GUIDANCE on Delirium Care for Older Adults in the Community

For Clinicians, Personal Support Workers,
Family Care Partners, and Older Adults

RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

About this document

Delirium is a sudden change in a person's memory, thinking, and behaviour. Its symptoms can fluctuate throughout the day, and include confusion, difficulty focusing or paying attention, disorganized thinking, and a change in level of alertness which may appear as restlessness and agitation or drowsiness and lethargy. Delirium can have many underlying causes, and is often overlooked or misdiagnosed. Timely recognition, prompt assessment, and collaborative management are needed, as delirium can result in poor outcomes including death. While delirium can affect people of all ages its impact is most profound on older adults.

Research and resources on delirium and its management have focused primarily on the hospital and long-term care settings; however, new research and evidence has emerged more recently to address delirium care in the community. With the help of an expert advisory panel of healthcare providers, older adults, and family care partners, this document was developed to integrate all available evidence into a guidance for the identification, assessment, and management of delirium in community settings.
Ontario's quality standard for delirium – care for adults provides a framework for this document. For guidance on delirium care in other settings, at end-of-life, or related to alcohol withdrawal, see Appendix 1.

Prevalence, outcomes and experience of delirium in the community

Delirium affects hundreds of thousands of community-dwelling older adults in Canada. Its prevalence increases with age. At least 10-22% of people 85+ years of age will experience delirium while living in the community (De Lange et al., 2013), and 8-17% of older adults will present to emergency departments with delirium (Inouye, 2013). In addition, up to 82% of older people will experience delirium while in hospital, and 29-55% of this population will be discharged into community care with ongoing symptoms (Dasgupta & Hillier, 2010). Up to 89% of people who had delirium in hospital will not have it documented in their discharge summary (Kakuma et al., 2003). Given the evidence that delirium is often overlooked or misdiagnosed these may be underestimations of its prevalence in the community. Despite its prevalence, few family care partners know about delirium (Bull 2011), primary care providers often lack confidence in its clinical management (Whyte et al., 2018) and few homecare nurses have received specific training in delirium (Malenfant & Voyer, 2012).

Adverse outcomes of delirium can include lasting and irreversible cognitive and functional impairment, lowered quality of life, reduced capacity for independent living, and premature death. Older adults are at greater risk of developing dementia after experiencing delirium (De Lange et al., 2013). For people with dementia, the decline of their cognition may be accelerated by delirium. Up to 30% of hospitalized older adults had persistent symptoms of cognitive decline 6 months after discharge (McCusker et al., 2004).

Delirium can be frightening and stressful for everyone, and its psychological impact on the person experiencing it, family care partners, and healthcare providers is often overlooked. Those involved in caring for someone with delirium report feeling anger and frustration, emotional distress, fear, guilt, and helplessness (Schmitt et al., 2017). Family care partners witnessing delirium's impact on their family member's behaviour often experience feelings of loss and uncertainty as to whether they will ever see the person again as they once were. Family care partners and older adults who remember their experience with delirium may also have feelings of post-traumatic stress long after the delirium has resolved (Bolten et al., 2021).

Improving Care: Quality Statements & Practical Recommendations

Quality Statement 1: Identify Delirium

- A sudden change in an older person's memory, thinking or behaviour prompts early recognition and screening for delirium

Delirium is often unrecognized, misdiagnosed as depression or dementia, or misattributed to aging by healthcare providers and family care partners. Timely recognition of delirium is important so that reversible causes can be identified and addressed promptly, and supportive care can be put in place to manage symptoms. A delay in identifying delirium can result in poor outcomes and distress for the person who is experiencing it, as well as for family care partners and healthcare providers.

Older community-dwelling adults (65+) are at higher risk for delirium, and especially if they:

- Are 85+ years old
- Have dementia
- Have recently been hospitalized
- Have experienced delirium before

Key features of delirium include:

- A sudden change or fluctuating course of symptoms
- A change in level of alertness – the person may be drowsy or lethargic (hypoactive delirium), or restless and agitated (hyperactive delirium)
- Disorganized thinking (e.g., not oriented to age, date of birth, place, current year)
- Difficulty focusing or paying attention

Sudden changes in memory, thinking, or behaviour that is not the person's normal behaviour should prompt you to think delirium! For someone with dementia, delirium symptoms ALWAYS deviate from their usual behavioural patterns, either by timing or by severity of symptoms.

Putting this into practice

Clinicians

Provide delirium information to the person and family care partners if they are at higher risk for delirium (see Quality Statement 2).

