CHAPTER 22

Confusion

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Objectives

After reading and studying this chapter, you should be able to:

1. Define delirium and dementia.
2. Identify the causes of acute confusion.
3. Explain the differences between delirium and dementia.
4. Discuss nursing assessment and interventions related to delirium and dementia.

Key Terms

Be sure to check out the bonus material on the Student CD-ROM, including selected audio pronunciations.

delirium (dĕ-LĬR-ē-ŭm, p. 321)
dementia (dē-MĒN-shē-ă, p. 321)

Confusion is a symptom experienced by various patients under varying circumstances. Older people sometimes experience confusion as a first symptom of disease. People of all ages may experience confusion under certain circumstances such as high fever, critical illness, or recovery from anesthesia. Confusion may be acute, transient, or permanent. It has many causes and names and can be very difficult to manage.

The symptoms associated with confusion can be divided into two categories: (1) acute confusional states, or delirium, and (2) chronic confusion, or dementia. **Delirium** is a short-term confusional state that has a sudden onset and is typically reversible. It is more prevalent in children and older adults. **Dementia** is a syndrome that is chronic and irreversible. It is characterized by impairment in memory and accompanied by many other cognitive deficits. Dementia is most prevalent in older adults. Delirium and dementia have been called *organic brain syndrome, acute brain syndrome, chronic brain syndrome, senile dementia,* and *senility.*

DELIRIUM

Delirium is characterized by disturbances in consciousness that impair a person's awareness of the environment. People with delirium may have difficulty focusing or paying attention, so that they are easily distracted. It may be difficult to engage people with delirium in a conversation, and questions often must be repeated several times. Impaired recent memory is common, along with disorientation and language problems. Speech may be slurred and disjointed, with aimless repetitions. Individuals may misinterpret what is going on in the environment and may develop delusional thinking and experience hallucinations. For example, they may think that the banging of a door is a gunshot and may develop the delusion that someone is trying to steal from them. There can be a disturbance in the sleep-wake cycle. A delirious person may alternate between hyperactivity and hypoactivity. The level of consciousness may fluctuate from drowsiness to stupor or coma. At the other extreme, the individual may be very alert and agitated. Other symptoms include anxiety, depression, irritability, anger, apathy, or euphoria. Acute confusion begins abruptly and usually lasts a short period of time, perhaps as long as a week but rarely more than a month. However, if the underlying cause is not identified and treated, delirium can become a permanent condition, especially in older adults. The symptoms tend to fluctuate and often become worse at night.

Examples of factors that can contribute to delirium are listed in Box 22-1.

DEMENTIA

Dementia is characterized by impaired intellectual function, problem-solving ability, judgment, memory, and orientation and by inappropriate behavior, as shown in Box 22-2. There are several types of dementia with various causes and symptoms. Some examples are Alzheimer's disease, vascular dementia, Pick's disease, Huntington's disease, and Creutzfeldt-Jakob disease. Some people who have Parkinson's disease develop dementia as well. Other conditions that are associated with dementia include normal pressure hydrocephalus, subdural hematoma, brain tumors, neurosyphilis, and acquired immunodeficiency syndrome (AIDS). Dementia is not a disease itself but a clinical syndrome, a collection of symptoms that can occur with many types of diseases. The two most prevalent types of dementia are Alzheimer's disease (AD) and vascular dementia. The cause of AD is unknown, but characteristic changes in the brain include deposits of

Box 22-1 *Systemic and Central Nervous System Causes of Delirium*

SYSTEMIC CAUSES		CENTRAL NERVOUS SYSTEM CAUSES	
Cardiovascular disease	Metabolic	Infections	Vascular
Congestive heart failure	Electrolyte and fluid imbalance	Meningitis	Transient ischemic attack
Arrhythmias	Hepatic, renal, or pulmonary failure	Encephalitis	Stroke
Cardiac infarction	Diabetes, hyperthyroidism, hypothyroidism, or other endocrine disorder	Septic emboli	Chronic subdural hematoma
Hypovolemia	Nutritional deficiencies	Neurosyphilis	Vasculitis
Aortic stenosis	Hypothermia and heat stroke	Brain abscess	Arteriosclerosis
Infections	Neoplasm	Neoplasm	Hypertensive encephalopathy
Pneumonia	Postoperative state	Primary intracranial	Subarachnoid hemorrhage
Urinary tract infections	Poisons	Metastatic	Seizure
Bacteremia	Heavy metals	Trauma	Ictal and postictal states
Septicemia	Solvents	Subdural hematoma	
Medications	Pesticides	Extradural hematoma	
Alcohol	Carbon monoxide	Contusion	
Amphetamines	Trauma		
Analgesics	Head injury		
Anticholinergics	Burns		
Antidepressants	Hip fracture		
Antihistamines			
Antiparkinsonian agents			
Cimetidine			
Diuretics			
Neuroleptics			
Sedative/hypnotics			

