Pharmacological management of delirium in the older person

Sedation (all sedatives can cause delirium)
- Use short acting benzodiazepine only where essential
  - to carry out tests or treatments
  - to prevent harm to self or others
  - to relieve distress
- Haloperidol useful first choice, short-term treatment
  - Dose 0.25mg – 0.5mg BD, if not responding up to a total of 2mg daily.
  - Unsuitable for patients with Parkinson's Disease or Lewy-Body Dementia.

If unsuccessful or contraindicated consider:
- Risperidone – 0.25mg BD (if syrup unavailable start at 0.5mg per day to a max. of 2mg per day)
- Olanzapine – 2.5mg per day, increasing to 5mg per day
- Oxazepam – may be used as an adjunct if necessary 7.5-15mg orally 2-3 x daily

- Review medication use daily for response, side effects, need for continuation. Discontinue a.s.a.p.
- Start low and go slow

Non-pharmacological management of delirium in the older person

Cognition – establish baseline & document changes.
Hydration and nutrition – ensure at least 2l fluids/day unless contraindicated.
Mobility and Falls – Early mobilization & self-care. Reduce use of restraints & immobilising equipment.
Sensory – Use hearing aids, glasses & dentures Reduce background noise.
Sleep – If possible allow for period of uninterrupted sleep at night. Minimise noise and activity.
Environment – remove unnecessary equipment & reduce environmental stimuli which may be misinterpreted & cause agitation. Adequate lighting. Minimise room changes. Provide orientating clues.
Provide distraction in simple activities or family visiting.
Behavioural Interventions – use simple one step commands – do not argue. Educate family to reassure & engage their support in patient care.
Communication – subtle reorientation in conversation. Quiet and calm approach. Reassurance. Anticipate needs.
Pain – observe non-verbal pain cues.
Request scheduled pain medication – not PRN

DELIRIUM
an acute medical condition

NSW Health
Hunter New England
Local Health Network

Identify & address the cause

HISTORY
- Medication
- Recent changes
- Include nonprescription and 'natural' medications
- Past medical history
- Alcohol history
- Dehydration
- History of dietary and fluid intake
- Bladder and bowel function
- Sensory impairments
- Premorbid cognitive and functional status
- Onset and course of confusion
- Falls
- Preadmission social circumstances
- Symptoms suggestive of underlying cause

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Diagnostic Algorithm for Delirium Confusion Assessment Method - CAM

The diagnosis of Delirium by CAM requires the presence of features 1 & 2 &either 3 or 4.

Feature 1. Acute onset and fluctuating course

Feature 2. Inattention

Feature 3. Disorganised thinking

Feature 4. Altered level of consciousness

DELIRIUM
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Predisposing RISK FACTORS

- Cognitive impairment
- Dehydration
- Immobility & functional impairment
- Visual & auditory impairment
- Sleep deprivation/disturbance
- Constipation

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an acute medical condition

Identify & address the cause

EXAMINATION
- Obtain vital signs
- ECG
- Cognitive assessment
- Neurological assessment
- Urinalysis and MSU (if UA abnormal)
- Skin inspection
- Presence of pain
- FBC, UEC, Gluc, Ca, LFTs, TFTs,
- Chest and abdominal x-ray

Further investigations will be dependant upon clinical features:
- Specific cultures
- Arterial blood gases
- CT Brain
- EEG
- Lumbar puncture
- B12 and folate