

SUPSI

DELIRIUM

Herausforderung für Gesundheitsberufe

Prevention and treatment of delirium in the older people

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24 aprile 2023

DELIRIUM
Herausforderung für Gesundheitsberufe

Open Lecture Auch Online!
19.4.2023 | 17:00 - 18:30 | H2 Campus 1

Christian Pozzi gibt Einblick über den aktuellen Stand des Wissens der Ergotherapie in Prävention und Behandlung von Delirium. Gezeigt werden klinische Fallbeispiele. Der Vortrag dauert 45 min und findet auf Englisch statt. Beim gemütlichen Ausklang mit Buffet bietet die Veranstaltung Möglichkeiten zur Vernetzung.

Vortragender: Christian Pozzi
Scuola universitaria professionale della Svizzera italiana (SUPSI)

Anmeldung bis 12.4.: fhnw.ac.at/ol-delirium

WIRTSCHAFT | WISSENS | GESUNDHEIT | UMSATZ | BERUFEN
Perspektiven durch Praxis!

Who am I? Where do I work? What do I do?



What is delirium?

- Delirium is a neuropsychiatric syndrome, characterized by an **acute change in cognitive performance, mainly attention** (i.e., ability to direct, focus, sustain, and shift attention) **and awareness** (i.e., reduced orientation to the environment), **with fluctuating symptoms**
- Complex syndrome, wide range of cognitive and non-cognitive disturbances, various psychomotor subtypes
- **Wide range of potential causes:** acute medical condition, substance intoxication or withdrawal, exposure to a toxin or multiple etiologies (**combination of causes**)

How do you assess the presence of delirium?

DSM-5

A. Disturbance in *attention* (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced *orientation to the environment*).

B. The disturbance develops over a short period of time (usually hours to a few days), *represents an acute change from baseline attention and awareness*, and tends to fluctuate in severity during the course of a day.

C. An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception).

D. *The disturbances in Criteria A and C* are not better explained by a pre-existing, established or evolving neurocognitive disorder and *do not occur in the context of a severely reduced level of arousal such as coma*.

E. There is evidence from the history, physical examination or laboratory findings that the disturbance is a *direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e. due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies*.

How do you assess the presence of delirium?

<https://www.the4at.com/4at-deutsche>



Patientenname:

Geburtsdatum:

Patientenetikett:

Datum:

Uhrzeit:

Untersucher:

Bitte
Ankreuzen

Test zur Bewertung von Delir und kognitiver Einschränkung

[1] Wachheit

Dieser Punkt soll auch bei schwer erweckbaren, schläfrigen oder agitierten/hyperaktiven Patienten angewendet werden. Beobachten Sie den Patienten. Wenn sie/er schläft, versuchen Sie sie/ihn durch Ansprache oder durch eine Berührung an der Schulter aufzuwecken. Fragen Sie etwa nach dem Namen und der Adresse, um die Beurteilung zu erleichtern.

Normale Reaktion (komplett aufmerksam, nicht agitiert).	0
Weniger als 10 Sekunden schläfrig, dann normal.	0
Deutlich unnormale Reaktion.	4

[2] Orientierung (AMT4)

Korrekte Nennung von Alter, Geburtsdatum, aktuellem Ort (Name der Klinik, des Gebäudes), aktuellem Kalenderjahr.

Fehlerfrei.	0
1 Fehler.	1
2 oder mehr Fehler.	2

[3] Aufmerksamkeit

Fordern Sie den Patienten auf: „Nennen Sie mir die Monate eines Jahres rückwärts, beginnend mit Dezember.“ Zum Verständnis der Aufgabe ist als Hilfestellung die Frage „Welcher Monat kommt vor dem Dezember?“, etc., erlaubt.

Nennung von sieben oder mehr Monaten in korrekter Reihe.	0
Beginnt, erreicht aber nicht sieben Monate, keine Compliance.	1
Nicht durchführbar (sediert/fehlende Wachheit, Unwohlsein).	2

[4] Akute oder fluktuierende Symptomatik

Hinweis auf deutliche Änderung oder wechselnde Symptome bezüglich Wachheit oder Wahrnehmung, (z.B. auch Wahn, Halluzinationen) die innerhalb von zwei Wochen begannen und in den vergangenen 24 Stunden noch bestanden.

Nein.	0
Ja.	4

4 oder mehr Punkte: Delir möglich
 +/- kognitive Beeinträchtigung
 1-3: mögliche kognitive Beeinträchtigung
 0: Delir oder schwere kognitive Beeinträchtigung
 unwahrscheinlich, aber möglich, wenn [4] unvollständig

4AT SCORE

Outline

- Subjective perception of Delirium (Peter's story)
- Occupational Therapy and Delirium: state of the art
- Case Study
- Possible collaborations and research horizons

