

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, 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.





Acute onset – changes can occur over hours to days

- A sudden deterioration/change in thinking and behaviour
- 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. Note, there are cultural variations around hallucinations. For example, it is not uncommon for Māori and other Indigenous peoples to see elders/spirits and this may not be a sign of unwellness at all
- Change to usual function



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 more agitated, let the registered nurse and/or general practitioner know
- Monitor pain (see *Pain Guide*)
- Increase supervision (see *Falls Guide*)



Early recognition is vital.

Delirium is a medical emergency

- **REPORT** to registered nurse, clinical manager, general practitioner or nurse practitioner
- Get help and advice
- Look for causes (see *Acute Deterioration Guide*)
- Assess – **STOP AND WATCH**. Note, if your facility uses the Deterioration Early Warning System (DEWS), it is likely the stop and watch early warning tool will be replaced with DEWS tools
- 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 and 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
- Encouraging food and drinks
- Correcting sight and hearing problems – using glasses/hearing aids, if required
- Completing the behaviour chart – looking for patterns or triggers
- Ensuring basic needs are being met by supporting continence, nutrition and mobility
- Preventing complications such as pressure areas, dehydration and falls
- Monitoring bladder and bowel function
- Taking falls precautions
- Encouraging family and whānau to support with care if able
- Considering regular checks or constant observer
- Reducing confusion, disorientation and agitation
- Treating pain
- Providing a quiet, calm, well-lit environment
- Maintaining a good sleep pattern



Non-pharmacological strategies

- **Reorientation** – clocks, calendars, newspapers
- **Consider communication barriers**, that is, level of understanding and language
- **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**
- **Sensor mat**
- **Monitor behaviour**, including what works well and what is a trigger. Report to registered nurse
- **Distraction** – consider including what works, such as fiddle mitts, photos, music, activity
- **Keep communication simple** and concise – one-step instructions



REPORT

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RECORD

Document in progress notes and update care plan