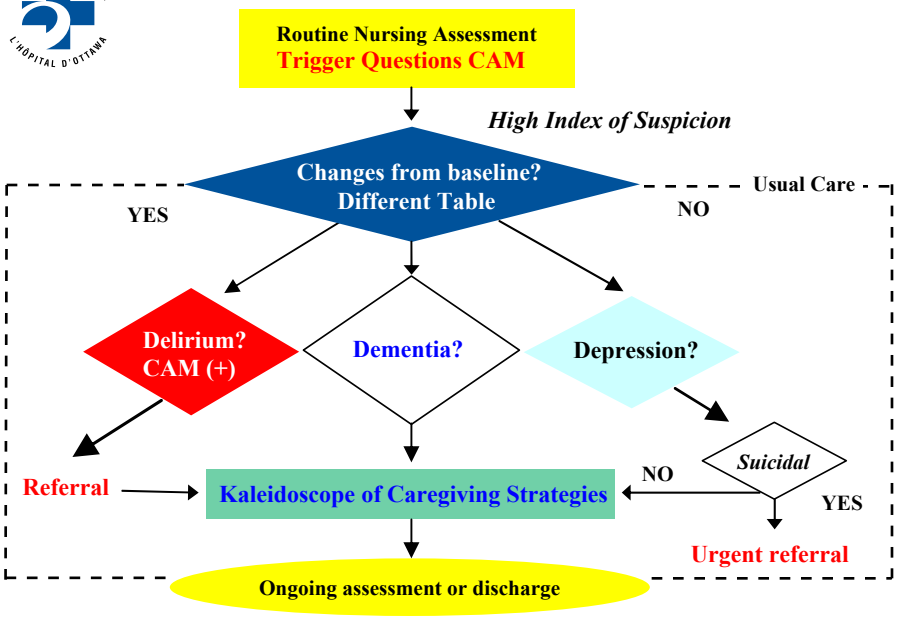
Screening Assessment Diagram for Delirium



CAM: Need presence of (1) & (2) & either (3) or (4)

1. Abrupt change?
2. Inattention, can't focus? Distracted?
3. Disorganized thinking? Incoherent, rambling, illogical?
4. Altered level of consciousness? Hyper-alert to stupor?

Trigger Questions

1. Acute changes in behaviour?
2. Changes in function?
3. Changes in cognition? MMSE
4. Changes in medications?
5. Physiologically unstable?

Adapted with permission from Registered Nursing Association of Ontario, (2003) Screening for Delirium, Dementia, Depression in Older Adults

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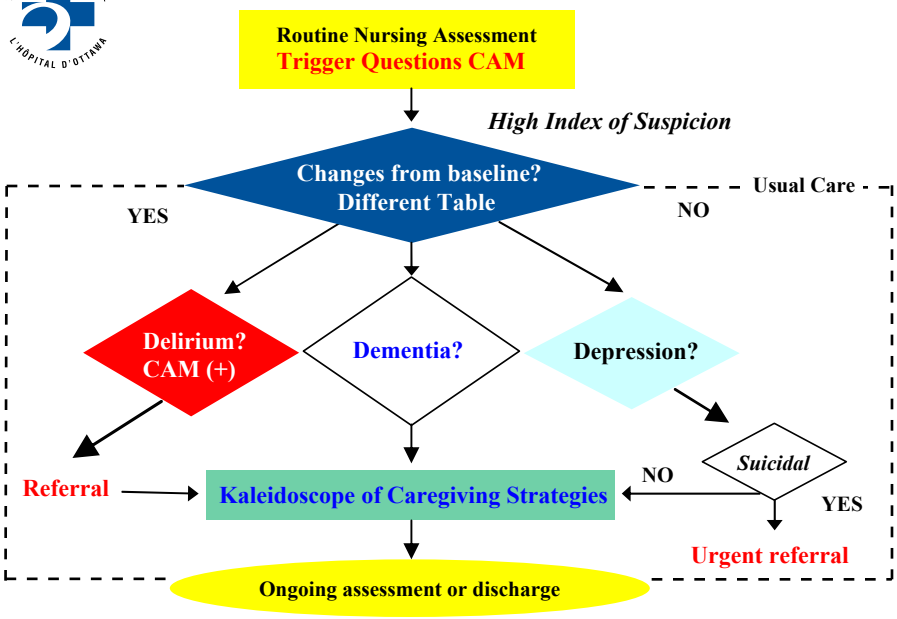

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Screening for Delirium in Older Adults

Definition of Delirium

An acute disturbance in mental status with a fluctuating course demonstrated by a reduced awareness of the environment, ability to focus and/or pay attention and changes in cognition. Usually, the result of underlying physiological alterations.

1. **awareness of environment; can't focus;**
2. **change in cognition: impaired memory, disorientation, hallucinations;**
3. **develops over short period of time and fluctuates during day.** *(DSM-IV-R)*

Recognizing Delirium: Look for

Onset	**Acute: abrupt**
Course	**Fluctuating, often worse @ night**
Awareness	**↓ perception of environment**
Attention	**↓ concentration, ↓ ability to focus**
Hallucinations	**Common**
Memory	**Impaired: ↓ recent & immediate**
Thinking	**Disorganized: rambling, illogical**

**** Look for:**

- **Changes in functioning**
- **Changes in behaviour**
- **Disturbances in sleep**
- **Hyper/hypo psychomotor activity**
- **Emotional disturbances: anxiety, fear, anger, apathy**

RULE OF THUMB:
Identify & reverse underlying etiology!!

Risk Factors for Delirium

- **Severe illness**
- **Sensory impairment: vision, hearing**
- **Older age**
- **Cognitive impairment: e.g. dementia, CVA**
- **Dehydration**
- **Multiple medications**
  - **sedatives**
  - **hypnotics**
  - **narcotics**
  - **anticholinergics**
  - **psychotropic**
- **Alcoholism/substance abuse**
- **Previous delirium**
- **Social isolation**
- **Infections**
- **Poor renal functioning**

What Can You Do?

1. **Consider team consults**
2. **Administer CAM**
3. **Review risk factors**
4. **Identify changes from baseline**
5. **Follow P & P**
6. **Communicate concern: Use W/U order form**
7. **Assess triggers e.g.:**
   - **Medications**
   - **Metabolic imbalance, e.g. Na, glucose, calcium dehydration, sats**
   - **Infection**
8. **Assess pain control & meds "around the clock" not prn**
9. **Offer glasses, aids, calendars**
10. **Mobilize**
11. **No/least restraints**
12. **Toileting regime**
13. **Provide nutrition**
14. **Family @ bedside**
15. **Comfort & reassurance**
16. **Sleep measures: hot drink**

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GEN 57 (REV 08–2007)

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