ONLINE EXCLUSIVE

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Delirium and acute problematic behavior in LTC patients: What's the best approach?

Expanded recommendations draw on recent research, and on insights from "hands-on" practitioners in long-term care.

- What are the best methods to assess delirium and acute problematic behavior in the long-term care setting?
- What is the most appropriate treatment for these patients?
- Why is monitoring of interventions critical to patient outcomes?

The answers to these questions are summarized at right and in the 2008 edition of *Delirium and Acute Problematic Behavior in the Long-Term Care Setting,* published by the American Medical Directors Association (AMDA). This comprehensive guideline, developed to improve quality of care, features a 15-step systematic approach to recognizing, assessing, treating, and monitoring long-term care patients with delirium and acute problematic behavior. It includes a simple algorithm to guide the decision-making process.

Initially developed to fill a gap

Delirium and acute problematic behavior are common in the long-term care setting, but management guidelines have been limited. To assist physicians, advanced practice nurses, nurses, and allied health professionals in long-term care facilities, the AMDA developed the initial version of this guideline in 1998. A multidisciplinary workgroup used a process that combined evidence- and consensus-based approaches: An electronic literature search identified pertinent guidelines, research articles, and review articles, and the recommendations were based on the opinions of the expert workgroup.

Guideline revision expands its scope

The guideline update was completed in 2008, under the direction of the AMDA Clinical Practice Guideline Steering Committee. The new version incorporates information published in peer-reviewed journals after the original guideline was released; it has also been expanded to incorporate recommendations from seasoned practitioners in long-term care.

The AMDA facilitated peer review of the revised guideline, with input from 175 individuals outside of the steering committee. The result is a well-written, practical guide to dealing with long-term care residents with altered mental states.

A few limitations

This guideline does not include grades for individual recommendations. Since the recommendations are based on expert opinion, the evidence is rated **C** using the SORT taxonomy.[1] The recommendations are easy to understand, but an executive summary would have been useful. The algorithm lacks detail, which weakens its clinical value.

In addition, this 36-page guideline is available only in print from the AMDA. Lack of Internet access limits its accessibility at the point of care.

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Source for this guideline

American Medical Directors Association (AMDA). Delirium and acute problematic behavior in the long-term care setting. Columbia, Md: American Medical Directors Association (AMDA); 2008. 36 p. (36 references). Available from the American Medical Directors Association. (http://www.amda.com/tools/cpg/alteredmentalstates.cfm).

Other guideline on this topic

American Psychiatric Association. Practice guideline for the treatment of patients with delirium. American Psychiatric Association. *Am J Psychiatry.* 1999 May;156(5 suppl):S1-S20. [135 references]. Guideline Watch. August 2004. Available at: www.psychiatryonline.com/content.aspx?aid=148944.

The APA guideline is not current. The major recommendations focus on psychiatric management, environmental and supportive interventions, and somatic interventions. Although the guideline is based on a systematic review of the literature, the APA does not describe the methods used to review the

Practice recommendations

Grade C Recommendations

Recognition/assessment

- Clearly identify the problematic behavior and altered mental function:
  - Assess symptoms, medical history, and medications.
  - Use the Confusion Assessment Method (CAM)[2] instrument and the American Psychiatric Association's (APA) diagnostic criteria for delirium.
  - Assess individual risk factors, both environmental and medical.
- Determine the urgency of the situation and the need for additional evaluation and testing.
- Identify the cause of the problematic behavior and altered mental function.
  - Assess for medical conditions and treatments that can affect behavior, including fluid or electrolyte imbalance, infection, acute renal or hepatic failure, head trauma, myocardial infarction, stroke, and medication-related adverse consequences.
  - Perform laboratory tests, such as electrolytes, blood urea nitrogen (BUN), glucose, creatinine, complete blood count (CBC), chest x-ray, urinalysis, electrocardiogram (EKG), and serum vitamin B_{12} level.
  - Consider possible psychiatric illnesses, such as psychosis, mood disorders, personality disorders, and dementia-related causes.

Management/treatment

- Initiate a plan for treatment.
- Provide both symptomatic and cause-specific management.
- Administer medications as needed, such as antipsychotics, antidepressants, cholinesterase inhibitors and memantine, anticonvulsants, and anxiolytics.

Monitoring

- Monitor and adjust interventions as indicated.
- Review the effectiveness and appropriateness of medications.
- Prevent, identify, and address any complications of the condition and treatment.

Strength of recommendation (SOR)
A Good quality patient-oriented evidence
B Inconsistent or limited-quality patient-oriented evidence
C Consensus, usual practice, opinion, disease-oriented evidence, case series

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evidence. Nor does it report ratings for the level of evidence. ■

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References

1. Ebell M, Siwek J, Weiss BD, et al. Strength of recommendation taxonomy (SORT): a patient-centered approach to grading evidence in the medical literature. *J Fam Pract.* 2004;53:111-120.
2. Inouye S, van Dyck C, Alessi C, et al. Clarifying confusion: the confusion assessment method. *Ann Intern Med.* 1990;113:941-948.