Dementia & Delirium: Behaviours, Symptoms & Integrated Person-Centred Care.

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What is Dementia & Delirium:

Behaviours, Symptoms & Integrated Person-Centred Care?

This is the name given to a teaching package incorporating Behavioural & Psychological Symptoms in Dementia (BPSD) and Stop Delirium! interventions for older people.

This is an enhanced educational package delivered to care home staff, which aims to improve the care of older people who are either experiencing or are at risk of delirium.

Your home has agreed to take part in the teaching and education sessions which will be starting soon!

How would you like to:

- Look after your residents as well as you can?
- Gain more job satisfaction?
- Help stop residents from getting more confused, distressed and presenting with difficult to manage behaviour?
- Feel more confident in your role?

What do I have to do?

- Take part in three informal one-hour education sessions.
- Use your new knowledge in your daily work.
- If you enjoy the sessions, and want to get really involved, volunteer to join a ‘working group’ or become your home’s Dementia & Delirium Champion?

Further Reading

Dementia

is a progressive, irreversible impairment of brain functioning.

- It is characterised by:
  - memory loss,
  - loss of social and occupational functioning,
  - impaired thinking,
  - speech deficits,
  - personality changes, and
  - behavioural and psychological disturbances

- It is not a normal part of aging.
- Can present major physical and emotional challenges for patients, families, and other caregivers.

Common Types of Dementia:

1. Alzheimer’s dementia
   The most common form of dementia, progresses slowly over time, affects short-term memory & language skills

2. Vascular dementia
   Related to stroke disease & TIAs, can produce marked 'step-wise' drops in function, affecting physical abilities

3. Mixed dementia
   A combination of Alzheimer’s & Vascular dementia

4. Fronto temporal dementia
   A rarer form of dementia, often with a marked effect on language skills, motivation and personality

5. Lewy-Body dementia
   Characterised by visual hallucinations, irrational beliefs, tremor and sleep disturbance.

6. Parkinson’s dementia
   Develops in advanced stages of Parkinson’s disease, similar presentation to Alzheimer’s type.

Behavioural & Psychological Symptoms of Dementia (BPSD)

BPSD are caused by a combination of:

1. the dementia condition,
2. the personality of the person with dementia
3. people’s reactions to the person with dementia.

- 2/3rds of people with dementia experience some BPSD at some stage of their condition,
- In 1/3rd of people with dementia living at home, BPSD will significantly affect their quality of life or that of their family.
- 80% of people with dementia living in care homes will experience BPSD
- Brain function in dementia usually worsens steadily over time, but BPSD tends to fluctuate, with restless agitation being the most persistent
- Treatment of BPSD can alleviate patient suffering and promote caregiver well-being
- Recognition of BPSD is the first and most important step in devising a management plan

The behaviour, the context, frequency, severity and impact on the patient and caregiver need to be assessed so that a targeted plan of action can be drawn up, likely to involve environmental, social, physical and/or medication changes.
Symptoms of BPSD

- Depression - Sadness, tearfulness, hopelessness, low self-esteem, anxiety, guilt
- Apathy - Social withdrawal, unable to feel happy
- Aggression - Physical resistance to care, physical or verbal aggression (often accompanies delusions)
- Restless/Agitation - Aimless walking, pacing, shadowing, restlessness, repetitive actions, inappropriate dressing/undressing, sleep disturbance.
- Psychosis – this includes any one or all of the following:
  - Delusions: that others are stealing, misidentification (patient no longer recognizes home or spouse/family), irrational sense of abandonment or sexual infidelity.
  - Hallucinations: less common than delusions in patients with Alzheimer's. Visual hallucinations are more common than other forms of hallucination, particularly in Lewy body dementia. Hallucinations are not necessarily disturbing and may not need treatment if the patient is not distressed.
  - Distress: Disturbances of mood, anxiety, behaviour (agitation, aggression, apathy, disinhibition, irritability, sleep wake cycle, unexpected changes in eating habits)

Causes of BPSD

The reasons why people with dementia develop behavioral or psychological symptoms are often complex and may be related to:

- the person's physical health
- depression
- possible undetected pain or discomfort
- side effects of medication
- personal history, religion, beliefs, spiritual and cultural identity
- relationships with other residents / family / care staff
- their physical environment patterns of behaviour i.e. triggers, timing, situation

