Dazed and Confused: Is it Dementia, Depression, or Life-threatening Delirium?

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Learning Objectives

- Describe why delirium is such a dangerous medical condition and such an important assessment consideration for physicians and nurses.

- Discuss why it is sometimes difficult to determine if an individual’s symptoms are due to delirium, depression, dementia or a combination of these conditions.

- Differentiate the clinical characteristics, onset, and course of delirium, dementia, and depression.
Learning Objectives

- Discuss various etiologies for cognitive impairment, including populations at risk as well as drugs, chemicals, and illnesses that can lead to delirium.

- Describe approaches for assessing and planning medical and nursing interventions for individuals with delirium.

- Describe challenges in appropriate treatment of medical delirium including implications for referral and implications of EMTALA requirements.
Overview

• Introduction.
• Delirium.
• Depression.
• Dementia.
Overview

• Differentiating between delirium, depression, and dementia.

• Medical and nursing management of delirium.

• Conclusions.
Overview

- Limitations: The content of this continuing education event is limited to adult case studies.
Introduction: Meet Mrs. Hill
Introductory Case Studies: Mrs. Hill

• Mrs. Hill, a 76 year-old female presents to the state hospital in an ambulance, via OPC, in February. The OPC was issued by a rural judge at the request of the nursing home where Mrs. Hill resides. Mrs. Hill has been assessed as psychotic with delusions and auditory hallucinations.
Introductory Case Studies: Mrs. Hill

She is transported to the state hospital in an ambulance because she also is having difficulty walking with periods of lethargy and social withdrawal except when she suddenly becomes very agitated and verbalizes seeing people in her room who are not there.
Introductory Case Studies:

Mrs. Hill

• Upon assessment in the admissions unit of the state hospital, the nurse notes that Mrs. Hill has tachycardia, low blood pressure, and significant dyspnea. Her lung sounds suggest significant congestion. Pulse oximetry reveals an oxygen concentration of 82. The patient is assessed by the MD who determines that the patient is not medically stable. The patient is not admitted to the hospital but is immediately transported to the closest general hospital where she dies three days later from pneumonia.

• More on Mrs. Hill later…the “rest of the story…”
Introductory Case Studies:
Mike Johnson

Mike lives on the Texas Gulf coast. He returns home after Hurricane Rita to find his roof is severely damaged. It is 100 degrees outside, the electricity is off, the city is still under mandatory evacuation and the only reason Mike and a few of his neighbors got back in the city limits is that they work for an oil refinery. After working all day at the refinery, Mike and a neighbor try to get their roofs secured.
Introductory Case Studies:

Mike Johnson

• Mike, with the help of his neighbor, gets his roof secured after a couple of hours of hard work. They then start on Mike’s neighbor’s house. It is very hot and humid. Mike and his friend drink some water but are mindful of a dwindling water supply (gallon bottles) they had taken with them upon returning home.

• Suddenly, Mike climbs off the roof, down the ladder and goes into the yard. He starts singing loudly and then urinates on a tree—right in the front yard. Mike’s friend realizes something is amiss and flags down a police officer. Mike gets belligerent with the officer and almost gets arrested but his friend prevails that Mike is not drunk—there is something terribly wrong.
Introductory Case Studies:
Mike Johnson

• Mike is taken to the hospital in a police car and is triaged in the ER parking lot.

• More on Mike later…the “rest of the story…”
What is Delirium and Why is This Such a Relevant Issue?

- Research has demonstrated that:
  - more than 60 percent of all cases of delirium go unrecognized.
  - delirium is often not considered to be a potential medical emergency.
  - in elderly patients with delirium symptoms, symptoms are often mistaken for dementia or mental illness.

What is Delirium and Why is This Such a Relevant Issue?

- **Consequences of undiagnosed delirium lead to:**
  - greater morbidity and mortality.
  - unanticipated death of previously healthy individuals.
  - longer hospital stays.
  - need for greater nursing resources in inpatient settings.
  - greater risk of complications and bodily injuries.
  - more use of restraint and more falls.
So, How Do We Know What We Are Seeing?

