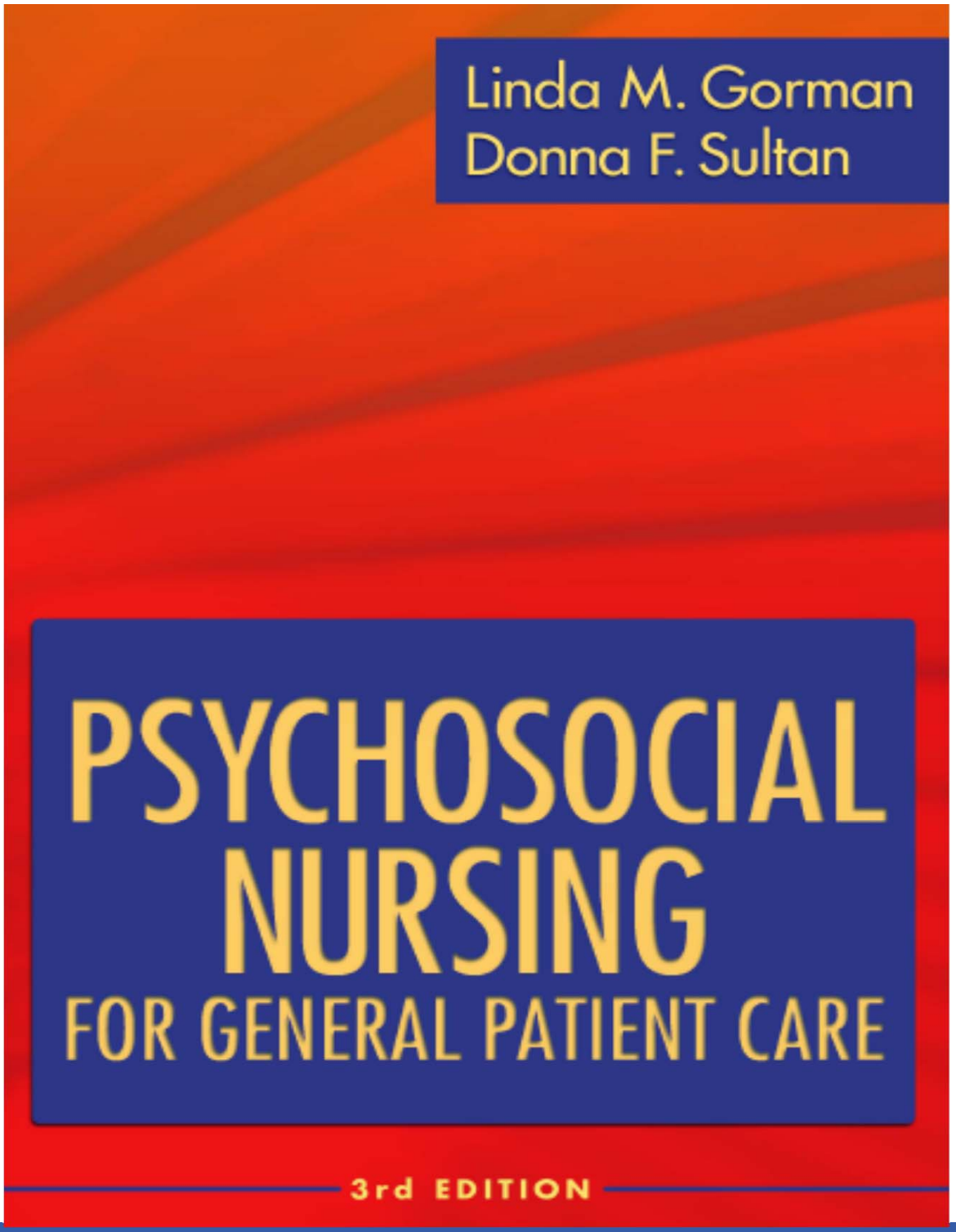

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8

Commonly Encountered Problems: Confusion

The Confused Patient

Learning Objectives

After the classroom discussion, the students will be able to:

1. **Differentiate between dementia and delirium.**
2. **List the most common types of dementia.**
3. **Describe common nurses' reactions to the confused patient.**
4. **Describe effective nursing interventions for the confused patient with the following: memory deficits, unable to verbalize his or her needs, and at risk for falling.**

