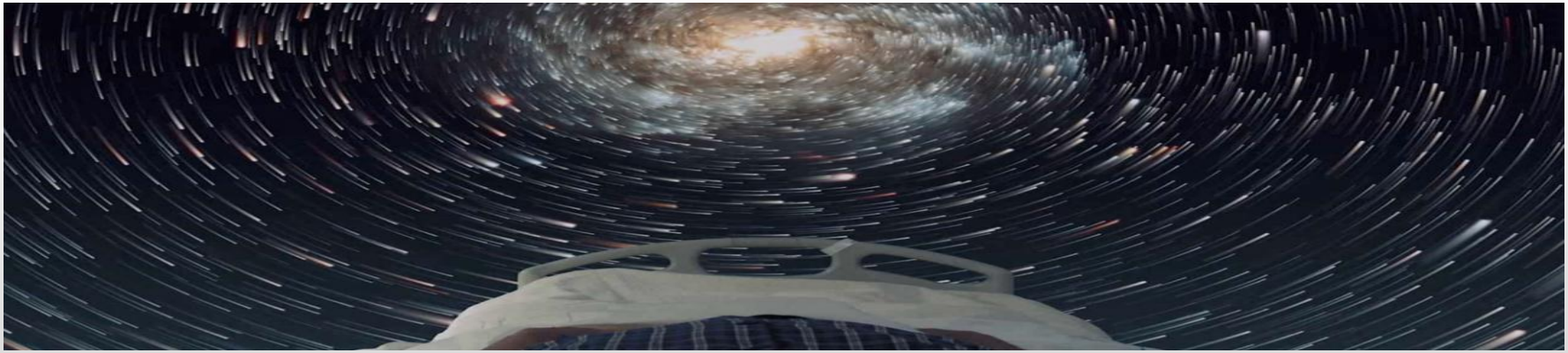

Delirium Experience

A serious game to improve skills and attitudes to treat delirious patients?

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What to expect?

Introduction presentation	10 min
Strain of care for delirium	15 min
Video + DOSS / DRS	20 min
Delirium Experience	30 min
Closing discussion and questions	15 min

Goal: Gain insight in how we can train skills and attitude?

Delirium

100.000 delirious patients in Dutch hospitals (1)

30 – 50% die within 1 year (1)

