamol and NSAIDS</td>
</tr>
<tr>
<td>3. Severe pain</td>
<td>&gt;6 out of 10</td>
<td>Strong opioids (morphine, fentanyl, oxycodone) +/- paracetamol and NSAIDS</td>
</tr>
</tbody>
</table>

*Not recommended in residential aged care

Opioids

**Basic principles** 46,48,49

- Start with low doses of short-acting opioids.
- Titrates slowly upward after evaluating pain scores until satisfactory relief is achieved.
- Only then, commence sustained/controlled release preparations e.g. oxycodone (Oxycontin), morphine (MS Contin, Kapanol), buprenorphine (Norspan) or fentanyl (Durogesic).
- Do not use sustained/controlled release preparations for acute pain or breakthrough dosing.
- Discuss common myths about opioids with the resident or family such as tolerance, physical dependence or addiction, or that ‘opioids are only used when someone is near death’.
- The parenteral (injectable) dose of morphine is approximately one-third of the oral dose.
- Anticipate, treat or avoid side effects of opioids (see Table 2). Changing to another opioid or another route of administration may be necessary.

Table 2
Opioid side effects 46,48

<table>
<thead>
<tr>
<th>Opioid side effect</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drowsiness</strong> is common initially</td>
<td>Reassure the resident that this is likely to only last a few days</td>
</tr>
<tr>
<td><strong>Nausea</strong> (less commonly vomiting) may occur when starting opioids. May be due to the bitter taste of morphine mixture</td>
<td>Tolerance generally develops and antiemetics can often be discontinued after 1 to 2 weeks</td>
</tr>
<tr>
<td><strong>Constipation</strong> is very common</td>
<td>Use regular prophylactic aperients to avoid faecal impaction</td>
</tr>
<tr>
<td><strong>Dry mouth</strong> is common</td>
<td>Refer to oral care section (see page 37)</td>
</tr>
<tr>
<td><strong>Dry eyes</strong></td>
<td>Use lubricating eye drops</td>
</tr>
<tr>
<td><strong>Respiratory depression</strong> is rarely a problem if doses are increased slowly and does not occur without accompanying sedation</td>
<td>Pain remains a potent respiratory stimulant</td>
</tr>
</tbody>
</table>
Considerations for residents with cognitive impairment

If there is any suspicion that the resident is experiencing pain:

**Step 1**
Trial a simple analgesic (such as paracetamol) and administer regularly.

**Step 2**
If more severe pain is suspected, and it is not relieved by paracetamol alone, consider oxycodone modified release 2.5 – 5 mg orally.

**Step 3**
If there is no clear improvement over several days, these medications should be reviewed.

**Adjuvant analgesics**
Adjuvants are medications whose primary role is other than relieving pain.

Used to either supplement analgesic medication or control symptoms that can exacerbate the perception of pain (e.g. inflammation, oedema, anxiety).

**Benefits:**
- reduce opioid related side effects by allowing for a lower opioid dose to be prescribed
- relieve pain that is insensitive to opioids.

Which adjuvant medications are needed, if any, will depend on the type and cause of pain.

**Examples**
- corticosteroids
- anticonvulsants and antidepressants
- bisphosphonates
- benzodiazepines
- skeletal muscle relaxants
- anticholinergic drugs.
**Write**

**Document your actions**

- Use the recommended pain assessment tools.
- Document all communication and consultation with residents, family members and other members of the aged care team.

**Avoid general statements**

<table>
<thead>
<tr>
<th>POOR COMMUNICATION</th>
<th>GOOD COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of PRN analgesia ‘with effect’ or ‘effective’.</td>
<td>‘Resident states pain has reduced to 2/10 score (was 5/10)’.</td>
</tr>
<tr>
<td>Note to GP ‘Please review Mrs Smith ASAP re pain in hip’.</td>
<td>‘Mrs Smith has a new pain in R) hip. Says its severe, average 5/10, walking = 8/10. Wakens her at night if she rolls over in bed. Have tried hot packs, massage and regular simple analgesia so far but there is no improvement’.</td>
</tr>
</tbody>
</table>

**Review**

**Evaluate and reassess as necessary**

Evaluate and document:

- changes in pain intensity, mood and function
- the effectiveness of an intervention every time it is administered.

Assessment and management of pain is an ongoing process rather than a single event.

A formal scheduled review using the ‘Modified Resident’s Verbal Brief Pain Inventory (M-RVBPI)’ or ‘Abbey Pain Scale’ may be more valuable than frequent, brief impressions.
Dyspnoea
Dyspnoea

Key points

Dyspnoea is an awareness of uncomfortable breathing. It can also be referred to as breathlessness or shortness of breath.8,14

Dyspnoea:
• is common but frequently under-recognised
• impairs activities of daily living, limits mobility, increases anxiety, fear and social isolation
• is often associated by residents and family with impending death
• triggers panic, and panic exacerbates dyspnoea, so the pattern becomes cyclical
• may be equally or even more distressing for the family
• may cause fear of suffocation and be the most troubling symptom at the end of life
• can significantly affect the ultimate place of death.8,14

A comprehensive care plan may prevent residents with gradually increasing dyspnoea being unnecessarily transferred to hospital. Ensure ready access to appropriate medications and utilise non-pharmacological interventions to reduce psychological distress.8,14,49

See

Recognise and assess

Undertake and document a comprehensive baseline assessment of the resident’s dyspnoea.

