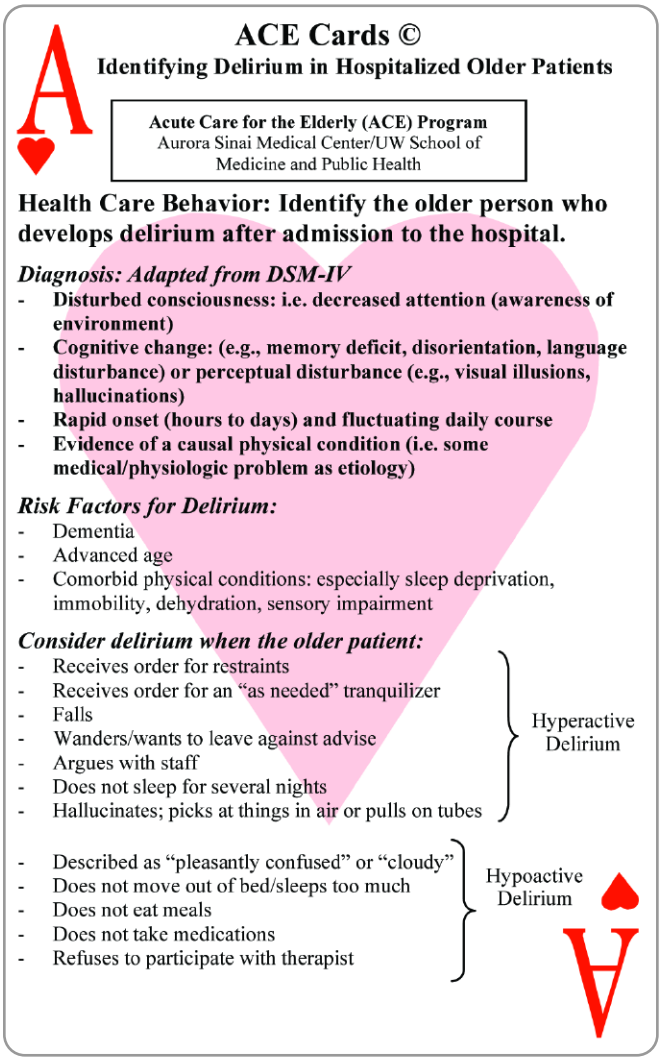
ACE Cards for Accessing Delirium

Hospital based Acute Care for Elders (ACE) units provide standard medical services infused with geriatric interventions. To prevent additional loss of physical function during hospitalization, ACE units deliver optimal care for older patients. The constantly changing care needs of assisted living (AL) residents demand similar interventions.

Dr. Michael Malone, Medical Director of Senior Services at the Aurora Sinai Medical Center's Geriatrics Institute in Milwaukee, WI, developed a series of pocket guides, referred to as "ACE Cards," as a quick reference to help manage common geriatric conditions. The cards offer guidelines for assessment of a particular behavior and list risk factors as well as suggestions for an initial approach.

This issue presents the ACE Card for Identifying Delirium. Future issues will include ACE Cards on subjects that include fall prevention, indicators of infection, influenza vaccine, and constipation.

The complete series of cards can be ordered from Dr. Michael Malone at Michael.Malone.md@aurora.org. ALC



ACE Cards ©

Identifying Delirium in Hospitalized Older Patients

Acute Care for the Elderly (ACE) Program
Aurora Sinai Medical Center/UW School of Medicine and Public Health

Health Care Behavior: Identify the older person who develops delirium after admission to the hospital.

Diagnosis: Adapted from DSM-IV

- **Disturbed consciousness: i.e. decreased attention (awareness of environment)**
- **Cognitive change: (e.g., memory deficit, disorientation, language disturbance) or perceptual disturbance (e.g., visual illusions, hallucinations)**
- **Rapid onset (hours to days) and fluctuating daily course**
- **Evidence of a causal physical condition (i.e. some medical/physiologic problem as etiology)**

