# Assessment and Intervention of Delirium in the Acute Care Setting

## Assessment

*Confusion Assessment Method – ICU (CAM-ICU) - attached*

*Narrative Delirium Questions:*

Have you had any strange experiences in the hospital? Yes No
Seeing things others don't see? Yes No
Hear things others don't here? Yes No
Thoughts that nurses or doctors are trying to harm you? Yes No
Are you experiencing any dreams or visions? Yes No

If yes, how often have you had these dreams or visions during the past 24 hours?
Once a day 2–4 times a day >4 times a day

Do these dreams or visions occur while you are asleep or awake?
Asleep Awake Both

Do the dreams/visions seem or feel real?
Yes No

Are these experiences comforting or distressing?
Extremely Distressing Distressing Neither Comforting Extremely Comforting

## Intervention

**Environmental and Behavioral Intervention for Delirious Patients:**

INTERACTIONS

- Model calm. If you are relaxed, he will be relaxed.
- Lower self below Xx's eye level when speaking to him.
- Talk slowly and softly and only with the most necessary and important words.
- Make decisions for the Xx. Do not ask "Do you want to...?"
- If he becomes agitated or has paranoid thoughts, say "Everyone is her for you, Xx. We love you." If agitation persists, try "This is one of those times when it is tough to know what is dream and what is real. Let's focus on what is real. Take two deep breaths. Name two things you can see. Name two things you are touching. Really good. Let's do that again..."

ENVIRONMENT

- Keep the envixxment quiet and relaxed
- Provide a distraction-free envixxment when communicating
  - Turn off the TV. If TV is on ONLY the C.A.R.E channel should be displayed (no other tv programs)
  - Limit visitors to one at a time
  - Keep the immediate area uncluttered to reduce the possibility of XX's attention wandering to objects in the room
- During breaks, consider playing classical music (which he loves). Give him something soothing to hold (e.g., a towel or soft blanket).
- Make sure the lighting matches the time of day (lights on and shades open during day, lights off at night)
- If XX becomes frustrated; discontinue the conversation, and give XX a break

## References

Ouimet, S., Kavanagh, B.P., Gottfried, S.B., Skrobik, Y. (2007). Incidence, risk factors, and consequences of ICU delirium. Intensive Care Medicine, 33, 66-73.

Guenther, U, et al. (2010). Validity and reliability of the CAM-ICU flowsheet to diagnose delirium in surgical ICU patients. Journal of Critical Care, 25, 144-151.

Girard, T.D., Pandharipande, P.P., Ely, E.W. (2008). Delirium in the intensive care unit. Critical Care, 12 (supplement 3).

Muldonado, J.R. (2008). Delirium in the acute care setting: Characteristics, diagnosis, and treatment. Critical Care Clinics, 24, 657-722.

Kerr, Christopher W., James P. Donnelly, Scott T. Wright, Sarah M. Kuszczak, Anne Banas, Pei C. Grant, and Debra L. Luczkiewicz. "End-of-life dreams and visions: a longitudinal study of hospice patients' experiences." *Journal of palliative medicine* 17, no. 3 (2014): 296-303.

Brown, S. M. (2016). *Through the valley of shadows: living wills, intensive care, and making medicine human*. Oxford University Press.