Outline

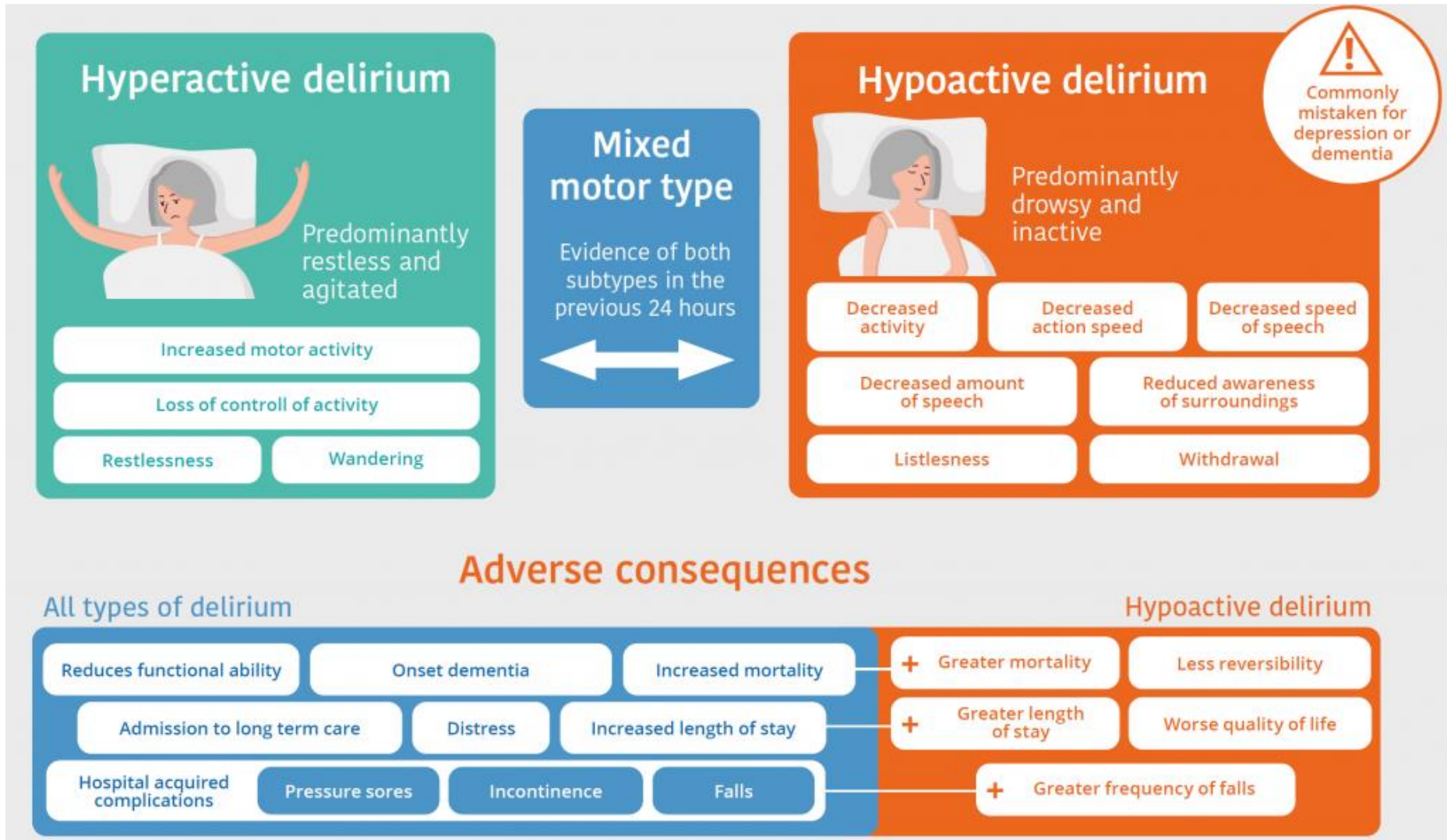
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Peter's Story

