DELIRIUM MANAGEMENT COMPREHENSIVE PATHWAY

SCOTTISH DELIRIUM ASSOCIATION

Developed in collaboration with Healthcare Improvement Scotland

This pathway is appropriate for adult patients (18 years & over)

This pathway is not exhaustive

Other causes of delirium exist and additional or alternative assessments, investigations, management strategies or therapies may be necessary for an individual patient.

Clinical judgement & decisions should be made by the appropriate responsible healthcare professional.

History of Acute Change – Think Delirium

Risk Factors for Delirium

- Acute illness
- Sensory Impairment
- Recent discharge from acute hospital
- Restraint
- Dementia
- Polypharmacy
- Depression
- Age over 70 years
- Recent anaesthetic/surgery
- Use of opioids, benzodiazepines or anticholinergics
- History of alcohol misuse*
- Frailty
- Catheterised
- Acute or chronic pain

*This pathway does **NOT** relate to **alcohol or substance** misuse. If this is suspected use appropriate local pathway.*

Clinical suspicion of delirium or "local tool" positive [e.g. 4AT or CAM]
[screening tools can be negative in the presence of delirium – use clinical judgement]

Act on acute, severe causes e.g. sepsis, hypoxia, hypoglycaemia, medication intoxication

The clinical team should take an informant history and assess capacity to consent to treatment.

If the patient is unable to consent to treatment complete an AWI Section 47 (consent to treatment) form. Treatment plan to be discussed with the patients informant/power of attorney (attach certificate to the treatment plan).

- An informant should be contacted to provide information about the history of cognitive impairment and functional ability, in addition to the history of current illness.
- The informant should be asked to clarify and quantify alcohol intake and recent changes to prescribed medication, falls, hydration & nutrition and identify current social support.
- If there is no informant then contact the patient's GP/social work/carers/care home.
- Use the IQCODE or AD8 to assist with informant history
- Identify current social support

Delirium is frequently undetected.

Be aware that patients with delirium may have paranoid ideas/delusions: risk assess and manage appropriately.

Assess with local tool & record baseline cognitive function.

- AMT4 AMT10 MOCA GPCOG
- Assess memory, mood, perception, sleep patterns, thinking

Do a full physical examination including detailed neurological examination, speech assessment, and level of arousal. Look for local signs of sepsis (e.g. bladder, lungs, skin), constipation and consider PR exam.

DOCUMENT DIAGNOSIS OF DELIRIUM & SUSPECTED CAUSES; REVISE AS APPROPRIATE

Medication Review

- Review age appropriateness
- Any drugs recently started/stopped?
- Dose changes to medication?
- Compliance/concordance issues with medication?
- Carefully consider ongoing needs for: Opioids / benzodiazepines / antipsychotics / antispasmodics / antiepileptics / antihistamines / antihypertensives (especially if hypotension) / corticosteroids / tricyclic antidepressants / digoxin / antiparkinsonian medication
- Avoid abrupt withdrawal of drugs with dependence potential or possible discontinuation syndrome.

Investigation

Dictated by the history and examination findings

- U&E / LFT / FBC / Glucose / CRP
- Calcium / Phosphate
- Thyroid function
- Oxygen saturation / arterial blood gases
- ECG
- Chest X-ray
- Urinalysis / urine culture
- Blood / sputum / stool culture as appropriate
- CT brain if anti-coagulated (urgent), head injury, focal neurological signs, or persistent symptoms.

Optimise Management of Co-morbidity

For example;

- Respiratory disease
- Diabetes mellitus
- Cardiac disease / heart failure
- Thyroid disease
- Parkinson's disease
- Cerebrovascular disease

AVOID

- ☐ Bed moves
- ☐ Unnecessary interventions
- ☐ Hypoxia
- ☐ Dehydration
- ☐ Constipation
- ☐ Catheterisation

Environmental & General Measures

- Approach patient calmly and gently from the front
- Sleep chart; maintain daytime wakefulness with activities
- Allow patients to mobilise as much as possible in an area which has been deemed safe given confusion/falls risk.
- Ensure glasses and hearing aids are working, treat ear wax
- Ensure adequate diet taken, keep daily food & fluid charts
- Regularly reassure and re-orientate (use clocks & calendars)
- Ensure buzzer close to patient and respond promptly to calls
- Listen to the patient's expression of needs
- Reduce noise (e.g. monitors and alarms) and background noise
- If language or hearing problems, consider an interpreter
- Refer to advocacy as appropriate e.g. if patient detained under Mental Health (Care and Treatment) (Scotland) Act

Treatment of Delirium Symptoms

- ☐ Relax visiting times - use family to reassure and support care
- ☐ Hypoactive delirium is common in older patients. Ask about psychotic symptoms which may be less evident.
- ☐ Treat psychotic symptoms if distressing
- ☐ Consider additional staff
- If patient's symptoms threaten their safety or the safety of others use low dose of one medication (start low – go slow method) and review every 24 hours
- ☐ Consider capacity to consent to treatment (AWI Section 47)
- ☐ Medications for unmanageable agitation/distress:
  - Haloperidol 0.5-1mg orally (max 2mg/24 hours)
  - Haloperidol 0.5mg IM (max 2mg/24 hours)
  - Or atypical antipsychotic at low dose, for example, Risperidone 0.25 mgs daily, maximum 1mg in 24 hours

  Do not use if signs of Parkinsonism or Lewy Body Dementia

  If antipsychotics are contra-indicated (as above),
  - Lorazepam 0.5-1mg orally (max 2mg/24 hours)
  - Midazolam 2.5mg IM (max 7.5mg/24 hours)
- ☐ Younger patients may need higher drug doses

There are often multiple causes of delirium but in up to 30% of cases no cause is found

Medical & Nursing Management

Treat underlying causes

- Infection/sepsis, urinary retention, constipation, hypotension, pain, dehydration, hypoxia, hypoglycaemia, hyponatraemia
- Ensure O_2 saturation > 95% (except in COPD - type 2 respiratory failure)
- Explain diagnosis to patient & carer and provide information leaflet
- Use Butterfly scheme / "Getting to know me" / "This is me" / "Forget me not"
- Assess and monitor pain (e.g. by using the Abbey Pain scale or similar)
- Consider if swallow safe

Triggers for Referral to Liaison Psychiatry

- Severe agitation or distress not responding to standard measures above
- Doubt about diagnosis
- If detention under the **Mental Health Act** is being considered

Psychiatric services may also hold useful information on background cognition and mental health.

Patient Improving

- Reduce and discontinue antipsychotic treatment
- Repeat cognitive assessment
- Consider post-delirium distress (eg. recall of delusional states)
- Encourage patients to share their experience with healthcare staff

Repeat delirium screening when clinically indicated until two successive daily negatives.

Improvement may also be seen with improving cognition or sleep pattern.

Patient NOT Improving

After one week or if severe delirium, refer to the appropriate local

Ongoing Cognitive Impairment

- Document diagnosis of delirium on discharge letter to GP
- High risk of recurrent delirium requiring prompt treatment
- Follow Cognitive Impairment Pathway

No Ongoing Cognitive Impairment

- Document diagnosis of delirium on discharge letter to GP
- High risk of recurrent delirium requiring prompt treatment
- Increased risk of dementia in the future in older people

Delirium can persist for weeks or months after the cause is treated

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