Acute Management of Delirium in Older Patients

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Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:

- AMU Consultant
- Discharge Matron
- OPM Service Director
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- Falls Prevention and Management Lead
- Occupational Therapy Service Manager
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Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospitals NHS Foundation Trust; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

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Quick reference

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Step 1 ►	**<u>Consider Delirium</u>** • **Screen** all older adults (65+ years) for cognitive impairment on admission using the Abbreviated Mental Test Score (AMTS) and the SQiD. • **Risk factors**: cognitive impairment, sepsis, fracture NOF, marked visual/hearing impairment, previous delirium. • Where possible, **consult** GP/carers for corroborative history. • **Consult** GP/carers where possible for corroborative history. • If in doubt check **diagnosis** of delirium with the 4AT delirium screening tool (4AT). Remember Delirium can be both hyper or hypo-active.
Step 2 ►	**<u>Assess and treat triggering factors</u>** • Assess and treat organic causes such as sepsis, metabolic disturbance, pain, constipation, adverse drug reactions, urinary retention, electrolyte imbalance, dehydration, alcohol withdrawal, hypoxia or a CVA (this list is not exhaustive)
Step 3 ►	**<u>Managing Delirium Behaviours – Non pharmacological</u>** • **A calm and sensitive approach to the patient is important:** • Speak slowly and clearly explaining what is being done and why, repeating information as necessary. • **Person-centred care -** treatment and care should take into account people's needs and preferences. • Avoid arguing with the patient and where possible offer reassurance. • Use orientation aids/prompts i.e. appropriate light levels for the time of day, calendars, clocks and daily newspapers. • Acknowledge how the patient is feeling i.e. frustration and fear rather than the content of rambling speech or vocalisations. • Minimise environmental stimulation including noise i.e. consider moving the patient into a side room. • It may help to involve people familiar to the patient in the delivery of care; they may need an explanation of delirium and reassurance, as it can be frightening to see it for the first time. • Encourage/assist the patient to maintain an adequate fluid intake. • Ensure that sensory aids are in good working order. • **Risks of harming self or others** may require close or special observations. In these cases obtain specialist advice at the earliest opportunity from the Mental Health team. • Monitor progress using behavioural tracking charts • Ensure falls risk assessment Parts 1& 2 and bed rails risk assessment have been completed and relevant initiatives provided. • Provision of the Medstrom Solo Ultra-Low bed • Give either the patient or the carer/NOK a copy of “Delirium -

	Information for patients and carers
Step 4 ►	**<u>Managing Delirium Behaviours – Pharmacological</u>** • If sedation proves necessary use sparingly and use **oral medication** if possible. • Remember that psychotropic medication for this purpose is for **short-term** use only and should be reviewed at least once every day with the MDT. • Aim to reduce and stop as soon as the patient's clinical presentation improves. • Avoid discharging patients on sedative medication. Put action plan for review within 6 weeks if discharging on sedatives. • If treatment is required for **more than 48 hours** then seek specialist advice - either an Older Peoples Medicine Consultant or Mental Health Liaison (use **"Mental Health Liaison – Over Age 65" tab under services on WEB ICE**) Use a single drug either: • Haloperidol 0.5mg to 1mg orally or IM, which can be given once every four hours if this proves necessary. A maximum dosage of 5mg in 24 hours is a general guide. If more than this is required then seek specialist advice as above. Do not use haloperidol with patients whom you suspect have Parkinson's disease or Lewy Body Dementia. Remember that haloperidol commonly causes extra pyramidal side effects, including akathisia, which may mimic agitation and/or lead to a deterioration. The Summary of Product Characteristics (SPC) now recommends that prior to commencing haloperidol a baseline ECG is carried out. Whilst a patient remains on therapy the dose should be reduced if the QT is prolonged, and discontinued if the QTc exceeds 500 ms. Or: • Lorazepam 0.5mg to 1mg orally or IM, which can also be given once every four hours if needed. The recommended maximum dosage is 3mg in 24 hours. Again, if more than this is required then seek specialist advice. Lorazepam may cause respiratory depression (10 or less breaths per minute), which is reversible with flumazenil. Please note Intravenous use of benzodiazepines is not permitted in the general ward setting, with the sole exception of Status Epilepticus protocols. ALTERNATIVES (to be used instead of the above, not alongside): • Can consider an atypical antipsychotic such as risperidone 0.25 mg to 0.5 mg orally initially, which can be given twice a day if needed. A maximum dosage of 3mg in 24 hours is a general guide. Or:

- Quetiapine can be used cautiously in small doses with patients who have Parkinson's disease or Lewy Body dementia. Initially 25mg as a single dose on the first day; usually in the evening when symptoms are worse. If necessary increase to 25mg twice a day. Monitor blood pressure for orthostatic hypotension, and again seek specialist advice if unsure.

MANAGEMENT OF SLEEP WAKE CYCLE

- Consider Melatonin, oral 4 mg at bedtime*

**for melatonin to be prescribed a request has to be made via the Drugs & Therapeutic Committee and if approved can only be prescribed for 1-2 weeks*

Additional Note re: Monitoring of Patients after Pharmacological Treatment is given

When initiating sedative or antipsychotic treatment for acute delirium, the patient is likely to need a more intense amount of monitoring of clinical observations, particularly of respiratory rate and oxygen sats, especially in the period after the first dose is administered. Given the range of treatment options provided, it is not possible to be proscriptive on the exact choice of monitoring regime, or the duration of heightened observation. This will need to be set by the prescribing doctor in consultation with an experienced practitioner (ST5 and above or a consultant).

The key to safety is the understanding that the higher the initial dose and cumulative total given, then a more frequent pattern of observations and a longer duration of heightened observation will be required.

Furthermore, it is good practice to recognise that patients who become drowsy after administration of any medicines with potential for sedative effects, at any time, should have "close observation" (i.e. hourly observations) until they become alert again). Equally, if there is any evidence of potential respiratory compromise due to oversedation (such as a drop in oxygen saturations below target range, or a respiratory rate less than 10 breaths a minute) then nursing teams should be empowered to urgently contact the parent medical team for review, even if this does not trigger on the NEWS score.

KEY LEARNING POINT:

When in doubt, requesting "close / 1 hourly observations" until senior advice is obtained, will in the first instance provide a safe level of care for our patients.

Acute Management of Delirium in Older Patients

1. Introduction

1.1. Rationale

Acute delirium is a common and significant condition that often affects older adult patients during their hospitalisation. Delirium is characterised by a sudden onset of fluctuating mental status, including alterations in attention, awareness, and cognition. It is often accompanied by disturbances in perception, thinking, and behaviour. In older adults, delirium can have severe consequences, leading to increased morbidity, mortality, functional decline, and prolonged hospital stays. Therefore, effective management of acute delirium is crucial to optimise patient outcomes.

Delirium poses significant challenges for both patients and healthcare providers. Older adults with delirium are at an increased risk of adverse events, such as falls, pressure ulcers, and medication errors. Delirium also complicates the diagnosis and management of underlying medical conditions, resulting in suboptimal treatment outcomes. Moreover, delirium is distressing for patients and their families, leading to emotional and psychological burdens.

In the hospital setting, delirium contributes to increased healthcare costs, prolonged hospital stays, severe impact on caregivers and spouses and a higher likelihood of institutionalisation following discharge and even death. It places a strain on healthcare resources and impacts the overall quality of care provided. Therefore, it is imperative to implement effective strategies for the prevention, early identification, and management of acute delirium in older adult patients.

1.2. Objective

The purpose of this guideline is to provide evidence-based recommendations and best practices for the management of acute delirium in older adult patients within the hospital setting. It aims to guide healthcare providers, including physicians, nurses, and interdisciplinary teams, in delivering comprehensive and individualised care to patients with delirium.