Screen for delirium promptly if you observe or are told of recent, sudden changes in the person's memory, thinking, or behaviour, or after discharge from hospital:

- Collect information about the person's baseline cognition and their symptoms in the last few hours and days, but don't delay screening or diagnosis if this information is not readily available. Since delirium symptoms fluctuate, knowing symptom history is important because not all symptoms may be present during screening.
- Complete a delirium screen using a tool such as the 4AT[NOTE 1]
- Use the Single Question in Delirium – "Do you feel that [person's name] has been more confused lately?" – to help identify new confusion and possible delirium.

Use a delirium screening tool

- *When delirium is suspected*
- *After discharge from hospital*

A delirium screening tool alone cannot confirm a delirium diagnosis; if the delirium screen is positive, conduct a further assessment using the current diagnostic standard for delirium (see Appendix 2).

If delirium is confirmed:

- Discuss the diagnosis with the person and their family care partners and provide printed information about delirium (see Quality Statement 2)
- Document and communicate the diagnosis with other involved healthcare providers
- Assess for underlying causes and develop a management plan (see Quality Statement 3)

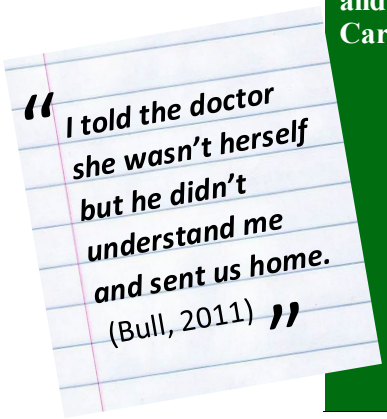
If the delirium screen is negative, re-screen if changes in the person's memory, thinking, or behaviour continue to be observed or reported.

NOTE 1: The 4AT is a screening tool designed for rapid (less than 2 minutes) initial assessment of delirium and cognitive impairment which can be used in the community. Pay attention to the guidance notes for the 4AT tool. It is free, and does not require any training, but some knowledge of delirium is essential. It is validated for use in a variety of settings, including the community. Other tools can be used in the community setting, such as the Confusion Assessment Method (CAM).

Personal Support Workers

You can help in the timely recognition of delirium by staying alert for sudden changes in memory, thinking, and behaviour. Remember that symptoms can come and go throughout the day (see Appendix 2). You can use the sfCare Learning Series for Personal Support Workers (PSWs) Pocket Guide as a handy reference.

	Delirium requires prompt medical attention. If you notice any of these changes or a family member tells you about them, document and share your concerns with family care partners and your supervisor right away.
Older Adults and Family Care Partners	Ask a healthcare provider what information is available to help you better understand delirium and how you can work together with them to support your family member if they are at risk or have delirium. A sudden change that is not the person's normal behavior - think delirium! If you notice sudden changes in their memory, thinking, or behaviour, report your concerns to a family doctor or nurse practitioner promptly so that they can assess for delirium (see Appendix 2). You can use the Delirium Detection Questionnaire to help you communicate what you are seeing. You can also use the Delirium: Know, Do, Tell, Ask handout as a handy reference about what to watch for, and what to do.



Quality Statement 2: Provide information for older adults and family care partners

- Older adults and their family care partners are provided with information about delirium.

Experiencing delirium can be frightening and distressing for the person who is experiencing it and their family care partners. Providing information and support to help people better understand delirium can lessen fear, improve understanding, and help people to cope with an episode of delirium.

Putting this into practice

Clinicians	Provide information to the person and their family care partners using plain language and visual tools. Information about delirium should meet people's cultural, cognitive, and language needs and should include: • An explanation of delirium, the importance of prompt medical attention, and the value of reporting sudden changes or fluctuations in memory, thinking, or behaviour. • Guidance on how to identify delirium, that symptoms can arise quickly (within hours or days) and fluctuate (i.e., confusion can come and go over the course of a day), and the difference between delirium, dementia and depression.[NOTES 1, 2] • Detailed information on who to contact (24/7).[NOTES 1, 2] • Ways to prevent delirium (see Appendix 2).[NOTE 1]

