**Definition:**
Delirium is an acute transient pathological disorder which manifests itself with impaired cognitive (often mistaken for dementia), perceptual, emotional and behavioral alterations. Up to 50% of all hospitalized patients will experience a delirium. Delirium can be very distressing for patients and family members; and the healthcare team should provide continuing reassurance to all.

To assist in the following process, please follow the decision tree (Appendix A). There is also an accompanying delirium learning package available online.

*Please note that this is not a permanent chart document. Please discard in confidential waste once patient is discharged.*

**Identification of Risk Factors**

Check all that apply:

- Severe illness
- Sensory impairment (hearing/vision)
- Age (65 years and over)
- Cognitive impairment (dementia)
- Dehydration
- Multiple medications (six or more)
- ETOH/substance abuse
- Previous delirium
- Infection
- Recovery from surgery
- Pain
- Impairment of activities of daily living

If you have checked yes to any of the above risk factors perform the Confusion Assessment Method (CAM) within first 8 hours of admission. If the CAM is positive then repeat q shift and prn.

**Confusion Assessment Method (CAM)**

**Answer these four questions:**

1) Was the onset acute and does behaviour fluctuate? ................................................................. □ Yes □ No

AND

2) Is there evidence of inattention? ................................................................. □ Yes □ No

(difficulty focusing attention, shifting and keeping track)

AND EITHER

3) Is there evidence of disorganized thinking? ................................................................. □ Yes □ No

(incoherent, rambling, illogical flow of ideas)

OR

4) Is there altered level of consciousness? (i.e. any state other than alert) ...................... □ Yes □ No

(Alterations include hyperalert, lethargic, stuporous and comatose)

**Features 1 and 2, and either 3 or 4 are required for a diagnosis of delirium**
Look for Causes and Contributing Factors

I – Infection (pneumonia, UTI, meningitis, syphilis, encephalitis, brain abscess, sepsis)

W – Withdrawal (ETOH [delirium tremens], benzodiazepines, opioids, other drugs)

A – Acute Metabolic (diabetes, renal failure, elevated BUN, electrolyte imbalances)

T – Trauma (closed head injury, hyperthermia, burns, postop, shock)

C – CNS Pathology (CVA, tumors, abscesses, hemorrhages, metastatic disease)

H – Hypoxemia (anemia, drop in BP, cardiac failure, CO poisoning)

D – Deficiencies (vitamins/minerals)/Degenerative brain diseases (MS, Huntington’s)

E – Endocrine Abnormalities (hypo/hyper: thyroidism, glycemia, calcemia)

A – Acute Vascular (shock, CVA, infarcts, arteriosclerosis, decreased blood supply)

T – Toxins (drugs: prescription, OTC, street drugs; especially narcotics)

H – Heavy Metals (lead poisoning)

To help guide physicians, check all that are required and order:

- CXR
- Electrolytes
- Urinalysis/cultures
- TSH/B12
- EKG
- Bun/Cr
- Medication review
- CBC
- Blood cultures
- Other:

Nurses Assess:

- Vital signs/O2 saturation
- Blood glucose
- Assess/treat pain
- Elimination (if no BM x 24 hours consider checking for fecal impaction)
- Fluid balance/retention (ins/outs)

Interventions

Environmental:

- Avoid over/understimulation
- Safety: avoid the use of restraints; follow falls protocol; approach patient with caution
- Family: elicit family support wherever possible to help with management
- Ensure patient has glasses/hearing aides in place and aides are in good working order

Cognitive:

- Determine baseline cognition; obtain collateral
- Reorientation: repetition is key to compensating for patient’s memory impairment (provide clocks, calendars, time/place, magazines/newspapers, familiar objects from home)

Communication:

- Clear and consistent communication from team when addressing patient and family
- Document delirious behaviors

Function:

- Encourage and facilitate early and ongoing activity/mobility

Psychological:

- Avoid disputing delusions
- Frequent reassurance to patient and family

Pharmacology:

- Taper or stop benzodiazepines where possible as they may worsen delirium (unless delirium is related to benzodiazepine or alcohol withdrawal)

For delirium with agitation please consider (unless contraindicated):

- Haldol: 0.5 - 1 mg iv/im/subcut/po bid
- Risperidone: 0.5mg po bid