Guidelines on dealing with dementia from a medical perspective	
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Medical Aspects of Behavioral issues in Dementia Care.

1.0. Dementia is a progressive and largely irreversible clinical syndrome that is characterized by a widespread impairment of mental function. Although many people with dementia retain positive personality traits and personal attributes, as their condition progresses they can experience some or all of the following:

- **memory loss,**
- **language impairment,**
- **disorientation,**
- **changes in personality,**
- **difficulties with activities of daily living,**
- **self-neglect,**
- **psychiatric symptoms (for example, apathy, depression or psychosis) and**
- **out-of-character behaviour (for example, aggression, sleep disturbance or disinhibited** sexual behaviour, although the latter is not typically the presenting feature of dementia).

1.1The challenges

People living with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour. The assessment should be comprehensive and include:

− the person’s physical health (appendix 1,2,3)
− depression
− possible undetected pain or discomfort (appendix 4)
− side effects of medication
− individual biography, including religious beliefs and spiritual and cultural identity
− psychosocial factors

− physical environmental factors

− behavioural and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers.

Individually tailored care plans that help carers and staff address the behaviour that challenges should be developed, recorded in the notes and reviewed regularly. The frequency of the review should be agreed by the carers and staff involved and written in the notes.

Medical Causes of Behavioural Aspects of Dementia.

Investigation - A basic dementia screen should be performed. It should include:

- routine haematology
- biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function)
- thyroid function tests
- serum vitamin B_{12} and folate levels.

A midstream urine test should always be carried out if delirium is a possibility. Consideration should be given to urosepsis (appendix 1).

Clinical presentation should determine whether investigations such as chest X-ray or electrocardiogram are needed.

Structural imaging should be used in the assessment of people with suspected dementia to exclude other cerebral pathologies and to help establish the subtype diagnosis. Nurses should discuss this possibility based on clinical presentation with the Medical Officer. Magnetic resonance imaging (MRI) is the preferred modality to assist with early diagnosis and detect subcortical vascular changes, although computed tomography (CT) scanning could be used.

Many cases of dementia may have mixed pathology (for example, Alzheimer's disease and vascular dementia or Alzheimer's disease and DLB). Unless otherwise stated in this guideline, such cases should be managed according to the condition that is thought to be the predominant cause of dementia.

Pharmacological interventions for the cognitive symptoms of Alzheimer's disease.

The three acetylcholinesterase inhibitors donepezil, galantamine and rivastigmine16 are recommended as options in the management of people with Alzheimer's disease of moderate severity only (that is, those with a Mini Mental State Examination [MMSE] score of between 10 and 20 points), and under the following conditions. **[NICE TA 2006]**

- Only specialists in the care of people with dementia (that is, psychiatrists including those specialising in learning disability, neurologists, and physicians specialising in the care of the elderly) should initiate treatment. **Carers' views on the patient's condition at baseline should be sought.**
- Patients who continue on the drug should be reviewed every 6 months by MMSE score and global, functional and behavioural assessment. Carers' views on the patient's condition at follow-up should be sought. The drug should only be continued while the patient's MMSE score remains at or above 10 points and their global, functional and behavioural condition remains at a level where the drug is considered to be having a worthwhile effect. Any review involving MMSE assessment should be undertaken by an appropriate specialist team, unless there are locally agreed protocols for shared care.

Interventions for non-cognitive symptoms and behaviour that challenges in people with dementia

Non-cognitive symptoms include hallucinations, delusions, anxiety, marked agitation and

associated aggressive behaviour. 'Behaviour that challenges' encompasses a wide range of difficulties that are often experienced by people with dementia and that may have an effect on those who provide care. It may include aggression, agitation, wandering, hoarding, sexual disinhibition, apathy and disruptive vocal activity such as shouting.

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish likely factors that may generate, aggravate or improve such behaviour. The assessment should be comprehensive and include:

- the person's physical health
- depression
- possible undetected pain or discomfort
- side effects of medication
- individual biography, including religious beliefs and spiritual and cultural identity
- psychosocial factors
- physical environmental factors
- behavioural and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers.

Individually tailored care plans that help carers and staff address the behaviour that challenges should be developed, recorded in the notes and reviewed regularly. The frequency of the review should be agreed by the carers and staff involved and written in the notes.

For people with all types and severities of dementia who have comorbid agitation, consideration should be given to providing access to interventions tailored to the person's preferences, skills and abilities. Because people may respond better to one treatment than another, the response to each modality should be monitored and the care plan adapted accordingly. Approaches that may be considered, depending on availability, include:

- aromatherapy
- multisensory stimulation
- therapeutic use of music and/or dancing
- animal-assisted therapy
- massage.

People with dementia who develop non-cognitive symptoms or behaviour that challenges should be offered a pharmacological intervention in the first instance only if they are severely distressed or there is an immediate risk of harm to the person or others. The assessment and care-planning approach, which includes behavioural management, should be followed as soon as possible

People with Alzheimer's disease, vascular dementia or mixed dementias with mild-to-moderate non-cognitive symptoms should not be prescribed antipsychotic drugs because of the possible increased risk of cerebrovascular adverse events and death.20

People with DLB with mild-to-moderate non-cognitive symptoms, should not be prescribed antipsychotic drugs, because those with DLB are at particular risk of severe adverse reactions.