This guideline covers various aspects of delirium management, including screening and assessment, prevention strategies, non-pharmacological and pharmacological management, multidisciplinary collaboration, post-delirium care, education and training, and monitoring and evaluation. It emphasises a holistic and patient-centred approach, focusing on both the immediate management of delirium symptoms and the long-term outcomes for older adult patients.

It is important to note that this guideline is intended to complement existing clinical judgement and should be adapted to the individual patient's specific clinical circumstances. Furthermore, it should be regularly reviewed and updated in light of emerging evidence and advancements in delirium management.

1.3. Scope

This guideline is to provide guidance to provide physicians, nurses, and interdisciplinary teams, in delivering comprehensive and individualised care to patients with delirium in the acute setting.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
Delirium	A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment). The disturbance develops over a short period of time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day. An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception). The disturbances are not better explained by another preexisting, established, or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma. There is evidence from the history, physical examination, or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e., due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple aetiologies
Hyperactive	The individual has a hyperactive level of psychomotor activity that may be accompanied by mood lability, agitation, and/or refusal to cooperate with medical care.
Hypoactive	The individual has a hypoactive level of psychomotor activity that may be accompanied by sluggishness and lethargy that approaches stupor

2. Responsibilities

Norfolk and Norwich University Hospital "Delirium Champion"	Dr Duduzile Musa

3. Processes to be followed:

3.1. Importance of Early Identification and Screening

Early identification and screening for delirium in older adult patients are essential for prompt intervention and optimal management. Delirium often goes unrecognised or is misattributed to other conditions, leading to delayed diagnosis and potential harm to the patient. Healthcare providers miss this syndrome more from lack of recognition than from misdiagnosis. The elderly in particular may have a "quieter," more subtle presentation of delirium that may evade detection. Therefore, healthcare providers

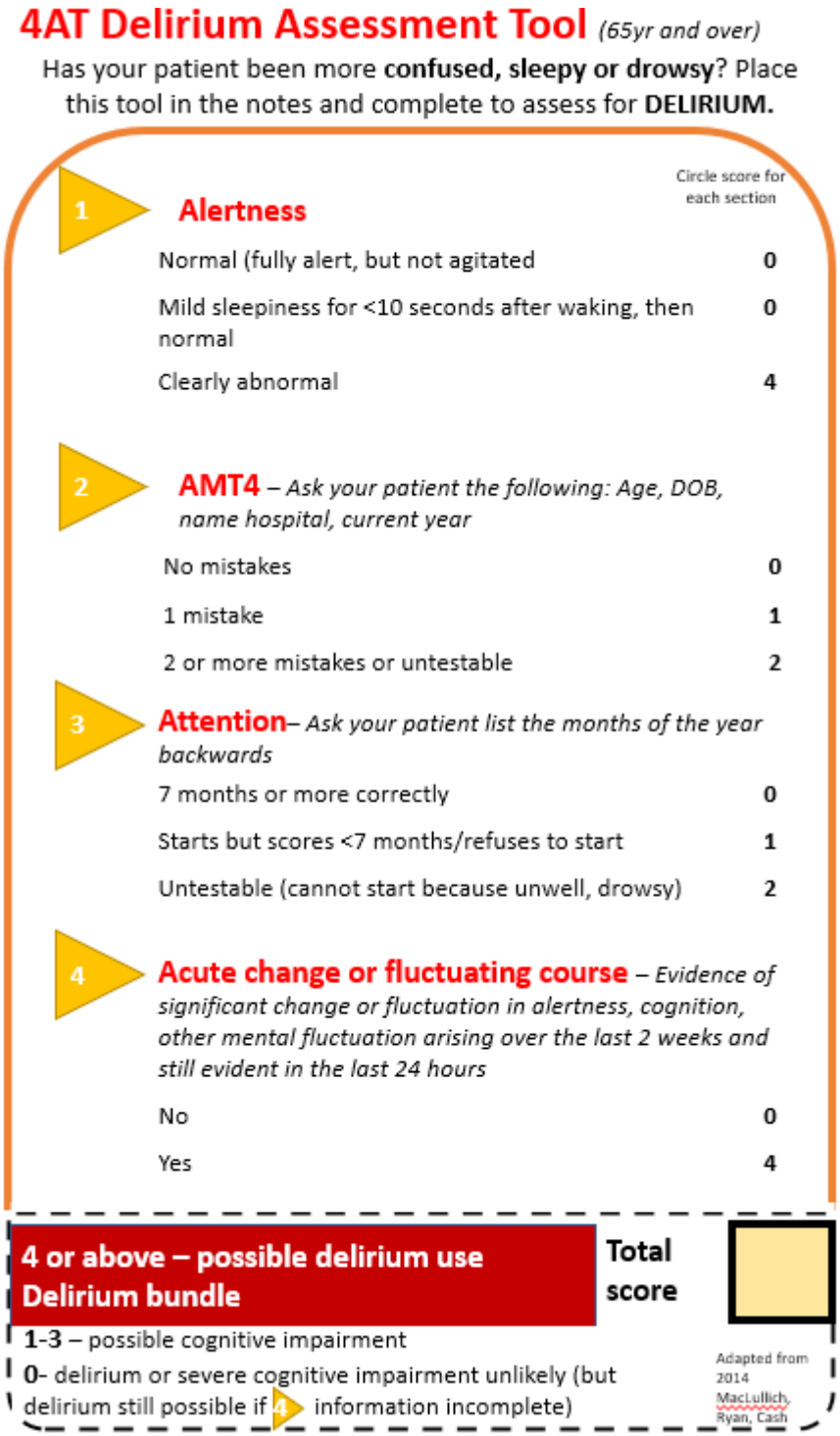
should prioritise routine delirium screening as part of the comprehensive geriatric assessment for older adults admitted to hospital. (Think Delirium!). Other criteria for assessment include

