Is it Dementia or Delirium?
Recognizing and Treating Delirium

Aida Wen, MD
Associate Professor
Department of Geriatric Medicine

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Mrs. CF

- Mrs. CF is an 89 year old lady of Samoan descent with a past medical history of mild dementia, ESRD recently placed on hemodialysis 2 months ago. She also has DM Type 2, HTN and hyperlipidemia. She lives with her daughter Tiare who is her primary caregiver. Her other daughter, Maria comes around 2 times a week and offers some limited support. They come to your office today to transfer care and seek help regarding behavioral problems.

- At baseline, patient is usually calm, able to recognize her family members and answer questions in short sentences. Around a month and a half ago, patient started having distressing night time behavioral issues around 3 times a week. She would believe she was up in a tree and be afraid to fall off. She would scream and cry for help, shouting “I’m falling! I’m falling” despite repeated reassurance that she was safe. She would call out for her daughters but would not recognize them. She would try to hit them and accuse them of being impostors when they would tell her who they were. This would go on all night until patient fell asleep at around midnight. By the next morning, she would be a bit better. By the next evening, she would be back to baseline.
Mrs. CF

Mrs. CF becomes so agitated during her episodes that she once fell off her chair. They took her to the ER at that time, but no acute issues were found and they were sent back home. Maria has moved in temporarily due to these behavioral issues. They are at their wits end on what to do and are having trouble coping.

On further questioning, it appears that the behaviors follow a pattern. They would occur on the evenings after each hemodialysis every Monday, Wednesday and Friday. Her daughters do not accompany her to dialysis, the transport company picks the patient up and escorts her back home.
WHAT CAUSES ALTERED MENTAL STATUS?

DEMENTIA

- cognitive decline due to brain disease.

DEPRESSION

- change in mood with feelings of worthlessness.

DELIRIUM

- acute change in mental status
DEMENTIA

DEPRESSION

DELIRIUM

**COMMON PRESENTING SIGNS**
- Impaired cognition
- Impaired function
- Anorexia/Wt loss
- Apathy/ Withdrawal
- Sleep-wake cycle disturbed
DEMENTIA is...

DEMENTIA = cognitive decline due to brain disease

- **60-80% Alzheimer's Disease**
  - Early onset
  - Late onset

- **Lewy Body Dementia**

- **Vascular Dementia**
  (includes WML)

- **Fronto-Temporal Lobe Dementias**

- **Other Dementias**
  - Metabolic
  - Drugs/toxic
  - Tumors
  - Depression
  - Infections
  - Parkinson's

Some forms are reversible
DEMENTIA: S-L-O-W Progression

- Over MONTHS to YEARS

Caregivers might say that they’ve noticed gradual changes in the past year....
- More forgetful...
- Previously independent in all ADLs
- Dependent in Shopping, Transportation, Finances
- Cooks basic meals (less frequent, less fancy)
- Complains of fatigue, naps a lot, only watches TV, doesn't leave house anymore.
DEPRESSION is...

Essential Symptoms
1. Depressed mood
2. Anhedonia

Physical Symptoms
3. Changes in sleep
4. Change in appetite or weight
5. Fatigue
6. Change in psychomotor activity

Psychological symptoms
7. Feelings of guilt or worthlessness
8. Difficulty in thinking, concentrating, or making decisions
9. Recurrent thoughts of death and/or suicidal plans or attempts
Fluctuates
- Days and nights might be different
- More difficulty concentrating, distractable
- Variable—rapid or slow and uneven time course, history may be recurrent
- Capable of giving answers, but often says, “I don’t know”, reflecting poor effort

Caregivers might say:
- She had an episode like this 10 years ago, but this resolved with antidepressants
- She is not eating her favorite foods anymore, even though I bring them every Saturday
- She has been irritable and refused to visit with family over the holidays.
DELIRIUM is...

- Disturbance of consciousness
- Cognitive change and perceptual disturbance not better accounted for by dementia
- Rapid development and fluctuation in symptoms
- Often due to a general medical condition or substances (medications or drugs)

GET MEDICAL ATTENTION!
WHO GETS DELIRIUM?

