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.
Key Features of Delirium (CAM)

**F1**  
**ACUTE= SUDDEN ONSET or FLUCTUATING**
New behaviors in the last 24-48 hours  
Consciousness, Attention, or Thinking fluctuates during interaction

**F2**  
**INATTENTION**
Very distracted  
Trouble keeping track of conversation  
Can't follow directions
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Very distracted
Trouble keeping track of conversation
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**F3: 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

**F4: CONSCIOUSNESS/ SLEEP-WAKE**
Hypervigilant, Awake all night, Restless
Falls asleep when you talk to them.
Sleeping all day

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Hypervigilant, Awake all night, Restless
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Falls asleep when you talk to them.
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**F4**  CONSCIOUSNESS/ SLEEP-WAKE

Hypervigilant, Awake all night, Restless

**OR**

Falls asleep when you talk to them.  
Sleeping all day  
HYPO-ACTIVE

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Hypervigilant, Awake all night, Restless
MIXED DELIRIUM
Falls asleep when you talk to them.
Sleeping all day

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

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

- Confused
- Possible Delirium

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

- Wrong answers
- Possible Delirium

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

- Falls Asleep
- Possible Delirium

**NO DELIRIUM**

adapted from: Silner et al. Journal of Hospital Medicine, 2020: Vol 15 (9)
Try the iOS UB-CAM Delirium Tool

New 2023!

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**

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.

- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participated less in activities
- Ate less
- No bowel movement in 3 days; or diarrhea
- Drank less
- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- 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, dehydration, 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: Treat the Underlying medical problem
FOR AGITATED BEHAVIORS

TOLERATE
If it is NOT Dangerous, allow patients to respond to their 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 their flow. Try distraction or humoring the patient.

TA-DA!
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
# Pharmacological Management of Behaviors

## Pharmacological Therapy of Agitated Delirium

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

*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.
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

<table>
<thead>
<tr>
<th>POTENTIAL COMPLICATION</th>
<th>PREVENTION STRATEGY</th>
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<tbody>
<tr>
<td>URINARY INCONTINENCE</td>
<td>SCHEDULED TOILETING PROGRAM</td>
</tr>
<tr>
<td>IMMObILITY AND FALLS</td>
<td>MOBILIZE WITH ASSISTANCE, PHYSICAL THERAPY</td>
</tr>
<tr>
<td>PRESSURE ULCERS</td>
<td>MOBILIZE, REPOSITION FREQUENTLY, MONITOR PRESSURE POINTS</td>
</tr>
<tr>
<td>SLEEP DISTURBANCE</td>
<td>SLEEP PROTOCOL, AVOID SEDATIVES</td>
</tr>
<tr>
<td>POOR NUTRITION AND HYDRATION OR ASPIRATION</td>
<td>ASSIST WITH FEEDING, ASPIRATION PRECAUTIONS, ADD SUPPLEMENTS</td>
</tr>
</tbody>
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### Prevent Functional Decline

<table>
<thead>
<tr>
<th>Functional Complication</th>
<th>Restoring Function</th>
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<tr>
<td>Cognitive Reconditioning</td>
<td>Reorient to time, place, person at least three times a day (if helpful)</td>
</tr>
<tr>
<td>Monitor for Depression</td>
<td>Depression will limit progress. Implement scheduled pleasurable events (behavioral activation)</td>
</tr>
<tr>
<td>Ability to perform ADLS &amp; IADLS</td>
<td>Families education: As delirium reverses, family can adapt to allow greater functioning matched to ability.</td>
</tr>
<tr>
<td>Persistent Delirium</td>
<td>Family education: Delirium may persist, and family may need to consider long-term support for ADLS/IADLS.</td>
</tr>
</tbody>
</table>

Families can help reinforce and restore function, **beyond PT/OT therapies**.

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

Adapted from AGS GEMS
CASE DISCUSSIONS & QUESTIONS