- Age 65 years or older.
- Cognitive impairment (past or present) and/or dementia (for guidance on diagnosing dementia, see the section on diagnosis in the NICE guideline on dementia). If cognitive impairment is suspected, confirm it using a standardised and validated cognitive impairment measure.
- Current hip fracture.
- Severe illness

3.1.1. Recommended Screening Tools

Several validated tools can aid in the screening and detection of delirium in older adult patients. The Single Question in Delirium (SQiD) - "Is this patient more confused than before?" is a very quick method to establish delirium and often will need a collateral history to determine the answer. If answered in the positive, this should trigger use of the other screening tools and the Delirium Bundle.

One commonly used tool is the 4AT (4 A's Test), which assesses attention, acute change or fluctuating course, additional cognitive deficits, and the presence of an acute physical or psychiatric condition. The 4AT has demonstrated good sensitivity and specificity for delirium screening in various healthcare settings (Bellelli et al., 2014).



The 4AT is the scoring system of choice at the Norfolk and Norwich University Hospital. Other screening tools, such as the Confusion Assessment Method (CAM-ICU), the Delirium Observation Screening Scale (DOSS) and the Abbreviated Mental Test Score, may also be employed based on local practices and resource availability.

Abbreviated Mental Test Score

Scores between 8 and 10 are considered normal; scores between 0 and 7 may indicate cognitive impairment.

- What is your date of birth?
- What is your age?
- What year is it?
- What is the time to the nearest hour?
- Do you know the name of the place where we are now?
- What year did the Second World War start?
- Who is the present monarch (king) of our country?
- Can you recall an address for me? Ask patient to remember “42 West Street” and score a point only if they recall it in full at the end of the test.
- Can you count backwards from 20 to 1?
- Can you recognise two people (e.g. doctor or nurse)?

3.1.2. Comprehensive Assessment of Delirium Severity and Aetiology

Following the identification of delirium, a comprehensive assessment should be conducted to determine the severity and underlying aetiology. This assessment should include a detailed medical history, physical examination, and relevant laboratory investigations.