Managing BPSD

- Identify any relevant environmental, psychological, or physical factors that might be causing or contributing to symptoms.
- Non-medication strategies should be explored before treatments are considered
- Look for patterns that often give clues: what precipitates, what improves
- See things as the person with dementia sees them: agitation may perfectly reasonable if you felt that you were being given drugs by people you don’t recognise, know or understand
- No one treatment is effective for all causes of BPSD
- BPSD symptoms often have a combination of causes, so will need a range of interventions to address them.
Psychological Approaches to BPSD

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<td><strong>Prompting rather than “doing-for”</strong></td>
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Non-Medication Management

- Look for any potentially reversible causes of distressed or agitated behaviours i.e.
  - emotional or physical pain,
  - medication side-effects,
  - withdrawal (e.g. from nicotine or alcohol)
  - infection

- Move the patient to a safer or well-observed area.
- Restrict access to means of harm (e.g., stairwells, sharp objects)
- Involve family members (familiar faces) in care and consultation
- Use of restraints only as a last resort and with great caution
- Non-medical interventions should be continued even if medications are prescribed for BPSD.
- The behaviour(s) should then be monitored both before and following medication initiation for at least two weeks to regularly review for impact and possible side-effects.
- Although medication may be necessary in some circumstances, it should only be considered if the patient is not responding to appropriate, sustained, person-centred social and occupational interventions.
Medical Treatment

Medication considered only when other approaches have limited success:

- Cholinesterase inhibitors (anti-dementia treatment)
- Benzodiazepines (relaxants)
- Anti-depressants
- Antipsychotics (for hallucinations / delusions)
- Mood stabilisers (for over / under-activity)
- Beta blockers (alternative anxiety treatment)

In general these medications should not be continued indefinitely and attempts at stopping these treatments should be made regularly.

Patients must be closely monitored for symptom relapse following medication discontinuation

Medications are generally not effective for behaviours such as:

- Wandering
- Unsociability
- Poor self-care
- Restlessness
- Nervousness
- Fidgeting
- Hoarding
- Sexual disinhibition
- Sun downing
- Shadowing
- Impaired memory
- Uncooperativeness without aggressive behaviour
- Inattention or indifference to surroundings
- Verbal expressions or swearing that does not pose a danger to the patient or others
UNDERSTANDING THE RESIDENT’S EXPERIENCE

Behaviour that challenges us or concerns us often happens as a result of an unmet need. It can occur:

1 - To meet a need
   eg: a resident may throw away things because they are bored and want a diversion.

2 – To communicate a need
   eg: crying because they need the toilet but don’t know where it is.

3 – As a result of frustration when a need is not met
   eg: a resident believes they need to return to home but are not allowed to leave the care home.

People may display the same behaviour but have different unmet needs. It is tempting to jump to possible solutions but we can generally understand the unmet need better if we know more about the person.

The model on this page provides us with a framework for understanding the needs of a care home residents needs and helps to remind us of areas we may have overlooked. Ideally it is best to speak with family and friends of the resident to gather as much information about the resident as possible.

The Newcastle Model framework (James, 2011)
It is often helpful to complete an ABC chart to identify triggers of a resident’s behaviour.

**Antecedent**  (what happened—or didn’t happen before the behaviour occurred)

**Behaviour**  (what behaviour exactly did the resident do)

**Consequence**  (what happened as a result of the behaviour)

Keeping a record of this information can help to spot a pattern of what might be triggering and reinforcing the resident’s behaviour. The findings can help us understand and so plan effectively how to manage this behaviour.

**Testing out interventions**

Once we have all the information we are more able to identify an idea about what is causing the behaviour. Causes are often linked to unmet needs. Once we have identified what is the most likely cause, the most suitable way to address the behaviour can be agreed and implemented.

So that we know the intervention has been effective, we need to keep a record of the frequency of the behaviour both before and after the intervention has been tested. If the behaviour reduces, you have found your cause and solution. If the behaviour continues you may need to change your intervention. Sometimes it can take a few attempts to identify the underlying need and the way of meeting this.

**Benefits of this approach**

This approach is more time consuming than just trying the first possible solution you think of. However this approach does have a number of benefits.

1. You will find out a lot more about your resident which will help you in the everyday care and support you provide for them.

2. The interventions you decide upon are more likely to be effective if they are tailored to the resident. This means the resident’s needs are more likely to be met sooner.

**Summary**

In order to identify a potential solution for a resident’s behaviour we should first try to understand the reasons why a resident is behaving that way. Collating information about all relevant areas of a resident’s life helps us to identify the possible causes of their behaviour and makes it easier for us to meet any unmet needs.