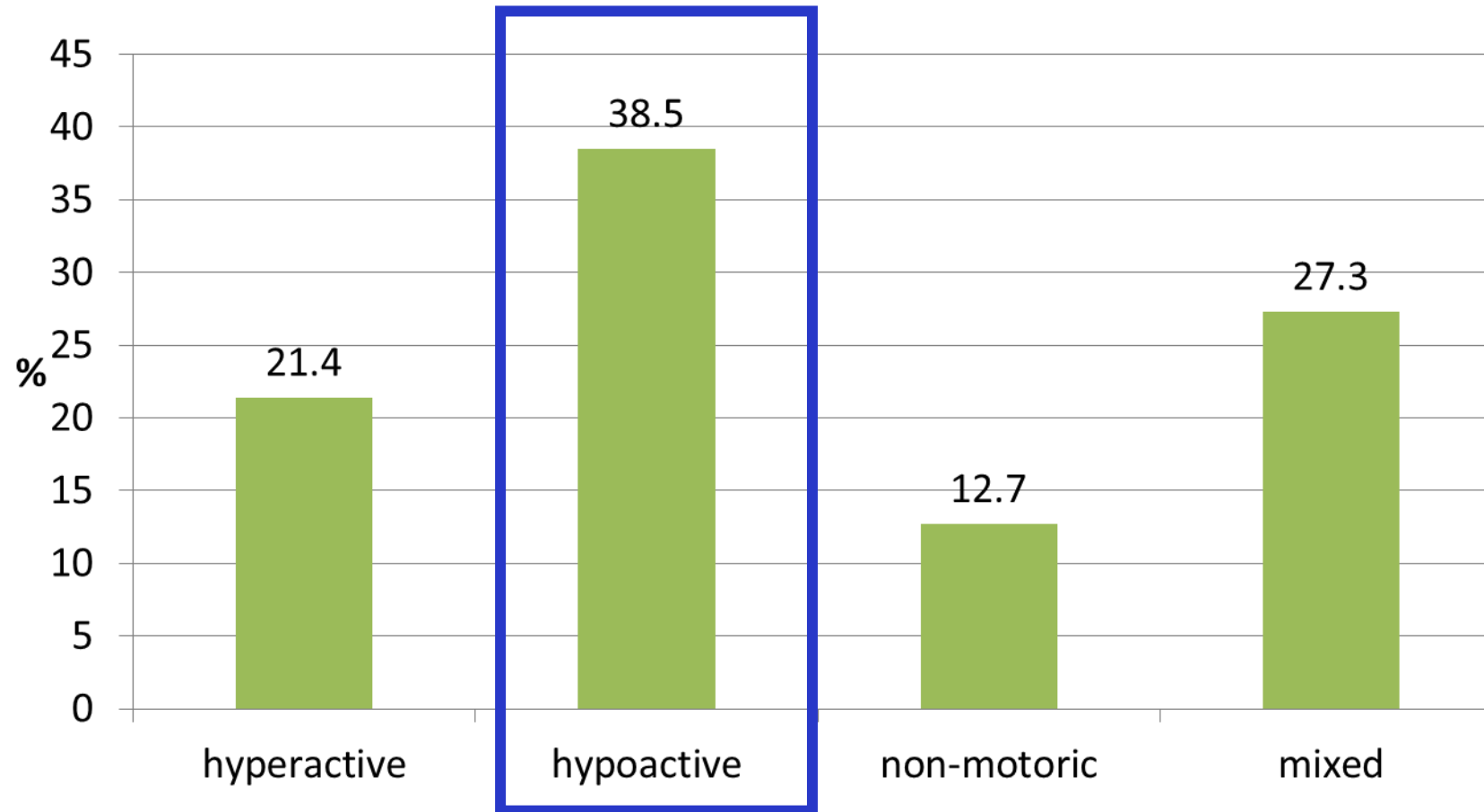
- <https://www.youtube.com/watch?v=vqfnkixlCbA>



Hyperactive – Hypoactive - Mixed



Hypercative – Hypoactive - Mixed



Outline

- Subjective perception of Delirium (Peter's story)
- **Occupational Therapy and Delirium: state of the art**
- Case Study
- Possible collaborations and research horizons

The beginning of the journey ...



**The nurse or another professional
in the hospital ward**

"Doctor, the patient is agitated"

"Well, he/she seems different from
yesterday, more agitated than usual"

"Keep sleeping"

Occupational Therapy and Delirium in ICU

Early physical and occupational therapy in mechanically ventilated, critically ill patients: a randomised controlled trial

William D Schweickert, Mark C Pohlman, Anne S Pohlman, Celerina Nigos, Amy J Pawlik, Cheryl L Esbrook, Linda Spears, Megan Miller, Mietka Franczyk, Deanna Deprizio, Gregory A Schmidt, Amy Bowman, Rhonda Barr, Kathryn E McCallister, Jesse B Hall, John P Kress


Occupational therapy for delirium management in elderly patients without mechanical ventilation in an intensive care unit: A pilot randomized clinical trial

Evelyn A. Álvarez, MS ^{a,b,}, Maricel A. Garrido, MS ^{c,1}, Eduardo A. Tobar, MD ^{d,2}, Stephanie A. Prieto, MS ^{a,c,3}, Sebastian O. Vergara, MS ^{c,4}, Constanza D. Briceño, MS ^{b,c,5}, Francisco I. González, MD ^{e,6}*

Occupational Therapy and Delirium in ICU

Mobilization = Less Delirium

Variable	Intervention (n=49)	Control (n=55)	P-value
ICU/Hosp Delirium Days	2 days	4 days	0.03
Time in ICU with Delirium	33%	57%	0.02
Time in Hosp. with Delirium	28%	41%	0.01

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Lancet 2009

Occupational Therapy and Delirium in ICU

Table 4

Functional outcomes at hospital discharge

	Control group (n = 65)	Experimental group (n = 65)	P
Functional Independence at discharge, n (%) ^a	31 (47.7)	53 (81.5)	<.0001
Motor FIM, median [p25-p75]	40 [25-56.5]	59 [44-82.5]	<.0001
Cognitive FIM, median [p25-p75]	33 [31.5-35]	35 [34-35]	.001
Grip strength dominant hand (kg), median [p25-p75]	18 [10-29.5]	26 [15-36]	.02
Grip strength nondominant hand (kg), median [p25-p75]	14 [9-23]	20 [14-35]	.01
MMSE, median [p25-p75]	26 [24-28]	28 [25-29]	.04

Motor FIM, scale 13-91; cognitive FIM, scale 5-35; MMSE, scale 0-30.

