North Simcoe Muskoka
Specialized Geriatric Services

HUDDLE TALK – DELIRIUM

In this fast-pace health care environment, it can often be difficult to provide a scheduled uninterrupted education session or in-service with a team of staff. **Huddle Talks** are an alternate option.

DIRECTIONS:

1. Understand your audience by getting a high-level sense of their learning needs in advance of the education event. Review the Huddle Talk tool in advance of the event and identify some key areas where you may want to target the education.
2. At the event, provide the team/individual with the overview below.
3. Ensure the team/individual drives the education event so that you meet their learning needs.
    - Let the team/individual ask questions and you can provide answers using the tool; and/or
    - Choose questions from the tool to ask the team/individual based on your understanding of their needs and/or based on the flow of discussion.

OVERVIEW / KEY MESSAGES[1]:

- Delirium is a **medical emergency**. It needs to be identified and managed quickly.
- Delirium (or acute confusion) is a **sudden change that causes confusion and uncharacteristic behaviours**. While there are several key signs and symptoms, screening focuses on four key areas:
    - Fluctuations in presentation and behaviours (confusion and behaviours fluctuate over the course of a day)
    - Inattention (difficulty focusing and concentrating)
    - Disorganized thinking (rambling, incoherent speech, unpredictable switching of subjects)
    - Altered level of consciousness (hyperactive, hypoactive)
- Delirium is **often not detected, or misdiagnosed** as dementia or depression. Systematic screening and prompt assessment are important. Early diagnosis and treatment offer the best chance of recovery.
- Delirium often has a **multifactorial etiology** with predisposing, precipitating and perpetuating factors.
- Delirium **can often be prevented**. Awareness of its potentially modifiable risk factors is key to prevention.
- Delirium **can often be reversed** with proper assessment and treatment by an interdisciplinary team.

[1] References: Regional Geriatric Program of Toronto: Senior Friendly Care (sfCare) Tools; Canadian Coalition for Seniors Mental Health: Delirium Tools Clinician Pocket Card

QUESTIONS:

1.	**Is delirium a medical emergency and if so, why?**
	• Yes, delirium is a medical emergency. • Delirium is an acute change in the patient's mental status caused by a direct physiologic consequence of a general medical condition, an intoxicating substance, medication use, or more than one cause. • Delirium is potentially preventable – or at least able to decrease duration and severity with early identification and management. • 22-76% of seniors who develop delirium during hospitalization have an increased chance of death during the months following discharge. • It is an independent predictor of sustained poor cognitive & functional status during the year after a medical admission to hospital. • Increase LOS and likelihood of admission to nursing home.
2.	**List 5 risk factors for developing delirium.**
	• Over 65 years of age • Acute/chronic disease • Trauma (surgery, fall, fracture) • Diagnosis of dementia/ cognitive impairment/ depression • Previous delirium episode • Environmental change • Medication side effects, toxicity • Nutritional deficiencies • Abnormal body temperature • Male gender • Infection (i.e. URI, UTI) • Sensory losses (sight, hearing) • Poorly managed pain • Social losses or social isolation • Recovering from surgery, administration of anaesthetic. • Dehydration • Substance use disorders (i.e. Alcoholism) • Mechanical ventilation • Continuous medical monitoring • Metabolic disturbances • Heart failure • Cumulative analgesia
3.	**List six key delirium prevention interventions.**
	• Stimulating the mind • Moving • Sleeping Well • Seeing and Hearing • Staying Hydrated • Eating
4.	**All patients with delirium can be expected to become agitated and restless.**
	NO – FALSE There are 3 kinds of delirium – Hyperactive – Hypoactive – Mixed. A patient with Hypoactive delirium may not become noticeably agitated or restless which is why this type is frequently missed.
5.	**Distinguishing dementia vs delirium is difficult in patients who exhibit hallucinations.**
	NO – FALSE Delirium can commonly have symptoms of hallucinations – often frightening or upsetting (e.g. bugs – when receiving opioids). Dementia does not commonly have symptoms of hallucinations – Lewy Body Dementia is one type which does have hallucinations as a hallmark symptom. These visions are typically non-threatening, presenting as pets or children.
6.	**A patient must have symptoms of inattention to be diagnosed with delirium.**
	YES – TRUE According to the **Confusion Assessment Method (CAM)** screening tool, delirium must have an acute onset, a fluctuating course, inattention and *either* altered level of consciousness or

