Recognising Delirium in Older Hospitalised Patients

Older people in hospital or long-term care may be at risk of delirium

Delirium also referred to as 'acute confusional' state is a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking. It is one of the most common complications of medical illness or recovery from surgery among older adults in the hospital.

Delirium has an abrupt onset, occurs over hours or days and symptoms fluctuate over time. Usually short term, lasting days to weeks but symptoms may persist for longer. It is a serious condition associated with poor outcomes and therefore **requires prompt investigation and treatment of the underlying cause.**

Delirium can be hyperactive (agitated, hyperalert) or hypoactive (lethargic, hypoalert) but some people may show signs of both (mixed). Hypoactive and mixed delirium may be more difficult to recognise.

Delirium is commonly mistaken for dementia, depression or accepted as part of old age. A careful history should be obtained from the patient's family or carer(s) in order **to establish their baseline cognitive status.**

RISK FACTORS

- **Aged 65 years or older**
- **Pre existing cognitive impairment, dementia or depression**
- **Previous history of delirium**
- **Current hip fracture**
- **Visual and/or hearing impairment**
- **Severe illness (that is deteriorating or at risk of deteriorating)**
- **Multiple medical problems**
- **Alcohol or drug abuse**

Nurses should maintain a high index of suspicion for delirium in the older adult, when a new onset/acute or sub-acute deterioration in behaviour, cognition, or function occurs.

PRECIPITATING FACTORS

- **Effects of medication e.g. narcotic analgesia, benzodiazepines, cardiac medications, anticholinergics, steroids**
- **Pain**
- **Illness, infection, burns**
- **Post surgery e.g. orthopaedic, cardiac**
- **Constipation**
- **Malnutrition**
- **Immobilisation**
- **Sleep deprivation**
- **Extremes of sensory input**
- **Physical restraints**
- **Indwelling catheters**
- **Substance withdrawal**
- **New and different environment**
- **Electrolyte imbalance**

SIGNS & SYMPTOMS OF DELIRIUM

- **A sudden change or fluctuation in mental status (may help to compare with MMSE before onset if available).**
- **Fluctuating level of consciousness (ranging from hyperalert to unrousable)**
- **Reduced ability to maintain attention or stay focused**
- **Memory impairment: poor registration and retention of new material**
- **Disorientation in time and often in place**
- **Disorganised thinking e.g. rambling, irrelevant, incoherent or inappropriate speech**
- **Perceptual distortions which may lead to misidentification, illusions and hallucinations**
- **Disturbed sleep-wake cycle**

TYPICAL SIGNS OF HYPERACTIVE DELIRIUM

- Hyperalert
- Restlessness, agitation - picking or pulling at clothes, bed linen, IVs, catheters, attempting to get out of bed/chair, wandering
- Labile mood: irritability, fear, anxiety, elation
- Lack of cooperation with reasonable requests, anger, belligerence, combativeness, aggression

TYPICAL SIGNS OF HYPOACTIVE DELIRIUM

- Lethargy
- Decreased alertness
- Drowsy, difficult to wake
- Lack of interest
- Staring into space, apathy
- Sparse or slow speech
- Reduced mobility/ movement

Patients with mixed-type delirium fluctuate between hyperactive and hypoactive delirium

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Source: NICE (2010) Clinical Guideline 103: Meagher et al (2000) Relationship between symptoms & Motoric Subtypes of Delirium; Journal of Neuropsychiatry & Clinical Neurosciences: (12) 51-56: AHMAC (2006)Clinical Practice Guidelines for the Management of Delirium in Older People.