The medical history should encompass pre-existing cognitive impairment, psychiatric conditions, medications, recent changes in medication regimens, substance use, sleep disturbances, and sensory impairments. Obtaining collateral history from family members or caregivers can provide valuable insights into the patient's baseline cognition and functional abilities.

The physical examination should encompass a thorough neurological assessment, including cognitive function, motor abnormalities, and signs of focal deficits. It is important to assess vital signs, hydration status, assess for urinary retention and signs of systemic illness or infection, as these factors can contribute to delirium development or exacerbation.

Laboratory investigations should be guided by clinical suspicion and may include complete blood count, urea and electrolytes, thyroid function tests, urinalysis, blood cultures, and other relevant tests to identify potential underlying causes of delirium, such as infections, electrolyte imbalances, organ dysfunction, or medication-related issues.

3.2. Non-Pharmacological Management

3.2.1. Environmental Modifications

Creating a delirium-friendly environment is essential for the effective management of acute delirium in older adult patients. Environmental modifications can help minimise delirium risk factors and provide a supportive atmosphere for patients. Consider the following strategies:

a. Noise Reduction: Implement measures to reduce excessive noise levels, such as using quiet equipment, providing noise-cancelling headphones, or establishing quiet zones.
b. Adequate Lighting: Ensure appropriate lighting levels, especially during daytime, to promote a normal sleep-wake cycle and reduce disorientation.
c. Orientation Aids: Use orientation aids, such as clocks, calendars, and visual cues, to help patients maintain a sense of time, place, and routine.
d. Familiar Objects: Encourage patients to have familiar objects from home, such as family photos or personal items, to create a more comforting and familiar environment.
e. Sensory Aids: Ensure that sensory aids are in good working order

3.2.2. Sleep-Wake Cycle and Daytime Activity

Maintaining a regular sleep-wake cycle and promoting daytime activity are crucial for managing delirium in older adult patients. Consider the following approaches:

a. Sleep Hygiene: Encourage good sleep hygiene practices, including avoiding daytime napping, minimising disruptions during nighttime hours, and promoting a relaxing bedtime routine.
b. Daytime Engagement: Engage patients in meaningful activities during the day, such as social interactions, cognitive exercises, and physical exercises appropriate to their abilities.
c. Mobility and Ambulation: Encourage mobility and regular ambulation, as appropriate, to prevent physical and cognitive decline, promote independence, and reduce the risk of delirium.
d. Nutrition and Hydration: Encourage and assist in mainatain adequate fluid and nutirition entake.

3.2.3. Engagement of Family Members

Involving family members or caregivers in the care of older adult patients with delirium can provide valuable support and contribute to better outcomes. Consider the following strategies:

a. Communication and Education: Foster open lines of communication with family members, providing regular updates on the patient's condition and involving them in care planning discussions. Educate family members about delirium, its potential causes, and strategies to support their loved one during the hospital stay.
b. Familiar Faces: Encourage family members to be present and actively participate in the patient's care to provide comfort, reassurance, and familiar faces in the hospital environment.
c. Collaboration in Care Planning: Involve family members in care planning decisions, respecting their knowledge of the patient's preferences, values, and routines. Engage them as active partners in the care team. Give either the patient or the carer/NOK a copy of “Delirium - Information for patients and carers

3.3. Pharmacological Management

3.3.1. Indications and Considerations for Pharmacotherapy

Pharmacological interventions may be necessary in the management of acute delirium in older adult patients, particularly in cases where non-pharmacological measures have been ineffective or when symptoms are severe and pose a risk to the patient's safety. In general, it is best to avoid the use of drugs in confused patients, because they further cloud the picture and may worsen delirium. However, the use of pharmacotherapy should be approached with caution, considering the individual patient's medical history, comorbidities, and potential medication interactions.