People with Alzheimer's disease, vascular dementia, mixed dementias or DLB with severe non-cognitive symptoms (psychosis and/or agitated behaviour causing significant distress) may be offered treatment with an antipsychotic drug after the following conditions have been met.

There should be a full discussion with the person living with dementia and/or carers about the possible benefits and risks of treatment. In particular, cerebrovascular risk factors should be assessed and the possible increased risk of stroke/transient ischaemic attack and possible adverse effects on cognition discussed.

Changes in cognition should be assessed and recorded at regular intervals. Alternative medication should be considered if necessary.

Target symptoms should be identified, quantified and documented. Changes in target symptoms should be assessed and recorded at regular intervals.

The effect of comorbid conditions, such as depression, should be considered.

- The choice of antipsychotic should be made after an individual risk–benefit analysis. **Nurses must discuss this with the Medical Officer**
- The dose should be low initially and then titrated upwards.
- Treatment should be time limited and regularly reviewed (every 3 months or according to clinical need).

For people with DLB, healthcare professionals should monitor carefully for the emergence of severe untoward reactions, particularly neuroleptic sensitivity reactions (which manifest as the development or worsening of severe extrapyramidal features after treatment in the accepted dose range or acute and severe physical deterioration following prescription of antipsychotic drugs for which there is no other apparent cause).

Behaviour that challenges requiring urgent treatment

The control of behaviour that challenges becomes a priority if violence, aggression and extreme agitation threaten the safety of the person living with dementia or others.

Health and social care staff who care for people with dementia should identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of behaviour that challenges, especially violence and aggression, and the risk of harm to self or others. These factors include:

- overcrowding
- lack of privacy
- lack of activities
- inadequate staff attention
- poor communication between the person living with dementia and staff

• conflicts between staff and carers
• weak clinical leadership.

Nursing Staff who use medication in the management of violence, aggression and extreme agitation in people with dementia should:

- be knowledgeable of the correct use of drugs for behavioural control, specifically benzodiazepines and antipsychotics
- be able to assess the risks associated with pharmacological control of violence, aggression and extreme agitation, particularly in people who may be dehydrated or physically ill
- understand the cardiorespiratory effects of the acute administration of benzodiazepines and antipsychotics and the need to titrate dosage to effect
- recognise the importance of nursing people who have received these drugs in the recovery position and of monitoring pulse, blood pressure and respiration
- be familiar with and trained in the use of resuscitation equipment
- undertake annual retraining in resuscitation techniques
- understand the importance of maintaining an unobstructed airway.

Principles of pharmacological control of violence, aggression and extreme agitation

For people with dementia who are at significant risk to themselves or others because of violence, aggression and extreme agitation, immediate management should take place in a safe, low-stimulation environment, separate from other service users.

Drug treatments for the control of violence, aggression and extreme agitation should be used to calm the person living with dementia and reduce the risk of violence and harm, rather than treat any underlying psychiatric condition. Healthcare professionals should aim for an optimal response in which agitation or aggression is reduced without sedation.

Violent behaviour should be managed without the prescription of high doses or combinations of drugs, especially if the person living with dementia is elderly or frail. The lowest effective dose should be used.

Drugs for behavioural control should be used with caution, particularly if the person living with dementia has been restrained, because of the following risks:

- loss of consciousness instead of sedation over-sedation with loss of alertness
- damage to the relationship between the person living with dementia, their carers and the health and social care team
- specific issues related to age and physical and mental health.

Psychological interventions for people with dementia with depression and/or anxiety

Care packages for people with dementia should include assessment and monitoring for depression and/or anxiety.

For people with dementia who have depression and/or anxiety, cognitive behavioural therapy, which may involve the active participation of their carers, may be considered as part of treatment.

A range of tailored interventions, such as reminiscence therapy, multisensory stimulation, animal-assisted therapy and exercise, should be available for people with dementia who have depression and/or anxiety.

Pharmacological interventions for people with dementia with depression

People with dementia who also have major depressive disorder should be offered antidepressant medication. Treatment should be started by staff with specialist training, who should follow the NICE clinical guideline 'Depression: management of depression in primary and secondary care' after a careful risk–benefit assessment. Antidepressant drugs

with anticholinergic effects should be avoided because they may adversely affect cognition. The need for adherence, time to onset of action and risk of withdrawal effects should be explained at the start of treatment.

Pain relief

If a person living with dementia has unexplained changes in behaviour and/or shows signs of distress, health and social care professionals should assess whether the person is in pain, using an observational pain assessment tool if helpful (appendix 4). However, the possibility of other causes should be considered.

The treatment of pain in people with severe dementia should involve both pharmacological and non-pharmacological measures. Non-pharmacological therapies should be used with the person's history and preferences in mind.

Other Factors.

Agnosia - Dementia can cause people to see or hear things that are not there, but more often if a person talks about things that aren't there it is because he has misinterpreted sights or sounds in the environment, such as shadows, mirrors, patterns on the carpet, or noise from the television.

Aphasia -Dysphasia, or aphasia, is impairment in communication. It's caused by damage to the part of the left side of the brain, which is responsible for language and communication.

