DELIRIUM
PREVENTION & TREATMENT

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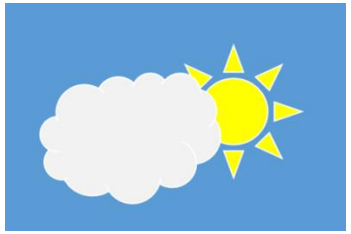
WHAT COMES TO MIND WHEN YOU THINK OF DELIRIUM?

Is this level of confusion ‘normal’ for the patient?

Yes

Dementia

No



Delirium

HYPO VS HYPER

Hypoactive Delirium	Hyperactive Delirium
Lethargic	Restless
Slow to respond	Impulsive
Confused	Hallucinating
Quiet	Confused
Poor eye contact	Aggressive
	Pulling at lines / NG tube
Can fluctuate between types, or have mixed presentation of symptoms	

WHY SHOULD WE CARE ABOUT DELIRIUM?

- Delirium affects 14-56% of all hospitalised elderly patients
- 35-40% of delirium cases are preventable
- ⅓ of patients remain delirious at 6 months
- ⅔ of patients at 1 year function at the same level of a moderate TBI
- 80% of ventilated patients will experience some level of delirium during their hospital stay
- Increases risk of falls, pressure injuries, length of hospital stay

WHY SHOULD WE CARE ABOUT DELIRIUM?

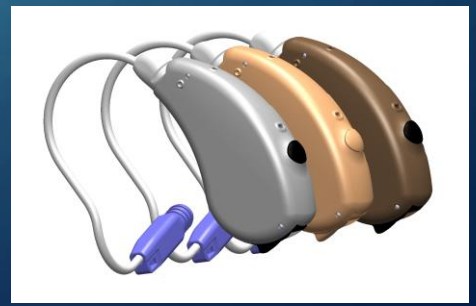
- Mortality Rate increases by 11% for every 48 hrs of delirium (González et al., 2009)
- Study of 45 UK acute care hospitals: delirium was associated with increased length of stay and increased mortality at 1 month (Geriatric Medicine Research Collaborative, 2019)
- Study of 6724 patients 65+ years in Scotland:
  - 35% had delirium / dementia / cognitive impairment on admission
  - Of those 52% died within 2 years
  - Delirium alone was associated with increased mortality 6 months after admission
  - Dementia (+/- delirium) associated with increased mortality 3 months after admission (Hapca et al., 2018)