• Does our patient have symptoms of:
  – Delirium?
  – Depression?
  – Dementia?
  – Some combination of the 3 Ds?

• Early recognition and treatment can defuse a time bomb!
Delirium: A Potentially Deadly Condition!

Definition

– An acute, usually reversible brain disorder, characterized by clouding of the consciousness (decreased awareness of the environment) and a reduced ability to focus and maintain attention.

– Develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
Delirium: A Potentially Deadly Condition!

**Definition (continued)**

- Evidence from a history, physical exam, or lab findings suggest that the disturbance is caused by the direct physiological consequences of a general medical condition.

- Delirium is a **medical** condition!
Delirium: Epidemiology and Incidence

- Populations at Risk
  - Elderly
  - Children

- Other Risk Factors
  - Pre-existing dementia
  - Functional dependence
  - Bone fracture
  - Infection
  - Medications or alcohol
  - Metabolic disturbances such as an electrolyte imbalance
  - Brain damage
  - Physical restraint
  - Use of bladder catheter
  - Visual and cognitive impairments
Delirium: Epidemiology and Incidence

- Research has shown that:
  - 60 percent of all nursing home residents are cognitively impaired and suffer visual impairments.
  - 80 percent of all nursing home residents are dehydrated.
  - 40 percent of all nursing home residents are periodically restrained and are prescribed three or more meds.

Delirium: Specific Drugs that Cause Delirium

- Anticholinergics (including antiparkinsonian drugs)
- Anticonvulsants (including phenobarbital)
- Antiinflammatory (including corticosteroids)
- Analgesics (including opiates and salicylates)
- Cardiac meds (including beta blockers, Pronestyl, and Aldomet)
Delirium: Specific Drugs that Cause Delirium

- Sympathomimetic (including amphetamines)
- OTC (including Sominex, Compoz, Excedrin)
- Other (including lithium, Keflex, and Antabuse)
- Other meds that affect electrolytes, e.g., diuretics, potassium supplements
Delirium: Compounds and Chemicals that may Produce Delirium

- Arsenic
- Mercury
- Lead
- Manganese
- Aluminum
- Toluene (Methyl benzene)
Delirium: Illnesses that can Cause Delirium

- Hypoxia/ischemia
- Substance withdrawal
- Substance intoxication
- Endocrine and metabolic disorders
- Sepsis
- Hepatic and renal failure
- Febrile illnesses.
- NMS
Delirium: Presenting S&S
Must be Recognized Early to Save a Life!

• **Disturbance of Conscience**
  – There may be fluctuating periods of coherence with periods of confusion.

• **Disorientation**
  – This worsens at the end of the day and may be referred to as “sundowners syndrome.” Note: Also seen in dementias.
Delirium: Presenting S&S

- Alternating periods of **hyperactivity** (often seen in drug withdrawal) to **hypoactivity** (typical of metabolic imbalance).

- **Hyperactive behaviors**
  - Rambling, bizarre, incoherent, rapid, pressured, or loud speech
  - Restlessness, picking at clothes or bed linen, irritability, euphoria
  - Calling out for help, striking out at others, bizarre and destructive behaviors, combativeness
Delirium: Presenting S&S

- **Hypoactive behaviors**
  - Limited dull speech
  - Lethargy, apathy, withdrawn behavior
  - Reduced alertness or awareness of environment

- Predominant emotion of **fear** with a high level of **anxiety**
Delirium: Presenting S&S

- **Sleep Disturbances**
  - Sleep pattern disturbances, including vivid dreams and nightmares

- **Cognitive Changes**
  - Diminished ability to focus attention and easily distracted
  - Disorientation to time and place
  - Impairment of recent and remote memory
Delirium: Presenting S&S

- **Additional Cognitive Changes**
  - Visual or auditory hallucinations, frightening delusions
  - Sleep pattern disturbances, including vivid dreams and nightmares

