# DELIRIUM

**Delirium is an acute disturbance in mental state and awareness that results in confused thinking and altered awareness. Delirium is a medical emergency.**

## Alert

### Early recognition is vital. Delirium is a medical emergency

**REPORT to registered nurse, clinical manager or general practitioner or nurse practitioner**

- **Delirium is acute.** It can occur when a resident is unwell or injured.
- Delirium is regarded as acute brain failure meaning the resident's brain does not work the way it usually would.
- Delirium is a potentially reversible condition. It needs immediate medical attention.
- Recognising delirium is essential, so appropriate interventions can be implemented.

# OBSERVE

## Acute onset – changes can occur over hours to days

- Agitation
- Altered alertness - more restless or sleepier
- Resident behaves differently from usual
- Changes to usual sleeping–waking pattern
- Changes can come and go, get better or worse over a 24-hour period
- Easily distracted or difficulty concentrating
- Increasing confusion or disorientation
- New hallucinations or abnormal thoughts or beliefs
- Change to usual function

# IDENTIFY

## Manage modifiable risk factors

- Walk, sit in chair for meals
- Monitor bowels
- Monitor skin – look for changes to skin, including pain, swelling or redness
- Get up, get dressed, get moving. Try to encourage a normal routine
- Monitor vital signs
- Monitor fluid intake –aim for at least 1.2 litres every 24 hours unless otherwise indicated
- If there are further changes, that is, resident is more sleepy or agitated, let the registered nurse and/or general practitioner know
- Monitor pain (see Pain Guide)

# ACTION

## Early recognition is vital.
## Delirium is a medical emergency

- **REPORT** to registered nurse, clinical manager or general practitioner or nurse practitioner
- Get help and advice
- Look for causes (see Acute Deterioration Guide)
- Assess – **STOP AND WATCH**
- Any behaviour change could indicate delirium
- Use behaviour chart
- Document any changes to behaviour or alertness
- Check vital signs (if this is part of your role)
- Look for triggers such as toileting or pain
- Feedback from family/whānau

## Maintaining safety, security and comfort

Residents with delirium are at **high risk** of falls, physical deterioration, developing infections or pressure injuries. Care is aimed at:

- maintaining dignity and/or privacy
- correcting sight and hearing problems – using glasses/hearing aids, if required
- ensuring basic needs are being met by supporting continence, nutrition and mobility
- monitor bladder and bowel function
- encouraging family/whānau to support with care if able
- reducing confusion, disorientation and agitation
- provide a quiet, calm, well-lit environment
- encouraging food and drinks
- complete behaviour chart – look for patterns or triggers
- preventing complications such as pressure areas, dehydration and falls
- falls precautions
- consider regular checks or constant observer
- treating pain
- maintaining a good sleep pattern

# ACTION

## Non-pharmacological strategies

- **Reorientation** – clocks, calendars, newspapers
- **Consider communication barriers**, that is, level of understanding and language
- **Use general conversation**, that is, "It's breakfast time"
- **Use environmental cues**, for example, open curtains during day and close at night
- **Maintain and restore sleep**–wake cycle patterns
- **Ensure visual and hearing aids** are used where possible
- **Encourage time in natural lighting**
- **Try to keep to familiar staff and environments**
- **Monitor behaviour**, including what works well and what is a trigger. Report to registered nurse
- **Distraction** – consider including what works fiddle mitts, sensor mats, photos, music and so on
- **Keep communication simple** – one step instructions

# RECORD

**Document in progress notes/update care plan**