Delirium Management

This patient has been identified as having delirium or being at high risk of developing delirium.
Delirium is an **acute disturbance of brain function** secondary to a wide variety of bodily illnesses. It may be characterized by acute confusion, fluctuating throughout the course of the day and can often be worse at night. Other signs of delirium can include changes in alertness, disorganized thinking, psychomotor changes, sensory misinterpretation or emotional changes. *(American Psychiatric Association's Diagnostic and Statistical Manual) (DSM IV) 2000.* Delirium is related to higher morbidity and mortality, prolonged length of stay, institutionalization and functional decline as well as increase stress and distress to the individual and their families**. Pts who have a delirium are at greater risk of falls and should be managed considering falls risks/hospital falls policy.**

'Screening for delirium' (otherwise known as the Confusion Assessment Method) should be completed within 24hrs of the patient's admission as indicated on the Adult Admission & Discharge Assessment (AADA) and repeated if there is a change in patient cognition or behaviour. The CAM is a validated tool to be used in assisting with the differential diagnosis of Delirium. It is important the CAM is used in conjunction with a formal cognitive assessment, good clinical and medical assessment, together with baseline cognition information from carers/family or residential aged care staff. *(Inouye et al., 1990).*

Consider use of one of the following cognitive assessment tools or refer to recently undertaken assessment:

- AMT (Abbreviated Mental Test) *(Hodkinson 1972)*
- MMSE (Mini Mental State Examiniation) *(Folstein 1970)*
- RUDAS (Rowland Universal Dementia Assessment Scale) (Rowland et al 2006)

IDENTIFYING DELIRIUM

A change in "Normal"	Psychomotor disturbance,agitation	Disorientation
Sudden onset confusion	Emotional lability	Disturbed sleep wake cycle
Clouding of consciousness…. fluctuates over 24 hours	Thinking, perception and short term memory impairment	Cognition and mood fluctuation
Processing of stimuli impaired	Hallucination & Delusion	

CONFUSION ASSESSMENT METHOD (CAM)

"Adapted from: Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003, Sharon K. Inouye, M.D., MPH."

1	Acute onset and fluctuating course	No	Yes	Uncertain, *Specify:* _____	Is there evidence of an acute change in mental status from the patient's baseline? If so, did the abnormal behaviour fluctuate during the day?	E.g. tend to come and go, or increase and decrease in severity
2	Inattention	No	Yes	Uncertain, *Specify:* _____	Did the patient have difficulty focussing attention during the interview?	E.g. being easily distracted, or having difficulty keeping track of what was being said?
3	Disorganised thinking	No	Yes	Uncertain, *Specify:* _____	Was the patient's thinking disorganised or organised?	E.g. Rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from one subject to another?
4	Altered level of consciousness	No	Yes	Uncertain, *Specify:* _____	Overall, how would you rate the patient's level of consciousness?	Altered E.g. Vigilant, Lethargic, Stupor, Coma, Uncertain.

