Recognising and managing delirium in residents with dementia

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Delirium occurring in residents with dementia is a common problem, but is frequently unrecognised or misdiagnosed. This may lead to prolonged hospitalisation and poor health outcomes, including further decline in cognitive and physical function.[1,2]

Features of delirium:
Acute onset and fluctuating changes in cognition, inattention, disorganised thinking, and altered level of consciousness.[3] Of these symptoms it is only disorganised thinking that is also a symptom of dementia.[2] Acute and fluctuating symptoms of altered mental state including inattention and changes in levels of consciousness are **not** normal in residents with dementia and the presence of these symptoms should trigger assessment.[1,2]

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Delirium subtypes[3]:

- Hyperactive (characterised by hallucinations, delusions, agitation, and disorientation)
- Hypoactive (particularly easy to miss; characterised by sleepy state and disinterest in activities of daily living; often unrecognised or labelled as dementia)
- Mixed (movement between hyperactive and hypoactive delirium).

Risk factors:
Acute illness, dehydration, pain, sepsis (e.g. urinary tract infection, respiratory infection), electrolyte imbalance, sensory impairment, urinary/faecal impaction, dementia, and some medications including opioids, anticholinergics, and benzodiazepines.[1-4]

Assessing for delirium in residents with dementia

Residents with hyperactive forms of delirium are easier to identify as they frequently present as restless and agitated, picking at bedclothes or constantly mobile and unable to rest. Residents who present as somnolent and lethargic with decreased physical activity may be overlooked. In normal circumstances a resident with dementia is not hypoactive until they are in the end stage of the disease. Delirium should be suspected in any excessively quiet or sleepy resident until it can be ruled out.[2] It is essential that all care staff receive up-to-date training on how to identify signs and symptoms of delirium occurring in residents with dementia. Registered and enrolled nurses also need to be skilled in the use of a delirium screening tool.[1]

Awareness of predisposing risk factors, early detection, and prompt response to managing the symptoms of delirium will reduce the severity of the condition and adverse resident outcomes.[1]

Confusion Assessment Method (CAM)

The CAM is a validated screening tool that can be used to assist with the identification of delirium.[1-5] A copy of the CAM is provided on page 54 of the *PA Toolkit. Module 3: Clinical Care.* The CAM requires observation and interaction with the resident, gathering information from family members and staff, and comparing presenting behaviours and cognition with previously assessed status.

Access PA Toolkit resources at: www.caresearch.com.au/PAToolkit

Management of delirium

If possible and appropriate, identify and treat the underlying cause(s) of delirium. In residents who are frail and deteriorating it may be difficult to determine an underlying cause(s), so the primary aim is to reduce distressing symptoms such as confusion, hallucinations, agitation, and anxiety (***PA Toolkit. Module 3: Clinical Care – Pharmacological and Non-Pharmacological Management of Delirium*** page 56 and *Therapeutic Guidelines: Palliative Care*[6] page 290).

Case study

Daphne Smith is an 88 year old resident who has advanced dementia, renal impairment, and osteoarthritis. She has a history of crush fractures in her lumbar spine and recurrent urinary tract infections (UTIs). An Abbey Pain Scale assessment indicated that Daphne was experiencing moderate to severe pain particularly when she was repositioned. She was on Osteo-eze bd. This was discontinued and she was commenced on a Norspan 5 mcg/hr patch. Several days later she was experiencing episodes of restlessness, agitation, and increased confusion. However, there were periods in the day when she appeared more alert and responsive. The Norspan patch was increased to 10 mcg/hr as it was thought that pain may have been contributing to changes in Daphne's behaviour and cognition. Over the next few days she became increasingly lethargic and drowsy. She required full assistance with all activities of daily living and oral intake was poor.

Daphne has risk factors that predispose her to delirium including dementia, a history of UTIs, recent increase of her opioid, and dehydration. Using the CAM to assess Daphne will assist in identifying changes in cognition and behaviour compared with baseline cognitive status. She is displaying evidence of an acute change in mental functioning and abnormal behaviours that fluctuate during the day, as well as an altered level of alertness and responsiveness.

Management of the delirium may include commencing antibiotics if a UTI is confirmed, removal of the Norspan patch if the current opioid dose is thought to be a contributing factor, initiating non-pharmacological strategies as appropriate, and encouraging fluid intake. If pain remains a problem and Daphne is able to swallow, reintroducing Osteo-eze and administering a small dose of opioid liquid (e.g. oxycodone 1 mg/ml – 1-2 mls) prior to repositioning may be an option. For information about the pharmacological management of symptoms such as agitation and confusion related to delirium read the ***PA Toolkit. Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents*** page 18.

Recognising, assessing, and managing delirium in a resident with dementia is challenging. A rapid response to the onset of delirium will reduce poor outcomes associated with the condition.

Further information

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