

# What's New in the Patient Safety World

December 2014

## American Geriatrics Society Guideline on Postoperative Delirium in Older Adults

Of our many columns on recognition, diagnosis, prevention and management of delirium (see the full list at the end of today's column) postoperative delirium has been a major focus.

The American Geriatrics Society has just published a best practice statement for Postoperative Delirium in Older Adults ([AGS Expert Panel 2014](#)). It's a guideline that really only recommends evidence-based best practices.

The guideline notes that between 5% and 50% of older adults develop delirium after surgery and that delirium may be preventable in up to 40% of cases. Yet the topic of delirium has been under-represented in surgical teaching. So this guideline/best practice statement is of significant importance since it is published in the Journal of the American College of Surgeons.

It emphasizes that delirium is a relationship between a physiologic stressor (in this case the surgery) and predisposing risk factors. Major risk factors listed are age > 65, chronic cognitive decline or dementia, poor vision or hearing, severe illness, presence of infection, functional dependence, self-reported alcohol abuse, and specific laboratory/electrolyte abnormalities. It notes that patients having 2 or more risk factors are at greater risk and that the risk for delirium is generally greater in the emergency setting.

The guideline notes that healthcare professionals caring for postsurgical patients must be trained to recognize and document the signs and symptoms of delirium, including hypoactive delirium. When a screening tool suggests delirium a healthcare professional competent in diagnosing delirium should perform a full clinical assessment. It emphasizes, as we have, that patients undergoing elective procedures should have baseline assessments of cognitive function pre-operatively. The guideline has multiple tables and appendices covering things like risk factors, symptoms and signs, screening tools, and diagnostic tools. It recommends that the healthcare team consider instituting daily postoperative screening of older patients for delirium.

The guideline notes there is a dearth of solid evidence about specific intraoperative factors in the prevention of postoperative delirium. In fact, the only recommendation is that the anesthesiology practitioner may use processed EEG monitors of anesthetic depth (eg. Bispectral Index) during sedation or general anesthesia of older patients to reduce postoperative delirium.

The next section focuses on medications that commonly induce delirium, especially anticholinergic drugs, sedative/hypnotics, meperidine, diphenhydramine, and benzodiazepines. Also, use of 5 or more total medications is associated with an increased risk of delirium. It emphasizes that management must be individualized. For example, while benzodiazepines should be avoided in most at-risk patients they may be necessary in a patient with a history of alcohol or benzodiazepine dependence.

The guideline has an excellent focus on pain and pain management. Insufficient pain control can contribute to delirium as can some of the medications used to treat pain. The guideline recommends non-opioid analgesics where possible and notes that use of regional anesthesia has been found to reduce delirium in some studies.

The guideline points out the contradictory evidence on the effect of antipsychotics in preventing delirium and does not recommend their use for prevention. It also recommends against administration of newly prescribed cholinesterase inhibitors.

The guideline goes on to describe the nonpharmacologic prevention and treatment of postoperative delirium. It recommends that hospitals and healthcare systems have educational programs with frequent refresher sessions on delirium. It recommends that an interdisciplinary team implement a multicomponent nonpharmacologic intervention program and follow that patient throughout the hospital course. It notes such interventions have reduced the incidence of delirium 30-40%. It stops short of recommending use of specialized hospital units, however, since the evidence is insufficient.

It goes on to describe the medical evaluation that should be undertaken once a patient is diagnosed as having delirium. It notes again that multicomponent interventions have been successful in reducing delirium duration and severity, length of stay, etc. but that it is not possible to conclude which specific component(s) are responsible.

If delirious patients are severely agitated or distressed and are considered a risk to self or others, judicious use of antipsychotics (at the lowest effective dose and for the shortest possible duration) may be considered. These should be used only when behavioral interventions have failed. It also emphasizes that benzodiazepines should not be used except where specifically indicated (such as patients undergoing withdrawal from alcohol or benzodiazepines).

We've discussed most of these issues more extensively in our many previous columns on delirium listed below. We'd again like to emphasize that we consider assessment for delirium risk one of the 3 most important elements of the preoperative evaluation (the

other two being screening for frailty and screening for sleep apnea or other potential cause for post-operative opioid-induced respiratory depression). These simple screens can usually be done in the office by the surgeon or a geriatrician or primary care giver.

**Some of our prior columns on delirium assessment and management:**

- October 21, 2008 “[Preventing Delirium](#)”
- October 14, 2009 “[Managing Delirium](#)”
- February 10, 2009 “[Sedation in the ICU: The Dexmedetomidine Study](#)”
- March 31, 2009 “[Screening Patients for Risk of Delirium](#)”
- June 23, 2009 “[More on Delirium in the ICU](#)”
- January 26, 2010 “[Preventing Postoperative Delirium](#)”
- August 31, 2010 “[Postoperative Delirium](#)”
- September 2011 “[Modified HELP Helps Outcomes in Elderly Undergoing Abdominal Surgery](#)”
- December 2010 “[The ABCDE Bundle](#)”
- February 28, 2012 “[AACN Practice Alert on Delirium in Critical Care](#)”
- April 3, 2012 “[New Risk for Postoperative Delirium: Obstructive Sleep Apnea](#)”
- August 7, 2012 “[Cognition, Post-Op Delirium, and Post-Op Outcomes](#)”
- September 2013 “[Disappointing Results in Delirium](#)”
- October 29, 2013 “[PAD: The Pain, Agitation, and Delirium Care Bundle](#)”
- February 2014 “[New Studies on Delirium](#)”
- March 25, 2014 “[Melatonin and Delirium](#)”
- May 2014 “[New Delirium Severity Score](#)”
- August 2014 “[A New Rapid Screen for Delirium in the Elderly](#)”
- August 2014 “[Delirium in Pediatrics](#)”
- November 2014 “[The 3D-CAM for Delirium](#)”

**References:**

The American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults. Postoperative Delirium in Older Adults: Best Practice Statement from the American Geriatrics Society. Journal of the American College of Surgeons 2014; Published Online: November 14, 2014

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