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The logo for Alzheimer's Australia Dementia Research Foundation, featuring the text 'ALZHEIMER'S AUSTRALIA' in small letters above 'DEMENTIA RESEARCH FOUNDATION' in larger letters, all in white on a teal background.

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ED Dementia Care Training

Providing best care to older people with dementia in emergency departments

Acknowledgments

The project team would like to express sincere appreciation to the many people who gave guidance, support and feedback in the development of this resource:

The ED Dementia Care Training Program: Providing best care to older people with dementia in emergency departments

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- General medicine
- Emergency Medicine
- Geriatrics
- Nursing
- Allied Health
- Pharmacy

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The ED Dementia Care Training Program: Providing best care to older people with dementia in emergency departments.

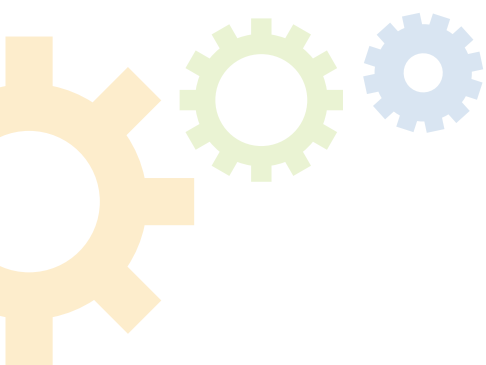
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Objectives

This topic aims to explore cognitive impairment and dementia in more detail. This topic will provide an overview of normal age related changes in the brain, types and stages of dementia and comparisons between Mild Cognitive Impairment, Dementia, Delirium and Depression – The 3 D's.



Learning outcomes

On completion of this topic, you will have an awareness and understanding of:

- What dementia is
- Normal age related changes in the brain
- Types of dementia
- Stages of dementia
- Differences between dementia and other cognitive conditions

1.1 What is dementia?

Dementia is an umbrella term used to describe a number of degenerative brain disorders characterised by impaired cognition, and changes in behaviour and mood. Dementia is the third leading cause of death in Australia and it is estimated that by 2020 there will be around 400,000 people in Australia with dementia.[1] Three in ten (30%) people over the age of 85 and one in ten (10%) people over 65 have a dementia diagnosis. The prevalence of dementia is particularly high in Indigenous Australians at approximately three times that of the general population.[2]



Reflective question

What do you know already about dementia?

What do you think of when you hear the term dementia?

Although dementia is not an inevitable part of ageing, dementia primarily affects older people. Many people with dementia rely on health services due either to their diagnosis or to other health conditions. Although dementia is more common in the older population, there are over 25,000 people in Australia with younger onset dementia,[2] which is used to describe any form of dementia diagnosed in people under the age of 65.[1]



Suggested further reading

- <https://www.fightdementia.org.au/about-dementia/health-professionals/dementia-the-essentials/dementia-statistics-and-epidemiology>

1. Cognitive Impairment and Dementia Explained

1.2 Dementia defined

In 2013 the American Psychological Association (APA) released the fifth edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) in which the term 'dementia' has been replaced with major Neuro-Cognitive Disorder (NCD) and minor neurocognitive disorder.[6] The aim of this change in terminology was to reduce the stigma associated with the term 'dementia'. It is however considered that the term dementia will remain in common use.

The DSM-5 describes six cognitive domains which may be affected in both mild and major NCD:

1. **Complex attention**, which includes sustained attention, divided attention, selective attention and information processing speed.
2. **Executive function**, which includes planning, decision making, working memory, responding to feedback, inhibition and mental flexibility.
3. **Learning and memory**, which includes free recall, cued recall, recognition memory, semantic and autobiographical long term memory, and implicit learning.
4. **Language**, which includes object naming, word finding, fluency, grammar and syntax, and receptive language.
5. **Perceptual-motor function**, which includes visual perception, visuoconstructional reasoning and perceptual-motor coordination.
6. **Social cognition**, which includes recognition of emotions, theory of mind and insight.

All or some of these domains could be affected in the person with dementia depending on the type and stage of dementia and on the individual person.

1.3 The brain, cognition and normal age-related change

As with all organs, the brain undergoes a number of age related changes.

Normal age related changes to the brain include:

- Reduced volume
- Some neuronal cell death
- Deterioration of myelin sheath
- Greater symmetrical activation of regional areas of the brain
- Dysregulation of neurotransmitter levels, hormones and other substances.[7]

As stated previously, dementia is not part of normal ageing. Pathological changes occur with dementia.

1. Cognitive Impairment and Dementia Explained

1.3 The brain, cognition and normal age-related change

Seven A's of dementia

The seven A's of dementia describes symptoms of dementia and represent damage to a particular part of the brain:

- 1) **Anosognosia (deficit of self- awareness/lack of insight)**
- 2) **Amnesia (memory loss)**
- 3) **Aphasia (inability to comprehend and formulate language)**
- 4) **Agnosia (inability to process sensory information)**
- 5) **Apraxia (motor disorder)**
- 6) **Altered perception (misinterpretation of information)**
- 7) **Apathy (lack of feeling, emotion, interest and concern).[8]**



Dementia myths[1]

1. Dementia is a normal part of ageing
2. Dementia cannot be slowed down
3. I am not able to support people with dementia
4. Early diagnosis of dementia is not beneficial

1.4 Types of dementia

It is important to be familiar with the different types of dementia. The type of dementia impacts on its presentation, risk factors and so treatment of the condition.

There are over one hundred different conditions that cause dementia. The most common types of dementia are listed below:[5]

- **Alzheimer's Disease (AD)** accounts for 50-70% of all types of dementia
- **Vascular Dementia (VaD)** accounts for 18% of all types of dementia
- **Lewy body disease** accounts for 15% of all dementia types
- **Mixed dementia** is a co-existence of AD and VaD
- **Frontotemporal dementia** accounts for 5% of all cases
- **Parkinson's related dementia** accounts for 3-4% of all types of dementia

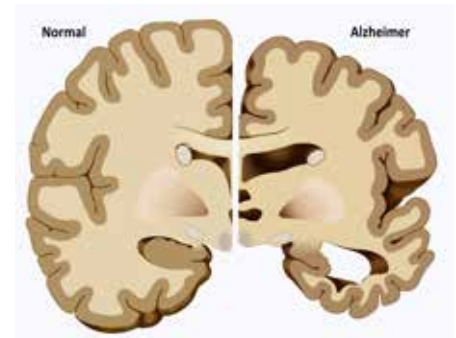
Less common types of dementia include Huntington's disease, alcohol related dementia (Kosakoff's dementia) and Creutzfeldt-Jacob disease. It is important to note that secondary dementias such as alcohol-related dementia, HIV-associated dementia and dementia associated with traumatic brain injury are more common in Younger Onset Dementia.

1. Cognitive Impairment and Dementia Explained

Alzheimer's Disease (AD)

Symptoms

- Lapses in memory
- Difficulty finding words for everyday objects
- Persistent and frequent memory difficulties, especially of recent events
- Vagueness in everyday conversation
- Apparent loss of enthusiasm for previously enjoyed activities
- Taking longer to do routine tasks
- Forgetting well-known people or places
- Inability to process questions and instructions
- Deterioration of social skills
- Emotional unpredictability



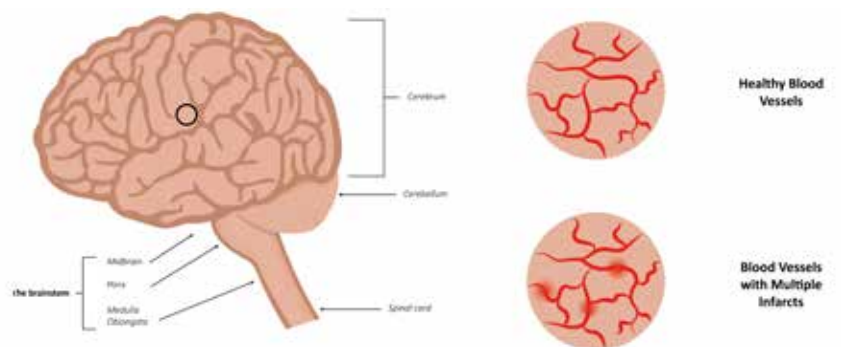
Vascular Dementia

Vascular dementia relates to dementia associated with problems of circulation of blood to the brain.

