## Initiate Delirium Order Set

*The delirium order set triggers a nursing pathway that includes:*

- Sensory enhancement: hearing aids, glasses to bedside
- Mobilization
- Cognitive orientation and stimulation
- Promote sleep: re-time labs/studies/vitals; daytime activity and mobility; melatonin is preferred sleep aid for this population
- Normalize environment: get rid of tethers (restraints, catheters, IVF, telemetry, oxygen), encourage family/caregiver involvement

## Recommendations for Antipsychotic Use

*In RARE cases WHEN A PATIENT POSES A THREAT TO SELF OR STAFF consider:*

| | Age < 70 yrs. | Age > 70 yrs. |
|---|---|---|
| PO option: Quetiapine | 25 mg x1<br>Can repeat x1 in 2 hr | 12.5 mg x1<br>Can repeat x1 in 2 hr |
| If unable to take PO: Haldol* | 1mg IV/IM x1<br>Can repeat x1 in 1 hr | 0.5 mg IV/IM x1<br>Can repeat x1 in 1 hour |

*NOTE: There is no convincing evidence to support the use of medication for treatment of delirium. This is off-label use.*

** This is contraindicated in the setting of Lewy body dementia.*

- *Check 12 lead EKG, hold if QTc > 500*
- *Use benzodiazepines only if there is a concern for delirium due to EtOH, benzodiazepine, or barbiturate withdrawal*

*Black box warning:*

- *Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death*

# 25%

of hospitalized patients are affected by delirium

Delirium indicates acute brain dysfunction and **must be taken seriously** to minimize its duration and impact. It can be traumatic for patients and their family.

Patients may experience anxiety and depression in the months following a delirium episode. Similarly, it may take days to months for patients to return to their cognitive baseline.

However, many cases of delirium resolve completely, and patients often return to normal cognitive function.

**Patient and family education is important.** Families can play a key role in treating delirium and need to know how they can help. Educational brochures are available at nurse's stations to facilitate discussions around delirium.

**visit: delirium.ucsf.edu**

# UCSF DELIRIUM REDUCTION

**30%** of hospital acquired delirium can be prevented through evidence-based, non-pharmacologic interventions.

**AWOL |** Determines risk of delirium

**If Score ≥2:**

1. Initiate Delirium Order Set
2. Discontinue precipitating medications

**NuDESC |** Screens for active delirium

**If Score ≥2:**

1. Treat underlying cause
2. Discontinue precipitating medications
3. Initiate Delirium Order Set

## Assess Underlying Causes*

**D**rugs/medications/polypharmacy
**E**lectrolytes (Na, Ca, CO2), **E**nvironment change
**L**ack of drugs (withdrawal), **L**ack of sleep
**I**nfection, **I**mmobility (catheters, feeding tubes), **I**atrogenic (e.g.,major surgery)
**R**estraints, **R**educed sensory input (vision/hearing)
**I**ntracranial (stroke, bleed, seizure, meningitis)
**U**rinary Retention, constipation, **U**ncontrolled pain
**M**etabolic (hypoxia, uremia, hepatic encephalopathy, thyroid)

WORKUP

- Physical exam: check surgical wound; check tubes/lines/drains; brief neuro exam
- Vital signs, pulse ox, pain assessment
- Labs: UA, CBC, BMP. Consider TSH, LFTs, UTox, cultures, EKG, Chest X-ray

**Patients with more risk factors (old age, cognitive impairment, poor functional status, hearing/vision impairment, depression, alcohol abuse) can develop delirium with minor precipitants.*

## Discontinue Precipitating Medications

- Review pharmacists delirium note, substance abuse history
- Common delirium inducing medications:
  - Anticholinergics: antihistamines, tricyclics, antimuscarinincs, antispasmodics, promethazine, paroxetine
  - Corticosteroids
  - Opiates
  - Sedative hypnotics: benzos, zolpidem
  - Polypharmacy: starting ≥5 new medications
  - Others: dopamine agonist, muscle relaxants

## AWOL

All non-ICU patients get **AWOL screening once upon arrival to the floor** by their primary RN. All ICU patients are considered high risk (thus AWOL is not indicated in the ICU).

**Scoring**

| A | W | O | L |
|---|---|---|---|
| Age ≥ 80 years | Unable to correctly spell 'WORLD' backwards | Not oriented to city, state, county, hospital name and floor | Nursing illness severity assessment of moderately ill or greater |
| **1 point** | **1 point** | **1 point** | **1 point** |

| AWOL Score | Delirium Risk |
|---|---|
| 0 | 2% |
| 1 | 4% |
| 2 | 14% |
| 3 | 20% |
| 4 | 64% |

**≥ 2 =** *High risk for developing delirium*

*NOTE: Patients delirious on admission will also screen positive on the AWOL*

## NuDESC
(Nursing Delirium Screening Scale)

All non-ICU patients are **screened for delirium Q shift** by their primary RN.

**Scoring** (Each behavior)
**0** | No altered behavior throughout shift
**1** | Mild alteration observed at any time during shift
**2** | Pronounced alteration

### BEHAVIORS

| | | |
|---|---|---|
| **Disorientation** | **Inappropriate behavior** | **Inappropriate communication** |
| **Illusions/ Hallucinations** | **Psychomotor retardation** | |

Overall Score **≥ 2** = Positive Screen

## CAM-ICU

All patients **screened for delirium Q shift** by their ICU RN

**Scoring**
POSITIVE if 1 and 2 and either 3 or 4 are present

**1** Acute onset of change in mental status OR fluctuating mental status **AND** **2** Inattention **AND** **3** Disorganized thinking

**OR**

**4** Altered level of consciousness (RASS other than 0)