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Dementia and Delirium

Dementia Action Week 17th – 24th May

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Group agreement

- There is no such thing as a silly question
- Respect and listen to each other's view points
- Confidentiality
- Use of MST and tool bar

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Main talking points

- What is dementia and delirium
- The difference between dementia delirium and depression
- Related risk factors
- How can we identify delirium, particularly when someone also has dementia.
- How can we prevent, treat delirium

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What is Dementia?

Dementia itself is not a disease

It is an umbrella term used to **describe the symptoms** caused by **many different diseases.**

These diseases are **progressive** symptoms will get worse but the rate varies with each person.

- **Memory difficulties**
- **Communication difficulties**
- **Functional skills** problems performing day to day activities and tasks.
- **Cognitive skills** problems processing information.

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Dementia causes progressive damage to brain cells (neurons)
Structural changes (plaques and tangles and/or poor blood supply causing brain cell death)
Chemical changes that effect communication between neurons (neuro-transmitters)

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What is Delirium?

- An acute confusional state
- Usually associated with being unwell
- Onset is **sudden** & **fluctuates**
- Affects the whole brain:
  Decline in abilities - Altered alertness - Lack of concentration / inattention - Disorganised thinking - Altered levels of consciousness

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Types of delirium

- Hypoactive – withdrawn, sleepy, not interacting
- Hyperactive – restless, agitated, hyperactive
- Mixed

Do I really need to know about delirium?

- Stressful for people experiencing delirium and their loved ones
- People with dementia are 5x more likely to develop delirium
- Poor outcomes if missed
  - More likely go into hospital, and stay longer
  - More likely to be placed in a care home if delirious in hospital
  - Increased risk of death
- 30% of older people admitted to hospital will have a delirium

Risk Factors.....

- Increasing age (65+)
- Dementia (5 x more likely)/cognitive impairment
- Hip fracture
- Hospitalisation / change in environment
- Impaired vision or hearing
- Urinary catheters
- Acute Illness or injury
- Reduced or impaired mobility
- Falls

Dementia, Delirium and Depression

- Important to know the difference between the three;
- Often mimic each other;
- All three can exist together.

Isn't delirium like dementia?

Feature	Delirium	Dementia	Depression
Onset	**Sudden**	Insidious	Gradual
Fluctuations	**Yes** – over hrs	Not usually	Situational
Duration	**Hours** – months	Months - years	Weeks - years
Cause	Acute illness - **reversible**	Chronic degeneration	Reactive / biochemical
Conscious level	**Abnormal**	Normal	Normal
Memory	Impaired	Impaired	May refuse to answer
Conversation	**Often slow, inappropriate**	Word finding difficulties	Sparse
Orientation	Varies	Impaired	Normal
Hallucinations	**Often present**	Rarely present	Rarely present
Night-time	**Worse**	Can be worse	No effect

Dementia and Delirium

"People with dementia are at considerable risk of developing delirium. When delirium is superimposed on dementia, it can be challenging to distinguish."

Ref: Royal College of Psychiatrists (2019)

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Think Delirium!

IF delirium identified early & all causes treated, it frequently resolves, people have better outcomes

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NICE guidance on delirium issued July 2010 and updated March 2019

- Assess all new patients for risk of delirium
- Within 24 hours of admission initiate an individualised prevention intervention for those at risk of delirium
- Identify and diagnose delirium at admission
- Follow management guidelines including effective communication, reorientation and non-pharmacological management of distress

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How can we identify delirium?

- If there is a **sudden** onset of symptoms that **fluctuates** (Think Delirium!) consider using one of the following screening tools and seek further advice:

  Cognitive Assessment Method (CAM)
  4AT

- PINCH ME (Portsmouth University Hospital Trust)

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PINCH ME

Common causes of delirium are:

- **P**ain
- **I**nfection
- **N**utrition
- **C**onstipation
- **H**ydration
- **M**edications
- **E**nvironment – where they are, what's happening

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P – PAIN

Signs that someone may be in pain

- Fidgeting ,restless, shouting, banging;
- Holding an area of their body;
- Calling out- for example for their mum, a nurse or just 'Help me';
- Reacting with fear or distress during personal care;
- Facial expression may be grimacing or tense;
- Changes to body language may include; pacing, tight fists, hitting out and pulling away;
- Apathy and withdrawal from activities and interactions.

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I - INFECTION

Urinary Tract Infection?
Chest Infection?
Wound infection?

Important to know person's medical history of previous infections

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N - NUTRITION

- May need to monitor the person's food intake daily;
- Ensure food is in the person's line of vision;
- Be aware of colour and contrast;
- Too much food can be overwhelming;
- Offer visual prompts;
- Support the person to be as independent as possible;
- Make sure snacks are visibly placed where the person is most likely to see them;
- Dietician and SLT assessments may be beneficial.

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C- CONSTIPATION

- **Complaining / showing signs of constipation?**
  - Take basic observations
  - Treat and prevent constipation –
    - Prevention – (3 F's) FLUIDS, FIBRE, FOOT WORK
    - Is the resident already on laxatives?
    - Consider overflow / diarrhoea
    - Consider medication review
  - Monitor & observe - use the Bristol Stool Chart

→ No improvement? Call GP, describe symptoms and what you have done so far

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H - HYDRATION

Check for signs of dehydration
- Take physical observations
- Monitor fluid intake and output
- Adjust fluids as needed
- When someone has dementia, it may be difficult to increase fluids, you can try offering small amounts of fluid very frequently
- Review after 24 - 48hrs

Has the person improved?
- **YES?** Prevent further dehydration, fluid chart
- **NO?** Take basic observations, Call GP, describe symptoms and what you have done so far

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M - MEDICATION

- Side effects?
  - starting or stopping
  - ↓ / ↑ dosages
- Unpleasant side effects / refusal / compliance
- Severe side effects? Adjust dose / add in a second medication / stop?
- Long-term medication can cause problems
- Everyone is should have an annual medication review

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E - ENVIRONMENT

What can YOU do to help?

- TV or radio - too loud?
- Are other people being noisy?
- Light or bright sunlight shining directly onto their face?
- Change in daily routines or activities?
- Change in circumstances that has affected their usual freedom?
- Are there unfamiliar people working in the environment?

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Top Tips!

- Spectacles – available and clean
- Hearing aids – available and working
- Cognitive stimulation
- Regular reorientation several times a day
- Tell people clearly what is happening and why **before** you approach someone, speak slowly, good eye contact
- Encourage sleep – quiet as possible, no medications at night, mobilise during day
- Encourage family to bring in familiar objects and visit
- Avoid bed / ward moves

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Keep in mind . . .

- **Think Delirium!**
- Delirium can ***fluctuate***, changes occur ***suddenly***
- Observe closely, ↑ risk of falling
- Identify people at risk of delirium
- **PINCH ME**
- Person centred care - important
- Delirium can take **WEEKS or MONTHS** to fully resolve
- Risk of further episodes increase when unwell
- Seek support / guidance from Primary Care / Dementia services as required

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Any questions . . .

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References

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