There are different types of vascular dementia with the most common two types being Multi- infarct dementia and Binswanger's disease. In both

these types of dementia, stroke related changes occur in the brain. Risk factors for vascular dementia include:

- Hypertension
- Smoking
- Diabetes
- Hypercholesterolemia
- History of Transient Ischaemic Attacks (TIA)
- Vascular disease
- Cardiac arrhythmias



Multi- infarct dementia

Causes	Symptoms
Damage to the cortex of brain	- Severe depression - Mood swings - Epilepsy

Binswanger's disease

Causes	Symptoms
Hypertension, atherosclerosis	- Slowness - Lethargy - Difficulty walking - Emotional instability - Lack of bladder control

1. Cognitive Impairment and Dementia Explained

Lewy Body Disease

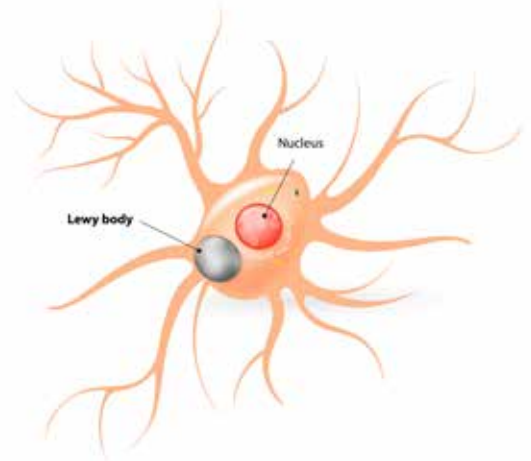
Dementia with Lewy bodies is due to the degeneration and death of neurones in the brain along with the development of spherical structures, known as Lewy bodies inside the neurones. Currently, there is no known cause for Lewy body disease and risk factors have not been identified.

Symptoms

- Difficulty with concentration and attention
- Extreme confusion
- Difficulties judging distances, often resulting in falls.

Two of the following symptoms must also be present to diagnose Lewy body disease:

- Visual hallucinations
- Parkinsonism - tremors and stiffness similar to that seen in Parkinson's disease
- Fluctuation in mental state
- Inability to process questions and instructions
- Deterioration of social skills
- Emotional unpredictability



Frontotemporal dementia (FTD)

Frontotemporal dementia refers to dementia due to progressive damage to the frontal and/or temporal lobes of the brain. The symptoms depend on which part of the brain is damaged however memory often remains unaffected in FTD.

Types and Symptoms

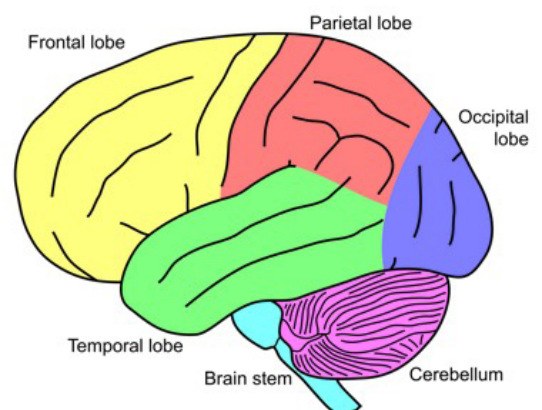
The various types of FTD include:

Behavioural-variant frontotemporal dementia – causes changes in behaviour, habits, personality and emotions. Symptoms include: loss of empathy, apathy and difficulty in reasoning, judgement and organisation.

Semantic dementia

Symptoms include: decline in language abilities – difficulties with reading, spelling and comprehension.

Progressive non-fluent aphasia (PNFA) – is the least common form of FTD. Symptoms include losing the ability to speak fluently, slow and distorted speech.



1. Cognitive Impairment and Dementia Explained



Video

Watch the following video on the different types of dementia.

<https://www.youtube.com/watch?v=OHT0jo1frhc> (1:41)

1.5 Stages of dementia



Most types of dementia are **gradual in onset**, are progressive and **irreversible**. Dementia is often categorised into three severity stages:

Deficits are evident in a number of areas such as memory and personal care, but the person can still function with minimal assistance.

In ED the person may require some assistance and individual needs and risk assessments should be considered.

Mild or early-stage dementia

Deficits become more obvious and severe, and increasing levels of assistance are required to help the person maintain their functioning in the home and community.

Characterised by almost total dependence on care and supervision by others.

In ED, many people with severe dementia will require continual supervision.[6]

Moderate or middle-stage dementia

Severe or late-stage dementia

1. Cognitive Impairment and Dementia Explained

1.6 Comparisons of cognitive impairment, dementia and delirium

It is important to understand the definitions and differences of mild cognitive impairment, dementia and delirium. Definitions below are taken from the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) [7] developed by the World Health Organisation.

Mild Cognitive Disorder	A disorder characterized by impairment of memory, learning difficulties, and reduced ability to concentrate on a task for more than brief periods. There is often a marked feeling of mental fatigue when mental tasks are attempted, and new learning is found to be subjectively difficult even when objectively successful. None of these symptoms is so severe that a diagnosis of either dementia or delirium can be made.
Dementia	Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.
Delirium	An etiologically nonspecific organic cerebral syndrome characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion, and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe.

1. Cognitive Impairment and Dementia Explained

Dementia, Delirium and Depression- The 3 Ds

It is useful to consider the background of a patient's symptoms as the clinical features of dementia, delirium and depression may overlap. Establishing a person's normal mood and cognitive status will assist with this.

Feature	Delirium	Dementia	Depression
Onset and duration	Sudden onset – over hours or days; duration – hours to less than one month, but can be longer.	Slow and insidious onset; deterioration is progressive over time.	Recent change in mood persisting for at least two weeks – may coincide with life changes – can last for months or years.
Course	Short and fluctuating; often worse at night and on waking. Usually reversible with treatment of the underlying condition.	Symptoms are progressive over a long period of time; not reversible.	Typically worse in the morning. Usually reversible with treatment.
Psychomotor activity	Hyperactive delirium: agitation, restlessness, hallucinations Hypoactive delirium: sleepy, slow-moving Mixed: alternating features of the above.	Wandering/exit seeking Agitated Withdrawn (may be related to coexisting depression)	Usually withdrawn Apathy May include agitation
Alertness	Fluctuates, may be hyper-vigilant through to very lethargic.	Generally normal	Normal
Attention	Impaired or fluctuates, difficulty following conversation.	Generally normal	May appear impaired

1. Cognitive Impairment and Dementia Explained

Feature	Delirium	Dementia	Depression
Mood	Fluctuating emotions – for example: anger, tearful outbursts, fear	Depression may be present in early dementia	Depressed mood Lack of interest or pleasure in usual activities Change in appetite (increase or decrease)
Thinking	Disorganised, distorted, fragmented	Difficulty with word-finding and abstraction	Intact; themes of helplessness and hopelessness present
Perception	Distorted – illusions, hallucinations, delusions; difficulty distinguishing between reality and misperceptions	Misperceptions usually absent (can be present in Lewy body dementia)	Usually intact (hallucinations and delusions only present in severe cases) [12]

Delirium superimposed on dementia (DSD)

Delirium superimposed on dementia occurs when delirium takes place concurrently with a pre-existing dementia. The prevalence of DSD ranges from 22% to 89% of hospitalised and community populations aged 65 years and over.[9]

Key Points

- Dementia is an umbrella term for a number of brain disorders
- Dementia primarily affects older people, but is not a normal part of ageing
- There are different types of dementia
- There are differences between mild cognitive impairment, dementia, delirium and depression



Suggested further reading

- Read 'Types of dementia'
<https://www.fightdementia.org.au/about-dementia/types-of-dementia>
- Read 'Diagnostic Criteria for Dementia'
https://www.fightdementia.org.au/files/helpsheets/Helpsheet-DementiaQandA11-DiagnosticCriteriaForDementia_english.pdf



Objectives

The aim of this topic is to understand delirium.



