Delirium

BEST PRACTICE QUICK REFERENCE GUIDE FOR CARE OF OLDER PERSONS

THIS QUICK REFERENCE GUIDE WILL ASSIST THE TEAM TO:

- Identify older adults at risk for delirium.
- Assess causes of delirium and implement appropriate interventions.
- Reduce the person's delirium-related anxiety and fear through appropriate management of the environment.
- Employ use of non-pharmaceutical interventions whenever possible.

KEY POINTS ABOUT DELIRIUM

- Delirium is the ***sudden onset*** of altered behaviour and mental status (disorientation, decreased ability to focus and pay attention, perceptual disturbances, impaired cognition).
- It is a ***transient state***—treatment of underlying cause(s) will usually reverse the alterations in mental status.
- Delirium in the older adult is frequently misdiagnosed—mental status changes are missed or wrongly attributed to dementia.
- Organic causes of delirium (medical illnesses) are often exacerbated by environmental changes and/or psychosocial issues in the older person's life.
- Sudden onset confusion can be the **first** or **only** sign of acute illness. Staff must assume that sudden changes in mental status are abnormal.
- **Almost any illness or medication can lead to delirium in the older adult.**

IS IT DELIRIUM OR DEMENTIA?

	DELIRIUM	DEMENTIA
ONSET	Rapid (hours, days)	Slow (months, years)
SYMPTOMS	Fluctuate over the course of the day	Relatively stable
DURATION	Days to weeks	Years
ORIENTATION	Disorientation and disturbed thinking are intermittent	Persistent disorientation
LEVEL OF CONSCIOUSNESS	Fluctuates, with inability to concentrate	Alert, stable
SLEEP/WAKE CYCLE	Sleep/wake cycle may be reversed	Sleep may be fragmented

(604) 266-3572
mlharrigan@shaw.ca

ASSESSMENT OF DELIRIUM

Is the Person at Risk?

- Dementia
- Advanced age (> 75 years)
- Polypharmacy
- History of delirium
- Chronic illnesses
- Recovery from surgery

Is Sudden Onset Confusion Present?

- Rapid onset
- Fluctuating symptoms
- Evidence of disordered thinking
- Altered attention span
- Altered level of consciousness
- Altered ability to do ADL's

Evaluate Mental Status Changes

- Mental status examination (MMSE)
- Confusion Assessment Method (CAM)
- Collateral information from family and friends
- Assess changes in ADL's and behaviour

Common Causes of Delirium	Assessment
Drug toxicity	New prescription, multiple drugs, drugs prescribed for many years; recent discontinuation of a usual drug; consider over-the-counter drugs and herbals
Infection	Vital signs, blood work, chest assessment, urinalysis, etc.
Pain	Assess efficacy of chronic and/or acute pain management
Dehydration	State of hydration and nutrition, electrolytes, etc.
Acute illness	Physical signs and symptoms, blood work, etc.
Exacerbation of chronic disease	Physical signs and symptoms, e.g., glucose meter reading for diabetics
Elimination problems	Constipation, impaction, urinary retention, etc.
Substance abuse	Alcohol use, drug misuse, alcohol/drug withdrawal
Psychosocial problems	Recent losses, grief, relocation trauma, fear/anxiety, sleep deprivation, sensory overload

Consult with Team and develop an interdisciplinary plan of care to resolve causative factors (e.g., resolve pain, treat infection, institute a bowel protocol for constipation).

Interventions

- Develop an interdisciplinary plan of care to resolve causative factors (e.g., resolve pain, treat infection, institute a bowel protocol for constipation).
- Provide ongoing education, reassurance and emotional support to person and family. Assure them that delirium is transient and can be treated, especially if recognized early.
- Maintain a comfortable and familiar environment (e.g., provide eyeglasses, hearing aids, consistent staffing).
- Establish a day routine to reduce the person's stress level; encourage family to stay with the person if this provides reassurance.
- Promote sleep at night by controlling noise and disruptions.
- Ensure 1500 ml. daily fluid intake unless medically contraindicated.
- Use non-pharmaceutical interventions whenever possible.
- Avoid restraint.

Prepared especially for VIHA Delirium DVD 2006