Apraxia -(Or Dyspraxia) A neurological disorder characterized by loss of the ability to execute or carry out learned purposeful movements, despite having the desire and the physical ability to perform the movements.

Delirium - Delirium is an acute and relatively sudden (developing over hours to days) decline in attention-focus, perception, and cognition.

Disinhibition/disinhibited - People with dementia may have a lowered ability to regulate their speech and behaviour. This can be a fairly common symptom of dementia.

Disorientation in time - People with dementia frequently experience a different reality, such as believing they are in a different time and place. This is, in part, due to memory problems, but it may also indicate the person's needs - for example, 30 years ago this woman may have been leading an active, fulfilling life, and her belief that she is back in that time tells us that she needs more activity and fulfilment in her present-day life.

Disorientation in space (spatial disorientation) - It can be quite common for a person living with dementia to feel lost even in very familiar surroundings. Following his wife around also indicates that he is probably feeling insecure, both because he is not sure where he is, and also because his poor short-term memory does not enable him to remember where his wife is unless he has her in his sight.

Dyspraxia - (Or Apraxia) A neurological disorder characterized by loss of the ability to execute or carry out learned purposeful movements, despite having the desire and the physical ability to perform the movements.

Frontotemporal dementia - The term 'fronto-temporal dementia' covers a range of conditions, including Pick's disease, frontal lobe degeneration, and dementia associated with motor neurone disease. All are caused by damage to the frontal lobe and/or the temporal parts of the brain. These areas are responsible for our behaviour, emotional responses and language skills.

Damage to the frontal and temporal lobe areas of the brain causes a variety of different symptoms. Each person will experience the condition in his or her own individual way, but there are some symptoms commonly experienced by people with the condition.

Typically, during the initial stages of fronto-temporal dementia, the person's memory is still intact but their personality and behaviour changes. People with fronto-temporal dementia may:

- lack insight, and lose the ability to empathise with others. This can make them appear selfish and unfeeling
- become extrovert when they were previously introverted, or withdrawn when they were previously outgoing
- behave inappropriately - for example, making tactless comments, joking at the 'wrong' moments, or being rude.
- lose their inhibitions - for example, exhibiting sexual behaviour in public
- become aggressive
- be easily distracted
- develop routines - for example, compulsive rituals.

The person with fronto-temporal dementia may also experience language difficulties, including:

- problems finding the right words
- a lack of spontaneous conversation
- circumlocution, using many words to describe something simple
- a reduction in or lack of speech.

Hallucinations - Some people with dementia may experiences hallucinations and/or delusions. Not everyone with dementia will be affected in this way, and not everyone who has these problems has dementia. It is important to remember that there are different types of hallucinations. Recent research shows that they are not as common in dementia as once thought.

Paranoia - It can be quite common for a person living with dementia to make accusations. Usually this is the result of the struggle to come to terms with loss of memory and the fear of being taken advantage of. People often rationalise losing things by blaming family members or thieves if they cannot remember where they have left things.

Perseveration - (Or repetition) People with dementia often repeat themselves because they have forgotten having already said something. It may also be that what the woman is saying or asking has particular significance for her, and perhaps she feels that she has not been listened to or given the response that she needed. Repetition can also occur as a direct symptom of dementia, when the person will become 'stuck' on a particular word or phrase and find themselves unable to move on to the next word.

Prosopagnosia - Difficulty in recognising faces can be quite a common symptom of dementia. This can be very stressful for the individual, as he may, for instance, mistake a family member for an unknown intruder. Sometimes a person may be more able to recognise someone by their voice or another aspect of their appearance, such as familiar clothing.

Repetition - (Or perseveration) People with dementia often repeat themselves because they have forgotten having already said something. It may also be that what the woman is saying or asking has particular significance for her, and perhaps she feels that she has not

been listened to or given the response that she needed. Repetition can also occur as a direct symptom of dementia, when the person will become 'stuck' on a particular word or phrase and find themselves unable to move on to the next word.

Delirium - Delirium (acute confusional state) is a common condition in the elderly affecting up to 30% of all elderly medical patients. Patients who develop delirium have high mortality, institutionalisation and complication rates, and have longer lengths of stay than non-delirious patients . Delirium is often not recognised by clinicians , and is often poorly managed. Delirium may be prevented in up to a third of older patients . The aim of these guidelines is to aid recognition of delirium and to provide guidance on how to manage these complex and challenging patients.

Diagnosis - Delirium is characterised by a disturbance of consciousness and a change in cognition that develop over a short period of time. The disorder has a tendency to fluctuate during the course of the day, and there is evidence from the history, examination or investigations that the delirium is a direct consequence of a general medical condition, drug withdrawal or intoxication (DSM IV)

In order to make a diagnosis of delirium,(appendix 3) a residentmust show each of the features 1-4 listed below:

1. Disturbance of consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention.

2. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a pre- existing or evolving dementia.

3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

4. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general

medical condition, substance intoxication or substance withdrawal.

Delirium may have more than one causal factor (i.e. multiple aetiologies). A diagnosis of delirium can also be made when there is insufficient evidence to support criterion 4, if the clinical, presentation is consistent with delirium, and the clinical features can not be attributed to any other diagnosis, for example delirium due to sensory deprivation.

