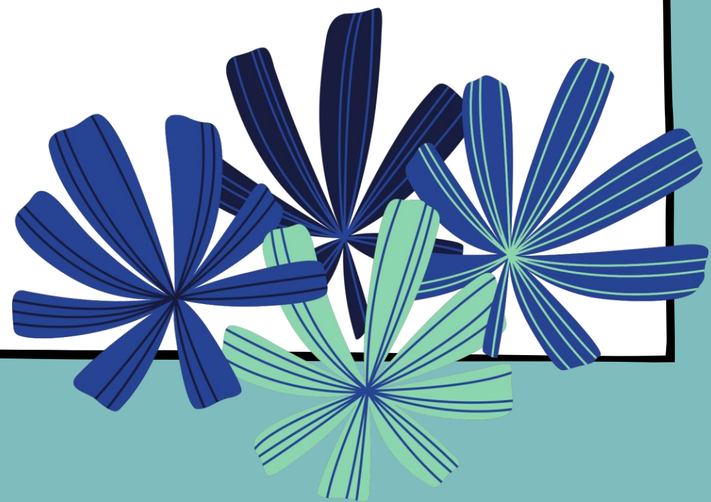
Delirium

Recognizing and Managing Delirium

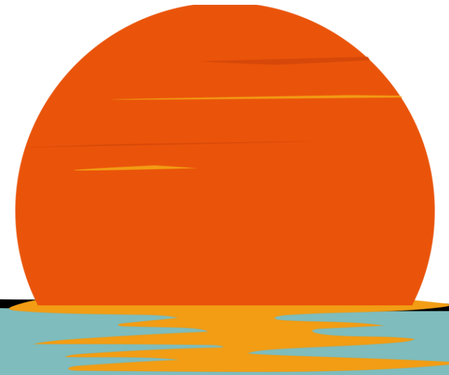
Learning Objectives

1. Be able to use different delirium assessment tools.
2. Know common causes of delirium
3. Understand how to manage delirium behaviors
4. Be able to manage and prevent consequences of delirium



Case Scenario

- It's Friday afternoon. Mrs. L's daughter calls about her mother. She is refusing her meds, tells you its poison, and throws her glass of water, and demands to be let out of this prison, and threatens to call the police.
- She has been eating less for a few days and refused breakfast this morning, because she wanted to sleep. She has difficulty answering questions.
- This is not like her.



"SUNDOWNING
"

Key Features of Delirium (CAM)

F1

ACUTE= SUDDEN ONSET or FLUCTUATING

New behaviors in the last **24-48** hours
Consciousness, Attention, orThinking fluctuates during interaction

+

F2

INATTENTION

Very distracted
Trouble keeping track of conversation
Can't follow directions

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PSYCHOSIS

Hallucinations (seeing things...)
Delusions (paranoid beliefs)

DISORDERED THINKING

Confused (thinks you are her husband)
Speech rambling, going different directions, unclear, no logic
Speech very limited or very little

OR

F4

CONSCIOUSNESS/ SLEEP-WAKE

Hypervigilant, Awake all night, Restless

Falls asleep when you talk to them.
Sleeping all day

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CONSCIOUSNESS/ SLEEP-WAKE

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MIXED DELIRIUM

Falls asleep when you talk to them.
Sleeping all day

CONFUSION ASSESSMENT METHOD (CAM CRITERIA)

typically used in the ED, hospital or NH

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What if they are an Outpatient?

Especially if cognitively intact, verbal, and not critically ill?

Try the Ultra-Brief CAM

Increased sensitivity

3 ITEMS

Start with the Ultra-Brief CAM (UB -CAM)

2 min

ASK: Have you felt confused in the past 24 hours?

↓

Please tell me the months of the year backwards. Let's start with December as your first month
(if previously no dementia)