^a At least 75 score for total FIM.

Journal of Critical Care, 2017



Contents lists available at ScienceDirect

Journal of Critical Care

journal homepage: www.jccjournal.org

Occupational therapy for delirium management in elderly patients without mechanical ventilation in an intensive care unit: A pilot randomized clinical trial



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Occupational Therapy and Delirium in Rehabilitation setting



Preliminary Evidence of a Positive Effect of Occupational Therapy in Patients With Delirium Superimposed on Dementia

Colloquio caregiver

Occupazioni personalizzate

ADL

Educazione caregiver

Modifiche dell'ambiente

- (1) A caregiver interview (Model of Human Occupation concept, history interview) to be acquainted with the occupational story of the patient and of the caregiver and to collect key information to begin the reorientation into the reality and to identify ordinary significant occupations for the patient⁶;
- (2) An external multisensory and cognitive stimulation by personal and significant occupations, which were identified as important for the patient through the caregiver interview⁷;
- (3) A basic ADL group of activities that promote independent living, which include mobilization, hygiene, personal grooming, and eating, in all morning sessions⁸;
- (4) A family education and involvement (education about implementation of base activities) that are necessary for a proper assistance and explanation of the phenomenology of delirium; and
- (5) Changes of the environment to promote rest, sleep-wake cycle, and spatial-temporal orientation.

Occupational Therapy and Delirium in Nursing Home

Table 2 Clinical characteristics and demographics of 22 patients with moderate dementia before delirium, at the delirium onset and delirium resolution

Variable	Before delirium	Delirium onset	Delirium resolution
Age	–	86.45 ± 6.46	–
Gender, female (N, %)	–	16 (72%)	–
s-MMSE	13.32 ± 3.29	3.27 ± 3.67	9.60 ± 6.34
D-O-M	–	20.86 ± 3.68	–
Barthel index	20.91 ± 17.44	12.59 ± 12.35	17.80 ± 16.67
Number of drugs	–	8.95 ± 2.95	–
CIRS severity index	–	2.22 ± 0.32	–
Tinetti score	–	2.27 ± 4.27	5.15 ± 5.32
COPM proxy performance	–	0.86 ± 1.25	5.2 ± 2.78
COPM proxy satisfaction	–	0.68 ± 1.46	4.85 ± 2.94

Occupational Therapy and Delirium in Nursing Home

Table 1 Occupational therapy procedures according to the level of agitation and sedation as measured with the modified-Richmond Agitation and Sedation Scale (m-RASS)

n-RASS – 5/– 4

Aids (e.g., bed, wheelchair, anti-decubitus aids, positioning, splint, if necessary): use of devices and adaptations to prevent edema and bedsores on the most vulnerable areas of the body

Transfer bed/wheelchair with education to the staff of the department

Knowledge of the caregiver: daily visits for previously trained family members

n-RASS – 3/– 2

Definition of necessary aids (e.g., wheelchair, anti-decubitus cushions, non-slip mats, etc.)

Transfer bed/wheelchair with education to the staff of the department

Seeking participation in the activity of eating or B/ADL (activity analysis and simplification)

Orientation through environmental adaptations (possibly with known objects)

Knowledge and communication with caregivers

n-RASS – 1/0/+ 1

Definition of necessary aids (e.g., wheelchair, anti-decubitus cushions, non-slip mats, etc.)

Transfer bed/wheelchair with education to the staff of the department, formal or informal caregiver

Basic activity of daily living, eg. eating and promotion of participatory life in the morning with nurses' assistants or caregiver (behavioural strategies)

Constant information to the caregiver and conscious participation of the family: education in the execution of personal and significant activities

Cognitive stimulation, execution through personal occupations (global activation), e.g., reading, writing, telephonic conversation on topics of interest

Engage the patient's motivation and routine

n-RASS + 2

Definition of necessary aids (e.g., wheelchair, anti-decubitus cushions, non-slip mats, etc.)

Transfer bed/wheelchair with education to the staff of the department, formal or informal caregiver

Basic activity of daily living, eg., eating and promotion of participatory life in the morning with OSS or caregiver

Specific education on behavioural disorders for nurses and caregivers (coaching in the ward)

Constant information to the caregiver and conscious participation of the family: education in the execution of personal and significant activities

Cognitive stimulation, execution through personal occupations (global activation), e.g., reading, writing, telephonic conversation on topics of interest several times a day for short moments

Engage the patient's motivation and routine

Occupational Therapy and Delirium in Nursing Home

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^aMean ± SD, unless otherwise noted

^bCumulative illness rating score (CIRS) is a screening tool for co-morbidity, assessing the chronic medical illness burden while taking into account the severity of chronic diseases; the score for each of the 14 items can range from 1 (absence of pathology) to 5 (maximum level of severity of the disease). The CIRS severity index is the result of the average score of the first 13 items

Table 3 Description of proportion of intervention delivered per each day according to delirium resolution and transfer to acute hospital for clinical instability

Day of delirium and acute hospital transfer	N	First daily treatment	Second daily treatment
Day 1	N=22	22 (100%)	14 (63.64%)
Transfer to acute hospital	N=0		
Day 2	N=11	11 (100%)	8 (72.72%)
Transfer to acute hospital	N=1		
Day 3	N=4	4 (100%)	1 (25%)
Transfer to acute hospital	N=1		
Day 4	N=3	3 (100%)	2 (66.67%)
Transfer to acute hospital	N=0		
Day 5	N=1	1 (100%)	1 (100%)
Transfer to acute hospital	N=0		
Day 6	N=1	1 (100%)	1 (100%)
Transfer to acute hospital	N=0		

Occupational Therapy – Physiotherapy and Delirium Delirium superimposed on dementia (DSD): scoping review



Review

Innovative Non-Pharmacological Management of Delirium in Persons with Dementia: New Frontiers for Physiotherapy and Occupational Therapy?

