

# Case Study

## Acute Care for the Elderly: Assessing the Delirious Patient

This ACE (Acute Care for the Elderly) Card on delirium was developed by Dr. Michael Malone and his colleagues at Aurora Health Care in Milwaukee, WI. The series of geriatric care reminder cards will be published in *MPM* as a resource to

help clinicians manage common conditions that plague elderly patients. The complete series of cards can be ordered from Dr. Michael Malone at Michael.Malone.md@aurora.org.

*A new patient arrives in your office accompanied by family members concerned about a recent change in her condition. Mrs. Jones is an 80-year-old African-American woman who is disorientated with a poor memory. In questioning her, you find her to be inattentive and argumentative to your questions. Her family notes a change compared to her baseline. Prior to starting some new medications, she was able to take care of herself and shop independently. You are considering delirium as your assessment, so you turn to the appropriate ACE Card for assistance.* MPM

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**Identifying Delirium in Hospitalized Older Patients**

Acute Care for the Elderly (ACE) Program  
Aurora Sinai Medical Center/UW School of  
Medicine and Public Health

**Health Care Behavior: Identify the older person who develops delirium after admission to the hospital.**

**Diagnosis: Adapted from DSM-IV**

- Disturbed consciousness: i.e. decreased attention (awareness of environment)
- Cognitive change: (e.g., memory deficit, disorientation, language disturbance) or perceptual disturbance (e.g., visual illusions, hallucinations)
- Rapid onset (hours to days) and fluctuating daily course
- Evidence of a causal physical condition (i.e. some medical/physiologic problem as etiology)

**Risk Factors for Delirium:**

- Dementia
- Advanced age
- Comorbid physical conditions: especially sleep deprivation, immobility, dehydration, sensory impairment

**Consider delirium when the older patient:**

<ul style="list-style-type: none"> <li>- Receives order for restraints</li> <li>- Receives order for an "as needed" tranquilizer</li> <li>- Falls</li> <li>- Wanders/wants to leave against advise</li> <li>- Argues with staff</li> <li>- Does not sleep for several nights</li> <li>- Hallucinates; picks at things in air or pulls on tubes</li> </ul>	}	Hyperactive Delirium
<ul style="list-style-type: none"> <li>- Described as "pleasantly confused" or "cloudy"</li> <li>- Does not move out of bed/sleeps too much</li> <li>- Does not eat meals</li> <li>- Does not take medications</li> <li>- Refuses to participate with therapist</li> </ul>	}	Hypoactive Delirium

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**The Confusion Assessment Method:**  
*The diagnosis of delirium requires the presence of features 1 and 2 and either 3 or 4.*

- 1. Acute change in mental status and fluctuating course**
  - Is there evidence of an acute change in cognition from the patient's baseline?
  - Does the abnormal behavior fluctuate during the day, ie, tend to come and go, or increase and decrease in severity?
- 2. Inattention**
  - Does the patient have difficulty focusing attention, eg, being easily distractible, or having difficulty keeping track of what was being said?
- 3. Disorganized thinking**
  - Is the patient's thinking disorganized or incoherent, eg, rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
- 4. Altered level of consciousness**
  - Is the patient's mental status anything besides alert, ie, hypervigilant (hyperalert), lethargic (drowsy, but easily aroused), stuporous (difficult to arouse), or comatose (unarousable)?

(Source: Inouye SK, vanDyck CH, Alessi CA, et al. Clarifying confusion: The Confusion Assessment Method: A New Method for Detection of Delirium. *Ann Intern Med.* 1990;113:941-948.) Reprinted with permission.

**Initial Approach:**

- Assess for reversible causes (common causes – infection, electrolyte abnormality, hypoxia, fecal impaction).
- Remember: usually multiple causes contribute to baseline risk.
- Carefully review medications.
- Basic laboratory evaluation: CBC with diff, pulse ox, CXR, urinalysis, metabolic panel, ECG.

*Michael Malone, MD & Ellen Danto-Nocton, MD – 7/17/06*