**eLearning:**

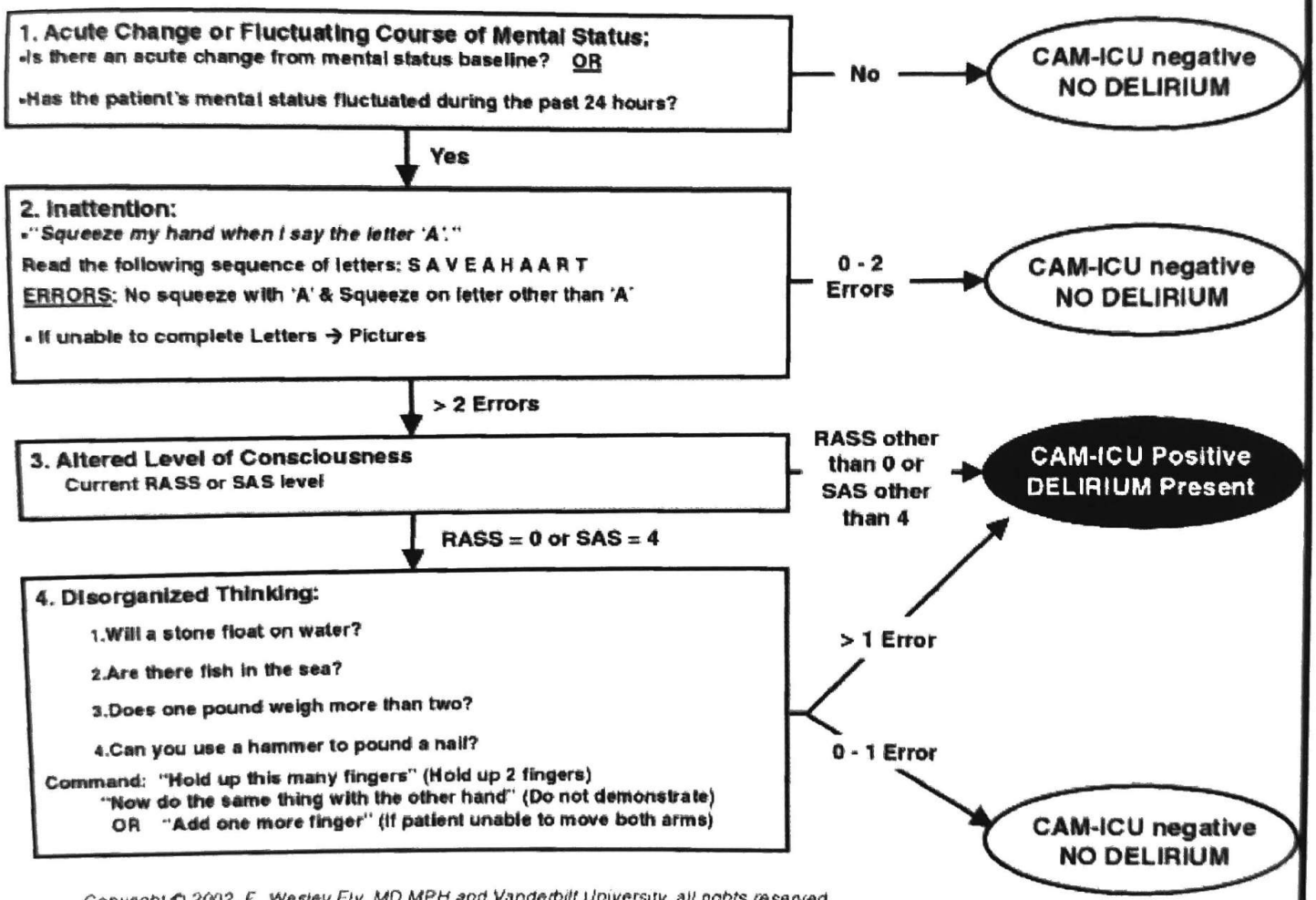
Patient accounts of delirium:

https://www.youtube.com/watch?v=bvm6_6vtGa4
https://www.youtube.com/watch?v=bvm6_6vtGa4
https://www.youtube.com/watch?v=mahm5WHxB7Q

How to spot delirium – BMJ talk
http://www.bmj.com/content/357/bmj.j2047/infographic

# Confusion Assessment Method for the ICU (CAM-ICU) Flowsheet

***Delirium can only be assessed in patients more alert than RASS -3 or SAS 3***



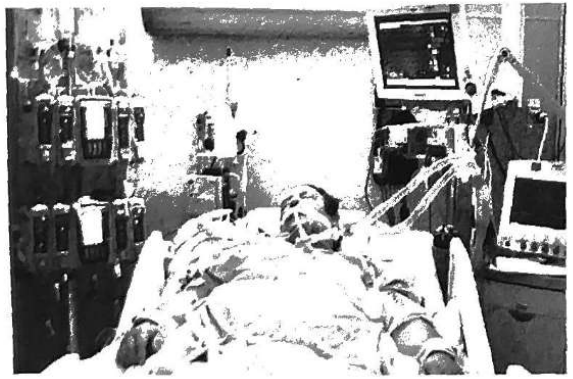
## What is delirium?

The word "delirium" is used to describe a severe state of confusion. People with delirium

- cannot think clearly
- have trouble paying attention
- have a hard time understanding what is going on around them
- may see or hear things that are not there. These things seem very real to them.

## Delirium is common

- About 2 out of 3 patients in ICUs get delirium.
- Seven out of 10 patients get delirium while they are on a breathing machine or soon after.



## Causes of delirium

Experts think delirium is caused by a change in the way the brain is working. This can be caused by:

- less oxygen to the brain
- the brain's inability to use oxygen
- chemical changes in the brain
- certain medicines
- infections
- severe pain
- medical illnesses
- alcohol, sedatives, or pain killers
- withdrawal from alcohol, nicotine

## People most likely to get delirium

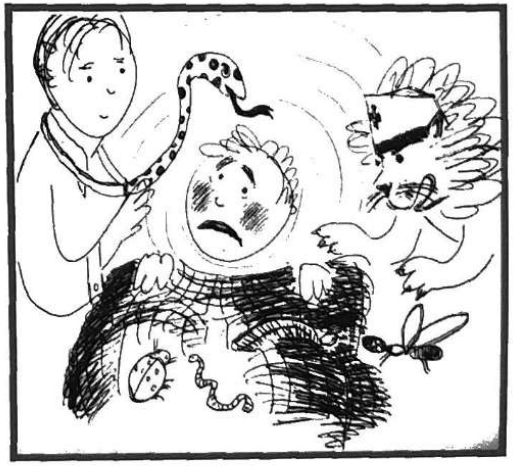
People who

- have dementia
- are advanced in age
- have surgery, especially hip or heart
- have depression
- take certain high-risk medicines
- have poor eyesight or hearing
- have an infection or sepsis
- have heart failure