3.3.2. Selection of Appropriate Medications

When pharmacological management is warranted, the choice of medication should be based on careful assessment and consideration of the patient's specific needs and clinical circumstances. Any drug should be given at the lowest dose and for the shortest time possible. Neuroleptics are the preferred agents. Medications commonly used in the management of acute delirium include antipsychotics such as haloperidol and risperidone. However, their use should be tailored to the patient, with careful attention to dose, duration, and monitoring for potential adverse effects. These patients should receive the lowest possible dose and should not get drugs such as phenobarbital or long-acting benzodiazepines. In particular, use of benzodiazepines can have a paradoxical effect in the elderly, causing agitation and confusion.

Haloperidol, the most widely used agent, causes less orthostatic hypotension and fewer anticholinergic side effects is available in parenteral form; however, it has a higher rate of extrapyramidal side effects and acute dystonias. Intravenous haloperidol should be administered in a monitored setting because its use results in a rapid onset of action, short duration of effect, and risk of hypotension and torsades de pointes; oral and intramuscular administration has a more optimal duration of action, and these are the preferred routes. The recommended starting dose is 0.25 to 0.5 mg of haloperidol orally or intramuscularly, repeated every 30 minutes after the observations have been rechecked, until sedation has been achieved. The end point should be an awake but manageable patient. The average elderly patient who has not been treated previously with neuroleptics should receive no more than 3 to 5 mg of haloperidol in a 24-hour period. Subsequently, a maintenance dose consisting of half the loading dose should be administered in divided doses during the next 24 hours, with doses tapered during the next few days – if anticipated use for over 48 hours – please consult with an Older Persons Medicine Consultant. **DO NOT USE IN LEWY BODY DEMENTIA OR PARKINSON'S DISEASE.**

Please see quick guideline for all other potential medications and doses.

3.3.3. Multidisciplinary Collaboration

Pharmacological management of delirium requires collaboration among healthcare providers from various disciplines. Older Persons Medicine Consultants, Acute Medicine Consultants, Psychiatrists, Pharmacists, and Nursing staff should work together to ensure appropriate prescribing, monitoring, and adjustment of medications. Regular communication and shared decision-making among the multidisciplinary team are crucial to optimise patient safety and outcomes.

3.4. Multidisciplinary Collaboration

3.4.1. Importance of a Collaborative Approach

The management of acute delirium in older adult patients requires a collaborative and interdisciplinary approach involving healthcare professionals from various disciplines. Collaboration enhances the quality of care provided and improves patient outcomes. The following principles guide effective multidisciplinary collaboration:

a. Communication: Establish open lines of communication among healthcare providers involved in the care of older adult patients with delirium. Regular team meetings, interprofessional discussions, and effective handover processes facilitate the exchange of information and promote coordinated care (Red 2 Green for example)

b. Integrated Care: Integrate care across disciplines to provide comprehensive and coordinated management.

3.4.2. Involvement of Older Persons Medicine Consultants, Psychiatrists and Mental Health Liaison

Older Persons Medicine Consultants, Psychiatrists and the Mental Health Liaison Teamplay crucial roles in the management of acute delirium in older adult patients. Their expertise in geriatric medicine and mental health contributes to comprehensive care and optimised patient outcomes. Please involve early in the patient journey.

3.5. Post-Delirium Care

Following the resolution of acute delirium, a comprehensive evaluation should be conducted to identify and address the underlying causes and comorbidities contributing to the delirium episode and should be documented in the medical record. A rehabilitation assessment and a psychosocial evaluation should be performed. If investigations in hospital show a slow, progressive decline in cognition then proceed a memory matters referral needs to be completed on ICE (under clinical forms). It is important to ensure that the patient and the next of kin aware and have consented to referral.

Do not refer someone who already has a diagnosis of dementia.

4. Perioperative Management of Delirium

Delirium and postoperative cognitive disorder are the commonest perioperative complication in patients aged over 65. NICE recommends assessment for risk of delirium with 24 hours of presentation to hospital, and delivery of a tailored multicomponent intervention package for those identified as at risk. It is a standard in the 2021 CPOC guideline that ‘all hospitals should have a guideline for prevention and management of delirium applicable to the perioperative setting.