Christian Pozzi ^{1,2,*}, Verena C. Tatzert ³, Cornelia Strasser-Gugerell ³, Stefano Cavalli ¹, Alessandro Morandi ^{4,5} and Giuseppe Bellelli ^{6,7}

For this scoping review, we focused on the studies that examined the role of OT and PT in preventing and treating delirium and DSD in older adults

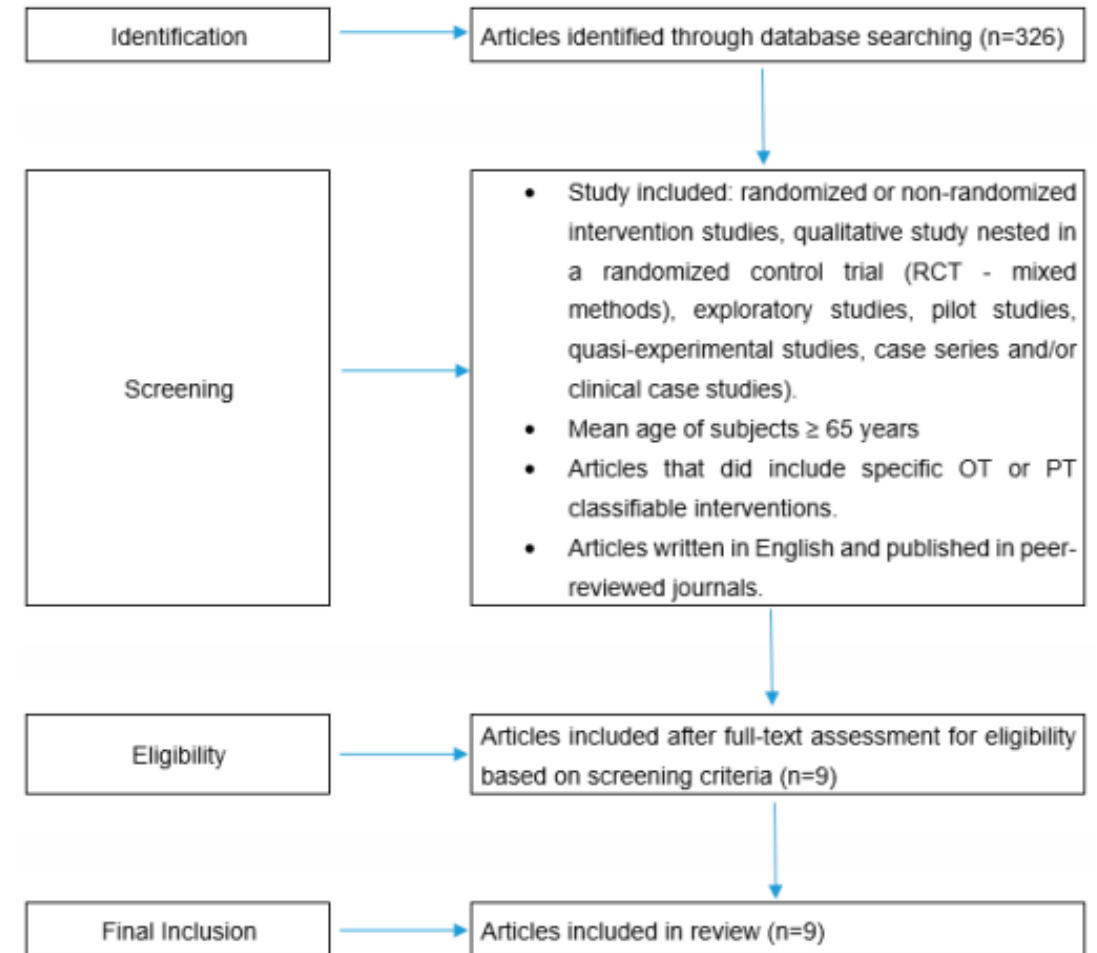


Figure 1. Study flow chart.

Occupational Therapy – Physiotherapy and Delirium Delirium superimposed on dementia (DSD): scoping review

- ✓ The global number of patients enrolled across studies was 887 (min 6 – max 370)
- ✓ The designs of the studies differed: two were RCTs, two case series, one was a qualitative study nested in an RCT, one a single-blind RC pilot trial, one a retrospective longitudinal study, one a prospective observational study and one a experimental feasibility study without control group
- ✓ 2 studies were conducted in an orthogeriatric unit, 2 studies in ICU, 2 in an acute care for the elderly (ACE) unit. In addition, one study was conducted in a rehabilitation ward, one in nursing home, and one in a hospice.

