DELIRIUM: What's the big deal?

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The big deal…

- Delirium reported to have a **mortality rate up to 76%** in older adults
- In one study, delirium was missed by:
  - Nurses up to 75% of the time
  - Physicians more than 50% of the time

What you NEED to know

- MOBILIZE early
- Reduce the NOISE
- Facilitate good SLEEP
- Stop the BENZOS
- Routine ASSESSMENTS

Presenter Disclosures

- This program has not received any financial support.
- This program has not received any in-kind support.
- Relationships with commercial interests:
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- Potential for conflict(s) of interest:
  - Stacey Middleton has not received any payment/funding from any organization.
  - There are no products that will be discussed in this program.
- I have no disclosures therefore there are no potential bias' to mitigate in this talk.

A bit about me…

- Advanced Practice Nurse
  - Clinical Nurse Specialist
- Surgery Inpatients
  - Royal Alexandra Hospital
- Trauma Inpatients
  - Stollery Children's Hospital
  - University of Alberta Hospital
  - Royal Alexandra Hospital

What you can expect

- Simple Presentation
  - New information for some, refresher for others
- Get your cell phones ready
  - Keep on silent please
- Key Practice Points that will make a difference

Delirium: The Very Basics

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Wait! I thought I was at an Orthopedics conference…

Trust me, I will get you there!

Delirium

- "Delirium is a neuropsychiatric syndrome characterized by a sudden deterioration in attention and cognitive function that develops over hours or days and typically fluctuates throughout the day."
- Affects from cradle to grave

Delirium

- Delirium is associated:
  - Increased mortality
  - Longer hospital stays
  - Poorer physical and social functioning
  - Increased rates of discharge to long-term care facilities

Signs of Delirium

- Quiet
- No Appetite
- Not drinking
- Drowsy
- Immobility

Familiar Signs

- Difficulty Focusing
- Confused
- Disoriented
- Agitated
- Combative

Types of Delirium

- Hyperactive
  - Loud, Rambunctious, Disruptive behaviour, Aggressive, Resistant
- Hypoactive
  - Quiet, Passive confusion, Not eating or drinking, Reduced independent mobility
- Mixed
  - Alternates between hypoactive and hyperactive delirium
- Normal consciousness
  - Alertness & appearance of normalcy, Disorganized thinking, Inability to focus

Who's at risk for Delirium?

- Trauma
- Elderly
- Frail
- Orthopedics
- Hip Fracture

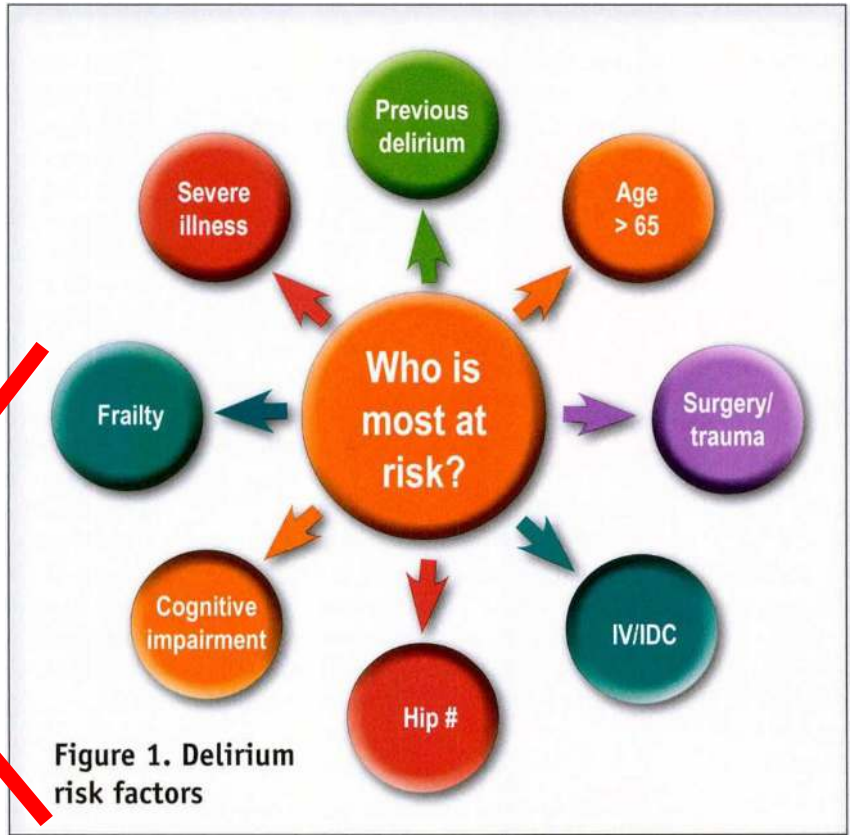

Figure 1. Delirium risk factors

Ortho patients at risk

Warning: Graphic Images

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At risk patient: Man v Guardrail