Initial assessment8,49

Previous medical history

Review the previous medical history for anything that may influence the severity of dyspnoea, including:
• pre-existing illnesses, e.g. chronic obstructive pulmonary disease (COPD)
• exacerbating factors, e.g. anaemia or profound anxiety
• additional factors, e.g. pulmonary embolism, infection or left ventricular failure.

Associated symptoms
• cough
• sputum
• haemoptysis (blood in sputum)
• wheeze
• stridor
• pleuritic pain
• fatigue
• anxiety or panic.

Aggravating and relieving factors

What makes it better or worse?
• physical activity?
• posture?
• environmental factors? (e.g., room sprays, pollen)
• emotional factors? (e.g., anxiety, excitement, fear)
• others?
Severity

Use a numeric or verbal rating scale similar to the pain rating scale.

**Because health professionals tend to under-report a patient's breathlessness the resident should be encouraged to rate the severity themselves.** 18,21,34

**Verbal**

*Ask:*

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

**Visual**

A visual scale needs to have large, clear letters and numbers. Present it to the resident under good lighting. Make sure the resident has their reading glasses on if required.

1. **Try a horizontal numeric scale first**

10 - point Numeric Rating Scale (NRS) Horizontal

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No shortness of breath</td>
<td>Moderate shortness of breath</td>
<td>Worst possible shortness of breath</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **A vertical scale is another option**

10 - point Numeric Rating Scale (NRS) Vertical

```
10  | No shortness of breath
9   |
8   |
7   |
6   |
5   | Moderate shortness of breath
4   |
3   |
2   |
1   |
0   | Worst possible shortness of breath
```

3. **With verbal descriptors**

Please note: Most residents with moderate degrees of dementia prefer verbal descriptors, rather than numeric rating scales.

Six-category Verbal Descriptor Scale (VDS)

```
No SOB  | Mild SOB  | Moderate SOB | Severe SOB | Very Severe SOB | Worst possible SOB
```

Full-sized copies of these scales for clinical use can be downloaded from the “PA Toolkit: Forms CD”.
Timing
- chronic or intermittent?
- when does it occur?
- how long does it last (duration) and how often does it occur (frequency)?
- interval between episodes.

Quality-of-life issues
Ask about:
- impact on mobility
- impact on social isolation
- coping strategies (behavioural and emotional).

Ongoing assessment
Use a Rating Scale for ongoing assessment. Record these ratings:
- at least daily
- preferably during an activity known to trigger the dyspnoea
- whenever dyspnoea is reported
- after interventions, to evaluate effectiveness.

Sometimes it is an Emergency
Do not wait to report dyspnoea that is severe and not controlled by existing measures. GPs and specialist palliative care services often have after-hours services that can provide reviews or telephone-based advice.

What to say when reporting your assessment of dyspnoea

Careworker to nurse
‘Mrs Smith appears to be short of breath. She cannot walk to the dining room without having to stop twice to catch her breath. She says it has been a problem for a few days now’.

Nurse to GP
‘Mrs Smith is reporting dyspnoea on exertion for the last three days. She says it is moderate when walking 20 metres to the dining room, usually 5/10. Given five minutes of rest it resolves slowly. We are taking her down in a wheelchair until she can be reviewed. She is not febrile and has no chest pain, wheezing or other symptoms’.

Is much better than
‘Mrs Smith has been short of breath lately. You need to see her to sort it out’.

Do not compare dyspnoea ratings/scores between individual residents. Everyone has his or her own level of tolerance.
Do

Manage the symptom

Combining pharmacological and non-pharmacological treatment strategies is more effective than a single approach.

Key points

- Consider simple measures for all residents with dyspnoea.
- If your assessment reveals a known cause, treat if appropriate within your scope of practice and the context of the resident's prognosis and known preferences.
- Consider symptomatic treatment if appropriate.

Non-pharmacological therapies

Simple measures

Environmental strategies
- Increase air movement around the resident, e.g. open doors and windows, use room or bedside fans.
- Prevent overheating, e.g. exhaust fan in bathroom, cool face washers if bed bound.
- Prevent claustrophobia, e.g. deflect the shower stream away from the face.
- Position appropriately, e.g. propping up the resident with pillows.
- Use and teach strategies to reduce the need for exertion, e.g. break up activities like showering or walking with short rest periods.
- Occupational therapists can advise on modifications of activity, e.g. dressing, aids.
- Breathing control techniques can be taught by nurses or physiotherapists.

Psychological
- Listen empathically to the resident's concerns, as they are likely to be scared or anxious (the family may need education and support as well).
- Provide reassurance and a calm presence.
- Provide advice and support about the management of dyspnoea to the resident and family.
- Teach and encourage relaxation techniques.
- Provide psychosocial support and counselling if there is ongoing anxiety or panic (referring to specialist counselling as necessary).

Targeted strategies

These are only appropriate for residents who are conscious and cognitively intact:
- Specialist counseling for ongoing anxiety or panic
- Counseling and relaxation techniques
- Teaching breathing control exercises.

Consider their use in the context of the resident's prognosis and expressed wishes.
Pharmacological therapies\textsuperscript{29,34,49}

Opioids
- Oral or parenteral opioids should be the first line pharmacological intervention for managing dyspnoea.
- There is no evidence to support the use of nebulised opioids.