Taking good care is a challenge for both nurses and doctors

Education

Book

Lecture

E-learning

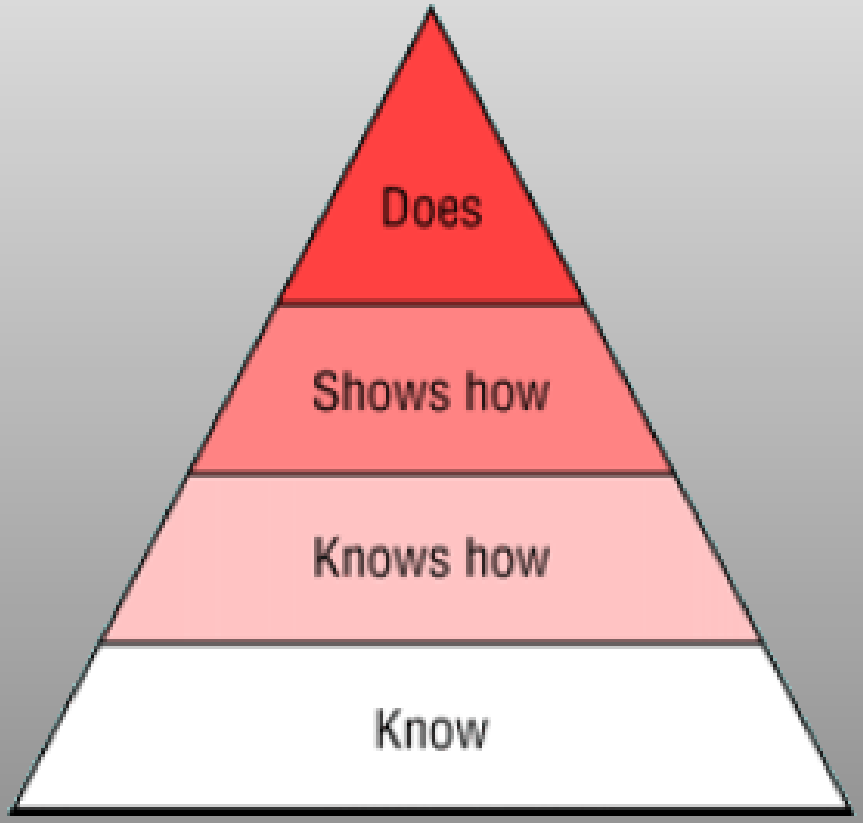
Refreshment courses

....

Knowledge

But what about skills and attitude?