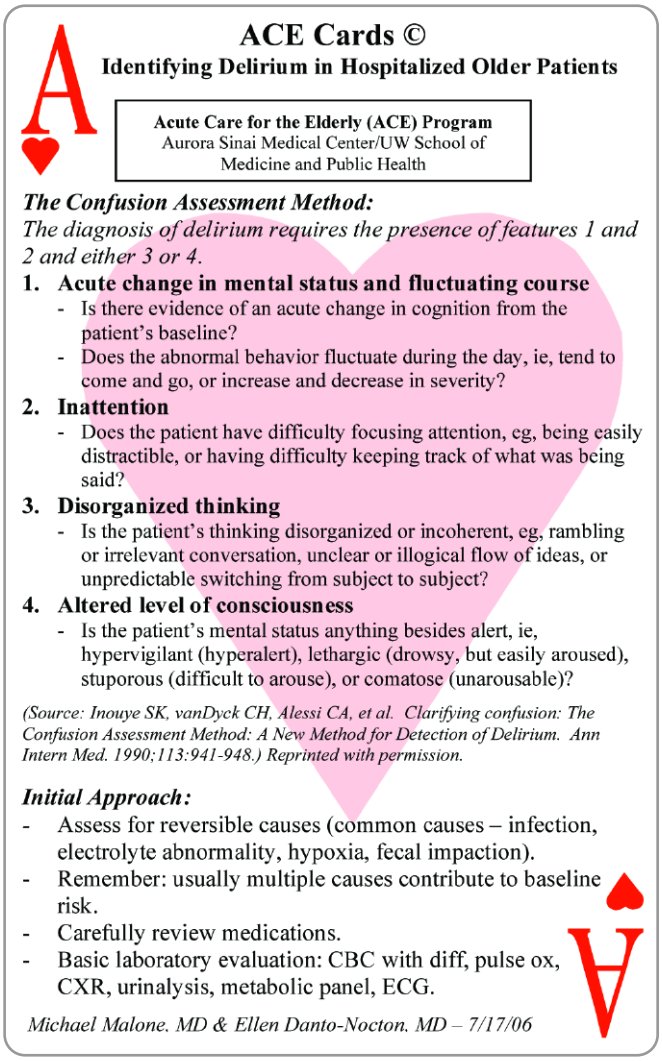
Risk Factors for Delirium:

- Dementia
- Advanced age
- Comorbid physical conditions: especially sleep deprivation, immobility, dehydration, sensory impairment

Consider delirium when the older patient:

Hyperactive Delirium
- Receives order for restraints
- Receives order for an "as needed" tranquilizer
- Falls
- Wanders/wants to leave against advise
- Argues with staff
- Does not sleep for several nights
- Hallucinates; picks at things in air or pulls on tubes

Hypoactive Delirium
- Described as "pleasantly confused" or "cloudy"
- Does not move out of bed/sleeps too much
- Does not eat meals
- Does not take medications
- Refuses to participate with therapist



ACE Cards ©

Identifying Delirium in Hospitalized Older Patients

Acute Care for the Elderly (ACE) Program
Aurora Sinai Medical Center/UW School of Medicine and Public Health

The Confusion Assessment Method:

The diagnosis of delirium requires the presence of features 1 and 2 and either 3 or 4.

1. **Acute change in mental status and fluctuating course**
   - Is there evidence of an acute change in cognition from the patient's baseline?
   - Does the abnormal behavior fluctuate during the day, ie, tend to come and go, or increase and decrease in severity?
2. **Inattention**
   - Does the patient have difficulty focusing attention, eg, being easily distractible, or having difficulty keeping track of what was being said?
3. **Disorganized thinking**
   - Is the patient's thinking disorganized or incoherent, eg, rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
4. **Altered level of consciousness**
   - Is the patient's mental status anything besides alert, ie, hypervigilant (hyperalert), lethargic (drowsy, but easily aroused), stuporous (difficult to arouse), or comatose (unarousable)?

(Source: Inouye SK, vanDyck CH, Alessi CA, et al. Clarifying confusion: The Confusion Assessment Method: A New Method for Detection of Delirium. Ann Intern Med. 1990;113:941-948.) Reprinted with permission.

Initial Approach:

- Assess for reversible causes (common causes – infection, electrolyte abnormality, hypoxia, fecal impaction).
- Remember: usually multiple causes contribute to baseline risk.
- Carefully review medications.
- Basic laboratory evaluation: CBC with diff, pulse ox, CXR, urinalysis, metabolic panel, ECG.

Michael Malone. MD & Ellen Danto-Nocton. MD – 7/17/06