Benzodiazepines
Consider short-term use of a benzodiazepine only:
- when there is associated acute anxiety and simple non-pharmacological measures have not been effective alone
- at the end of life.

Already taking benzodiazepines?
There is a strong possibility the resident will be tolerant to benzodiazepines and either substantial dose increases will be needed or opioids will need to be the mainstay of therapy.

Anxiolytics
- Anxiolytics can be used to alleviate anxiety or panic associated with dyspnoea.
- Medications least to most sedating: alprazolam, clonazepam, diazepam.

Midazolam may be useful for an acute episode of anxiety when its amnesic effect might be beneficial.

Please note
It is more sedating than the benzodiazepines above and requires ongoing monitoring after administration as late respiratory depression has been reported after parenteral dosing.

For residents at the end of life or those with severe anxiety, combining an oral opioid and benzodiazepine treatment may be beneficial, but monitoring for sedation is necessary.

Consult ‘Therapeutic Guidelines: Palliative Care’ for additional and comprehensive prescribing recommendations. Version 3 of these guidelines is included in the PA Toolkit.

Oxygen\textsuperscript{8,29,34}
- Few residents with dyspnoea will benefit from oxygen.
- Being short of breath does not always mean that a resident is hypoxaemic and needs oxygen.
- Oxygen is often considered to be a non-specific treatment for dyspnoea. However, individuals can become highly dependent on oxygen supplementation to the extent that some people consider it to be their ‘lifeline’.

A trial may be indicated
- if oxygen saturation (SaO2) is persistently <90\% at rest, or on minimal exertion (e.g. dressing, getting out of bed)
- if there is a prior history of continuous oxygen therapy (prescribed in accordance with Thoracic Society guidelines)
- if the resident or family have a profound conviction that it is or will be helpful, and are distressed at any suggestion otherwise
- as part of an acute intervention with respiratory infection, pulmonary emboli or cardiac failure, while the underlying pathology is treated
- to facilitate discharge from hospital for someone in the terminal stages of a life-limiting illness.

In practice
- Initiating (or changing flow rates) of oxygen may be contra-indicated for residents (e.g. residents with chronic respiratory conditions). The commencement of oxygen should only be undertaken under the direction of a medical practitioner.
- If indicated, nasal cannula (specs) is recommended, as a face mask can be frightening and claustrophobic.
When all else fails

Dyspnoea that causes severe distress and does not respond to medical management is a challenging problem and may require sedation as the only appropriate intervention.⁴⁹

Write

Document your actions

- Document clinical assessments and care plans using the guidelines in this domain.
- Document all communication and consultation with residents, family members and other members of the aged care team.

Avoid general statements

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</tr>
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<td>Note to GP</td>
<td>‘Careworkers report Mrs Smith is reporting dyspnoea on exertion for the last three days. She reports severity = moderate (5/10) when walking 20 metres to the dining room. Relieved by resting for 5 minutes. Careworkers are wheeling her down in a chair until she is reviewed. Afebrile, no chest pain, wheezing or other symptoms’.</td>
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POOR COMMUNICATION

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</tr>
</tbody>
</table>
Review

Evaluate and reassess as necessary

Assessment of dyspnoea is an ongoing process rather than a single event.

- Evaluate and document the effectiveness of an intervention every time it is administered.
- A formal scheduled review using the assessment tools detailed in this section may be more valuable than subjective, brief impressions.
- Evaluate and document changes in dyspnoea intensity and its effect on mood and function.
Nutrition and hydration
Nutrition and hydration

Key points
- Artificial nutrition or hydration is generally considered 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 the 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.

See

Recognise and assess
Always consider: ‘Is malnutrition or dehydration related to a potentially reversible or treatable cause?’

However, decisions need to be made considering the resident’s prognosis and any previous decisions or wishes about life sustaining care.

Nutrition
The ‘Meals on Wheels’ mnemonic tool provides a useful checklist to identify reversible or treatable causes of malnutrition or unintended weight loss.

Onset or worsening of any combination of the problems identified in Table 3 may indicate a need for further investigation.

### Table 3

<table>
<thead>
<tr>
<th>Meal on Wheels mnemonic tool</th>
<th>Side effects, amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Depression, anxiety</td>
</tr>
<tr>
<td>Emotional problems</td>
<td></td>
</tr>
<tr>
<td>Anorexia (late onset anorexia nervosa)</td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td></td>
</tr>
<tr>
<td>Late-life paranoia</td>
<td></td>
</tr>
<tr>
<td>Swallowing disorders</td>
<td></td>
</tr>
<tr>
<td>Oral factors</td>
<td></td>
</tr>
<tr>
<td>Not culturally appropriate</td>
<td>Food, presentation or environment</td>
</tr>
<tr>
<td>Wandering and other dementia-related behaviours</td>
<td></td>
</tr>
<tr>
<td>Hyperthyroidism, hyperparathyroidism, hypoadrenalism</td>
<td></td>
</tr>
<tr>
<td>Enteric problems (malabsorption)</td>
<td></td>
</tr>
<tr>
<td>Eating problems</td>
<td>Resident unable to feed themselves</td>
</tr>
<tr>
<td>Low-salt, low-cholesterol diets</td>
<td>Tremors resulting in spillage</td>
</tr>
<tr>
<td>Socially inappropriate</td>
<td>Therapeutic diets</td>
</tr>
</tbody>
</table>

Food; environment, lack of interaction, inappropriate positioning of resident
A swallowing assessment is mandatory if there is any sign of dysphagia (swallowing difficulties).
Consult a registered speech pathologist as necessary.

