DELIRIUM: SCREENING AND ASSESSMENT

PREDISPOSING RISK FACTORS:

- Cognitive impairment
- Over 80
- Chronic illness
- Multiple co-morbid conditions
- Sensory deficits
- Alcohol abuse
- Immobility
- Insomnia
- 5+ medications

SCREENING TOOL: CAM

Presence of features 1 and 2 & either 3 or 4:

1. **Acute onset & fluctuating course**
2. **Inattention:**
   -difficulty focusing attention
   - easily distracted
3. **Disorganized Thinking:**
   -rambling speech
   - illogical flow of ideas
4. **Altered Level of Consciousness**
   - agitated
   - alert
   - lethargic

Identification:	Assessment:	Interventions:

P	<u>Pain</u>
	• Regular pain assessment & monitoring
	• Use consistent pain scale
	
	<u>Poor Nutrition</u>
	• Dehydration/malnutrition
	• ↓Albumin or protein levels
	• Swallowing difficulties
	• Electrolyte/glucose imbalance
	• Monitor weight
		<u>Pain</u>
		• Regular scheduled analgesia (not prn)
		• Non-pharmacological support: turning, re-positioning
		• Document effect of analgesia
		
		<u>Poor Nutrition</u>
		• Fluid intake at least 1500cc/24hrs
		• Dietary consult:
		  • Recent wt loss/gain (>10lbs in last year)
		  • Total protein < 64 g/L and Albumin level < 35 g/L
		• OT Consult for swallowing difficulties

R	<u>Retention</u> • Determine continence ability; bowel pattern • Assess for urinary retention • Palpate abdomen for distention/impaction • Evaluate fluid balance/output <u>Restraints</u> • Explore alternatives to restraints whenever possible to maximize functional status and safety	<u>Retention</u> • In/out catheterization if suspect retention • Nurse continence advisor consult if in retention • Regular toileting schedule (minimize use of incontinence pads) • Initiate bowel protocol • Ensure person is well hydrated <u>Restraints</u> • Minimize use of restraint: physical/chemical • Use only if patient a danger to him/herself or others • Involve substitute decision maker around informed consent • Engage multi-disciplinary team
I	<u>Infection/Illness (new)</u> • Ongoing monitoring for urinary, chest, wound infection <u>Immobility</u> • Determine pre-morbid functional abilities	<u>Infection/Illness (new)</u> • Monitor VS & O2 sats; compare to baseline (note as normal process of aging, temperature may remain normal); ↑↓ BP, postural ↓ BP • Request appropriate diagnostic/lab tests (e.g. C&S, chest x-ray) <u>Immobility</u> • Encourage mobility; implement fall prevention strategies • OT/PT Consult
S	<u>Sleep</u> • Assess for altered sleep/wake cycles • Use a sleep pattern record <u>Skin</u> • Assess for areas of skin breakdown • Braden Scale <u>Sensory</u> • Assess for sensory deficits and aides used	<u>Sleep</u> • Document changes in pattern – day/night reversal • Implement non-pharmacological sleep promotion measures • Intersperse activities during the day with planned rest periods <u>Skin</u> • Pressure reducing mattress as indicated; turn q2h • Refer to wound/continence nurse if wound present <u>Sensory</u> • Ensure eyeglasses, hearing aids & dentures are working and used • Use Pocket talker to assist with communication/assessments
M	<u>Mental Status</u> • Monitor for sudden changes in ability or cognition • Other causes of behavior • Grief, loss, emotional trauma <u>Medications</u> • Polypharmacy (>5 meds) • Medication side effects • Withdrawal – alcohol, benzodiazepines, nicotine • Toxicity (digoxin, dilantin) <u>Metabolic</u> • Monitor for abnormal lab results/hemodynamic status	<u>Mental Status</u> • Maximize non-pharmacological behaviour strategies • Identify self; use a calm/gentle approach; use cues to orient • Acknowledge and validate fears related to changes in cognition • Use interdisciplinary interventions to support restoration of normal activity i.e. Volunteers/family, mobility, activities, familiar objects and photos, routines, clocks/calendar <u>Medication</u> • Review med profile with pharmacist for recent changes, adverse effects, toxicity, drug interactions • Start Low, Go Slow! • Assess psychotropic med response & report side effects (ie. ↑ anxiety/agitation; Parkinson-like symptoms, postural ↓ BP) <u>Metabolic</u> • Evaluate lab results and notify physician of abnormalities
E	<u>Environment</u> • Self-care ADL's ability • Relocation stress (eg. unfamiliar surroundings/routine)	<u>Environment</u> • Provide calm & safe environment • Promote normal ADL routines; consistent staff • Encourage family/support persons to provide support • Provide adequate lighting and exposure to daylight

CAM: screens for the presence of absence of a delirium

PRISME: an acronym that can assist in identifying and relieving underlying factors that are modifiable and can contribute to the onset and perpetuation of delirium

PRISME: Adapted from Maureen Shaw, 2008; CAM: Inouye SK, found at Delirium in the Older Person, VIHA 2006; Developed and shared with permission from VCH-05/03/2013