Learning outcomes

By the end of this topic, you will have an awareness and understanding of:

- Delirium in ED

There is a need to differentiate between slowly **progressing cognitive changes** as a result of dementia and **acute changes** caused by delirium. It is also important to note that some patients will present to ED with delirium and others may develop delirium while in the ED. Delirium can occur both in patients with cognitive impairment or dementia (dementia superimposed on delirium), and in patients without a history of cognitive impairment.

Studies have shown that approximately 10% of older ED patients aged 65 years and over have delirium.[11, 12] Kakuma and colleagues found that older patients with unrecognised delirium have an increased mortality risk compared to those where delirium was identified by ED staff. [11] Interventions for preventing delirium initiated in the ED may reduce negative health outcomes associated with delirium in the older ED population. It is important that delirium prevention interventions, often targeting the delirium risk factors, are utilised at the earliest possible opportunity.

2.1 Delirium Risk Factors

Several factors, many of which are common in patients presenting to the ED, increase the risk of delirium. These include:

- Systemic illness
- Medications (e.g. the start of a new medication, interactions, polypharmacy)
- Cognitive impairment
- Visual and hearing impairment
- Functional dependence
- Dehydration
- Sleep deprivation
- Impaired nutritional status
- Pain
- Surgery



2. Delirium Explained

There are no universally accepted strategies for managing patients with delirium in the ED. However, the delirium clinical care standard,[16] developed by the Australian Commission of Safety and Quality in Health Care (ACSQHC), supports the delivery of appropriate care for persons with delirium or at risk of delirium and promotes shared decision making between patients, carers and health professionals.

Delirium Clinical Care Standard	
Screening	<p>Any patient at risk of delirium should receive screening using a validated test.</p> <p>Patient and/or carer should be questioned about recent changes in behaviour or thinking.</p>
Presentation or Acute Change	<p>Any patient presenting at hospital with cognitive impairment or who has an acute change in behaviour or cognitive function should be assessed using a validated tool.</p> <p>Patient and/or carer should be questioned about recent changes in behavior or thinking.</p> <p>The patient's diagnosis is discussed with the patient and carer and is documented in the medical record.</p>
Interventions	<p>Interventions are administered to those patients at risk of delirium and patients should be regularly monitored for changes in behaviour, cognition and physical condition.</p>
Causes addressed	<p>The causes of delirium (based on a comprehensive assessment) are addressed.</p>
Risks	<p>A patient with delirium receives care based on their risk of falls and pressure injuries.</p>
Medication	<p>Treatment with an antipsychotic medicine is only considered if a patient with delirium is distressed and the cause of their distress cannot be addressed and non-drug strategies have not effectively relieved symptoms.</p>
Care plan	<p>A collaborative individualised care plan (including strategies to reduce delirium, prevent complications and ongoing treatments) is developed prior to discharge from hospital.</p>

2. Delirium Explained

Delirium can be prevented if the right care is provided. Specific delirium prevention interventions include:

- Identifying the person's delirium cause (e.g. severe medical illness, medication, review other risk factors)
- Correcting dehydration, malnutrition and constipation
- Mobilising (i.e. maintain function)
- Assessing and managing pain
- Regular reorientation and reassurance
- Assisting patients with auditory and visual aids
- Non-pharmacological measures to promoting sleep
- Employing noise reduction strategies and preventing day and night reversal
- Medication review

These interventions should be implemented both for patients with delirium and those at risk of delirium.

The involvement of family or a person that knows the patient well is a key aspect of delirium prevention. Encourage family/friends to stay at bedside. This person can provide reassurance, answer questions, reorient the patient, and notify staff if the person needs assistance.

Key Points

- Delirium can occur in patients with or without dementia
- Certain factors increase the risk of delirium occurring
- Delirium can be prevented if the right care is provided



Objectives

The aim of this topic is to understand the impact of the ED processes and structures (environment) on the person with dementia.



Learning outcomes

By the end of this topic, you will have an awareness and understanding of:

- The impacts of ED processes and structures on the person with dementia
- Risks of harm for people with dementia in ED

Cognitive impairment is highly prevalent in older ED patients at between 26% and 40% of the ED population.[12] Delirium occurs in around 10% of older ED patients.[13] There is evidence that older ED patients with cognitive impairment are at increased risk for negative events and health outcomes, including ED re-presentation, hospitalisation, institutionalisation, functional decline and death.[14]

It is important to consider that older people have specific characteristics and needs that should be considered when presenting to ED. The ED environment can be perplexing for older people with dementia. Admission to the ED means disrupting continuity of care that was provided in the community or residential aged care facility. Compared to those environments, the ED is hectic and often lacks orientation cues, sufficient signage, adequate access to drinks and food, geriatric screening tools, activities and exercises to maintain function, appropriate attention to polypharmacy, and staff with expertise and knowledge to meet their care needs. These factors may impact on the occurrence of adverse events (e.g. prescription of inappropriate medication, not detecting delirium, under treatment of pain) and health outcomes. Care for the older person with dementia presenting to ED should be holistic,[15] integrated, safe and person-centred.

Patients with dementia are:

2X MORE LIKELY

to experience harm while in hospital (from falls, pressure injuries or infections)

2X MORE LIKELY

to die in hospital [17]

6X MORE LIKELY

to develop delirium [16]

2X MORE LIKELY

to be readmitted to hospital [23]

3. Impact of the ED on people with dementia



Reflective question

How do you think the ED environment affects a person with dementia?



Video

The following videos demonstrate the experience of a person with dementia.

<https://www.youtube.com/watch?v=z15-0xZTng4> (1:05)

<https://www.youtube.com/watch?v=VFXirEnjfTI&list=PLo2qfDuEgLZaEUHugrCTkn-ap5g2S7MU6&index=1> (13:22)

Key Points

- The ED has significant impacts on people with dementia.
- ED patients with cognitive impairment are at increased risk of harm.



Objectives

The aim of this topic is to understand the importance of screening for cognitive function, delirium and other geriatric syndromes in the ED. You will learn about benefits of screening, the screening process and different screening tools available for the ED setting.



Learning outcomes

By the end of this topic, you will have an awareness and understanding of:

- The benefits of screening
- The importance of screening
- Different types of screening tools available



Reflective question

From your existing knowledge and understanding of dementia, who do you think should be screened for cognitive impairment on presentation to the ED?

Benefits of using screening tools:

- Standardisation
- Facilitates communication
- Provides a baseline

4.1 Screening For Cognitive Impairment

Altered mental status, defined as delirium or cognitive impairment without delirium, in older ED patients is highly prevalent. It is estimated that up to 40% of older patients presenting to EDs have issues in cognitive functioning.[18] It is estimated that approximately 10% of older ED patients experience delirium during their ED episode.[12,19,20] Over 70% of the ED patients with identified cognitive impairment, the cognitive issue is detected for the first time in the ED setting.[21]

When to screen?

Cognitive screening should be performed routinely on admission to the ED.[17, 22] It has been suggested that cognition is monitored along with other vital signs [23] as a means of encouraging routine screening. Due to the fast pace of the ED and the time constraints in this environment, it is suggested that the tool selected is quick, easy to administer and relevant to the target audience.

