Standardised care process (SCP): delirium

health

Topic

Detection of and response to delirium

Objective

To promote evidence-based practice in the detection of and response to delirium

Rationale

Delirium is common in older people and can have a negative impact on their health and quality of life. Delirium is frequently not detected or is misdiagnosed. In many cases delirium is preventable and reversible. Recognising and minimising risk factors can reduce the likelihood of delirium developing (Clinical Epidemiology and Health Service Evaluation Unit: Melbourne Health, 2006; Tullman, Mion, Fletcher & Foreman, 2008).

Definition

Delirium: a temporary mental condition typified by 'disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours or days) and tends to fluctuate during the course of the day' (Clinical Epidemiology and Health Service Evaluation Unit: Melbourne Health, 2006 p. v).

Team

Manager, RNs, ENs, PCAs, resident and/or family, GP, pharmacist, physiotherapist

Evidence base for SCP

Clinical Epidemiology and Health Service Evaluation Unit: Melbourne Health, 2006, *Clinical practice guidelines for the management of delirium in older people*, Department of Human Services, Melbourne.

National Clinical Guideline Centre 2010, *Delirium: diagnosis, prevention and management*, National Clinical Guideline Centre, UK.

Royal Australian College of General Practitioners (RACGP) 2006, *Medical care of older persons in residential aged care facilities* (4th ed.), RACGP, Melbourne.

Tullman DF, Mion LC, Fletcher K & Foreman MD 2012, Delirium, in M. Boltz, E. Capezuti, T. Fulmer, D. Zwiker (Eds.), *Evidence-based geriatric nursing protocols for best practice*, Springer, New York.

Brief SCP: delirium

Recognition and assessment	On admission conduct a delirium assessment: • complete a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS) • assess the presence of risk factors for delirium • assess the presence of symptoms of delirium • complete the Confusion Assessment Method (CAM). Continually monitor resident for emergence of new risk factors or symptoms. If at any time symptoms present or if there is a sudden change in a resident's cognition, behaviour or medical condition: • repeat above assessment • refer to GP for diagnosis and treatment • implement appropriate interventions.
Interventions	Risk minimisation, including: • ensure resident is in a safe location - remove potentially dangerous objects and care for resident away from others • in conjunction with the resident's GP implement interventions to remove or minimise risk factors where possible. If symptoms present or there is a sudden change in a resident's condition, cognition or behaviour: • seek and treat readily identifiable causes (such as constipation, pain, fever) • refer to GP • in conjunction with the resident's GP implement interventions for management and treatment.
Referral	• GP for assessment and treatment of risk factors and/or causes and symptoms • GP and pharmacist for medication review • Physiotherapist for mobility
Evaluation and reassessment	• Assess resident every shift for symptoms of delirium • Repeat the CAM at least weekly to monitor effect of interventions and treatment until symptoms are no longer present • Repeat the PAS at least weekly to monitor whether cognition returns to baseline status • Continue to monitor and, where possible, manage risk factors
Resident involvement	• Information about delirium and risk factors • Discuss interventions to minimise risk factors • Family involved in promoting orientation
Staff knowledge and education	• Delirium: causes, risk factors, symptoms and management

Full SCP: delirium

Recognition and assessment

On admission conduct a delirium assessment:

- complete a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS)
- assess the presence of risk factors for delirium:
  - over 70 years of age
  - cognitive impairment
  - dehydration
  - depression
  - pain
  - infection
  - hypoxia
  - impaired mobility
  - taking multiple medications or medication toxicity or withdrawal
  - metabolic disorders (for example, hypoglycaemia, hyponatremia)
  - physical restraint in use
  - constipation
  - urinary catheter in situ
  - impaired vision/impaired hearing
  - environmental factors (for example, noise, poor lighting, multiple instructions being given)
  - hospital admission.

Assess the resident for symptoms of delirium:

- complete the abbreviated Confusion Assessment Method (CAM) (this tool does not diagnose delirium – higher scores indicate a need for further investigation). Symptoms include:
  - sudden acute change in resident's condition, cognition or behaviour
  - fluctuation in consciousness: could vary from drowsy to hyperactivity
  - difficulty in paying attention, following conversation and concentrating, and is easily distracted
  - difficulty in remembering names, events and instructions
  - disorientated to time and place
  - disorganised thinking
  - rambling and erratic speech, jumping from one subject to another
  - visual and auditory hallucinations
  - fluctuation in functional ability (for example, the ability to complete activities of daily living (ADLs) independently or the level of assistance required with ADLs)
  - altered sleep pattern
  - not as active as normal
  - withdrawn
  - disinterested
  - symptoms may fluctuate over course of the day (resident may be disorientated to time and place at some times and lucid at others); usually worse at night.

Continually monitor resident for emergence of new risk factors or symptoms. If at any time symptoms present or if there is a sudden change in a resident's cognition, behaviour or medical condition:

- repeat above assessment
- refer to GP for diagnosis and treatment
- implement interventions below.

Interventions	Risk minimisation: • ensure resident is in a safe location - remove potentially dangerous objects and care for resident away from others • in conjunction with the resident's GP implement interventions to remove or minimise risk factors where possible: – conduct a medical assessment and treat underlying disorders, particularly blood tests, urine test (MSU if indicated), take temperature, blood pressure, pulse, pulse oximetry – as it is not possible to remove or minimise the impact of all risk factors, continually monitor the resident for symptoms of delirium • check medications to assess their potential for causing current or future problems and, where possible, cease use of drugs that may be contributing • conduct nursing assessment and implement strategies to address hypoxia, pain, constipation, dehydration, poor sleep patterns • encourage the resident to wear their glasses and hearing aids at all times • encourage adequate nutritional intake • promote a quiet, calm environment • ensure resident is given single step instructions and only one person speaks at a time • avoid use of restraints • avoid use of urinary catheter • maximise mobility • maintain continuity of care staff wherever possible • ensure appropriate levels of sensory stimulation • encourage family/friends to visit • provide familiar objects from home.
Interventions	If symptoms present or there is a sudden change in a resident's condition, cognition or behaviour: • seek and treat readily identifiable causes (for example, hypoxia, constipation, pain, fever) • refer to GP • in conjunction with the resident's GP: – conduct a medical assessment and treat underlying disorders – check medications to assess their potential for causing current or future problems – avoid use of antipsychotic medications.
Referral	• GP for assessment and treatment of risk factors and/or causes and symptoms • GP for medication review • Physiotherapist for mobility • Pharmacist
Evaluation and reassessment	• Assess resident every shift for symptoms of delirium • Repeat the CAM at least weekly to monitor effect of interventions and treatment until symptoms are no longer present • Repeat the PAS at least weekly to monitor whether cognition returns to baseline status • Continue to monitor and, where possible, manage risk factors
Resident involvement	• Information about delirium and risk factors • Discuss interventions regarding minimising risk factors • Family involved in promoting orientation
Staff knowledge and education	• Delirium: causes, risk factors, symptoms and management

Disclaimer: This Standardised Care Process (SCP) was prepared by the Department of Health and then subject to a pilot program to determine its suitability for use in public sector residential aged care settings. The research that informs this document was conducted from 2008 to 2009. This document is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. The Department of Health and the State of Victoria do not represent or warrant that the content of this document is accurate, current, or suitable for the use to which it may be put. To the extent allowed by law the Department of Health and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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