SEARCHING FOR THE CAUSE OF DELIRIUM

Delirium Symptom list (from Confusion Assessment Method)

- Sudden change in mental status
- Change in behaviour that fluctuates from normal to abnormal over a 24 hour period
- Difficulty in focusing attention
- Disorganized thinking and/or altered level of consciousness

Begin your assessment with the highest probable risk for the person's situation.

Drug Toxicity?

a. On more than six medications, especially:

- anticonvulsants – barbiturates
- histamine H_2 antagonist – thiazide diuretics
- insulin/hypoglycemic agent – anticholinergics
- antipsychotics – antidepressants
- benzodiazepines – cardiac glycosides
- narcotics – anesthetic

b. Receiving a medication for more than 5 years

c. Age 75 or older

d. Running drug levels beyond or at the high end of therapeutic range

Order drug chemistry and/or trial discontinuation of medicine.

Changes in Chronic Illness?

Physical and psychosocial assessment reveals exacerbation* of previously diagnosed condition, such as:

- Diabetes mellitus – Hypo/hypertension
- COPD – ASHD
- Cerebrovascular insufficiency – Pain
- Cancer – Alzheimer disease/dementia
- Depression – Hypoxia
- Substance misuse (e.g., alcohol, drugs, tobacco)

Request appropriate diagnostic tests

(* Exacerbation may be accompanied by increased levels of pain and/or decreased functional abilities)

New Disease Process?

a) Cardio and cerebrovascular conditions
1. Silent MI
2. TIA/CVA
3. CHF

or

b) GI conditions, GI bleed, if evidence of daily use of NSAIDS or steroids

or

c) Other medical conditions
1. Hypo/hyperglycemia
2. Hypo/hyperthyroidism
3. Electrolyte imbalance
4. Cancer
5. Neurological conditions (e.g., normal pressure hydrocephalus)
6. Pain
7. Abuse or withdrawal from alcohol, drugs, tobacco
8. Low B12

Request appropriate diagnostic tests

(e.g., PE, pulse oximetry, EKG, hemoglobin and hematocrit, chemistry screen, electrolytes, TSH, specific test for cancer detection, CAT)

or

d) Psychiatric conditions, especially if evidence of family history

Request psychiatric evaluation, dementia work up

Adapted from:

Inouye, SK, et.al. (1990). Clarifying Confusion: The Confusion Assessment Method. A new method for detection of delirium. *Annals of Internal Medicine, 113*: 941-8.

Inouye, SK. (2006). Delirium in older persons. *The New England Journal of Medicine, 354*(11), 1157-1165.

Henry, M. (2002). Descending into delirium. ANJ, 102(3), p.49-56.

Mentes, (1995) *Journal of Gerontological Nursing* in Henry, M. (2002, March). Descending into delirium. *ANJ,102*(3), p.49-56.]

Infection?

a. elevation in baseline temperature, even less than 37.56°C rectally

b. history of lower respiratory infection or UTI more than twice per year

c. history of any chronic infection

d. recent episode of falling

Request appropriate diagnostic tests.

Most common: urinalysis, chest X-ray, sputum cultures as indicated

Elimination Problems?

a. Urinary problems
1) history of incontinence, retention, or indwelling catheter
2) signs or symptoms of dehydration, tenting, increased BUN
3) decreased urinary output
4) taking anticholinergic medication
5) abdominal distention

b. Gastrointestinal problems
1) immobility for more than 1 day in persons previously mobile
2) abdominal distention
3) decreased number of bowel movements or constipated stool
4) decreased fluid intake – dehydration
5) decreased food intake, especially bulk

Request in-out catheterization for postvoid residual and/or incontinence assessment, or both.

Accomplish digital rectal exam, request enema, initiate appropriate bowel regimen.

Sleep Disturbance?

a) Assess baseline normal sleep pattern

b) Identify causes of sleep disturbance, e.g., Medications / pain / environment

Post Operative?

a) reaction to anesthetic

b) analgesia

c) opioids / anticholinergics

Ensure "elder friendly" approach

a) Inactivity

b) Restraint

Mobilize early **Manage pain**

Psychosocial? Environmental?

a) grief, losses (family members, significant life items)

b) alteration in personal space

c) recently admitted

d) increase or decrease in sensory stimulation

e) interpersonal difficulties

Initiate home assessment –

a) ADLs and AIDLs

b) Safety

c) User-friendly environment
- labels, pictures
- put orienting items in room

d) Supports: social, family; counseling

e) Encourage family involvement