Delirium Screening

4. Screening for Cognitive Function and Delirium

Screening for delirium in ED requires a feasible and valid tool that suits the fast-paced ED environment. There are some delirium assessment tools that have been validated in the ED setting.[24, 25]

Van de Meerberg et al suggest that the Confusion Assessment Method (CAM) –Intensive of Care Unit (CAM-ICU) version is a reliable screening tool in the ED, with high sensitivity (i.e. ability to identify those without delirium), specificity (i.e. ability to identify those with delirium), and positive and negative predictive value (i.e. the probability that patients with a positive/negative test truly have delirium/not delirium).[26]

Both the CAM and CAM-ICU are validated instruments for the diagnosis of delirium in a variety of care settings. However, CAM and CAM-ICU both present higher specificity than sensitivity. Therefore, the use of these tools should not replace clinical judgment[27] and should be combined with other formal cognitive screening measures to avoid missing hypoactive, subtle, or atypical cases of delirium.[28] The CAM has also been indicated to detect delirium superimposed on dementia.[29]

The following table gives a comparison of some of the different screening tools.

Delirium Tool	Diagnostic Performance
Delirium Triage Screen [30]	98% sensitive, 55% specific
(Brief) Confusion Assessment Method [30]	78-86% sensitive, 95.8-100% specific
CAM-ICU [30, 31] mCAM-ED [32]	68-72% sensitive, 98.6% specific
Richmond Agitation Sedation Scale (RASS) [33]	82-85% sensitive, 85.1-87.6% specific

Links

The following links provide further information on different screening tools.

<http://www.aci.health.nsw.gov.au/chops/chops-key-principles/undertake-cognitive-screening>

<https://www.fightdementia.org.au/national/about-dementia-and-memory-loss/for-health-professionals/clinical-resources/cognitive-screening-and-assessment>

4. Screening for Cognitive Function and Delirium

4.2 Delirium Triage Screening

The Geriatric ED Guidelines[22] recommend a two-step process for cognitive screening in older ED patients.

STEP 1

Basic Delirium Triage Screen

STEP 2

More detailed screening tool

The use of a screening tool specifically suited to the ED.

4.3 Delirium Screening Process

Early screening ensures that all patients with delirium and those at risk of delirium are identified at an early stage to enable appropriate management which includes the use of preventative strategies.

Patients with one or more of the following risks:

- Age over 65 years and over 45 years in ATSI peoples
- Cognitive impairment
- Severe medical illness
- Current hip fracture[34]
- Undergoing surgery

Hip Fracture

Due to an increased falls risk, coupled with the bone fragility associated with advanced age, hip fracture is common in patients with dementia. It has been estimated that around 42% of patients with hip fracture have a degree of cognitive impairment.[35] It should also be noted that mortality is increased in hip fracture patients who have cognitive impairment.[36]

Hwang's comparative study indicates, compared to cognitively intact patients, that older (≥ 50 y) ED patients with hip fractures and cognitive impairment have a significant likelihood of under-treatment of pain, considerable delays in analgesic administration once pain was identified, and treatment with inappropriate analgesics in the ED.[37]

Who performs screening?

Cognitive screening can be performed by any member of the multidisciplinary team who has been trained in the use of the selected screening tool.[38]

4. Screening for Cognitive Function and Delirium

When to Re-screen?

It is suggested that re-screening for delirium should occur on a regular basis including but not limited to:

- When changes in vital signs occur
- When any new behaviour change is noted
- Prior to discharge from ED
- Prior to transfer to the ward.

How to screen?

- Which tool – become familiar with the tool used in your area
- Utilise the tool
- Score is a trigger for further assessment

How to obtain history?

- Involve carers, family and friends
- Contact patient's GP
- Determine if cognitive impairment is recent
- Use interpreter (if required)
- Identify advance care plan if in place
- Use effective documentation and communication

4.4 Capacity and informed consent

Assumptions should not be made regarding a person's ability to make decisions based on their appearance, disability or behaviour. It should be presumed that all adults have capacity unless you are informed otherwise. If a person has dementia, this may be a trigger for capacity assessment if a decision needs to be made.



Suggested further reading

Access the following document for more detailed information on decision-making capacity and dementia.

<http://capacityaustralia.org.au/wp-content/uploads/2013/10/123626-AUST-CENTRE-OF-CEP-DISABILITIES-QLD-Legal-kit-12pp.pdf>



4.5 Communication trail

Once a patient has been identified as having cognitive impairment it is important that an effective communication trail is followed. If screening takes place this should be documented in the patient chart, even if the screening is negative.

4. Screening for Cognitive Function and Delirium

If the screening is positive, hospital guidelines should be followed as to the next steps to be taken. It is recommended that people with a potential diagnosis of dementia should be offered referral to memory assessment specialists or other appropriate services for comprehensive assessment.[39]



Key Points

- Screening for cognitive impairment is important
- There are different screening tools
- The screening tool selected should be appropriate to the ED environment
- Family/care provided should be present for the initial assessment/triage process if possible.
- Consider the patient's normal cognitive function
- Screening can be carried out by any member of the multidisciplinary team who has been trained in the use of the selected screening tool



Suggested further reading

<https://www.fightdementia.org.au/national/about-dementia-and-memory-loss/information-for-health-professionals/clinical-resources/cognitive-screening-and-assessment>



Objectives

The aim of this topic is to provide information on optimal care of the person with dementia in ED.



Learning outcomes

By the end of this topic, you will have an awareness and understanding of:

- Research recommended interventions
- Risk assessment for patients with cognitive impairment and dementia
- Communication and dementia
- Pain assessment and management
- Medical management of the patient with cognitive impairment and dementia
- Environmental factors that impact on the person with dementia and improvement strategies
- Behavioural and psychological symptoms of dementia

5.1 Research Recommended Interventions

Providing safe, high quality individualised care

Following the principles of patient centred-care it is important to:

1. Individualise patient care
2. Manage medical issues
3. Prevent/manage delirium
4. Prevent/minimise harm from identified risk factors
5. Appropriately responding to behavioural changes
6. Modify environment
7. Document and communicate patient information on transition[17]

Key Points

- Interventions should be evidence based
- Care should be individualised
- Non-pharmacological interventions should be used first
- Care provided should be safe, high quality and individualised

5. Interventions for Dementia Care

5.2 Risk Assessment

Falls

Older people with dementia are at increased risk of falling. Many hospitals have a comprehensive falls risk screening tool. It is suggested that the ED presentation is an opportunity to identify and manage older people at risk of falls.[40] It is recommended that assessment includes intrinsic and extrinsic factors for falls.[22]

Falls Management should include:

- **Screening and assessment**
 - Screening tool used on admission and when indicated
 - Comprehensive risk assessment
- **Prevention strategies**
 - Multi-factorial falls prevention plan
 - Referral to appropriate services
- **Communication**
 - Provide patient education on risks, prevention strategies and management
 - Development of falls prevention plan

Link

See standard 10 NSQHS Standards – Preventing Falls and Harm from Falls

http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard10_Oct_2012_WEB.pdf

Pressure injuries

Older persons have an increased risk of developing pressure ulcers, especially those with advanced age (≥ 80 years). Besides pressure in combination with shear and/or friction, as the major causative factor in pressure ulcer, other contributing factors include advancing age, decreased mobility, decreased sensation, moisture, dementia, low blood pressure, smoking, elevated body temperature, and dehydration.[41] Depending on risk factors, pressure injuries can develop in several hours. There is little evidence of the specific prevalence and incidence of pressure ulcer in older ED populations, however pressure ulcers are common in patients admitted to Australian acute care settings.

According to ACSQHC [17], a standard screening tool should be used to assess all patients and determine those at risk for pressure injuries. When a patient is identified as being at risk, a comprehensive assessment should be performed and repeated regularly.

