Alberta Health Services

Seniors Delirium Protocol

Affix patient label within this box.

Confusion Assessment Method Score			
		Yes	**No**
For a diagnosis of delirium these two must be present	Was the onset acute and/or does behaviour fluctuate?		
and	Is there evidence of inattention? *(difficulty focusing, attention, shifting and keeping track)*		
and at least one of these	Is there evidence of disorganized thinking? *(incoherent, rambling, illogical flow of ideas)*		
and/or	Is there altered level of consciousness? *(i.e. hypoactive or hyperactive)*		
Management of delirium in older persons should always be individualized.		**Score**	**/4**

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Alcohol Use

If alcohol use suspected, give the following

- ☐ Thiamine 100 mg IV/PO daily for 3 days
- ☐ Folic acid 5 mg po daily for _____ days
- ☐ Implement CIWA assessment and alcohol withdrawal protocol *(where available)*

Laboratory Tests, Diagnostic Imaging and Other Investigations

Laboratory Tests

☐ CBC and differential	☐ urinalysis	☐ random glucose	☐ sodium
☐ potassium	☐ chloride	☐ CO2	☐ creatinine
☐ urea	☐ calcium	☐ magnesium	☐ albumin
☐ ALP	☐ ALT	☐ bilirubin	☐ ABG

Cultures

- ☐ Urine for C and S ☐ MSU ☐ In/Out Catheter
- ☐ sputum for C and S ☐ blood cultures *(if temperature is 1.2 0C above normal)*

Consider performing the following tests if not completed in the last 6 weeks

☐ B12 ☐ TSH

Diagnostic Imaging *(check all that apply)*

- ☐ ECG ☐ Chest x-ray *(as indicated)* ☐ Flat Plate Abdomen *(as indicated)*
- ☐ CT head *(as indicated)* ☐ MRI head *(as indicated)*

☐ Other investigations *(specify)* _____

Orders

Vital Signs

q _____ h while awake

Maintain O2 saturations greater than or equal to 90%

☐ Initiate oxygen at 2 L/minute and titrate as appropriate *(caution if CO_2 retention)*

☐ Intake and output

If oral intake less than 1200 mL/24 hours

☐ push fluids or ☐ IV / ☐ Clysis _____ at _____ mL / hour for _____hours

Name of prescriber and designation *(print)*	Signature	Date *(yyyy-Mon-dd)*

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Practitioner to assess for Delirium

Perform Confusion Assessment Method *(CAM)* evaluation,

Perform general physical examination *(focusing on infection, urinary retention, fecal impaction, injury, including head injury).*

Treat underlying and precipitating conditions. Make diagnosis of delirium or suspected delirium if criteria are met.

Review medications, especially narcotics *[e.g. avoid propoxyphene (Darvon), Codeine, meperidine (Demerol)],* benzodiazepines and anticholinergics *(e.g. benztropine).*

Reduce and/or discontinue medications causing or contributing to delirium. **Do not** discontinue benzodiazepines or barbiturates in continuous use abruptly.

Review laboratory and diagnostic data *(focus on hydration, electrolytes and infection).*

The CAM symptoms are also possible signs of increased intracranial pressure.

Try to avoid Foley catheter use and restraint use. Remove unnecessary invasive and restricting interventions *(IV, monitors, drains, etc)*

Bowel Management Routine *(maintain patients usual habits and routine)*

If no routine established; day one *[no BM]* – laxative po qhs; day two *[no BM]* – laxative po bid; day three *[no BM*] rectal intervention in am, notify prescriber if no results.

Add warm prune juice/ fruitlax to diet

Add lactulose 15 – 30 mL po daily to BID prn *(preferred laxative through tubefeeds)*

Add Magnesium hydroxide 30mL po daily to BID prn

Add Senokot po qhs or BID prn *(max 8 tabs in 24 hours)*

Glycerine suppository PR daily prn

Bisacodyl suppository 10 mg PR daily prn

Guidance from local expert opinion regarding opioid analgesic use and dosage in older adults.

Pain management steps when patient **is already receiving an opioid**

Assess need to increase or reduce the dose **(usually by a factor of 30%-50%)** or to switch to another opioid *(consult the equianalgesic tables to guide with conversion dose).*

Consider the need to change route *(e.g. patient unable to swallow),* remembering that a **50% reduction in dose** is necessary when switching from the **PO to subcutaneous or IV routes.**

Pain management steps when patient **is opioid naïve**

Acetaminophen 650 mg q 4 hours *(maximum 4 g in 24 hours or 2 g in 24 hours for hepatic concerns)*, if not effective, add:

Morphine 1 mg subcutaneously **or** 2 mg po **q 1 hours PRN. If 3 or more doses in 24 hours**, then change to regular order:

Morphine 1 mg subcutaneously **or** 2 mg po **q 4 hours Around The Clock *(ATC)*** and morphine 1 mg subcutaneous **or** 2 mg po **q 1 hours PRN for breakthrough *(BT)* pain. If 3 or more BT doses of opioid are used in 24 hours**, consider increasing the dose as follows:

Morphine 2.5 mg sc **or** 5 mg po **q 4 hours ATC** and 1 mg sc **or** 2.5 mg po **q 1 hours PRN for BT pain.**
(For BT pain, the BT dose should be approximately 10% of the total 24 hour regular dose).

Consider Hydromorphone (0.5 mg to 1 mg) as alternative to morphine if morphine contributes to confusion.