## Signs of delirium

Your family member may

- appear agitated or even quiet
- be confused
- be aggressive
- use inappropriate words
- not be able to pay attention or follow directions
- be unsure about where they are
- be unsure about the time of day
- see things that are not there
- act different from usual
- have changes in sleeping habits
- have emotional changes
- have movements that are not normal, like tremors or picking at clothes
- have memory problems



## Delirium is different from dementia

**DELIRIUM**

- Delirium comes on quickly, in hours or days. Signs of delirium can change from one day to the next.
- Delirium can make memory and thinking problems worse.
- Delirium usually clears up after a few days or even a week.

**DEMENTIA**

- Usually dementia is a permanent condition.
- Dementia is a disturbance of thinking. It comes on over months or even years.
- Patients with dementia are more likely to develop delirium.

## Does delirium cause thinking problems after a patient leaves the hospital?

- Research shows that patients who develop delirium might have dementia-like thinking problems that can last for months.
- At this time we cannot predict who might develop dementia-like thinking problems.

## How you can help

- Speak softly and use simple words or phrases
- Remind the patient of the day and date.
- Talk about family and friends.
- Bring glasses, hearing aids.
- Decorate the room with calendars, posters, or family pictures. These familiar items might be reminders of home.
- Provide the patient with favorite music or TV shows.
- If your loved one has delirium, we might ask you to sit and help calm them.

ICU Delirium &
Cognitive Impairment
Study Group

*www.ICUdelirium.org*

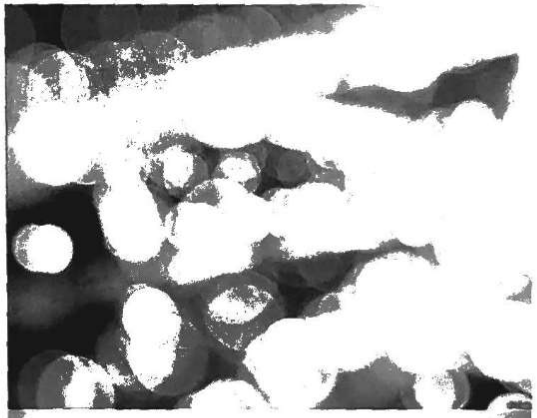
for questions, please email
*delirium@vanderbilt.edu*



In the Intensive Care Unit

# Delirium

*A guide for families and patients*



*www.ICUdelirium.org*

Visual summary

# Quietly delirious

Hypoactive delirium can be more difficult to recognise than hyperactive delirium, and is associated with worse outcomes. This infographic summarises the main differences between the two forms of delirium.

## Delirium

According to the DSM-5* classification, to be diagnosed with delirium a patient must display all of the following:

### Disturbance in attention

Ask patient to name the months of the year backwards

### Disturbance in awareness

Ask patient their age, date of birth, place and current year

### + An additional disturbance

Such as defecit in:

- Memory
- Visuospatial ability
- Language
- Perception

### Acute change

- Develops over a short period of time
- Sudden change from baseline
- Fluctuates during the course of a day

May require information from other staff, carers, or case notes

### No better explanation

These disturbances are not better explained by a pre-existing, established or evolving neurocognitive disorder or coma state

### Evidence of cause

Evidence that disturbance is a consequence of one or more of:

- Another medical condition
- Substance intoxication
- Substance withdrawal
- Exposure to a toxin

## Hyperactive delirium

Predominantly restless and agitated

- Increased motor activity
- Loss of control of activity
- Restlessness
- Wandering

## Mixed motor type

Evidence of both subtypes in the previous 24 hours

## Hypoactive delirium

Predominantly drowsy and inactive

Commonly mistaken for depression or dementia

- Decreased activity
- Decreased action speed
- Decreased speed of speech
- Decreased amount of speech
- Reduced awareness of surroundings
- Listlessness
- Withdrawal

## Adverse consequences

**All types of delirim**

- Reduced functional ability
- Onset of dementia
- Increased mortality
- Admission to long term care
- Distress
- Increased length of stay
- Hospital acquired complications
- Pressure sores
- Incontinence
- Falls

**Hypoactive delirium**

- + Greater mortality
- Less reversibility
- + Greater length of stay
- Worse quality of life
- + Greater frequency of falls

* DSM-5 = Diagnostic and Statistical Manual of Mental Disorders (fifth edition)

thebmj Read the full article online http://bmj.co/delirium