Communicating with patients who have dementia

By Cathy Sendecki, BSN, RN, GNC(C)

Communicating with patients with dementia in the emergency department (ED) can be challenging; getting and giving information effectively often takes longer than with cognitively intact individuals. These patients may have a diagnosis of dementia, or we may identify this in the ED.

Dementia is an umbrella term for a variety of brain disorders, with symptoms including loss of short-term memory, judgment and reasoning, and changes in mood and behaviour. Brain function is affected to the extent the person loses abilities to function in everyday activities, but the needs for identity, attachment, inclusion, and comfort are preserved. Alzheimer's disease is the most common form of dementia. In general, dementia is a progressive condition. This article refers to those with moderate to severe dementia.

In 2011, it was estimated that approximately 9% of Canadians aged 65 years and older had dementia. By 2031 that number is expected to double. Although individuals younger than 65 can develop dementia, it is more prevalent with increasing age. The risk for dementia doubles every five years after the age of 65. Overall, more women than men are diagnosed with dementia.

How can we provide effective, timely, respectful care to these patients?

- Once we have established that the patient is hemodynamically stable, we need to know if he has any change of mentation from baseline. If a caregiver is present, she may be able to describe any recent changes, or indicate if this is his usual behaviour.
- Although we may be inclined to speak with the patient's companion, remember to speak first to the patient. Although his short-term memory may be poor, he may be very attuned to emotions and non-verbal cues, and will generally appreciate being greeted as any adult, by name, rather than a term of endearment.
- A calm, friendly approach can be the start of a cooperative interaction.
- Ensure the patient knows you are speaking to her. Hearing or vision may be impaired. Be visible, with the light on your face, rather than behind you. Establish eye contact.
- Observe for signs of understanding. If necessary, try restating the message. If at all possible, have a quiet, calm environment, so the patient is not overwhelmed by noise and other stimuli.
- Short, simple statements will be easier to understand: "Does your arm hurt?", as you touch one arm, rather than asking "What happened?"
- Ask one question at a time, or give directions one step at a time. Ask questions with a yes or no answer, or two choices.
- Give the patient time to respond. Prepare him when a new topic is introduced. Tell him what he can do, not what he cannot do.
- Use names of persons or things, not pronouns.
- If this patient is no longer able to understand speech, she may understand gestures. Speak in an encouraging tone.
- The patient with dementia generally is aware of what she feels now, and cannot recall dealing with this in the past, nor what she has been told a few minutes ago. Reminding her, "don't you remember? I just told you not to touch your IV; you told me you wouldn't" will convey displeasure rather than helpful information. On the other hand, going back a few minutes later to offer more fluids or another spoonful of crushed medication in applesauce may be surprisingly successful.
- Avoid trying to convince her she is wrong; focus and acknowledge the feeling expressed, for example frustration, and help her to deal with this.
- Distraction and redirection may help, perhaps physical activity, which also provides an opportunity for assessment of mobility.
- Emergency nurses are adept at assessing non-verbal cues—use this skill as you assist a patient to move, or compare ease of movement in the uninjured limb to the painful area.
- While the patient may not be able to describe pain, or even respond to questions about pain, a change in behaviour when the painful area is touched, or reluctance to move in certain ways provide clues.

A comprehensive guide, *Pain Assessment in the Patient Unable to Self-Report*, by Kunz et al., 2009, is available online at **www.aspmn.org**. The *Pain Assessment in Advanced Dementia Scale (PAINAD)*, available at **www.healthare.uiowa.edu** and other sources, is useful when ongoing pain and management are issues.

Not long ago, I was reminded of some of these challenges and opportunities: I went to see a woman in her late 80s who had come a few hours earlier by ambulance. The notes indicated she had gastrointestinal symptoms, and could not remember ever feeling as bad as she did this morning. I expected to find a woman in distress with pain, nausea and dehydration. To my surprise, she was sitting up on the stretcher, smiling, her nearly finished IV infusing well. By this time, she had no more symptoms, and described to me that she had been brought to hospital

by mistake. Her only concern now was to go home. I assured her we could help her with this request. Once we found she was tolerating her oral fluids, obtained a urine spec, and started her on antibiotics for a UTI, we were able to arrange her discharge, with a referral to Home Health to ensure she had appropriate support to manage well.

Caring for seniors with dementia is not often this simple, but the reward is in finding which techniques help us to make contact with the person, and communicate that we are doing our best to help.

About the author

Cathy Sendecki has worked in Burnaby Hospital ED since 1987. As Educator, in 2005 she worked with the Clinical Nurse Specialist for Acute Care of Older Adults to improve the care of seniors in our ED. What started as a three-month project by an ED nurse who did not see great areas for improvement, became a full-time position that continues to be fascinating and challenging. She appreciates the opportunity to assess patients with a geriatric and emergency "lens" to assist the emergency team to provide the best care to those seniors with complex presentations.

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Identifying emergency-sensitive conditions for the calculation of an in-hospital standardized mortality ratio specific to emergency care

By Simon Berthelot, MD, CFPC(EM), FRCPC, Eddy S. Lang, MD, CFPC(EM), CSPQ, Hude Quan, MD, PhD, Henry T. Stelfox, MD, FRCPC, PhD, On behalf of the Panel on Emergency-Sensitive Conditions (PESC)

Introduction

The *Canadian Institute for Health Information* (CIHI) provides annual *Hospital Standardized Mortality Ratios* (HSMR) for each Canadian hospital. As a first step to developing an ED HSMR variant, we identified diagnosis groups (DGs) where high-quality emergency department (ED) care would be expected to reduce in-hospital mortality (emergency-sensitive conditions).

Methods

We used a two-step approach to identify emergency-sensitive conditions:

1. Using a modification of the RAND/UCLA Appropriateness Methodology, a multidisciplinary national panel of emergency care providers and managers (n=14) serially rated DGs included in the CIHI HSMR (n=72) according to the extent that ED management potentially decreases mortality.
2. The DGs selected by the panel were sent to members (n=2,507) of the *Canadian Association of Emergency Physicians* and the *National Emergency Nurses Affiliation* for evaluation. Using an electronic survey, they were asked to agree or disagree (binary response) with the panel classification.

Results

The expert panel rated 37 DGs (e.g., sepsis) over three rounds of review as having mortality potentially reduced by ED care. In addition, panelists identified 40 DGs (e.g., stroke) where timely ED care was critical, 43 DGs (e.g., atrial fibrillation) where ED care could reduce morbidity and 47 DGs (e.g., bacterial meningitis) not included in the Canadian HSMR, as diagnoses whose mortality could be decreased by ED care. Of the 37 DGs selected by the panel, 32 were rated by more than 80% of survey respondents (n=719) to be emergency-sensitive conditions for mortality. The level of agreement was above 68% for the five remaining DGs.

Conclusion

We identified 37 DGs representing emergency-sensitive conditions that will enable the calculation of an in-hospital standardized mortality ratio that is more relevant to emergency care.

Department(s) and institution(s) to which the work should be attributed

Department of Community Health Sciences, University of Calgary, Division of Emergency Medicine, University of Calgary, Institute of Public Health, University of Calgary.