

BP Blogger

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Myth Busting: The Delirium Issue

Myth 1: It's just a bit of confusion



Health care professionals often describe an older person with delirium as "confused" but fail to tell the difference between delirium and dementia. Delirium is an acute syndrome with a fluctuating course of symptoms. Whereas, dementia is usually a gradual course of cognitive decline. The **central feature of delirium** is the person's inability to maintain focused **attention**.



This is combined with an abnormal level of consciousness (arousal). Delirious residents may be oriented but are distractible, oversensitive to stimuli, anxious, and can't concentrate on environmental sounds and sights. They simply can't keep focused on a conversation, being continuously distracted by irrelevant things. Perception distortions such as hallucinations, illusions, and

delusions are common. Language becomes abnormal and there may be mood changes (depression). Delirium is especially common in older people with dementia. It is also the most common complication of hospital admission, 30-50% for older people over 70, 35% after heart surgery, 40-60% after hip fracture surgery, and 64% for those in LTC. Delirium has serious consequences and has been associated with increased death and illness. Estimated in-hospital deaths are over 20% and within 1 year are 35-50%. Survivors of delirium have a risk of nearly 50% permanent neurocognitive impairment. Staff are critical in recognizing delirium symptoms as they have the most frequent interaction with residents. This is important since the diagnosis of delirium rests solely on clinical observation skills, symptoms are often subtle but serious. There are no specific diagnostic tests for delirium.

Myth 2: Delirium is about being "hyper"

There are 3 Subtypes of Delirium: hyperactive, hypoactive and mixed.

Hyperactive

- This subtype displays all major features of delirium, and +/-
 - Heightened arousal, awareness
 - Sensitive to immediate surroundings (sounds, sights, smells)
- Verbally and/or physically threatening and aggressive
- Pulling repeatedly at clothing (carphologia)
- Restlessness, wandering
- Speech disturbance



Hypoactive

This subtype is more difficult to observe and is actually **more common** than the hyperactive type. Good observational skills are needed to detect this subtype. This type displays all major features of delirium, and +/-

- Often described as "confused"



- Drowsy, lethargy, staring into space, excessive sleep
- Usually cooperative

Mixed (Hypoactive and Hyperactive)

Mixed subtype usually fluctuates unpredictably between hyperactive and hypoactive types.

More information on This and Other Best Practices

• **Contact** your **Regional LTC Best Practices Coordinator**. They can help you with Best Practices Info for LTC.

Find them at:

- www.rgpc.ca
Click on Long Term Care
- www.shrtn.on.ca
Click on Seniors Health
- Check out** the **Hamilton Long Term Care Resource Centre** www.rgpc.ca

• **Surf the Web** for BPGs Some sites and resources are listed on pg 2.



Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

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Myth 4: You can't prevent delirium

Research confirms that there are several prevention strategies that can reverse or reduce the severity, duration and frequency of delirium and its functional/cognitive impact.

Delirium prevention strategies:

- Know the causes of delirium
- Educate staff on delirium
- Detect symptoms early
- Frontline staff are critical, observe daily for changes in behaviour and cognition
- Treat all potentially reversible causes (e.g., UTI, constipation)
- Use basic care prevention strategies
 - Push fluids, medication reviews, ↓ psychoactive meds, sleep promotion, reduce noise, control pain, wearing of hearing aids/glasses, verbal reminders & orientation, safety, keep daily routines, cognitive assessments (MMSE or MDS-RAI: CPS), regular toileting, monitor for infection, family visiting, encourage doing activities, hold something comforting, free movement, wandering, calm music

Special thanks in Central Ontario Regional Geriatric Program-Central, Seniors Health Research Transfer Network (SHRTN), Alzheimer's Society PRCs of Central Ontario, Palliative Pain and Symptom Management Consultant-PPSM Program Brant, Haldimand and Norfolk Counties

Myth 3: Delirium doesn't happen at the end-of-life

and can persist until death (restlessness and terminal anguish). This is much higher than staff expect and unanticipated for families. The most likely causes of delirium are medications (narcotics), poor hydration or dehydration, liver failure, anemia, urinary retention and constipation. Residents may rapidly and dramatically decline. Many families may find witnessing delirium very emotionally distressing. As such, families appreciate being warned in advance that delirium may develop. It is important to provide care tailored to the resident's and family's needs. Helpful care strategies may include: treat the delirium (consider hydration), respect the resident's current perceptions; treat residents with respect and as unique individuals, explore unmet physiological needs (thirst, hunger toileting); promote meaningful communication (listen closely); facilitate preparation for death; encourage families to stay (modify room); reassure and support families, encourage family to participate in care as desired; and provide information about delirium and it's causes for the resident.