RISK FACTORS

- OLDER
- DEMENTIA
- MANY COMPLEX MEDICAL PROBLEMS
DELIRIUM: SUDDEN Onset

- Caregivers will notice:
  - Restless at night (hyperactive)
  - Sleeping all day (hypoactive)
  - Refusing therapy
  - Resistive to personal care
  - Placed in hallway by nurses station because trying to climb out of bed
  - Pulled out catheters

- Mother confusing son for her deceased husband
- Picks in the air
- Falls asleep while others trying to talk to her
- New behavior
Delirium: Presentation may be Variable

<table>
<thead>
<tr>
<th>Disorientation</th>
<th>Sleep change</th>
<th>Speech Slow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucination</td>
<td>Delusion</td>
<td>Easily Distracted</td>
</tr>
<tr>
<td>Restless Tremor</td>
<td>Lethargic to Hyperalert</td>
<td>Apathy-Irritable</td>
</tr>
<tr>
<td>Aggressive</td>
<td>Awake, oriented</td>
<td>Passive, Mute</td>
</tr>
</tbody>
</table>

Hyperactive  Mixed  Hypoactive
CONFUSION ASSESSMENT METHOD

DSM-IV-TR criteria, although precise, are difficult to apply; therefore, Confusion Assessment Method (CAM) is preferred.

CAM-ICU is a variant of the CAM and does not require verbal responses from the patient.

<table>
<thead>
<tr>
<th>DSM IV-TR Criteria</th>
<th>Confusion Assessment Method (CAM) Diagnosis requires: #1 and #2 and either #3 or #4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disturbance of consciousness with reduced ability to</td>
<td>1. Acute change in mental status and fluctuating course:</td>
</tr>
<tr>
<td>focus, sustain, or shift attention</td>
<td>- Is there evidence of an acute change in cognition from the patient's baseline?</td>
</tr>
<tr>
<td></td>
<td>- Does the abnormal behavior fluctuate during the day (tend to come and go, or increase or decrease in severity)?</td>
</tr>
<tr>
<td>A change in cognition (memory, orientation, language,</td>
<td>2. Inattention:</td>
</tr>
<tr>
<td>etc.) or the development of a perceptual disturbance</td>
<td>- Does the patient have difficulty focusing attention?</td>
</tr>
<tr>
<td>(hallucinations, etc.) that is not better accounted for</td>
<td>- Can use one of the following tests for attention:</td>
</tr>
<tr>
<td>by a preexisting, established, or evolving dementia</td>
<td>- Digit span</td>
</tr>
<tr>
<td></td>
<td>- Days, months</td>
</tr>
<tr>
<td></td>
<td>- Continuous performance task</td>
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<tr>
<td></td>
<td>- Serial 7’s</td>
</tr>
<tr>
<td></td>
<td>- “World” backward</td>
</tr>
<tr>
<td>Disturbance develops over a short period of time</td>
<td>3. Disorganized thinking:</td>
</tr>
<tr>
<td>(hours to days) and tends to fluctuate during course of</td>
<td>- Is the patient’s thinking disorganized or incoherent (rambling or irrelevant</td>
</tr>
<tr>
<td>the day</td>
<td>- or irrelevant conversation, unclear or illogical flow of ideas, unpredictable</td>
</tr>
<tr>
<td></td>
<td>- predictive switching from subject to subject?</td>
</tr>
<tr>
<td>History, physical exam, or lab findings provide</td>
<td>4. Altered level of consciousness:</td>
</tr>
<tr>
<td>evidence that the disturbance is caused by the direct</td>
<td>- Is the patient’s mental status anything other than alert (vigilant, lethargic,</td>
</tr>
<tr>
<td>physiologic consequences of a general medical condition,</td>
<td>- stuporous, comatose)?</td>
</tr>
<tr>
<td>a drug, or both</td>
<td></td>
</tr>
</tbody>
</table>

> 90% sensitivity and specificity

AGS GEM TOOLKIT
## Prevalence: Hospital & Post-acute

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Post-acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient: 25-33% among age $&gt;70$</td>
<td>• In SNF, about 15% of new admissions have delirium</td>
</tr>
<tr>
<td>• Post cardiac or hip surgery: 50%</td>
<td>• May last even 3-6 months!</td>
</tr>
<tr>
<td>• In ICU: more than 75%</td>
<td>○ Discharge: 45%</td>
</tr>
<tr>
<td>• At end of life: up to 85%</td>
<td>○ 1 month: 33%</td>
</tr>
<tr>
<td></td>
<td>○ 3 months: 26%</td>
</tr>
<tr>
<td></td>
<td>○ 6 months: 21%</td>
</tr>
</tbody>
</table>

Delirium is NOT so transient for some individuals....
Delirium in the Community

Underlying Diagnosis for those with Delirium

- Alzheimer’s: 43%
- VaD: 18%
- LBD: 39%

1-2% in Community?
Usually s/p Hospitalization

BUT, likely UNDER-RECOGNIZED

Based on referrals to memory clinics: Among the 206 patients for dementia evaluation, delirium criteria met in 40 (19.4%). – Hagesawa, 2014