Occupational Therapy – Physiotherapy and Delirium Delirium superimposed on dementia (DSD): scoping review

Main Results scoping review - intervention in physiotherapy and Occupational Therapy

- Moderate intensity and individualized exercises can improve motor performance, autonomy, cognitive function, and quality of life, but not the incidence of delirium.
- Early mobilization can reduce 30-day hospital readmissions, falls, pressure sores, and adverse respiratory events in patients discharged from the ICU. This intervention can improve independence in activities of daily living but cannot reduce length of stay.
- OT intervention is feasible in different care settings, may improve participation and independence, may decrease the duration and incidence of delirium, may reduce behavioral disturbances, and may facilitate patient discharge home.

Occupational Therapy – Physiotherapy and Delirium Delirium superimposed on dementia (DSD): scoping review

Main Results scoping review - intervention in physiotherapy and Occupational Therapy

- Person-centered approach is crucial (standardize occupational history collection, personalization and facilitation of meaningful activities)
- Modifications to the environment to promote orientation and rest (e.g., calendar, visible clocks, photographs)
- Inclusion of caregivers during rehabilitation sessions and education in understanding Delirium
- Encouragement of action and doing – proactivity approach
- Early mobilization

Interdisciplinary statement

- Complex problem needs complex and coordinated responses.
- **Interprofessionalism** refers to coordination and close collaboration among specialists from various disciplines and professions. Various surveys indicate that successful interprofessionalism increases the quality of care and promotes cost-effective use of resources.
- **There is no WaW effect in this area: it takes consistency, flexibility, culture and cooperation**

Morandi et al. *BMC Geriatrics* (2019) 19:253
<https://doi.org/10.1186/s12877-019-1264-2>

BMC Geriatrics

DEBATE

Open Access

An interdisciplinary statement of scientific societies for the advancement of delirium care across Europe (EDA, EANS, EUGMS, COTEC, IPTOP/WCPT)



Alessandro Morandi^{1,2*}, Christian Pozzi³, Koen Milisen^{4,5}, Hans Hobbelen^{6,7}, Jennifer M. Bottomley^{7,8}, Alessandro Lanzoni^{9,10}, Verena C. Tatzert¹¹, Maria Gracia Carpena¹², Antonio Cherubini¹³, Anette Ranhoff¹⁴, Alasdair M. J. MacLulich^{15,16}, Andrew Teodorczuk¹⁷ and Giuseppe Bellelli^{18,19}

Abstract

Background: Delirium is a geriatric syndrome that presents in 1 out of 5 hospitalized older patients. It is also common in the community, in hospices, and in nursing homes. Delirium prevalence varies according to clinical setting, with rates of under 5% in minor elective surgery but up to 80% in intensive care unit patients. Delirium has severe adverse consequences, but despite this and its high prevalence, it remains undetected in the majority of cases. Optimal delirium care requires an interdisciplinary, multi-dimensional diagnostic and therapeutic approach involving doctors, nurses, physiotherapists, and occupational therapists. However, there are still important gaps in the knowledge and management of this syndrome.

Main body: The objective of this paper is to promote the interdisciplinary approach in the prevention and management of delirium as endorsed by a delirium society (European Delirium Association, EDA), a geriatrics society (European Geriatric Medicine Society, EuGMS), a nursing society (European Academy of Nursing Science, EANS), an occupational therapy society (Council of Occupational Therapists for European Countries, COTEC), and a physiotherapy society (International Association of Physical Therapists working with Older People of the World Confederation for Physical Therapy, IPTOP/WCPT).

Short conclusion: In this paper we have strongly promoted and supported interdisciplinary collaboration underlying the necessity of increasing communication among scientific societies. We have also provided suggestions on how to fill the current gaps via improvements in undergraduate and postgraduate delirium education among European Countries.

Keywords: Delirium, Interdisciplinary collaboration, Physical therapy, Occupational therapy

Background

Delirium is a geriatric syndrome characterized by an acute change and fluctuation of cognitive function, inattention and impaired awareness [1]. Delirium is a multifactorial condition that does not fit the traditional disease model. There are several predisposing factors,

such as dementia, malnutrition, and sensory impairment, and it is generally triggered by medical causes, pain and/or drugs [1, 2]. It occurs on average in one out of 5 hospitalized older patients [3]. Although the majority of studies have been performed in the hospital, delirium is not limited to geriatric wards or a geriatric inpatient population. Delirium prevalence in hospitals varies according to the clinical settings. It ranges from less than 5% in with some elective surgery, 18 to 35% in medical/geriatric wards and up to 80% in Intensive Care Units (ICUs) [4]. The highest incidence is observed in ICUs

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Outline

- Subjective perception of Delirium (Peter's story)
- Occupational Therapy and Delirium: state of the art
- **Case Study**
- Possible collaborations and research horizons





Case Study

Participates in activities of daily living in the morning (hygiene), assisted by the carer