4.1. Perioperative Quick Reference

Preoperatively:

All patients aged ≥65 years being booked on the Emergency or Trauma list should be assessed for delirium risk, and the delirium risk assessment tool on ORSOS completed.

↓

In theatre:

If delirium, or risk of delirium, has been identified it should be named at the WHO briefing and the principles of '*Reducing perioperative delirium*' (see below) applied to anaesthetic care. PACU should be informed of the risk early, and the patient handed over as at risk of delirium.

↓

In Recovery:

In PACU if delirium, or risk of delirium is identified, the principles of '*Reducing perioperative delirium*' (see below) should be applied to their PACU care.

If delirium, or risk of delirium has been identified, it must be handed over to the receiving ward nurse.

5. Monitoring and Evaluation

5.1.1. Quality Indicators and Outcome Measures

This should be based on the NICE: Delirium in adults Quality standard (SQ63)

Statement 1 Adults newly admitted to hospital or long-term care who are at risk of delirium are assessed for recent changes that affect cognition, perception, physical function or social behaviour.

Statement 2 Adults newly admitted to hospital or long-term care who are at risk of delirium receive a range of tailored interventions to prevent delirium.

Statement 3 Adults with delirium in hospital or long-term care who are distressed or are a risk to themselves or others are not prescribed antipsychotic medication unless de-escalation techniques are ineffective or inappropriate.

Statement 4 Adults with delirium in hospital or long-term care, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

Statement 5 Adults with current or resolved delirium who are discharged from hospital have their diagnosis of delirium communicated to their GP.

5.2. Conclusion

Summary of Key Recommendations

In this guideline, we have outlined evidence-based recommendations and best practices for the management of acute delirium in older adult patients within the hospital setting. The key recommendations highlighted throughout the guideline include:

- Prioritising early identification and screening of delirium in older adult patients upon admission and throughout their hospital stay.
- Implementing multicomponent interventions for delirium prevention, including cognitive stimulation, orientation aids, sleep-wake cycle management, mobilisation, medication review, and sensory optimisation.
- Promoting a delirium-friendly environment by reducing noise, ensuring adequate lighting, and incorporating familiar objects from home.
- Emphasising the importance of interdisciplinary collaboration among healthcare providers, including geriatric specialists, psychiatrists, and relevant specialists, in delirium management.
- Considering pharmacological interventions judiciously, with careful monitoring for potential adverse effects.
- Offering post-delirium care, including comprehensive evaluation, management of underlying causes and comorbidities, rehabilitation strategies, and cognitive and psychological assessments.
- Monitoring and evaluating delirium management practices through quality indicators, outcome measures, regular audits, and continuous improvement strategies.

The management of acute delirium in older adult patients within the hospital setting is a complex and multifaceted task. By adhering to evidence-based recommendations and adopting a holistic, patient-centred approach, we all can optimise outcomes, enhance patient safety, and improve the overall quality of care for older adults with delirium.

6. Related Documents

1. National Institute of Clinical Excellence Falls in older people: assessing risk and prevention
2. National Audit of Inpatient Falls (NAIF) RCP London
3. Policy for Assessment, Prevention and Management of Inpatient falls Document ID: 19800 Trust Docs (nnuh.nhs.uk)
4. Standard Assessment and Falls Prevention Actions for all Adult Inpatients Document ID: 19787 Trust Docs (nnuh.nhs.uk)
5. Adult Patient Bedrail Risk Assessment Document ID: 19788 Trust Docs (nnuh.nhs.uk)
6. Policy for Perioperative Management of Delirium
   Document ID:

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Appendices

Appendix 1: 4AT Delirium Assessment Tool (65yr and over)

4AT Delirium Assessment Tool *(65yr and over)*

Has your patient been more **confused, sleepy or drowsy**? Place this tool in the notes and complete to assess for**DELIRIUM.**

Circle score for each section

1 Alertness

Normal (fully alert, but not agitated	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

