North Simcoe Muskoka
Specialized Geriatric Services

DELIRIUM

A Summary For Teams Caring for Older Adults

Ask family members "Is this a change?"

- Delirium is **NOT** dementia.
- Delirium is often **misdiagnosed** or **not detected**.
- Up to 75% of older adults experience delirium after acute illness or surgery.
- 75% will recover in days/week. 25% will have persistent delirium that may last for months and, in some cases, never resolve.
- Delirium **can often be prevented** if you are aware of the potentially modifiable risk factors.

Types of Delirium

Hyperactive - repetitive behaviours such as plucking at sheets, picking, wandering, restless, or perceptual disturbances such as illusions or hallucinations

Hypoactive - appear quiet and withdrawn and may appear sleepy or sedated

Mixed - hypoactive and hyperactive symptoms that fluctuate and includes lucid periods

Delirium is …

A **sudden** change that causes confusion and uncharacteristic behaviours. It is characterized by:

- Fluctuations in presentation and behaviours
- Inattention (difficulty focusing and concentrating)
- Disorganized thinking (rambling, incoherent speech, unpredictable switching of subjects)
- Altered level of consciousness (hyperactive, hypoactive)

Delirium is a MEDICAL EMERGENCY. It needs to be identified and managed quickly. Early diagnosis and treatment offer the best chance of recovery.

Additional Signs & Symptoms:

- Disorientation to time and/or place
- Memory problems
- Perceptual disturbances like hallucinations, illusions or misinterpretations
- Psychomotor agitation (restlessness, picking at clothing, tapping, sudden changes in position)
- Psychomotor retardation (moving slowly, sluggish, staring into space, staying in one position)
- Altered sleep-wake cycle

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Some Risk Factors

- Advanced Age
- Dementia
- Sensory (hearing, vision) or Functional Impairment
- Malnutrition
- Dehydration
- Urinary Retention
- Constipation
- Infection
- Surgery
- Pain
- Medication
- Metabolic Disorders
- Substance Use Disorders

References

Regional Geriatric Program of Toronto: **Senior Friendly Care (sfCare) Tools**

Canadian Coalition for Seniors Mental Health: Delirium Tools

McCabe, D. (2019). The **Confusion Assessment Method**. Try This; Best Practices in Nursing Care for Older Adults. Issue 13. The Hartford Institute for Geriatric Nursing, New York University, Rory Meyers College of Nursing

Tate, J. & Balas.M (2019). The **Confusion Assessment Method for the ICU (CAM-ICU)**. Try This; Best Practices in Nursing Care for Older Adults. Issue 25. The Hartford Institute for Geriatric Nursing, New York University, Rory Meyers College of Nursing

Delirium Screening Tool

In the NSM region, the most commonly used tool for the assessment of delirium is the:

- Confusion Assessment Method (CAM) (short)

Delirium Present. Now What?

As an *interdisciplinary* team:

- Ensure patient safety.
- Address the underlying cause(s) of the delirium.
- Anticipate, plan and take steps to prevent common complications.
- Assess and manage behaviour symptoms.
- Alleviate patient and caregiver distress.
- Make every effort to preserve functional abilities and mobility.

Other Intervention Strategies:

- Use clear and simple language.
- Orientate to present (i.e. clocks, calendars).
- Maintain a comfortable and familiar environment, minimizing changes in location and encouraging the presence of familiar caregivers.
- Provide daily routine to reduce stress and promote sleep at night by controlling noises and disruptions.
- Provide appropriate lighting.
- Promote use of sensory aids (glasses, hearing aids).
- Provide service in mother-tongue as often as possible; engage interpreters as required.
- Ensure fluid daily intake unless medically contraindicated; monitor skin integrity; monitor elimination patterns.
- Assess and manage pain using safest interventions.
- Provide education about delirium.
- Avoid restraints.