Midland DHBs Delirium Care Guide

Definition: Delirium is characterised by a disorder in consciousness and change in cognition that develops over a short space of time and may fluctuate in intensity. It is a medical illness that can be treated with the expectation that the patient will return to a previous level of functioning. Early identification is essential. Effective nursing and medical care can prevent/minimise the impact of delirium.

Signs and symptoms:

- Clouding of consciousness
- Acute onset (usually hours to days)
- Fluctuating course
- Disorientation in time and space/place
- Anxiety / extreme fearfulness
- Changes in attention
- Agitation or apathy
- Changes in sleep/wake cycle
- Disorganised behaviour
- Perceptual distortion with hallucinations
- Disturbed mood and emotional disturbances
- Language/speech disturbance e.g. rambling speech
- Memory impairment (recent)
- Disturbance in psychomotor behaviour

Causes of delirium:

- Medications - polypharmacy, drug or alcohol withdrawal
- Infections – encephalitis and meningitis, severe infections or any infection in the elderly
- Metabolic – electrolyte imbalance, uraemia and liver failure, thyroid disease, hyper/hypoglycaemia
- Hypoxia
- Neurological – head injury and subdural, cerebrovascular disease, seizure and epilepsy, Parkinson's disease
- Urinary retention or constipation
- Recent surgery
- Urinary catheterisation
- Pain
- Dehydration and poor nutrition
- Diseases – dementia, Alzheimers disease, cardiac, pulmonary, haematologic, oncologic, renal, hepatic, metabolic, endocrinologic and infections
- Environmental changes e.g. move to a new room or ward
- Sleep disturbance

ASSESSMENT

Comprehensive physical assessment

Record vital signs: Temperature, pulse, respirations, blood pressure, oxygen saturation, blood sugar level. Assess hydration and nutritional status, infection, urinary retention, constipation, cardiac, respiratory, abdominal, pain

Neurological assessment:

- Glasgow coma scale
- Confusion Assessment Method (CAM)

Medication check: Is the patient on anticholinergics, sedatives or opiates? Has a new medication been added or one been withdrawn?

Diagnostic tests and investigations

Delirium screen:
Organise laboratory tests – midstream urine and blood.

Blood tests should include:

- Liver Function
- Serum medication levels (if applicable)
- Calcium level
- Thyroid
- B12/folate
- Urea and electrolytes
- Full blood count
- ESR
- CRP
- Glucose
- Troponin

Check for the following exacerbating factors:

- Previous episode or history of delirium
- Uncomfortable e.g. too hot or cold, incontinent, needing position change, toileting, hungry / thirsty
- Non-English speaking
- Noisy environment
- Know to have history of mental illness
- Recent environmental change

DELIRIUM IS A MEDICAL EMERGENCY

Early recognition is critical

COMPREHENSIVE PHYSICAL ASSESSMENT and CAM ASSESSMENT

If patient displays concerning behaviours consider criteria for **care intensity level** to manage patient safety: Intentional rounding / 15-30 minute checks / constant observation

DIAGNOSTIC TESTS and INVESTIGATIONS
(to be ordered by medical staff)

CONFUSION ASSESSMENT METHOD (CAM)

FEATURE	SOURCE/CRITERIA	QUESTIONS
1. Acute onset and fluctuating course	Usually obtained from a family member or nurse and is shown by positive responses to 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 or decrease in severity?
2. Inattention	Shown by positive responses to question	Did the patient have difficulty focusing attention for example being easily distractible, or having difficulty keeping track of what was being said?
3. Disorganised thinking	Shown by positive responses to question	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?
4. Altered level of consciousness	Shown by an answer other than alert to the question	Overall, how would you rate this patient's level of consciousness? Alert (normal), vigilant (hyperalert), lethargic (drowsy, easily roused), stupor (difficult to rouse) or coma (unrousable)?

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

Adapted from: Waitemata District Health Board (2012). RN Care Guides – Waitemata District Health Board and Waikato District Health Board (2014). The prevention, detection assessment and management of delirium.

Nursing management:

- Complete the change in mental status sticker and contact the Doctor
- Complete the CAM tool
- Orientation to time, place and person. Note: patients are often fearful so be calm and let the patient know that you will keep them safe.
- Avoid unnecessary bed space or room changes
- Provide adequate hydration and nutrition
- Look for signs of infection / avoid unnecessary catheterisation
- Check oxygen levels
- Call bell in reach
- Hearing and visual aids worn at all times during daylight hours
- Exercise and early mobilisation
- Adequate pain relief given
- Maintain a structured and consistent routine
- Maintain a calm, well lit environment
- A full medication review, avoid unnecessary medications
- Increased communication with family / carers
- Clocks and calendars to help with orientation
- Keep bed as low to the ground as possible and implement falls minimisation strategies
- Use non-slip socks or suitable footwear
- Use firm, non-confrontational directions (do not argue)
- Anticipate care needs, increase surveillance/intentional rounding
- Bowel chart commenced, assess for constipation
- Document behaviours clearly and any management strategies that are working or are clearly ineffective