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WRHA Palliative Care Program

Delirium Assessment and Management Strategy

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Purpose

This document is a collection of evidence-based information and resources on delirium in the adult palliative care patient population.

Building on the work of established Winnipeg Regional Health Authority (WRHA) delirium initiatives, this document seeks to address the specific needs of the palliative care patient population; providing a supportive and informative document to health care providers involved in care that outlines;

- Fundamental delirium information
- Resources to support delirium assessment and management
- Information and resources to support the care of a patient experiencing delirium and their family

The term "patient" refers to an individual experiencing delirium and "family" refers to family, friends, substitute decision maker etc. in a supportive role to the "patient."

Background

Delirium is an acute change in cognitive function characterized by fluctuating confusion, impaired concentration and inattention. It is a common complication for those with advanced disease (Breitbart & Alici, 2008; Watt et al., 2019) and although variable, it can occur frequently, in up to 88% of individuals towards the end of life (Breitbart & Alici, 2008; Finucane, et al., 2017; Watt et al., 2019). Despite this, it is often underdiagnosed in the palliative care patient population (Bush, Tierney, & Lawlor, 2017; Hui, et al., 2014; Senel et al., 2017).

The causes of delirium can be attributed to reversible and non-reversible causes (Hosker & Bennett, 2016). The underlying etiology of delirium is multifactorial, complex and at this time not well understood (Moyer, 2011). **Delirium requires immediate clinical attention**. Therefore, understanding risk factors, implementing preventive and supportive strategies, and recognizing and managing the symptoms in a timely and effective way are important.

Definitions

Criteria for delirium according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V*) includes;

- Disturbance in attention (i.e. reduced ability to direct, focus, sustain, and shift attention) and awareness
- Change in cognition (i.e. memory deficit, disorientation, language disturbance, perceptual disturbance) that is not better accounted for by a preexisting, established, or evolving dementia
- The disturbance develops over a short period (usually hours to days) and tends to fluctuate during the course of the day
- There is evidence (history, physical examination, laboratory findings) that the disturbance is caused by a direct physiologic consequence of a general medical condition, an intoxicating substance, medication use, or more than one cause

Delirium includes sudden onset of (Grassie et al, 2015; Hosker & Bennett, 2016);

- Disorientation
- Memory Impairment
- Agitation/Nighttime restlessness
- Hallucinations
- Alterations in level of consciousness
- Reduced awareness of the environment
- Sleep-wake cycle disruption
- Fluctuating attention/inability to focus

Note: Delirium is different from dementia and depression, although symptoms may sometimes resemble each other (Downing, Caprio & Lyness, 2013) (see Appendix A)

Delirium Subtypes (Close & Long, 2012)**;**

Hyperactive Delirium: increased psychomotor activity characterized by:

- An agitated state
- Wandering
- Combative or uncooperative
- Loud, fast speech
- Verbal behaviours (i.e. shouting, calling out, swearing)

Hypoactive Delirium: decreased psychomotor activity characterized by:

- Quietly confused
- Some anxiety
- Lethargic, withdrawn and less alert
- Slow, limited speech
- Less frequently recognized as it's often dismissed as a transient and insignificant change because of the absence of disruptive, injurious behaviours

Mixed Delirium: unpredictable fluctuations between hypoactive and hyperactive delirium.

Risk Factors and Prevention

Risk Factors

The palliative care patient population has unique risk factors that contribute to the likelihood of developing delirium (Bush et al, 2018; Senel et al., 2017). Health care providers assessing for delirium is important (Leonard et al., 2014, Hey et al., 2013, Watt et al., 2019). When evaluating risk factors, consider both predisposing and precipitating influences. Predisposing risk factors will be present within the patient before onset of delirium whereas the presence of precipitating risk factors will correlate with the start/onset of a delirium (Bush et al, 2018; McMaster University, 2014).

