What is Delirium?

Delirium is defined as short-term and severe, sudden state of mental confusion. It harms a person's ability to receive, process, store and recall information (discussed as "inattention" and "disorganized thinking"). This condition usually develops within hours to days. Typically reversible, delirium is usually a result of intoxication or withdrawal from a substance (i.e. drugs, alcohol), medication, toxic exposure (i.e. lead poisoning) or a consequence of a medical condition (severe infection). (Ely, 2014)

Delirium is common. After surgery, 15-53% of older adults experience delirium and 80% of patients in the intensive care unit (ICU). (Lewis, 2014, p. 1458)

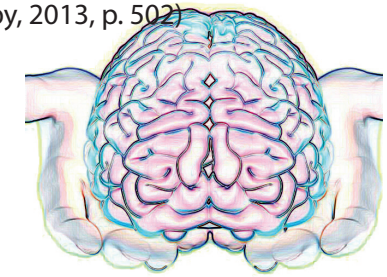
Three main subtypes of delirium:

Hyperactive: agitation and restlessness (i.e. trying to remove tubes and lines)

Hypoactive: withdrawal from a substance (i.e. alcohol, drugs), flat affect (diminished emotional expression), apathy (lack of interest), tired, decreased responsiveness

Mixed: fluctuate between both hyperactive and hypoactive subtypes (Ely, 2014)

Delirium is NOT dementia. Dementia can take weeks, months, and years to develop and has different levels of mental problems. It is described by long-lasting personality breakdown/changes with a decline of intellectual capacity and function. (Elsevier Mosby, 2013, p. 502)



THINK (CAUSES OF DELIRIUM)

Toxic Situations: congestive heart failure, shock, dehydration, medications that can cause delirium, new organ failure (liver, kidney)

Hypoxemia (low oxygen in the blood): blood loss, pneumonia

Infection/sepsis, inflammation, immobilization, or is there a new hospital acquired infection?

Nonpharmacologic interventions: early mobility/early exercise, hearing aids, visual aids (glasses), reorientation, sleep hygiene, music, noise control

K+ or other electrolyte and metabolic problems (think Gatorade)

(Ely, 2014)

WAYS YOU CAN HELP

- Use simple words and speak softly
- Remind loved one of the day and date.
- Talk about family and friends.
- Bring glasses, hearing aids.
- Decorate room with family pictures or posters, familiar items might be reminders of home.
- Provide the patient with favorite music or TV shows.
- If your loved one has delirium, we might ask you to sit and help calm them.

(Ely, 2014)

References

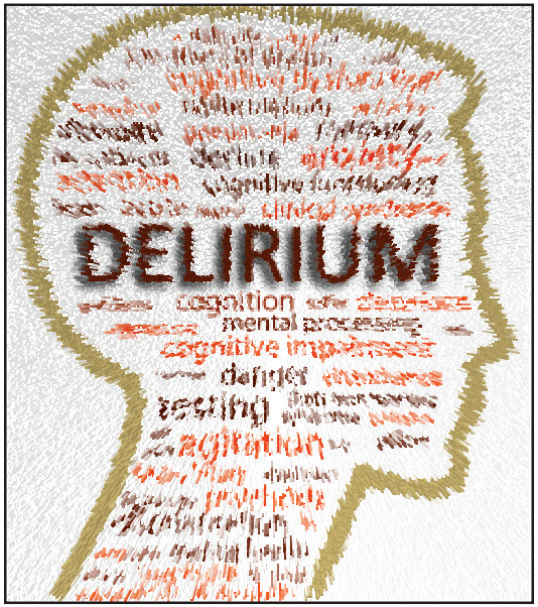
Elsevier Mosby. (2013). Mosby's Dictionary of Medicine, Nursing and Health Professions. St. Louis, MO: Elsevier.

Ely, E. W. (2014, March). Confusion Assessment Method for the ICU (CAM-ICU): The Complete Training Manual. Nashville, TN, United States of America. Retrieved from Vanderbilt University: ICU Delirium: http://www.icudelirium.org/resources.html

Lewis, S. M. (2014). Medical-Surgical Nursing. St. Louis, MO: Elsevier Mosby.

CAM-ICU

confusion assessment method
(intensive care unit)
for
families and patients



D isorganized thinking, dehydration

E lectrolyte imbalances, emotional stress

L ung, liver, heart, kidney, brain

I nfection, intensive care unit

R x Drugs

I njury, immobility

U ntreated pain, unfamiliar environment

M etabolic disorders

(Lewis, p. 1459)

Feature 1: Acute Onset or Fluctuating Course

Is the person different than his/her normal mental status?

OR

Has the person had any changes in mental status in the past 24 hours as evidenced by changes on a sedation/level of consciousness scale (i.e., RASS --> Richmond-Agitation-Sedation Scale)?

Score

Either question Yes ➔ ☐

Feature 2: Inattention

Directions: Say to the person, "I am going to read you a series of 10 letters. Whenever you hear the letter 'A,' indicate by squeezing my hand." Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T or C A S A B L A N C A

Errors are counted when patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."

Number of Errors >2 ☐

Feature 3: Altered Level of Consciousness

Present if the Actual RASS score is anything other than alert and calm (zero)

RASS anything other than zero ➔ ☐

Feature 4: Disorganized Thinking

Yes/No Questions

1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the person incorrectly answers a question.

Command

Say to person: "Hold up this many fingers" (Hold 2 fingers in front of patient) "Now do the same thing with the other hand" (Do not repeat number of fingers) *If the person is unable to move both arms, for 2nd part of command ask patient to "Add one more finger"

An error is counted if the person cannot complete the entire command.

Combined number of errors >1 ☐

Overall CAM-ICU
Feature 1 plus 2 and either 3 or 4 present = CAM-ICU positive

Criteria Met ➔ ☐	CAM-ICU Positive (Delirium Present)
Criteria Not Met ➔ ☐	CAM-ICU Negative (No Delirium)

Level of Consciousness: RASS

+4 COMBATIVE - combative, violent
+3 VERY AGITATED - removes tubes or catheters; aggressive
+2 AGITATED - frequent non-purposeful movement, fights ventilator
+1 RESTLESS - anxious, apprehensive, movements not aggressive
0 ALERT & CALM - spontaneously pays attention to caregiver
-1 DROWSY Not fully alert, but has sustained awakening to voice (eye opening & contact >10 sec)
-2 LIGHT SEDATION - briefly awakens to voice (eyes open <10 sec)
-3 MODERATE SEDATION - movement or eye opening to voice (no eye contact)
-4 DEEP SEDATION - no response to voice, but movement or eye opening to physical stimulation
-5 UNAROUSABLE - no response to voice or physical stimulation

If RASS is ≥ -3 proceed to CAM-ICU

If RASS is -4 or -5 ➔ STOP (patient unconscious), RECHECK later