Hospice Taranaki
Te Kahu Pairuri ki Taranaki

ACF NEWSLETTER

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#HospiceLink

hospicetaranaki.org.nz | lisa.mourie-hanrahan@hospicetaranaki.org.nz

DELIRIUM

Delirium is everyone's business. It is FAR easier to PREVENT than TREAT.
We need to talk Delirium and as nurses we can own this!
It is a condition that nurses can really engage in and the care that we provide can make such a difference.

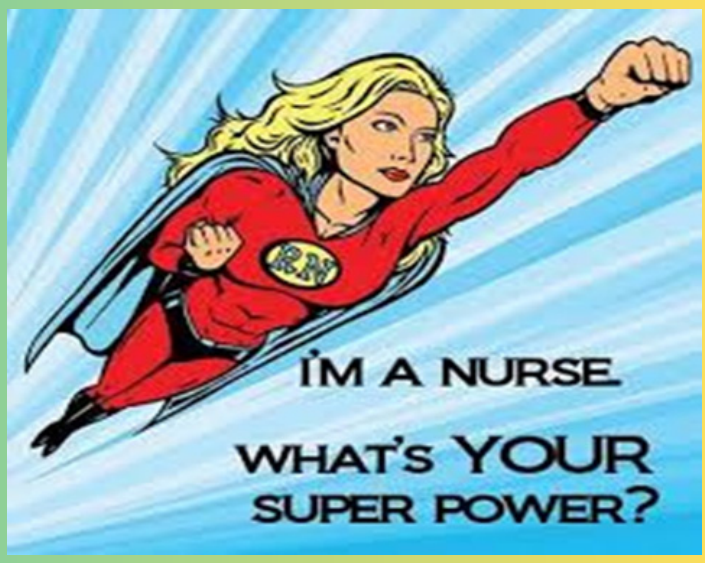
What is Delirium?

- Delirium is an acute disorder of attention and cognition which can have serious adverse outcomes
- There can be multiple causes for delirium, and often the specific causes are not found despite investigations
- Delirium affects 30% of elderly patients in hospital
- It is more common in those with Dementia or a pre existing cognitive impairment
- Delirium can have a poor long term prognosis and the duration is variable as is severity
- Most importantly – it can be preventable and possibly reversible.
- It can be most distressing for patients, family and staff
- If irreversible, it may be an indication of impending death. Toxic confusional states like delirium can be common in people who are dying.

What can delirium look like?

- **Clouding in consciousness**
- **Disorientation in time and place**
- **Changes in attention**
- **Language disturbance**
- **Agitation or apathy**
- **It takes a fluctuating course**
- **Changes in sleep/wake cycle**

- **Perceptual distortion with hallucinations**
- **Disorganised behaviour**
- **Disturbed mood**
- **Extreme fearfulness**
- **Overall reduced level of functioning**
- **People can present with hyperactive (frenzy) or hypoactive (lethargic, sluggish, inactive) or a mixture of both!**



Risk factors/causes can include:

Advancing age; Chronic co morbidities (CVA, malignancy, renal, hepatic, cardiac, pulmonary)
Existing cognitive impairment or Dementia | Infection | Severe Trauma eg hip fracture
Metabolic and Endocrine disturbances | Dehydration | Nutritional deficiencies
Medications such as sedatives, anticholinergics, opioids, steriods | Severe anaemia
Constipation/faecal impaction | Bladder Catheter and Urinary retention
Impaired functional status – frailty/ deconditioning | Pain –under and over treated
Unfamiliar excessive stimuli and environmental changes | Hypoxia
Cerebral mets, cerebral haemorrhage, epilepsy – post ictal

What can we do? ... Remember our super powers nurses!

Orientation

- Introduce yourself and your role often
- Consider appropriate tone, body language
- Validate feels expressed
- Facilitate regular visits from family and friends
- Introduce cognitively stimulating activites
- Sensory input

Sensory Input

- Ensure hearing and visual aids if required are used
- Avoid room changes
- Identify usual routines, likes/dislikes
- Have personal objects/photos/momentos displayed
- Provide natural lighting and maintain some lighting at night
- Clear signage
- Have clock and calendar easily visible to patient
- Provide quiet environment at rest times
- Avoid boredom and loneliness

Hydration/Nutritional needs

- Encourage/assist the person to eat and drink
- Offer finger foods if tolerated
- Offer snack, esp in evening if appropriate
- Monitor intake to ensure it is adequate
- Sit out of bed for meals if able

OTHER REALLY USEFUL RESOURCES FOR STAFF...

Frailty Care guidelines – see Delirium

Video about Delirium

Brochure – helping people understand delirium and tips to prevent it – useful for families

Immobility/limited mobility

- Exercise - mobilisation, stimulation and sunshine if possible

Infection

- ·Look for and treat infections
- ·Infection control procedures to reduce risk
- ·Pain
- Assess for pain and treat with medications, positioning, mobilising as necessary
- Look for non verbal signs, be mindful that people with dementia may not be able to inform/describe their pain

Sleep Disturbance

- Avoid nursing or medical procedures during sleeping hours
- Schedule medication rounds to avoid disturbing sleep
- Reduce noise to a minimum

Continence and Bowel Care

- Avoid unnecessary catheterisation
- oRegular bowel function – avoid constipation and complete bowel charts

Remember to not...

- Dismiss any patient as 'pleasantly confused' or assume they have existing Dementia and do nothing……
- Ignore lethargy and withdrawal – because hypoactive Delirium is easily missed
- Miss the opportunity to talk to family
- Dismiss a carers or families concerns. Claims of 'He/She is not usually like this should be taken seriously
- Use drugs routinely

PALLIATIVE CARE LECTURE SERIES

7 December 2023 - 0730am – 0830am

Caring for Māori at end of life

Dr Tess Moeke-Maxwell - Research Fellow in the School of Nursing, University of Auckland, and she is a founding member of the Te Ārai Palliative Care and End of Life Research Group.

Watch the Palliative Care Lecture Series wherever you are, you'll be able to access all you need for the lecture via a private webpage.

Watch previous lectures from here - wherever you are,

Monthly Brain Teaser:

A monkey, a squirrel and a bird are racing to the top of a coconut tree. Who will get the banana first??

Last month: Congratulations to Sandra Heal at Kohatu RH who was first with the correct answer - his name was "Andrew"