Managing Older Adult with Dementia or Delirium in the Emergency Department

Christine L. Maghrak RN, DNP, PMHCNS–BC
February 4, 2016
Weston, WI
Wisconsin Emergency Nurses Association
Importance of Addressing the Issue of Older Persons in the ED

- Frequent consumers of health care services across the continuum
- Risk for adverse health outcomes increases with age
- Impact on service capacity and delivery in the ED
- Models of emergency care do not adequately respond to complex needs
  - What’s acute?
  - What’s chronic with an exacerbation?
Risk Factors Associated With Negative Outcomes

- Functional impairment
- Recent hospitalization or ED use
- Often living alone
- Poor/Inadequate/Lack of social support
- Increasingly complex care needs as level of frailty increases
Who Are All These People?

- Older adults use emergency services at higher rates than younger persons
- Visits have a higher level of urgency
- Stays in the department are longer
- More likely to be admitted
- More likely to have repeat ED visits
- Demonstrate higher rates of adverse health outcomes after discharge
- No surprise that the older adult patient is part of the reason for focused effort to reduce readmissions
Common Co-morbid Conditions

*Top 3 conditions seen in patients with Dementia presenting to ED

- Hypertension*
- Cardiac Dysrhythmias*
- UTI*

- Dehydration
- Heart failure
- Hyponatremia
- Diabetes
- COPD
- Ischemic heart disease
- Falls
Most Common Nursing Diagnoses

- Altered health maintenance
- Knowledge deficit
- Potential for injury
- Potential for infection
- Pain
- Impaired physical mobility
- Altered thought processes

(Nursing Minimum Data Set Study Park et.al. 1996)
What is the Real Problem Here?

Need to distinguish ‘presentation’ to target the ‘real problem(s)’:

- Is this a patient with Dementia?
- Is this a patient with Delirium?
- Is this a patient with Delirium superimposed on Dementia?
Dementia

- Characterized by functional loss in many domains
- Cognitive impairment is ‘chronic’ in nature
- Cognitive loss is most prominent particularly for memory
- Decline in cognitive functions affects the daily living
  - Impacts ability to manage complex tasks such as managing money or cooking
  - Impacts communication with difficulty finding words to express wants or needs
  - Increases dependency on others to have basic needs met
Characteristics of Dementia

- Difficulty learning new material
- Tendency to lose things or forget what they are doing
- Difficulty with spatial tasks (e.g., finding their way)
- Poor judgment and poor insight
- Underestimate risk in activities
- Little awareness of the degree of impairment
- Unrealistic self-appraisal of abilities/limits
Other Features of Dementia

- Disinhibited behavior
- Neglect of personal hygiene
- Increased sensitivity to stimulation
- Decreased ability to screen stimuli
- Intense response to minor stresses (e.g., change in routine or environment)
- Depressed mood is common (r/o Pseudodementia)
- Psychotic symptoms: Delusions of persecution; visual hallucinations
Sundowning

- ‘Sundowning’: peak period of evening agitation
- Daytime drowsiness combined with night-time confusion, agitation and anxiety
- Tendency to wander, say and do things not consistent with their character
- Have a strong need for maintaining contact with a familiar environment
- What remains intact of cognitive function is enhanced during the daytime, may even have periods of lucidity
- At night, patients with dementia feel less safe and less confident; staying awake makes them feel more secure
Alzheimer’s Dementia

- Estimated to affect 4 million in the USA
- Onset in late life; can be earlier in the 40’s-50’s
- Prevalence doubles every 5 years beyond age 65
- Incidence increases with age
- Course varies greatly and is always progressive
- Duration from onset to death 8-10 years
- Caused by nerve cell degeneration
- Estimated to cost $100 million alone in lost productivity of the patient and caregiver
Alzheimer’s Dementia Continued

- Insidious onset with gradual decline
- Deficits in recent memory followed by deficits in language
- Deficits in executive functions for multi-step task performance
- Personality change or increased irritability
- Psychotic symptoms in mid to late stage
- Late stage motor disturbances (e.g., gait problems, slurred speech)
- May become incontinent
- May become mute and bed-ridden
Vascular Dementia

- Also called Multi-infarct Dementia
- Abrupt onset and stepwise course
- Certain cognitive functions affected early while others remain unimpaired; patchy and inconsistent
- Associated focal neurological signs and symptoms
  - Extensor plantar response
  - Gait abnormalities
  - Exaggeration of deep tendon reflexes
  - Weakness of an extremity
- Imaging studies show multiple vascular lesions of the cerebral cortex and subcortical structures
Vascular Dementia Continued

- Prevalence unknown (second most common type)
- Onset may occur at anytime in late life, but less common after age 75
- Typically patient has a long history of cardiovascular disease
- Recent evidence suggests that small strokes may increase expression of Alzheimer’s Disease
- May see an intensification of personality characteristics
- Despite stepwise progression there can be static periods without change
Other Dementias