MEDICAL CAUSES

- Drugs
- Alcohol (withdrawal)
- Labs (EX: low sodium, kidney failure)
- Infections
- Stroke
- Severe Constipation, Urinary retention
- Heart Attack
- Low Oxygen
- Severe Pain
Top 3 Causes of Outpatient Delirium

- Among 44 cases referred to a outpatient psychiatry clinic, who met criteria for delirium:
  - Drug related (68%)
  - Infectious (61%)
  - Metabolic-endocrine (50%) disturbances

## Causes of Delirium

<table>
<thead>
<tr>
<th>D</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Electrolyte-metabolic/ Endocrine</td>
</tr>
<tr>
<td>L</td>
<td>Lack of Drugs (withdrawal)</td>
</tr>
<tr>
<td>I</td>
<td>Infection</td>
</tr>
<tr>
<td>R</td>
<td>Retention</td>
</tr>
<tr>
<td>I</td>
<td>Ictal, Intracranial</td>
</tr>
<tr>
<td>U</td>
<td>Undernutrition/ Underhydration</td>
</tr>
<tr>
<td>M</td>
<td>Myocardial/Pulmonary</td>
</tr>
<tr>
<td>S</td>
<td>Subdural, Surgery</td>
</tr>
</tbody>
</table>
### DRUGS: Anticholinergic medications

1. **Benztropine and related medications (Cogentin)**
2. **First generation antihistamines (diphenhydramine)**
3. **Oxybutynin**
4. **H2 blockers**

5. **Low potency antipsychotics**
6. **Paroxetine**
7. **Tricyclic antidepressants**
<table>
<thead>
<tr>
<th>DRUGS: Other Classes</th>
</tr>
</thead>
</table>
| **Opioids**  
  - meperidine |
| **Antibiotics**  
  - ciprofloxacin, quinolones  
  - cefepime |
| **Anticonvulsants**  
  - benzodiazepines, phenytoin,  
  - Carbamazepine |
| **Muscle Relaxants**  
  - Cyclobenzaprine |
| **Lithium** |
| **Hypoglycemics** |
| **Corticosteroids** |
| **NSAIDs** |
| **Antiparkinsonian meds**  
  - Dopaminergic drugs |
| **Cardiac meds**  
  - clonidine,  
  - calcium channel blockers |
| **Herbal preparations** |
| **Antidepressants**  
  - SSRI / TCA |
INFECTION

- Urinary tract infection
- Pneumonia
- Sepsis
- Delirium may be the first sign of infection in an elderly patient
METABOLIC

- Metabolic
  - Anemia
  - Dehydration
  - Chemistries
  - Glucose
  - Hypercalcemia
  - Thyroid
FAILURE TO DIAGNOSE AND TREAT DELIRIUM IS:

- COSTLY
- LIFE-THREATENING
- LEADS TO COMPLICATIONS
- LOSS OF FUNCTION
- LOSS OF INDEPENDENCE
## AGS GEM TOOLKIT

### MANAGEMENT STRATEGIES

<table>
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<tr>
<th>STEP</th>
<th>KEY ISSUES</th>
<th>PROPOSED TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify and treat reversible contributors</td>
<td>Medications</td>
<td>Reduce or eliminate offending medications, or substitute less psychoactive medications</td>
</tr>
<tr>
<td></td>
<td>Infections</td>
<td>Treat common infections: urinary, respiratory, soft tissue</td>
</tr>
<tr>
<td></td>
<td>Fluid balance disorders</td>
<td>Assess and treat dehydration, heart failure, electrolyte disorders</td>
</tr>
<tr>
<td></td>
<td>Impaired central nervous system oxygenation</td>
<td>Treat severe anemia (transfusion), hypoxia, hypotension</td>
</tr>
<tr>
<td></td>
<td>Severe pain</td>
<td>Assess and treat; use local measures and scheduled pain regimens that minimize opioids; avoid meperidine</td>
</tr>
<tr>
<td></td>
<td>Sensory deprivation</td>
<td>Use eyeglasses, hearing aid, portable amplifier; clear cerumen</td>
</tr>
<tr>
<td></td>
<td>Elimination problems</td>
<td>Assess and treat urinary retention and fecal impaction</td>
</tr>
<tr>
<td>2. Maintain behavioral control</td>
<td>Behavioral interventions</td>
<td>Teach hospital staff appropriate interaction with delirious patients; encourage family visitations</td>
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<td>If necessary (see Pharmacologic Therapy of Agitated Delirium)</td>
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<td>3. Anticipate and prevent or manage complications</td>
<td>Urinary incontinence</td>
<td>Implement scheduled toileting program</td>
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<td>Immobility and falls</td>
<td>Avoid physical restraints; mobilize with assistance; use physical therapy</td>
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<td>Mobilize; reposition immobilized patient frequently and monitor pressure points</td>
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<td>Feeding disorders</td>
<td>Assist with feeding; use aspiration precautions; provide nutritional supplementation as necessary</td>
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<tr>
<td>4. Restore function in delirious patients</td>
<td>Hospital environment</td>
<td>Reduce clutter and noise (especially at night); provide adequate lighting; have familiar objects brought from home</td>
</tr>
<tr>
<td></td>
<td>Cognitive reconditioning</td>
<td>Have staff reorient patient to time, place, person at least three times daily</td>
</tr>
<tr>
<td></td>
<td>Ability to perform ADLs</td>
<td>As delirium clears, match performance to ability</td>
</tr>
<tr>
<td></td>
<td>Family education/support/participation</td>
<td>Provide education about delirium, its causes and reversibility, how to interact, and family’s role in restoring function</td>
</tr>
<tr>
<td></td>
<td>Discharge</td>
<td>Because delirium can persist, provide for increased ADL support; follow mental status changes as &quot;barometer&quot; of recovery</td>
</tr>
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BEHAVIORAL MANAGEMENT

