Care of Patient with Delirium

Introduction

Delirium is an alteration in consciousness involving confusion and other changes in cognitive ability that has a brief duration.[1] Patients specifically at risk for delirium include older adults, patients who have metabolic syndrome, and those who recently have had surgery. Other causes of delirium include infection, respiratory disorders in which poor oxygen circulation is involved, fluid and electrolyte disorders, cardiac disorders, and chemically induced delirium. Delirium is the most common psychiatric symptom seen in the medical-surgical acute care setting. Delirium is commonly confused with dementia, but there are distinct differences between the two conditions. (See *Differentiating delirium and dementia*.)

DIFFERENTIATING DELIRIUM AND DEMENTIA		
Although delirium and dementia both affect a patient's cognitive abilities, the nurse must be aware of the characteristics of each condition to ensure proper diagnosis and treatment.		
Characteristic	**Delirium**	**Dementia**
Onset	Rapid	Gradual and insidious
Duration	Brief (1 month or less), depending on the cause	Long, with progressive deterioration
Course	Daytime alterations, with more exacerbations at night	Stable progression of symptoms, with increased confusion in the evenings (sundowning effect)
Memory	Disorganized and impaired short-term memory	Short-term and long-term memory impairments progressing to complete loss
Orientation	Markedly decreased, especially to environmental cues	Progressively decreases
Language	Rambling, pressured, irrelevant	Difficulty recalling the correct word, loss of language in later stages
Perceptual disturbance	Environment unclear, progressing to illusions, hallucinations, and delusions	Commonly absent but can progress to paranoia, delusions, hallucinations, and illusions
Level of consciousness	Fluctuating cloudiness; inattentive to hyperalert with distractibility	Not affected
Sleep	Day–night reversal, insomnia, vivid dreams and nightmares	Possible day–night reversal in late stages
Psychomotor actions	Sluggish to hyperactive; changes unpredictable	Not affected initially; restlessness with pacing in late stages
Emotional status	Anxious with changes in sleep, fearful if experiencing hallucinations, weeping, yelling	Depression or anxiety when insight into the patient's condition is present; anger with outbursts in late stages

A disturbance in the patient's sleep patterns and a period of restlessness or fearfulness commonly precede the onset of delirium. Typically, the patient is oriented to person but not to time or place. Other signs of delirium include altered perceptions, such as visual illusions or hallucinations; loud, argumentative, and incoherent speech; impairment of recent memory; and disorganized thoughts. The patient may be agitated, restless, and combative, or he may be lethargic and difficult to awaken. Some patients alternate between agitation and lethargy. Signs of delirium are usually worse at night or when the patient awakens from sleep.[1]

Preventing delirium is much easier than treating delirium when symptoms are present. However, if delirium does occur, the goals of treatment are to eliminate its cause and maintain the patient's safety. (See *Targeted interventions to prevent and treat delirium*.)

TARGETED INTERVENTIONS TO PREVENT AND TREAT DELIRIUM

Targeted interventions performed before the onset of delirium or early in its course can prevent or significantly decrease the patient's symptoms.

Prevention

1. Maintain the patient's blood pressure and oxygen saturation within normal limits.
2. Provide warm blankets for the postoperative patient, which are usually soothing, especially to the elderly patient.
3. Reduce disturbing stimuli or provide soothing ones, such as soft music.
4. Whenever possible, place the patient in a quiet area with decreased noise and light, even when minor symptoms of delirium are present.
5. Use simple, clear language in communication and provide reassurance.
6. Encourage the patient to communicate with staff or his roommate or family.
7. Institute a nonpharmacologic sleep protocol.
8. Ambulate or mobilize the patient early and often.
9. Provide range-of-motion exercises.
10. Remove catheters, I.V. lines, physical restraints, monitoring electrodes and wires, and other devices from the critically ill patient as soon as possible.
11. Initiate a scheduled pain management protocol.
12. Encourage the patient's use of eye glasses, magnifying lenses, and hearing aids.
13. Ask the family to bring family photos and familiar objects from patient's home to place in his room.

Treatment

1. Administer antibiotics for infection as indicated.
2. Treat underlying metabolic disorders.
3. Restore and maintain fluid and electrolyte balance.
4. Repeatedly reorient the patient and provide cognitively stimulating activities several times per

day.

5. Discontinue the inappropriate use of anticholinergics, sedatives, or analgesics, which can cause confusion and decreased cognition and may cause a paradoxical increase in agitation as the sedative effects wear off.
6. Administer antipsychotic medications as ordered. Haloperidol is most commonly used *because it has few anticholinergic adverse effects, few active metabolites, and a relatively small likelihood of causing sedation and hypotension*.