From Zisook, S., & Braff, D.L. (1986). Delirium: Recognition and management in the older patient. *Geriatrics, 41*(6), 67-78.

amyloid (a protein), neurofibrillary tangles (tangled microtubules in neurons), and a deficiency of acetylcholine (a chemical that transmits signals in the brain). These changes affect the structure and function of the neurons in the brain. Vascular dementia results from damage to brain cells caused by inadequate blood supply. Patients with vascular dementia often have had a series of small strokes that cause progressive damage.

What Does Culture Have to Do with Dementia?

Caregivers from lower socioeconomic families are more likely to be caring for older parents at an earlier age when the caregiver is employed or still has children at home.

NURSING CARE

Assessment

The first step in collecting data about a confusional state is to observe the patient's behavior and to collect data about orientation, memory, and sleep habits. Family members may be able to provide helpful information if the patient cannot. Ask when the symptoms of confusion started and whether the confusion is constant or intermittent. List any known acute or chronic illnesses and all medications the patient has been taking (including home remedies and over-the-counter drugs). Drugs that most often cause confusion include anticholinergics, digoxin, H_2-receptor blockers, benzodiazepines, nonsteroidal anti-inflammatory drugs, and many antidysrhythmic and antihypertensive drugs.

These assessment data help the physician determine whether the patient is suffering from delirium or dementia. Some major differences between the clinical features of delirium and dementia are described in Table 22-1. Nursing care of delirium and dementia are addressed separately even though they have some common interventions. For tips on helping CNAs provide nursing care for patients with delirium and dementia, see the Management and Supervision box on p. •••.

Nursing Diagnoses, Goals, and Outcome Criteria: Delirium

Nursing Diagnoses	Goals and Outcome Criteria
Disturbed Thought Processes related to drugs, infection, dehydration, unfamiliar setting, sensory overload or deprivation, etc.	Improved thought processes: orientation to person, place, and time; calm, no combative behavior
Disturbed Sleep Pattern related to agitation, mood alterations, drug effects	Restoration of patient's usual sleep pattern: fewer nighttime awakenings, patient reports feeling rested
Risk for Injury related to agitation, disorientation, unfamiliar setting	Safety maintained: absence of injury

Box 22-2 ***Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) Criteria for Dementia***

A. The development of multiple cognitive deficits manifested by both:
   1. Memory impairment (impaired ability to learn new information or to recall previously learned information)
   2. One (or more) of the following cognitive disturbances:
      a. Aphasia (language disturbance)
      b. Apraxia (impaired ability to carry out motor activities despite intact motor function)
      c. Agnosia (failure to recognize or identify objects despite intact sensory function)
      d. Disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)

B. The cognitive deficits in criteria A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.

C. The deficits do not occur exclusively during the course of delirium.

Features of Specific Dementias

Dementia of the Alzheimer's Type

The course is characterized by gradual onset and continuing cognitive decline.

The cognitive deficits in criteria A1 and A2 are not due to any of the following:

1. Other central nervous system conditions that cause progressive deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, Huntington's disease, subdural hematoma, normal-pressure hydrocephalus, brain tumor)
2. Systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B_{12} or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis, human immunodeficiency virus [HIV] infection)
3. Substance-induced conditions

Dementia Due to Other General Medical Conditions

There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiologic consequence of one of the following medical conditions: dementia due to HIV disease, dementia due to head trauma, dementia due to Parkinson's disease, dementia due to Huntington's disease, dementia due to Pick's disease, dementia due to Creutzfeldt-Jakob disease, dementia due to normal-pressure hydrocephalus, etc.

