

# DELIRIUM INFORMATION

## A MAP OF DELIRIUM PROJECT INITIATIVE



Hospital admission  
Age >65

Reassess cognitive function if any change in mental status, behaviour or confusion noted

Assess cognitive function  
- With valid tool (eg AMT)  
- Collateral history to see if change from baseline

**Prevention of delirium**  
Address these modifiable risk factors for delirium in the nursing care plan

1. Provide Orienting Communication
2. Encourage Early Mobilisation
3. Use Visual aids
4. Use Hearing Aids
5. Prevent Dehydration / Poor Nutrition
6. Provide Uninterrupted Sleep Time

As possible – avoid use of restraints, IDC and multiple medications.

If abnormal (eg AMTS score <8 or further drop in score of 2) or confusion noted .....  
**INITIATE MEDICAL REVIEW**

**Change in mental status – Inform Medical Staff**

Chronic

Acute

Dementia evaluation

Assess for presence of delirium using CAM (utilise MMSE)

Delirium confirmed

Consider coexisting dementia, depression, mania, psychosis

Adapted from: Inouye, [23]

Optimise preventative strategies

Find the cause (often multiple)

Support and prevent complications

Manage symptoms

**Medical Evaluation**  
History ? drug or alcohol withdrawal  
Examination – vitals, physical and neurological, ?PR, ?bladder scan  
Investigations - FBC, U+E, Ca, Glucose, LFT's ?infection - CRP, +/- BC, dipstick urine +/- MSU, CXR, ECG

**Review medications**  
Check medication list and actual meds (brought in by patient)  
Review prescribed medications  
Consider occult drug or alcohol use (e.g benzodiazepine)

**Prevent complications**  
Prevent aspiration (positioning, Speech Path)  
Optimise oxygenation (O2)  
Maintain volume status (sc /iv fluids)  
Provide nutritional support (supplements/dietician)  
Prevent pressure ulcers (nurse)  
Prevent DVT (TEDs, clexane, mobilisation)

**Treatment strategies - Nonpharmacologic**  
Use support person trained in caring for people with delirium  
Employ validation and reality orientation strategies  
Involve family (see below)  
Use same staff  
Utilise Interpreter where communication difficulties  
Regular analgesia (example regular Paracetamol)  
Discourage napping during daytime.  
Manage constipation.  
Reduce restraints  
Reduce invasive equipment (IV lines, IDC etc)  
Eliminate irritating noises

**Pharmacologic management**  
Ensure all other aspects of flow chart are addressed  
Nursing staff check prepharm checklist (appendix 2)  
Refer to Pharmacology flow diagram  
Use safe prescribing and review regularly  
Maintain effective dose for 2-3 days

**Likely causes identified**

**Remove or alter potentially harmful drugs**  
Change to less noxious alternative  
Lower doses  
Nonpharmacologic approaches

Yes

No

**Treatment Monitoring**

**Consider further investigation (see guidelines)**  
ABG, Ammonium, Specific Cultures, Drug levels, toxicology screen, TFT's, B12/folate, AXR, CT head, LP, EEG  
**Consider Geriatric referral**  
Particularly if functional decline and likely to need rehabilitation

Involve family (assistance with aids/memos, assist in cognitive stimulation and orientation) allowing the family to visit and sit with the patient (and re-orientate) for as long as possible (including overnight) – give Carer Information Leaflet