- **Dementia due to Parkinson’s Disease**
  - Insidious onset and slow progression
  - Characterized by cognitive and motor slowing
  - Problems with memory retrieval and executive functions

- **Lewy Body Dementia**
  - Similar to Alzheimer’s Disease with earlier more prominent hallucinations or psychotic symptoms
  - Rapid evolution of symptoms and decline
  - Very sensitive to extrapyramidal effects of antipsychotic medications
Delirium

- Acute onset of impairment (e.g., attention, alertness and perception)
- Caused by medical illness or medication
- Common in older patients with acute or chronic illness
- Common co-morbid conditions include HTN, COPD, dementia, stroke
- Under-recognition delays or prevents timely intervention
- If recognized early, and intervention initiated can be the condition may be reversed
Symptoms of Delirium

- Develops acutely over hours or days (‘Acute Brain Failure’)
- Disorientation (often to place and time and situation)
- Disturbances in attention
- Perceptual disturbances (e.g., hallucinations)
- Tachycardia, sweating and agitation
- Striking variability in clinical manifestations
- Thinking becomes increasingly labored and slow or rapid but incoherent
- “Lucid intervals” are characteristic; some waxing and waning
- May show alterations in personality
Etiology – Predisposing Factors

- Age > 65
- Sensory impairment
- Impaired ADLs
- Brain damage or chronic brain disease (especially dementia)
- Chronic pain (poorly managed)
- Multiple medications (prescribed and OTC)
- Nutritional deficiencies
- Alcohol and drug abuse
Management Problems in ED

- Problems with cognition
  - Changes in routine and environment may cause increased anxiety
  - Multiple competing stimuli in the ED setting

- Problem behavior
  - Competing demands that exceed functional and emotional capacity
  - Decreased ability to adapt in the setting and increased stress response result in disruptive behavior

- Hazards
  - Things that add to the stress of the environment and may contribute to disruptive behavior
The challenge of managing patients with dementia in the ED due to lack of time to treat the patient satisfactorily in the setting

- Models of care focus on management of urgent and emergent problems
- Model of care may require health care providers to move quickly and seem abrupt on contact
- Patients with brain disease have unique needs for pacing of activity
- The pressure to get on top of problems can exacerbate communication problems
Milieu in ED Continued

- The physical environment
  - Room temperature
  - Noise
  - Glare
  - Activity

- The interpersonal environment
  - Rushed
  - Activity highly stimulating
  - Rapid processing may be required
Pacing or providing a balance of activity or interaction is required that does not overly stress or deprive the person with stimulation.

The goal is sensoristasis or equilibrium (think balance).

Interventions may require adjustment to mitigate imbalances from too much or too little stimulation:
- periods of stress
- environmental change
- progression of illness
Problems With Cognition

- **Disorientation**
  - Provide only the orientation that the person needs to remain safe in the setting (e.g., person, place and situation)

- **Learning and retaining new information**
  - Patients with dementia have difficulty remembering recent conversations so expect to repeat information often
  - May misplace objects in the room and become fretful
Handling complex tasks
- Often have difficulty following complex train of thought so keep things simple
- May struggle with task completion so be patient and slow down

Reasoning ability
- Become overwhelmed when confronted with too many choices
- Have difficulty receiving, processing and responding to environmental stimuli
Cognition Problems Continued

- **Spatial ability and way finding**
  - Trouble navigating in unfamiliar environments
  - May be prone to wandering to improve level of orientation to place

- **Behavior**
  - May be more passive and less responsive
  - May be more irritable than usual
  - May misinterpret visual or auditory stimuli
  - May be noisy and disruptive
Cognition Problems Continued

- **Language**
  - Biggest problem is with finding the words to express needs and wants or communicate about what is wrong
  - May confabulate to fill in the blanks

- **Decisional Capacity (decision-making)**
  - May not be capable of giving informed consent
  - May not have POA-HC document
  - May have a POA-HC document that is not activated
Behavior as Communication

“Disturbing behavior” may be a signal for an understandable need(s)

Functional Impairment
- Insomnia
- ADL assist

Potential for violence
- Agitation
- Psychotic symptoms
- Wandering
Hazards

- Rooms or bays loaded with equipment serve as a source of stimulation.
- Proximity to the nursing station for monitoring places the patient close to sources of high levels of noise and activity.
- Diagnostic and treatment activity that often involves a lot of testing and interaction contributing to levels of high stimulation.
- Unpleasant activity, which is often associated with diagnostic intervention is also associated with higher levels of agitation.
- Providing support to people with functional dependence places care providers at higher risk for injury, especially when it involves support to meet personal cares.
Interaction Strategies

