“Delirium, an acute decline in attention and cognition, is a common, life-threatening, and potentially preventable clinical syndrome …”
(Inouye, Sharon K. 2006)

Prevalence

- Delirium affects approximately one in five elderly individuals who are hospitalized on medical units, and 40-60% of residents living in long term care
- Delirium usually presents as decreased concentration, and patients/residents often express a need to “get out of here”

Possible Interventions

- Has a medication review been done and/or a new medication been added recently?
  - Discontinue medications that aren’t helping
  - Review Beers criteria
  - Check anticholinergic load
- Screen for underlying physical cause (infection, blood work, pain, etc.)
- Improve fluid/nutritional intake
- Avoid caffeine, which acts as a stimulant
- Ensure adequate pain management
- Track behaviour (observe behaviour patterns and triggers)
- Ask family/sitter to stay when restlessness is worst and target care plan interventions for this period
- Don’t argue or try to convince patients/residents to do something; redirect and reassure them instead
- Read tips on communicating with someone who is hallucinating/delusional
- Identify yourself and your role at each meeting
- Avoid the use of physical restraints
- Increase physical activity and minimize protracted immobility in a chair
- Minimize fatigue with uninterrupted rest periods
- Ensure glasses and hearing aid batteries work
- Provide regular toileting and prevent constipation
- Bring in familiar items from home, e.g. clock, bedspread, photos
- Maintain a calm, reassuring approach
- Speak slowly, using simple sentences
- Use night lights to improve observation
- Play soothing music that the patient/resident enjoys
• Provide a clock with large numbers
• Use short-term (preferably less than 1 week) pharmacological interventions to control restlessness only as a last resort
• Give family the Nova Scotia Health Authority’s Patient Pamphlet on Delirium

Recovery may take days or months