Vascular Dementia

Focal neurologic signs and symptoms (e.g., exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity) or laboratory evidence indicative of cerebrovascular disease (e.g., multiple infarctions involving cortex and underlying white matter) that is judged to be etiologically related to the disturbance.

Substance-Induced Persisting Dementia

There is evidence from the history, physical examination, or laboratory findings that the deficits are etiologically related to the persisting effects of substance use (e.g., a drug of abuse, a medication).

Modified with permission from American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

Management and Supervision

Working with dementia patients can be frustrating for CNAs. The best thing the LPN/LVN can do is model good interactions with patients. Also, explain to CNAs that:

- Rudeness and uncooperative behavior are symptoms of dementia that are best managed with kindness and patience.
- Because dementia patients have memory impairments, information and instructions may have to be repeated at intervals.
- When patients resist care, let the licensed nurse know and try a different approach later.

Interventions: Delirium

When managing delirium, the physician focuses on identifying and treating the cause of the problem. During an episode of confusion, you should focus your attention on supporting the patient to provide safety and comfort and to reduce anxiety (see Nursing Care Plan: The Patient with Delirium on p. •••). Nursing care can be more effective than drugs in managing confusion.

Disturbed Thought Processes

Patients with delirium often need hospitalization. If possible, the patient should be in a private room with continuous supervision. Keep the room quiet and uncluttered to avoid agitation caused by extraneous stimuli. Lighting should be soft and diffuse to avoid shadows that may be misinterpreted and add to the patient's fears. Familiar objects such as pictures, a clock, and a large calendar placed in the room can help orient the patient to time and person (Fig 22-1). Patients who normally wear hearing aids and glasses should be encouraged to use them.

Communication with a confused patient should be simple and direct. Anyone dealing with a delirious patient should be calm, warm, and reassuring. It is helpful if the same personnel are assigned to care for the patient. Avoid sudden movements and handle the patient gently during procedures or turning.

Patients with delirium may have frightening hallucinations that cause them to strike out, cry, or scream. The best response is to orient the patient to the reality of being sick and hospitalized and to explain that the hallucinations are not real even though they seem to be. You might say, "You are sick in the hospital, and

Table 22-1 ***Clinical Features in Delirium and Dementia***

FEATURE	DELIRIUM	DEMENTIA
Duration	Few weeks to 3 months	In progress at least 1-2 years
Paranoid states	Prominent while cognitive impairment is mild or variable	More consistent with degree of impairment; less prominent paranoia
Fluctuations	Marked contrasts in levels of awareness	Not seen in such contrast; progressive decline
Persecutory delusions	Ordered and cohesive	Vague, random, contradictory
General intellectual powers	Preserved during lucid intervals	Consistent loss and decline
Affect	Intermittent fear, perplexity, or bewilderment	Flat or indifferent affect
Perceptual disturbances	Hallucinations often disturbing and very clearly defined	Hallucinations vague, fleeting, ill-defined; in many cases difficult to make a clear judgment that they exist

From Chenitz, W.C., Stone, J.T., & Salisbury, S.A. (Eds.). (1991). *Clinical gerontological nursing* (p. 485). Philadelphia: Saunders.

NURSING CARE PLAN

The Patient with Delirium

ASSESSMENT

Health History: An 81-year-old man was admitted for hip replacement surgery 2 days ago. Before his surgery he lived alone and cared for himself. He was active, alert, and independent. However, since his surgery he has been confused and at times combative with the nurses. His physician believes that he is suffering from delirium related to the anesthesia from surgery and that it should resolve within a few days.

Physical Examination: Blood pressure, 165/95; pulse, 98 with slight irregularity; respiration, 20; temperature, 97.4° F measured orally. Height, 5′7″; weight, 178 lb. Alert, disoriented to time, place, and sometimes person; combative. Awakens during the night. Dark circles around eyes. Refuses food or fluids.

