



Delirium

Standardised care process

Objective

To promote evidence-based practice in the detection of, and response to, delirium for older people who live in residential care settings.

Why the prevention and management of delirium is important

Delirium is common in older people and can have a negative impact on their health and quality of life. Delirium is frequently undetected or is misdiagnosed. In many cases delirium is preventable or reversible. Recognising and minimising risk factors can reduce the likelihood of delirium developing (Blevins 2020).

Definitions

Delirium: 'a clinical syndrome of disordered attention, presenting as an inability to focus, shift or sustain attention. It generally occurs acutely (over hours to days), but it can also occur over longer periods of time and the diagnosis may be missed' (Therapeutic Guidelines Limited 2017).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), allied health professionals (such as a physiotherapist, occupational therapist and exercise physiologist), residents and/or family/carers.

Acknowledgement

This standardised care process (SCP) has been developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Care (ACEBAC) at La Trobe University through the Department of Health and Human Services Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives. This SCP is one of a series of priority risk areas reviewed based on the best available evidence in 2020.



Brief standardised care process

Recognition and assessment

On admission or when delirium is suspected, conduct a delirium assessment:

- Complete a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS).
- Assess the presence of risk factors for delirium.
- Assess the presence of symptoms of delirium.
- Complete the Confusion Assessment Method (CAM).
- Where possible, differentiate between hypoactive and hyperactive delirium.

Interventions

If symptoms present or there is a sudden change in a resident's condition, cognition or behaviour:

- Seek and treat any readily identifiable causes.
- Refer to a GP.
- In conjunction with the resident's GP, implement interventions for management and treatment.
- Provide reassurance to the resident and their family/carers.

Implement prevention strategies for residents at risk of delirium:

- In conjunction with a GP, implement interventions to remove or minimise risk factors where possible.
- Communicate clearly.
- Adapt the environment so it is calm, with adequate lighting for wayfinding.
- Document the effectiveness of interventions.

Referral

- GP
- Pharmacist
- Physiotherapist

Evaluation and reassessment

- Daily monitoring (as a minimum) for changes in symptoms or emergence of new risk factors.
- Repeat the CAM at least weekly.
- Repeat the PAS at least weekly.
- Where possible, manage risk factors.

Resident involvement

- Provide information about delirium and its risk factors.
- Discuss interventions to minimise risk factors.
- Involve family/carers in promoting orientation.

Staff knowledge and education

- Delirium: causes, risk factors, symptoms, prevention and management
- Differentiate between clinical features of delirium, dementia and depression



Full standardised care process

Recognition

Delirium should be suspected if sudden changes in the resident's cognitive function, perception, physical function or social behaviour are observed or reported.

Assessment

On admission or when delirium is suspected, conduct a delirium assessment:

- Complete a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS) to establish the resident's baseline cognitive functioning.
- Assess the presence of risk and precipitating factors for delirium.
- The following factors quadruple the risk of delirium:
 - physical restraint in use
 - malnutrition.
- The following factors treble the risk of delirium:
 - cognitive impairment and dementia
 - infection (chest, urinary and central nervous system)
 - impaired vision/hearing
 - urinary catheter in situ
 - taking multiple medications or medication toxicity or withdrawal.
- The following factor doubles the risk of delirium:
 - dehydration.
- Other factors include:
 - depression
 - pain
 - discomfort (e.g. uncomfortable clothing/ footwear, too hot, feeling cold)
 - hypoxia
 - impaired mobility
 - metabolic disorders (for example, hypoglycaemia, hyperglycaemia, hyponatremia)
 - organ failure
 - constipation

- acute health events (cardiac, intracranial seizures)
- environmental (for example, noise, poor lighting, multiple instructions being given)
- recent hospital admission
- over 65 years of age.

Assess the resident for symptoms of delirium.

- Complete the abbreviated Confusion Assessment Method (CAM) – this tool does not diagnose delirium ; higher scores indicate a need for further investigation.
- Take a medical history, including corroborating any history of changed cognition and behaviour from family or knowledgeable others.
- Undertake a physical examination.
- Conduct the following investigations:
 - blood pathology
 - urinalysis (and midstream specimen of urine if indicated)
 - blood pressure
 - temperature
 - pulse
 - pulse oximetry.