	• Strategies to manage delirium and advice on how to help the person if behavioural symptoms are distressing (see Appendix 3). NOTE 1 • The expected course and potential consequences of delirium. Include the possibility that recovery may take weeks, that recovery may not be full and that there is a risk of cognitive decline in the 2 years after the episode of delirium (Tsui et al., 2022). • A description of people's experiences of delirium (including the person who is experiencing it and their family care partners). Also encourage people who have had delirium to share their experiences during their recovery if they are comfortable doing so. NOTE 1 • Where family care partners can find information, services or support. NOTES 3, 4 NOTE 1: The Changes in Thinking and Behaviour: Delirium and Delirium Prevention and Care with Older Adults booklets for older adults and family care partners provides information on these topics; however, additional information that is customized to the person's needs should be provided. NOTE 2: The Delirium Detection Questionnaire can help family care partners communicate what they are seeing, and the 1-page Delirium: Know, Do, Tell, Ask handout can be used as a quick reference for what to watch for, and what to do. NOTE 3: The Ontario Caregiver Helpline: 1-833-416-2273 is available 24/7 and is a one-stop resource for information and referrals connecting family care partners to the supports they need. NOTE 4: 211ontario.ca and health811.ontario.ca (or the phone numbers 211 and 811, respectively) quickly and confidentially connect people to social or health services and community programs across the province 24/7.
Personal Support Workers	If the person you provide care for or their family care partner have received information about delirium, let them know that you can support them.
Older Adults and Family Care Partners	Ask a healthcare provider what information is available to help you better understand delirium and how you can work together to support your family member if they are at risk or have delirium. Share the information you have been given with other care partners such as your personal support worker.

Quality Statement 3: Identify and treat underlying causes & manage symptoms

- Older adults who have been diagnosed with delirium or who are suspected of having delirium receive a comprehensive assessment to identify the causes, and participate (along with their family care partners) in the development of a plan to treat the causes and manage the symptoms.

Delirium requires prompt recognition, investigation, and treatment of underlying causes. Delirium is often managed in the community where early identification and treatment may reduce its duration, severity, and enduring complications. There are many possible causes of delirium, and causes may co-occur, so a comprehensive assessment is critical.

The most common causes of delirium for community dwelling older adults are:

- **I**nfection (mostly respiratory and urinary)[NOTES 1, 2]
- **M**edication (polypharmacy, anticholinergics, opioids, and psychotropic medications such as benzodiazepines)[NOTE 3]
- **E**lectrolytes (especially hyponatremia and hypercalcemia)
- **D**ehydration
- Pain
- Intracerebral event (e.g., stroke or hemorrhage)
- Malnutrition
- Constipation
- Hypoxia
- Hypoglycemia
- Other causes (e.g., disturbed sleep, sensory deficits, recent major surgery, falls, over or under stimulation, recent hospitalization, etc.)

NOTE 1: Infections cause 50% of delirium in community dwelling older adults (respiratory and urinary are the most common) (Magny et al., 2018).

NOTE 2: There is no evidence associating asymptomatic bacteriuria and delirium. Systematic reviews find no clinical benefit from treating asymptomatic bacteriuria. There is no evidence that the use of antibiotics for asymptomatic bacteriuria decreases the duration or severity of delirium. Current guidelines suggest assessing for other causes and careful observation before treating asymptomatic bacteriuria in a person with delirium (Laguë et al., 2022).

NOTE 3: For a list of medications that may cause or worsen delirium in older adults refer to the American Geriatrics Society 2023 Beers Criteria.

Putting this into practice

Clinicians	If you suspect or have diagnosed delirium, an assessment for the most common causes (infections, medications, electrolytes, and dehydration) is an essential initial step in advance of a more comprehensive assessment. The basic bundle of assessments depending on history and physical includes: • Blood work (state on req. "Urgent - delirium bloodwork to be done within 24 hours"): • CBC • Biochemistry – calcium, albumin, magnesium, phosphate, creatinine, urea, electrolytes, liver function tests (ALT, AST, bilirubin, alkaline phosphatase), glucose • Thyroid function tests (e.g., TSH) • Blood culture • Urinalysis (urine culture, if required after assessment of symptoms) Complete a comprehensive assessment which includes both patient and environmental factors. Develop a management plan that treats the causes you have identified, prevents complications, and optimizes supportive care (see Appendix 3).[NOTES 1, 2] Reassess for resolution of delirium. If delirium does not improve, consider another possible cause and/or the possibility that an underlying dementia might be complicating progress.[NOTE 2] Once resolved, monitor regularly for persistent cognitive and functional concerns and consider referral for geriatric services.[NOTE 2] NOTE 1: There is no consistent evidence demonstrating that using antipsychotic medication for delirium management shortens symptom duration or lessens severity. Their use may worsen clinical outcomes (Nikooie et al., 2019) (see Quality Statement 4). NOTE 2: Reassessment after resolution of delirium is essential (Rummans et al., 1995) as cognitive deficits can persist for weeks and may be the precursor of dementia or of future functional decline. Older adults with a healthy baseline cognitive function who develop delirium are at higher risk of developing cognitive impairment. This group might benefit the most from additional functional support and post-delirium follow-up (Tsui et al., 2022).
Personal Support Workers	Create a calm and supportive environment and ensure basic needs are met (see Appendix 2), and use supportive communication techniques (see Appendix 3). If symptoms are not improving, are getting worse, if the person is at risk of harm to themselves or others, or if they are in severe distress, document and report it to a supervisor promptly.