Pressure injury prevention plans should include:

- implementing skin protection strategies[42]
- considering the nutritional needs of a patient[42]
- consideration of the need for constant low pressure redistribution support surfaces[42]
- regular re-positioning[42]

5. Interventions for Dementia Care

- appropriate input from allied health team members (for example, dieticians for nutritional advice and pharmacists for medicines review, occupation therapists for strategies to assist with activities of daily living)
- patient education

Pressure Injury Management should include:

- **Prevention**
 - Identifying risk factors through use of a screening tool
 - Comprehensive skin inspections
 - Prevention plans
- **Management**
 - Best practice management and ongoing monitoring
- **Communication**
 - Provide patient education on risks, prevention strategies and management
 - Develop a management plan

Link

See Standard 8 NSQHS Standards – Preventing and managing pressure injuries

http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard8_Oct_2012_WEB.pdf

Key Points

- People with dementia have a higher risk of falls and developing pressure injuries
- Management should include screening, preventative strategies and patient education

5.3 Communication

Losing the ability to communicate is one of the most challenging aspects for people with dementia and communication difficulties increase as the disease progresses. Others may have difficulty understanding the person with dementia and the person with dementia may have difficulty in clearly expressing themselves. It is suggested that people with dementia, delirium and communication difficulties are at particular risk of negative experiences of care [43] and that suboptimal communication is associated with adverse events.[44, 45]

5. Interventions for Dementia Care

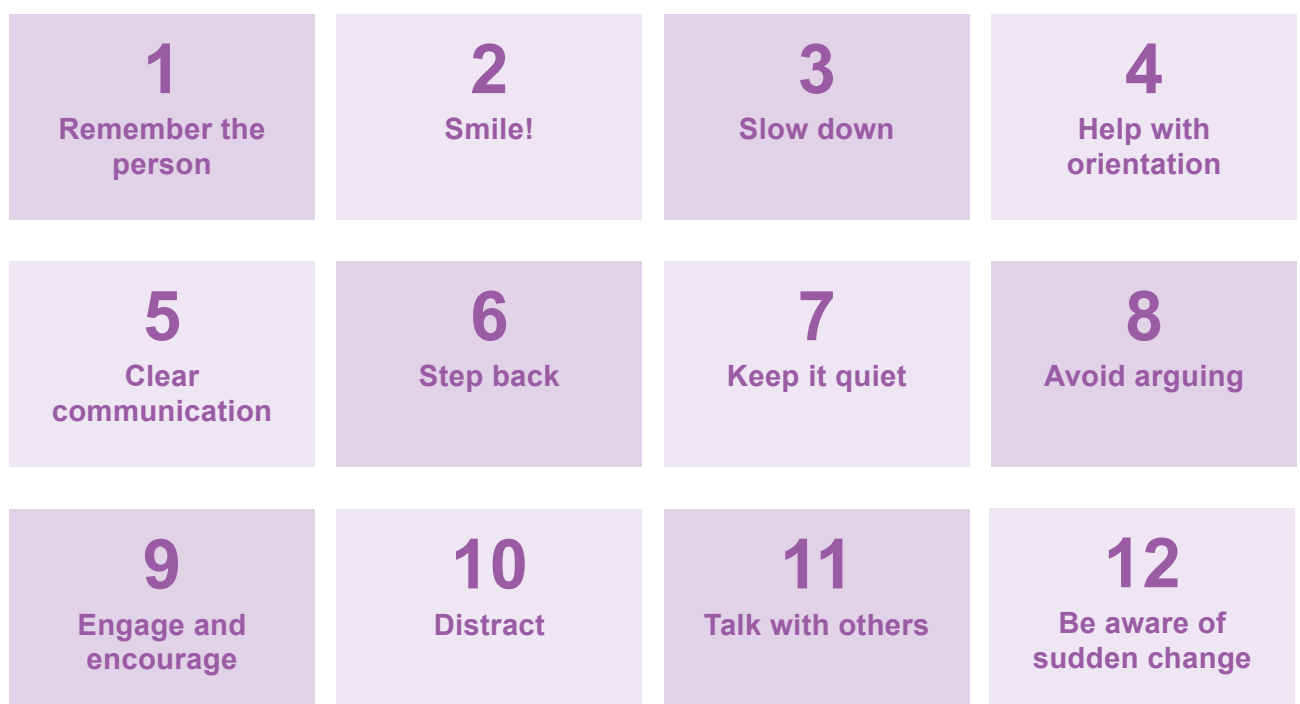
Communication skills training in dementia care has been shown to significantly improve the quality of life and wellbeing of people with dementia and increase positive interactions in various care settings[16]. Training in communication skills with people with dementia is also advocated by Livingston and colleagues[46] who suggest that agitation in dementia can be reduced with effective communication. During communication, it is essential to remember that each person is an individual and will have different communication needs.

The characteristics of the ED environment, such as crowding, noisy waiting rooms, frequent care interruptions, and hurried staff are often far from ideal to enable optimal communication. Hearing and visual impairment in older persons may also prevent effective communication. Behavioural and psychological symptoms of dementia in older persons with cognitive impairment, such as agitation, restlessness, or vocalisation may be the only way to communicate unmet needs.

Within the ED, effective communication with older patients is essential to assess their care needs and to provide tailored quality of care for the individual and their families, including advising, educating, providing psychological support, and exchange of information. Effective communication allows for information sharing. It also allows the healthcare professional to develop an understanding of what is 'normal' behaviour for that patient and may highlight rapid changes in cognition, which can indicate delirium.

12 Top Tips in Working with People with Dementia

The following communication tips have been developed by the Northern Territory Dementia Behaviour Management Service[47] to assist in working with people with dementia.



5. Interventions for Dementia Care

Communication deficits experienced by people with dementia[1]

- Difficulty in finding the right word
- Lack of coherence or logic in speech
- Unable to understand others
- Deterioration in writing and reading skills
- Loss of normal social conventions of conversations; interrupting or ignoring a speaker, or failing to respond when spoken to
- Difficulty expressing emotions appropriately

Skills for effective communication

- Being aware of sensory loss and cognitive impairment
- Adjusting communication to meet differing needs
- Being appropriately assertive
- Using active listening and recognising non-verbal triggers
- Providing feedback
- Minimising conflict and tensions

Communicating with the person with dementia	
<p>Avoid terms such as:</p> <ul style="list-style-type: none">• Demented• Dementia victim• Dementia sufferers <p>Avoid medical and technical jargon</p> <p>Avoid complex instructions</p>	<p>Use short simple sentences</p> <p>Allow the person time to answer</p> <p>Speak slowly and clearly</p> <p>Use appropriate body language and facial expression</p> <p>Reinforce verbal information with visual materials</p> <p>Approach the person calmly, gently and relaxed</p>
[49]	

5. Interventions for Dementia Care

Advanced Health Directives and family involvement are important communication issues in the care for older patients, especially for those with cognitive impairment. Older patients may have advance directives (AD) which states their care wishes regarding resuscitation, invasive procedures and the appointment of an agent or guardian to make decisions about medical treatment on the patient's behalf. There are a lack of studies exploring advanced health directives in emergency departments.[48] However, Taylor et al. identified that only 8% of 403 patients (mean age 73y) admitted to an Australian ED possessed an AD.[49]

5.4 Carer Involvement

Involvement of carers is important to enhance the care for older people while in hospital.[50] Older persons often have a supportive caregiver present during their ED visit who may help with providing health histories and who can psychologically and physically support the older person during their ED visit. They can provide the patient a feeling of continuity and comfort in the challenging ED environment. Families can provide assistance in care (e.g. drinking, eating, walking), which can be very helpful. Carers of older patients should be seen as important members of the health care team because they are the experts on the person's personal care. [51]



Written materials are also suggested to provide the patient and carer with information, support verbal information and aid retention of information.

