Managing Delirium Complications

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Learning Objectives

1. Brief review of recognizing delirium
2. The most common causes of delirium
3. How to manage delirium behaviors
4. How to manage and prevent consequences of delirium

Case Scenario

- Mrs S is an 80 year old woman who had a fall 3 weeks ago which resulted in bleeding in the head. It was not very big, and the rest of her medical work-up was fine. She was started on an antidepressant 1 week ago because since her fall, was "not motivated" to do anything, staying in bed to rest. The last 2 days, was overall sleepier than usual during the day, but also more restless at night. She is having difficulty following directions and making her needs known.

What's going on?

CONFUSION ASSESSMENT METHOD (CAM CRITERIA)

typically used in the ED, hospital or NH

F1

ACUTE= SUDDEN ONSET or FLUCTUATING

New behaviors in the last 24-48 hours
Consciousness, Attention, or Thinking fluctuates during interaction

+

F2

INATTENTION

Very distracted

Trouble keeping track of conversation

Can't follow directions

F3

PSYCHOSIS

Hallucinations (seeing things...)

Delusions (paranoid beliefs)

DISORDERED THINKING

Confused (thinks you are her ex-husband)
Speech rambling, going different directions, unclear, no logic
Speech very limited or very little

OR

F4

CONSCIOUSNESS/ SLEEP-WAKE

Hypervigilant, Awake all night, Restless

Falls asleep when you talk to them.

Sleeping all day

Provide your Observations and Descriptions

- SUDDEN CHANGES IN DAILY ROUTINES
- PSYCHOSIS, “CRAZY TALK”,
- CAN’T FOLLOW DIRECTIONS
- RANDOM SLEEP/WAKE CYCLES
- PHYSICAL OR AGGRESSIVE
- POSSIBLE HARM TO SELF OR OTHERS

Case Scenario: find the "clues"

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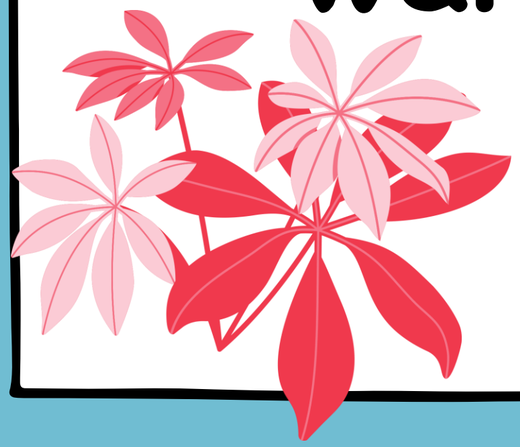
Caregivers should LOOK for early warnings!



Stop and Watch
Early Warning Tool

INTERACT®
Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated less in activities
a	Ate less
n	No bowel movement in 3 days; or diarrhea
d	Drank less
W	Weight change
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more than usual

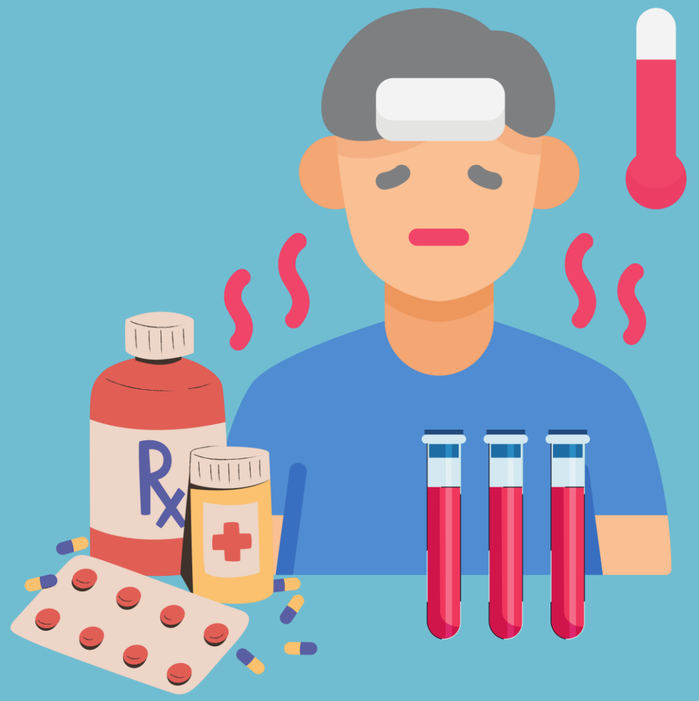
☐ Check here if no change noted while monitoring high risk patient

TOP 3 CAUSES OF DELIRIUM:

DRUGS (esp anticholinergics)

INFECTION (UTI, PNEUMONIA, SEPSIS)

LABS (Ex: anemia, dehydrtion, chemistries, glucose, calcium, thyroid, etc. ...)