Nursing Diagnosis	*Goals and Outcome Criteria*	*Interventions*
Disturbed Thought Processes related to anesthesia during surgery	The patient will have improved thought processes, as evidenced by orientation to time, place, and person and absence of combative behavior.	Place in a private room with minimal stimuli, soft lighting. Request a family member to stay with patient. Maintain consistency with the nursing staff caring for the patient. Approach and communicate with the patient in a calm, reassuring manner. Have patient use hearing aid or glasses if used previously. Reorient patient frequently and consistently. Place familiar objects in the room: pictures, clock, calendar.
Disturbed Sleep Pattern related to agitation and mood alterations	The patient will have adequate sleep and rest, as evidenced by fewer awakenings during the night, absence of dark circles around the eyes, and no complaints of fatigue.	Provide a back rub or offer milk at bedtime. Engage in soothing conversation to relax the patient. Plan activities for long periods (at least 2-4 hours) of uninterrupted sleep.
Imbalance Nutrition: Less Than Body Requirements related to confused state and inability to feed self	The patient will have adequate fluid and food intake, as evidenced by eating meals as offered and maintaining normal body weight.	Assist the patient with feeding. Offer small, light meals more frequently. Stay with the patient during meals to monitor and provide safety.

? CRITICAL THINKING QUESTIONS

- Assuming that the patient's delirium is indeed related to the anesthetic, explain how the patient's age might have played a role in his current state.
- What other factors must a nurse consider when caring for older patients?

FIGURE 22-1 A clock and calendar may help orient a patient with delirium; however, they must be in a place where they can be seen easily. In addition, patients with sensory impairments should wear their glasses and/or hearing aids, if possible.

what you are seeing is part of the illness." Hallucinating patients in a delirious state need one-to-one nursing observation and repeated verbal reorientation. They need to be assured that the medical and nursing staff are helping them and keeping them safe.

Frequent orientation to the surroundings and the situation is important for patients with delirium. Orienting phrases such as "here in the hospital" or "now that it is evening" can be woven into the conversation. Keep choices to a minimum. Simple, direct statements ("Now it is time to take your bath") are better than questions ("When would you like to take a bath?"). All communication and nursing care should be carried out in a way that conveys respect and preserves the patient's dignity.

Disturbed Sleep Pattern

Sleep deprivation can cause or contribute to disorientation and confusion. Nursing measures such as giving a back rub, providing a glass of warm milk, and having a soothing conversation may help the patient relax and fall asleep. Schedule medications or treatments at times that do not interrupt nighttime sleep. The presence of a family member may help calm an agitated and confused patient (Fig. 22-2).

Risk for Injury

The patient with delirium may pull on tubes, try to get out of bed unassisted, or attempt to leave the setting. It can be challenging to protect the patient from harm without imposing excessive restrictions. Avoid using physical restraints, which tend to increase anxiety and agitation in confused patients and often result in injuries. Rather, ask a family member to remain with the patient or assign a staff member to do so. Use common sense. Position tubes out of sight. Put the bed in low position. Postpone activities that are flexible. If there is no reason that confused patients need to stay in bed, try having them sit in chairs or even "visit" the nurses' station in a wheelchair. Avoid arguing with delirious patients. Gently explain what you are doing and why. Try to elicit their cooperation.

FIGURE 22-2 The presence of a family member may help calm a confused patient.

These nursing diagnoses are only a few that might apply to the patient with delirium. Depending on the situation, there will be different priorities.

Nursing Diagnoses, Goals, and Outcome Criteria: Dementia

Nursing Diagnoses	Goals and Outcome Criteria
Self-Care Deficit related to impaired thinking, sensory and motor dysfunction	Maximum possible independence in ADL: patient participation in bathing, grooming, feeding, toileting with assistance as needed
Imbalanced Nutrition: Less than Body Requirements related to difficulty with self-feeding, inattention	Adequate nutrition: stable weight (within 5 lb. of ideal)
Disturbed Sleep Pattern related to neurologic changes, altered perceptions	Adequate sleep: patient rests at night and remains physically active and awake during the day
Risk for Injury related to poor judgment, physical decline, sensorimotor changes	Absence of injuries: patient has no falls, suffers no bruises, cuts, fractures
Disturbed Thought Processes/Impaired Verbal Communication related to memory loss, altered perception, impaired judgment, anxiety, etc.	Cooperative behavior: patient calm, no combative behavior, no dangerous behavior Effective communication: patient needs are recognized by caregiver

Interventions: Dementia

Most people with dementia suffer from chronic, debilitating illnesses with little hope for recovery. The goal for patients with dementia is to maintain the highest level of functioning possible as their abilities gradually diminish (see Nursing Care Plan: The Patient with Dementia on p. •••).