Prevalence of delirium

Some older people arrive at hospital with delirium (prevalent) while others develop during their hospital stay (incident). Hospital prevalence rates for delirium vary widely because of different residentcharacteristics in the different studies – the highest rates are seen in older patients in critical care settings. The average prevalence of delirium in older people in general hospitals is 20% (range 7 – 61%) [6]. Post fracture neck of femur the prevalence varies from 10% to 50% [7].

Prognosis of delirium

Patients with delirium have increased length of stay, increased mortality and increased risk of institutional placement . Hospital mortality rates of patients with delirium range from 6% to 18% and are twice that of matched controls]. Patients with delirium are also three times more likely to develop dementia. Delirium appears to be an important marker of risk for dementia or death, even in older people without prior cognitive or functional impairment

Prevention

Patients at high risk should be identified at admission and prevention strategies incorporated into their care plan.

Up to a third of delirium is preventable Early attention to possible precipitants of delirium and adopting the approaches detailed under "management of confusion" in those patients at increased risk of delirium may prevent the development of delirium and improve the outcome in those who go on to develop it . Delirium is more common in those with a

pre-existing organic brain syndrome or dementia , and may co-exist with disorders such as depression, which are also common in the elderly . Patients with dementia are five times more likely to develop delirium . Risk factors for the development of delirium are shown in Table 1, Precipitating factors are shown in Table 2.

Table 1 - Risk factors for developing delirium

Old age
Severe illness
Dementia
Physical frailty
Admission with infection or dehydration
Visual impairment
Polypharmacy
Surgery e.g. fracture neck of femur
Alcohol excess
Renal impairment

Table 2. Precipitating factors for delirium.

Immobility
Use of physical restraint
Use of bladder catheter
Iatrogenic events
Malnutrition
Psychoactive medications
Intercurrent illness
Dehydration

ASSESSMENT - Aids to diagnosis

Cognitive testing should be carried out on all elderly patients admitted to hospital

- Serial measurements in patients at risk may help detect the new development of delirium or its resolution
- A history from a relative or carer of the onset and course of the confusion is essential to help distinguish between delirium and dementia.
- The diagnosis of delirium can be made by non psychiatrically trained clinicians quickly and accurately using the Confusion Assessment Method (CAM) screening instrument [An initial assessment of the cognitive function of all patients should be made and recorded. When confusion is suspected the use of cognitive screening tools (such as the Abbreviated Mental Test (AMT) score [32] and Mini Mental State Examination (MMSE) [33]) may increase recognition of delirium present on admission. However by themselves these tools cannot distinguish between delirium and other causes of cognitive impairment.

Delirium is frequently a complication of dementia. Care is needed therefore to distinguish between the two. The most helpful factor is an account of the patient's pre-admission state from a relative or carer. Use of the Confusion Assessment Method or serial measurements of cognition can help to differentiate delirium from dementia or detect its onset during a hospital admission .

Delirium can be subdivided into hypoactive, hyperactive and mixed subtypes . It is important to recognise that hypoactive and quiet delirium is the commonest type. Health staff should always be alert to the possibility of confusion when communicating with patients. Hyperactive delirium is characterised by increased motor activity with agitation, hallucinations and inappropriate behaviour. Hypoactive delirium in contrast is characterised by reduced motor activity and lethargy and has a poorer prognosis. Delirium may be unrecognised by doctors and nurses in up to two-thirds of cases.

Differential diagnosis - The differential diagnosis of delirium includes:

- Dementia
- Depression
- Hysteria
- Mania
- Schizophrenia
- Dysphasia
- Non convulsive epilepsy/ temporal lobe epilepsy

Clinical Assessment

The underlying cause of delirium is often multi-factorial. Common contributory medical causes of delirium include :

- Infection (e.g. pneumonia, UTI)
- Cardiological (eg myocardial infarction, heart failure)
- Respiratory (eg pulmonary embolus, hypoxia, infection)
- Electrolyte imbalance (eg dehydration, renal failure, hyponatraemia)
- Endocrine & metabolic (eg cachexia, thiamine deficiency, thyroid dysfunction)
- Drugs (particularly: those with anticholinergic side effects, eg tricyclic antidepressants, antiparkinsonian drugs, opiates, analgesics, steroids)
- Drug (especially benzodiazepine) and alcohol withdrawal.
- Urinary retention
- Faecal impaction
- Severe pain
- Neurological (e.g. stroke, subdural haematoma, epilepsy, encephalitis)
- Multiple contributing causes

History

Many patients with delirium are unable to provide an accurate history. Where ever possible corroboration should be sought from the carer, general practitioner or any source that knows them well. In addition to standard questions in the history, the following information should be specifically sought

- Onset and course of confusion
- Previous intellectual function (eg ability to manage household affairs, pay bills, compliance with medication, use of telephone and transport)
- Full drug history including non-prescribed drugs and recent drug cessation [especially benzodiazepines]
- Alcohol history
- Functional status (eg activities of daily living)
- History of diet and food intake
- History of bladder and bowel voiding
- Previous episodes of acute or chronic confusion
- Symptoms suggestive of underlying cause (eg infection)
- Sensory deficits
- Aids used (eg hearing aid, glasses etc.)
- Pre-admission social circumstances and care package
- Comorbid illness