Key Points

- Communication can be a challenge both for the person with dementia and the person communicating with the person with dementia
- Effective communication skills can improve the flow and accuracy of information
- Carer involvement is important

5.5 Pain Assessment and Management

Pain is prevalent in people with dementia [52] and at least 50% of people with dementia regularly experience pain.[53] It is suggested that that people who have Alzheimer's disease do not have a reduced pain perception and processing. However, due to cognitive deficits, persons with dementia may find difficulty verbalising their pain experience. Persons with dementia may therefore express their discomfort in different ways compared to cognitively intact persons. Altered behaviour, such as agitation, calling out, refusing food, wandering, increased confusion, or diminished socialisation may be the only signs indicating pain. Therefore, recognition of pain in patients with dementia can be difficult, which places the person at increased risk for under treatment of pain.[54]

5. Interventions for Dementia Care

Dementia has been cited as a reason that a lack of pain assessment occurs in the ED.[55] It should also be noted that unresolved pain has been identified as a significant delirium trigger. Pain assessment in patients with cognitive impairment can be challenging for clinicians due to the inability of some patients to accurately verbalise their pain. Particularly in advanced dementia, pain is often expressed through challenging behaviours.

Accurate pain assessment is a prerequisite for adequate pain management and to evaluate the effectiveness of analgesic medication and other pain management strategies. However, standardised pain assessment tools (e.g. verbal pain scale) are unlikely to be effective when used in patients with dementia and additional pain assessment strategies (e.g. observational assessment tools) are required. Literature supports the need for a pain assessment tool applicable to people with dementia, however no tool has been identified to be more reliable and valid than another.[53, 55]

Why is pain not adequately assessed in people with dementia?

- Unreliable pain assessment
- Not involving carers
- Unable to verbalise or express pain in the usual way (consider behaviours)

Many pain assessment instruments for use in people with dementia are based on the recommendations that pain can be expressed via facial expressions, vocalisation and body movements.[22] The tool selected for pain assessment should also identify when a treatment response occurs. To do this, the instrument should be able to assess changes in pain intensity following treatment.[53]



Pain Assessment Tools for People with Dementia

Two of the pain assessment tools that are useful in assessing pain in the person with dementia are identified below.

Abbey pain scale

The Australian Pain Society recommends the Abbey pain scale as a useful tool to assess people with severe cognitive impairment.

http://prc.coh.org/PainNOA/Abbey_Tool.pdf

PAINAD

The Pain Assessment in Advanced Dementia (PAINAD) is another pain assessment tool.

http://www.med.upenn.edu/gec/user_documents/9_pain_assessment-dementia-07.pdf

5. Interventions for Dementia Care



Video

The following video discusses pain assessment using the PAINAD tool for people with dementia in the ED.

https://www.youtube.com/watch?v=c16RjwCF9_I (4:22)

Pain management in the person with dementia

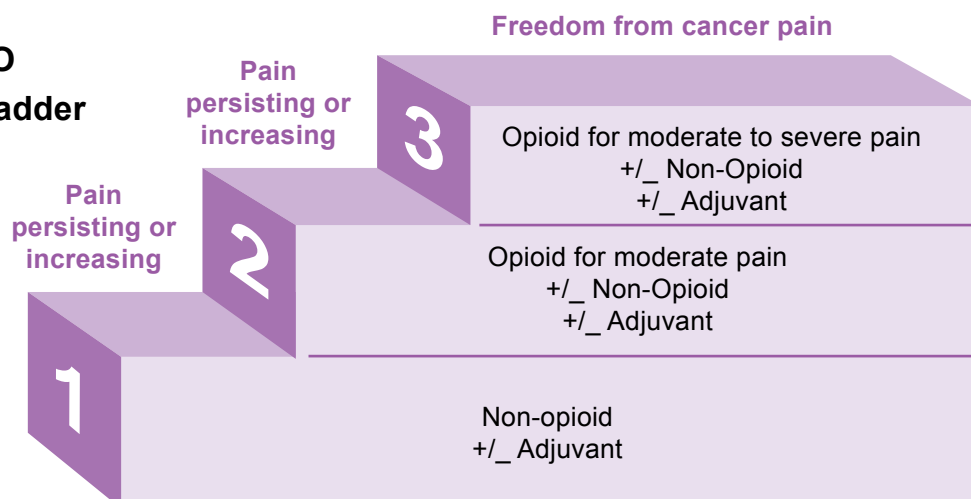
Although research on nonpharmacological pain management for people with dementia is limited, non-pharmacological approaches should not be neglected and have a role before or as an adjunct to pharmacotherapy. Thorough clinical evaluation is likely to highlight opportunities for both pharmacological and non-pharmacological treatments.[56]

Pain treatment in older ED patients with cognitive impairment includes the identification of the type of pain (somatic, visceral or neuropathic pain) and whether the pain is acute or chronic (> 6 months). It is assumed that persons with dementia presenting to EDs are likely to have acute pain. History taking to identify the timing and sequence of pain (which often require the involvement of family or carers) and physical examination to identify the pain cause are important.

Management of pain involves a multi-disciplinary approach which includes three components:

- Physical interventions. For example physiotherapy, such as repositioning or the use of compresses, may be particularly helpful in patients with musculoskeletal pain.
- Psychological interventions. Only helpful when the patients have the mental capacity to utilise these strategies (relaxation therapy).
- Pharmacological interventions. Pharmacological management involves the commencement with the least toxic drug, which has the least side effects, in the lowest possible doses, until pain symptoms are controlled. Pain medication side effects may include confusion, irritability, or behavioural disturbances in patients with dementia. The WHO 3-step Ladder (figure 1) may support the management of pain in people with dementia. There is evidence that regular administration of paracetamol may reduce agitation in patients with dementia experiencing chronic pain.

The WHO 3-step Ladder



5. Interventions for Dementia Care

The following recommendations for pain management in people with dementia are provided by the Australian Pain Society:

- Pharmacological treatments require a diagnosis where possible and co-existing medical conditions must be considered.
- Medications should be tailored to the type of pain and its severity.
- Consideration of age-related changes in drug sensitivity, efficacy, metabolism and side effects is essential.
- A pharmacological approach to pain relief must feature an understanding of the mode of action, common side effects and common drug interactions of medications.
- Symptoms other than pain, such as constipation, insomnia and depression, must be treated.
- Medication dose, administration, monitoring and adjustment must be carefully considered.



Suggested further reading

https://www.fightdementia.org.au/files/helpsheets/Helpsheet-DementiaQandA16-PainAndDementia_english.pdf

Key Points

- People with dementia experience pain
- Poorly managed pain increases the risk of delirium
- Usual pain assessment tools are unreliable in people with dementia
- Alternative pain assessment tools are available

5.6 Medical Management

Medical management of the presenting complaint is similar for the older person with dementia and without dementia. However, the impacts of treatment for clinical conditions will be different for a person with dementia. For example, all patients with a simple distal radius fracture may receive immobilisation treatment with a cast. For all patients this will pose challenges in some ADLs. However, for a person with cognitive impairment these impacts may be greater. For example, they may have difficulty in effectively recruiting help from others as they may be unable to readily ask for assistance or make adaptations so that they can perform everyday tasks such as eating, food preparation and getting dressed.



Reflective question

How do you think tethering interventions such as insertion of an IDC or IVC, impact upon the older person with dementia?

5. Interventions for Dementia Care

Atypical Presentations

Atypical presentations are more common in older patients with a prevalence of around one third of older adults in the ED having an atypical presentation.[57] Atypical presentations include:

- Lack of pain (e.g. in acute coronary syndrome)[58]
- Lack of fever (e.g. with infection)[59]
- An acute change in behaviour or functional ability
- Urinary incontinence as a predictor of nosocomial blood stream infections[59]

Key Points

- Medical management is often the same but the impact of treatments may be more significant
- Medical issues should be addressed early

5.7 Environmental factors

Many EDs are not supportive environments for people with cognitive impairment and are busy, noisy, and often confusing. An optimal environment has shown to be effective in reducing behavioural and psychological symptoms of dementia.[60] Dementia friendly environments are those which have been modified or purposefully designed to consider the needs of people with dementia.

