DIAGNOSING, PREVENTING & MANAGING DELIRIUM IN OLDER PATIENTS

Delirium is a common problem in all healthcare settings with a prevalence of 20%-30% on medical hospital wards, 10%-50% on surgical wards and under 20% in long term care (NICE, 2010). The etiologies of delirium are diverse and multifactorial and may be caused by acute illness, medical complication or drug intoxication. More than one etiology is often responsible for delirium.

For inpatients who are elderly, medically unwell and patients in the postoperative period, delirium may result in a prolonged hospital stay, increased complications, increased cost, and long-term disability. Delirium is also associated with higher mortality rates both during hospitalisation and post-discharge.

The identification and management of delirium requires **a multidisciplinary team approach** and involves identifying and correcting the underlying problem, supporting functional needs, reducing distress and managing agitation. Many patients with delirium are discharged before their symptoms are fully resolved, and this factor must be accounted for in planning their post-discharge care.

Clinical Presentation

Delirium always should be suspected when an acute or subacute deterioration in behavior, cognition, perception or function occurs, especially in patients who are elderly, have dementia, or are depressed.

Diagnosis

The diagnosis of delirium is clinical and includes:

- Observation: Patients with **hyperactive delirium** demonstrate features of restlessness, agitation and hypervigilance and often experience hallucinations and delusions. By contrast, patients with **hypoactive delirium** present with lethargy and sedation, respond slowly to questioning, and show little spontaneous movement and fail to progress in rehabilitation. Patients with **mixed delirium** demonstrate features of both types.
- Obtaining a thorough history of onset and course i.e. from family, carers, nursing notes
- A careful and complete medical history and physical examination including mental status examination
- Medication review
- Laboratory and radiology tests to highlight possible underlying causes
- Several screening tools are available to aid in identifying delirium. Comparison with an AMTS (Abbreviated Mental Test Score) or MMSE (Mini Mental State Examination) score before the onset of delirium is ideal. Administering the AMTS or MMSE several times during the course of delirium can be a way to assess improvement. Other available tools include The Confusion Assessment Method (CAM), The Delirium Rating Scale (DRS) and the Delirium Observation Scale (DOS). Choice of assessment tool will depend on training/expertise and setting.

(The current standard for the diagnosis of delirium appears in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition).

Preventing Delirium

- Following admission to hospital assess and monitor people at risk of developing delirium.
- Avoid moving at risk people within and between wards.
- Ensure appropriate placement on the unit - Avoid too much noise, glaring lights/shadows.
- Provide frequent explanation and reassurance.
- Use clocks/signage to orientate.
- Ensure prompt assessment and treatment for constipation, dehydration, hypoxia, pain, infection or nutritional problems.
- Avoid unnecessary catheterisation, cannulation and restraints.
- Encourage early mobilisation following surgery or illness.
- Reduce noise and avoid nursing or medical procedures during sleeping hours if possible.
- For people with sensory impairments ensure they have access to their glasses or hearing aids.

Managing Delirium

- Identification and treatment of the underlying cause(s).
- Continue with measures outlined under prevention.
- Ensure the diagnosis of delirium is documented in the person's nursing notes/hospital record/ discharge letter.
- Ensure effective communication, reorientation and reassurance –Enlist the help of family/friends where appropriate.
- Ensure regular assessment to check for improvement or deterioration.
- Non-pharmacological treatment is best, but pharmacological treatment may be necessary where a patient is very distressed or agitated.

Where symptoms do not resolve: Re-evaluate for underlying causes: Follow up and assess for possible dementia

Developed by Anne Quinn, Advanced Nurse Practitioner Dementia, St Patrick's Hospital Cashel, Co Tipperary as part of The National Dementia Education Project ONMSD (2011)

References: NICE (2010) NICE Clinical Guideline 103/Delirium: Diagnosis, Prevention & Management. American Psychiatric Association. Treatment of Patients with Delirium Practice Guideline http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Inouye, S.K (2006) Delirium in Older Persons. New England Journal of Medicine. 354: 1157-1165