

The logo for 'try this:' features the words 'try this:' in a white, lowercase, serif font. A yellow dot is positioned above the 'i' in 'this:'. The text is set against a dark purple background that has a white and grey triangular graphic on the left side.

Best Practices in Nursing Care
for Hospitalized Older Adults
with dementia

from The John A. Hartford Institute for Geriatric Nursing
and the Alzheimer's Association

Volume 1, Number 8, 2005

Series Editor: Marie Boltz, APRN-BC, MSN

Assessing and Managing Delirium in Persons with Dementia

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WHY: Delirium in a patient with preexisting dementia is a common problem that may have life-threatening complications, especially if unrecognized and untreated. Acute changes in mental status in persons with dementia are often 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, rehospitalization, nursing home placement, and death.¹⁻³ Delirium in persons 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, benzodiazepines, anti-depressants, and anti-psychotics.⁴ An unrecognized delirium may interfere with recovery and rehabilitation after a hospitalization.⁵

TARGET POPULATION: Any older person with dementia who is hospitalized, at home, in the nursing home, or in the emergency room with a change in mental or physical functioning. All persons with dementia who experience an acute change in mental or physical functioning should be assessed for delirium superimposed on the dementia.

BEST TOOLS: Delirium is difficult to assess in persons with dementia and in hospitalized older adults due to overlapping features of delirium and dementia and the uncertainty of the patients' baseline mental status. Most tools to assess delirium are less specific when assessing delirium in persons with dementia. Use a standardized tool to measure delirium, if possible, such as the Confusion Assessment Method⁶ (See *Try This: Confusion Assessment Method*⁷). The **CAM** focuses on the **KEY FEATURES OF DELIRIUM:** Acute onset and fluctuating course, inattention, disorganized thought, and altered level of consciousness.

STRENGTH AND LIMITATIONS:

While the CAM is a useful tool, the patient's baseline mental status is a critical parameter for assessing and treating delirium. The patient's medical record should be checked for indications of pre-existing dementia, and the patient's family, if any, should be asked whether the patient has a diagnosis of dementia or signs and symptoms of possible dementia. Patients with dementia who present to the hospital without previous medical evaluation, and/or family members who cannot describe their mental status pre-hospitalization, are at increased risk for undetected delirium. Another significant barrier to detecting the presence of delirium can be ageism, wherein clinicians attribute further cognitive loss in a person with dementia as an inevitable fact of life for older adults.

REFERENCES:

1. Rockwood K, Cosway S, Carver D, et al. (1999). The risk of dementia and death after delirium. *Age Ageing*, 28, 551-556.
2. Fick DM, Agostini JV, Inouye SK (2002). Delirium superimposed on dementia: a systematic review. *J Am Geriatr Soc*, 50, 1723-1732.
3. Fick D, Foreman M (2000). Consequences of not recognizing delirium superimposed on dementia in hospitalized elderly individuals. *J Gerontol Nurs*, 26, 30-40.
4. Han L, McCusker J, Cole M, Abrahamowicz M, Primeau F, Elie M (2001). Use of medications with anticholinergic effect predicts clinical severity of delirium symptoms in older medical inpatients. *Arch Intern Med*, 161, 1099-1105.
5. McCusker J, Cole M, Dendukuri N, et al. (2001). Delirium in older medical patients and subsequent cognitive and functional status: a prospective study. *CMAJ*, 165, 575-583.
6. Inouye S, van Dyck C, Alessi C, Balkin S, Siegel A, & Horwitz R (1990). Clarifying confusion: the confusion assessment method. *Ann Internal Med*, 113(12), 941-948.
7. *Try This: Best Practices in Nursing Care for Hospitalized Older Adults with Dementia*. Available at www.hartfordign.org

Delirium Algorithm

Preventive Care

Assess: pre-morbid cognitive functioning (See *Try This: Recognition of Dementia in Hospitalized Older Adults*⁷) and baseline mental status (See *Try This: The Mini Mental State Exam*⁷)

Address risk factors:

- sensory loss
- sleep deprivation
- immobility
- pain (See *Try This: Assessing Pain in Persons with Dementia*⁷)
- polypharmacy and/or potentially offending medications (See *Try This: Beers Criteria for Potentially Inappropriate Medication Use in the Elderly*⁷)
- decreased oral intake of food and/or fluids
- substance abuse/withdrawal

Normalize environment as much as possible: items from home, family schedule of visits, control noise and lighting.



Identify delirium promptly

Assess for:

- *acute* onset of *change* in cognition (memory loss, disorientation, hallucination, delusions, and impaired function)
- altered level of consciousness
- inattention
- behaviors such as verbal and/or physical aggression, resistance to care, and wandering (See *Try This: Wandering in the Hospitalized Older Adult*⁷). *Educate* the family about the nature of delirium, indicating this is not a “worsening of dementia” but an acute process.



Assess for physiologic causes of delirium:

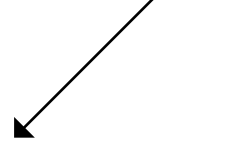
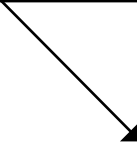
- Medication(s)
- Fecal impaction
- Urinary retention
- Infection (urine, lungs, skin)
- Hypoxia
- Dehydration
- Hypo/hyperglycemia
- Pain

Prevent injury:

- Use of sitters
- Room near nurse’s station
- Motion sensor alarm
- Fall risk: low bed, hip pads, etc.
- Remove/camouflage tubes when possible.

Modify other risk factors:

- environmental stimuli
- level of activity
- nonpharmacologic treatments



Follow-up Assessment

Continue to assess cognition using CAM and observing behaviors.
Monitor hydration and nutrition.