TREATING PATIENTS WITH DEMENTIA IN THE EMERGENCY DEPARTMENT

Assessment:

- Early recognition is key - Use a standard screening tool (such as the Brief Alzheimer Screen or Mini-Cog™©)
- Consider the **CURVES** mnemonic to assess medical decision-making capacity[1]:

Choose and Communicate – can the patient communicate a choice?

Understand- Does the patient understand the risks, benefits, alternatives, and consequences?

Reason- Is the patient able to provide a logical explanation for the choice?

Value- Is the choice consistent with their value system?

Emergency- Is there an imminent, serious risk?

Surrogate- Is there a surrogate decision maker available?

Communication:

- If possible, obtain a secondary history of present illness (e.g., caregiver or residential or nursing facility, EMTs)
- Remember that communication between different sites and providers of care is important, especially in formulating a disposition plan.

Management:

- Use the PAINAD instrument to assess pain
- "Consider the **ABC Approach** (Antecedents, Behavior, Consequences) to interpreting and addressing causes of distressed behavior"[2] such as resistance to care, exit-seeking, or aggression
- "Begin with nonpharmacologic approaches to distressed behaviors"[2] that address potentially unmet needs, including enabling caregiver presence.

1. Chow, G.V., et al. CURVES: a Mnemonic for determining medical decision-making capacity and providing emergency treatment in the acute setting" *Chest 2010* Feb;137(2):421-7.
2. Perry, A., et al. Assessment of Dementia Patients in the Emergency Department #72. Geriatricfastfacts.com

Clinician Education:

- Consider training initiatives for staff, such as the Dementia-Friendly Hospital Initiative (see https://www.hcinteractive.com). the GeriEM.com education model, the GENE course (for nurses), and the GEMS course (for EMTs)
- Know atypical presentations of dementia
- Adverse medication events are common in patients with dementia. Know high-risk and potentially inappropriate medications for older adults (e.g., reference AGS' BEERS List)

Discharge Planning

- Aim to avoid extended length of stay in the ED, admission, and transfers of patients with dementia when possible and reasonable.
- Consider whether the patients is at risk for "**RISKS**"

Roaming /wandering

Imminent danger — falls or fire-setting

Suicidal ideation

Kinship and relationships (elder abuse, adequate social support)

Safe driving Substance misuse, Self neglect

- Remember we are not newly diagnosing dementia in the ED, rather identifying (perhaps temporary) cognitive impairment and then referring for screening
- Use the "teach-back" method
- Involve caregivers in discharge planning whenever possible
- Consider referral options (e.g., PCP follow-up, Memory Clinic)
- Know about appropriate residential care options
- Consider available community resources (it helps to have a list of these resources on hand – contact your Area Agency on Aging (AAA) for information)