Continue to assess pain control. Assess need to increase or reduce the dose ***(usually by a factor of 30-50%).***

For patients starting regular opioid administration

Metoclopramide (Maxeran) 10 mg po or subcutaneously q 4 hours ATC for the first 48 hours and prn for nausea thereafter *(maximum 120 mg in 24 hours)*. **Note: Caution with use in elderly patients especially those with Parkinsons disease.**

Ondansetron (Zofran) 8 mg po q8 hours ATC *(maximum 24 mg in 24 hours).*

Ensure a bowel routine is established to prevent constipation *(see above).*

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Place Label Here

Assessments and Consults

Bladder Assesment *(Post void residual volume)*

- ☐ Bladder Scan
- ☐ In and Out Catheterization
- ☐ Intermittent catheterization q 8 h if residual greater than 200 mL *(until volume less than 200 mL)*
- ☐ Toileting routine q 2 h

Bowel Management *(see guidance on back of page 1)*

List medications

_____

Activity Level

- ☐ Up in chair
- ☐ Activity as tolerated
- ☐ Weight bearing status
  - ☐ Weight bear as tolerated ☐ Partial weight bear ☐ Feather weight bear
- ☐ Fall risk assessment and prevention *(see guidance on back of page 2)*
- ☐ Consult Physio Therapist

Constant Supervision

If need for constant supervision is present, seek

☐ Family ☐ Nursing attendant ☐ Security, for _____ days

Consultation

- ☐ Speech Language Pathology/ Swallow Assessment Team for swallowing assessment
- ☐ Dietician
- ☐ OT for ADLs and/or cognitive assessment in 24 hours
- ☐ Social Work for discharge needs
- ☐ Pharmacist for medication review
- ☐ Geriatric Medicine/Psychiatry/Internal Medicine if delirium not resolving in 72 hours

Nutrition

☐ NPO ☐ DAT ☐ Specified diet _____

Orientation

Ensure patient has

☐ Teeth ☐ Glasses ☐ Hearing Aids

- ☐ Orient patient on every contact *(see guidance on back of page 2)*
- ☐ Provide family/caregiver with pamphlet Patient and Family Information on Delirium

Pain Management *(see guidance on back of page 1)*

Medications

_____

_____

Medication Management of Disturbed Behaviors *(see guidance on back of page 2)*

Medications

_____

_____

Name of prescriber and designation *(print)*	Signature	Date *(yyyy-Mon-dd)*

Fall Prevention suggestions
Bed in low position. Minimal rail use. Call bell/ personal items/walking aids/footwear in reach. Remind patient to call for help. Comfort rounds q2-3 hours *(toilet, reposition, snack/drink, pain, warm enough, bed alarm)*.

Orientation techniques
Orient to time of day, location. Provide calendar/clock in room. Patient photos. Calm approach, explain care, learn about patient, avoid restraining *(adds to agitation)*. Promote sleep *(eg: reduce noise and light – calm approach, back rub; warm blanket; warm milk, relaxation techniques)*.

Medication Management of Disturbed Behaviors

Drug Management of agitation, hallucinations, delusions and aggressive behavior in delirium.
No specific drugs are approved for the management of delirium. The guidelines provide local expert opinion on appropriate drugs and dosages in senior adults. Antipsychotics may be used to manage agitation, aggression, hallucinations and delusions. Benzodiazepines may be used for alcohol and substance withdrawal. Benzodiazepines and antipsychotics may be used concomitantly. Neither should be used to control wandering, since they increase the risk for falls. Whatever drugs are used, physicians and nurses should reassess frequently and reduce or discontinue all drugs for management of agitation as soon as possible. **Medication choice may be dependent on availability and restrictions within zone formulary.**

The maximum suggested doses apply to initial treatment of senior in-patients with delirium. Higher dose and more frequent doses may be required especially in cases of substance use or withdrawal from alcohol and/or benzodiazepines. Younger individuals and those accustomed to higher doses of these medications may require higher doses. Available evidence supports haloperidol as a drug of choice. Alternate oral drugs are indicated in parkinsonian disorders *(e.g. Parkinson's Disease, Dementia with Lewy Body)* or in patients who are at high risk of, or are experiencing adverse effects with haloperidol *(these include extrapyramidal syndrome and tardive dyskinesia).*

Oral drugs *(tablets and liquids)*	**Initial dosage range**	**Suggested frequency**	**Suggested maximum in first 24 hours**
Haloperidol	0.5 – 1 mg	Q 2-4 hours	2.5 mg
Loxapine	2.5 - 5 mg	Q 4 hours	20 mg
Olanzapine	2.5 – 5 mg	Q 12 hours	10 mg
Risperidone	0.25 – 0.5 mg	Q 4-6 hours	2 mg
Quetiapine	12.5 – 50 mg	Q 8 hours	100 mg

Alternate oral drugs	**Initial dosage range**	**Suggested frequency**	**Suggested maximum in first 24 hours**
Risperidone *(M tabs)*	0.25 – 0.5 mg	Q 4-6 hours	2 mg
Olanzapine *(Zydis)*	2.5 – 5 mg	Q 12 hours	10 mg

Injectable drug *(for rapid symptom control if severely agitated or if prominent psychotic symptoms)*	**Initial dosage range**	**Suggested frequency**	**Suggested maximum in first 24 hours**
Haloperidol	0.25 – 0.5 mg	Q 1 – 8 hours Up to 4 doses	2 mg
Loxapine	2.5 – 5 mg	Q 4 hours	20 mg
Olanzapine *(Psychiatry only)*	2.5 – 5 mg	Q 6 hours	10 mg

Adjuvant Drugs	**Initial dosage range**	**Suggested frequency**	**Suggested maximum in first 24 hours**
Lorazepam	0.5 – 1 mg PO/subcutaneously	Q 1-2 hours	1 mg
Trazodone	12.5 – 50 mg PO	at bedtime or Q 8 hours	100 mg