GET A MEDICAL EVALUATION RIGHT AWAY!

OTHER CAUSES OF DELIRIUM :

- STROKE
- HEART ATTACK
- LOW OXYGEN
- CONSTIPATION, URINARY RETENTION

GET A MEDICAL EVALUATION RIGHT AWAY!

Case Scenario, continued

- Vital Signs: all normal, no constipation
- Exam: sleepy but arousable, answers with short phrases, responds slowly, no opening eyes for neuro checks. You notice some skin breakdown on buttocks due to moisture from her refusing to be changed.
- CT head: no change
- Labs: Low sodium 130 (normal 135-145), Dehydrated (elevated BUN/Cr), Urine- some WBCs and some bacteria, but not a lot.

CONCLUSION: Delirium due to low sodium, dehydration, possibly from new antidepressant side effect, with lingering effects of head injury.

Treatment?

The underlying medical problem must be treated

TREATMENT for Mrs. S: replace sodium, push fluids, stop antidepressant

The problem now….

How can we get her to cooperate with the treatment plan?

FOR AGITATED BEHAVIORS → TA -DA!

TOLERATE

If it is NOT Dangerous, allow patients to respond to their environment. Observe them. You might get clues about what is upsetting them.

ANTICIPATE

Behaviors are a way of communicating. If they cannot tell you, try to think ahead to meet their needs and avoid frustration or danger.

DON'T AGITATE

If they cannot reason or understand, don't try. Even re-orienting them can make them mad. Go with their flow. Try distraction or humoring the patient.

GETTING TO COOPERATION

CREATE SAFETY

Patient has an urgent need to feel safe.

Be aware of body language

Speak slowly and calmly

Show Empathy, Respect

Address feelings

Apologize, Agree with them,

Back off (Try again later)

SHOW CONCERN

"I noticed that you did not eat breakfast this morning..."

Can I do anything to help you feel more comfortable?

Listen. Do not dismiss them

PERSONALIZED

Don't "DO TO" them

Do "WITH" them- use a favorite food/drink, person, music, etc.

Ask for permission

Redirect

Consider music therapy, gentle sensory stimulation

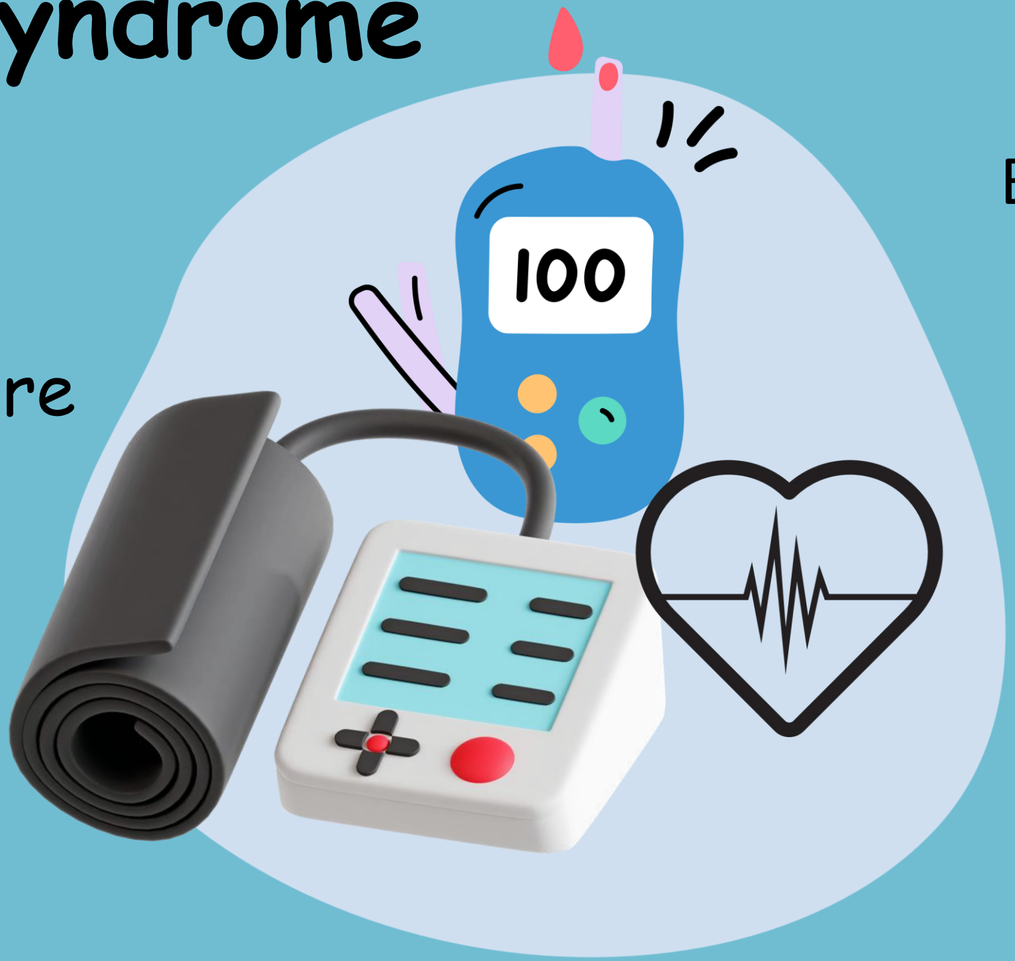
What about Medicines to Manage Delirium and Psychosis?