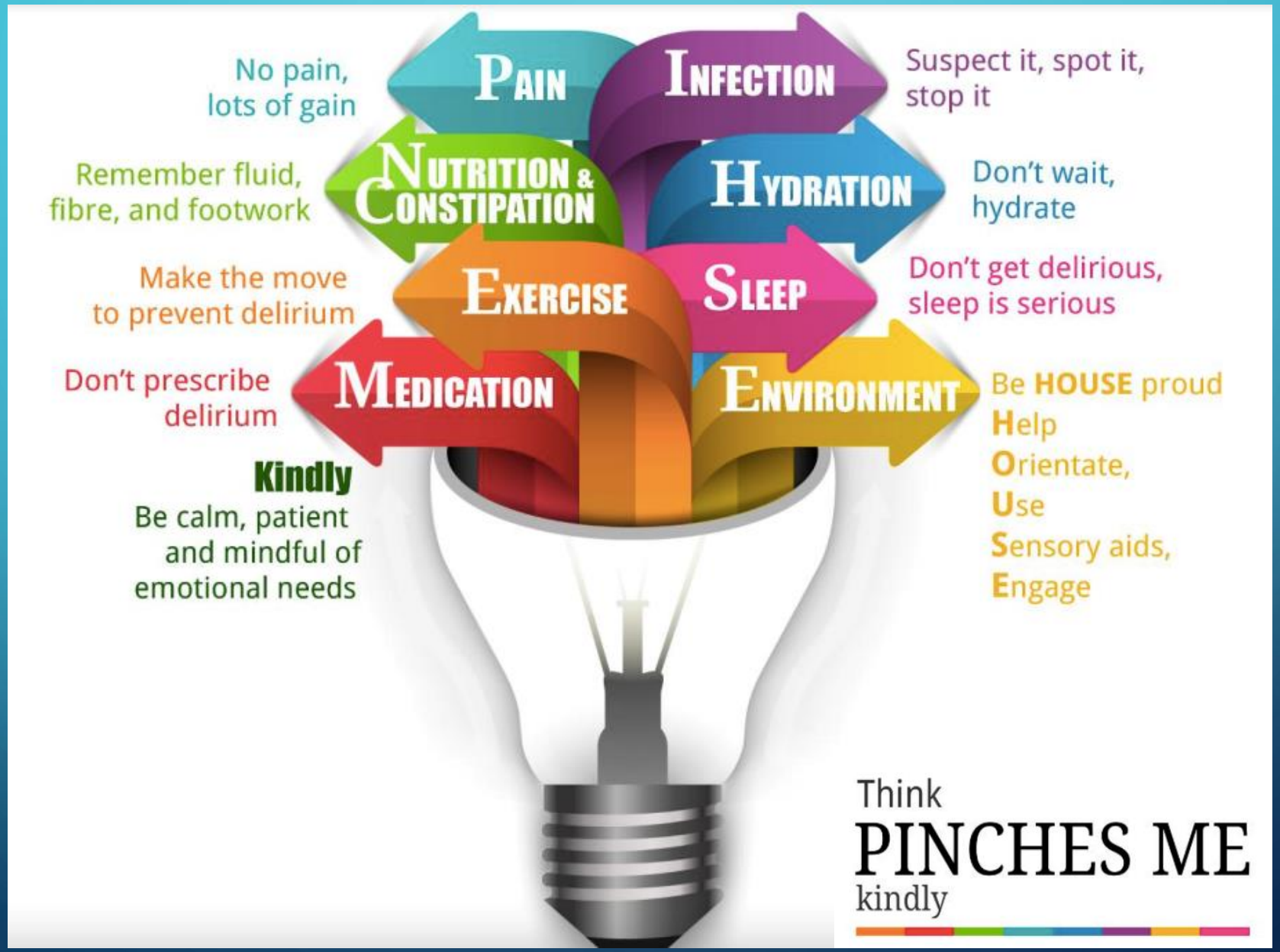
LONG TERM EFFECTS

- Decreased social engagement
- Poor stress management
- Difficulty managing finances/ medication
- Difficulty managing appointments
- Grocery shopping/ meal planning
- Depression
- Decreased quality of interpersonal relationships
- PTSD

RISK FACTORS

- History of dementia
- Advanced age
- Have poor eyesight or hearing
- Have an infection or sepsis e.g. UTI
- Surgical patients
- Certain high-risk medicines
- Have heart failure
- High medical acuity (restraints, invasive lines)