Table 1: Predisposing and Precipitating Risk Factors

Predisposing	Precipitating
Advanced age	Infections
Altered mentation / cognition	Physical restraints
Male gender	Electrolyte / metabolic imbalance
Impaired / altered sensory function	Hematological sources
Brain pathology, brain cancer / metastasis	Pain
Comorbidities	Altered elimination status (i.e. constipation, urinary retention)
Heavy alcohol intake	Medications, Polypharmacy Drug withdrawal states
Advanced clinical illness	Sleep disturbances
Use of many medications	Hypoxia
Immobilization / declining functional status	Organ failure
	Dehydration, Malnutrition

Source: Bush et al, 2018; Close, 2012, Grassie et al, 2015, Hosker and Bennett, 2016, Moyer, 2011, McMaster University, 2014, Senel et al., 2017

Prevention

Research pertaining to prevention of delirium is an evolving field. Although delirium may not be preventable or even reversible in many cases, there is some emerging evidence to suggest a preventative approach can reduce the occurrence of delirium. Since the cause of a delirium is often multi-factorial, strategies for prevention must also be multi-faceted and target more than one potential risk factor. These strategies are often simple and straight forward interventions, similar to non-pharmacological delirium management approaches (See Table 2). Efforts should be made towards prevention of delirium where possible (McMaster University, 2014).

Assessment

The literature suggests delirium is underdiagnosed in the palliative care patient population (Hey et al., 2013; Moyer, 2011). The use of a single screening question directed towards a patient's family, "do you think [name of patient] is more confused lately?" can be useful when querying about delirium (Sands et al., 2010). Family members often pick up on subtle cognitive changes with the patient early, often providing early indication of mental compromise. Although such a screening question is not sensitive enough to definitively confirm or rule out a delirium, it may help detect

subtle cognition change early and is a useful starting point for delirium assessment (Wilber & Ondrejka, 2016).

There are several evidence-based tools with high sensitivity and specificity for delirium assessment. The *Confusion Assessment Method* (CAM) is a well-known delirium screening tool that is widely used and scientifically validated in the palliative care patient population (Bush et al, 2018; Leonard et al., 2014) (see Appendix B).

It is recommended that the CAM assessment be done;

- During admission visit (in the home)
- Upon transfer from community, to a palliative care unit or hospice (IPASSTHEBATON)

Reassessment of CAM should occur as follows;

- With any noted cognitive changes
- As needed based on palliative care nurse or team member assessment

If CAM is positive, proceed with Palliative Care Interventions and Strategies for Care as appropriate

If CAM is negative, continue to monitor, following reassessment guidelines

Palliative Care Interventions and Strategies for Care

Delirium can be attributed to reversible or non-reversible causes. In palliative care when delirium is present, consideration should be given as to whether further investigation and treatment of underlying causes will occur. This is influenced by multiple factors and must be carefully evaluated by the health care team within the context of each patient's circumstances (Hosker & Bennett, 2016).

Note: Delirium in the final hours/days of life (terminal delirium) is considered non-reversible and continues until death (Hui et al., 2014).

Clinical Considerations (Bush et al., 2017; Hosker & Bennett, 2016);

- Patient and family goals of care
- Patient's clinical status, context of and progression of illness
- Speculated underlying cause of delirium
- Current location of care and access to services/resources for investigation
- Clarifying substitute decision maker and their potential role

Approach to care and interventions are often multi-focal which may include;

1) Reduction of modifiable risk factors
2) Investigation and treatment of underlying reversible causes
3) Implementation of non-pharmacological measures to maintain a safe environment that mitigates the effects of delirium and reduces potential harm to the patient and others
4) Education and support of family and the health care team
5) Implementation of pharmacological measures to reduce the effects of delirium

1. Modifiable Risk Factors

An approach to delirium in palliative care may involve addressing a predisposing or precipitating risk factor (see Table 1). If certain risk factors have been identified, intervention may be considered

2. Investigation and Treatment

The sources of a delirium can be broad. Here is an acronym for consideration when identifying potential underlying causes of delirium (Grassie et al, 2015):

'**DELIRIUM**'

D - Drugs
E - Electrolyte disturbances
L - Lack of drugs (ex: withdrawals, uncontrolled pain)
I - Infection (ex: UTI, pneumonia)
R - Reduced sensory input (ex: visual, hearing)
I - Intracranial (ex: CVA, metastasis)
U - Urinary/fecal retention
M - Myocardial/pulmonary causes

Potential investigations for contributors may include;

- Medication review
- Vital signs
- Oxygen saturation
- Urine analysis
- Chest x-ray
- ECG
- Recent blood work including blood glucose
- Recent diagnostic imaging (to compare with baseline if available)

Individual medications or medications in combination may cause or contribute to delirium. Consider contacting a pharmacist as part of a medication review to investigate medications and/or geriatric psychiatry for additional input as medications and/or doses may need to be adjusted. Numerous medications are associated with delirium and the list below identifies several categories of drugs that are known contributors (LeGrand, 2012 and Senel et al., 2017)

