NURSING MANAGEMENT OF DELIRIUM

Delirium is very common in serious illness. Although usually associated with terminal illness, many episodes of delirium are reversible.

Types of delirium:
- **Hyperactive** – usually includes agitation
- **Hypoactive** - withdrawn behaviors (more likely to be missed on assessment)
- **Mixed**

Presentation of delirium:
- Agitation
- Impaired cognition
- Altered attention span
- Change in consciousness
- Altered perceptions and hallucinations

**Potential Causes of or Contributors to Delirium:**
- Constipation or bladder distension - especially with older adults
- Dehydration
- Dementia
- Electrolyte imbalance (hypercalcemia, hyponatremia, hypernatremia, hypomagnesemia)
- Hearing impairment
- Hypoxemia
- Immobility
- Infection (pneumonia, urinary tract infection)
- Intracranial disease (primary or metastatic brain tumor, leptomeningeal disease, stroke)
- Medications (opioids, anticholinergics, corticosteroids, antidepressants, benzodiazepines)
- Metabolic abnormalities (hypoglycemia, hypothyroidism)
- Nutritional or vitamin deficiencies
- Older age (> 75 years of age)
- Rapid withdrawal of medications (opioids, benzodiazepines) and/or alcohol, nicotine
- Renal, cardiac and/or hepatic failure
- Unrelieved pain
- Use of restraints

**ASSESSMENT**

Several delirium assessment tools are available; select a tool based upon your setting and population. In many circumstances, delirium can be identified based upon a strong history and physical examination.

**Conduct history and physical assessment:**
- Review common signs including disturbed sleep/wake cycle, agitation, restlessness, moaning, hallucinations, and delusional thoughts.
- Assess for signs of sepsis, dehydration, urinary retention or urinary tract infection, constipation, unrelieved pain.
- Evaluate the medication list for possible causes or contributors; consider polypharmacy or rapid dose escalation.
- Weigh the potential for possible withdrawal from alcohol, nicotine, opioids, benzodiazepines, antidepressants, cannabis, or other sedatives.

Consider laboratory and radiological tests, depending on the patient’s goals of care (e.g., CBC, electrolytes, calcium, renal/liver function, UA, CXR, O2 saturation, imagery of the brain via CT or MRI).

The Confusion Assessment Method (CAM) is a commonly used, sensitive, and brief (5 minutes) tool. There is a brief version (bCAM – 2 minutes), critical care (CAM-ICU), family caregiver recognition (FAM-CAM) and a 3 minute diagnostic version (3D-CAM). Mobile apps are also available.

When possible address potentially reversible etiologies such as fever (antibiotics/antivirals), constipation (bowel regimen), dehydration (oral or IV/SQ fluids), urinary retention (catheterization), polypharmacy (discontinue unnecessary medications), metabolic abnormalities (correct electrolytes), and sleep deprivation (promote day/night cycles).

**Pharmacologic Management**

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<tr>
<th>1st Generation Antipsychotics</th>
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<th>2nd Generation Antipsychotics</th>
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<td>Olanzapine</td>
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<td>Risperidone</td>
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**Nonpharmacologic Management**

- Ensure eyeglasses and/or hearing aids are in place and functioning
- Promote sleep/wake cycle with daytime light, reduce nighttime interruptions
- Provide soothing or favorite music
- Orient gently, do not aggressively reorient
- Reduce noise, pump alarms
- Use clocks, calendars and whiteboards
- Support family – this is extremely distressing to loved ones!

**References**


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