	disorganized thinking for diagnosis.
7.	**Early and progressive mobilization is an important intervention to prevent delirium.**
	YES – TRUE Especially in ICU – mobilization has been proven to be a key prevention intervention.
8.	**Patients with Dementia can develop delirium.**
	YES – TRUE Delirium can be superimposed over dementia – this is why it is important to know your patients baseline mental status. The key is understanding whether there has been a sudden or recent change from that baseline status.
9.	**Constipation and poor pain control are two precipitating factors of delirium.**
	YES – TRUE Especially in those who have a pre-existing cognitive impairment.
10.	**Medications may cause adverse reactions and not delirium.**
	NO – FALSE Delirium caused by a medication is considered an adverse reaction.
11.	**The best medication to give an elderly, frail patient to manage the symptoms of delirium is Ativan.**
	NO – FALSE Ativan is one medication that has a high risk of causing delirium in the frail senior. Ativan should only be used for Delirium Tremens due to alcohol withdrawal in the older patient.
12.	**When your patient is CAM positive you should request a MoCA assessment to confirm the diagnosis of delirium.**
	NO – FALSE The MoCA or MMSE is an assessment of cognitive impairment. It is not a diagnostic test. A MoCA / MMSE cannot distinguish between dementia, delirium, depression or any other cause of cognitive impairment. A physician must confirm a diagnosis of delirium based on further clinical testing. The MoCA and MMSE should not be done in cases where delirium is suspected as it presents an inaccurate reflection of the patient's true baseline status.
13.	**A MRI of the head will confirm a diagnosis of delirium.**
	NO – FALSE There is no specific diagnostic test to diagnose delirium – it is based on clinical presentation. Diagnostic tests may determine causes of delirium such as UTI, pneumonia, vit B12 deficiency, etc. The CAM and CAM-ICU are commonly used screening tools for delirium.
14.	**Give one way to determine if inattention in your patient.**

	• Check hearing first to ensure decreased hearing is not contributing to the findings. Questions may need to be repeated because attention wanders.
	• Tools:
	  o Days of week or months of year backwards (must be able to recite forwards)
	  o Serial 7s – serial subtraction of seven beginning with the number 100
	  o Squeeze my hand when I say the letter "A" – SAVEAHAART – BADBADDAAY
	• Evidence of inattention:
	  o Unable to gain respondent's attention or to make any prolonged eye contact.
	  o Respondent's focus seems to be darting about room.
	  o Respondent keeps repeating answer to previous question (perseveration).
	  o Respondent is dazedly staring at the TV. When you ask a question, he looks at you momentarily but does not answer. He then continues to stare at the TV.

15.	**Your patient is difficult to arouse, vigorous shaking will momentarily illicit groaning but no eye opening. Can you do the CAM assessment?**
	NO

	You must be able to assess the 4 features of delirium, acute change in mental status, inattention, altered level of consciousness and disorganized thinking to complete the CAM. If your patient is unarousable you cannot complete the full assessment. However, you should consider that you may be observing signs of a hypoactive delirium.
16.	**To control symptoms in an elderly patient with delirium it is best to use multiple medications. E.g. antipsychotic (Seroquel) and antidepressant (Trazedone)**
	NO – FALSE Management of the cause(s) of the delirium is key. When behaviour symptoms appear, medications should only be used when other methods of managing symptoms have been unsuccessful. When medications are required, it is recommended to only use a single medication, start on a low dose and titrate up as required *(start low, go slow)*. Using multiple medications may cause drug interactions which may increase delirium.
17.	**Medications used to manage the symptoms of delirium should be stopped as soon as possible.**
	YES – TRUE Additional medications increase the risk for developing delirium. These medications, typically antipsychotics, may cause sedation and other side effects which will increase the risk of harm to the patient.
18.	**Pain control in the elderly is best managed with PRN analgesics.**
	NO - FALSE Pain control is best managed with routinely scheduled analgesics with PRN breakthrough doses. This provides a constant level of analgesia in the system. The World Health Organization (WHO) cancer pain ladder should be followed i.e. start first with routine administration of Tylenol or other non-narcotic analgesic (unless contraindicated) before introducing opioids.
19.	**It has been estimated that up to 80% of elderly patients hospitalized for the treatment of acute physical illness experience an episode of delirium.**
	YES- TRUE The range in the literature is wide – 14-80%. The take away: it is quite common and needs to be recognized.
20.	**Delirium can be prevented.**
	YES – TRUE Evidence suggests that hospital acquired delirium can be reduced by 33% by providing the following interventions: - Promote cognitive / mental stimulation - Promote physical activity – passive/active ROM for bedridden to ambulation - Prevent sleep deprivation - Prevent dehydration - Promote healthy vision - Promote healthy hearing
21.	**A patient who rambles and uses made up words shows evidence of disorganized thinking?**
	YES - TRUE Disorganized thinking causes illogical, nonsensical thought patterns. This disorganization is also noticeable in the way an affected person talks. A person with disorganized thinking may not be able to stay on track in a conversation, instead jumping from one unrelated idea to another, so that it's impossible to understand what the person is trying to say. Making up words is common.