

# G2C Case Studies- Primary Care

Regional Geriatric Programs of Ontario  
GiiC Initiative for FHTs and CHCs

# think

**Geriatrics**  
**Interprofessional**  
**Interorganizational**  
**Collaborative Care**

## Delirium

A geriatric nurse is accompanying a mental health worker on a noontime home visit. The MH Worker urgently requested her help after receiving a phone call from the police. They had been receiving several calls from Mr. Polska about “strangers” in his home. Mr. Polska is 80 years old, a retired farmer who lives alone. He was a client of the community mental health geriatric outreach team last year. The MH Worker is worried that he may have been in his workshop and forgotten to eat and drink. He chronically abuses alcohol. He has no family physician and is highly distrustful of health care. He is generally a cooperative quiet person in his neighbourhood. His only daughter lives 3 hours away and is supportive. He was hospitalized 1 year ago for 3 months for dehydration and delirium and is not taking medication.

On arrival, the doors and windows are covered. Woodworking tools are on the front porch. After banging on the door, Mr. Polska cautiously opens it. He is dishevelled, unsteady, guarded and anxious. The house is clean with several 1/2 empty glasses of juice in the kitchen. He is emotionally labile, cries and is distracted about the supposed marriage of his niece to the Prime Minister. He covers his windows to keep out strangers. He claims he has no health problems other than being very sleepy with no energy. A neighbour arrives with groceries. The neighbour is very concerned about Mr. Polska and provides some more information. Mr. Polska has been more confused, moody and irritable over the last 4 days. A delivery service brings regularly supplies including alcohol. Suddenly, Mr. Polska begins ranting about the neighbour’s spouse and utters death threats. When the MH Worker challenges him on the seriousness of the threats and lets him know that actions may be taken, he backs down and denies any intent.

**Collaborating for better patient outcomes . . .**

- ◆ Is ideal mental and general health achievable?
- ◆ What are the challenges?



*Mr. Polska demonstrates the difficulties in recognizing delirium in frail older people in the community. His deteriorating mental status is compounded by alcohol, dehydration, cognitive decline and limited social contact. Delirium interventions are multifaceted for cognitively, mentally and functionally declining older adults. In fact, it is the most common complication of hospital admission, 30-50% for older people over 70. Delirium has serious consequences and has been associated with increased death and illness. Estimated in-hospital deaths are over 20% and within 1 year of hospitalization are 35-50%. Survivors of delirium have a risk of nearly 50% permanent neurocognitive impairment.*

## How and why?

How does delirium relate to general health ?  
How urgent is his situation? Why is he “high risk”?  
Why is delirium often misdiagnosed as just a “confused senior”?  
How do you differentiate delirium from dementia, from depression?  
What are the clinical signs of delirium? What do you observe?  
How do you communicate with older adults presenting with sudden confusion/ delirium in their home?  
What about his functional and cognitive decline, family and community supports, alcohol abuse, other issues?

## Who and Where?

Who should be involved in his care?  
Health care professionals? Careproviders? Agencies?  
Is it possible to collaborate? On what issues?  
Who will be assessing, monitoring and treating his health?  
Are there financial and physical barriers to receiving care?  
What is the goal of care? Is it age-appropriate? Is it patient-centred? Is it home-based?  
Who will advocate ? How will his choices /values be respected?

Developed by ML van der Horst, RGP-Central /M Beatty, Upper Grand FHT-Fergus /S Gregg, S O'Connor & L Sullivan, Trellis Mental Health, Waterloo-Wellington

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For Delirium, 3D, & IPC resources, go to  
[www.rgpc.ca](http://www.rgpc.ca) & [www.rgp.toronto.on.ca](http://www.rgp.toronto.on.ca)