↓

OBSERVE: Does the patient appear sleepy, and FALLS ASLEEP during the interview

↓

NO DELIRIUM

Confused → Possible Delirium

Wrong answers → Possible Delirium

Falls Asleep → Possible Delirium

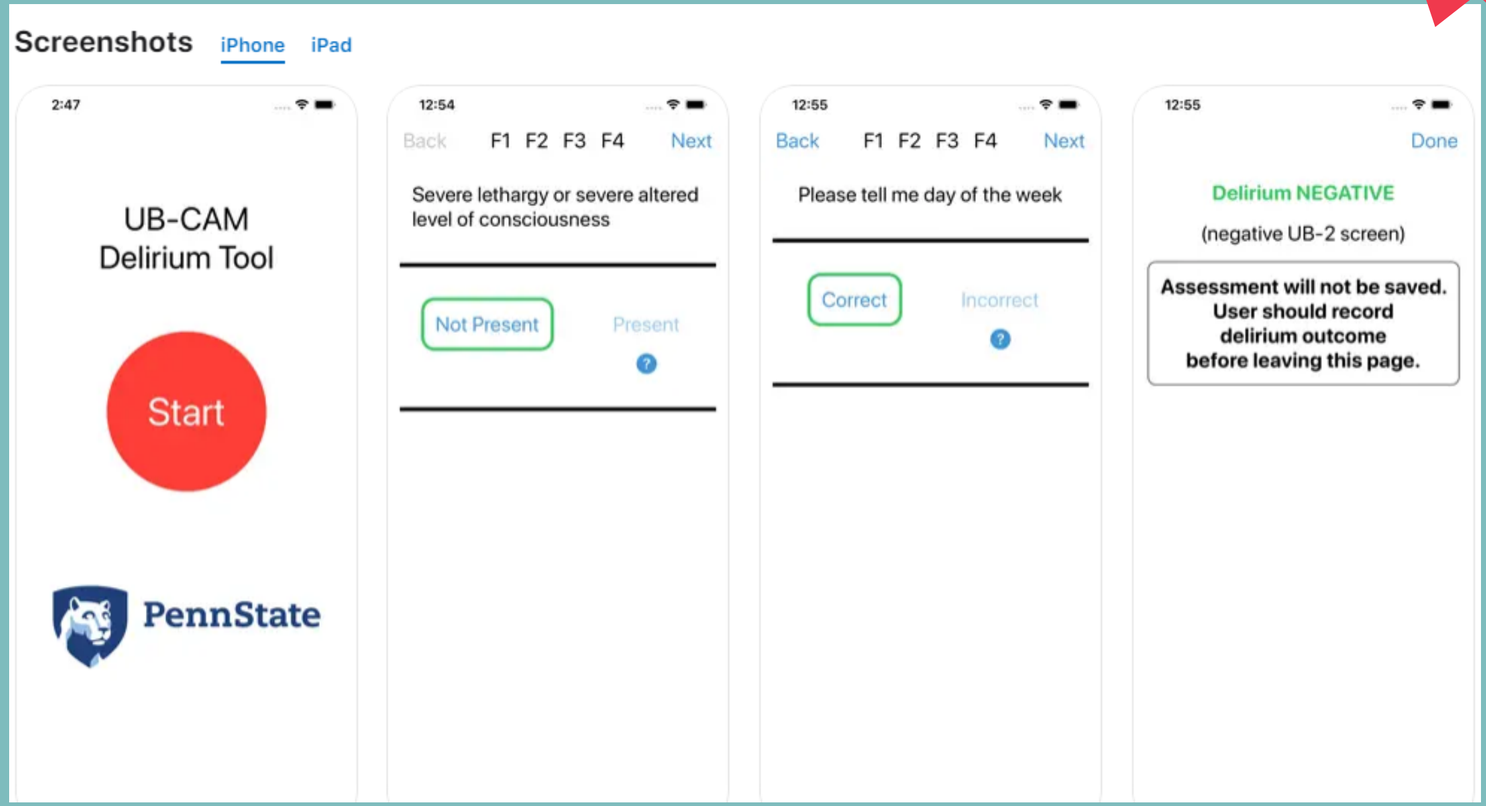
→ **CAM**

adapted from: Silner et al. Journal of Hospital Medicine, 2020: Vol 15 (9)

NEW 2023!

Try the ios UB-CAM Delirium Tool

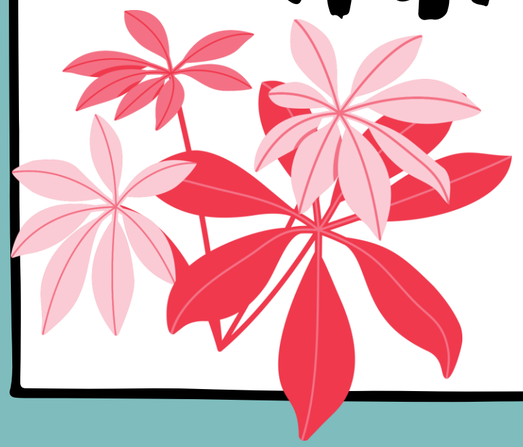
FREE App!



Goes through the UB-CAM, and if Delirium is a possibility, it automatically goes on to CAM checklist and highlights each Delirium Feature and calculates!

Tell caregivers:

LOOK for early warnings!



Stop and Watch
Early Warning Tool

INTERACT®
Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated less in activities
a	Ate less
n	No bowel movement in 3 days; or diarrhea
d	Drank less
W	Weight change
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

TOP 3 CAUSES OF DELIRIUM :

DRUGS (esp anticholinergics)

INFECTION (UTI, PNA, SEPSIS)

LABS (Ex: anemia, dehydrtion, chemistries, glucose, calcium, thyroid, etc. ...)

START MEDICAL WORK-UP RIGHT AWAY!

OTHER CAUSES OF DELIRIUM :

- STROKE
- HEART ATTACK
- LOW OXYGEN
- CONSTIPATION, URINARY RETENTION

START MEDICAL WORK-UP RIGHT AWAY!

Treatment?

Treatment: Treat the Underlying medical problem

FOR AGITATED BEHAVIORS → TA-DA!