- Anticholinergics
- Benzodiazepines
- Steroids
- Opioids
- Antidepressants
- Antibiotics

3. Non-Pharmacological Measures

Non-pharmacological care strategies are essential and support a safer care environment. A fundamental part of the non-pharmacological approach is incorporating the personhood (belief, hobbies, interests, etc.) of the patient into care, for a whole person approach. Such information can be elicited through ongoing conversations with patients and families and with the help of tools such as the '*Get to Know Me*" instrument (see Appendix C). Non-pharmacological interventions for delirium are broad in nature and tend to focus on environmental, physical activity, sleep, communication, sensory function support, and safety factors.

Table 2: Non-Pharmacological Measures to Prevent and / or Minimize Delirium

Environmental	• Provide orientation items (i.e. clock, calendar) • Minimize noise • Maintain consistent staff • Provide food / fluids for pleasure • Encourage the presence of familiar people (family, friends) and objects (i.e. family photographs) • Structure daily routine with mobility as tolerated • Allow television or play soothing music that appeals to patient • Encourage cognitively stimulated activities previously enjoyed by the person (i.e. reading, puzzles, crosswords) • Tactile stimulation • Modify low non-glare lighting to promote clear visibility
Physical Activity	• Limit physical restraints or invasive equipment (i.e. IV, indwelling Catheter) • Maintain physical activity during the day
Sleep	• Reduce noise, lights and other distractions at night • Facilitate sleep hygiene measures (offer blankets, warm drink, at bedtime) • Limit caffeine after noon

Table 2: Non-Pharmacological Measures to Prevent and / or Minimize Delirium (Continued)

Communication	• Face the patient when speaking using patient's name and identify yourself with each contact • Speak calmly and indicate your purpose for the interaction • Acknowledge and validate patient's fears, emotions and provide reassurance • Do not argue with the patient, instead acknowledge you have heard what the patient is saying to you • Elicit family input regarding patient's interests / hobbies • Encourage regular visits by family and reminiscing
Sensory Function Support	• Ensure glasses and hearing aids are used and working properly • Keep lights on during the day with blinds open
Safety	• Use safety devices (i.e. bed / chair alarm) when possible • Encourage patient to be in close vicinity to caregivers • Minimize the risk for falls • Ensure the environment has limited hazards (mattress low to floor, remove clutter or sharp objects) • Ensure proper footwear with non-skid soles and walking aides • If exhibiting any physically combative behaviours, keep your hands in sight and avoid threatening gestures or movements.

Source: Angel, Brooks & Fourie, 2016; Breitbart & Alici, 2008; Close & Long, 2012; Vancouver Island Health 2006, Wilber & Ondrejka, 2016.

4. Family Education and Support

Delirium in the palliative care patient population is a significant concern for patients, families and health care providers. Providing education and support should be considered early on when a delirium is suspected. As delirium is prevalent in the palliative care patient population, discussing the possibility of delirium may also be done preemptively.

Delirium can contribute to experiences of distress and fear for the patient, cause strain in patient relationships with family and create challenges in clinical care interactions between patients and health care providers (Wright, Brajtman, and Macdonald, 2014).

A patient with delirium has difficulty sorting out the environment around them and may say or do things that are not within their normal behaviours. The patient's ability to manage their own emotions like anxiety and fear may be impaired and they may exhibit paranoid behaviour or say inappropriate or hurtful comments. Family members should be counselled that a patient who is delirious cannot control what they are saying and their thoughts are not always rational. In a fully alert state, they would likely not think or say the same things (Harlos, 2017).

With patients and families, it is important to address the potential emotions (shame, embarrassment, distress etc.) that may accompany such an experience and discuss the impacts this may have on them. Similarly, health care providers should also bear these points in mind when providing care for a patient with delirium.