Delirium is present if features 1 and 2 AND either 3 or 4 are present

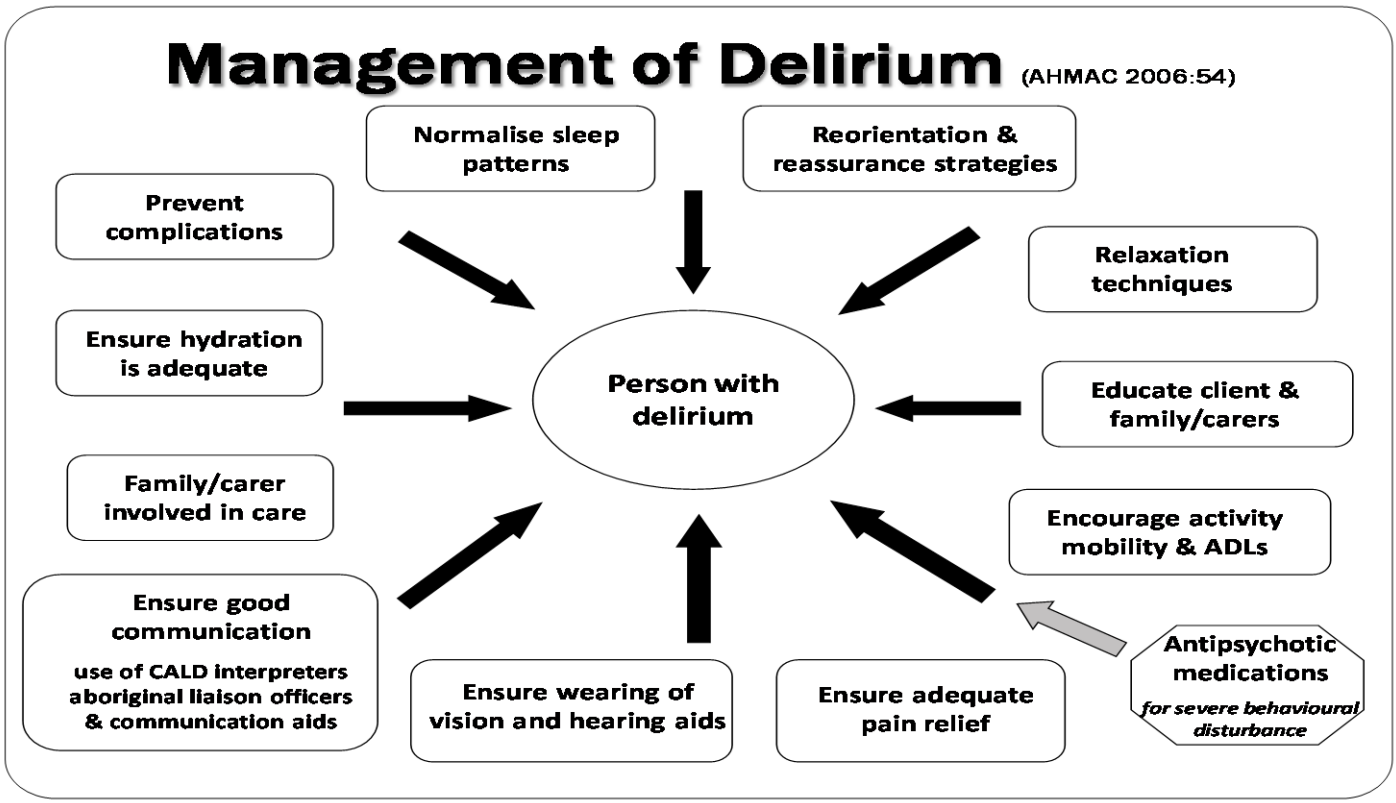
Delirium symptoms: not present / present	Date: / /
Medical Officer notified? Yes / No	

STRATEGIES TO PREVENT DELIRIUM MAY INCLUDE:

○ **Prioritise stability of care** – aim to streamline transfer to appropriate ward and bed area, minimise changes of bed, nurse patient in an area close to the nurses station. Aim for continuity of nursing and medical care
○ **Optimise physical health** – ensure adequate hydration and nutrition, (patient may require assistance with feeding) and oxygenation. Avoid constipation and urinary retention; also avoid urinary catheters if possible. Maintain mobility, regular supervised walks may be appropriate, Avoid restraints. Try to minimise sleep deprivation (but avoid hypnotic drugs if possible.
○ **Suitable environment** – be aware that bed rails and monkey bars, oxygen masks and all other unfamiliar items in the patient's environment may be perceived as threatening.
○ **Orientate** – to time, and place using verbal and visual cues, ie calendar, clock, whiteboard messages. Use a night light and familiar objects to aid orientation.
○ **Drugs** – that may cause confusion include, sedatives / hypnotics, as well as some analgesics, anticholinergics, cardiac, gastrointestinal drugs and any drug which acts on the brain.
○ **Drug and Alcohol assessment** – this may need to be obtained from an ancillary source. The rapid cessation of alcohol, or benzodiazepines can precipitate withdrawal delirium.
○ **Relieve Pain** – but avoid analgesic toxicity

NURSING MANAGEMENT OF DELIRIUM SHOULD INCLUDE:

- Inform medical staff and relevant CNC
- Thorough documentation and handover of behaviour each shift
- Be organised and timely with interventions
- Physical Restraints should be avoided and psychotropic medications should be limited
- Reorientation & reminiscence strategies – involve families/significant others (ie use of clock, family photos..)
- Maintain mobility, identify as falls risk (refer to falls policy)
- Encourage oral fluids, assist with meals as required
- Quiet environment with reduced activity/stimulation & soft lighting at night (to assist with reorientation)
- Relaxation strategies to help sleeping and reduce anxiety
- Make sure hearing aides and glasses are insitu and in good repair
- Education and support of the patient and their family
- Be flexible with visiting hours for family members, consider a family roster



Resources

	Clinical Practice Guidelines for the management of Delirium in Older People (2006) Delirium Management policy CRG_PD2011_81