2 AMT4 – *Ask your patient the following: Age, DOB, name hospital, current year*

No mistakes	**0**
1 mistake	**1**
2 or more mistakes or untestable	**2**

3 Attention– *Ask your patient list the months of the year backwards*

7 months or more correctly	**0**
Starts but scores <7 months/refuses to start	**1**
Untestable (cannot start because unwell, drowsy)	**2**

4 Acute change or fluctuating course– *Evidence of significant change or fluctuation in alertness, cognition, other mental fluctuation arising over the last 2 weeks and still evident in the last 24 hours*

No	**0**
Yes	**4**

4 or above – possible delirium use Delirium bundle

Total score

1-3 – possible cognitive impairment

0- delirium or severe cognitive impairment unlikely (but delirium still possible if information incomplete)

Adapted from 2014 MacLullich , Ryan, Cash

Appendix 2: Delirium Pathway (for patients over 65yrs)

Acute Management of Delirium in Older Patients

This patient has DELIRIUM

Norfolk and Norwich University Hospitals NHS Foundation Trust

Delirium Pathway

For patients over 65 years

- If your patient is more confused than usual intitiate this pathway
- Place this in the patient's notes and highlight to the nurse & clinician

Affix Patient Label

Date:	Time:	Ward:

Step 1

The following will put your patient at higher risk of delirium

(Tick all applicable)

NOT for Alcohol intoxication/withdrawal

Age 65yr

- ☐ Severe Illness
- ☐ Dementia
- ☐ Physical Frailty
- ☐ Infection
- ☐ Dehydration
- ☐ Sensory/Impairment
- ☐ Polypharmacy
- ☐ Renal/Liver Failure
- ☐ Psychoactive Drugs
- ☐ Acute/Chronic Pain
- ☐ Catherisation

Step 2

- ☐ This patient seems more confused than usual
- ☐ Family/Carer think the patient is more confused

Document the 4AT score: ☐

Tick when complete:

Nurses tasks:

- ☐ NEWS2 score (think sepsis)
- ☐ Blood Glucose
- ☐ ECG

Clinician tasks:

- ☐ **Medication review**
- ☐ Pain review
- ☐ Assess for urinary retention
- ☐ Assess for constipation
- ☐ Assess hydration
- ☐ Bloods (FBC, U&E, Ca, LFT, CRP, TFTs, Mg, Glucose)
- ☐ Assess for infection
- ☐ Review ECG

Delirium is not a diagnosis and you must determine the underlying cause

Probable cause of delirium:

Document Delirium in your differential

Step 3

Identify and treat the underlying cause

The following strategies may be used to manage delirium:

D – Disorientation & Dehydration
- Re-orientate (time/place)
- Involve family/carers
- Avoid ward/bay transfers
- Oral/intravenous fluids

E – Environment
- Calm/quiet/comfortable

L – Lighting
- Day/night orientation
- Use of clocks

I – In pain?
- Assess for non-verbal signs
- Consider regular analgesia

R – Retention of stool or urine
- Bladder scan/encourage
- Laxatives if necessary

I – Infection
- Look for and treat (UTI/LRTI)
- Avoid catherisation

U – U&Es and bloods
- Monitor bloods as necessary

M – Medications
- Review meds

S – Sensory impairment
- Visual/hearing aids

Family support & information
Avoid sleep disturbance
Monitor O_2 sats and BP
Encourage mobility/exercise
Optimise nutrition

8. Equality Impact Assessment (EIA)

Type of function or policy	New

Division	Medicine	**Department**	Medicine
Name of person completing form	Dr Duduzile Musa	**Date**	01/04/2024

Equality Area	**Potential Negative Impact**	**Impact Positive Impact**	**Which groups are affected**	**Full Impact Assessment Required YES/NO**
Race	None	None		No
Pregnancy & Maternity	None	None		No
Disability	Yes	None	Hearing Impairment Learning Disabiltity	Yes
Religion and beliefs	None	None		No
Sex	None	None		No
Gender reassignment	None	None		No
Sexual Orientation	None	None		No
Age	None	None		No
Marriage & Civil Partnership	None	None		No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?	N/A			

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.