**Delirium**

**Key Points**

Approximately 14-56% of all hospitalized older adults experience delirium (Fong, Tubevaev, & Inouye, 2009).

Older adults admitted to Intensive Care Units have a 70-80% incidence of delirium (Fong, Tubevaev, & Inouye, 2009).

Delirium is associated with up to a 10-fold increase in risk for medical complications, including death (Inouye, 2006).

**Overview**

Delirium is an acute clinical state with fluctuating change in mental status and varying levels of attention and consciousness.

Delirium is often a missed diagnosis.

It is important to recognize the signs and symptoms of delirium, determine the causative factor(s) and treat those factor(s).

Delirium may be classified as:

- **Hyperactive** (increased activity with agitation);
- **Hypoactive** (drowsiness, lethargy); or
- **Mixed states** (clinical components of both Hyperactive and Hypoactive).

Delirium is often a symptom of a serious illness in older adults; and sometimes the only presenting symptom.

Delirium is associated with prolonged hospitalization, functional decline, and increased use of chemical and physical restraints.

Factors that precipitate delirium can be remembered using the mnemonic **DELIRIUM**:

- **D**rug use (hypnotics, anticholinergic)
- **E**lectrolyte abnormalities
- **L**ack of drugs (withdrawal)
- **I**nfection
- **R**educed sensory input (blindness, deafness)
- **I**ntracranial problems (stroke)
- **U**rinary retention and fecal impaction
- **M**yocardial problems (MI, heart failure, arrhythmias).
Assessment

Delirium assessment includes utilizing the Confusion Assessment Method (CAM) developed by Sharon K. Inouye (2006).

The CAM has 4 Features:

1. Acute Onset and Fluctuating Course: Is there evidence of an acute change in mental status from patient's baseline? This is usually best answered by someone close to the patient, such as family, a care provider, or a nurse.
2. Inattention: Did the patient have difficulty focusing? Were they easily distracted or could they not stay awake?
3. Disorganized Thinking: Was the patient's thinking disorganized or incoherent?
4. Altered Level of Consciousness: Overall, how would you rate this patient's level of consciousness? The answer should be anything other than alert (normal).

For the CAM to be positive for delirium, it requires the presence of both features 1 and 2, AND either 3 or 4.

The following table is helpful in distinguishing dementia from delirium:

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>Delirium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Insidious</td>
<td>Rapid associated with an identified event</td>
</tr>
<tr>
<td>Main symptom</td>
<td>Loss of memory, especially recent event(s)</td>
<td>Inattention</td>
</tr>
<tr>
<td>Etiology</td>
<td>May be related to underlying brain disorder, such as Alzheimer disease, vascular dementia, or Lewy body dementia</td>
<td>Nearly always related to underlying acute change, such as dehydration, infection, or starting or stopping medications</td>
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<tr>
<td>Orientation</td>
<td>Impaired</td>
<td>Fluctuates</td>
</tr>
<tr>
<td>Level of consciousness</td>
<td>May be normal until advanced stages</td>
<td>Fluctuates</td>
</tr>
<tr>
<td>Language</td>
<td>May be problematic with word choices</td>
<td>Slowed or rapid speech, frequently with incoherent and/or inappropriate language</td>
</tr>
<tr>
<td>Progression</td>
<td>Slow</td>
<td>Causes variations in mental function- people are alert one moment and sluggish and drowsy the next</td>
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<td>----------------------------------------------------------------------------------------------</td>
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<tr>
<td>Development</td>
<td>Often permanent</td>
<td>Fluctuates; days to weeks to months</td>
</tr>
<tr>
<td>Treatment</td>
<td>Needed; slows progression but does not cure</td>
<td>Immediate; usually reversible</td>
</tr>
</tbody>
</table>


**Management**

Identify and treat the underlying cause of delirium (i.e. infection, drugs, electrolyte imbalance).

Reassure the patient by having well known family members or caregivers at the bedside.

Discern day from night surroundings (decreased stimulation at night to promote sleep; blinds open during day with more activity).

Avoid bed rest if possible and the use of restraints (chemical or physical).

Encourage interprofessional interventions:

- physical and occupational therapy (increase ambulation, range of motion, decreasing bed rest time);
- consult with pharmacist and do a complete medication review (rule out medications that are causing delirium, for example, anti-cholinergic drugs);
- nursing interventions to insure urinary catheters are removed (prevent urinary tract infections), no fecal impactions, no pressure ulcers, frequent re-orientation, insure patient is wearing glasses and hearing aids (decrease sensory deprivation) and assessment of the patient's cognitive and physical status;
- dietary consult to insure proper fluid and nutrition (prevent dehydration and low caloric intake).
References