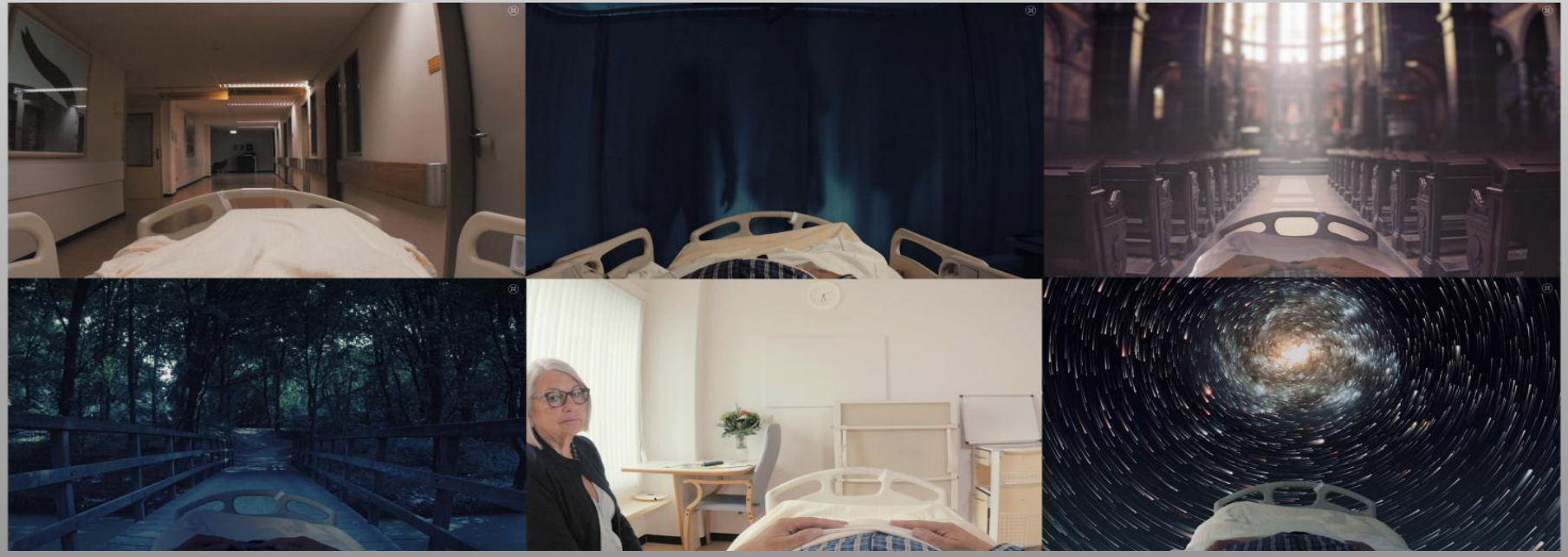
Miller's pyramid



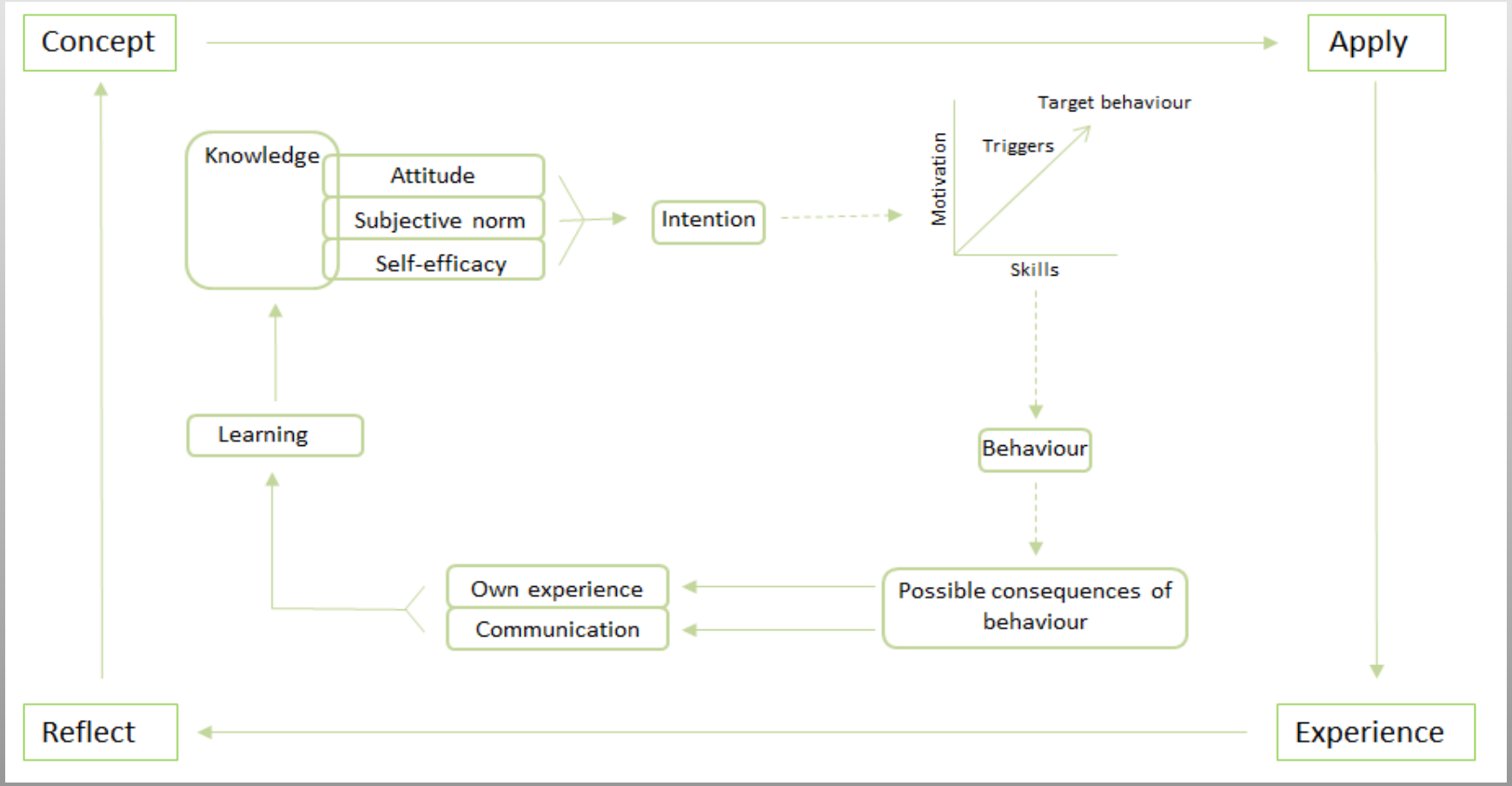
New educational tool

Delirium Experience

Simulation-based Serious Game



Why a Serious Game?