The template is a useful guide to remember the various reasons that may be contributing to a resident’s behaviour and can be a helpful starting point in providing a person centred response.
**Delirium**

Delirium is more commonly known as Acute Confusion, and is a sign that something is wrong.

- It is a **sudden** change in a person’s mental state over a few hours or days, and tends to **fluctuate** during the day – people may be confused at some times and seem their normal selves at other times.
- People with delirium typically have difficulty paying **attention** to what is going on around them.
- Thinking seems **more disorganised** than usual.
- People are more **agitated** OR more **sleepy** than usual.

**Delirium can last for weeks and even months in older people.**

**The Importance of Delirium**

- It is a sign that they may be physically unwell
- It is stressful for the person, their visitors and staff caring for them
- Delirium is often mistaken for worsening dementia, or just old age
- Delirium can cause LOTS of problems:
  - A person with delirium is more likely to go into hospital and stay there longer
  - May lose some of their abilities
  - Has an increased chance of dying!

**Causes**

Delirium can be caused by many things, including:

- Pain
- Infection (UTI, pneumonia, infected pressure sore)
- Constipation
- Dehydration
- Reaction to medication
- Withdrawal (from prescribed drugs if stopped too quickly)

**In older people there are often several causes of delirium.**

**Risk Factors**

There are several things that can mean a person is more at risk of becoming delirious:

- Dementia – *people with dementia are five times more likely of having delirium.*
- Poor vision or hearing problems
- Disorientation
- Dehydration
- Constipation
- Poor nutrition
- Urine catheters (increased risk of infection)
- Illness
- Immobility
- Falls
- Poly-pharmacy
Recognising Delirium

- Have you noticed a **sudden** change in the person?
- **Do they seem more confused than usual over the last few hours or days?**
- Does the confusion **fluctuate** during the day – sometime the person seems very confused but other times not too bad?
- **Are they more confused at night?**
- Do they seem to have more difficulty than usual focusing **attention?**
- **Do they find it hard to follow a conversation or are they easily distracted?**
- Do they seem to be rambling or jumping from one topic to another?
- **Does their thinking seem more disorganised than usual?**
- Does the person seem more **agitated** OR more **sleepy** than usual?

**If the answer to any of these questions is **YES**, you should think of delirium.**

Other symptoms may include memory problems, disorientation, hallucinations, delusions and changing sleep patterns. If a resident seems to have changed suddenly but you are unsure why, it is safest to assume delirium and check for a physical cause.

### Delirium, Dementia & Depression

Delirium can be difficult to tell apart from other common problems in older people – dementia and depression. It can be especially tricky if someone has delirium as well as having dementia or depression, but this is VERY common. In fact someone with dementia is **five times** more likely to develop delirium than someone who hasn’t got dementia. This table gives some useful pointers for telling them apart.

<table>
<thead>
<tr>
<th></th>
<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Sudden (hours/days)</td>
<td>Usually Gradual (months)</td>
<td>Gradual (weeks/months)</td>
</tr>
<tr>
<td><strong>Alertness</strong></td>
<td>Fluctuates Sleepy/agitated</td>
<td>Generally Normal</td>
<td>Generally Normal</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td>Fluctuates difficulty</td>
<td>Generally normal</td>
<td>May have difficulty</td>
</tr>
<tr>
<td></td>
<td>concentrating, easily</td>
<td></td>
<td>concentrating, distractible</td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
<td>Change in sleeping</td>
<td>Can be disturbed /</td>
<td>Early morning</td>
</tr>
<tr>
<td></td>
<td>pattern (often more</td>
<td>night time wandering and</td>
<td>wakening</td>
</tr>
<tr>
<td></td>
<td>confused at night)</td>
<td>confusion possible</td>
<td></td>
</tr>
<tr>
<td><strong>Thinking</strong></td>
<td>Disorganised - jumping from</td>
<td>Abstract thought problems,</td>
<td>Slower, preoccupied with</td>
</tr>
<tr>
<td></td>
<td>one idea to another</td>
<td>poor judgement, sometimes</td>
<td>negative thoughts e.g.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>problems word finding</td>
<td>hopelessness/helplessness/self-</td>
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<td></td>
<td></td>
<td></td>
<td>depreciation</td>
</tr>
<tr>
<td><strong>Perception</strong></td>
<td>Illusions, delusions and</td>
<td>Generally normal</td>
<td>Generally normal</td>
</tr>
<tr>
<td></td>
<td>hallucinations common.</td>
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Management of Delirium