The following symptoms may fluctuate over course of the day and are usually worse at night:

- sudden acute change in the resident's condition, cognition or behaviour (hours/days)
- fluctuation in consciousness – could vary from drowsy to hyperactivity
- fluctuation in functional ability [for example, the ability to complete activities of daily living (ADLs) independently or the level of assistance required with ADLs]
- difficulty in paying attention, following a conversation and concentrating
- visual and auditory hallucinations, misperceptions, paranoid delusions
- difficulty in remembering names, events and instructions
- disorientation to time and place
- disorganised thinking
- altered sleep pattern.



Where possible, differentiate between hypoactive and hyperactive delirium:

- **Hypoactive delirium** behaviours include:
 - being withdrawn and disinterested
 - slowed communication and concentration
 - low mood
 - lethargy.
- **Hyperactive delirium** behaviours include:
 - restlessness and agitation
 - easily distracted
 - rambling and erratic speech, jumping from one subject to another.

Interventions

If symptoms present or there is a sudden change in a resident's baseline condition, cognition or behaviour, treatment and management should be prioritised as urgent.

- Seek readily identifiable causes (for example, infection, hypoxia, constipation, pain, fever).
 - In conjunction with the resident's GP:
 - conduct a medical assessment and treat the underlying causes
 - review the resident's medication
 - assess, monitor and control the resident's pain
 - undertake a physical or neurological examination
 - undertake blood pathology, urinalysis and imaging where indicated.
 - Implement non-pharmacological measures:
 - Maintain a high level of observation of the resident in a safe location.
 - Involve family/carers where feasible to provide reassurance, promote a feeling of safety and engage in meaningful activity.
 - Monitor the resident's vital signs.
 - Ensure adequate hydration, nutrition and pain relief.
 - Manage the environment (calm, quiet, adequate lighting, orientation).
 - Implement communication strategies such as speaking clearly and slowly and only one person at a time.
 - Provide reassurance to the resident and their family/carers.
- Where delirium is causing distress to the resident or risks to self or others, establish the underlying meaning of behaviours/unmet needs and use de-escalation techniques (verbal and non-verbal) as the first-line response.
 - Implement appropriate pharmacological management to alleviate delirium symptoms and/or manage pain.
 - Antipsychotic medications should only be considered when symptoms are distressing to the resident or affect resident safety.
 - Benzodiazepines should be avoided.

Prevention strategies for residents at risk of delirium:

- Check the resident's medications to assess their potential for causing current or future problems and, where possible, cease use of drugs that may be contributing.
- Ensure optimal management of underlying disorders in conjunction with the resident's GP.
- Always encourage the resident to wear their glasses and hearing aids.
- Do not use restraints.
- Avoid urinary catheterisation.
- Maximise the resident's mobility and encourage activity.
- Encourage adequate fluid and nutritional intake.
- Regulate the resident's bowel function.
- Use non-pharmacological approaches to promote sleep management.
- Manage the resident's pain.
- Communicate clearly, slowly, single-step instructions and ensure only one person speaks at a time.
- Ensure frequent eye contact and touch (where culturally appropriate).
- Ensure frequent reassurance and reorientation.
- Ensure the environment is quiet and calm.
- Ensure levels of appropriate sensory stimulation.
- Support orientation to time, place and person with easily visible clocks, calendars, signage and staff wearing name badges.
- Ensure adequate lighting that is appropriate for the time of day.
- Promote familiarity through personal belongings, continuity of staff and close involvement of family and friends.

Document the effectiveness of all interventions.



Referral

- GP for assessment and treatment of risk factors and/or causes and symptoms
- Pharmacist
- Physiotherapist

Evaluation and reassessment

- Monitor at least daily for changes in symptoms or emergence of new risk factors.
- Repeat the CAM at least weekly to monitor the effect of interventions and treatment until symptoms are no longer present.
- Repeat the PAS at least weekly to monitor whether cognition returns to the baseline status.
- Where possible, manage risk factors.

Resident involvement

- Provide information about delirium and its risk factors.
- Discuss interventions regarding minimising risk factors.
- Involve the resident's family/carers in promoting orientation.

Staff knowledge and education

- Delirium: causes, risk factors, symptoms, prevention and management
- Differentiate between clinical features of delirium, dementia and depression.



Evidence base

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Important note: This standardised care process (SCP) is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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