Self-Care Deficit

As with patients with delirium, the first priority for patients with dementia is to meet their basic needs. Adequate nutrition, fluid and electrolyte balance, sleep, elimination, and hygiene must be maintained. Patients with dementia have varying levels of competence when it comes to carrying out these functions. Determine the patient's level of functioning, and then provide whatever assistance is needed. Patients may be able to participate in self-care if you break down tasks into individual steps to be done one at a time. For example, instead of instructing patients to get dressed, first direct them to put on underclothes, then socks, pants, shirts, belt, and shoes. Allow time for the patient to complete each step before giving another direction. Praise completion of each task.

Dementia patients may be incontinent of urine and feces. Frequent, routine toileting helps prevent incontinence episodes. Document stools, and be alert for signs of constipation (straining, abdominal distention, poor appetite, passage of liquid stool). Avoid laxatives if possible; instead, high-fiber foods in the diet are more effective for promoting regular bowel movements. If constipation cannot be managed with diet, fluids, and exercise, a bulk-forming stool softener may be needed. However, bulk-forming softeners can actually cause impaction if the patient cannot take adequate fluids.

Imbalanced Nutrition: Less Than Body Requirements

People with dementia may eventually need help with eating. Assistance with meals may mean cutting food or total feeding. Foods that can be managed with a single utensil may facilitate self-feeding. Finger foods high in protein and carbohydrates allow patients to feed themselves more easily. Small, frequent meals are less confusing to the patients. Remove distractions from the eating area. Group meals may be helpful because patients often imitate behaviors of others. Offer fluids frequently during the day.

Disturbed Sleep Pattern

Sleep and awakening are often reversed in dementia patients. It is helpful to try to keep them awake during the day and get them to sleep at night. Tests and treatments can be scheduled during the morning and early afternoon to allow the patients time to wind down by bedtime. Some caregivers have found that a quiet hour in the afternoon with soft music playing promotes sleep at night. Patients who awaken during the night and become confused and agitated should be reassured in a soft, soothing manner to avoid precipitating extreme agitation and loss of control.

Risk for Injury

A safe, structured environment is essential for a person with dementia. Nothing should be left around that could harm the patient. Falls and injuries may be prevented with careful observation, muscle strengthening, and a fall prevention program.

Disturbed Thought Processes/Impaired Verbal Communication

Communication usually becomes increasingly difficult. Patients with dementia are disoriented, and their thinking ability is impaired. They are confused by what is going on around them. Communication should be simple and direct. Patients must be approached gently, calmly, and quietly. They tend to copy the behavior of people around them, so a caregiver who is anxious or upset can easily convey these feelings to a patient. Nonverbal communication is extremely important. Look for cues from patients' actions and facial expressions because they frequently are not able to express their needs verbally. When patients resist activities such as bathing or dressing, avoid confrontations. Confrontations only provoke agitation and possible violence; it is better to come back at another time. A consistent schedule of care given by the same caregivers provides security for a dementia patient.

Whereas constant reality orientation is helpful for the patient with delirium, such orientation is not effective for the patient with dementia. Clocks, calendars, constant mention of the date and time, and other such orientation reminders used to be a staple of care for demented patients. However, it is now thought that reality orientation tends to agitate people with dementia by pointing out to them their forgetfulness and confusion. It is better to assist them in a nonconfrontational manner and redirect activities without constantly reminding them of their deficits.

Put on Your Thinking Cap!

A patient's daughter is distressed because her mother does not seem to recognize her at times. What could you say to help the daughter? What suggestions could you give her to promote communication with her mother?

GUIDELINES FOR WORKING WITH DEMENTIA PATIENTS

It is helpful to keep in mind two important concepts when taking care of patients with dementia: (1) they usually forget things relatively quickly, and (2) they are usually unable to learn new things. For example, if persons with dementia start to become very rest-

NURSING CARE PLAN

The Patient with Dementia

ASSESSMENT

Health History: A 75-year-old woman is admitted to a long-term care facility by her daughter because she has been unsafe living alone at home. Her daughter reports that the patient has been in good health, but during the past 5 years she has gradually had more and more problems with her memory, and during the past year, she has refused to take a bath or change her clothes. Lately she has had times when she has not even known her daughter. At times she has been unable to find the bathroom and has been incontinent of urine. She often forgets to eat, and when she does eat, prefers only junk foods. Recently she has begun "wandering." She was found at a local park not knowing who she was or where she lived. Her physician has diagnosed Alzheimer's disease.