Older Adults and Family Care Partners	If you have delirium, your family doctor or nurse practitioner will work with you and your family care partner to find out what is causing your delirium and how to treat it. They may examine you and run tests (e.g., blood tests, urine tests, chest x-ray). They may ask about medications you are taking, any recent medication changes, and whether you are in pain. You will receive treatments based on the cause(s) of your delirium. Your healthcare providers and family care partner will work together to create a calm and supportive environment and ensure your basic needs are met (see Appendix 2).

Quality Statement 4: Don't use antipsychotics as your first choice to manage delirium symptoms

- Only consider antipsychotic medication for an older adult with delirium if they are at immediate risk of harm to themselves or others, or in severe distress from psychotic symptoms of delirium.

Evidence has not confirmed that antipsychotic medication shortens the duration of delirium symptoms or lessens their severity (Nikooie et al., 2019). Antipsychotics have been linked to adverse effects including stroke, heart attack, abnormal heart rhythm, falls, and death (Agar et al., 2017; National Institute for Health and Care Excellence [NICE], 2023). Antipsychotic medication should also be avoided or used with caution in people with Parkinson's disease (NICE, 2023).

Putting this into practice

Clinicians

No consistent evidence demonstrating shorter duration / less severity / resolution of delirium symptoms with use of antipsychotics, and they may be associated with worse clinical outcomes.

Before considering an antipsychotic medication as an adjunct therapy:

- Ensure that underlying causes of delirium have been investigated and are being treated
- Ensure that the symptoms of delirium are being managed with non-pharmacologic strategies, such as optimizing the environment and communication strategies for managing behavioural symptoms (see Quality Statement 3)

If you feel that an antipsychotic medication is necessary:

- Identify the target symptom(s) that are putting the person or others at risk or causing severe distress
- Discuss the harms and benefits with the person and their family care partner
- Start with a very low dosage and go slow

Closely monitor the response (i.e., vital signs, changes in the person's behaviour) before considering any dose increases. Follow-up within a week. Limit use for as short a period as possible. If the target symptoms are not improving, consider trying a different antipsychotic. If symptoms still aren't improving, consider getting

	another opinion. Include a planned process for stopping the medication, including safe tapering where appropriate. Although the person may still have cognitive symptoms of confusion, antipsychotics should be discontinued after risk of harm or distressing behavioural symptoms of delirium have resolved. Provide an explanation to family care partners so they know what to expect during tapering and discontinuation and why these medications aren't used long term (i.e., the risks outweigh the benefits, and serious side effects such as stroke and sudden cardiac arrest are possible). If appropriate, you may want to consider providing a few PRN doses so that a family care partner can restart if symptoms recur. This can help to alleviate fear that they will be left to deal with a difficult situation if medication that was helping is stopped. You can use the Delirium Assessment and Treatment for Older Adults - Clinician's Pocket Guide as a handy reference for selecting an antipsychotic and dosing, or the Antipsychotic Toolkit, or consult with GeriMedRisk as needed for guidance.
Personal Support Workers	If the person is taking antipsychotic medication, watch for changes and for common side effects of antipsychotics, especially drowsiness. Share concerns with the family care partner and a supervisor. Extra care will need to be taken to assist the person when they want to get up or walk since antipsychotics can increase the risk of falls.
Older Adults and Family Care Partners	If you have delirium and have distress related to your symptoms (e.g., unpleasant hallucinations, delusions) or if you are at immediate risk of harm to yourself or others, a doctor or nurse may speak with you and your family care partner about prescribing an antipsychotic medication at a low dose for a limited time. If your family member is taking antipsychotic medication, watch for how it might be affecting them and report any changes to a doctor or nurse practitioner. A common side effect of antipsychotic medication is drowsiness. Extra care will need to be taken to assist the person when they want to get up or walk since antipsychotics can increase the risk of falls.

