

Management of delirium

DOES YOUR PATIENT SHOW SIGNS OF:

- Disturbance of consciousness (alertness and/or sleepiness)?
 - Change in cognition/attention over short period of time (hours to days)?
 - Fluctuating course?
 - Increased confusion at night?
- THINK DELIRIUM

HIGH RISK PATIENTS

- Advanced age
- Severe illness (for example in critical care)
- Diagnosis of dementia
- Physical frailty
- Admitted with dehydration/infection
- Visual impairment
- Surgery
- On certain drug treatments such as anticholinergics and opiates
- Alcohol excess

COMMON CAUSES

- Infection
- Neurological – for example stroke, epilepsy, acute brain injury
- Cardiological for example heart attack
- Respiratory – for example pulmonary embolism, hypoxia
- Endocrine/Metabolic – for example hyperglycaemia
- Drugs

MANAGEMENT OF CONFUSION

- Treat underlying cause
- Appropriate lighting levels
- Consider single room/small bay/close to nursing station
- Provide repeated visible and verbal clues to orientation for example clocks/calendars
- Provide reassurance/explanation in short sentences
- Ensure continuity of care for example one nurse to establish a rapport
- Ensure glasses/hearing aids are worn and working
- Avoid inter and intra ward moves
- Avoid catheters
- Encourage early mobilisation
- Ensure adequate pain control-regular pain relief is preferential to 'as required'
- Establish regular sleep pattern – maintain and restore pattern. Avoid 'naps'
- Ensure good diet and fluid intake
- Avoid constipation
- Avoid sedation
- Avoid physical restraint
- Eliminate unexpected noises for example pump alarms
- Encourage visits from family and friends

The Confusion Assessment Method (CAM)

The CAM should be used as a screening tool for delirium. It is easy to use and in addition to good observation skills helps to identify whether a patient has delirium. The CAM should be used on admission and frequently throughout admission to detect improvement/deterioration in confusional state.

CONFUSION ASSESSMENT METHOD

YES / NO

| CONFUSION ASSESSMENT METHOD | YES / NO |
|---|----------|
| <p>1. The history of acute onset and fluctuating course Obtained from family member or nurse and is shown by positive response to the following questions: Is there evidence of acute change in mental status from the patient's baseline? Does the (abnormal) behaviour fluctuate during the day, that is, does it tend to come and go or increase or decrease in severity?</p> | |
| <p>2. Inattention This feature is shown by a positive response to the following question: Does the patient have difficulty focusing attention, such as are they easily distracted or do they have difficulty keeping track of what is being said?</p> | |
| <p>3. Disorganised thinking This feature is shown by a positive response to the following questions: Is the patient's thinking disorganised or incoherent? Is the conversation rambling or irrelevant, unclear with an illogical flow of ideas or unpredictable switching from one subject to another?</p> | |
| <p>4. Altered level of consciousness This feature is shown by any answer other than 'alert' to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyper alert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable]) The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.</p> | |

FOR FURTHER ADVICE PLEASE CONTACT:

Emma Ouldred
Dementia Nurse Specialist
Extension 3420 or Air Call KH 3420

Nicola Cook
Modern Matron Neurosciences
Extension 8820 or Air Call KH 4445

Dr Dan Wilson,
Consultant Geriatrician
Air Call KH 3166