- A tendency to convulse
Delirium: Detection

- Detection of Delirium requires an examination of the patient’s:
  - **History**
    - Recent level of functioning and presenting picture different than what is revealed in current assessment.
  - **Cognition**
    - Shows reduced ability to distinguish and integrate sensory information and to differentiate if from hallucinations, dreams, and imagery.
  - **Thinking**
    - The thinking process is fragmented and disorganized to the extent that the person is unable to reason, abstract, or solve problems.
  - **Memory**
    - Memory is impaired in all three spheres, the person is unable to register, retain, or recall information.
Delirium: Detection

- Cognitive Changes and Impairments
  - Mental status exam is vital, with a focus on orientation (especially time)
  - Rating scales such as the NEECHAM confusion scale
  - More on tools later
Delirium: Detection

• Associated Behavioral Changes

  – Watch for hypokinetic delirium
    • lethargy, sleepiness, apathy, the “quiet patient” for whom the diagnosis is often missed

  – Watch for hyperkinetic delirium
    • psychomotor hyperactivity, marked excitability
Delirium: Detection

- **Associated Physical Changes**
  - Review of systems.
  - Vital signs critical.
  - CBC, glucose, BUN, creatinine, electrolytes, liver functions, oxygen saturation, EEG.
  - Research has demonstrated that two of the best predictors for development of D.T.s in alcohol withdrawal are:
    - 1) a prior case of D.T.s and,
    - 2) a pulse rate of 100 or higher.
    
  *So, take a good history and monitor pulse.*

Neecham Confusion Scale

• Easily done by nurses
  – Results in a numerical score with definitions for each of three score ranges.
• Asks for assessment in the following areas:
  – Processing (Attention, alertness, responsiveness).
  – Processing-Command (recognition, interpretation, action).
  – Orientation.
  – Behavior.
    • Motor and verbal behavior.
  – Vital signs and pulse oximetry reading.
  – Urinary control.
Narcotic and Alcohol Withdrawal Assessments

• Clinical Institute Narcotic Assessment (CINA)
• Clinical Institute Withdrawal for Alcohol (CIWA-Ar)
• ASE scale-Alcohol Detox Monitoring
• Wang scale- Detox Monitoring

http://www.csam-asam.org/pdf/misc/BupAppendixB.pdf
Another Case Study: Mr. Newman

- Mr. Newman, a 60 Y/O WM, presented with a long history of Tranxene and Placidyl use. He expressed a desire to discontinue both medications and he was admitted to the hospital for detox.

- Although he presented no diagnostic dilemma, he exhibited a textbook example of symptoms
  - Hallucinations and paranoia
  - Motor agitation and restlessness
  - Break with reality
Case Study
Mr. Newman…the rest of the story…

• His behavior was so difficult to manage in the medical hospital he required transfer to a psychiatric facility for more individualized observation, containment, and care.

• After 4 days of the symptoms above, he was noted to be alert and oriented and he began to ask questions about the previous few days as he had no memory of his condition during his detoxification.
I WATCH DEATH
(A Useful Acronym)

I - Infection: encephalitis, meningitis sepsis
W - Withdrawal: alcohol, barbiturates, sedative
A - Acute Metabolic: acidosis, alkalosis, electrolyte imbalance, organ failure
T - Trauma: closed head injury, heat, stoke, burns
C - CNS Pathology: abscess, hemorrhage, infections, tumors, metastases
H - Hypoxia: Anemia, hypotension, pulmonary or cardiac failure

I WATCH DEATH

- **D-** Deficiencies: Vitamin B12, folate, niacin, thiamine
- **E-** Endocrinopathies: Hyper- or hypo-adrenocorticoidism, hyperthyroidism
- **A-** Acute Vascular: stroke, arrhythmia, shock
- **T-** Toxins or drugs
- **H-** Heavy metals: lead, mercury, manganese

Delirium: Diagnostic Criteria

- **DSM IV TR Criteria**
  - Delirium due to ...(indicate the medical condition)
    - Disturbance of consciousness
    - Change in cognition
    - Disturbance develops over a short period of time, usually hours to days, and tends to fluctuate during course of day.
    - There is evidence, from history, physical exam, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.
Deliriums: Medical Interventions and Management