When a patient has delirium regardless of whether the presentation is hyperactive or hypoactive, family often experience high levels of distress (Breitbart, Gibson, Tremblay, 2002; Bruera et al., 2009; Morita et al., 2007). Families need both education and support to manage their distress and to continue to participate in the patients care (see Appendix D). Considerations can include;

- Educating families about delirium, the high prevalence for the palliative care patient population, and signs and symptoms
- Enquire on a regular basis if family have noted changes in cognition or behaviour
- Facilitate opportunities for families to talk about delirium, its impact and their emotions
- Discuss with family's ways to ensure personhood and dignity are maintained
- Provide families with resources and tools to help support and provide guidance
- Being present for the patient and family

5. Pharmacological Management

The pharmacological interventions to mitigate the distressing symptoms of delirium will vary depending on the patient scenario. It is essential to review side effects of potential medications, especially if sedation is expected (Bush et al, 2018). The following medication categories are commonly used if pharmacological management of delirium is required (Bush et al, 2018; Finucane, Jones, Leurent, Sampson, Stone, Tookman, & Candy, 2020; Grassi et al., 2015).

- Antipsychotic drug class: (typically first choice)
  - First generation/Typical antipsychotics (i.e.: haldoperidol, methotrimeprazine)
  - Second generation/Atypical antipsychotic (i.e.: olanzapine, quetiapine)
- Benzodiazepine drug class (i.e. lorazepam)
  - Benzodiazepines may worsen a delirium (paradoxical agitation) and should only be considered in specific clinical contexts such as alcohol withdrawal and Parkinson's disease, or where there are limited alternate medication choices and the goals of care include sedation (Bush, Tierney, Lawlor, 2017; Grassie et al., 2015).

Pharmacological Management (De-prescribing)
If the addition or escalation of such medications remains ineffective in managing a delirium (symptoms get worse), consider the need to step back or reevaluate the pharmacologic approach (Bush et al., 2018).

Refractory Delirium Considerations

Sedation for Palliative Purposes (SPP) is the planned and proportionate use of sedation to reduce consciousness in an imminently dying patient with the goal to relieve suffering that is intolerable to the patient and refractory to other interventions (interventions must be acceptable to the patient).

SPP should only be considered when it is expected that, in the best judgment of the involved health care team; the patient will die from an underlying condition within two weeks (WRHA Sedation for Palliative Purposes Guideline).

Sedation may be appropriate for patients with advanced disease at the end of life when the (Bush et al, 2018; Hosker & Bennett, 2016);

- Cause of delirium is judged to be irreversible
- Manifestations of delirium, such as frightening cognitions and hallucinations, overwhelm the patient, or the
- Patient's behaviour is a threat to him/herself or others.

See WRHA Guideline: Sedation for Palliative Purposes
https://professionals.wrha.mb.ca/old/extranet/eipt/files/EIPT-045.pdf

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Appendix A: Differentiating Delirium, Dementia, and Depression

Feature	Delirium / Acute Confusion	Dementia	Depression
Onset	Acute / Sub Acute; develops suddenly over hours or days	Chronic; insidious	Variable; May appear abrupt
Course	Short, fluctuating often worse at night	Long, progressive, yet stable loss over time	Diurnal effects; typically worse in the morning
Progression	Abrupt	Slow, but even decline	Variable; rapid - slow
Duration	Hours to one month; may last longer in seniors	Months to years	At least two weeks; can be months to years
Awareness	Reduced	Clear	Clear
Alertness	Fluctuates; lethargic or hyper-vigilant	Generally normal	Normal
Attention	Impaired; fluctuates, unfocused, distracted	Generally normal; varies with extent of disease	Minimal impairment, but distractible
Orientation	Impaired; fluctuates in severity	Increased impairment over time	Selective intact "I don't know"
Memory	Recent and immediate memory impaired	Recent and remote memory impaired	Selective or patchy Memory impairment "islands" of intact memory
Thinking	Disorganized, distorted, fragmented, rambling; may have frank psychotic symptoms	Difficulty with abstraction, judgments poor	Intact, but with themes of hopelessness, helplessness or self-deprecation
Delusions	Common	Sometimes	Rare
Perception / Hallucination	Distorted; visual tactile, olfactory hallucinations occur in 40% of cases	Uncommon	Rare; hallucinations Absent, except in severe cases (psychosis)

Source: WRHA Occupational Therapy Cognition Toolkit FAQs, 2012

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Appendix A: Confusion Assessment Method (CAM)

