

Delirium Policy

Prepared by Geoffrey Kidd (Clinical Nurse Consultant Gerontology), John Death (Geriatrician) and Helga Merl (Manager of Central Coast Dementia Advisory Service), 2003.

Policy Statement

It is critical to recognise and manage the person with **delirium** (acute confusion). Delirium is associated with death, personal distress, greater sickness, increased confusion and risk of admission to residential care. The focus of care for a person with delirium is to provide supportive and protective care while the cause/s are identified and treated. Delirium is the result of a combination of predisposing factors, including dementia, poor nutrition, vision, hearing and/or dehydration. Precipitating factors may be multiple, eg. infections, urinary retention, postural hypotension, dehydration, constipation or pain. The onset is usually over hours to days, with a fluctuating course, so that it may seem to be better or worse, or to come and go.

Delirium is characterised by:

1. Inattention. Eg. difficulty keeping track of conversation or difficulty focusing attention.
2. Disorganised thinking. Eg. disorganised thoughts and, at times, hallucinations and paranoid delusions, disorientation, rambling speech, irrelevant replies, impaired memory, language problems and/or behavioural changes such as under- or over-activity.
3. Altered level of consciousness ranging from drowsy to very alert. Eg. a person with delirium may sometimes be noisy and aggressive or apathetic and sleepy.
4. Delirium also effects the coordination of movements and can result in swallowing problems and changes to balance and mobility.

One method, the Confusion Assessment Method, identifies delirium as the presence of the above features (1) and (2) and either (3) or (4):

Policy Guidelines

- Delirium should always be ruled when a change in behaviour or a challenging behaviour occurs in a person with dementia.
- Carers should be involved in orientating and comforting the delirious person.
- Families and carers should be informed of care and referred to the attending medical officer as required.
- Consent to care may not be possible from a confused patient therefore the "person responsible" or a Guardian may need to be consulted.

Management strategy options

- Individuals with delirium can be easily overwhelmed by over-stimulation. Minimise the expectations on the patient and simplify the environment to reduce confusing stimuli.
- Seek a medical review to identify possible physical or psychological cause of behaviour and commence appropriate observations and treatment. Assist with obtaining a good history, physical examination and appropriate investigations.
- Increased attention to risks (such as falls) is indicated.
- The confused patient will have difficulty comprehending the need for care and safety. Therefore ongoing, thoughtful care, supervision, explanation and reassurance is essential.
- Plan care to minimise interventions, minimise changes and remove confusing stimuli.
- Reduce distracting stimuli by minimising unnecessary equipment, activity and interruptions.
- Ongoing reassurance about what is happening and who you are is invaluable. Simple explanations are best. One to one attention may be required to enable essential care.
- Use care and environment as opportunities for orientation and positive interactions. Simple discussions of current events, structured reminiscence, visible clocks and a board with simple information can help.
- Present a calm and helpful manner. Arguing will make things worse. One person only should explain care. Personal care may be misinterpreted as threats or restraints.
- Call for assistance if the safety of the person and/or other people is threatened.
- Call for assistance if you are not sure why the patient is behaving that way.

Management strategy options

- Advocate for treatment of distress. Seek possible causes of behaviour such as constipation, retention of urine or changes to existing painful conditions like arthritic pain.
- Minimise use of medications, as adverse reactions may lead to further complications. Eg. sedation will not usually stop wandering, but will increase risk of falls.
- The movement disorder and inability to stay still may make falls more likely.
- Encourage physical activity such as walking, exercises and self-care (unless contraindicated). Eg. provide walking aids. Avoid the use of catheters.
- Encourage normal sleep pattern, avoid caffeine, offer relaxing music, warm drink, back massage or aromatherapy.

- Minimise noise. Eg. lower voices and turn down phones.
- Minimise the effects of visual and hearing impairment. Eg. look for poor hearing due to ear wax, missing / non-functioning hearing aids, provide spectacles and adequate lighting
- Encourage and monitor fluid intake and nutrition. Eg. provide frequent small amounts of preferred drinks.
- People with delirium may require prompting and assistance.
- The person should be supervised and encouraged to sit up and forwards with food and fluids because of impaired swallowing. Specially modified diets may be needed, such as thickened fluids.
- Document what works and tell everyone!

References

Creasey, H. 1996, 'Acute confusion in the elderly'. *Current Therapeutics*, August, 21-27

Inouye, S. K., Bogardus, S.T., Charpentier, P.A., Leo-Summers, L., Acampora, D., Holford, T.R. & Cooney, L.M. 1999, 'A multicomponent intervention to prevent delirium in hospitalized older patients.' *The New England Journal of Medicine* (340), 9, 669-676.

Sturmberg J.P. & Death J. 2000, 'Delirium and confusional states.' *Australian Family Physician* (29), 11, 1063-1065.