Hydration
Clinical signs of moderate to severe dehydration include:
• dry skin
• dry mucosa
• dry furrowed tongue
• sunken eyes
• decreased urine output
• postural or orthostatic hypotension
• headaches
• cramps
• irritability
• drowsiness
• weight loss
• disorientation
• upper body muscle weakness

As the resident approaches the end of life, factors contributing to dehydration include:
• prolonged bed rest
• side effects of medications
• mouth breathing
• supplemental oxygen administration
• the use of oral supplements.

Biochemical tests
Biomechanical tests can assist to determine if the resident is dehydrated e.g. haematocrit, serum osmolality, serum urea nitrogen/creatinine ratio and urine specific gravity.

Fluid intake charts alone are not recommended. They do not accurately determine dehydration unless they also take into account urine output, perspiration and other fluid losses.

Say

What to say when reporting your assessment of nutrition and hydration

Careworker to nurse
‘Mrs Smith 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’.

Nurse to GP
‘Mrs Smith is reporting that she feels like she has had trouble for a few days with swallowing. This morning at breakfast the careworkers observed that she was coughing when eating her cereal’.

Is much better than
‘Mrs Smith couldn’t eat her breakfast today’.

Do

Manage the symptom
The benefits of artificial nutrition or hydration must outweigh the potential burden and side effects for the resident.
Decision-making \(^{14,22,35,45,49}\)

- Residents and family members cannot make informed choices if they do not have all the information about the positive and negative aspects of artificially providing food or fluids.
- Deciding to withhold or withdraw artificial feeding or hydration needs to involve recognition of the emotional impact on family and staff, particularly careworkers.
- It is very important to listen to and consider the views of the resident and their family (including their cultural and religious views).
- Without clear guidance and support, stopping hydration or feeding may be interpreted in the same context as switching off mechanical ventilation.
- When interest in food and fluid becomes minimal, do not force the resident to receive them.
- When a resident is no longer able to swallow food or fluids, consider oral care as a priority. Refer to the oral care section (see page 40).

Nutrition \(^{9,14,19,35}\)

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 more traditional-sized offerings.
- Select a diet based on resident preferences, lifelong food habits and identification of swallowing problems.
- Consulting a dietician experienced 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.
- A swallowing assessment is mandatory if there is any sign of dysphagia, consult a registered speech pathologist as necessary.

Tube feeding

For residents requiring a palliative approach, there is limited evidence that enteral tube feeding prolongs life, improves comfort or quality-of-life, prevents aspiration pneumonia, leads to better nourishment or decreases the risk of pressure sores. \(^{14,20,24,30,45}\)

Hydration

While the resident is still able to swallow, nurses and careworkers should diligently offer sips of fluid every time they enter the resident’s room. Encourage family members to do the same. \(^{14}\)

Artificial hydration

Establish clear time lines to review the effectiveness of artificial hydration before commencing therapy as well as indications for its withdrawal.

Artificial hydration:
- is not normally used when a resident is expected to die within 48 – 72 hours
- is most appropriately administered via the subcutaneous route (hypodermoclysis)
- may be useful as a time-limited intervention when the cause of the dehydration is potentially reversible:
  - over treatment of diuretics
  - unintended sedation from medications (e.g. opioids)
  - recurrent vomiting or diarrhoea
  - hypocalcaemia. \(^{4,23,49}\)

Fluid accumulation may be an adverse effect of artificial hydration at end of life:
- increased urinary output
- increased fluid in the gastrointestinal tract causing vomiting
- pulmonary oedema, pneumonia
- respiratory tract secretions
- ascites. \(^{49}\)
Write

Document your actions

- Document clinical assessments and care plans using the guidelines in this domain.
- Document all communication and consultation with residents, family members and other members of the aged care team.

Avoid general statements

<table>
<thead>
<tr>
<th>POOR COMMUNICATION</th>
<th>GOOD COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of artificial hydration 'with effect' or 'effective'.</td>
<td>'Resident denies thirst or discomfort, oral mucosa moist and intact, urinary output still moderate'.</td>
</tr>
<tr>
<td>Note to GP 'Please review Mrs Smith ASAP regarding dehydration'.</td>
<td>'Mrs Smith has &lt;300ml fluid intake last 24hrs. ~400ml the day before. Skin turgor poor. Dry mouth but denies thirst. Says she 'can’t be bothered' drinking. Advance directive is clear re no artificial hydration however family concerned and asking about a drip'.</td>
</tr>
</tbody>
</table>

Review

Evaluate and reassess as necessary

Regularly review artificial nutrition or hydration to ensure it is still the most appropriate intervention for the resident. At the end of life, this should be every day.

Consider not only any adverse physical effects but also the resident’s overall condition. Be sure to check-in with family members to ensure they are fully informed and coping with what is occurring.

If there are intolerable side effects, cease interventions in consultation with the resident and/or family members.
Oral care
Oral care

Factors that may decrease oral health:
• ageing process, even when uncomplicated by illness
• medication (including oxygen therapy)
• poly-pharmacy
• mouth breathing
• particular medical conditions, e.g. diabetes, anaemia and malnutrition
• poorly fitting dentures
• chemotherapy and radiotherapy for cancer treatment
• increasing functional dependence
• cognitive impairment.