Delirium Experience

- Take care of a patient with delirium
- Experience in 30 minutes
  - What it is like being delirious
  - What are the consequences of your actions as care professional
- Personal feedback
- Experiment with different actions (Dark game)

Development

- In collaboration with
  - Older people
  - Professionals
  - IJsfontein
- Based on stories of older adults who experienced delirium
- Guideline delirium 2014 (1)

Strain of Care for Delirium(2) (1)

Degree of difficulty in taking care of:

Geriatric patients with delirium:

1. Are withdrawn, unusually quiet
2. Are apathetic, unmotivated
3. Have decreased amount of motor activity
4. Have a lack of knowledge or understanding of their situation of illness
5. Have difficulty concentrating, are easily distracted

Strain of Care for Delirium (2)

6. Speak slowly or in an hesitant manner
7. Show little eye contact
8. Call someone known to him/her by another name
9. Are talking to people not actually present
10. Show repetitive behaviour
11. Speak incoherently
12. Alternate between lucid moments and confused episodes

Strain of Care for Delirium (3)

13. Have disturbed sleep-wake cycle
14. Are restless, agitated
15. Are noisy/yelling
16. Are irritable
17. Have increased amount of motor activity
18. Are uncooperative, difficult to manage
19. Try to get out of bed inappropriately
20. Pull at tubes, dressings, ….

Delirium Observation Screening Score[3] (1)

1. Dozes off during conversation or activities
2. Is easily distracted by stimuli from the environment
3. Maintains attention to conversation or action
4. Does not finish question or answer
5. Gives answers that do not fit the question
6. Reacts slowly to instructions
7. Thinks they are somewhere else

Delirium Observation Screening Score (2)

8. Knows which part of the day it is
9. Remembers recent events
10. Is picking, disorderly, restless
11. Pulls IV tubing, feeding tubes, catheters, etc.
12. Is easily or suddenly emotional
13. Sees / hears things which are not there

Delirium Rating Scale-Revised-98(4)

1. Sleep-wake cycle disturbance

Rate sleep-wake pattern using all sources of information, including from family, caregivers, nurses' reports, and patient. Try to distinguish sleep from resting with eyes closed.

0. Not present
1. Mild sleep continuity disturbance at night or occasional drowsiness during the day
2. Moderate disorganization of sleep-wake cycle (e.g., falling asleep during conversations, napping during the day or several brief awakenings during the night with confusion/behavioral changes or very little nighttime sleep)
3. Severe disruption of sleep-wake cycle (e.g., day-night reversal of sleep-wake cycle or severe circadian fragmentation with multiple periods of sleep and wakefulness or severe sleeplessness.)

Delirium Rating Scale-Revised-98

2. Perceptual disturbances and hallucinations

Illusions and hallucinations can be of any sensory modality. Misperceptions are “simple” if they are uncomplicated, such as a sound, noise, color, spot, or flashes and ‘‘complex’’ if they are multidimensional, such as voices, music, people, animals, or scenes. Rate if reported by patient or caregiver, or inferred by observation.

0. Not present
1. Mild perceptual disturbances (e.g., feelings of derealization or depersonalization; or patient may not be able to discriminate dreams from reality)
2. Illusions present
3. Hallucinations present

Delirium Rating Scale-Revised-98

3. Delusions

Delusions can be of any type, but are most often persecutory. Rate if reported by patient, family or caregiver. Rate as delusional if ideas are unlikely to be true yet are believed by the patient who cannot be dissuaded by logic. Delusional ideas cannot be explained otherwise by the patient's usual cultural or religious background.

0. Not present
1. Mildly suspicious, hypervigilant, or preoccupied
2. Unusual or overvalued ideation that does not reach delusional proportions or could be plausible
3. Delusional

Delirium Rating Scale-Revised-98

4. Lability of affect

Rate the patient's affect as the outward presentation of emotions and not as a description of what the patient feels.

0. Not present

1. Affect somewhat altered or incongruent to situation; changes over the course of hours; emotions are mostly under self-control

2. Affect is often inappropriate to the situation and intermittently changes over the course of minutes; emotions are not consistently under self-control, though they respond to redirection by others

3. Severe and consistent disinhibition of emotions; affect changes rapidly, is inappropriate to context, and does not respond to redirection by others

Delirium Rating Scale-Revised-98

5. Language

Rate abnormalities of spoken, written or sign language that cannot be otherwise attributed to dialect or stuttering. Assess fluency, grammar, comprehension, semantic content and naming. Test comprehension and naming nonverbally if necessary by having patient follow commands or point.

