Delirium Assessment and Management

Definition of Delirium
Acute onset of impaired attention, cognition (memory, orientation, language), consciousness, perception, behaviors, and/or emotions that may fluctuate, **have a medical cause**, and are not due to dementia. Often called "acute confusion." Terminal delirium: irreversible and can occur in the days before dying; antipsychotics used more liberally for comfort in these cases.

1. Is the person more confused today than usual? If yes, the person might have delirium and a brief cognitive assessment should be done.

2. Brief Cognitive Assessment: People with the level of dementia indicated can usually perform these attention-based tasks, while those with delirium cannot. Severe dementia is difficult to test. Change in cognitive status is usually determined by observation. Compare vs. recent baseline.

- Mild Dementia: list days of week and months of year backwards.
- Moderate Dementia: count backwards from 20 to 1.

3. Delirium Screening: See the screening tool, derived from the Confusion Assessment Method (CAM), CAM-ICU, and MDS, on the ***other side***.

4. If the screening suggests delirium, assess and treat possible causes:

- Vitals (pulse, blood pressure, temperature, respiratory rate, pulse-oximetry, pain).
- Physical examination to diagnose infections or other acute medical conditions such as constipation, pneumonia, pressure ulcers, MI (heart attack), CVA/TIA (stroke).
- Basic laboratory evaluation (urinalysis, creatinine, sodium, potassium, calcium, glucose, CBC with differential).
- Review medications with particular attention to anticholinergics, benzodiazepines, or new medications (see ***Drugs that May Cause Delirium or Problem Behaviors).*** Discontinue if benefit does not outweigh potential harm.
- Review restraints (foley catheter, IV lines, other tethers) and discontinue if benefit doesn't outweigh potential harm.
- Assess pain—Is pain management adequate and appropriate?

5. Use non-drug management:

- Sleep: Allow continuous sleep at night. Keep noise down. Recognize that an altered sleep-wake cycle is often a symptom of delirium.
- Orientation: Orient to date and place. Clock and calendar in room. Light on from 7 a.m. to 7 p.m. (sunrise to sunset). Always introduce yourself.
- Environment: Keep hearing aids and glasses accessible. Offer beverage of choice frequently for hydration. Encourage low-key family visits.

6. Use antipsychotic short-term for agitation or distressing psychotic symptoms, e.g. hallucinations. See ***Antipsychotic Prescribing Guide***.

- E.g. haloperidol 0.5 mg PO/IM q1 hour PRN agitation or distressing hallucinations. Can double dose if ineffective. Schedule once or twice daily dose based on the total amount needed to achieve treatment goal in 24 hours. When delirium resolves, discontinue the antipsychotic.

Delirium Screening Tool

Suspect delirium if answer is yes on items 1 + 2 + (3 or 4) below.
First perform a Brief Interview of Mental Status, Staff Assessment, or brief cognitive test described on ***other side***.

1) Acute onset [ ] yes [ ] no [ ] uncertain*
Is there evidence of an acute change in mental status from the person's baseline?
*If uncertain, gather more information.

2) Inattention [ ] yes [ ] no [ ] uncertain*
Does the person have difficulty focusing attention (i.e., easily distracted or can't follow what is being said)?
*If uncertain, perform an Attention Screening Examination (ASE):

Directions: Say to the patient, **"I am going to read you a series of 10 letters. Whenever you hear the letter 'A,' indicate by squeezing my hand."** Read letters from the following letter list in a normal tone.

S A V E A H A A R T

Scoring: Errors are counted when patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A." Inattention is present if **3** or more errors are observed.

3) Disorganized thinking [ ] yes [ ] no [ ] uncertain*
Is the person's thinking disorganized or incoherent, as evidenced by rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject?
*If uncertain, conduct the following question/command assessments:

Questions:
1. **Will a stone float on water?**
2. **Are there fish in the sea?**
3. **Does one pound weigh more than two pounds?**
4. **Can you use a hammer to pound a nail?**

Score: Patient earns 1 point for each correct answer out of 4.

Command:
Say to patient: **"Hold up this many fingers"** (Examiner holds two fingers in front of patient then puts them back down) **"Now do the same thing with the other hand"** (Not repeating the number of fingers).
Score: Patient earns 1 point if does entire command.
Disorganized thinking is present if combined scores are less than 4.

4) Altered Level of Consciousness [ ] yes [ ] no
Is the patient anything other than alert, calm and cooperative (at current time)? This may include **vigilant** (easily startled), **lethargic** (frequently dozed off when asked questions), or **stuperous** (very difficult to arouse and keep aroused), or **comatose** (could not be aroused).

Psychomotor retardation: (sluggishness, staring into space, staying in one position, moving slowly) may also count as a "yes" for this domain.