2. Maintain behavioral control

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- Repetitive Actions
- Aggressive
- Accusing others of cheating
- Irritable
- Restless
- Abusive
- Wanting to go home
- Repetitive calling out

Behavior = Communication of unmet needs
- (can’t find words, decreased understanding and decreased coping capacity)
BEHAVIORAL MANAGEMENT: NON-PHARMACOLOGIC

- **TADA! = Tolerate, Anticipate, Don’t Agitate!**
- **Body Language**
  - Approach from the front, Speak slowly and calmly, Acknowledge and nod your head (shows you are listening), Show affection
- **Anticipate & Address Basic Needs:**
  - Physical - hungry, thirsty, cold, hot, tired
  - Psychologic - fear, anxiety, depression
  - Environment - over-stimulation or under-stimulation
- **Approach (verbal)**
  - Don’t argue - logic and normal reasoning doesn’t work.
  - “Listen” to their feelings and address those. Respect, Reassure and Redirect
- **Consider activities:** Music Therapy, Gentle Sensory Stimulation
# Behavioral Management: Pharmacologic

<table>
<thead>
<tr>
<th>Agent</th>
<th>Mechanism of Action</th>
<th>Dosage</th>
<th>Benefits</th>
<th>Adverse Events</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Haloperidol</td>
<td>Antipsyhcotic</td>
<td>0.25–1 mg po or IM q4h prn agitation</td>
<td>Relatively nonsedating; few hemodynamic effects</td>
<td>EPS, especially if &gt;3 mg/d</td>
<td>Usually agent of choice(^a)</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Antipsyhcotic</td>
<td>2.5–5 mg po or IM q24h, max dosage 20 mg q24h (cannot be given by IV infusion)</td>
<td>Fewer EPS than haloperidol</td>
<td>More sedating than haloperidol</td>
<td>Small case series only(^b); oral formulations less effective for acute management</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Antipsyhcotic</td>
<td>25–50 mg po q12h</td>
<td>Fewer EPS than haloperidol</td>
<td>More sedating than haloperidol; hypotension</td>
<td>Small case series(^b)</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Antipsyhcotic</td>
<td>0.25–1 mg po or IV q4h prn agitation</td>
<td>Similar to haloperidol</td>
<td>Might have slightly fewer EPS</td>
<td>Case series only(^b)</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Sedative</td>
<td>0.25–1 mg po or IV q8h prn agitation</td>
<td>Use in sedative and alcohol withdrawal, and history of neuroleptic malignant syndrome</td>
<td>More paradoxic excitation, respiratory depression than haloperidol</td>
<td>Second-line agent, except in specific cases noted</td>
</tr>
</tbody>
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ANTICIPATE & PREVENT COMPLICATIONS

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- Let the family/caregivers know that they should provide:
  - 24/7 supervision
  - Regular toileting
  - Frequent repositioning
  - Feeding Assistance
- And that this may needed for months....
PREVENT FUNCTIONAL DECLINE

- Family/Caregivers must help reinforce and restore function (beyond PT/OT)
  - Provide frequent orientation/cues/ glasses and hearing aides
  - Early mobilization
  - Adequate socialization
- ADL support required for the long haul....
### Summary

