Leamington Mennonite Home
Long Term Care

POLICY AND PROCEDURE

CATEGORY:	**SUBJECT:**	**SECTION:**
Resident Care	**Delirium**	**D**
		POLICY:
		4
DATE:	**Administrator:** _____	
January 2025		
REVISION DATES:	**Director of Care:** _____	

DELIRIUM

PURPOSE:

To ensure that all staff have an understanding and ability to identify "Delirium", types of delirium, its causative factors, risk factors, assessment, treatment, and interventions.

It is important for the staff to know the residents' baseline behavior, level of consciousness (LOC), and normal self, to be able to identify any unusual behaviour that could signal an acute (sudden) onset of delirium.

DEFINITION of DELIRIUM:

Delirium is a complex neuropsychiatric syndrome marked by a sudden onset, fluctuating course, of altered level of consciousness, inattention, and disorganized thinking usually lasting for one to seven days.

Delirium can signal a medical emergency, and its consequences may include permanent neurological effects, the development or worsening of dementia, falls, functional decline.

Small changes in the person's environment or medical conditions may trigger the onset of delirium.

Seniors with multiple morbidities and dementia are at high risk for developing delirium.

There are three main types of delirium:

1. **Hyperactive** delirium is characterized by heightened arousal, restlessness, agitation, delusions, and/or aggressive behaviour.
2. **Hypoactive delirium** is characterized by sleepiness, quieting of symptoms, and/or disinterested behaviour (most common in seniors)
3. **Mixed delirium** is characterized by alternating hyperactive and hypoactive states

Risk factors for delirium include advanced age (older than 65 or 70); alcohol use/abuse; depression; extensive surgery that causes greater-than-usual physiological stress; hip fracture; previous delirium; severe illness or co-morbidity burden.

Delirium may have a single cause or more than one cause. For example, a medical condition combined with the side effects of medication could cause delirium.

Treatment goal of delirium is to address any causes or triggers. That may include stopping certain medications, treating an infection (UTI, Respiratory) or treating an imbalance in the body related to decreased fluid intake.

Sudden Changes That May Indicate Delirium

Cognitive function changes:	Decreased concentration, slow responses, memory impairment, disorganized thinking, disorientation, shifting attention, reduced level of consciousness, trouble understanding speech
Perception changes:	-Visual or auditory hallucinations
Physical function changes:	-Reduced mobility, reduced movement, agitation, motor restlessness, changes in appetite, sleep disturbance
Social behaviour changes:	-Quick changes in mood, personality changes, calling out, moaning or making other sounds, alterations in communication, mood, and/or attitude, being restless, anxious or combative

PROCEDURE:

1. Upon moving into the Home each resident will be screened for the presence of delirium risk factors.
2. The registered staff will complete the **N Adv Can - RNAO Delirium: Screening, Assessment and Management Clinical Pathway** and initiate care planning interventions.
3. The PSW staff are to be aware of and report changes noted in a resident's LOC, behaviour, and normal appearance in character as soon as possible to the Registered Staff and record the changes on Point of Care task '**Observation of Changes in Health'**.
4. When a change in a resident's LOC, behaviors and normal appearance in character is reported, the registered staff is to assess the resident for delirium. Assessment involves vital signs, including temperature, behaviour changes as indicated above, assessment of communication and LOC.
5. Review any recent medication changes, changes in environment and or changes to the care staff.
6. Review incident history e.g., falls with possibility of head injury, infections, and antibiotic therapy.
7. Contact primary Physician for further care directives.
8. Contact resident's Substitute Decision Maker (SDM) or Power of Attorney (POA) and provide update on status changes and planned interventions.
9. Document assessment and interventions on PCC once the interventions to address the acute onset of delirium have been initiated.