Poor oral health can affect a resident’s quality-of-life in many ways:
• bad breath
• bleeding gums, tooth loss or decay
• difficulty with eating and swallowing leading to malnutrition or dehydration
• impaired communication
• weight loss
• physical appearance
• changes in behaviour.\textsuperscript{14,40,44}

Dry mouth (xerostomia) is the most common oral problem at the end of life.\textsuperscript{44}

See

Recognise and assess

Common oral problems
Table 4 provides details of common oral problems and their signs.

Initial assessment
A comprehensive baseline assessment of the resident’s oral cavity should be undertaken by a nurse using the Oral Health Assessment Tool\textsuperscript{44} (see Form 3).

Ongoing assessment
Daily ongoing assessments should be completed by either a nurse or careworker based on directions on the Oral Health Care Plan\textsuperscript{44} developed by SA Dental as part of the Better Oral Health project (see Form 4).
Table 4
Common oral problems and their signs

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>CHECK FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lips</td>
<td></td>
</tr>
<tr>
<td>Sore corners of mouth (Angular cheilitis)</td>
<td>• Soreness and cracks at corners of the mouth</td>
</tr>
<tr>
<td>Tongue</td>
<td></td>
</tr>
<tr>
<td>Sore tongue (glossitis)</td>
<td>• Reddened smooth areas</td>
</tr>
<tr>
<td></td>
<td>• Swollen or sore tongue</td>
</tr>
<tr>
<td>Thrus (candidiasis)</td>
<td>• Patches of white film that leave a raw area when wiped away</td>
</tr>
<tr>
<td></td>
<td>• Red inflamed areas on the tongue</td>
</tr>
<tr>
<td>Gums and Tissues</td>
<td></td>
</tr>
<tr>
<td>Gum disease (gingivitis)</td>
<td>• Swollen red gums that bleed easily when touched or brushed</td>
</tr>
<tr>
<td></td>
<td>• Bad breath</td>
</tr>
<tr>
<td>Severe gum disease (periodontitis)</td>
<td>• Receding gums</td>
</tr>
<tr>
<td></td>
<td>• Exposed roots of teeth</td>
</tr>
<tr>
<td></td>
<td>• Loose teeth</td>
</tr>
<tr>
<td></td>
<td>• Tooth sensitivity</td>
</tr>
<tr>
<td></td>
<td>• Bad breath</td>
</tr>
<tr>
<td>Oral cancers</td>
<td>• Ulcers that do not heal within 14 days</td>
</tr>
<tr>
<td></td>
<td>• White or red patch, or change in texture of oral tissues</td>
</tr>
<tr>
<td></td>
<td>• Swelling</td>
</tr>
<tr>
<td></td>
<td>• Unexplained changes in speech</td>
</tr>
<tr>
<td></td>
<td>• Difficulty swallowing</td>
</tr>
<tr>
<td>Ulcers and sore spots</td>
<td>• Sensitive area of raw tissue caused by rubbing of denture</td>
</tr>
<tr>
<td></td>
<td>• Broken denture or teeth</td>
</tr>
<tr>
<td></td>
<td>• Bad breath</td>
</tr>
<tr>
<td></td>
<td>• Difficulty eating</td>
</tr>
<tr>
<td></td>
<td>• Changed behaviour</td>
</tr>
<tr>
<td>Sore mouth (stomatitis)</td>
<td>• Red swollen tissues often where covered by dentures</td>
</tr>
<tr>
<td>Saliva</td>
<td></td>
</tr>
<tr>
<td>Dry mouth (xerostomia)</td>
<td>• Difficulty with talking or swallowing</td>
</tr>
<tr>
<td></td>
<td>• Dry oral tissues</td>
</tr>
<tr>
<td></td>
<td>• Thick or stringy saliva</td>
</tr>
<tr>
<td>Too much saliva (hypersalivation)</td>
<td>• Drooling</td>
</tr>
<tr>
<td></td>
<td>• Moist, macerated tissues especially in corners of lips</td>
</tr>
<tr>
<td>Natural Teeth</td>
<td></td>
</tr>
<tr>
<td>Tooth decay (caries)</td>
<td>• Broken, holed or discoloured teeth</td>
</tr>
<tr>
<td>Retained or decayed roots</td>
<td>• Bad breath</td>
</tr>
<tr>
<td></td>
<td>• Oral pain or sensitivity</td>
</tr>
<tr>
<td></td>
<td>• Difficulty eating</td>
</tr>
<tr>
<td></td>
<td>• Changed behaviour</td>
</tr>
<tr>
<td>Dentures</td>
<td></td>
</tr>
<tr>
<td>Requiring attention or poorly fitting</td>
<td>• Residents name on the denture</td>
</tr>
<tr>
<td></td>
<td>• Matching set of dentures</td>
</tr>
<tr>
<td></td>
<td>• Chipped or missing teeth or acrylic (pink) section</td>
</tr>
<tr>
<td></td>
<td>• Bent or broken wires on partial plate</td>
</tr>
<tr>
<td></td>
<td>• Ulceration or pain</td>
</tr>
<tr>
<td></td>
<td>• Refusal to wear denture</td>
</tr>
<tr>
<td>Oral Cleanliness</td>
<td></td>
</tr>
<tr>
<td>Poor oral hygiene</td>
<td>• Dental plaque on teeth or denture</td>
</tr>
<tr>
<td></td>
<td>• Bleeding gums</td>
</tr>
<tr>
<td></td>
<td>• Bad breath</td>
</tr>
<tr>
<td></td>
<td>• Coated tongue</td>
</tr>
<tr>
<td></td>
<td>• Retained food</td>
</tr>
<tr>
<td>PAIN</td>
<td>Dental pain is under-detected and under-treated in residential aged care.</td>
</tr>
<tr>
<td></td>
<td>Residents may not report it but express discomfort by their behaviours such as:</td>
</tr>
<tr>
<td></td>
<td>• Disinterest in food</td>
</tr>
<tr>
<td></td>
<td>• Chewing of the lip, tongue or hands</td>
</tr>
<tr>
<td></td>
<td>• Grinding of teeth or dentures</td>
</tr>
<tr>
<td></td>
<td>• Aggression (especially during ADLs)</td>
</tr>
<tr>
<td></td>
<td>• Alteration in activity (weariness, drowsiness, screaming &amp; restlessness)</td>
</tr>
</tbody>
</table>
### Form 3: Oral Health Assessment Tool