Examination - A full physical examination should be carried out including in particular the following areas:

- Conscious level USE GLASGOW COMA SCALE
- Nutritional status

- Evidence of pyrexia
- Search for infection: lungs, urine, abdomen, skin
- Evidence of alcohol abuse or withdrawal (eg tremor)
- Cognitive function using a standardised screening tool eg AMT or MMSE, including tests for attention (eg serial 7`s, WORLD backwards, 20-1 Test)
- Neurological examination (including assessment of speech)
- Rectal examination – if impaction suspected

Investigations - The following investigations are almost always indicated in patients with delirium in order to identify the underlying cause

- Full blood count including C Reactive Protein
- Urea and electrolytes, Calcium
- Liver function tests
- Glucose
- Chest X-ray
- ECG
- Blood cultures
- Pulse oximetry
- Urinalysis

Other investigations may be indicated according to the findings from the history and examination. Nurses within Drogheda Services for Older People should discuss these with medical officer.

These include:

- CT head (see below)
- EEG (see below)
- Thyroid function tests

- B12 and folate
- Arterial blood gases
- Specific cultures eg urine, sputum
- Lumbar puncture (see below**)**

CT Scan

Although many patients with delirium have an underlying dementia or structural brain lesion (eg previous stroke), CT has been shown to be unhelpful on a routine basis in identifying a cause for delirium and should be reserved for those patients in whom an intracranial lesion is suspected.

Indications for the use of CT scanning (Grade C):

- Focal neurological signs
- Confusion developing after head injury
- Confusion developing after a fall
- Evidence of raised intracranial pressure

Management - Treatment of underlying cause

The most important approach to the management of delirium is the identification and treatment of the underlying cause (Grade C).

- Incriminated drugs should be withdrawn wherever possible. In the cases of opiates causing delirium, it may be possible to reduce the dose or change to an alternative .
- Biochemical derangements should be corrected promptly.
- Infection is one of the most frequent precipitants of delirium. If there is a high likelihood of infection (eg abnormal urinalysis, abnormal chest examination etc.), appropriate cultures should be taken and antibiotics commenced promptly,

selecting a drug to which the likely infective organism will be sensitive.

- Parenteral thiamine should be administered when alcohol abuse or under nutrition is apparent

Management of confusion

In addition to treating the underlying cause, management should also be directed at the relief of the symptoms of delirium.

Environment

The residentshould be nursed in a good sensory environment and with a reality orientation approach, and with involvement of the multi-disciplinary team

Ensure

- Lighting levels appropriate for time of day. Remember older people need a lighting level 3 times greater than we do.
- Regular and repeated cues to improve personal orientation.
- Use of clocks and calendars to improve orientation.
- Hearing aids and spectacles should be available as appropriate and in good working order.
- Continuity of care from nursing staff.
- Encouragement of mobility and engagement in activities and with other people.
- Approach and handle gently.
- Elimination of unexpected and irritating noise (e.g. alarms).
- Regular analgesia, for example regular Paracetamol.
- Encouragement of visits from family and friends who may be able to help calm the patient. Explain the cause of the confusion to relatives. Encourage family to bring in familiar objects and pictures from home and participate in rehabilitation.
- Fluid intake to prevent dehydration (use subcutaneous fluids if necessary)

- Good diet, fluid intake and mobility to prevent constipation.
- Adequate CNS oxygen delivery (use supplemental oxygen to keep saturation above 95%).
- Good sleep pattern (use milky drinks at bedtime, exercise during the day).

Avoid:

- Inter and intra ward transfers .
- Use of physical restraint .
- Constipation.
- Anticholinergic drugs where possible and keep drug treatment to a minimum.
- Catheters where possible.

Depending on the layout and nature of the ward, these measures may be facilitated by nursing the residentin a single room.

Wandering - See other information on wandering.

Patients who wander require close observation within a safe and reasonably closed environment. The least restrictive option should always be used when acting in the best interests of the residentto keep them safe from assessed risk. In the first instance attempts should be made to identify and remedy possible cause of agitation - eg pain, thirst, need for toilet. If the cause of the agitation cannot be remedied, the next least restrictive option is to try distracting the agitated wandering patient. Relatives could be encouraged to assist in this kind of management as they will have information about the person which will help when offering meaningful distractions. The use of restraints or sedation should only be used as a final option, once others have been tried, and only if they can be justified as being in the best interests of the patient

This step wise approach should be adopted consistently by the whole team including relatives and other informal carers.

Rambling speech

Patients with delirium often exhibit confused and rambling speech, it is usually preferable not to agree with rambling talk, but to adopt one of the following strategies, depending on the circumstance.

- Tactfully disagree (if the topic is not sensitive).
- Change the subject.
- Acknowledge the feelings expressed – ignore the content.

Sedation

The use of sedatives and major tranquillisers should be kept to a minimum

All sedatives may cause delirium, especially those with anticholinergic side effects . Many elderly patients with delirium have hypoactive delirium (quiet delirium) and do not require sedation. Early identification of delirium and prompt treatment of the underlying cause may reduce the severity and duration of delirium . The main aim of drug treatment is to treat distressing or dangerous behavioural disturbance [e.g. agitation and hallucination]

Drug sedation may be necessary in the following circumstances

- in order to carry out essential investigations or treatment
- to prevent residenten dangering themselves or others
- to relieve distress in a highly agitated or hallucinating patient

It is preferable to use one drug only, starting at the lowest possible dose and increasing in increments if necessary after an interval of two hours

All medication should be reviewed every 24 hours .