Quality Statement 5: Provide delirium care after an ED visit or hospitalization

- Older adults who have been in hospital (ED visit or hospitalized for any reason) receive delirium care when they return home regardless of their delirium status.

Delirium is not always detected in the ED or when admitted to hospital. For people who are diagnosed with delirium in hospital, up to 89% will not have it documented in their discharge summary (Kakuma et al., 2003). Recovery from symptoms of delirium is seldom complete upon discharge and can take weeks to resolve.

Putting this into practice

After discharge from hospital All older adults require delirium care, whether they experienced delirium in hospital or not.

Clinicians	Check the discharge summary to see if an episode of delirium (current or resolving) has been documented. If there is no documentation about delirium, ask the person and their family care partners if an episode of delirium occurred or symptoms of delirium were experienced. If the person has been discharged on antipsychotic medication that was prescribed for delirium in hospital, it is important to reassess and develop a plan for stopping the medication, including safe tapering where appropriate (see Quality Statement 4). Screen as required (see Quality Statement 1). Provide ongoing management for resolving delirium (see Quality Statement 3). Put a plan in place with the older adult and family care partners so they know what to watch for and what to do (whether the person had delirium or not). Don't assume that they have all of the information they need about delirium when discharged from hospital. Ensure that there is communication across care providers regarding the person's progress.
Personal Support Workers	Watch for signs of delirium, and document and report them to the family care partners and a supervisor if they occur. Create a calm and supportive environment and ensure basic needs are met (see Appendix 2). If someone is recovering from delirium, use supportive communication techniques (see Appendix 3).
Older Adults and Family Care Partners	If you experienced delirium in hospital, you may still have symptoms when you are discharged and will continue to receive care to help you recover from delirium (see Appendix 2 and Appendix 3).

Appendices

Appendix 1 – Beyond the scope of this document

For delirium care related to non-community healthcare settings, specific guidance for delirium care at end-of-life, or related to alcohol withdrawal, please refer to the following documents:

- In other healthcare settings (such as hospitals or long term care homes): Quality Standard for Delirium – Care for Adults (Ontario Health)
- At end of life (all settings): Guideline on the Assessment and Treatment of Delirium in Older Adults at the End of Life (Canadian Coalition for Senior's Mental Health)
- Experiencing confusion related to withdrawal from alcohol: Quality Standard for Problematic Alcohol Use and Alcohol Use Disorder (Ontario Health)

Appendix 2 – Identify delirium

Clinicians

Symptoms of delirium

- Cognitive function (e.g., worsened concentration, slow responses, or confusion)
- Perception (e.g., visual, auditory, or tactile hallucinations, or delusions)
- Physical function (e.g., reduced mobility, reduced movement, restlessness, agitation, changes in appetite, or sleep disturbance)
- Social behaviour (e.g., difficulty with or inability to cooperate with reasonable requests, withdrawal, or alterations in communication, mood, or attitude)
- Alertness (e.g., altered level of alertness or consciousness, such as difficult to rouse and markedly drowsy or sleepy, or hyper alert)

Characteristics of delirium defined by the DSM-5-TR criteria

- Disturbance in attention (reduced ability to direct, focus, sustain, and shift attention) and awareness
- The disturbance develops over a short period of time (usually hours to days), represents a change from baseline, and tends to fluctuate during the course of the day
- An additional disturbance in cognition (memory deficit, disorientation, language, visuospatial ability, or perception)
- The disturbances are not better explained by another pre-existing, evolving, or established neurocognitive disorder, and do not occur in the context of a severely reduced level of arousal, such as coma
- There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication or withdrawal, or medication side effect

Additional features that may accompany delirium

- Psychomotor behavioural disturbances such as hypoactivity, hyperactivity with increased sympathetic activity, and sleep impairment
- Variable emotional disturbances, including fear, depression, or euphoria

Delirium subtypes

Delirium has been classified into subtypes depending on the changes in level of consciousness:

- Hyperactive (restlessness, agitation, non-purposeful walking, insomnia)
- Hypoactive (drowsiness, somnolence, withdrawn)
- Mixed: alternating hyperactive and hypoactive subtypes