- Reorientation efforts must be continuous to be effective
- Focus on critical information in the most basic manner
- What does the patient need to know to be safe?
- Time is relative; focus on relationships to ordinary events when offering orientation cues
- Environmental events are perceived as vague threats
- Information needs to be concrete; avoid slang terms and abstract comparisons (e.g., is it a shooting pain)
- Excessive use of the word ‘no’ increases resistance, use positive phrases (e.g., you can wait here)
Communication Strategies

- Let the patient know when you need to touch them, tell the patient what you are doing and why
- Tell the patient exactly what you want them to do using one-step commands which are simple, concise and concrete
- Make eye contact to make sure you have the patient’s attention
- Use other signals besides words to convey what you mean; point, touch or demonstrate; gestures can assist with comprehension
- When you don’t know what they mean, ask the individual to point to it, describe it or show you how it works
- Do not use words such as ‘on’, ‘below’, ‘beside’ or ‘between’ because these words are difficult for the patient with dementia to understand
Communication Strategies Continued

- Identify the patient’s vocabulary and use it.
- Introduce yourself each time you interact.
- Use the person’s name, role (e.g., daughter), or object (e.g., pillow) to be more specific.
- Speak using a calm, soft slow voice pattern; patient’s respond more to your manner than the actual content of what you say.
- Allow more time for the patient to process information; if the patient doesn’t respond to your initial comment or question, repeat it exactly to avoid increased confusion.
- Repeat what the patient says and state your response rather than use vague reaffirmations.
If the person is having difficulty finding the right word, supply the word or offer a choice using 2 selections to limit frustration (avoid being intrusive and completing their thoughts).

In offering choices for action, put the actual choices in the last half of the question (e.g., ‘drink water or milk’ versus ‘water or milk to drink’) to simplify the question.

Avoid arguing or reasoning, these are power struggles that only increase the patient’s anxiety and lack of confidence in navigating the environment.

Patient’s may confuse current information with information from the past (who are they talking about and what is the agenda for that person).
Reduce Stimulation

- Move slowly and avoid overwhelming the patient physically or verbally
- Eliminate other distraction when seeking compliance with specific requests
- Eliminate extraneous and competing noises
- Minimize commotion at change of shift or hand-offs
- One provider talking at a time
- Remember that your emotional response in the interaction can be a source of stimulation
**Monitoring**

- Frequent short contacts for reassurance provide an opportunity to know where the patient is and what they are doing.

- Family may be available to provide the physical monitoring however they need your supportive contacts throughout the process as well.

- Remind the patient you’re the nurse and are taking care of him/her; meet the patient in the moment.

- Ask the patient the ‘why’ question to find out the reason for repeated requests so you can provide reassurance to reduce anxiety.

- Anticipate basic needs (e.g., toileting, hydration, nutrition, pain management etc.)
In Closing...

- Resources included for additional detail regarding the etiology of delirium.

Questions?

Comments?
Etiology – Precipitating Causes

- Central Nervous System Disorder
  - Head trauma
  - Seizures / postictal state
  - Vascular disease (hypertensive encephalopathy)
  - Degenerative disease
  - Infection
Etiology – Precipitating Causes

Metabolic Disorder

- Renal failure (uremia)
- Hepatic failure
- Anemia
- Hypoglycemia
- Thiamine deficiency
- Endocrinopathy
- Fluid or electrolyte imbalance
- Acid – base imbalance
Etiology – Precipitating Causes

- Cardiopulmonary Disorder
  - Hypoxia
  - Myocardial infarction
  - Congestive heart failure
  - Cardiac arrhythmia
  - Shock
  - Respiratory failure
Etiology – Precipitating Causes

- **Systemic Illness**
  - Substance intoxication or withdrawal
  - Infection
  - Neoplasm
  - Severe trauma
  - Sensory deprivation
  - Temperature dysregulation
  - Postoperative state
Substances that Can Cause Delirium (Intoxication or Withdrawal)

- Drugs of Abuse
  - Alcohol
  - Amphetamines
  - Cannabis
  - Cocaine
  - Hallucinogens
  - Inhalants
  - Opioids
  - Phencyclidine
  - Sedatives
  - Hypnotics
Medications That Can Cause Delirium

- Anesthetics
- Analgesics
- Antiasthmatic agents
- Anticonvulsants
- Antihistamines
- Antihypertensive and cardiovascular agents
- Antimicrobials
Medications That Can Cause Delirium

- Antiparkinsonian medications
- Corticosteroids
- Gastrointestinal medications
- Muscle relaxants
- Immunosuppressive agents
- Lithium and psychotropic agents
Toxins That Can Cause Delirium

- Anticholinesterase
- Organophosphate insecticides
- Carbon monoxide
- Volatile substances, such as fuel or organic solvents
Reference List


References Continued


References Continued


Contact Information

Christine Maghrak RN, DNP, PMHCNS-BC
Email: christine.maghrak@ministryhealth.org
Office: 715-387-7079