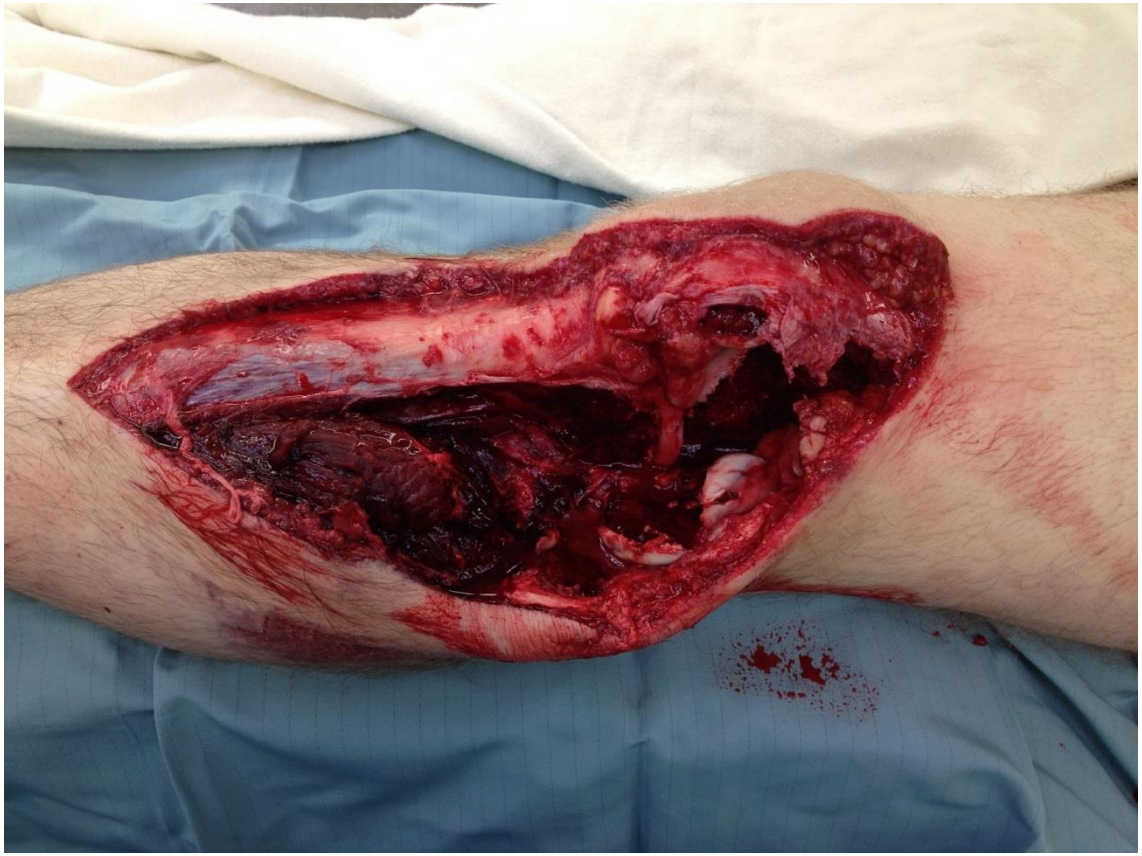

Photo credit: Dr. Catherine Hui

At risk patient: Infected Knee

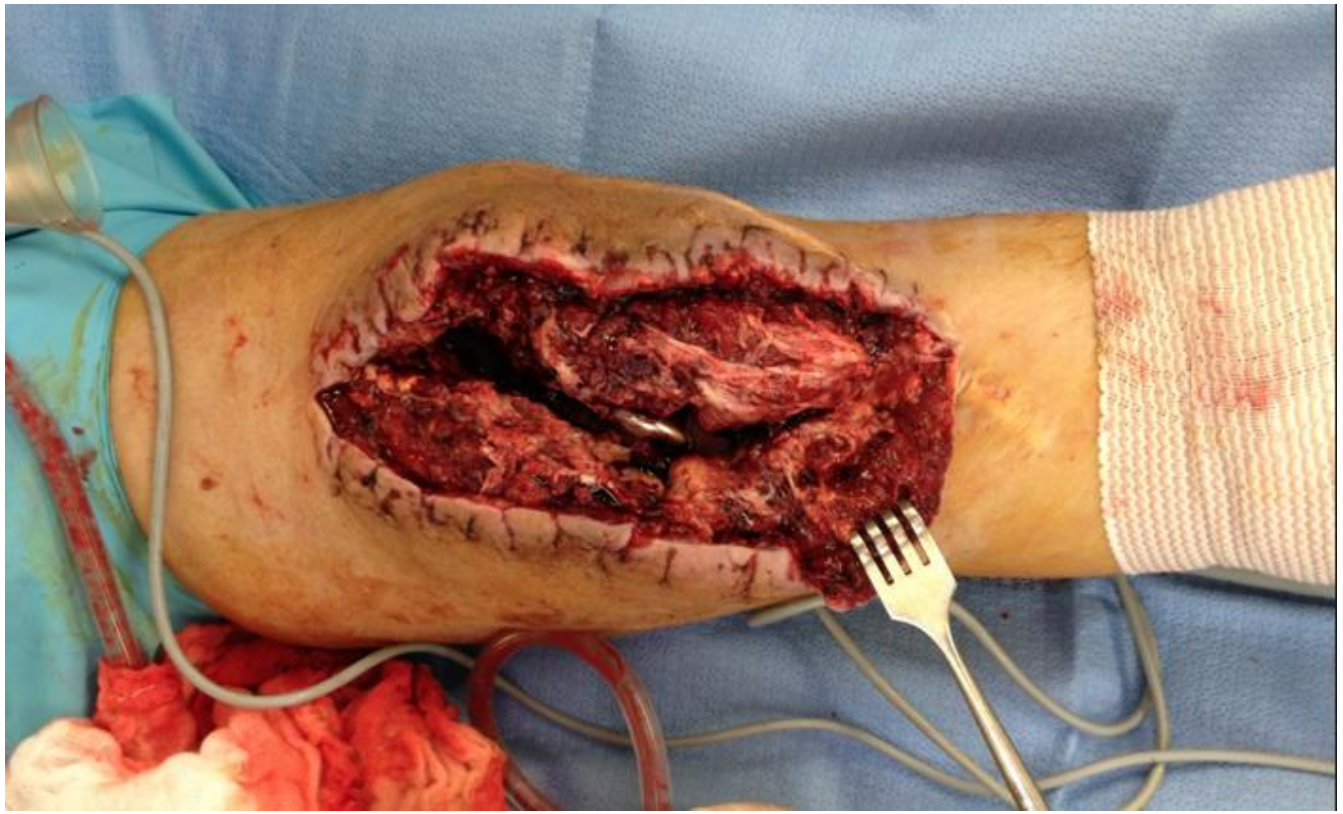

Photo credit: Dr. Catherine Hui

Delirium Facts

- Delirium is **NOT** a normal consequence of aging
- Delirium **IS** usually reversible with early diagnosis and treatment

Delirium Facts

- Delirium often goes unrecognized, due in part to LACK OF EDUCATION OF NURSES about the condition.
- Delirium is considered a medical emergency and can be fatal!

The real consequence of Delirium…

- Up to 50% of patients who experience delirium die within 12 months of diagnosis
- 23–33% patients die within 3 months
- Up to 75% of older inpatients who experience delirium die during the immediate hospitalization

Preventing Delirium

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Delirium Prevention

- Protocols for preventing delirium are successful
- Requires a multidisciplinary team of clinicians
  - assess risk factors
  - develop individualized patient care plans

Delirium Interventions

- early mobilization
- early repletion of lost fluids and electrolytes
- managing hearing and vision deficits
- discontinuing unnecessary, high-risk medications
- promoting normal sleep patterns
- early identification and treatment of infection, if present

Delirium Prevention

- **MOBILIZE** early
- Keep the **NOISE** to a minimum
- Support good **SLEEP**/wake patterns
- Avoid **BENZODIAZEPINES** medications
  - May be necessary with agitated/combative delirium
- Routine **ASSESSMENTS**
  - Confusion Assessment Method (CAM)
  - Intensive Care Delirium Screening Checklist (ICDSC)

Confusion Assessment Method (CAM)