PART I: Confusion Assessment Method (CAM) – Delirium Screening

• Conduct delirium screening by assessing for the presence or absence of each listed feature • Delirium is present if <u>both</u> A and B and either C or D features are noted (i.e. CAM Positive) • If this sequence is not present, delirium screening is negative (i.e. CAM Negative)			**Check ✓ If Yes**
A	Acute Onset & Fluctuating Course	• Is there evidence of acute change in mental status from baseline? • Does the behaviour fluctuate during the day? • Does the behaviour tend to come and go or increase and decrease in severity?	☐
B	Evidence of Inattention	• Is there evidence of difficulty focusing attention? For example: ○ Being easily distracted ○ Difficulty keeping track of what was being said	☐
C	Disorganized Thinking	• Was the patient's thinking disorganized or incoherent? • Any presence of rambling, or irrelevant conversation? • Unclear or illogical flow of ideas? • Unpredictable switching from subject to subject?	☐
D	Altered Level of Consciousness	• Any state other than alert? Alterations may include: ○ Vigilant / hyper alert ○ Lethargic (drowsy but easily roused) ○ Stupor (difficult to rouse) ○ Comatose (unarousable)	☐

PART II: Palliative Care Interventions and Strategies for Care

CAM: ☐ Positive

1. Review / liaise with palliative team members to determine an approach to care incorporating:

• Clinical Considerations:	• Care / Intervention Considerations
❖ Patient / family goals of care ❖ Patient's clinical status, context of and progression of illness ❖ Speculated underlying cause of delirium ❖ Current location of care and access to services / resources for investigation ❖ Clarifying substitute decision maker and their potential role	❖ Reduced modifiable risk factors ❖ Investigate and / or treat underlying reversible causes ❖ Implement non-pharmacological measures ❖ Educate and support patient, family and health care team ❖ Implement pharmacological measures if needed

2. Provide and review a copy of the handout "*Information on Delirium for Patients and Families*"

CAM: ☐ Negative

1. Continue to monitor – provide reassessment as follows:

• With any noted cognitive changes	• As needed per nurse / team member assessment

Name:	**Date (DD/MM/YY):**	

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Winnipeg, Manitoba
R2H 2A6 Canada

Programme de soins palliatifs
409 avenue Taché, A8024
Winnipeg (Manitoba)
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Appendix C: Get to Know Me Exemplar

Get to Know Me …

NAME: _____
I like to be called: _____

Occupation: _____

FAVORITES:

MOVIE: _____
TV SHOW: _____
BOOK: _____
MUSIC: _____
SPORT: _____
COLOR: _____
FOODS: _____
PETS: _____
QUOTE/SAYING: _____

Place Photos Here:

ACTIVITIES/HOBBIES: _____

ACHIEVEMENTS OF WHICH I AM PROUD: _____

THINGS THAT STRESS ME OUT: _____

THINGS THAT CHEER ME UP: _____

OTHER THINGS I'D LIKE YOU TO KNOW ABOUT ME: _____

AT HOME I USE: ☐ Glasses ☐ Hearing Aid ☐ Contact Lenses
☐ Dentures ☐ Other _____

Source: Institute for Healthcare Improvement
http://www.ihi.org/resources/Pages/Tools/GetToKnowMePatientInfoForm.aspx

Appendix D: Patient and Family Education Material (English)

Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

WRHA Palliative Care Program
Information on Delirium for Patients and Families

Delirium is a sign that the brain is not working normally. It is an acute change in mental thinking and function noted by fluctuating confusion, impaired concentration, and inattention. Many things can cause delirium such as changes in one's health, environment, or medications. It can occur quickly, over hours or a few days. Many patients in palliative care will experience delirium at some point in their illness.

Someone with delirium may:

- Be mixed up about where they are, what day or time it is
- Say or do unusual things
- See or hear things that are not there (hallucinations)
- Be restless, agitated or more sleepy than usual
- Be confused, frustrated or unable to concentrate well

Impacts of delirium can range from minor to significant. Simple strategies can be used to support and comfort someone experiencing delirium, including:

- Familiarizing the environment (family photos, favorite items/clothing, familiar people and care providers)
- Ensuring glasses and hearing aids are used
- Speaking calmy and providing reassurance when needed
- Reducing noise and other distractions at night
- Reminding them of their location, the date, time etc. when needed

The cause of delirium is not always known and in many cases, the condition may not be reversible. Medications are sometimes used to help address the symptoms of delirium. For those supporting or caring for someone receiving palliative care, if there are changes in your loved one's behavior or concerns about delirium, speak to their Palliative Care nurse or coordinator, or call the after-hours team at (204)237-2015 for assistance.