<table>
<thead>
<tr>
<th>Name of Resident:</th>
<th>Completed by:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resident:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is independent</td>
<td>needs reminding</td>
<td>needs supervision</td>
</tr>
<tr>
<td>Will not open mouth</td>
<td>Grinding or chewing</td>
<td></td>
</tr>
<tr>
<td>Is aggressive</td>
<td>Bites</td>
<td></td>
</tr>
<tr>
<td>Cannot rinse and spit</td>
<td>Will not take dentures out at night</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Lips</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>Smooth, pink, moist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry, chapped or red at corners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swelling or lump, red/white/ulcerated bleeding/ulcerated at corners</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Tongue</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>Normal moist, roughness, pink</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patchy, fissured, red, coated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patch that is red and/or white/ulcerated, swollen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Gums and Oral Tissue</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>Moist, pink, smooth, no bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry, shiny, rough, red, swollen, sore, one ulcer/sore spot, sore under dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Saliva</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>Moist tissues watery and free flowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tissues parched and red, very little/no saliva present, saliva is thick, resident thinks they have a dry mouth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Natural Teeth</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>No decayed or broken teeth or roots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3 decayed or broken teeth/roots, or teeth very worn down</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 or more decayed or broken teeth/roots or fewer than 4 teeth, or very worn down teeth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dentures</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>No broken areas or teeth, worn regularly, and named</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 broken area or tooth, or worn 1-2 hours per day only or not named</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 or more broken areas or teeth, denture missing/denture not worn, need adhesive, or not named</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Oral Cleanliness</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>Clean and no food particles or tartar in mouth or on dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food, tartar, plaque 1-2 areas of mouth, or on small area of dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food particles, tartar, plaque most areas of mouth, or on most of dentures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dental Pain</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>Changes</td>
<td>Unhealthy</td>
</tr>
<tr>
<td>No behavioural, verbal or physical signs of dental pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal &amp;/or behavioural signs of pain such as pulling at face, chewing lips, not eating, changed behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal &amp;/or behavioural signs (pulling at face, not eating, changed behaviour)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Unhealthy signs usually indicate referral to a dentist is necessary

Assessor Comments

This form can be downloaded from “PA Toolkit: Forms CD”.

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43 • Module 3 - Clinical Care
Form 4: Oral Health Care Plan

Last Oral Health Assessment (OHA) Date: ____________________________

(OHA) Review Due Date: ____________________________

Oral Health Care Considerations

Problems:
- difficulty swallowing
- difficulty moving head
- difficulty opening mouth
- fear of being touched

Interventions:
- bridging
- chaining
- hand over hand
- distraction (activity board/toy)
- rescue
- other

Daily Activities of Oral Hygiene

**Natural Teeth**

- Yes
- No

Cleaned by:
- Self
- Supervise
- Assist

**Morning**
- clean teeth, gums, tongue

**After Lunch**
- rinse mouth with water
- antibacterial product (teeth & gums)

**Night**
- clean teeth, gums, tongue

Replace toothbrush (3 monthly) Date: ____________________________

**Denture**

- Full
- Partial
- Upper
- Lower

Inserted/ removed by:
- Self
- Staff

Cleaned by:
- Self
- Supervise
- Assist

**Disinfect dentures** (weekly) Specify day: ____________________________

**Oral Hygiene Aids**

- soft toothbrush
- modified toothbrush
- toothbrush grip
- denture brush
- spray bottle (labelled)

**Oral Health Care Products**

- mild soap (denture)
- antibacterial product
- saliva substitute
- lip moisturiser
- high fluoride (5000 ppm) toothpaste

**Additional Oral Care Instruction**

- antifungal gel
- denture adhesive
- interproximal brush
- tongue scraper
- normal saline mouth toilet

Check daily, document and report to RN if:

- bad breath
- bleeding gums
- lip blisters/sores/cracks
- tongue for any coating/change in colour
- sore mouth or gums
- mouth ulcer
- swelling of face/mouth
- broken/lost denture
- difficulty eating
- refusal of oral care
- denture not named
- excessive food left in mouth
- broken teeth

Signed RN: ____________________________

Date: ____________________________

This form can be downloaded from “PA Toolkit: Forms CD”
Say

Report your assessment

What to say when reporting your assessment of the oral cavity

Careworker to nurse

‘Mrs Smith 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’.