- Recognition of Delirium is Critical
- Delirium is common, associated with poor outcomes, and often under-recognized
- A Doctor must evaluate and treat the underlying cause.
- Anticipate and Prevent Complications
- Prevent functional decline
- Nonpharmacologic support is preferred
- Neuroleptics are preferred if needed
- Prevention is the best approach
- Delirium is a risk factor for Dementia—education and follow-up for at least 6 months are important
WHAT HAPPENED TO MRS. CF?
Mrs. CF

- Mrs. CF is an 89 year old lady of Samoan descent with a past medical history of mild dementia, ESRD recently placed on hemodialysis 2 months ago. She also has DM Type 2, HTN and hyperlipidemia. She lives with her daughter Tiare who is her primary caregiver. Her other daughter, Maria comes around 2 times a week and offers some limited support. They come to your office today to transfer care and to seek help regarding behavioral problems.

- At baseline, patient is usually calm, able to recognize her family members and answer questions in short sentences. Around a month and a half ago, patient started having distressing night time behavioral issues around 3 times a week. She would believe she was up in a tree and be afraid to fall off. She would scream and cry for help, shouting “I’m falling! I’m falling” despite repeated reassurance that she was safe. She would call out for her daughters but would not recognize them. She would try to hit them and accuse them of being impostors when they would tell her who they were. This would go on all night until patient fell asleep at around midnight. By the next morning, she would be a bit better. By the next evening, she would be back to baseline.
Mrs. CF becomes so agitated during her episodes that she once fell off her chair. They took her to the ER at that time, but no acute issues were found and they were sent back home. Maria has moved in temporarily due to these behavioral issues. They are at their wits end on what to do and are having trouble coping.

On further questioning, it appears that the behaviors follow a pattern. They would occur on the evenings after each hemodialysis every Monday, Wednesday and Friday. Her daughters do not accompany her to dialysis, the transport company picks the patient up and escorts her back home.
### Medications (no changes in last 5 mo)

- Insulin Glargine (Lantus) 30 units a day
- Insulin Apart (Novolog) 8 units with meals
- Furosemide (Lasix) 40 mg BID
- Donepezil (Aricept) 10 mg daily
- Sevelamer (Renvela) 400 mg TID with meals
- Atorvastatin (Lipitor) 80 mg daily
- Aspirin 81 mg daily
- Multivitamin 1 tablet daily
- Cholecalciferol (Vitamin D) 10,000 units daily

### Physical Exam

- General: Elderly lady, frail appearing, not in any apparent distress, calm and pleasant
- Vitals: BP 150/80, HR 89, RR 14, T 98.7; Current wt = 124 lbs (dry wt = 120 lbs)
- **Positive for orthostasis.**
- ENT: No apparent abnormalities
- Lungs: Clear to auscultation
- CVS: Regular rate and rhythm, PMI displaced inferolaterally, (+) 3/6 systolic murmur R upper sternal border
- Ext: No edema, poorly palpable pulses
- Neuro: Nonfocal.
- Cognition: Alert, oriented to person (able to recognize daughters) and loosely to place (clinic, but unable to state specifics). 3 item recall: 1 out of 3. Unable to participate in clock drawing test, stares at paper saying "I don't know what you want me to do" despite repeated simple explanations.
Mrs. CF

Labs:
- Blood sugar in clinic (non fasting): 90
- A1C: 6.8
- BMP: electrolytes normal but of course, creatinine is elevated at 5.4
- CBC: unremarkable
- Lipid panel: LDL 75
Mrs. CF

- **Delirium due to:**
  - Hypoglycemia
  - Orthostatic Hypotension

- **Interventions:**
  - Reduce Lantus dose
  - Reduce amount of fluid removed during HD
  - Increase Lasix 60-80 mg BID
Mr. TR

- Mr. TR is a 65 M, DM, Parkinson’s disease, brought into the ED by neighbors when he was found lethargic and confused. He was admitted to the hospital for cellulitis L great toe. He received IV Rocephin x 7d and has improved greatly. However, he remains confused, and has had 1:1 sitter since admission. He is unable to return home right now, and nursing facilities will not accept him.

- What do you think is going on?
- What is your plan?
Mr. TR

- What do you think is going on? **Delirium**
- What is your plan?
  - Evaluate and reduce contributory factors (e.g. meds, sensory, bowels, etc.)
  - Capacity evaluation (may need DPOA or guardian)
  - Get him off the 1:1 sitter (behavior management)
  - Long-term plan to prevent complications
  - Long term plan to restore function
Any other Questions or Cases to Discuss?

YOUR OPPORTUNITY FOR CURBSIDE CONSULTATIONS!