Benzodiazepines	Lorazepam (Ativan)	ZZZZ... Basically, a Tranquilizer
Antipsychotics	Haloperidol (Haldol) Quetiapine (Seroquel) Risperidone (Risperdal) Olanzapine (Zyprexa) Aripripazole (Abilify) Pimavanserin (Neuplazid)-NEW	Blocks Dopamine
Serotonin reuptake Inhibitors	Citalopram (Celexa) Escitalopram (Lexapro)	**Antidepressants**
Mood stabilizers:	Lithium Anticonvulsants (gabapentin)	**Anti-Seizure**

Common Antipsychotic Side Effects:

Metabolic Syndrome

Diabetes
High Blood Pressure
High Cholesterol
Weight Gain



BLACK BOX WARNING

Heart Attacks
Stroke
Death

Common Antipsychotic Side Effects: Movement Disorders

Extrapyramidal symptoms (EPS)

Parkinsonian symptoms (tremors, shuffling gait, slow movements)

Akathisia (restlessness)

Dystonia (involuntary painful muscle contraction- ex: neck twisted)

Tardive Dyskinesia (involuntary tongue thrusting, blinking, squirming, twisting, arm/leg movement)

To Medicate or Not?

Antipsychotics & Sedatives are ONLY to be used as a last resort.
If the patient is very distressed, or in danger of hurting themselves or others, THEN consider medications for the short term...

IF BEHAVIORS ARE DANGEROUS

➡ CALL 911

GET HELP

If the patient is in danger of seriously hurting themselves or others, call 911 However, you should know that there are few/no geriatric psychiatry hospital beds available, and admission may only be for a medical workup only. Hospitalization or medications may not solve the problem- Ultimately, a change in approach is still the most effective intervention.

ANTICIPATE & PREVENT COMPLICATIONS

Families and caregivers should know that they should expect to provide 24/7 until the Delirium is cleared. This may take weeks to months.

POTENTIAL COMPLICATION	PREVENTION STRATEGY
URINARY INCONTINENCE	SCHEDULED TOILETING PROGRAM
IMMOBILITY AND FALLS	MOBILIZE WITH ASSISTANCE, PHYSICAL THERAPY
PRESSURE ULCERS	MOBILIZE, REPOSITION FREQUENTLY, MONITOR PRESSURE POINTS
SLEEP DISTURBANCE	SLEEP PROTOCOL, AVOID SEDATIVES
POOR NUTRITION AND HYDRATION OR ASPIRATION	ASSIST WITH FEEDING, ASPIRATION PRECAUTIONS, ADD SUPPLEMENTS

adapted from AGS GEMS

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PREVENT FUNCTIONAL DECLINE

Families can help reinforce and restore function, BEYOND PT/OT therapies

FUNCTIONAL COMPLICATION	RESTORING FUNCTION
COGNITIVE RECONDITIONING	REORIENT TO TIME, PLACE, PERSON AT LEAST THREE TIMES A DAY (IF HELPFUL)
MONITOR FOR DEPRESSION	DEPRESSION WILL LIMIT PROGRESS. IMPLEMENT SCHEDULED PLEASURABLE EVENTS (BEHAVIORAL ACTIVATION)
ABILITY TO PERFORM ADLS & IADLS	FAMLIES EDUCATION: AS DELIRIUM REVERSES, FAMILY CAN ADAPT TO ALLOW GREATER FUNCTIONING MATCHED TO ABILITY.
PERSISTENT DELIRIUM	FAMILY EDUCATION: DELIRIUM MAY PERSIST, AND FAMILY MAY NEED TO CONSIDER LONG TERM SUPPORT FOR ADLS/ IADLS.

https://www.uptodate.com/contents/delirium-beyond-the-basics

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However, ADL support may be required for the long haul....

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SUMMARY

1. Early recognition of delirium is important.

2. The most common causes of Delirium are medications, infections, and chemical imbalance.

3. A calm, reassuring approach is the best approach.

4. You can anticipate and help manage and prevent potential complications of delirium.

CASE DISCUSSIONS & QUESTIONS