The preferred drug is Haloperidol [69,70,71] 0.5 mg. orally which can be given up to two hourly. A maximum dosage of 5 mg [orally or IM] in 24 hours is general guide but may need to be exceeded depending on the severity of distress, severity of the psychotic symptoms, weight and sex. Haloperidol can be given IM, 1 – 2 mg. An alternative in patients with Dementia with Lewy Bodies and those with Parkinson's Disease is Lorazepam 0.5 mg. to 1 mg. orally which can be given up to two hourly (maximum 3 mg. in 24 hours). If necessary, Lorazepam can be given 0.5 mg. – 1.0 mg. IV or IM (dilute up to 2 mls. with normal saline or water) up to a maximum of 3 mg. in 24 hours.

One to one care of the residentmay be required and should be provided while the dose of neuroleptic medication is titrated upward in a controlled and safe manner.

Sedation should only be used in situations as indicated above and should not be used as a form of restraint. If sedatives are prescribed, the prescription should be reviewed regularly and discontinued as soon as possible. The aim should be to tail off any sedation after 24 – 48 hours.

For delirium due to alcohol withdrawal (delirium tremens) a benzodiazepine (eg diazepam or chlordiazepoxide) are preferred in a reducing course. Detailed guidelines for this condition are beyond the scope of these guidelines.

Prevention of complications

The main complications of delirium are :

- Falls
- Pressure sores
- Nosocomial infections
- Functional impairment
- Continence problems

- *Over sedation*
- Malnutrition

Restraints (including bedrails, "geriatric chairs" etc.) have not been shown to prevent falls and may increase the risk of injury . It may be preferable to nurse the residenton a low bed or place the mattress directly on the floor. Adoption of the good practices described should make the use of physical restraints unnecessary for the management of confusion.

Pressure sores

Patients should have a formal pressure sore risk assessment (eg Waterlow score), and receive regular pressure area care, including special mattresses where necessary . Patients should be mobilised as soon as their illness allows.

Functional impairment

Assessment by a physiotherapist and occupational therapist to maintain and improve functional abilityshould be considered in all delirious patients . There is evidence that patients who are managed by a multidisciplinary team do better than those cared for in a traditional way.

Continence

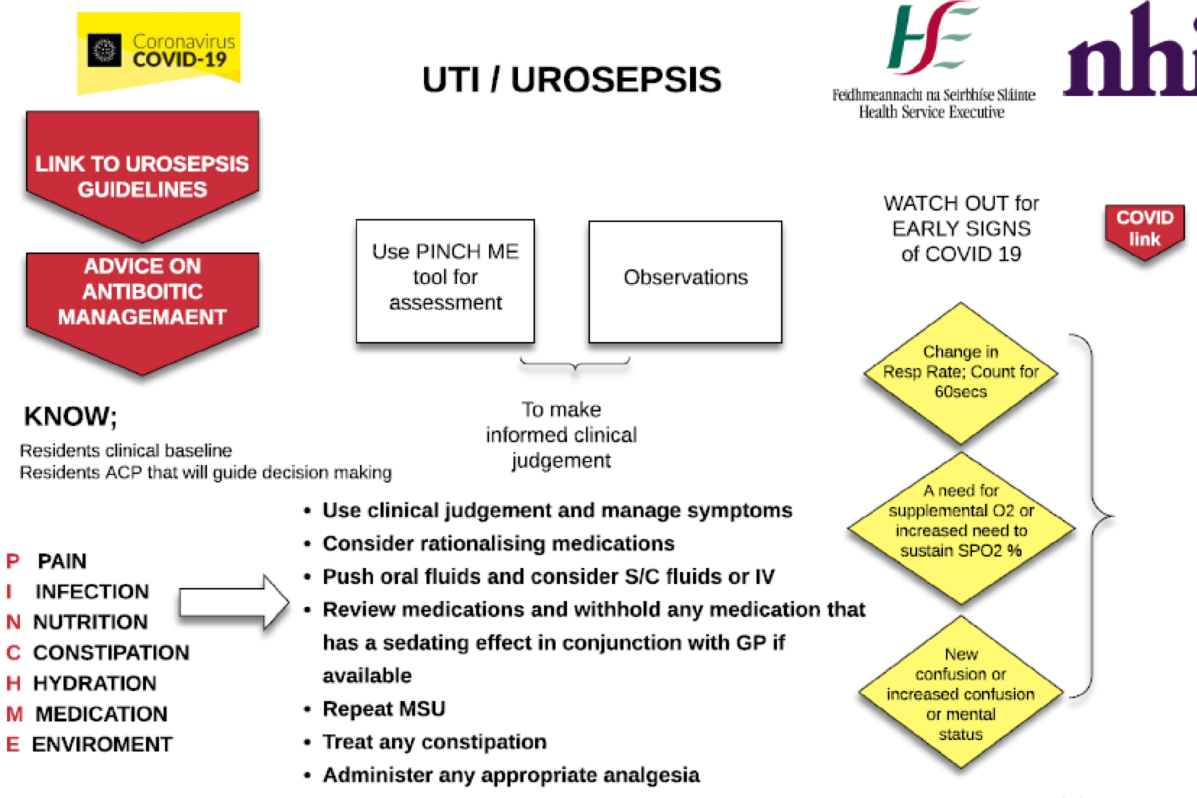
A full continence assessment should be carried out. Regular toileting and prompt treatment of UTI`smay prevent urinary incontinence. Catheters should be avoided where possible because of the increased risks of trauma in confused patients, and the risk of catheter associated infection..

