Ten Delirium Misconceptions Juxtaposed with Best Evidence

	Misconception	Best Evidence
1	This patient is oriented to person, place, and time. They're not delirious.	Delirium evaluation minimally requires assessing attention, orientation, memory, and the thought process, ideally at least once per nursing shift, to capture daily fluctuations in mental status.
2	Delirium always resolves.	Especially in cognitively vulnerable patients, delirium may persist for days or even months after the proximal "causes" have been addressed.
3	We should expect frail, older patients to get confused at times, especially after receiving pain medication.	Confusion in frail, older patients always requires further assessment.
4	The goal of a delirium work-up is to find the main cause of delirium.	Delirium aetiology is typically multifactorial.
5	New-onset psychotic symptoms in late life likely represents primary mental illness.	New delusions or hallucinations, particularly nonauditory, in middle age or later deserve evaluation for delirium or another medical cause.
6	Delirium in patients with dementia is less important because these patients are already confused at baseline.	Patients with dementia deserve even closer monitoring for delirium because of their elevated delirium risk and because delirium superimposed on dementia indicates marked vulnerability.
7	Delirium treatment should include psychotropic medication.	They are best used judiciously, if at all, for specific behaviours or symptoms rather than delirium itself.
8	The patient is delirious due to a psychiatric cause.	Delirium always has a physiological cause.
9	It's often best to let quiet patients rest.	Hypoactive delirium is common and often under-recognized.
10	Patients become delirious just from being in the intensive care unit.	Delirium in the intensive care unit, as with delirium occurring in any setting, is caused by physiological and pharmacological insults.

Source: Oldham, M., Flanagan, N., Khan, A., Boukrina, O. & Marcantonio, E. (2018) Responding to Ten Common Delirium Misconceptions With Best Evidence: An Educational Review for Clinicians. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 30:1, 51-57.