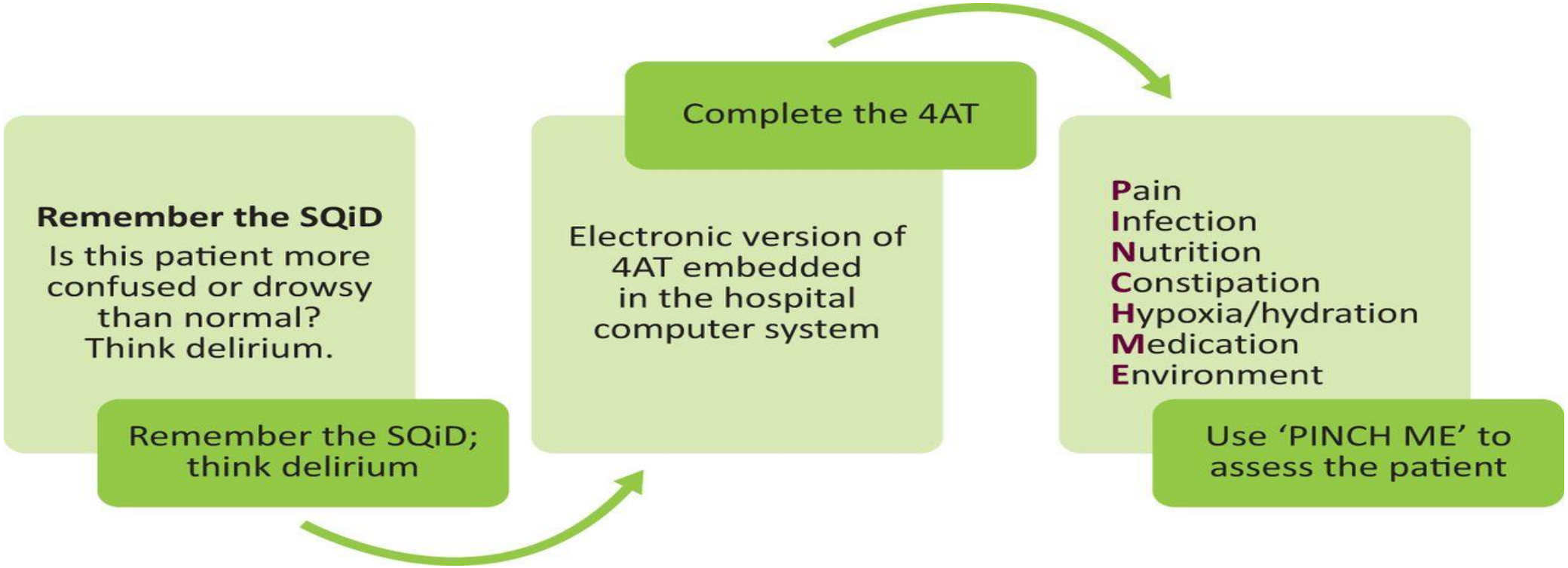



No pain, lots of gain
Pain
Infection
Suspect it, spot it, stop it
Remember fluid, fibre, and footwork
Nutrition & Constipation
Hydration
Don't wait, hydrate
Make the move to prevent delirium
Exercise
Sleep
Don't get delirious, sleep is serious
Don't prescribe delirium
Medication
Environment
Be HOUSE proud
Help
Orientate,
Use
Sensory aids,
Engage
Kindly
Be calm, patient and mindful of emotional needs
Think
PINCHES ME
kindly

PREVENTION IS KEY!

- Pain
- Infection
- Nutrition
- Constipation
- Hydration
- Exercise
- Sleep
- Medication
- Environment

Delirium Pathway



SQUID-SINGLE QUESTION IN DELIRIUM

4AT – Screening for Delirium & Cognitive Impairment

The 4 AT is a screening tool designed for rapid initial assessment of delirium and cognitive impairment.

Instructions for completion:

- Part of routine admission assessment of all patients >65 years, repeated each shift for 5 days and if score 0 stop.
- All patients with a history of dementia, delirium, or cognitive impairment
- Rescreen if RADAR (Recognise Acute Delirium as Routine) has a new score of 1 or more
- **DOCUMENT Each score on patients' observation chart and in notes**

Test	Result	Score
Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.	• Normal, fully alert, but not agitated, throughout assessment • Mild sleepiness for <10 seconds after waking, then normal • Clearly abnormal	0 0 4
AMT4 Age, date of birth, place (name of the hospital or building), current year	• No mistakes • 1 mistake • 2 or more mistakes/untestable	0 1 2
Attention Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted.	• Achieves 7 months or more correctly • Scores <7 months / refuses to start • Untestable (cannot start because unwell, drowsy, inattentive)	0 1 2
Acute change or fluctuating course Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs	• No • Yes	0 4
4AT score 4 or above: possible delirium +/- cognitive impairment, 1-3: possible cognitive impairment 0: delirium or cognitive impairment unlikely but still possible		

WHAT CAN WE DO ABOUT IT?

"Non-pharmacological interventions are the treatments of choice for delirium"

(Andersen-Ranberg et al., 2022)

Non-pharmacological multicomponent interventions are shown to be most effective in decreasing incidence of delirium and preventing falls

(Martinez et al., 2015; Hshieh et al., 2015)

Te Whatu Ora
Health New Zealand

Supporting Patients with a Delirium

Hypoactive Delirium
- Lethargic
- Slow to respond
- Confused
- Quiet
- Poor eye contact
- Tearful/low mood

Mixed / Fluctuating
- Frequently changing

P	Pain
I	Infection
N	Nutrition &
C	Constipation
H	Hydration
E	Exercise
S	Sleep
M	Medication
E	Environment

Hyperactive Delirium
- Restless
- Impulsive
- Hallucinating
- Confused
- Aggressive
- Pulling at IV lines / NG tube