• IV’s will be needed! Need a patent IV line as almost any medical intervention will include IV’s

• Transfer to medical facility, especially if patient is in or has already been transferred to a psychiatric setting

• Medical intervention of underlying problem causing delirium

• Medical interventions to address behavioral symptoms
  – Assessment including EEG
  – Low doses of haloperidol, risperidone, or olanzapine
  – Low doses of benzodiazepines
Deliriums: Medical Interventions and Management

- Provide a comfortable environment
- Reduce stimulation as much as possible
- Use verbal reorientation
- Involve the family
- Avoid physical restraint if possible
- Address sensory deficits
  - Vision
  - Hearing
Challenges for Mental Health Facilities

- Individuals with medical delirium are often inaccurately assessed in general medical facilities/ER’s and symptoms are erroneously determined to be due to an underlying psychiatric disorder.

- Even more worrisome is the person with mental illness who has a medical delirium.
Deliriums: Medical Interventions and Management

EMTALA (Emergency Medical Transfer and Active Labor Act) challenges

• Memoranda of Transfers from ER’s should not be effected without consideration given to a possible diagnosis of medical delirium.
Deliriums: Nursing Management Interventions and Management

- Nursing Biologic Interventions

  - Assessment
    - Vital signs!

  - Safety
    - In an inpatient setting-low beds, guard rails. In the field- whatever actions possible to keep the victim safe.
Deliriums: Nursing Management Interventions and Management

• Additional Nursing Biologic Interventions
  – Administering and monitoring meds
    • maintenance of fluids and correction of electrolyte imbalance

• Frequent communication with the physician.

• Frequent monitoring.
Deliriums: Nursing Interventions and Management

- Nursing psychological and social interventions
  - Help improve orientation with a clock and calendar
  - Provide a simple, structured environment
  - Access to a window
  - Pictures of family members and visits from family members
Deliriums: Nursing Interventions and Management

• Other Nursing psychological and social interventions

  – Watching limited amounts of TV

  – Radio music

  – Control noise level

  – Provide patient with personal eyeglasses and hearing aid
Epidemiology of Depression

- 6% of older people living at home suffer from a minor form of depression and 15% from a minor form of depression.

- These figures can increase to 45% for older people with somatic illness who are hospitalized.
Depression Risk Factors

- Gender
- Social status
- Relationship problems
- History of physical or sexual abuse
- Family history of depression
- Use of drugs or alcohol
- Childbirth
- Smoking
- Anxiety
- Insomnia
Depression Additional Risk Factors

- History of heart disease
- Serious, ongoing, chronic illness, such as diabetes, cancer, or chronic pain
- Certain medical conditions, such as anemia, thyroid disease, and autoimmune disorder
- Recent serious illness or surgery
- Use of certain meds that might trigger depression, such as steroids or narcotics for pain relief
- A stressful life event, such as losing a job or the death of a loved one. This is especially true for older people who have many social stressors, such as becoming dependent upon others for care
Depression Assessment

• Beck Depression Inventory
  – 21 items
  – Self-report

• Hamilton Depression Rating Scale
  – 21 items
  – Administered by clinician

• No substitute for a thorough and accurate history

• Get collateral information
Dementia: Focus on Alzheimer's Disease or Dementia Alzheimer’s Type (DAT)

- A progressive disease that has an average course over 5-10 years, with a range of 2-20 years. The earlier the onset, the more rapid the deterioration.
Dementia: Focus on Alzheimer's Disease or Dementia Alzheimer’s Type (DAT)

- **Stage 1 - (2-4 yrs)**
  - Difficulty performing complex tasks related to recent decline in memory
  - Disorientation about time but memory about people and places remains
  - Increased distractibility. Difficulty making accurate judgments or in planning
  - Appearance deteriorates
  - Poor driving skills
  - Anxiety and depression
  - Beginning of psychotic symptoms
  - Hypertonia
  - Verbal skills decline
Dementia: Focus on Alzheimer's Disease or Dementia Alzheimer’s Type (DAT)