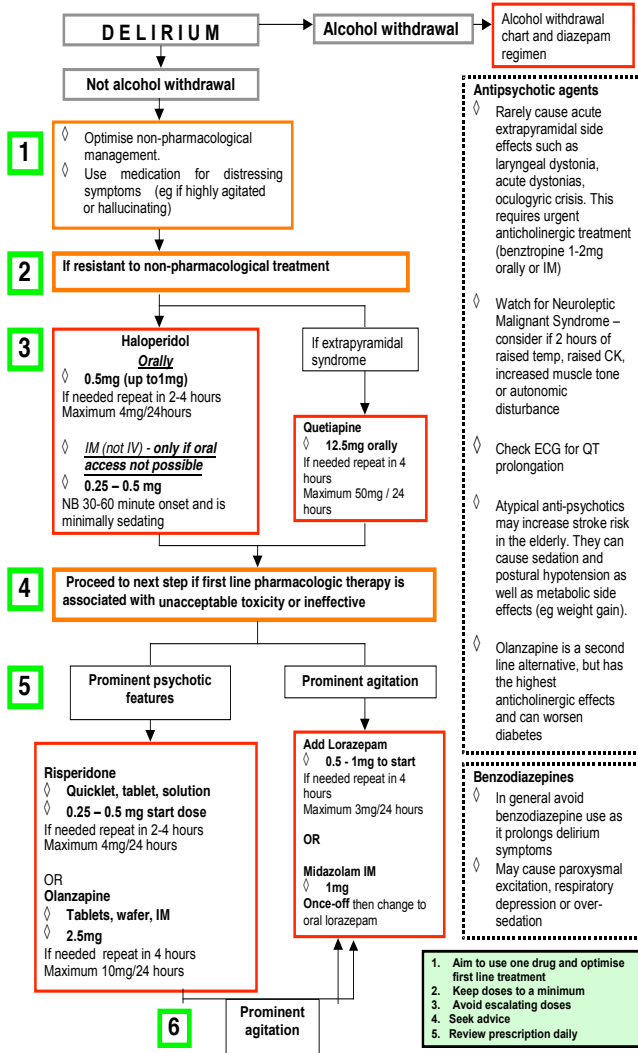
If persistent problematic behaviour consider need for specialist consultation (DGM, Adult Psychiatry or Psycho - geriatrics).

# DELIRIUM INFORMATION

## A MAP OF DELIRIUM PROJECT INITIATIVE



### Acute Pharmacological Management Guideline – for Older In patients



### A MAP of Delirium – Quick Guide

Delirium is an acute confusional state, present in 20% of general medical patients, but at best only half of cases are recognised. It leads to prolonged admission, falls, residential care placement and death.

This quick guide provides some key pointers and links to the complete delirium guidelines. The **Delirium Pathway flow chart** (see over) shows a comprehensive way of approaching Delirium (§ means medical responsibility). **Remember** - Managing the patient comprehensively not only leads to a better outcome, but also reduces the workload and admission time.

#### PREVENTION

There is good evidence delirium can be prevented - "excellent nursing care" is the key. The nurses perform risk screening and modify these factors, where applicable, in the nursing care plan.

The doctor can assist by avoiding IDC use, restraint use, and avoid adding to the medication burden.

#### ASSESSMENT

The nursing staff will perform an AMT, if the score is <8 it is abnormal, needs further assessment by the doctor and explaining. It is most commonly delirium, dementia, or both. (use guidelines)

Using the CAM (ideally with MMSE) to improve the diagnostic approach (attached) and assume it is delirium until proven otherwise. It is about observing patient behaviour and responses.

**The key is to look for inattention, the inability to focus.** This can be observed (the patient shifts attention, loses track) and tested (serial 7's, 20-1).

The **onset is critical** and may require talking to the family or residential care.

Further details of how to assess and investigate your delirious patient can be found in the **delirium guidelines**.

#### MANAGEMENT

**Treating the underlying cause** is the key and is what doctors do well. The cause of delirium is usually multifactorial so don't stop at one problem. Consider medication(s), alcohol and drug withdrawal, and bowels and bladder function (often neglected).

Ideally **good nursing care** should avoid the need for medication (antipsychotics), but if the patient is a danger to themselves or others, or disturbed by their symptoms, medication(s) may be indicated.

Use the **Pharmacological Management flow diagram**, the Geriatric and Psychiatry departments have endorsed them - they are only a **guide**.

Use **low dose medication** while avoiding escalation and **don't prescribe without reviewing the patient**.

**# Perform an MMSE, observe patient behaviour then address the Confusion Assessment Method (CAM)**

### Confusion Assessment Method (CAM)

Perform an MMSE, observe patient behaviour then address the following features to diagnose delirium

#### Feature 1: Acute Onset and Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: 'Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?'

#### Feature 2: Inattention

This feature is shown by a positive response to the following question: 'Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?'

#### Feature 3: Disorganised thinking

This feature is shown by a positive response to the following: 'Was the patient's thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?'

#### Feature 4: Altered Level of Consciousness

This feature is shown by any answer other than "alert" to the following question: 'Overall, how would you rate this patient's level of consciousness? alert [normal], vigilant [hyperalert]), lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable].

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4

(Source: Inouye SK, VanDyck CH, Alessi CA et al. Ann Intern Med. 1990; 113:941-8)