Although large scale environmental changes are not always possible, there are a number of simple and inexpensive adaptations that have been shown to be positive for the person with dementia in reducing delirium and reducing iatrogenic complications.[61]

It is suggested that supportive care environments for older people with confusion should:

- Promote safety
- Promote meaningful interactions
- Promote well being
- Encourage eating and drinking
- Promote mobility
- Promote continence
- Promote independence
- Promote orientation
- Promote calmness and security[62]

Environmental interventions that are supportive of the person with dementia include maintenance of privacy and promote effective communication.[63] Strategies to orientate the older person with confusion include clear signage, using identifying colours or images to indicate, for example, a toilet.[5]

5. Interventions for Dementia Care



Orientation clocks and calendars can aid temporal orientation.



Prominent colour contrast can be used to foreground objects and add clarity to the environment.



Consider the typical ED cubicle – cluttered, noisy, lack of privacy



An adapted ED cubicle – less cluttered with a reduced amount of medical equipment, reduced noise, more private and access to natural light.

(Photo source: Princess Alexander Hospital, with thanks to E. Burkett)

Suggested environmental adaptations for people with dementia [64]

- Lighting appropriate to time of day
- Provide a clock and calendar for orientation
- Encourage carer/family visits
- Avoid room changes
- Minimise under- and overstimulation in environment – noise / visual
- Provide single room
- Fixed walls

5. Interventions for Dementia Care



Reflective question

How can these be addressed in your ED environment?

Promote meaningful interactions	
Promote well being	
Encourage eating and drinking	
Promote mobility	
Promote continence and independence	
Promote orientation	
Promote calmness and security	

Key Points

- The traditional ED environment is not a supportive place for people with dementia
- Simple and inexpensive environmental changes can have a positive impact on the person with dementia

5.8 Behavioural and Psychological Symptoms of Dementia

Behavioural and psychological symptoms of dementia (BPSD) are defined as:

1. problems in the psychological domain, such as psychosis, depression, anxiety, apathy, euphoria
2. issues in the behavioural domain, including eating and sleep disturbances, agitation, cursing, aggression, restlessness, abnormal vocalisation, wandering, overactivity, apathy, and sexual disinhibition [65] Treatment of BPSD should initially include the exclusion of delirium, which can result in BPSD, as the cause of altered behaviour. Then staff should identify any unmet needs by carry out an extensive history, which should include information obtained from direct carers, and physical examination. Personal, environmental and biologic factors should be considered as a cause of the behavioural concerns.

5. Interventions for Dementia Care

Considerations for the ED

- Consider underlying physical conditions e.g. pain, wanting to use the bathroom.
- Avoid physical restraints[66] and catheterisation[67, 68] as these limit mobility which is an associated risk factor of delirium.
- Provide access to and offer food and fluid regularly.[69]
- If possible, provide activities for cognitive engagement.

Managing BPSD

Approaches that best meet unmet physiological and emotional needs should be chosen. Remember that monitoring and evaluation the impact of the intervention is an integral part of the process.

Activity boxes are one method of providing cognitive stimulation and may be effective in managing BPSD in the ED.



Restraint

There is no significant evidence that the use of physical restraints prevent injuries (resulting from falls) in cognitively impaired people. If used, physical restraints should be removed as soon as practical. An institutional policy regarding physical restraints use should be accessible and adhered to.[66]



It is also essential to recognise that, to a person with dementia or delirium, indwelling catheters, intravenous lines and monitoring leads can act as a form of restraint, limiting movement and restricting mobilisation. Bed rails should also be considered a form of restraint.

Key Points

- BPSD can have physiological or emotional causes
- Restraints do not work to manage BPSD
- Monitor and evaluate any interventions



Suggested further reading

Read 'Non-pharmacological Treatment Options'

<https://www.fightdementia.org.au/about-dementia/health-professionals/clinical-resources/non-pharmacological-treatments>

Read 'Managing changes in communication'

<https://www.fightdementia.org.au/national/support-and-services/carers/managing-changes-in-communication>

Read 'Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A Handbook for NSW Health Clinicians.'

https://www.ranzcp.org/Files/Publications/A-Handbook-for-NSW-Health-Clinicians-BPSD_June13_W.aspx

Website

The following website provides further information on dementia enabling environments:

<http://www.enablingenvironments.com.au/>

Objectives

The aim of this topic is to explore pharmacological intervention in people with dementia. This includes commonly used medications for the treatment of dementia, high risk medications, and medication management and monitoring.

Learning outcomes

By the end of this topic, you will have an awareness and understanding of the following:

- Commonly used medications in dementia
- High risk medications for people with dementia
- Medication management and monitoring



6.1 Common medications used for dementia

Anticholinesterases for Alzheimer's Dementia

- Donepezil
- Galantamine
- Rivastigmine

The acetylcholinesterase inhibitors (donepezil, galantamine or rivastigmine) are recommended as options for managing the symptoms of mild to moderately severe Alzheimer's disease.

Acetylcholine is an important neurotransmitter for memory. People with Alzheimer's disease have low levels of acetylcholine in their brain. Acetylcholine is broken down by enzymes called cholinesterases. Cholinesterase inhibitor drugs inhibit enzymes from breaking down acetylcholine resulting in higher levels of acetylcholine leading to increased communication between neurones.



Suggested further reading

https://www.fightdementia.org.au/files/helpsheets/Helpsheet-DementiaQandA01-CholinesteraseInhibitors_english.pdf

Other medications for Alzheimer's Dementia

- Memantine

Memantine is a neurotransmitter and belongs to a group of medicines called N-methyl-D-aspartate (NMDA) receptor antagonists. In people with Alzheimer's Disease, glutamate is present in higher

6. Pharmacological Interventions

levels. When too much glutamate is present it sticks to neuroreceptors, allowing too much calcium to move into the brain cells causing damage. Memantine blocks glutamate, and this prevents too much calcium from moving into the brain cells.

Memantine is used to alleviate symptoms for people with moderate-to-severe Alzheimer's disease who are intolerant of or have a contraindication to acetylcholinesterase inhibitors. Potential adverse effects include: nausea, vomiting, diarrhoea, dizziness, increased urinary incontinence and frequency, falls, muscle cramps, weight loss, anorexia, headache and insomnia. Heart block is a rare adverse event. Review and consideration of de-prescribing is recommended at regular intervals. [38]



Suggested further reading

https://www.fightdementia.org.au/files/helpsheets/Helpsheet-DementiaQandA03-Memantine_english.pdf

Behavioural and psychological symptoms of dementia and medications

If non-pharmacological strategies are ineffective and medications are necessary for the control of violence, aggression and extreme agitation in people with dementia, oral medication should be offered before parenteral medication. In some rare situations, parenteral medication may be required for the management of people with dementia with extreme behavioural and psychological symptoms. Because circumstances vary from setting to setting, local evidence-based guidelines should be developed to provide clinicians guidance about the appropriate use of parenteral medication in these situations. [38]

6.2 High Risk Medications

Older people are at high risk for adverse events associated with medication.[70] The older population tends to have more co-morbidities, take more medications and have differing responses to those medications. Normal aging progresses also affect the pharmacokinetics and pharmacodynamics of a drug, which tend to increase sensitivity to medications.[71]

The Beers Criteria for Potentially Inappropriate Medication (PIM) Use in Older Adults[72] was developed to improve the effectiveness and safety of prescription practices for geriatric patients. For those patients presenting to the ED, consideration should be given both to existing medications and to those prescribed while in the ED. It is suggested that all older patients presenting to the ED have an accurate medication list created as soon and possible.[22] Involving the GP and carers will improve accuracy and a multi- disciplinary team, including the pharmacist, approach is recommended.