Stage 2 - (Several yrs)
- Progressive recent and remote memory loss
- Failure to recognize family members or past significant events
- Poor impulse control, emotionally labile
- Disorientation, wandering
- Psychotic symptoms are common
- Perseveration and confabulation
- Comprehension of language deteriorates
Dementia: Focus on Alzheimer’s Disease or Dementia Alzheimer’s Type (DAT)

Stage 3 - (1-2 yrs)
- Hyperorality
- Hyperetamorphosis (the need to touch and examine everything in the environment)
- Motor skills deteriorate such that the person cannot walk, sit up, or smile
- Emotional responses dwindle to non-responsiveness
Dementia: Focus on Alzheimer's Disease or Dementia Alzheimer’s Type (DAT)

- Collecting a comprehensive history with collateral information is vital
- Family history
- Onset of symptoms
- Progression of symptoms
- Behavioral or personality changes
- Medication history
Dementia: Focus on Alzheimer's Disease or Dementia Alzheimer’s Type (DAT)

- Neuropsychological testing
- Neurologic examination
- B12 levels
- Thyroid hormone levels
- CT or MRI
- Need to rule out treatable causes for dementia
- Definitive diagnosis on autopsy
### Differentiating Between The Three D’s

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<thead>
<tr>
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<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
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<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Sudden, Abrupt.</td>
<td>Insidious/ slow/ usually unrecognized. Over age 50.</td>
<td>Variable. Coincides with life changes.</td>
</tr>
<tr>
<td><strong>Course</strong></td>
<td>Short with diurnal fluctuations in symptoms.</td>
<td>Chronic and progressive.</td>
<td>Variable symptoms. Typically worse in AM.</td>
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<td>Orientation</td>
<td>Generally impaired, severity varies.</td>
<td>Progressively loses orientation to person, place, and time—loses time orientation first, then place, then person.</td>
<td>Selective disorientation.</td>
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<tr>
<td>Progression</td>
<td>Abrupt</td>
<td>Protracted</td>
<td>Variable</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Altered</td>
<td>Clear except in severe cases</td>
<td>Clear</td>
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<tr>
<td><strong>Attention</strong></td>
<td>Impaired; Fluctuates.</td>
<td>Initially normal.</td>
<td>Minimal impairment but is distractible.</td>
</tr>
<tr>
<td><strong>Memory</strong></td>
<td>Recent and immediate Impaired.</td>
<td>Recent and remote impaired.</td>
<td>Selective or patchy Impairment.</td>
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<td>Perception</td>
<td>Misperceptions common with illusions, hallucinations, and delusions.</td>
<td>Misperceptions usually absent.</td>
<td>Intact except in major depression.</td>
</tr>
</tbody>
</table>
# Differentiating Between The Three D’s

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<tr>
<td>Thinking</td>
<td>Disorganized and incoherent</td>
<td>Difficulty with abstraction, thoughts impoverished</td>
<td>Intact with themes of hopelessness and helplessness</td>
</tr>
<tr>
<td>Assessment Reaction</td>
<td>Distracted from task; numerous errors.</td>
<td>Struggles with assessment to find appropriate response.</td>
<td>Generally lacks motivation, Frequent “I don’t know” answers.</td>
</tr>
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Differentiating Between Delirium and Dementia

- **Delirium**
  - EEG: Diffuse slowing of fast cycles related to state of excitement.
  - Hallucinations, delusions, illusions, labile affect.
  - May have seizures.
  - Is an urgent life-threatening event.

- **Dementia**
  - EEG: Normal or mildly slow.
  - Progressively loses orientation to person, place, and time—loses time orientation first, then place, then person. Gradual changes in personality; normal peculiarities becomes exaggerated: suspiciousness becomes paranoid, compulsions becomes rigid. May eventually develop psychotic symptoms. Affect becomes increasingly labile. May have social withdrawal and apathy.
  - Is not an urgent life-threatening event.
Case Study: Remember Mrs. Hill?

…the rest of the story...