Comparison of clinical features of delirium, dementia, and depression

	Delirium	Dementia	Depression
Onset	Sudden (hours/days)	Usually gradual and progressive (months/years)	Gradual (weeks/months)
Duration	Usually less than a month	Years to decades	Months, can be chronic
Course	Reversible, when causes identified	Not reversible, progressive deterioration	Recovers within months, can relapse
Alertness, levels of consciousness	Fluctuates (sleepy/agitated) depending on hyper or hypo types	Generally normal or slowed	Generally normal
Attention	Fluctuates, difficulty concentrating, easily distracted	Generally normal	May have difficulty concentrating
Sleep	Change in pattern, often awake through the night and more confused	Can be disturbed / night time wandering and confusion possible as disease progresses	May experience early morning wakening, or difficulty in getting off to sleep
Thinking	Disorganized – jumping from one idea to another	Abstract thought problems, poor judgement, sometimes problems word finding	Slower, preoccupied with negative thoughts (e.g. hopelessness/ helplessness/ self-deprecation)
Perception	Illusions, delusions, and hallucinations common	Generally normal in early stages	Generally normal

In the case of uncertainty over whether delirium or dementia or both are present, it is best to assume it is delirium unless there is clarification from the medical record or from family care partners that the mental state is clearly in keeping with their usual mental state (Scottish Intercollegiate Guidelines Network, 2019).

Personal Support Workers AND Older Adults and Family Care Partners

Signs and symptoms of delirium

They can fluctuate throughout the day, and there may be periods of no symptoms. The most common signs and symptoms include:

- Lack of concentration and getting distracted easily
- Not being able to respond to a question by getting stuck on a thought or an opinion
- Poor recent memory
- Being disoriented to time and place
- Difficulty understanding speech, readings, and writings
- Hallucination (seeing things that do not exist)
- Delayed response and movement
- Significant changes in sleep habits
- Rapid and unpredictable mood changes
- Feeling depressed or euphoric without reason

Create a calm and supportive environment and ensure basic needs are met to support older adults who are at increased risk of developing delirium or who have delirium:

- Encourage balanced nutrition. If they are struggling to eat full meals, encourage them to try eating smaller amounts more frequently.
- Encourage the person to drink six to eight cups of fluid, for example water, each day. A normal cup or glass size counts as one drink.
- Ensure the person has their eyeglasses, and that they are clean. Encourage regular eye tests to ensure that the prescription is still correct.
- Ensure the person has their hearing aids and check these are working. Encourage regular hearing tests.
- Encourage exercise, for example to sit, or get out of bed, or get up and walk.
- Make sure the person has a good night's sleep. Avoid alcohol or caffeinated drinks (such as tea and coffee) before bedtime.
- Make sure the person is going to the toilet regularly.
- Monitor for pain and keep this under control.
- Keep the person's mind active by encouraging them to do things they enjoy.
- Explain where the person is and provide reassurance if they are in an unfamiliar place.
- Provide familiar objects, such as pictures of family to chat about

with the person.

- Write things down, using clocks and newspapers as cues for date and time.

Review medications with a doctor, nurse practitioner, or pharmacist. Some medications increase the risk of developing delirium, or sudden withdrawal of some medications will, too.

Delirium in the community: urgency or emergency?

Delirium requires prompt medical attention which considers the person's goals of care. Quick reference sheets for Clinicians, Personal Support Workers, and Family Care Partners can help you take action. (Use these links for printing the quick reference sheets on the next 3 pages)

Delirium: Urgency or Emergency?

Quick reference for **clinicians** in community settings

What to do if an older adult has a **sudden change** in memory, thinking, or behaviour

Think delirium! Key features of delirium include:

- A **sudden change** or fluctuating course of symptoms
- A change in level of alertness - the person may be drowsy or lethargic (hypoactive delirium), or restless and agitated (hyperactive delirium)
- Disorganized thinking (e.g., not oriented to age, date of birth, place, current year)
- Difficulty focusing or paying attention

Delirium requires prompt medical attention which considers the person's goals of care

Act with URGENCY

If any signs of delirium are observed or reported, **promptly have causes assessed**, and help optimize supports for community management.

