Delirium

**Key Points about Delirium**

- **Delirium is a medical and nursing emergency.**
- Delirium is a disturbance of consciousness with a *sudden onset* of altered behaviour and mental status (disorientation, decreased ability to focus and pay attention, perceptual disturbances, impaired cognition).
- It is a *transient state*—treatment of underlying cause(s) will often reverse the alterations in mental status.
- Delirium in the older adult is frequently misdiagnosed—mental status changes are missed or incorrectly attributed to dementia.
- There are three types of delirium: hypoactive, hyperactive and mixed.
- Hypoactive delirium can be mistaken for depression or fatigue because the older adult presents as lethargic, quiet and withdrawn.
- Delirium resulting from organic causes such as medical illness can be exacerbated by environmental changes and/or psychosocial issues in the older person’s life.
- Sudden onset confusion can be the *first or only* sign of acute illness. Staff must assume that sudden changes in mental status are abnormal.
- Almost any illness or medication can lead to delirium in the older adult.

### Is it Delirium or Dementia?

<table>
<thead>
<tr>
<th></th>
<th>Delirium</th>
<th>Dementia</th>
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</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Rapid (hours, days)</td>
<td>Slow (months, years)</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Fluctuate over the course of the day</td>
<td>Relatively stable</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Days to weeks</td>
<td>Years</td>
</tr>
<tr>
<td><strong>Level of Consciousness</strong></td>
<td>Fluctuates, with inability to concentrate</td>
<td>Alert, stable</td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td>Disorientation and disturbed thinking are intermittent</td>
<td>Persistent disorientation</td>
</tr>
<tr>
<td><strong>Sleep/Wake Cycle</strong></td>
<td>Sleep/wake cycle may be reversed</td>
<td>Sleep may be fragmented</td>
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### ASSESSMENT HIGHLIGHTS

#### Is the Older Adult at Risk?
- Dementia
- Advanced age (> 75 years)
- Polypharmacy
- History of delirium
- Chronic illnesses
- Recovering from surgery/general anaesthetic

#### Is Sudden Onset Confusion Present?
- Rapid onset
- Fluctuating symptoms
- Evidence of disordered thinking
- Altered level of consciousness
- Altered ability to perform ADL’s or IADL’s

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#### Evaluate Mental Status Changes
- Mental status examination (MMSE)
- Confusion Assessment Method (CAM)
- Collateral information from family and friends
- Assess changes in ADL’s or IADL’s and behaviour

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#### Common Causes of Delirium

<table>
<thead>
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<th>Assessment</th>
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<tbody>
<tr>
<td>Drug toxicity</td>
<td>Consider new prescriptions, dosage increases, multiple drugs, anti-cholinergic medications, serum drug levels</td>
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<tr>
<td>Infection</td>
<td>Vital signs, blood work, chest assessment, urinalysis</td>
</tr>
<tr>
<td>Pain</td>
<td>Assess efficacy of persistent/chronic and/or acute pain management</td>
</tr>
<tr>
<td>Dehydration</td>
<td>State of hydration, nutrition, electrolytes</td>
</tr>
<tr>
<td>Acute illness</td>
<td>Physical signs and symptoms, blood work</td>
</tr>
<tr>
<td>Exacerbation of chronic disease</td>
<td>Physical signs and symptoms specific to illness, e.g., glucose meter reading for diabetics</td>
</tr>
<tr>
<td>Elimination problems</td>
<td>Constipation, impaction, urinary retention</td>
</tr>
<tr>
<td>Substance misuse or abuse</td>
<td>Alcohol use, drug misuse, alcohol/drug withdrawal</td>
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<tr>
<td>Psychosocial problems</td>
<td>Recent losses, grief, relocation trauma, fear/anxiety, sleep deprivation, sensory overload</td>
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#### Communicate and plan with the team.

#### Care Team Interventions
- Develop an interdisciplinary plan of care to resolve causative factors (e.g., resolve pain, treat infection, institute a bowel protocol for constipation).
- Provide ongoing education, reassurance and emotional support to the older adult and family. Assure them that delirium is transient and treatable.
- Maintain a comfortable and familiar environment (e.g., provide eyeglasses, hearing aids, calendars, consistent staffing).
- Establish a daily routine to reduce the older adult’s stress level; encourage the family to stay with the person if this provides reassurance.
- Promote sleep at night by controlling the environment (e.g., minimize noise and disruptions).
- Ensure 1500 ml. daily fluid intake unless medically contraindicated.
- Use non-pharmacological interventions whenever possible.
- Avoid use of physical restraints, as they exacerbate delirium-related agitation and increase fall risk. To provide support, consider the need for close or constant care.

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