Nurse to GP

‘Mrs Smith has a very dry mouth and oral candida. It seems to have become worse since commencing the opioid analgesics last week. She has a candida on her tongue and in the corners of her lips. Please review her for some anti-fungal medication. We will continue with frequent oral care’.

Is much better than

‘Mrs Smith has problems with her mouth. You need to see her to sort it out’.

Do

Manage the symptom

Standard protective care

Provide standard protective care for all residents requiring a palliative approach who can still eat and drink.

Own teeth

- high fluoride (5000ppm) toothpaste morning and night
- soft toothbrush to brush teeth, gums and tongue morning and night
- antibacterial product after lunch
- keep mouth moist (drink water after meals, medications and 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 and other drinks and snacks.
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
- use a saliva substitute such as a water spray or oral balance gel/liquid.

Pain or ulceration
- rinse or swab mouth with warm saline three to four times a 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 seven days.

Coated tongue, mucosa or teeth
- remove debris with soft toothbrush or mouth swab
- mouth rinses with water or warm saline four times a 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.

End of life protocol

Every time a staff member attends a resident who can no longer eat or drink safely at the end of life:

Apply:
- dry mouth products (e.g., water spray, oral balance gel/liquid) via mouth swabs
- water based lip moisturisers.

Please note
Petroleum based products can increase risk of inflammation and aspiration pneumonia, and are 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.

These may damage oral tissues and increase risk of infection.
Write

**Document your actions**

- Document clinical assessments and care plans using the guidelines in this domain.
- Document all communication and consultation with residents, family members and other members of the aged care team.

**Avoid general statements**

<table>
<thead>
<tr>
<th>POOR COMMUNICATION</th>
<th>GOOD COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of interventions ‘with effect’ or ‘effective’.</td>
<td>‘Resident commenced on treatment for mouth ulcers. Sore spot on inside of mouth resolved’.</td>
</tr>
<tr>
<td>Note to GP ‘Please review Mrs Smith ASAP re mouth ulcer’.</td>
<td>‘Mrs Smith has ulceration on top right gum tissues under where denture usually sits. Contributing to decreased oral intake lately. Simple measures have not helped. Please review re a topical order and script’.</td>
</tr>
</tbody>
</table>

Review

**Evaluate and reassess as necessary**

It is important to evaluate and document the effectiveness of each intervention each time it is administered.

Residents who are no longer eating or drinking are especially at risk and need at least a daily review by a nurse.
Delirium
Delirium

Key points

- Delirium is distressing not only for the resident but for family and health workers.
- Delirium in older people is often overlooked and misdiagnosed, especially at the end of life.\(^5\)

See

Recognise and assess

Recognising delirium

- Delirium is characterised by disorganised thinking and behaviour and reduced ability to focus, sustain or shift attention. Hallucinations or delusions can also occur.\(^5\)
- The disturbance develops over a short period of time and generally fluctuates during the course of the day. Delirium usually only lasts for a few days but may persist for weeks or even months.\(^5\)
- Dementia on the other hand is a long-term impairment of cognition with generally clear consciousness.
**Table 4**

**Differences between delirium, dementia and depression**

This table can be used as a guide when assessing residents and to differentiate between delirium, dementia and depression.

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

- Medications
  - opioids (especially with renal impairment)
  - tricyclic antidepressants
  - benzodiazepines
  - corticosteroids
  - any drug with anti-cholinergic activity
- Drug withdrawal
  e.g. opioids, alcohol, nicotine, benzodiazepines
- Metabolic disorders
  - dehydration (diuretic use, hot weather)
  - hypoglycaemia
  - hypercalcaemia
- Urinary retention or constipation
- Infections (especially with indwelling urinary catheter)
- Kidney or liver failure
- Sensory impairments
- Uncontrolled pain

Delirium is often caused by a combination of factors
e.g. dehydration or renal failure in a resident taking opioid analgesics.

Initial and ongoing assessment

Confusion Assessment Method (CAM) tool

Use the Confusion Assessment Method (CAM) (see Form 5) as a screening tool to provide confirmation of a likely delirium.

The CAM requires observation and interaction with the resident plus other information from their family member or other staff.

Vital signs

Additionally, reviewing the resident’s vital signs may help determine a potential cause of a delirium:

- temperature
- pulse
- respiratory rate
- blood pressure
- urinalysis
- oxygen saturation (SaO2).

Initial and ongoing assessment
Form 5: Confusion Assessment Method (CAM) - Shortened version

Name of resident: __________________________

Date of Birth: ____________________________

Date: __/__/_________ Time: __________

I. ACUTE ONSET AND FLUCTUATING COURSE
   a) Is there evidence of an acute change in mental status from
      the patient’s baseline? Yes □ No □
   b) Did the (abnormal) behaviour fluctuate during the day,
      that is tend to come and go or increase and decrease in severity?
      Yes □ No □

II. INATTENTION
    Did the patient have difficulty focusing attention, for example, being easily
distractible or having difficulty keeping track of what was being said?
    Yes □ No □

III. DISORGANISED THINKING
    Was the patient’s thinking disorganised or incoherent, such as rambling or
    irrelevant conversation, unclear or illogical flow of ideas, or unpredictable
    switching from subject to subject?
    Yes □ No □

IV. ALTERED LEVEL OF CONSCIOUSNESS
    Overall, how would you rate the patient’s level of consciousness?
    Alert (normal) □
    BOX 3
    Vigilant (hyperalert) □
    Lethargic (drowsy, easily aroused) □
    Stupor (difficult to arouse) □
    Coma (unarousable) □
    Do any checks appear in box 3? Yes □ No □

If all items in Box 1 are ticked and at least one item in Box 2 is ticked a diagnosis of
delirium is suggested.

