island health

SEARCHING for SOLUTIONS for DELIRIUM

Communication

- Acknowledge the person's emotions and encourage verbal expression, offering frequent reassurance, as often they are afraid.
- Explain to the person that they are experiencing a delirium, if this would help decrease their fear.
- Always explain delirium and the behaviours associated with it to family caregivers.
- Give instructions and explanations clearly, slowly, with simple statements; use repetition if necessary.
- Face the person when speaking.
- Convey an attitude of warmth and firm kindness.
- Use gestures, pointing to things if this helps support and clarify your words.
- Use the person's name and identify yourself frequently.
- Use handshake to establish "personal boundary bubble".

Environment

- Support the family to personalize the environment: provide orienting items (calendars, clock, family pictures, visitors book)
- Provide minimal light for those with evening disorientation
- Decrease noise such as intercoms which can be misperceived
- Discourage napping during the day to support normal sleeping pattern at night
- Avoid or minimize the number of room changes
- Use alarmed mattress

Orientation

- Keep the person in familiar surroundings as much as possible.
- Ensure the room has a clock and calendar with the correct date.
- Verbally remind the person of the time, day and place.
- Remove any items that might possibly be misinterpreted.
- Evaluate their need for eyeglasses, hearing aides, foreign language interpreters, etc.

Pharmacologic Support

- See VIHA Prepared Physician Orders.

Physical Activity

- Encourage mobilization.
- Ask for a consult to OT or PT if necessary
- Allow free movement as long as the person is safe.
- Encourage self-care and other personal activities to reinforce competence and enhance self-esteem.
- Involve the person in any social activities they can tolerate.
- If they cannot tolerate being with others, distract them with bedside activities, e.g., looking at magazines, undoing zippers or buttons, folding sock or towels.
- Give them something comforting and soft to hold, e.g., fleece, stuffed animal.
- Play calming music.
- Ensure the person mobilizes frequently; toilet frequently.

Physical Stability

- Assess for dehydration and encourage adequate fluid intake and nutrition.
- Assess oxygenation using pulse oximetry.
- Ask physician to review medications
- Review chart for abnormal electrolyte results
- **Monitor bowel and bladder functioning**
- Assess mobility; mobilize as soon as possible.

Psychological Support

- Encourage the person to participate in activities of daily living.
- Avoid confronting person about misperceptions, instead understand and accept the person's perceptions as his/her reality and respond with actions that relate to the person's feelings (e.g., fear, anger) and provide reassurance of his/her protection and safety
- Encourage family participation in care
- **Provide family with Delirium Pamphlet**
- Encourage "touch" contact with family
- Use TVs and radios for appropriate stimulation or for relaxation, unless they prove agitating
- Move closer to the nursing station for more frequent interaction with staff, unless this location increases agitation
- Integrate simple orienting statements into conversation (e.g., "What a beautiful morning.")
- Try to maintain a structured and consistent routine.
- Try to maintain the same caregivers each day on each shift.
- When lucid, engage the person in discussions of their interests, hobbies, occupation, etc.
- Be conscious of the person's fears (heights, lifts, etc.)

Safety

- Minimize risk for falls
- Keep the environment hazard-free, e.g., remove any unsafe items (cane, scissors, etc.)
- Avoid physical restraint.
- Keep side rails down and lower the bed, if the person has a tendency to get out of bed on their own. If necessary, place a mattress on the floor.
- If the client becomes aggressive, keep your hands in sight and avoid any threatening gestures or movements. Keep a friendly look and reassure the person that they are safe. Do not force care or "gang up on the person" as this increases their fear and paranoia.
- Ensure adequate nutrition, rest and sleep.

Sensory Function Support

- Ensure glasses and hearing aides are worn, and are functioning properly.

Sleep

- Return to normal sleep pattern
- Decrease levels of noise and light at night
- Encourage daytime wakefulness and mobility

Adapted from: Burne, D. (2002). Recognizing Delirium. Nursing Staff Curriculum, Patient Care Administration. *Delirium Action Research Program*. Cornwall,On.
Inouye, SK. (2006). Delirium in older persons. *The New England Journal of Medicine, 354*(11), 1157-1165.