• In September, she told her only daughter, who lived in NY with her family, that she was going to check herself into the nursing home for the winter since she did not feel confident about driving on icy roads during the winter. There was no retirement center in the small town. She maintained her house and drove herself to the nursing home where her car was still parked in the parking lot.
Case Study: Remember Mrs. Hill?  
...the rest of the story...

- She drove herself to the beauty shop once a week while at the nursing home. She still paid her own bills and was socially active in the nursing home. She had **no history or psychiatric illness and had no psychiatric symptoms until she started suddenly started acting strangely in the nursing home.**
Case Study: Remember Mike?

…the rest of the story...

• Mike was treated for life-threatening hypovolemic hyponatremia. He was the first admission to the ICU as the hospital re-opened. After three days in ICU, he was moved to an open unit in the hospital and was then discharged. He had no permanent disability.
Case Study: Remember Mike?  
...the rest of the story...

- His water and sodium levels were both extraordinarily low. This occurred due to exertion in the heat without adequate replenishing of fluids. His condition was exacerbated by:
  - the fact that he was very thin,
  - The fact he not been eating properly because of the disaster conditions in which he was living,
  - the high heat and humidity levels.

*PS - Mike and his family are just getting over Hurricane Ike now. Lessons learned saved him this time.*
Still Another Case…Mr. Waters

• Mr. Waters, a 55-year-old man, is admitted to the hospital on an emergency warrant after assaulting a sheriff’s deputy who was responding to a disturbance call. The patient was known to the hospital staff but had not been hospitalized for almost three years since he had started taking a new generation anti-psychotic. Mr. Waters’ symptoms had been managed so effectively that he had been working for more than a year in a leather factory in the small town where he resided with his elderly mother.
Still Another Case…Mr. Waters

- On admission, Mr. Waters appears to have flight of ideas and is delusional. He has a history of emphysema due to smoking and he is very congested. His blood work comes back indicating lymphocytosis, macrocytosis, and eosinophilia. More tests are ordered and in the meantime, Mr. Waters’ symptoms increase and include severe tremors, ataxia, drowsiness and psychosis, including visual hallucinations.
Mr. Waters…the rest of the story…

- An internist is called in because the treatment team is concerned that Mr. Waters’ has a medical delirium in addition to schizophrenia. The patient is transferred to a regional medical facility where it is determined that Mr. Waters is suffering from exposure to toluene, a chemical used in the leather tanning process.

- Mr. Waters is treated symptomatically and is able to be discharged back home. He quits his job in the leather tanning factory.
Case Study: Mrs. Dropper

• A 36 Y/O WF who was referred for hospitalization by her therapist after she began to display increasing paranoia and depressive symptoms and was apparently non-responsive to antidepressants.

• Additional history included:
  – A family history of depression
  – A dysfunctional family of origin
  – Two recent miscarriages
  – Money problems due to opening a new business—forced to move in with in-laws
Case Study
Mrs. Dropper…the rest of the story…

- Increasing symptoms for 2-3 weeks prior to admission
- Confusion, decrease in energy, insomnia
- Mental status exam showed decreased psychomotor activity, halting speech, difficulty finding words, inappropriate affect
- Additionally, ideas of reference and paranoid delusions were present
Case Study
Mrs. Dropper…the rest of the story...

- After numerous consultations and tests, Mrs. Dropper was diagnosed with Systemic Lupus Erythematosi
  with Lupus Cerebritis. She was treated with Cytoxan and Prednisone and her psychiatric symptoms ultimately resolved.
Conclusions: Clinical Pearls

• Delirium is a medical emergency.
• Onset is swift.
• The patient history is important. Is the patient acting different in a way not easily explainable? Otherwise, be suspicious of delirium.
• ER’s may miss delirium in patients with known psychiatric diagnoses.
• Older people with dementia already have two risk factors for the development of delirium.
• Delirium may often occur in otherwise high-stress life events such as a mandatory evacuation, disaster, etc.
• Be alert to signs of delirium. Maintain an especially high index of suspicion for delirium in the older adult!
• Call the physician!
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References

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References

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