Equipment

- Stethoscope
- Sphygmomanometer
- Thermometer
- Pulse oximeter
- Equipment for specimen collection as ordered
- Optional: Medications as ordered, audio equipment and music per patient's preference, clock and calendar

Implementation

1. Review the patient's medical record *to determine whether he has any documented predisposing conditions for or symptoms of delirium.*
2. Confirm the patient's identity using two patient identifiers according to your facility's policy.[4]
3. Approach the patient from the front and call him by his name.
4. Introduce yourself to the patient.
5. Use a calm voice when interacting with the patient and remain nonjudgmental.
6. Obtain a comprehensive health history from the patient or his family. *Obtaining the patient's medication history, establishing his normal cognitive pattern, and identifying any metabolic disorders, infections, or respiratory disorders will help determine his cognitive ability before hospitalization and identify factors that may have contributed to the delirium.*
7. If any factors causing delirium are identified, initiate treatments, as ordered, *to reduce or eliminate them.* (See *Targeted interventions to prevent and treat delirium.*)[1]
8. Explain any procedures that the patient may need before attempting to perform them. Use simple terms and continue to assure the patient that you'll keep him safe. Say his name frequently and avoid making sudden movements. Don't present him with too many choices or decisions, *which can agitate the patient with delirium.*
9. Allow the patient to verbalize any feelings of fear or anxiety during an episode of delirium.
10. Assess the patient's level of consciousness on admission and continually on an ongoing basis. *Signs and symptoms of delirium fluctuate throughout the day.*

11. Observe for disturbance in the patient's sleep/wake cycle, *which is an early sign of delirium.*[1]
12. Assess the patient for psychomotor or verbal agitation.
13. Assess the patient for pain and review any pain medications he is taking. *Both of these factors can contribute to delirium.*

Nursing alert: The delicate balance between too much and not enough pain medication must be maintained. Assess the patient for pain and provide medications as ordered. After administering pain medication, monitor the patient for its effectiveness and adverse effects.

1. Assess the patient's vital signs and oxygen level.[1]
2. Obtain blood, urine, and other specimens, as indicated, for laboratory analysis.[1]
3. Assess the environment for safety hazards and remove any excess clutter and equipment from the room *because misinterpretation of the environment is common in patients with delirium and can be a safety hazard.*
4. Evaluate the need for one-on-one observation *to prevent falls and protect the patient from injury by creating a safe environment.*[1]
5. Reduce environmental stimulants in the patient's environment by keeping lighting soft, noise at a low level, and providing the patient with needed audio or visual assistive devices, such as a hearing aid or glasses. *Nonpharmacological strategies can be useful in decreasing anxiety and fear in the patient at risk for or experiencing delirium.*
6. Frequently tell the patient who you are, where he is, and what time it is.
7. Provide the patient with a clock and calendar *to assist him with orientation.*
8. Create a familiar, stable environment by placing photographs of the patient's friends and family in view and playing his favorite music.
9. Determine whether the patient's family is a source of support.
10. Encourage family members to stay with the patient unless they seem to distress him. If the patient experiences distress, tactfully ask the family to leave until he's calm again.
11. Administer medications as prescribed by the doctor, and monitor for adverse reactions or increased confusion.[1]
12. Teach the family about the signs, symptoms, and causes of delirium.[1]
13. Document the procedure.[5]

Special Considerations

- The patient experiencing delirium is, in fact, having difficulty processing and interpreting information and the environment. It isn't unusual for patients with delirium to mistake common everyday items in their environment.

- Patients with delirium require frequent reorientation and constant reassurance. Speaking in a calming voice may be helpful, but soft restraints may be necessary when all other alternatives are exhausted and there's a danger of the patient harming himself.

Complications

Incontinence, falls, failure to maintain adequate hydration, a prolonged hospital stay, and death are more likely to occur in the patient with delirium. Dysfunctional cognition in the patient with delirium hinders communication between the patient and his family and between the patient and health care personnel. As a result, reliable symptom assessment, counseling, and active patient participation in the therapeutic decision-making process are all compromised.

Documentation

Record all of your patient assessments and any behaviors you observed, including any verbal or psychomotor agitation. Document your interventions to prevent or treat delirium and note which ones were successful in reducing the patient's signs and symptoms. If specimens were collected, note what was collected and the date and time they were sent to the laboratory. Record whether the patient's family or friends were present, their interactions and effect on the patient's condition, and any teaching provided.

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7. If factors causing delirium are identified, initiate treatments as ordered.
8. Explain any procedures that the patient may need.
9. Allow the patient to verbalize feelings of fear or anxiety.
10. Assess the patient's level of consciousness on admission and continually on an ongoing basis.
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