WRHA Palliative Care Program – Spring 2021

Appendix D: Patient and Family Education Material (French)

Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

Programme de soins palliatifs de l'ORSW
Renseignements à l'intention des patients et de leur famille à propos du délire

Le délire est un signe que le cerveau ne fonctionne pas normalement. Il s'agit d'une modification aiguë de la fonction mentale et de la pensée qui se manifeste par une confusion changeante, des difficultés de concentration et de l'inattention. Les causes possibles du délire sont nombreuses, comme une modification de l'état de santé, certaines conditions du milieu ou des médicaments. Le délire peut survenir rapidement, en quelques heures ou quelques jours. Bon nombre de patients en soins palliatifs souffriront d'un délire à un stade ou un autre de leur maladie.

Dans un tel cas, ces patients peuvent manifester ce qui suit :

- Ne plus se rappeler de l'endroit où ils se trouvent ou du moment de la journée, ni même de la date du jour.
- Dire ou faire des choses inhabituelles.
- Voir ou entendre des choses qui ne sont pas là (hallucinations).
- Devenir agités ou manifester une instabilité psychomotrice, ou être plus somnolents que d'habitude.
- Être confus, frustrés ou incapable de se concentrer convenablement.

Les conséquences du délire peuvent varier, de mineures à grave. Des stratégies simples permettent d'aider et de réconforter une personne en délire, par exemple ce qui suit :

- Créer un milieu de vie familier au moyen de photos de famille, d'objets significatifs, de vêtements préférés, de personnes et prestataires de soins bien connus de la personne délirante.
- Veiller à ce que la personne porte ses lunettes et ses prothèses auditives.
- Lui parler calmement et la rassurer au besoin.
- Réduire le bruit et autres distractions possibles la nuit.
- Lui rappeler où elle se trouve, la date, l'heure, etc. au besoin.

On ne trouve pas toujours la cause du délire et, dans bien des cas, il arrive qu'il soit irréversible. On administre parfois des médicaments pour soulager les symptômes du délire. Les personnes qui s'occupent d'un ou une malade en soins palliatifs doivent s'adresser à l'infirmière ou au coordonnateur des soins palliatifs si elles remarquent des changements dans le comportement de leur être cher ou se demandent s'il ne souffrirait pas d'un délire. Elles peuvent aussi composer le 204 237-2015 pour obtenir de l'aide en dehors des heures d'ouverture.

Programme de soins palliatifs – Printemps 2021

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Appendix E: Roadmap for Delirium Assessment and Management

Characteristics - Observe for sudden onset of:

- Disorientation
- Memory Impairment
- Agitation/Nighttime restlessness
- Hallucinations
- Alterations in level of consciousness
- Reduced awareness of the environment
- Sleep-wake cycle disruption
- Fluctuating attention/inability to focus

Screen for Delirium using CAM;

- On admission visit (in the home)
- Upon transfer from community, to a palliative care unit or hospice (IPASSTHEBATON)
- With any noted cognitive changes, or as needed based on provider assessment

Palliative Care Interventions and Strategies for Care

Clinical Considerations:

- Patient/family goals of care
- Patient's clinical status, context of & progression of illness
- Speculated underlying cause of delirium
- Current location of care & access to services/resources for investigation
- Clarifying substitute decision maker and their potential role

Approach to Care and Interventions:

- Reduce modifiable risk factors
- Investigate/treat underlying reversible causes
- Implement non-pharmacological measures
- Educate & support the patient/ family / health care team
- Implement pharmacological measures if needed

Non-Pharmacological Measures

- **Environmental -**provide orientation items; limit noise; presence of familiar people/staff; structure daily routine, include cognitively stimulated activities; music
- **Physical Activity** -limit physical restraints/invasive equipment, maintain physical activity
- **Sleep** -reduce noise, lights; provide sleep hygiene
- **Communication -**speak calmly; address patient by name; do not argue with patient; acknowledge/ validate fears and emotions; involve family
- **Sensory Function Support –** ensure glasses/ hearing aids are used if needed
- **Safety –**limit environmental hazards; use proper footwear, walking aids & safety devices

Family Education & Support

- Educate family about delirium (prevalence, signs & symptoms) & provide resources
- Enquire regularly if family have noted changes in cognition or behavior
- Be present and allow family to talk about delirium, its impact and their emotions
- Discuss ways to ensure personhood & dignity are maintained

Pharmacology Management (including de-prescribe as appropriate)

- Drug categories to consider: antipsychotics & benzodiazepines (in specific situations)