Definition:

A transient reversible organic brain syndrome. It is a medical illness that can be treated with expectation that the patient will return to a previous level of functioning.

Signs & symptoms:

- KEY INDICATOR: Fluctuating level of consciousness (main difference from dementia or depression diagnosis)
- Acute onset (usually hours to days)
- Global impairment of cognitive functioning:
  - Confusion
  - Anxiety
  - Disorientation
- Overall reduced level of functioning
- Disturbances of sleep-wake cycle; restlessness
- Hallucinations (particularly visual) and paranoid delusions

Causes of delirium:

- Constipation
- Medications (adverse drug events, drug interactions etc)
- Infections – respiratory, UTI, septicaemia
- Metabolic – hypoxia, electrolyte imbalance, hyper/ hypoglycaemia
- Neurological – sub arachnoid haemorrhage, tumour, trauma, CNS infection, seizure, alcohol/drug withdrawal
- Vascular - TIA, stroke
- Urinary retention
- Pain
- Fatigue
- Diseases – dementia, Alzheimers disease, cardiac, pulmonary, haematologic, oncologic, renal, hepatic, metabolic, endocrinologic and infections
- Environmental changes, eg. move to a new room or facility

ASSESSMENT

1

Comprehensive physical assessment
Record vital signs:
Temperature, pulse, respirations, blood pressure, oxygen saturation, blood sugar level, assess hydration and nutritional status.
Assess for all possible causes:
Your assessment should include pain assessment, cardiac examination, respiratory assessment, abdominal assessment

2

Neurological assessment
Glasgow Coma Scale
Mini Mental Status Examination
Confusion Assessment Method (CAM)
Assess for obvious neurological deficits

3

Medication review
Is patient on anticholinergics, sedatives or opiates? Has a new medication been added?

4

Diagnostic tests & investigations:
Delirium screen:
Organise laboratory tests: mid stream urine and blood. Blood tests should include:

- Liver function
- Serum medication levels
- Calcium level
- Thyroid
- B12/folate
- Urea and electrolytes
- Full blood count
- ESR
- CRP
- Glucose
- Troponin

If no doctor or diagnostic services are available, if after hours, transfer to hospital once 1, 2 and 3 from above completed

Check for the following exacerbating factors:

- Previous episode or history of delirium
- Uncomfortable or too hot/cold e.g. incontinent, needing position change
- Hungry / thirsty
- Non English speaking
- Noisy environment
- Known to have a history of mental illness
- Recent environmental change

Present and discuss assessment finding with resident's GP

If chest infection is suspected a chest X-ray to be organised by GP

If client displays severe agitation or aggression contact resident's GP

If suspected cause is cardiac consult with GP and organise ECG and consider admission to hospital

CONFUSION ASSESSMENT METHOD (CAM)		
FEATURE	SOURCE / CRITERIA	QUESTIONS
1. Acute onset and fluctuating course	Usually obtained from a family member or nurse and is shown by positive responses to questions	Is there evidence of an acute change in mental status from the patient's baseline? Did the abnormal behaviour fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?
2. Inattention	Shown by a positive response to question	Did the patient have difficulty focusing attention for example, being easily distractible, or having difficulty keeping track of what was being said?
3. Disorganised thinking	Shown by a positive response to question	Was the patient's thinking disorganised or incoherent such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
4. Altered level of consciousness	Shown by any answer other than "Alert" to the question	Overall, how would you rate this patient's level of consiousness? Alert (normal), vigilant (hyper alert), lethargic (drowsy, easily aroused), stupor (difficult to arouse) or coma (unrousable)?
The diagnosis of delirium by CAM requires the presence of features 1 & 2, and either 3 or 4.		

Nursing management:

- Maintain a low stimulus, calm, well lit environment
- Increase nursing supervision and monitoring
- Keep bed as low to the ground as possible
- Use firm but non confrontational directions/ do not argue
- Avoidance of all unnecessary medications
- Maintenance of food and fluid intake
- Re-orientation to time, place and person
- Regular monitoring of vital signs
- Education and reassurance of family/ friends
- Document: behaviours clearly; management strategies that are working and those that are clearly ineffective
- Ensure resident has working hearing aids and glasses if appropriate
- Photographs of family/friends & significant others, placed within their room.
- Clocks and calendars to help with orientation
- Regular exposure to sunlight

If resident's condition deteriorates CALL AN AMBULANCE

If resident is unconscious or difficult to arouse CALL AN AMBULANCE

If head trauma is suspected CALL AN AMBULANCE