Assessing and Managing Delirium in Older Adults with Dementia

By: Donna Fick, PhD, APRN, BC, FGSA, FAAN, The Pennsylvania State University School of Nursing and Lorraine Mion, PhD, RN, FAAN, Vanderbilt University School of Nursing

WHY: Delirium in a patient with pre-existing dementia is a common problem that may have life-threatening complications, especially if unrecognized and untreated. Acute changes in mental status in older adults with dementia are often missed, mislabeled, or mistakenly attributed to the underlying dementia or “sundowning.” Delirium is thought to occur 4-5 times more often in a person with dementia. Delirium superimposed on dementia is less likely to be recognized and treated than is delirium without dementia. In patients with dementia, delirium can substantially worsen long-term outcomes, including prolonged hospitalization, further decline in cognitive and physical functioning, re-hospitalization, nursing home placement, and death. Delirium in older adults with dementia may be a sign of preventable and treatable medical problems or serious underlying illnesses such as a myocardial infarction, urinary tract infection, pneumonia, pain, or dehydration. Common medications causing delirium include diphenhydramine, benzodiazipines, anti-depressants, sedative-hypnotics, and anti-psychotics. An unrecognized delirium may interfere with recovery and rehabilitation after a hospitalization.

BEST TOOLS: Delirium is difficult to assess in older adults with dementia and in hospitalized older adults due to overlapping features of delirium and dementia and the uncertainty of the patient’s baseline mental status. Most tools to assess delirium are less specific when assessing delirium in older adults with dementia. Use a standardized tool to measure delirium, if possible, such as the Confusion Assessment Method (CAM) (See Try This: Confusion Assessment Method). The CAM focuses on the KEY FEATURES OF DELIRIUM: Acute onset and fluctuating course, inattention, disorganized thinking, and altered level of consciousness. The Delirium Superimposed on Dementia Algorithm suggested on page two recommends a process to assess for delirium for people with a pre-existing dementia. Poor attention is a key marker in delirium and delirium superimposed on dementia. Many of these tools can be integrated into the electronic medical record.

TARGET POPULATION: The Delirium Superimposed on Dementia Algorithm should be used with any older adult with dementia who is hospitalized, at home, in assisted living, in the nursing home, or in the emergency room with a change in mental or physical functioning. All older adults with dementia, who experience an acute change in mental or physical functioning and/or behavior changes, should be assessed for delirium superimposed on the dementia.

STRENGTHS AND LIMITATIONS: While the CAM is a useful tool, the Delirium Superimposed on Dementia Algorithm recognizes that the patient’s baseline mental status is a critical parameter for assessing and treating delirium. It recommends review of the patient’s medical record for indications of pre-existing dementia, and checking with the patient’s family, if any, as to whether the patient has a diagnosis of dementia or signs and symptoms of possible dementia. If a patient is admitted from an assisted living or long term care facility, the nurse should question the staff at the facility about the patient’s baseline mental and functional status. The algorithm presents practical ways for bedside nurses to assess delirium and CAM features such as poor attention and fluctuation. The algorithm can be used with patients with dementia who present to the hospital without previous medical evaluation, and/or family members who cannot describe the patient’s mental status pre-hospitalization, who are at increased risk for undetected delirium. The algorithm helps address ageism, a significant barrier to detecting the presence of delirium, wherein clinicians attribute further cognitive loss or lethargy in a person with dementia as an inevitable fact of life for older adults. (See Try This: Recognition of Dementia in Hospitalized Older Adults).

FOLLOW-UP: The algorithm includes assessment of mental status and physical functioning on a daily basis. Communication amongst interdisciplinary team members across health care settings is crucial to the detection and treatment of delirium in older adults, especially during times of acuity and transition.

REFERENCES:
Best practice information on care of older adults: www.ConsultGeriRN.org

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Delirium Superimposed on Dementia Algorithm

Assess for pre-hospital cognitive function:
- Review the patient’s medical record for indications of pre-existing dementia and/or functional difficulties.
- Ask the patient’s family, if any, whether the patient has a diagnosis of dementia or signs and symptoms of possible dementia. Ask about mental status in past 6 months to one year.
- If a patient is admitted from an assisted living or long term care facility, question the staff about the patient’s baseline mental and functional status.
- Complete a tool, such as the Family Questionnaire, to help assess pre-hospital cognitive and functional abilities (See Try This: Recognition of Dementia in Hospitalized Older Adults).

Assess for and identify delirium promptly:
- Use an instrument, such as the Confusion Assessment Method (CAM), to identify delirium quickly and at the bedside (Inouye, 1990).
- Acute onset (acute meaning minutes, hours, shifts, days--up to 2 weeks) or any change in cognition (inattention, memory loss, disorientation, hallucinations, delusions) or any change in function.
- Acute change in behaviors such as verbal and/or physical aggression, resistance to care, and wandering (See Try This: Wandering in the Hospitalized Older Adult).
- Fluctuation of mental status (unusual or changing function).
- Inattention: Assess by asking to say Days of the Week backwards or spell WORLD backwards and by observing for problems focusing, staring off into space, or losing track of questions.
- Disorganized thinking: Assess by asking, “What would you do if your home or room were on fire?”
- Altered level of consciousness. Hyperactive or hypoalert. Remember lethargy, falling asleep, staring off into space, and decreased motor activity is NOT NORMAL in older adults with dementia.

(See Try This: Confusion Assessment Method)

Assess for physiologic causes and risk factors for delirium:
- Medication(s) (See AGS 2012 Beers Criteria; Try This: Beers Criteria)
- Fecal impaction
- Urinary retention
- Infection (urine, lungs, skin)
- Hypoxia
- Dehydration
- Hypo/hyperglycemia
- Pain (See Try This: Assessing Pain)
- Immobility
- Sensory impairment

Prevent injury:
- Room near nurse’s station (monitor for excessive noise and stimulation due to location)
- Motion sensor alarm
- Asses fall risk (See Try This: Fall Risk Assessment)
- Remove/camouflage tubes when possible
- Use of increased surveillance & rounding

Additional preventative strategies:
- Environmental stimuli as appropriate
- Mobilize
- Non-drug alternatives and sleep protocol
- Provide sensory aides
- Cognitive stimulation
- Hydration & nutrition
- Personalize activities/room (all about me poster)

Follow-up assessment
- Educate the family about the nature of delirium, indicating this is not a “worsening of dementia” but an acute or emergent health issue. Do admission and discharge teaching.
- Continue to assess cognition using the CAM and observing behaviors.
- Continue with preventative strategies.
- Educate and counsel family regarding signs of re-occurrence and duration (2 weeks to 6 months) of delirium.