

MDS Alert

PHARMACOTHERAPY: Help Keep Residents Delirium-Free With These 3 Key Strategies

Doing a little homework will earn you high marks with surveyors in this area of preventive care.

What's the best medicine for preventing delirium? Avoid giving residents medications known to cause people to become delirious.

Start by doing a history at admission to determine whether the resident has developed a medication-related delirium in the past, advises **William Simonson, PharmD**, a consultant in Suffolk, Va. "If so, it's likely to occur again," he warns.

Example: In one case, a resident became very delirious when treated with an antibiotic.

Staff initially attributed the delirium to his infection, but the resident's symptoms escalated after the UTI symptoms began to resolve. When asked, the resident's wife told staff that the resident had become "out of his mind" twice before when treated with the same antibiotic.

2 More Ways to Keep Delirium at Bay

1. Flag high-risk meds. For example, "medications with anticholinergic properties pose a higher risk for causing delirium," says Simonson. "And nursing home residents may be on several medications that have anticholinergic properties." Examples include meds used to treat urinary incontinence and OTC sleep aids (see page 105 for a chart prepared by IPRO, a quality improvement organization in New York).

In addition to medications with anticholinergic properties, medications known to cause delirium include benzodiazepines, and sleep medications, such as zolpidem, says **Darren M. Triller, PharmD**, director of pharmacy services for IPRO in New York State. "Some of the antiseizure drugs used for neuropathic pain can also cause delirium," Triller adds. "Digoxin can cause delirium but nursing homes tend to do a good job of monitoring the drug levels for that medication."

More meds: Other medications known to cause delirium include anti-Parkinson's medications, H2 blockers, such as cimetidine, antiemetics, antihistamines, opioids, tricyclics, some blood pressure medications, antipsychotics, and muscle relaxants, according to The Merck Manual of Health & Aging (www.merck.com/pubs/mmanual_ha/tables/tb26_1.html).

2. Do a risk-benefit assessment for each medication. Look at the goal for a medication, advises Triller. "If an elderly person with dementia is incontinent eight to 10 times a day, is the medication changing that [scenario]? If the medication can help the person be more independent in the facility or go home," that's a different risk-benefit profile, he adds.

Also consider what's known as anticholinergic load when adding a medication. "There are tools that pharmacists can use where drugs are ranked as being high, medium, or low in terms of their anticholinergic properties," says Triller. "That way you can eyeball the patient's medications and assign a score."

Examples: A person may have been on an anticholinergic for bladder incontinence for some time, says Triller. But due to a recent cold and insomnia, the person "is now also taking a cold preparation that has an anticholinergic in it, and Tylenol PM, a product containing the anticholinergic diphenhydramine for sleep," adds Triller.

A person may be able to tolerate 10 mg of amitriptyline for neuropathic pain whereas he'd be at higher risk for developing delirium when taking 50 to 100 mg of that same medication for depression, cautions Simonson.