TOLERATE

If it is NOT Dangerous, allow patients to respond to thier environment. Observe them. You might get clues about what is upsetting them.

ANTICIPATE

Behaviors are a way of communicating. If they cannot tell you, try to think ahead to meet their needs and avoid frustration or danger.

DON'T AGITATE

If they cannot reason or understand, don't try. Even re-orienting them can make them mad. Go with thier flow. Try distraction or humoring the patient.

GETTING TO COOPERATION

CREATE SAFETY

Patient has an urgent need to feel safe.

Be aware of body language

Speak slowly and calmly

Show Empathy, Respect

Address feelings

Apologize, Agree with them,

Back off, (Try again later)

SHOW CONCERN

"I noticed that you did not eat breakfast this morning..."

Can I do anything to help you feel more comfortable?

Listen. Do not Dismiss them

PERSONALIZED

Don't "DO TO" them

Do "WITH" them- use a favorite food/drink, person, music, etc.

Ask for permission

Redirect

Consider music therapy, gentle sensory stimulation

PHARMACOLGIC MANAGEMENT OF BEHAVIORS

PHARMA-COLOGICAL THERAPY OF AGITATED DELIRIUM

Agent	Mechanism of Action	Dosage	Benefits	Adverse Events	Comments
Haloperidol[OL]	Antipsychotic	0.25–1 mg po or IM q4h prn agitation	Relatively nonsedating; few hemodynamic effects	EPS, especially if >3 mg/d	Usually agent of choice[a]
Olanzapine[OL]	Antipsychotic	2.5–5 mg po or IM q24h, max dosage 20 mg q24h (cannot be given by IV infusion)	Fewer EPS than haloperidol	More sedating than haloperidol	Small case series only[b];oral formulations less effective for acute management
Quetiapine[OL]	Antipsychotic	25–50 mg po q12h	Fewer EPS than haloperidol	More sedating than haloperidol; hypotension	Small case series[b]
Risperidone[OL]	Antipsychotic	0.25–1 mg po or IV q4h prn agitation	Similar to haloperidol	Might have slightly fewer EPS	Case series only[b]
Lorazepam[OL]	Sedative	0.25–1 mg po or IV q8h prn agitation	Use in sedative and alcohol withdrawal, and history of neuroleptic malignant syndrome	More paradoxic excitation, respiratory depression than haloperidol	Second-line agent, except in specific cases noted

from AGS GEMS

To Medicate or Not?

Medications: Antipsychotics & Sedatives are ONLY to be used as a last resort.
If the patient is very distressed, or in danger of hurting themselves or others, consider medications...

IF BEHAVIORS ARE DANGEROUS → CALL 911

GET HELP

If the patient is in danger of seriously hurting themselves or others, call 911

However, you should know that there are few/no geriatric psychiatry hospital beds available, and admission may only be for a medical workup only. Hospitalization or medications may not solve the problem- Ultimately, a change in approach is still the most effective intervention.

ANTICIPATE & PREVENT COMPLICATIONS

Let families and caregivers know that they should expect to provide 24/7 supervision, regular toileting, frequent repositioning, and feeding assistance until the Delirium is cleared. This may take weeks to months.

adapted from AGS GEMS

POTENTIAL COMPLICATION	PREVENTION STRATEGY
URINARY INCONTINENCE	SCHEDULED TOILETING PROGRAM
IMMOBILITY AND FALLS	MOBILIZE WITH ASSISTANCE, PHYSICAL THERAPY
PRESSURE ULCERS	MOBILIZE, REPOSITION FREQUENTLY, MONITOR PRESSURE POINTS
SLEEP DISTURBANCE	SLEEP PROTOCOL, AVOID SEDATIVES
POOR NUTRITION AND HYDRATION OR ASPIRATION	ASSIST WITH FEEDING, ASPIRATION PRECAUTIONS, ADD SUPPLEMENTS

PREVENT FUNCTIONAL DECLINE

Families can help reinforce and restore function, BEYOND PT/OT therapies

ADL support may be required for the long haul....

FUNCTIONAL COMPLICATION	RESTORING FUNCTION
COGNITIVE RECONDITIONING	REORIENT TO TIME, PLACE, PERSON AT LEAST THREE TIMES A DAY (IF HELPFUL)
MONITOR FOR DEPRESSION	DEPRESSION WILL LIMIT PROGRESS. IMPLEMENT SCHEDULED PLEASURABLE EVENTS (BEHAVIORAL ACTIVATION)
ABILITY TO PERFORM ADLS & IADLS	FAMLIES EDUCATION: AS DELIRIUM REVERSES, FAMILY CAN ADAPT TO ALLOW GREATER FUNCTIONING MATCHED TO ABILITY.
PERSISTENT DELIRIUM	FAMILY EDUCATIONI: DELIRIUM MAY PERSIST, AND FAMILY MAY NEED TO CONSIDER LONG TERM SUPPORT FOR ADLS/ IADLS.

adapted from AGS GEMS

CASE DISCUSSIONS & QUESTIONS