BUT

PAIN AD = 7 Pina reports verbal and non-verbal back pain
Nurse case manager asks me for advice: **Delirium Vs BPSD?**

DELIRIUM vs BPSD



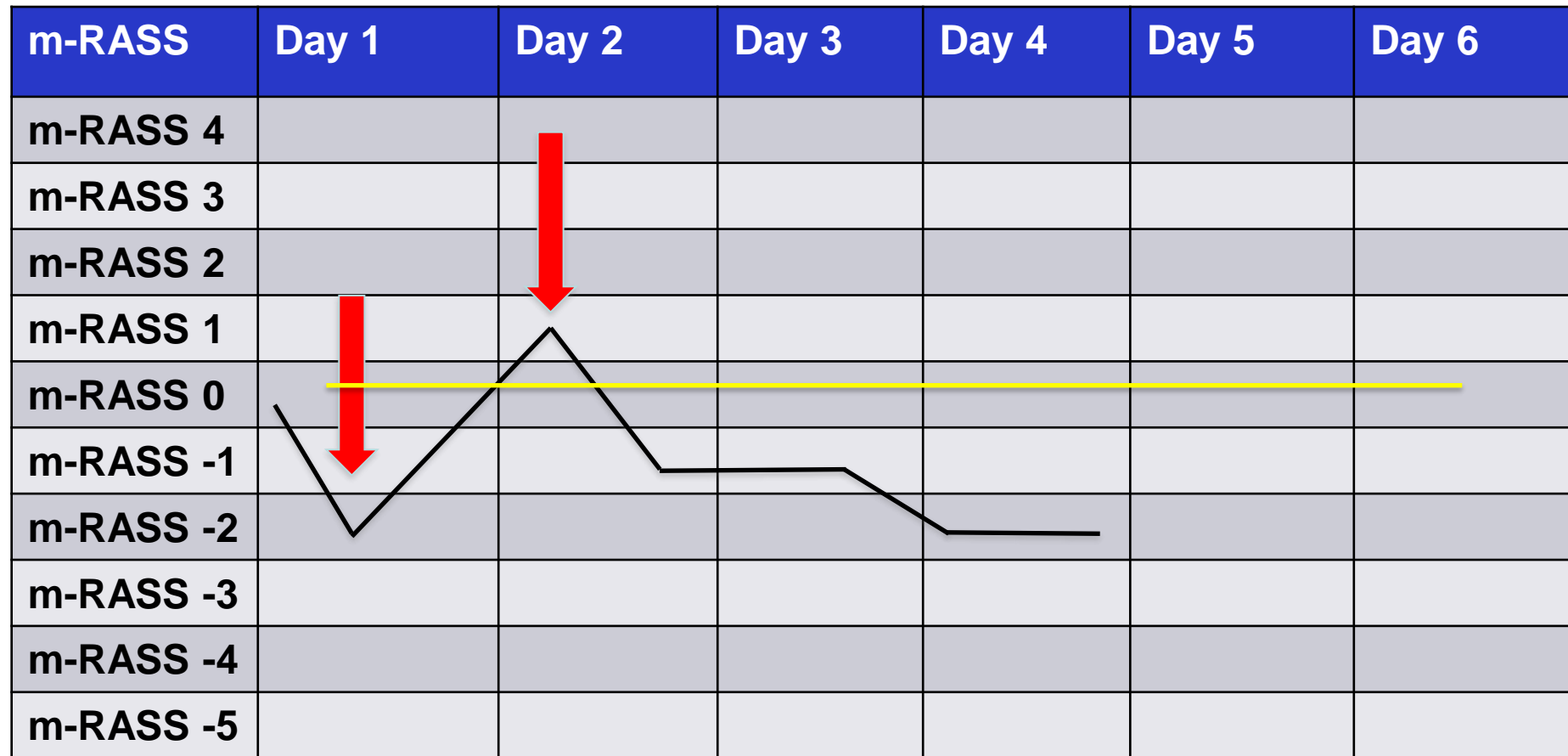
Case Study

m-RASS: +1/-2

delirium initially hyperkinetic with traits of verbal aggression; now delirium mixed with moments of drowsiness and subsequent moments of agitation

4 AT: positive

Case Study – m-RASS



Pozzi C, Tatzer VC, Álvarez EA, Lanzoni A, Graff MJL. The applicability and feasibility of occupational therapy in delirium care. *Eur Geriatr Med.* 2020 Apr;11(2):209-216. doi: 10.1007/s41999-020-00308-z. Epub 2020 Mar 23. PMID: 32297202.



