Quick Reference Guide

Residential Care

DELIRIUM

This Quick Reference Guide Will Help the Nurse To

- Identify older persons who are at risk for delirium.
- Recognize the signs and symptoms of a delirium in older persons who also suffer from dementia.
- Take quick action to coordinate appropriate care when delirium has been identified.
- Implement environmental, pharmaceutical, and supportive communication interventions to promote wellbeing and safety.

Key Points About Delirium

- If not recognized, an untreated delirium can lead to increased mortality and morbidity in older adults.
- It is recognized as a medical emergency.
- There are predisposing risk factors that can assist the clinician with determining who is at a greater risk of developing a delirium.
- There are three subtypes in the presentation of a delirium: hyperactive, hypoactive, mixed hyper and hypo active presentation.
- A delirium is treatable; this involves identifying and treating the underlying cause and providing a therapeutic and supportive environment.

Predisposing Risk Factors for Delirium

- ✦ Cognitive impairment
- ✦ Over the age of 80
- ✦ Polypharmacy – on 5 medications or more
- ✦ Sensory impairment: visual or auditory
- ✦ Chronic or acute illness
- ✦ Multiple comorbidities
- ✦ Sleep deprivation
- ✦ Immobility
- ✦ Dehydration and malnutrition
- ✦ Alcohol abuse

Warning Signs of Delirium

- ✦ Rapid onset
- ✦ Sudden change in behaviour
- ✦ Changes in level of consciousness
- ✦ Impaired Cognitive Function:
  - ▪ Disorganized thinking
  - ▪ Transient memory loss
  - ▪ Poor judgement
- ✦ Difficulty paying attention
  - ▪ Rambling, disjointed speech
- ✦ Day/Night sleep reversal
- ✦ Psychomotor agitation/retardation
- ✦ Psychosis: hallucination, delusion, illusion
- ✦ Fluctuating symptoms

Nursing Assessment of Delirium

Screening Tool: CAMI

Presence of features 1 and 2 & either 3 or 4:

1. **Acute onset & fluctuating course**
2. **Inattention:**
   - difficulty focusing attention
   - easily distracted
3. **Disorganized Thinking**
   - rambling speech
   - illogical flow of ideas
4. **Altered Level of Consciousness**
   - agitated
   - alert
   - lethargic
   - stuporous
   - comatose

Identification of Causes

- **P** – Pain, Poor Nutrition
- **R** – Retention (urinary/bowel), Restraints
- **I** – infection/illness, Immobility
- **S** – Sleep, Skin, Sensory
- **M** – Mental Status, Medications, Metabolic
- **E** – Environment

Supporting Data

- Lab results/hemodynamic status
- MMSE
- Pain Assessment
- Braden Scale for Predicting Pressure Sore Risk
- Collateral information from family or friends
- Sleep Record
- Intake and Output Record; Weight Chart
- Behaviour Chart

Nursing Interventions

For Delirium

Environment interventions

- Adequate lighting
- Reorientation verbal, non-verbal, contextual cues
- Calm environment
- Safety re: falls risk; encourage mobility
- Use of glasses/hearing aides
- Support familiarity with surroundings, personal belongings, staff

Psychoactive medication interventions

- Used when resident is a safety risk to self or others
- To enable medical treatment
- To correct sleep disturbance and some behavioural symptoms
- **Not** recommended for: Purposeless or repetitive activity, resistance to care, wandering, pacing, exit seeking, calling out, foul language.

Communication and approach

- Simple and calm communication
- Validation fear and anxiety
- Reassurance for personal safety and emotional support
- Promote continued participation in ADL/self-care
- Maintain normal routine
- Involve family/familiar companions
- Avoid arguing or agreeing with hallucinations or delusions. Validate feelings, provide reassurance, use distractions, and check for triggers.