Hypoactive Delirium	All Delirium patients	Hyperactive Delirium
'PINCHES ME' Kindly has been evaluated (above) Patient Personal Profile (101746) and/or Sunflower (200177) should be completed for all patients		
Family Involvement • Encourage them to prompt activities	**Family Involvement** • Receive delirium information • Have open access visiting • Complete personal profile/ sunflower • Bring in patient's clothes and personal items • Support care as able	**Family Involvement** • Reassures patient if experiencing visual disturbances or hallucinations

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Activities/Orientation • Assistance with eating meals and drinking as may be struggling to initiate • Ensure Meal Tray mat red side is used	**Activities/Orientation** • Daily routine • Mobilise, sit in chair for all meals • Dress daily in own clothes • Encourage normal sleep/wake • Use My Care Plan Boards • Reorientate: clocks, calendars, newspapers, windows	**Activities/Orientation** • Folding towels • Magazines, board games • Word finds, sudoku (print from internet if none on ward)
Patient care and support • Regular toileting prompts • Monitor for constipation or urinary retention	**Patient care and support** • Intentional Rounding • Hygiene needs assistance • Pressure Injury Prevention • Reduce catheter/IV lines where possible	**Patient care and support** • Increased falls risk if impulsive movements (consider falls alarm though may not tolerate)
Sensory • Radio with music choice from personal profile if possible • Hand massage with moisturiser • Consider shared room to increase stimulation	**Sensory** • Clear communication • Hearing aids • Glasses • Avoid unnecessary bed moves	**Sensory** • Noise awareness – may be overstimulated • Consider single room • Be aware of 'triggers'

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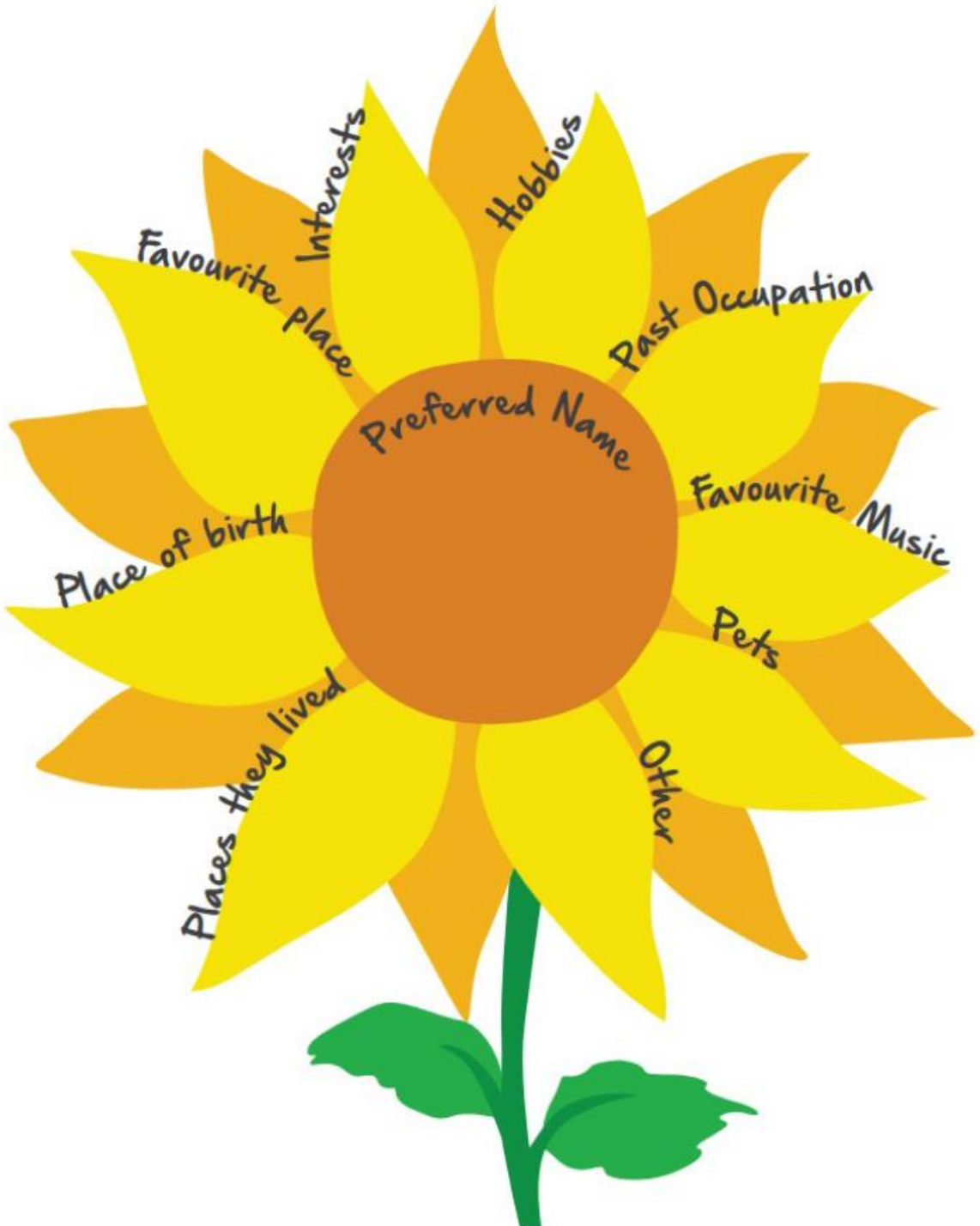
HOW TO HELP – ALL TYPES