Physical Examination: Blood pressure, 170/95; pulse, 88; respiration, 22; temperature, 98.2° F. Height, 5'3"; weight, 126 lb. Inability to bathe and dress self. Disoriented to time, place, and person.

Nursing Diagnosis	*Goals and Outcome Criteria*	*Interventions*
Self-Care Deficit related to impaired thinking, sensory and motor dysfunction	The patient will perform activities of daily living (ADL) as independently as possible, as evidenced by participation in bathing and dressing with the assistance of the nurse as needed.	Assess the patient's ability to perform own ADL. Allow the patient to perform as many of own ADL as possible. Remain with the patient while she performs ADL to maintain safety. Work out a routine toileting schedule and encourage patient to go to bathroom at regular intervals.
Imbalanced Nutrition: Less Than Body Requirements related to difficulty with self-feeding, inattention	The patient will maintain adequate nutrition, as evidenced by keeping within 5 lb. of ideal weight.	Cut the food into small portions. Offer finger foods. Offer foods high in protein and carbohydrates. Offer small, frequent meals and snacks. Offer fluids frequently. Stay with the patient while eating.
Disturbed Sleep Pattern related to neurologic changes, altered perceptions	Patient will have adequate sleep, as evidenced by quiet restfulness at night and remaining physically active and awake during the day.	Try to keep her awake during the day and encourage sleep only at night. Minimize activities late in the day to allow her to "wind down" by bedtime. Have a quiet hour in the evening with soft music. If she awakens during the night and becomes confused or agitated, reassure in a soft, soothing manner to avoid precipitating extreme agitation and loss of control. Try gently stroking and singing to her. Provide a comfort object if she has one (e.g., blanket, doll).
Risk for Injury related to poor judgment, physical decline, sensorimotor changes	Absence of injuries: patient has no falls, suffers no bruises, cuts, fractures.	Provide a safe environment: no clutter, no medications or dangerous chemicals within reach. Avoid use of restraints. Provide opportunities for safe, supervised walking. Monitor exits to prevent wandering from the premises.
Disturbed Thought Processes/Impaired Verbal Communication related to memory loss, altered perception, impaired judgment, anxiety	The patient will remain calm, free of combative behavior, as evidenced by a calm, cooperative manner during times when nursing care is performed.	Speak to patient in a calm, reassuring manner. Avoid confrontations with patient. Break tasks down into individual steps to be done one at a time. Provide consistency in nursing care. Attempt to understand what patient is communicating verbally and nonverbally.

? CRITICAL THINKING QUESTIONS

- Why is it important to stay with patients while they complete ADLs and while they feed themselves?
- How might you prepare the environment to minimize falls and accidents?

less, anxious, or agitated and are becoming more so by the minute, it may be effective to divert their attention somewhere else. They may be gently guided to another activity, and usually within a relatively short period of time they will forget what was bothering them in the first place and focus on the new activity (Fig. 22-3). Sometimes agitation indicates pain, hunger, stress, fear, or the need for toileting. Investigate whether any of these problems are present. Take advantage of the fact that patients with dementia are usually slow or unable to learn new things. For example, putting new locks on the doors in new

FIGURE 22-3 It is best to calmly divert the attention of confused, agitated patients somewhere else by gently guiding them to another activity.

places may prevent wandering patients from opening exit doors. You can be very creative in the care of dementia patients by using these two concepts as a basis for their care.

