GREATER SOUTHERN
AREA HEALTH SERVICE
NSW HEALTH

DELIRIUM ALERT

This patient has been identified with delirium OR is 'at risk' of developing delirium

THINK :

- Hydration & nutrition
- Pain relief
- Falls risk
- Bowel & bladder management
- ORIENTATION to environment
- Wearing of visual and hearing aids
- Monitoring and documenting of behaviour and cognition
- If at RISK and cognition changes – Complete CAM

See over for clinical and environmental delirium prevention and management strategies

References: NCAHS *Delirium Alert &* AHMAC, 2006

DELIRIUM PREVENTION

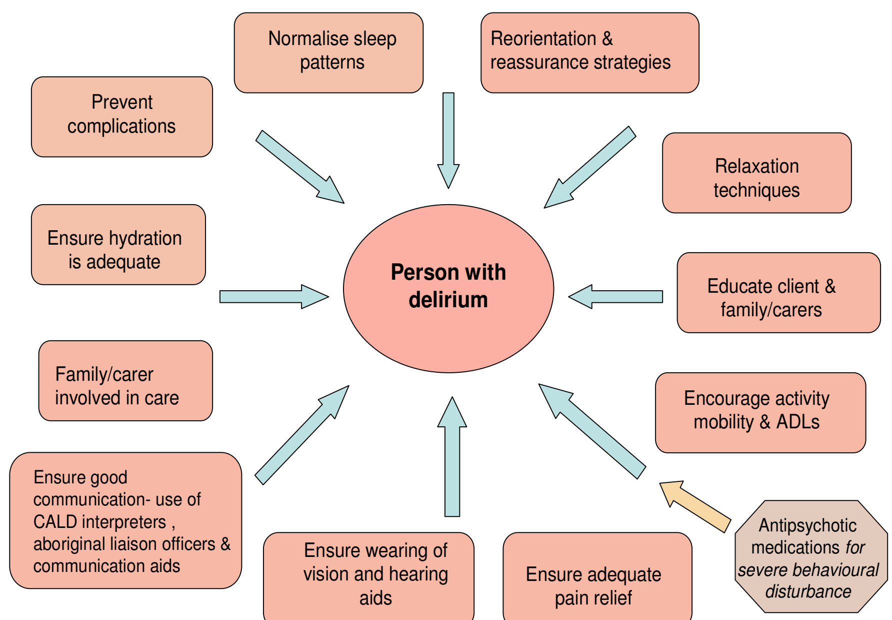
Care Domain	Prevention Strategies
Promotion of Sleep and Rest	▪ Reduce noise (quiet or single room if possible) ▪ Keep room light during the day and minimal lighting at night ▪ Warm drinks/back or feet massage ▪ Assess and treat any pain
Orientation	▪ Provision of clocks and calendars that patients can see ▪ Talk about current events and surroundings ▪ Always introduce yourself and tell the patient what your role is and what you are doing ▪ Encourage families/carer to bring in patients personal belongings and objects that are important to them. ▪ Avoid room changes – frequent changes can increase disorientation
Ensure adequate nutrition and hydration	▪ Assist and encourage with eating and drinking to ensure adequate intake; assess nutritional status – **refer to dietician** ▪ Commence fluid balance chart if drowsy and unable to take fluids independently. ▪ Monitor and correct electrolyte imbalances
Avoid constipation	▪ Implement bowel monitoring chart and give aperients
Vision and hearing	▪ Ensure patients who usually were hearing and visual aids are encouraged and assisted to use them. ▪ Ask relatives to bring aids in to hospital if they have been left at home
Promote mental stimulation & therapeutic activities	▪ Ask carer to complete family/carer questionnaire. ▪ Use personal profiles to identify appropriate activities and mental stimulation. – **involve/refer to OT** ▪ Encourage family and friend involvement and visiting
Promote physical activity and mobilisation and prevent falls	▪ Avoid physical restraints and catheters ▪ Identify and try to maintain normal activities and routines ▪ Encourage independence in ADL's ▪ Encourage and assist with mobility ***Assess risk for falls*** ▪ Refer for physiotherapy assessment
Cognition and communication	▪ Medication review – identify and avoid psychoactive drugs – **refer to pharmacist** ▪ Monitor cognition with AMT/SMMSE – complete CAM if change ▪ Use of interpreters and other communication AIDS for CALD ▪ Use Aboriginal liaison officers for aboriginal patients

DELIRIUM MANAGEMENT

Includes the following:

- Identify cause where possible
- Address the cause and precipitating factors
- Manage the symptoms – *always implement non pharmacological management first*
- Refer to guidelines for pharmacological management
- Gain specialist advice – Dementia/Delirium CNC or geriatrician
- Provide a supportive environment
- Prevent complications
- Educate and support family and carers – **provide delirium brochure**

Multicomponent management of delirium symptoms



References: NCAHS *Delirium Alert* & AHMAC, 2006