- Short form is a quick bedside tool
- Assessing for 4 features of delirium:
  - an acute change in mental status (**ACUTE ONSET**)
  - difficulty focusing attention (**INATTENTION**)
  - disorganized or incoherent thinking (**DISORGANIZED THINKING**)
  - changes in level of consciousness (**ALTERED LEVEL OF CONSCIOUSNESS**)
- CAM tells us:
  - Delirium is present or it's not present

Pop Quiz: Get Your Cell Phones Ready

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It's time to Kahoot!

- Go To: Kahoot.it
  - Enter game PIN on screen
- Pick your username
  - Your username will be displayed – FYI ;)
- Have Fun!

Prevention is the best medicine

- MOBILIZE ASAP
- Minimize NOISE Levels
- Let your patient SLEEP
- Stop BENZODIAZAPINES
  - (& Opioids)
- ASSESS for delirium

Question #1

- Fact or Fiction: Confusion is a normal part of the aging process?
  - Fiction

Question #2

- What are the 4 types of delirium?
  - Hyperactive
  - Hypoactive
  - Mixed
  - Normal consciousness

Question #3

- Fact or Fiction: Delirium can be fatal?
  - Fact

Question #4

- What are the 4 assessments looking for in short form CAM?
  - Acute onset
  - Inattention
  - Disorganized thinking
  - Altered level of consciousness

Question #5

- Fact or Fiction: Orthopedic patients are not at risk for delirium?
  - Fiction

Question #6

- What were the 5 delirium prevention tips in this presentation?
  - Mobilize early
  - Minimize noise
  - Good sleep
  - No Benzodiazepines
  - Assess (CAM or ICDSC)

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Questions?

Thank You!

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