One approach that can also guide care for dementia patients is the Cognitive Developmental Approach (CDA). The CDA adapts interventions based on the patient's cognitive abilities. It is thought to reduce patient stress and frustration by eliminating unrealistic expectations and allowing the patient to do as much as he or she is able. Some principles derived from the CDA that you can apply include the following:

- Accept that the patient with dementia may no longer be able to make adult decisions and behave as a healthy adult would. Offer limited choices to simplify decision making.
- Adapt the environment to the patient rather than trying to adapt the patient to the environment. For example, create a safe environment for wandering instead of trying to keep the patient from wandering.
- Encourage self-care at whatever level the patient can function. If the patient can eat independently with his hands but not with utensils, provide finger foods.
- Recognize irrational fears such as fear of the bathtub and arrange alternative ways to give personal care.
- Accept that, in advanced dementia, patient behaviors and thinking are not typical of a healthy adult. Some strategies that work with children often work with dementia patients also.
- Recognize that the patient deserves to be treated with dignity regardless of abilities or behaviors.

Even the most impaired patient can probably sense compassion in a caregiver.

- The two major types of confusion are (1) acute confusional states, or delirium, and (2) chronic confusion, or dementia.
- Older adults are the most susceptible to confusion associated with delirium or dementia.
- Delirium is a short-term confusional state that usually develops over a short period of time and is often reversible.
- Delirium is characterized by disturbances in attention, thinking, perception, orientation, short-term memory, and sleep.
- Delirium is usually caused by some underlying illness such as neurologic, pulmonary, or cardiovascular disease or conditions such as infection, dehydration, and overmedication.
- Dementia is chronic and irreversible.
- Dementia is characterized by inappropriate behavior and impairment of intellectual function, problem-solving ability, judgment, memory, and orientation.
- Dementia is not a disease entity itself but a clinical syndrome, a collection of symptoms that may be part of the profile of many diseases, including Alzheimer's disease, vascular dementia, Huntington's disease, and Parkinson's disease.
- The first step in assessing a confusional state is to observe the patient's behavior and to evaluate orientation, memory, and sleep habits.
- Try to determine how long the symptoms of confusion have been present and how and when they started.
- In caring for a patient with delirium, provide safety and comfort and provide frequent orientation to the surroundings and the situation.
- The goal for patients with dementia is to maintain the highest level of functioning possible as their abilities gradually diminish.
- A safe, structured environment is essential for patients with dementia, and tasks should be broken down into individual steps that can be performed one at a time.
- When patients with dementia resist activities such as bathing or dressing, it is best to avoid confrontations and divert their attention elsewhere.
- The Cognitive Developmental Approach adapts interventions to the patient's cognitive level.

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REVIEW QUESTIONS *Choose the best answer.*

1. What is the primary difference between delirium and dementia?
   1. Delirium is typically reversible; dementia is irreversible.
   2. Agitation is constant with delirium but intermittent with dementia.
   3. The onset of delirium is gradual; the onset of dementia is typically rapid.
   4. Delirium usually lasts only a few minutes; dementia lasts weeks to months.

2. A confused patient repeatedly cries out for her daughter in the middle of the night. What is the best intervention?
   1. Check to see if she has an order for a sedative.
   2. Call her daughter and ask her to come see her mother.
   3. Calmly tell her where she is and that her daughter is not here.
   4. Tell her she needs to be quiet because she is disturbing other patients.

3. A patient with Alzheimer's disease wanders away from the table during meals, leaving most of his food uneaten. What should you do?
   1. Consult with the dietitian about providing finger foods.
   2. Restrain the patient in his seat during meals.
   3. Tell him he must sit down and finish his meal.
   4. Ask another patient to try to keep him at the table.

4. Which message is most appropriate for the patient with dementia?
   1. "You need to be dressed for church in 30 minutes."
   2. "Put your arm in the sleeve of your shirt."
   3. "Put your shirt on."
   4. "What would you like to wear today?"

5. A new nurse on the Alzheimer's special care unit repeatedly asks patients what time it is and if they know where they are. What information should you share with her?
   1. If a patient cannot answer the questions correctly, wait 5 minutes and ask again.
   2. Consistently tell patients the time, date, and place to keep them oriented.
   3. Frequent attempts at orientation tend to agitate Alzheimer's patients.
   4. Have the patient repeat the date, time, and place after you say them.

6. If you applied principles of the Cognitive Developmental Approach to care of a dementia patient, you would:
   1. Consistently follow very specific interventions for dementia patients
   2. Have the patient confront irrational fears so they can be overcome
   3. Insist that the patient behave as a mature adult at all times
   4. Adapt your expectations and interventions to the patient's abilities