Look for the cause and treat it

Infection
- Test the residents urine with a dip stick for signs of infection
- Reduce the risk of problems caused by medication
- Make sure that prescriptions are reviewed regularly by the GP, practice nurse or pharmacist
- Has the resident got any infect pressure sours
- Do they have signs of chest infection

Medication
- Has any new medication been started recently?
- Have any medication stopped suddenly? (refusing medication)
- Sometimes if a person becomes unwell medication may have been on for a long time may cause problems

Constipation
- Encourage the residents to drink more fluids
- Make sure their diet contains enough fibre and fruit
- Think about using a laxative if needed
- Encourage the resident to mobilise

Dehydration
- Encourage the resident to drink more fluids throughout the day (at least eight glasses)

Pain
- Is the resident in pain
- Is the current pain management adequate and appropriate?

Identifying and treating the cause of confusion is the most important thing you can do to manage delirium; but several other things may be useful...

Managing behaviour

- If a person is agitated talk to the resident in a calm manner and avoid being confrontational
- Try to find out the reason why the resident is behaving oddly e.g. they may need the toilet, be thirsty, or be in pain
- If a person is being uncooperative stop and think; could what you are doing wait until the person is more settled?
- Try distracting the resident to discourage unwanted behaviours – e.g. if someone is going into other residents rooms and going through their clothes give them a box of clothes to sort through

If a person is rambling, hallucinating or seems to have strange beliefs you could:

- Focus on the emotion in what the resident is saying rather than content (e.g. “I feel frightened of soldiers coming” “you feel frightened?”)
- Tactfully disagree if the topic is not too sensitive
- Change the subject
- Remove things that could be misinterpreted (e.g. pile of clothes that the person may think is a cat)

Medication could be considered as a way of managing behaviour as a last resort if other measures do not contain the behaviours. However medication needs to be used carefully as it could worsen confusion or over sedate the resident and increase the risk of falls or cause other side effects.

Usually ONE-TO-ONE care is more helpful.
Offer explanation/reassurance
- Speak calmly to the resident avoid being confrontational
- Introduce yourself to the resident and explain what you are going to do
- Give clear simple instructions one at a time to avoid frustration and over stimulation explain that they seem more confused because they are unwell at the moment
- Encourage visits from relatives and friends, it can be helpful to have familiar people around

Help with reorientation
- Make sure they person wears glasses if needed and that the glasses are clean
- If the resident uses a hearing aid make sure they wear it and that it is clean, turned on and working properly.
- Provide clocks, calendars and orientation boards
- Make sure they are positioned so they can be easily be seen and show the correct time, date and information
- Remind the person of wear they are

Environmental stimulation
- Prevent over stimulation by making sure the area the residents is sitting on it not too hectic and make sure there are not too many people around
- Prevent boredom and feeling of isolation
- Ensure the environment is not under stimulating, leaving the person with absolutely no distraction may make them more withdrawn
- Make sure the lighting is adequate

Encourage a good sleep routine
- Discourage day time napping
- Avoid caffeinated drinks after teatime
- Offer warm non caffeinated drink at bed time (milk or herbal tea)
- Provide a relaxing environment and a regular bed time routine

Make sure they have enough to eat and drink
- A resident who has delirium may need extra help to eat and drink enough, or small portions of food to tempt them to eat.

Reduce the risk of problems caused by medication
- Make sure that prescriptions are reviewed regularly by the GP, practice nurse or pharmacist.
- Ensure any adverse reactions observed are recorded and reported to the appropriate Health Care Professional.

Look out for increased risk of falls
- A confused person may wander more, or be more unsteady on their feet, especially if the resident has been given sedating medication.

Toileting
- When a person is confused, they may have trouble recognising that they need to use the toilet or may not be able to tell anyone in time.
- It may help to encourage them to use the toilet every 2-3 hrs.
After the Confusion ….

- Give the person a chance to talk about their experience if they want to. Many people who have had delirium worry that it may be a sign that they are going mad or getting dementia.

- Explaining the reasons for their confusion can help them to understand their experiences better and reduce their worries.

- Talking with a resident afterwards about their confusion can be helpful for staff too, especially if the person behaved in ways that were unusual for them.

- Relatives and friends of the resident may need information to help them understand what happened to their loved one, and may also be in need of reassurance and support afterwards.