3-322 delirium as a chronic condition

TIPS Question:
How long can a person be in a delirium and can it be permanent rather than fatal?

What are the significant factors you have learned as a result of working through the six-question template?

- Resident was admitted pc fracture hip, has been increasingly agitated since admission
- Had all the overdose symptoms of Tegretol – which was discontinued
- UTI was found – behaviours continued – was on Serax with no help – now on Risperdal 0.25 BID
- Now more cognitively impaired and behaviours still continue.
- Waiting 2 weeks to do repeat urine
- Question complication of surgery – is this the way the resident will always be or is there something more we can try?
- Pharmacist reviewed meds but was unable to help
- Is she experiencing a delirium or is this just the way she is now?

Response:

Delirium by definition is an acute confusional episode and should be reversible if the etiology is found and measures taken to correct the underlying pathology. If no etiology is found it can continue for a prolonged period and can result in irreversible cognitive impairment, decreased functional abilities and often increased mortality.

It sounds like you have been working through an assessment of this resident considering many possible contributing factors. You have not mentioned use of the 6-Question Template to help you organize the issues and determine next steps. If you have, that is great! It will help you to structure the assessment.

In terms of possible causes, with this resident it would be interesting to know from the partners in care:

- level of cognitive impairment, physiologic and mental status, and what medications were prescribed prior to the hip fracture.

You will find the U-First Wheel helpful in guiding dialogue with the family or caregivers and for reviewing the P.I.E.C.E.S. together – what do we know at this point and what information (and what investigations) do we still need to gather and from whom? This information will be invaluable in coming to an understanding of the current presentation. There is a very high rate of delirium in elderly clients post hip fracture repair. Anesthesia, pain, analgesia, psychotropic medication, dehydration, infection, changes in placement can all contribute to confusion.

It is important to screen for physiologic contributors. You have discovered a UTI which hopefully was treated. Was there a follow up urine test done to see if the infection was treated adequately? Are there any other physiologic complications? Is the blood work indicative of any other pathology?

Are there any other medications possibly contributing to the presentation? Tegretol has been discontinued. It would be important to compare the list of medications prior to hip fracture and currently. Is there anything the client is receiving now that may account for the changes? Can the medications be further streamlined? Serax itself may cause delirium. If it was not helpful, was it discontinued? Risperdal may also cause delirium and the client needs to be monitored for side effects such as anticholinergic, extrapyramidal reactions, CNS depression. Are Serax and Risperdal being used together and perhaps causing difficulties in interaction?

If the client has been suffering a delirium for a prolonged period they may have difficulties with dehydration, mobility, and may be a safety risk. It is important to monitor fluid status, encourage mobility, provide appropriate level of stimulation, attend to visual and hearing impairment, provide reassurance, orientation or validation as appropriate, emotional support, encourage the family to visit and support as appropriate. Non-pharmacologic sleep protocol should be used to rationalize the use of medication.

To help you focus team observations and the sharing of those observations, levels of agitation and distress can be tracked using the Dementia Observation System, for 7 days, 24 hours/day to gain an understanding of the resident's patterns. Mental Status can be monitored with the Confusion Assessment Method and interview to monitor for hallucinations/delusions and distress.

Even when you think you may have tried everything, it is always helpful to be prepared to take a step back and reassess; refer to the U-First! wheel often as you and the team try to problem solve together and track where you are at in the reassessment process and where to go next.

If careful review of physiologic status, pharmacologic interventions and nursing measures do not resolve the issues, then referral to a specialist in your area such as a Clinical Nurse Specialist, Nurse Practitioner, Geriatric Mental Health Outreach Program, Geriatric Psychiatrist, Geriatrician would be advisable to achieve the best health status for this individual.

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.*