Useful Terminologies

1. *Agnosia* – Loss of ability to recognize objects
2. *Apraxia* – Inability to carry out motor activities despite intact motor function
3. *Agraphia* – Difficulty writing and drawing
4. *Alzheimer's disease* – Progressive deterioration of memory, and intellectual functioning, often leading to complete loss of functioning and personality. Autopsy reveals brain atrophy, senile plaques, and neurofibrillary tangles.
5. *Delirium* – Rapid fluctuations in mental status, memory deficits, disorientation, and perceptual disturbances over a short period of time.

Useful Terminologies

6. *Dementia* – Multiple cognitive deficits: aphasia, apraxia, agnosia, or disturbance in executive function such as organizing or abstracting.
7. *Mild cognitive impairment* – Subtle but measurable memory disorder when memory problems are greater than what are normally expected with aging but no other dementia symptoms.
8. *Mixed dementia* – Vascular dementia and Alzheimer's disease simultaneously.

Useful Terminologies

9. *Nocturnal delirium (sundowning syndrome)* – Increased confusion and agitation at dusk.
10. *Prompts* – Staff actions used to help dementia patient initiate self-care or other desired behaviors after loss of verbal comprehension.
11. *Pseudodementia* – Depression in elderly people that appears similar to dementia.
12. *Substance-induced persisting dementia* – Dementia caused by intoxication or withdrawal from a substance such as alcohol or drugs.
13. *Vascular dementia* – Dementia caused by multiple strokes that have usually occurred at different times and involve the cortex and underlying white matter.

Introduction

- Confusion is not just a state of the mind seen in elderly people. It has many causes and can occur at any age. It significantly influences a patient's dignity, independence, personality, and support system, and can complicate the diagnosis and treatment of an illness.

- Confused patients are experiencing an alteration in higher level brain functioning such as comprehension or abstract thinking caused by delirium or dementia.

- These patients have difficulty remembering, learning, following directions, and communicating needs and pains.

BOX 10–1

Factors That Contribute to Misdiagnosis in Dementia and Delirium

- The symptoms of dementia and delirium are similar.
- Several causes may occur simultaneously to bring about dementia.
- Delirium occurring in a patient with a dementia can exacerbate already existing symptoms.
- Health-care personnel may harbor unfounded beliefs that serious memory deficits, confusion, and other progressive intellectual deficits are a normal part of the aging process.
- Health-care personnel may harbor unfounded beliefs that confusion always indicates Alzheimer's disease in an older patient.
- Confusion and behavioral changes may be the first sign of medical illness in the elderly.
- Head injuries and other conditions causing brain tissue trauma may present with symptoms similar to those of dementia.
- Confusion is an adverse reaction to many medications.

BOX 10–2
Characteristics of Delirium and Dementia

Delirium	Dementia
• Fluctuating levels of awareness and symptoms	• Slow, insidious onset with less fluctuation of symptoms
• Sudden onset	• Deterioration of cognitive abilities
• Clouding of consciousness	• Impaired long-and short-term memory (memory impairment always present)
• Perceptual disturbances (hallucinations, illusions)	
• Memory disturbance, more often for recent events	• Personality changes
• Highly distractible	• May focus on one thing for a long time
• Reversibility possible with treatment	• Often irreversible

Delirium is a reaction to underlying physiologic (illness, drug reaction, or exposure to a toxin) or psychologic stress. Nurses in the intensive care unit often see delirium induced by the disorienting and confusing environment, sensory deprivation, or sensory overload.

Dementia is generally a permanent condition caused by a variety of factors that lead to cellular brain changes or malformations. It is characterized by slow, insidious onset affecting memory (impaired ability to learn new information or to recall previously learned information), intellectual functioning, and the ability to problem solve.