This form can be downloaded from "PA Toolkit: Forms CD".

Adapted from: Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RL.
Clarifying confusion: The Confusion Assessment Method. A new method for detection
Say

**Report your assessment**

Residents get the best outcomes when you provide clear information when discussing or documenting the incidence or assessment of delirium.

**What to say when reporting your assessment of delirium**

**Careworker to nurse**

‘Mrs Smith appears to be confused. She says there are spiders on the wall and keeps plucking at the bed sheets with her hands. She thinks she is in a motel at the seaside’.

**Nurse to GP**

‘Mrs Smith is confused, agitated and distressed. She can see spiders on her walls, plucking bed sheets with her hands and is disoriented in time and place.

She has had more opioid breakthrough analgesic doses than usual today and is febrile 37.9 deg C. Her urine from IDC is malodorous’.

**Is much better than**

‘Mrs Smith is confused. You need to see her to sort it out’.

Do

**Manage the symptom**\(^{23,48,51}\)

- Use simple measures detailed below for all residents exhibiting a delirium.
- If there is an obvious cause, treat if appropriate within your scope of practice and in the context of the resident’s prognosis and known preferences.
- In the terminal phase, it may not be appropriate to investigate or treat reversible causes of a delirium.
Non-pharmacological measures 34-47,49,51

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

Clinical practice strategies
- address anxiety; patients with delirium are often very frightened
- regular reassurance and reorientation
- manage discomfort or pain
- minimise sensory deficits by providing and assisting with hearing and visual aids e.g. clean spectacles and remove wax deposits in hearing aids, check batteries are fresh
- encourage presence of people familiar to the resident e.g. family and friends and regular staff members
- reassure the resident and family by explaining the possible causes and management plan to the resident and their family
- avoid use of physical restraints
- use interpreters and communication aids for residents with culturally and linguistically diverse (CALD) needs
- promote relaxation and sufficient sleep
  e.g. assisted by massage and/or encouraging wakefulness during the day
- minimise use of indwelling urinary catheters
- medication review
  e.g. ceasing or reducing all non-essential medications, swapping to another opioid can sometimes be effective.

Pharmacological therapies 33,47,49,51

The primary aim is to reduce the resident’s distress by targeting any agitation or hallucinations.

Antipsychotic drugs

Haloperidol
oral tablet/liquid or subcutaneous injection

For residents with Parkinson’s disease or at very high risk of extra-pyramidal side effects:
  Risperidone - oral
  Olanzapine - oral or sublingual

Precautions are necessary for residents with Lewy-Body dementia.

Benzodiazepines

Benzodiazepines:
- do not improve cognition but may help associated anxiety
- may worsen a delirium if not used in combination with an antipsychotic drug.

Use short term and short acting preparations
  Lorazepam - oral or sublingual
  Midazolam - subcutaneous

Consult “Therapeutic Guidelines: Palliative Care” for additional and comprehensive prescribing recommendations. Version 3 of these guidelines is included in the PA Toolkit.
Avoid general statements

When all else fails\textsuperscript{33,49,51}

Agitation and delirium which causes severe distress and does not respond to medical management, especially in the terminal phase, is a challenging problem and may require sedation as the only appropriate intervention.

- Midazolam - Subcutaneous infusion
- Clonazepam - Sublingual drops

Consultation with a specialist palliative care service is advisable.

**Write**

**Document your actions**

- Document clinical assessments and care plans using the guidelines in this domain.
- Document all communication and consultation with residents, family members and other members of the aged care team.

<table>
<thead>
<tr>
<th>POOR COMMUNICATION</th>
<th>GOOD COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of interventions 'with effect' or 'effective'.</td>
<td>'Resident commenced on treatment for delirium, delirium resolved'.</td>
</tr>
<tr>
<td>Note to GP 'Please review Mrs Smith ASAP re delirium'.</td>
<td>'Careworkers report Mrs Smith says she can see spiders on her walls, is agitated and very distressed, plucking the bed sheets with her hands and is disoriented in time and place. She has had more opioid breakthrough analgesic doses than usual today and is febrile 37.9 deg. Her urine from IDC is malodorous'.</td>
</tr>
</tbody>
</table>

**Review**

**Evaluate and reassess as necessary**

It is important to evaluate and document the effectiveness of each intervention each time it is administered.

Delirium can develop and worsen quickly. Assessment and review at least daily, utilising the CAM, is important.
Bibliography – Module 3


6 Brisbane South Palliative Care Collaborative, Queensland Health/ Griffith University (2010a) Residential Aged Care End of Life Care Pathway (RAC EoLCP), Brisbane

7 Brisbane South Palliative Care Collaborative, Queensland Health/ Griffith University (2010b) Link Nurse Resource Folder, Brisbane


39 Parker D (2010) Palliative care in residential aged care facilities. Progress in Palliative Care, 18 (6), 352-357