(label)

Case Study – 4AT

Assessment test for delirium & cognitive impairment

Patient name: _____

Date of birth: _____

Patient number: _____

Date: _____ Time: _____

Tester: _____

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

- Normal (fully alert, but not agitated, throughout assessment)
- Mild sleepiness for <10 seconds after waking, then normal
- Clearly abnormal

CIRCLE

0
0
4



[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

- No mistakes
- 1 mistake
- 2 or more mistakes/untestable

0
1
2



[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

- Months of the year backwards
- Achieves 7 months or more correctly
 - Starts but scores <7 months / refuses to start
 - Untestable (cannot start because unwell, drowsy, inattentive)

0
1
2



[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

- No
- Yes

0
4



4 or above: possible delirium +/- cognitive impairment
 1-3: possible cognitive impairment
 0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE

I worked by individualising procedures and defining non-pharmacological procedures with the family members

- **Change of mobilisation (natural awakening or awakening at 9:00 a.m. presence of two people required; should not remain in bed)**
- **hydration with appealing drinks (several times a day)**
- **request anti-decubitus wheelchair cushion**
- **informing relatives of the change (trying to explain the reasons)**
- **Eliminate many personalised activities except THE PRIEST'S MESS on TV**
- **I prescribe assisted feeding with chopped food diet. Avoid continuous verbal cues. Calm and relaxing environment, average warm temperature.**
- **Inform geriatric doctor and case manager nurse.**

Case Study – take home message

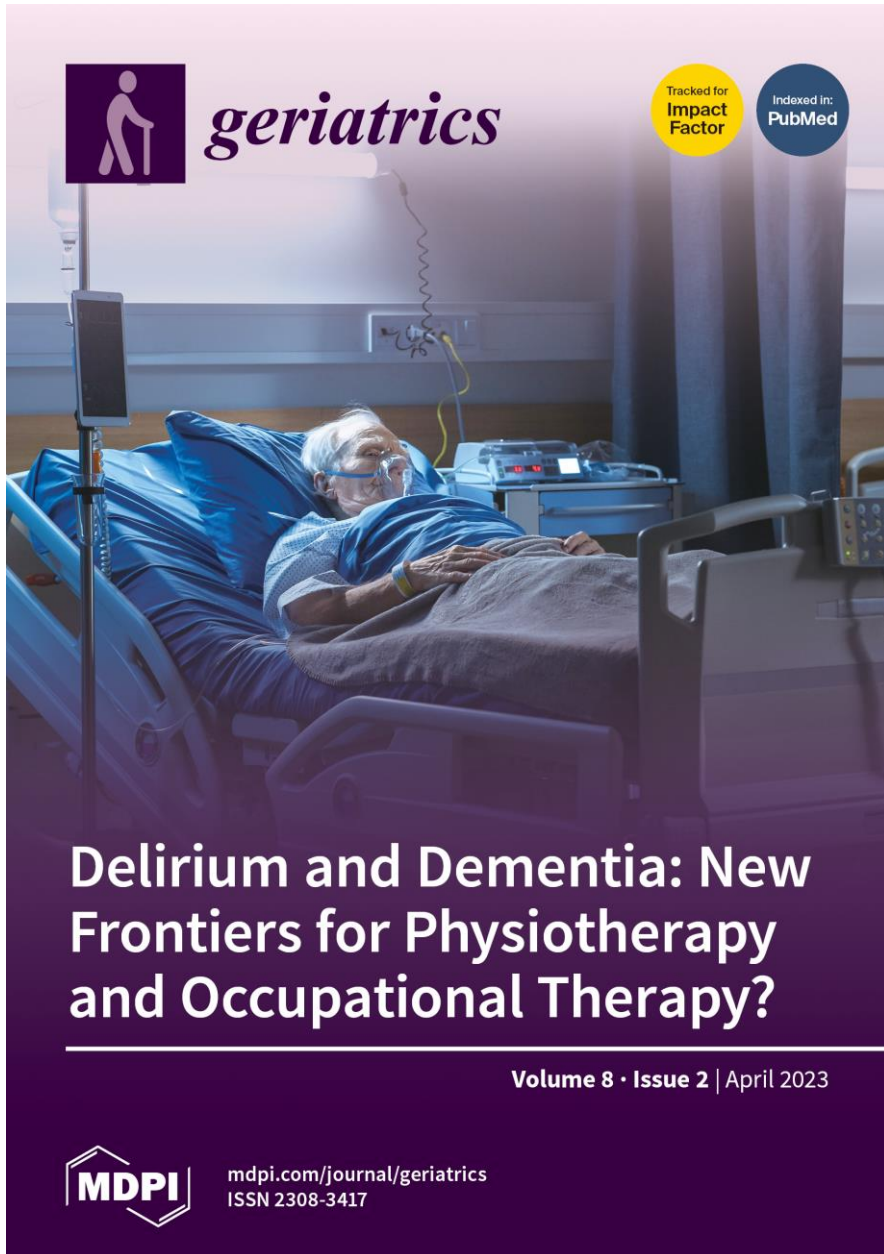
- Delirium issue solved
- Promptness of occupational therapist is the key to success
- Hospitalization not necessary

Outline

- Subjective perception of Delirium (Peter's story)
- Occupational Therapy and Delirium: state of the art
- Case Study
- **Possible collaborations and research horizons**

Take home message and "real world" research developments

- It is important to integrate physiotherapist and occupational therapist in geriatric teams
- Interesting research insights could be:
 - Can effective programs for the treatment of BPSD in dementia (e.g., Tailored activity program by Laura Gitlin) also be employed in the person with delirium or DSD?
 - What are the correct treatment timelines? What Intensity?
 - Which modality is best to educate and train the caregiver?



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www.3dcare.it

www.deliriumday.com/