Types of Delirium

Assessments	Hypoactive-Hypoalert	Hyperactive-Hyperaltert	Mixed
Level of alertness	Lethargic, falls asleep between questions, difficult to arouse	Overly attentive to cues	Alternates between hyperalert and hypoalert states within hours or days
Motor activity	Decreased activity	Moves quickly	Alternates within one episode of delirium
Ability to follow commands	Follows a simple command, e.g., lift your foot Is passively cooperative	May be combative, pulls at tubes, tries to climb out of bed	Alternates between hypoactive and hyperactive states, may be unpredictable
Thinking Ability	Difficulty in focusing attention, disorganized	Easily distracted, rambles May mumble, swear, or yell	Alternates between hypoactive and hyperactive states in an unpredictable manner

ETIOLOGY

Delirium can have biological and psychological causes.

Biological causes include a variety of medical conditions, exposure to toxins, and drugs. The onset of symptoms is related to exacerbation of a medical condition or introduction of a new medication for example, and contributes to the diagnosis.

Psychological causes include sensory deprivation or overload, relocation or sudden changes, sleep deprivation, and immobilization.

ETIOLOGY

- Dementia can be caused by a variety of *biological factors* including the direct physiological effects of a medical condition, the persisting effects of a substance (drug of abuse, medication, or toxin), or multiple etiologies such as the combined effects of a stroke and Alzheimer's disease.

- Alzheimer's disease destroys brain cells and nerves leading to shrinkage as gaps develop in the temporal lobe and hippocampus where storing and retrieval of new information occurs.

- Diagnosis can now be made by magnetic resonance imaging (MRI) and positron emission tomography (PET) scan to document the brain atrophy.

ETIOLOGY

- The etiology of Alzheimer's disease remains the focus of much research.
- Current theories under investigation include decrease in the activity of the neurotransmitter acetylcholine and presence in the brain of the protein beta-amyloid.
- Thus far, theories of environmental toxins, poisons, or a slow-acting virus are unsupported.
- Genetic factors may also be present.
- There is a greater incidence of Alzheimer's disease in the family members of patients who acquire the disease before the age of 60 (Schutte, 2006).

RELATED CLINICAL CONCERNS

Delirium

- Medical conditions that can generate delirium include systemic infections, hypoxia, hypercapnia, hypoglycemia, fluid or electrolyte imbalances, hepatic or renal disease, thiamine deficiency, sequelae of head trauma, postictal states, postoperative states, and complications of cancer.

- Some of the risk factors for delirium include vision impairment, cognitive impairment, restraints, malnutrition, and addition of more than three new medications (Samuels & Neugraschl, 2005).

RELATED CLINICAL CONCERNS

Dementia

- Medical conditions that contribute to development of dementia include stroke, Parkinson's disease, Huntington's disease, AIDS, Creutzfeldt-Jakob disease, hypothyroidism, multiple sclerosis, traumatic brain injury, brain tumors, anoxia, lupus, and hepatic failure. Substance-induced persisting dementia can also occur with a long history of alcohol or substance abuse.

- The dementia patient is at risk for many complications including unrelieved pain due to inability to express it. In addition this patient is at risk for skin breakdown, aspiration pneumonia, weight loss, and sepsis.

LIFE SPAN ISSUES

Children

- Children may be more susceptible to delirium than adults, particularly in the presence of febrile episodes and in response to some medications such as anticholinergics.

- Assessment may be complicated by difficulty in eliciting the signs of problems in thinking, memory, and orientation. In fact, delirium can be mistaken for uncooperative behavior.

- One indication of delirium may be the inability of familiar figures to soothe the child. Children and teens may be at risk for delirium when they abuse club drugs, PCP, inhalants, or combinations of several illicit drugs.

LIFE SPAN ISSUES

Children

- Dementia is rare in children and adolescents but can occur as a result of medical conditions including AIDS, brain tumors, and head injury.

- As with delirium, dementia can be difficult to identify in young children. It may present as a deterioration in function, as in adults, or as a significant delay or deviation in normal development.

- Deterioration in school performance may be an early sign.

LIFE SPAN ISSUES

Older Adults

- Delirium is extremely common in medically ill elderly people. It is a complex process that is caused by many age-related physiologic changes in the brain and other organs (Bond, Neelon, & Belyea, 2006).

- Dementia in general is most common after the age of 85 and is often seen in residents of nursing homes. It occurs with increasing frequency after the age of 65 but is not a normal or expected part of the aging process. Mixed dementias are also more common as people continue to live longer.