0. Normal language

1. Mild impairment including word-finding difficulty or problems with naming or fluency

2. Moderate impairment including comprehension difficulties or deficits in meaningful communication (semantic content)

3. Severe impairment including nonsensical semantic content, word salad, muteness, or severely reduced comprehension

Delirium Rating Scale-Revised-98

6. Thought process abnormalities

Rate abnormalities of thinking processes based on verbal or written output. If a patient does not speak or write, do not rate this item.

0. Normal thought processes
1. Tangential or circumstantial
2. Associations loosely connected occasionally, but largely comprehensible
3. Associations loosely connected most of the time

Delirium Rating Scale-Revised-98

7. Motor agitation

Rate by observation, including from other sources of observation such as by visitors, family and clinical staff. Do not include dyskinesia, tics, or chorea.

0. No restlessness or agitation
1. Mild restlessness of gross motor movements or mild fidgetiness
2. Moderate motor agitation including dramatic movements of the extremities, pacing, fidgeting, removing intravenous lines, etc.
3. Severe motor agitation, such as combativeness or a need for restraints or seclusion

Delirium Rating Scale-Revised-98

8. Motor retardation

Rate movements by direct observation or from other sources of observation such as family, visitors, or clinical staff. Do not rate components of retardation that are caused by parkinsonian symptoms. Do not rate drowsiness or sleep.

0. No slowness of voluntary movements
1. Mildly reduced frequency, spontaneity or speed of motor movements, to the degree that may interfere somewhat with the assessment.
2. Moderately reduced frequency, spontaneity or speed of motor movements to the degree that it interferes with participation in activities or self-care
3. Severe motor retardation with few spontaneous movements.

Delirium Rating Scale-Revised-98

9. Orientation

Patients who cannot speak can be given a visual or auditory presentation of multiple choice answers. Allow patient to be wrong by up to 7 days instead of 2 days for patients hospitalized more than 3 weeks. Disorientation to person means not recognizing familiar persons and may be intact even if the person has naming difficulty but recognizes the person. Disorientation to person is most severe when one doesn't know one's own identity and is rare. Disorientation to person usually occurs after disorientation to time and/or place.

0. Oriented to person, place and time
1. Disoriented to time (e.g., by more than 2 days or wrong month or wrong year) or to place (e.g., name of building, city, state), but not both
2. Disoriented to time and place
3. Disoriented to person

Delirium Rating Scale-Revised-98

10. Attention

Patients with sensory deficits or who are intubated or whose hand movements are constrained should be tested using an alternate modality besides writing. Attention can be assessed during the interview (e.g., verbal perseverations, distractibility, and difficulty with set shifting) and/or through use of specific tests, e.g., digit span.

0. Alert and attentive

1. Mildly distractible or mild difficulty sustaining attention, but able to refocus with cueing. On formal testing makes only minor errors and is not significantly slow in responses

2. Moderate inattention with difficulty focusing and sustaining attention. On formal testing, makes numerous errors and either requires prodding to focus or finish the task

3. Severe difficulty focusing and/or sustaining attention, with many incorrect or incomplete responses or inability to follow instructions. Distractible by other noises or events in the environment

Delirium Experience

http://demo.ijsfontein.nl/delirium/experience.php

If you prefer the Delirium Experience in Dutch, please let me know

Evaluation and motivation(5)

1. It was challenging to perform well in the delirium experience
2. I think the Delirium Experience can be valuable for me
3. I think the Delirium Experience is helpful for me to take care of delirious patients
4. It was fun to work with the Delirium Experience
5. I liked this way of learning
6. After working through the Delirium Experience, I felt encouraged to study it again
7. During learning, I could tell whether I was doing well
8. I could experience myself what did and did not work
9. I received sufficient feedback

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Further reading on delirium:

Inouye SK, Westendorp RGJ, Saczynski JS. Delirium in Older People. The Lancet, 2013 http://dx.doi.org/10.1016/S0140-6736(13)60688-1

Questions or suggestions?

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