*** Delirium TIP ***

SUSPECT Delirium

When residents have ACUTE changes in behaviour or cognition > Safest approach > all residents presenting with confusion have delirium until proven otherwise REMEMBER: delirium is frightening and causes great suffering for the person experiencing it



Who's at risk? Possible causes:

- Cognitive impairment
- Medication side effects, toxicity
- Dehydration, electrolyte imbalance
- Renal disease
- Poorly managed pain
- Cardiovascular disease, CHF
- Low blood pressure
- Nutritional deficiencies
- Abnormal body temperature
- Abnormal blood glucose
- Trauma (fall, fracture, surgery)
- Males > females, > 65 years
- Limited social contact
- Admission (hospital, LTC)
- Infection (UTI, URI)
- Stroke or seizure

Confusion Assessment Method (CAM)

Developed to provide a quick, accurate method for detection of delirium. For non-psychiatry health care professionals - - -

CAM assesses 4 criteria for the presence and severity of delirium:

1. acute onset & fluctuating course
2. inattention
3. disorganized thinking
4. altered level of consciousness

The diagnosis of delirium requires the presence of criteria: 1, 2 and 3 or 4.



Delirium (confusion) is the most common cognitive disorder in terminally ill residents, occurs in 40%



The Definition: DSM-IV Criteria for Delirium

- Disturbance of consciousness with reduced ability to focus, sustain or shift attention
- Changed cognition or the development of a perceptual disturbance (core feature > impact on cognitive function)
- Disturbance develops in a short period of time and fluctuates over the course of the day
- History, physical examination, and laboratory findings show that delirium can be a physiological consequence of general condition; caused by intoxication; caused by medication; and caused by more than one etiology

Check out these Best Practices & Guidelines. Answers to the Myths came from them. Find out more!

Canadian:

• Registered Nurses Association of Ontario (2003). *Screening for delirium, dementia and depression in older adults. Nursing Best Practice Guideline*. Toronto, ON: Author. www.rnao.org

• Registered Nurses Association of Ontario (2004). *Caregiving strategies for older adults with delirium, dementia and depression*. Toronto, ON: Author.

• The Patient/Family Care Sub-committee of the Windsor/Essex End of Life Steering Committee. (2006). *The Erie St. Clair palliative care management tool*. (V 3.1). Windsor, ON. Author. www.ccaac-ont.ca/Upload/esc/General/Palliative_Care_Management_Tool_v3_1.pdf

Others:

• University of Iowa Gerontological Nursing Interventions Research Centre. (1998). *Acute confusion/delirium. Research-based protocol*. Iowa City, Iowa: Author. www.nursing.uiowa.edu

• American Medical Directors Association (1998). *Altered mental states. Clinical practice guideline*. Columbia, MD: Author. www.amda.com

• American Psychiatric Association. (1999). *Practice guideline for treatment of patients with delirium*. *American Journal of Psychiatry*, 156(5), 1-20.

• Milisen, K., Lemiengre, J., Braes, T., and Foreman, M.D. (2005). Multicomponent intervention strategies for managing delirium in hospitalized older people: systematic review. *Journal of Advanced Nursing*, 52(1), 79-90.

• Young, J., and Inouye, S.K. (2007). Delirium in older people. *Clinical Review*. *BMJ*, 334, 842-846.

• National Health and Medical Research Council. (2006). *Guidelines for a palliative approach in residential aged care*. Commonwealth of Australia: National Palliative Care Program. www.health.gov.au/palliativecare