TIPS Question:

How do you differentiate Delirium from existing dementia/head injury?

- 79-year old woman admitted to LTC facility 3 years ago with post head injury episode secondary to fall and alcohol abuse. Within the 3 years at LTC facility she experienced multiple TIA's and strokes. No paralysis is evident.
- Observations: variable degrees of agnosia, apraxia, amnesia, altered perception, apathy, withdrawn, unpredictable, resistive to care and sometimes verbally and/or physically aggressive. At times would follow directions sometimes would not respond at all, and sometimes would speak in a full sentence. Decreased psycho-motor abilities.
- DOS- no consistency. Increased aggression with personal contact.
- Clock and Folstein tests-unable to conduct as contact with patient not reached.
- Cohen-Mansfield Agitation Inventory -not disruptive

Response:

The resident described above is vulnerable to developing delirium because of several risk factors including, advanced age, cognitive impairment, head injury, prior alcohol abuse, TIAs and strokes. The cognitive impairment and functional deficits associated with the above insults hopefully have been well documented in past examinations by neurologists, and OT's speech/language pathologists, and scans/x-rays. It is important to be aware of the pattern of the resident's decline. Your knowledge of the resident's usual presentation, functional abilities and any changes in the mental status and functional abilities related to events such as TIAs, strokes, illnesses, and addition of pharmacologic treatments will assist you in determining if the resident does have a delirium. The P.I.E.C.E.S. framework is helpful to guide you in gathering information regarding all aspects of the resident's condition. This person has many deficits related to medical conditions and previous insults. It would be important to review the pharmacologic interventions and discontinue non-essential medications that may be adversely contributing to the resident's condition.

Severely impaired residents pose special difficulties in assessment because of communication deficits. Often an important clue regarding delirium for individuals that cannot communicate verbally is functional decline. Observation, gathering information from vital signs, palpation/auscultation, lab work, monitoring changes in functional abilities, intake and output, hydration levels, and collateral information from family and caregivers will all assist in your assessment of the individual, and fluctuations in their cognitive/ physical status.

Delirium is characterized by an acute change in a person's condition with a fluctuating course. The nine features which are the most common presentations of delirium are:

1. Acute onset
2. Inattention
3. Disorganized thinking
4. Altered level of consciousness
5. Disorientation
6. Memory Impairment
7. Perceptual Disturbances
8. Psychomotor Agitation/Retardation
9. Altered sleep wake cycle

The *Confusion Assessment Method* developed by Dr. Sharon Inouye is useful for screening for delirium. If you have 1 & 2 of the above, and either 3 or 4 then you score positive on this screening tool, and should follow up with further investigations for the causes of delirium. The tool was developed for vulnerable elderly, however, and not for the severely cognitively impaired individual.

The *Dementia Observation System* is a tool that is helpful for determining sleep/wake reversals, or fluctuating states characteristic of delirium.

(Both tools are detailed in the P.I.E.C.E.S. Resource Guide)

After careful assessment and review of possible reversible causes of the presentation, it may be helpful to involve your partners in care in such a complex case. Delirium is considered to be a medical emergency with high rates of morbidity and mortality. Referral to specialty services such as geriatric medicine, geriatric psychiatry or neurology may be appropriate for assessment and intervention.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*