Best Practice Quick Reference Guide
Care of Older Adults
Delirium

This Quick Reference Guide will Assist the Team to:

- Identify older adults at risk for delirium.
- Assess factors that cause and contribute to delirium, and implement appropriate care interventions.
- Reduce the older adult's delirium-related anxiety and fear through appropriate management of the environment.
- Employ use of non-pharmacological interventions whenever possible.
- Avoid use of physical restraints.
- Engage family and friends who wish to support the older adult.

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Hypoactive delirium can be mistaken for depression or fatigue because the older adult presents as lethargic, quiet and withdrawn.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?

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

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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

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

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

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.