Malnutrition

It is often difficult for delirium patients to eat adequately to meet increased metabolic needs. Food alternatives that take into account the patient's preferences, and the option of finger foods should be considered. Adequate staffing levels should be ensured to

support and encourage eating. Oral nutritional supplements can be considered and in severe cases short-term feeding by nasogastric tube may need to be considered , although this is rarely a practical option.

Appendix 1 - Urosepsis Alogrithm



Appendix 2 – Suspected Delirium

SUSPECTED DELIRIUM

Person presenting with;
- Agitation
- Aggression
- Disturbed sleep

Mixed Hyperactive Delirium

USE PINCH ME TOOL and CLINICAL JUDGEMENT AND CONSIDER

- Face time family -for baseline/ Use Life Story - for baseline
- If possible redeploy staff from another area
- Walk outside in fresh air if possible
- Try to give hidden fluids e.g. soup / ice cream / add extra milk to cereal
- Thicken fluids to custard consistency- maybe easier to take **particularly if concerns of aspiration**
- Use clinical judgement and consult with Senior Nurse Management and or most appropriate clinician available

P PAIN	Use both pharmacological & non-pharmacological treatment where possible. Start with simple paracetamol before going to stronger medications.
I INFECTION	Is there a concern with a urinary catheter? **See Urosepsis/ Catheter Care Algorithm.** Is there signs of respiratory tract infection or aspiration?
N NUTRITION	Consider snacks as desired if not able to concentrate on main meals.
C CONSTIPATION	Check Bowel Chart if Bowels Not Open in last 2-3 days consider oral laxatives both pharmacological or natural fibre based. Have PR laxatives prescribed PRN in case resident becomes drowsy or at risk of aspiration.
H HYDRATION	Encourage fluids as able & consider urinary retention if signs of lower abdominal discomfort or bloating. Keep fluid intake and output chart.
M MEDICATION	Is their medications driving the behaviour - check with GP or Hospital liaison service if available; Be cautious of causing drowsiness with any new medication
E ENVIRONMENT	Quieten the environment / reduce noise / glare from lights if possible. Check glases are clean and comfortable. **If none of the above apply try paracetamol for hidden pain.**

WATCH DELIRIUM INFORMATION VIDEO DELIRIUM LINK

Person presenting with;
- Drowsiness
- Decreased Oral intake
- Apathy
- Unwilling to cooperate

Hypoactive Delirium

USE PINCH ME TOOL and CLINICAL JUDGEMENT AND CONSIDER

- Particularly investigate for constipation and get both oral and rectal laxatives prescribed.
- Withhold all oral medications and ask GP to change medications to alternative routes of adminstration.
- Continue to observe closely and monitor vital signs regulary.
- Use clinical judgement and consult with Senior Nurse Management and or most appropriate clinician available.
- Encourage fluids as tolerated in line with any pre-existing diet or fluid modifications or use S/C fluids if appropriate.
- Ensure good oral care.
- **Communicate with family as appropriate on all of the above as needed.**

01/04/2020 v1

Appendix 3 – Breathlessness

Initial Management of Severe Breathlessness in Dying Patients with Covid-19 (in the Last Hours or Days of Life) one-pager.

For more detailed guidance, see https://www.palliativecareguidelines.scot.nhs.uk AND/OR contact Specialist Palliative Care team for advice.

Adherence to guideline recommendations will not ensure a successful outcome in every case. It is the responsibility of all professionals to exercise clinical judgement in the management of individual patients. Palliative care specialists occasionally prescribe or recommend other drugs, doses or drug combinations.

Who is this guide for?

The anticipatory prescribing and syringe pump one-pagers will provide symptom control for most patients, however some patients with Covid-19 may experience **severe, uncontrolled breathlessness** that requires rapid dose titration and urgent palliative care advice.

This is a guide to assist in the **first 90 minutes** of management of severe breathless **only**.

Principles of management:

- A clear decision to incorporate a palliative care approach has been made by senior decision-maker
- Start with lowest effective dose and titrate to effect.
- Reassess frequently.
- Use in combination with other one pagers.
- Seek specialist palliative care advice early
- Start a regular infusion to maintain symptom control once acute distress is relieved (specialist palliative care can advise as needed).

1. Supplemental Oxygen for patients at end of life

- Patients who are hypoxic may benefit from supplemental oxygen for comfort, if available.
- However, patients who are agitated/distressed by oxygen masks or tubing can have oxygen discontinued and breathlessness managed with an opioid/anxiolytic combination instead.
- Monitoring oxygen saturations is not required at end of life.
- High flow oxygen systems, NIV (BiPAP and CPAP) are not appropriate for patients at end of life.