- Daily routine
  - Up in chair for all meals
  - Dress daily in own clothes (provides familiarity)
  - Encourage normal sleep/wake cycle
- Sensory aids
  - Hearing aids (and charger or batteries) glasses, ask family to bring these in if needed
- Orientation
  - Orientation board
  - Newspaper
  - Able to see out the window, see clock or watch

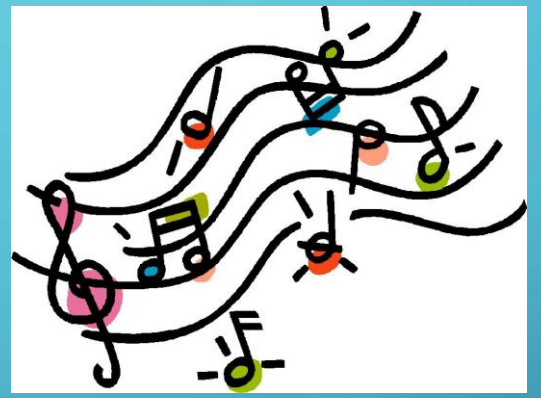
HOW TO HELP – ALL TYPES

- Family involvement
  - Request to bring in patient's clothes, personal belongings, family photos
  - Complete the Personal Profile (101746) or Sunflower includes information of patient's interests, whanau, music preferences. Can be utilised in conversation with Patient Watch
  - Understanding-and-preventing-delirium-tips-for-family-13-Sept.pdf (sialliance.health.nz)
- Remove catheters when able
- Mobilisation early and regularly in admission
- Allied Health Assistant or Health Care Assistant Programmes


Preferred Name
Hobbies
Past Occupation
Favourite Music
Pets
Other
Places they lived
Place of birth
Favourite Place
Interests

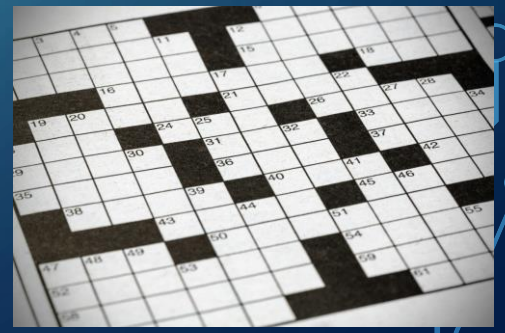
HOW TO HELP - HYPOACTIVE

- Assistance with meals
- Toileting prompts
- Oral hygiene
- Sensory input
  - Music
  - Hand massage



HOW TO HELP - HYPERACTIVE

- Activities
  - Folding towels
  - Wiping tables
  - Word finds, sudoku, colouring in (can be downloaded)
  - Utilise Personal Profile to support meaningful tasks
- Noise awareness
  - May be overstimulated
  - Clear communication
  - Single room may be beneficial



- Family involvement
  - Reassurance in light of hallucinations / visual disturbances

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DELIRIUM OPERATIONAL GROUP

- Sensory kits for each ward in process of being purchased
- Involved in training HCAs in delirium care and monitoring
- Supporting roll out of 4AT assessment tool (to replace the CAM)
- Keen to have members from each ward represented on the group

ANY QUESTIONS?

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