Delirium Assessment

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Objectives

- Define delirium
- Differentiate delirium from dementia
- Identify predisposing and precipitating factors leading to delirium.
- Describe several delirium assessment tools utilized in the medical/surgical areas.

What is Delirium ?

A medical illness of acute or sub-acute onset that presents with psychiatric symptoms, including:

- Disturbance in attention
- Change in cognition (e.g. perception, thought, and memory) and/or
- Perceptual impairments (illusions, hallucinations, or delusions)

Distressing for patients, families and healthcare workers…

Delirium– It's Preventable and Difficult to Resolve

- Occurs in 5-61% of orthopedic patients, especially those with hip fractures
- Up to two-thirds of patients with delirium have dementia
- Costs $164 billion annually
- Only 4% of patients have completely resolved delirium at discharge

Outcomes of Delirium

- Increased length of stay
- Increased morbidity and mortality
- Increased risk of adverse events: falls, aspiration pneumonia, pressure ulcers
- Inability to return to same level of care at discharge
- Long term cognitive impairment/PTSD

Differentiating Delirium and Dementia

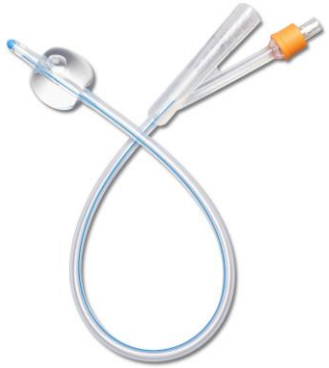
Delirium	Dementia
Acute or abrupt onset	Insidious, slower changes over time
Inattention	No changes
Changes in the level of consciousness (lethargy to vigilant)	No changes until late in illness
Fluctuating course, tends to be worse at night	Steady decline
Sleep/wake cycle impaired- may be reversed	Fragmented; may awaken frequently
Visual and auditory hallucinations	Visual hallucinations with Lewy body dementia
Psychomotor behavior- hyperactive, hypoactive or mixed	No change

Predisposing Factors for Delirium

- Dementia/ Cognitive impairment(present or past)
- Substance abuse
- Visual/ hearing impairment
- Parkinson's disease
- Hip fracture
- Age 65 years or older
- Traumatic brain injury
- Chronic kidney disease
- Severe illness

Precipitating Factors for Delirium

- Hypoxia
- Infections
- Electrolyte imbalances
- Anemia
- Medications
- Pain
- Tethers (catheters, O2, NG, lines, etc.)



Top 10 Medications that are Linked to Delirium

- Benzodiazepines (Ativan)
- Antihistamines (Benadryl)
- Narcotics (Morphine)
- Sedatives (Ambien, Restoril)
- Tricyclic's
- Hydroxyzine (Vistaril)
- Lithium
- Meclizine
- Parkinson's medications
- Bladder drugs