2. Medication titration in the first 90 minutes

Initial Medication:

- **Opioid naive**: Give Morphine Sulphate 2.5mg SC
- **If already on opioids**: Give the appropriate PRN dose of the patient's regular opioid. The appropriate PRN dose is calculated as follows:
  - Divide the total 24-hour oral dose of opioid by 6 to get the oral PRN dose
  - Divide that number by 2 to obtain the SC PRN dose
  - E.g. The SC PRN dose for a patient taking MST 30mg PO BD is Morphine Sulphate 5mg SC hourly prn.

Reassessment at 30 minutes:

- If **effective** and patient is now comfortable PRNs may be repeat at hourly intervals as needed.

OR

- If **ineffective** repeat previous PRN opioid dose SC in combination with midazolam 2.5mg SC.

Reassessment at 60 minutes:

- If **effective** and the patient is now comfortable PRNs may be repeated at hourly intervals as needed

OR

- If **ineffective** increase the Morphine Sulphate PRN dose to 5mg SC (or in non-opioid naive increase dose by 50%) and give in combination with midazolam 5mg SC.

Reassessment at 90 minutes:

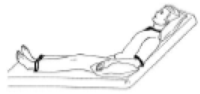
- If **ineffective**, repeat the last dose of the PRN opioid and midazolam **AND** seek **IMMEDIATE** palliative care advice which is available 24/7.

3. Diuretics if evidence that fluid overload is contributing to breathlessness

- Patients who have a history of congestive cardiac failure or who have received large volume fluid resuscitation may benefit from Furosemide 20-40mg SC PRN.

4. Non-Pharmacological

- Reassurance
- Well ventilated room/open window if possible
- Partial upright supported positioning in the bed as tolerated (see images below)

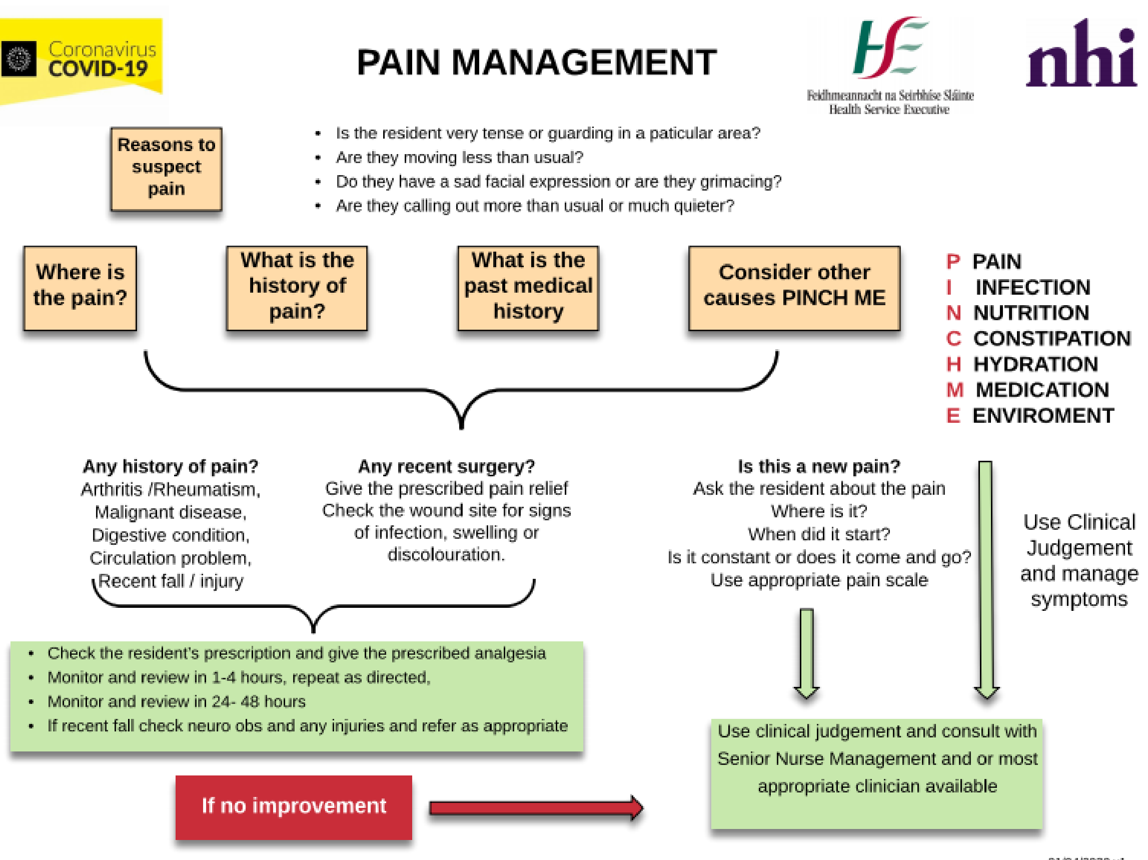


5. Further management

- Patients will require commencement of a syringe pump to maintain comfort following initial period of dose titration. Specialist palliative care will advise on appropriate doses.

Version 5 1.4.2020
https://hse.drsteevenslibrary.ie
for updated versions.

Appendix 4 – Pinch Me



Appendix 5 – Cough description