POSSIBLE NURSES' REACTIONS

- May have a more positive attitude and take more active measures in care of patients if they believe the confusion is reversible.
- May feel very frustrated and helpless because of lack of improvement, constant need to repeat instructions or break tasks down step by step, repetition of the same question, and time requirements for care of patients with irreversible dementia.
- To avoid feeling hopeless and helpless, may become emotionally detached and give only impersonal care.
- May find themselves bored, unfocused, or confused if patients have considerable problems in communicating verbally.
- May be angry with patient's pathology; may believe patient can control own behavior.
- May become impatient with negative, hostile, impulsive patients who are very slow to respond.
- May feel repulsed by poor hygiene, messy eating behaviors, incontinence, or inappropriate behaviors.

ASSESSMENT

1. Behavior and Appearance
2. Mood and Emotions
3. Thoughts, Beliefs, and Perceptions
4. Relationships and Interactions
5. Physical Responses
6. Pertinent History

COLLABORATIVE MANAGEMENT

1. *Pharmacological*

- A great many medications cause confusion. Confused patients who are taking multiple medications may need to have the medications withdrawn one at a time to determine their impact on the symptoms and the underlying illness.

- Any medications used to treat confusion should be started at lower dosages. Drugs that commonly cause delirium include anticholinergics, benzodiazepines, steroids, antiemetics, and opioids.

COLLABORATIVE MANAGEMENT

- Haloperidol (Haldol) is frequently used to treat agitation and aggression.
- Atypical antipsychotics like Resperidone are also useful.
- Other medications used with this population include short acting benzodiazepines like lorazepam and selective serotonin reuptake inhibitors (SSRIs).
- Buspirone (Buspar) has been used successfully in patient's with Alzheimer's disease, although it may take several weeks to take effect fully.
- Medications to slow down the decline of Alzheimer's disease include cholinesterase inhibitors such as donepezil hydrochloride (Aricept), rivastignine (Exelon) and Galantamine (Rozadyne) have been used to temporarily improve cognitive function. Memantine (Namenda) is used to treat moderate to advanced Alzheimer's disease.

COLLABORATIVE MANAGEMENT

2. Rehabilitation

- A multidisciplinary approach for the patient with dementia is essential.
- Physical and occupational therapy, nutritional support, speech therapy, psychiatry, social work, nursing, and medicine all need to be part of the long-term management of this patient.
- It is important that families use all available resources to reduce their isolation and stress.
- A variety of non-pharmacological approaches have been. helpful to reduce agitation. Some include pet therapy, massage, therapeutic touch, and aromatherapy.

NURSING MANAGEMENT

IMPAIRED VERBAL COMMUNICATION evidenced by inability to name objects or sensations such as pain; inability to comprehend verbal instructions; inability to communicate needs; inappropriate, dramatic reactions or accusations, catastrophic reactions related to confusion, disorientation, memory loss.

Patient Outcomes

- Demonstrates understanding of nurses and communication
- Able to communicate thoughts and needs
- Responds appropriately

NURSING MANAGEMENT

Interventions

- Look directly at patient when speaking. Call patient by name frequently. Identify yourself by name before each conversation and refer to others by their names rather than “he” or “she.”
- Keep interactions simple. Use short words and simple sentences that express one thought or question at a time.
- Ask specific questions such as “Does your stomach hurt?” rather than general ones like “How are you?”
- Reinforce speech with nonverbal techniques. For example, point, touch, or demonstrate an action while talking about it. For instance, if the patient is trying to tell you about his or her body, point as well as ask “Is this where it hurts?”

NURSING MANAGEMENT

- Note in the chart or on the care plan the phrases, key words, and techniques that the patient responds to so that others can use them as well.
- If patient keeps repeating a question, try distraction and give reassurance that he or she will be cared for. Repetitive questions may indicate anxiety, and you want to be reassuring.
- If patient is searching for a particular word or trying to communicate something, guess at what it is, and ask if your guess is correct. If you are unable to determine what he or she is trying to say, focus on the feelings possibly being communicated. Always ask patient to confirm whether your determination is correct.
- If patient is reacting inappropriately, remain calm and reassure him or her that you are there to help.