Minnesota Hospital Association – Best Evidence

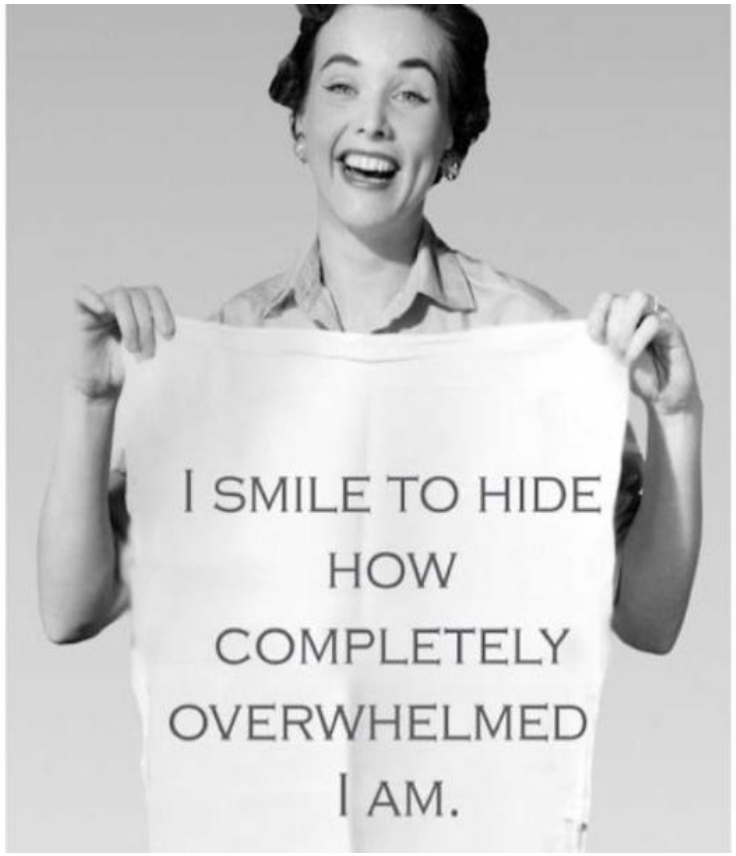
Mnemonic for Delirium

- D--Drugs
- E—Eyes, Ears
- L—Low sats, states (heart attack, stroke)
- I-- Infection
- R-- Retention
- I– Ictal state
- U– Underhydration/nutrition
- M– Metabolic causes
- S– Subdural hematoma
    - St. Louis University Geriatrics Evaluation Mneumonics Screening Tools

T.H.I.N.K. Mnemonic

Determining a Delirium Assessment Tool

- Evidence-based tool (validity, sensitivity, specificity)
- Ease of use for nursing staff
  - Length of tool
  - Amount of time to complete
  - Intuitive
- Electronic medical record may drive tool access
- Involve staff with decision on tool



Delirium Assessment Tools

- Confusion Assessment Method (CAM)
- NEECHAM acute confusion scale
- NU-DESC
- Delirium Observation Screening

Confusion Assessment Method (CAM)

- Acute and fluctuating course
- Inattention
- Disorganized Thinking
- Change in level of consciousness

NEECHAM Acute Confusion Scale (Severity Score)

- Information Processing (Cognitive)
  - Attention and alertness
  - Orientation
  - Complex command
- Processing (Behavioral)
  - Posture/Appearance
  - Psychomotor behavior
  - Verbal (initiation/content of speech)
- Vital Signs
  - Foley catheter usage, vital signs

NU-DESC (Screening Tool)

- Disorientation (verbal or behavioral)
- Inappropriate behavior
- Inappropriate communication
- Illusions/Hallucinations
- Psychomotor retardation

Delirium Observation Screening Tool

- Dozes during conversation or activity
- Is easily distracted
- Maintains attention to conversation or action
- Does not finish question or answer
- Gives answers which do not fit the question
- Reacts slowly to instructions
- Thinks to be somewhere else
- Knows which part of the day it is
- Remembers recent event
- Is picking, disorderly, restless
- Pulls IV tubing, feeding tubes, etc.
- Is easy or suddenly emotional
- See persons, things as somebody/something else

Delirium Prevention is Key!!

References

- Cole, M.G. (2004). Delirium in older patients. American Journal of Geriatric Psychiatry. 12(1). 7-21.
- Gaudreau, J. Gagnon,P. et. Al. (2005). Fast, systematic, and continuous delirium assessment in hospitalized patients: The nursing delirium screening scale. 29(4), 368-375.
- Hshier, T., Yue, J,. Oh, E., et. al. (2015). Effectiveness of multicomponent non pharmacological delirium interventions: a meta-analysis. Journal American Medical Association- Internal Medicine. April 175(4)., 512-20.
- McCusker, J., Cole, M., et. al. (2002). Delirium predicts 12 month mortality. Archives of Internal Medicine. 162(4), 457-463.
- Robertson, B. and Robertson, T. (2006). Current concepts review Postoperative delirium after hip fracture. The Journal of Bone and Joint Surgery. September 88-A (9). 2060-2068.