IMED: The most common causes of delirium in the community

Infection (especially respiratory and urinary

Medication (polypharmacy, anticholinergics, opioids, and psychotropic medications such as benzodiazepines

Electrolytes (especially hyponatremia)

Dehydration

Basic bundle of assessments (depending on history and physical)

- **Blood work** (state on req. "Urgent - delirium bloodwork to be done within 24 hours"): **CBC**; **Biochemistry** - calcium, albumin, magnesium, phosphate, creatinine, urea, electrolytes, liver function tests (e.g., ALT, AST, bilirubin, alkaline phosphatase), glucose; **Thyroid function tests** (e.g., TSH); **Blood culture**
- **Urinalysis** (urine culture, if required after assessment of symptoms)

Or treat as as an EMERGENCY

Consider transfer to an emergency department for the following reasons:

- If a serious underlying medical problem or injury requires emergency care
- If assessments are not available
- If cause can't be confirmed following assessment
- If care needs cannot be met
- If your clinical judgement says it's needed

Provide information to the family care partner including how they can support the person

- Be calm and reassuring
- Have a familiar person present as much as possible
- Help maintain normal routines and ensure basic needs are met such as eating, drinking, regular toileting, controlling pain, using eyeglasses or hearing aids, keeping the mind and body active, and getting a good night's sleep

Delirium: Urgency or Emergency?

Quick reference for **Personal Support Workers** in community settings

What to do if an older adult has a **sudden change** in memory, thinking, or behaviour

If you notice **sudden changes** (which can come and go throughout the day), **think delirium!**

The person says or does things that seem strange or uncharacteristic for them or don't make sense, such as:

- Forgetting things that have happened recently
- Having difficulty paying attention
- Not knowing where they are or what time it is (disoriented)
- Seeing things that do not exist (hallucinations)
- Being restless and agitated, or drowsy

Delirium requires prompt medical attention

Act with URGENCY

If you notice any signs of delirium, or a previously diagnosed delirium is not getting better or is getting worse, promptly talk with:

- Your supervisor
  AND
- A family care partner (if available)

Or treat as as an EMERGENCY

Call 911 if you notice any signs of delirium AND any of the following apply:

- If you suspect a serious medical problem, such as a stroke, heart attack, or injury
- If you are unable to reach your supervisor or a family care partner
- If delirium symptoms, such as disorientation or hallucinations are putting the person at immediate risk of harm to themselves, you, or others
- If the person is unable to care for themselves and care can't be put into place
- If your instinct or intuition tells you to

Support the person while waiting for medical attention

- Be calm and reassuring
- Encourage a familiar person to be with them as much as possible
- Help maintain normal routines and ensure basic needs are met such as eating, drinking, regular toileting, controlling pain, using eyeglasses or hearing aids, keeping the mind and body active, and getting a good night's sleep

Delirium: Urgency or Emergency?

Quick reference for **family care partners**

What to do if an older family member has a **sudden change** in memory, thinking, or behaviour

If you notice **sudden changes** (which can come and go throughout the day), **think delirium!**

The person says or does things that seem strange or uncharacteristic for them or don't make sense, such as:

- Forgetting things that have happened recently
- Having difficulty paying attention
- Not knowing where they are or what time it is (disoriented)
- Seeing things that do not exist (hallucinations)
- Being restless and agitated, or drowsy

Delirium requires prompt medical attention

Act with URGENCY

If you notice any signs of delirium, or a previously diagnosed delirium is not getting better or is getting worse, promptly contact or go to one of the following:

- Family doctor or nurse practitioner
- Home care nurse or community paramedic (if these services are in place in the home already)
- Walk-in clinic or urgent care centre (call 211 or check health811.ontario.ca to find the closest one that is open)

You can use the Delirium Detection Questionnaire to help you communicate what you are seeing.

Or treat as as an EMERGENCY

Call 911 or go to the emergency department if you notice any signs of delirium AND any of the following apply:

- If you suspect a serious medical problem, such as a stroke, heart attack, or injury
- If you are unable to reach a doctor, nurse, or community paramedic
- If delirium symptoms, such as disorientation or hallucinations are putting the person at immediate risk of harm to themselves or others
- If the person is unable to care for themselves and care can't be put into place
- If your instinct or intuition tells you to

Support the person while waiting for medical attention

- Be calm and reassuring
- Have a familiar person present as much as possible
- Help maintain normal routines and ensure basic needs are met such as eating, drinking, regular toileting, controlling pain, using eyeglasses or hearing aids, keeping the mind and body active, and getting a good night's sleep