NURSING MANAGEMENT

- If patient makes inappropriate accusations, such as accusing the staff of stealing his or her glasses, help look for the missing item. Remember that the patient may accuse you of stealing because of memory loss.

- Also, routinely check wastebaskets for missing items.

- Family/caregiver support to deal with difficult behaviors. Resources for support should be provided to avoid reactions to behavior with frustration and aggression.

NURSING MANAGEMENT

IMPAIRED MEMORY evidenced by confusion, decreased ability to perform activities of daily living (ADLs), or inability to follow therapeutic regimen; inappropriate emotional or behavioral responses related to delirium, dementia, or other cognitive deficits.

Patient Outcomes

- Demonstrates improved orientation to person, place, and time
- Demonstrates improved ability to perform ADLs
- Displays less emotional or behavioral agitation

NURSING MANAGEMENT

Interventions

- Establish a baseline assessment of patient's mental status and functioning
- Assess if patient is willing to discuss memory lapses. Determine emotional responses to these lapses. Do not push the discussion if the patient becomes agitated or defensive.
- Be aware that patient may try to disguise memory loss by confabulation, avoiding responding, or by speaking in a rambling style to hide the fact that no thought or information is being expressed.
- Be aware that when social skills and personality are still intact, patient may mistakenly appear stubborn and resistant rather than unable to remember.

NURSING MANAGEMENT

- Do not argue with patient about what he or she remembers. Rather, focus on immediate and specific tasks to be completed. Give patient step-bystep instructions on what needs to be done. Be directive without being domineering.
- Do not make demands that the patient cannot handle or focus on topics that clearly cause distress. Such demands will only add to the confusion and/or agitation.
- Break down complex tasks into individual steps.
- Establish a regular and predictable routine.
- Attempt to arrange for consistent staff to care for patient.
- Keep surroundings simple. Reduce clutter. Do not leave equipment in the patient's room if possible.

NURSING MANAGEMENT

- Personalize the patient's room.
- Place a large, visible clock and calendar in the patient's room.
- Write lists of daily activities or tasks patient needs to do if still able to read and comprehend.
- Avoid an overstimulating environment.
- If the patient tends to wander, make sure all staff are aware of this problem and can bring him or her back to the unit.
- Provide some form of night light.

NURSING MANAGEMENT

RISK FOR INJURY evidenced by falls and bumping into objects related to problems in gait, vision, hearing, lack of coordination, confusion, or lack of understanding of environmental hazards.

Patient Outcomes

- Remains free of injury
- Demonstrates appropriate actions to avoid injury
- Reduce use of restraints

NURSING MANAGEMENT

Interventions

- Be aware of factors that increase risk for falls
- If patient is a fall risk, keep side rails up and bed in lowest position.
- Even with side rails up, be aware that patient may get out of bed.
- Make rounds frequently for patients at high risk for falling.
- Use restraints only after all other methods are ineffective.
- If the patient has an unsteady gait, have him or her take your arm instead of the reverse while walking.
- Make sure the patient receives adequate exercise within the limitations of his or her abilities and condition.

NURSING MANAGEMENT

Interventions

- If the patient wears glasses or a hearing aid, make sure that these are in place before any activity. Be sure to check that the hearing aid battery is good.
- Ensure that the room is adequately lighted for any activity and that the call light is within reach when patient is in bed, in bathroom, or sitting in chair.
- Check the patient routinely for bruises, cuts, or burns.

NURSING MANAGEMENT

ALTERNATE NURSING DIAGNOSES

1. *Confusion, Acute*
2. *Confusion, Chronic*
3. *Family Processes, Interrupted*
4. *Sensory Perception, Disturbed*
5. *Sleep Pattern, Disturbed*
6. *Therapeutic Regimen Management: Ineffective*
7. *Thought Processes, Disturbed*

WHEN TO CALL FOR HELP

- Sudden onset of confusion
- Episodes of patient's becoming physically combative
- Patient who becomes a danger to self or others because of poor judgment (driving, cooking, etc.)
- Severe agitation unresponsive to medication or other interventions
- Delirium that does not remit or gets worse

WHO TO CALL FOR HELP

- Social Worker
- Security
- Psychiatric Team
- Geriatrician

End of Chapter