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The medication list should be screened for the following: [72]

- **Polypharmacy**
- **High-risk medications** - Consider Beers criteria or list developed in consultation with the hospital pharmacy which should at least include:
 - Anticoagulants and antiplatelet medications
 - Anticholinergics
 - Hypoglycaemic agents
 - Cardiovascular medications including digoxin, amiodarone and vasodilators
 - Non-steroidal anti-inflammatory drugs
 - Opioids
 - Antipsychotics, benzodiazepines and some antidepressants
 - Immunosuppressant medications, including chemotherapy agents and corticosteroids

6.3 Polypharmacy

A particular challenge in this population is the issue of polypharmacy, which is the use of multiple medications. There is a lack of consensus on the definition of polypharmacy[73], but it is often defined as > 5 regular medications. Polypharmacy is associated with negative health outcomes such as falls, confusion and functional decline.

Steps to manage polypharmacy [74]

1. **Prevention** – Avoid prescription of medications for minor complaints. Only prescribe when there is a strong need for the medication and good evidence of efficacy.
2. **Review** - Review medications regularly. ED presentation is an ideal opportunity to review medications. An accurate drug history is required. Review should include appropriateness of medications, ongoing need, adverse reactions and interactions.
3. **Non-pharmacological approaches** – Use lifestyle measures where possible.
4. **Communication** – Discuss with patients their concerns about medications, adverse effects, ability to follow the regime.
5. **Simplify** – Reduce regime to essential drugs only. Consider fewest dosage intervals and dose reduction where appropriate.



6. Pharmacological Interventions

6.4 Pharmacological Treatment of Delirium

Some medications have been shown to be effective in the treatment of delirium and are outlined in the table below.[67] However, pharmacological interventions are only to be considered as a last resort (if the patient's behaviour is so extreme as to be a potential source of harm). Commencing antipsychotic medications should be in small doses and for short periods of time. Antipsychotic medications are not recommended for long-term treatment.

Pharmacologic Treatment of Delirium			
Class and Drug	Dose	Adverse Effects	Comments
Antipsychotic Haloperidol	0.5-1.0 mg twice daily orally, with additional doses every 4 hr as needed (peak effect 4-6 hr) 0.5-1.0 mg intramuscularly; observe after 30-60 min and repeat if needed (peak effect, 20-40 min)	- Extrapyramidal symptoms, especially if dose is >3mg per day - Prolonged corrected QT interval on ECG	- Usually agent of choice - Effectiveness demonstrated in RCTs - Avoid intravenous use because of short duration of action
Atypical Antipsychotic Risperidone Olanzapine Quetiapine	0.5 mg twice daily 2.5-5.0 mg once daily 25 mg twice daily	- Extrapyramidal effects equivalent to or slightly less than those with haloperidol - Prolonged corrected QT interval on ECG - Avoid in patients with withdrawal syndrome, hepatic insufficiency, neuroleptic malignant syndrome	- Tested only in small uncontrolled studies - Associated with increase mortality rate among older patients with dementia
Benzodiazepine Lorazepam	0.5-1.0 mg orally, with additional doses every 4 hr as needed*	- Paradoxical excitation, respiratory depression, oversedation	- Second-line agent - Associated with prolongation and worsening of delirium symptoms demonstrated in clinical trial - Reserve for patients undergoing sedative and alcohol withdrawal, those with Parkinson's disease, and those with neuroleptic malignant syndrome
Antidepressant Trazadone	25-150 mg orally at bedtime	Oversedation	Tested only in uncontrolled studies

* Intravenous use of lorazepam should be reserved for emergencies.

(Source: Inouye, 2006)

6. Pharmacological Interventions

Key Points

- Older patients presenting to the ED should have an accurate medication list compiled.
- Medication lists should be screened in the ED and referred to the pharmacist if there are polypharmacy or high risk medication concerns.



Suggested further reading

Read 'Pharmacological Treatment Options'

<https://www.fightdementia.org.au/about-dementia/health-professionals/clinical-resources/pharmacological-treatment>

Read 'Drug treatments and dementia'

<https://www.fightdementia.org.au/national/about-dementia/how-is-dementia-treated/drug-treatments-and-dementia>

Additional Resources

The following resource is aimed at the pharmacist and their role in supporting people with dementia but is a useful source for all health professionals working with people with dementia.

<http://detectearlyqa.w6digital.com.au/wp-content/uploads/2014/08/Dementia-the-pharmacists-role-Alzheimers-Australia-CPD-Article.pdf>

The following resource provides further information for people with dementia and their carers.

http://www.nps.org.au/__data/assets/pdf_file/0020/316541/NPSMW-medicines-and-dementia-booklet-2016.pdf



Objectives

This aim of this topic is to explore some of the psychosocial aspects of dementia and how psychosocial needs can be assessed in ED.



Learning outcomes

By the end of this topic, you will have an awareness and understanding of the following:

- The psychosocial aspects of dementia
- Assessing psychosocial needs
- Addressing psychosocial needs in ED and beyond

7.1 Assessing psychosocial needs

Psychosocial aspects of dementia include:

- Coming to terms with a dementia diagnosis
- Maintaining physical independence
- Maintaining a social life and relationships
- Reducing stress and improving mood
- Maintaining quality of life, health and happiness
- Support for carers

Assessing psychosocial needs can be done in history taking. The patient themselves may be able to provide information but the carer of the person with dementia will often be able to provide far more detail on the person's usual psychosocial status.

Questions to ask:

- What is the person's usual mood/emotional state?
- What makes the person happy/calm?
- What makes the person upset/display signs of BPSD?
- What is the person's physical ability?
- What is their level of independence? Do they live alone? With a carer? In residential care?
- Does the carer require support?
- What support services are used/in place?
- Are further support services required?
- What can the staff in the ED do to provide the best care for the person?

7. Psychosocial Needs of People with Dementia

7.2 Addressing psychosocial needs

Many interventions used to address psychosocial needs for people with dementia are more applicable to the community setting rather than the ED. Some of these strategies include:

- Cognitive retraining and cognitive rehabilitation
- Animal assistive therapy
- Play therapy
- Drama therapy/storytelling
- Creative art therapy
- Music therapy
- Support groups

Although the setting of the ED may not be the appropriate place to incorporate such interventions, it is useful to be aware of what (if any) interventions are already in place for the person with dementia in the community. This information can then be integrated into their care. For example, a patient who receives animal assisted therapy could be asked about the animal/pet that visits them, this may in turn stimulate conversation.



T Talk to the Carer

O Obtain the information

P Personalise the care

5 5 strategies developed

It is also useful to be aware of some of these strategies and share information that may assist the patient, with their carer.

The TOP 5 is a concept conceived and implemented in NSW and is an approach to engage with carers to gain information that personalises care.[75]

Some specific strategies and interventions that are applicable to the ED environment include:

- Assistive technology (e.g. telecare, digital scrapbook, immersive space, intelligent lighting)
- Meal positioning
- Therapeutic use of touch
- Occupational-based therapies
- Involving support person/s
- Music therapy





Suggested further reading

Read the following document from the British Psychological Society

[https://www.bps.org.uk/system/files/user-files/DCP%20Faculty%20for%20the%20Psychology%20of%20Older%20People%20\(FPoP\)/public/a_guide_to_psychosocial_interventions_in_dementia.pdf](https://www.bps.org.uk/system/files/user-files/DCP%20Faculty%20for%20the%20Psychology%20of%20Older%20People%20(FPoP)/public/a_guide_to_psychosocial_interventions_in_dementia.pdf)

The myagedcare website is an excellent resource and provides information on services to assist older people.

<https://www.myagedcare.gov.au/personal-stories/costa>

Read 'Assistive Technology'

<https://nt.fightdementia.org.au/nt/about-dementia-and-memory-loss/resources/resources-nt/assistive-technology>

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