Appendix 3 – Manage delirium

Clinicians	**Develop a management plan** which includes interventions to address the identified underlying causes, supportive care to manage delirium symptoms, and proactive care that prevents complications and promotes recovery to baseline, including: • Continuing to treat other conditions the person has, as these may be contributing to and sustaining the delirium. • Continuing to review for any further or missed underlying, ongoing causes that may be sustaining the delirium. • Managing the medications the person is taking for other conditions, as these may need to be reduced or stopped, if it is felt that they may contribute to sustaining the person's delirium. • Reviewing any new medications that may have caused delirium. If the person is on benzodiazepines, then do not suddenly stop these. Request a pharmacist's review as necessary. • Monitoring for and reducing the risk of the person developing pressure ulcers. Consider referring for an assessment for pressure relieving equipment. • Monitoring for and reducing the risk of the person falling, which includes undertaking risk assessments of the environmental factors that may contribute to the person's falls risk. • Encouraging the person to continue to meet their usual care needs (make sure you have knowledge of the person's baseline level of functioning). Consider a referral for an assessment of the person's functioning, as well as any necessary aids and adaptations. For example, if the person is remaining in bed for long periods, or if the person is getting up out of bed and needs equipment (e.g., bed levers, commodes, standing aids, kitchen perching stools, frames around toilets, chair raisers, etc.). • Referring for homecare support or changes in homecare support as needed (consider frequency of visits, duration or timing of visits, changes to staff). • Monitoring the person regularly for changes in behaviour or cognitive function (see Quality Statement 3), including clinical deterioration. • Referring to the emergency department for investigation of causes and treatment as needed (e.g., when the tests or care required are not available in the community). • Referring for a consultation with a specialist physician in geriatrics or geriatric psychiatry, a geriatric nurse practitioner,

	or a neuropsychologist if needed (e.g., those with severe agitation or distress related to their delirium symptoms, those who are not responding to the standard measures above, those whose diagnosis is in doubt). There are regional variations in access to these services and to healthcare professionals who have special expertise in assessing and managing delirium. • Asking family care partners to monitor whether delirium is improving and to support the older adult's basic needs. Make a plan together for how they should report when things are not improving or getting worse.
All – Clinicians, Personal Support Workers, Family Care Partners	**Communication techniques to support a person with delirium:** • Be a good listener: ○ Have a friendly, smiling approach. ○ Be patient and give them time to reply. Repeat what you said, if necessary. ○ Acknowledge how they are feeling. For example, if their answer to "Are you having a good day?" is "No," try something like: "I am sorry that today is not a good day for you so far. I hope that it gets better. Is there anything that we can talk about that might make you feel a little better?" ○ Try not to correct them. It's not actually helpful and may increase distress in the person who is already confused. Try to validate their confusion or fear. For example, when someone asks for a deceased parent, instead of responding with "They have been dead for 20 years", try posing questions like "Why are you asking about [deceased parent]? What's going through your mind right now?" • Keep conversation simple: ○ Use questions that only require a "Yes" or "No" answer. For example, "Are you having a good day?" instead of "How are you?" ○ Give simple, short directions when a task needs to be done, and break down the task into simple steps. For example, one-step directions, such as "Follow me" or "Eat this". ○ Keep choices simple and don't offer too many. For example, "Red shirt or blue shirt?" instead of "Which shirt do you want to wear today?" • Address issues that might interfere with communication: ○ Reduce noise and remove items that might distract the person when talking to them (e.g., turn off the TV).

- Make sure eyeglasses are clean.
- Make sure batteries are working in hearing aids.

Communication techniques to support a person with delirium who is experiencing hallucinations or agitation:

- When the person is experiencing hallucinations:
  - Use a calm voice and reassuring words. For example, "I can tell that you aren't feeling well / are afraid. It's going to be okay".
  - Focus on how the person is feeling. What is real is how they feel. For example, "You think a man is in your room? I can see why you feel uncomfortable".
  - Let them know that you are with them and that they are safe. For example, rather than saying "There are no snakes, you are hallucinating", try something like, "I know you see snakes on the floor and that you are scared, but I am here with you and you are safe".
  - Check for things in the room that the person might think are something else. For example, "Man in the room" may be a coat hanging in the corner; "People in the room talking" could be the TV; "God talking" could be the radio.
- When the person is experiencing agitation:
  - If you appear anxious or fearful, it may increase the person's agitation. Stay calm, maintain a safe distance from the person in order to make them feel safe, and have someone else present if possible for support and assistance, as needed. Only one person should talk to the person with delirium.
  - Verbally engage and get the person's attention by calling their name in a gentle tone of voice: "Hello _____ (use preferred name). I am _____, your _____."
  - Establish a collaborative relationship: "I can see you are upset. I want to help you."
  - Verbally de-escalate: "It's okay. I am sorry you are upset. I am here to help you and keep you safe. How can I help you?" Repeat your message, if needed, as the upset person may not be able to hear and/or respond the first time.
  - Try to establish what may be causing the person distress and take time to explain and calmly reassure.

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