Patient Name:
NHS No:
Hosp No:
D.O.B.

Delirium assessment & management (TIME bundle)

Mersey and West Lancashire Teaching Hospitals NHS Trust

4AT Score

Practitioner name: …… Practitioner signature: ……

Designation …… Date/time score recorded: ……

Initiate TIME bundle within 2 hours (initial and write time of completion)		Assessed / sent	Results seen	Abnormality found
T	Think exclude and treat possible triggers			
	NEWS2 (think sepsis pathway)			
	Capillary blood glucose (BM)			
	Medication history (identify new medications/change of dose/medication recently stopped, alcohol or benzodiazepine withdrawal).			
	Pain assessment			
	Urinary retention – confirm with bladder scan. Urinary retention can be present when someone is passing urine and without a palpable bladder.			
	Assess for constipation - consider rectal examination			
I	Investigate and intervene to correct underlying causes			
	Assess hydration and start fluid balance chart			
	Bloods (Delirium order set on Medway)			
	Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment			
	ECG (ACS)			
M	Management Plan			**Completed**
	Initiate treatment of ALL underlying causes found above			
E	Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours)			
	Engage with patient/family/carer – explore if this is usual behaviour. Ask: How would you like to be involved? Ensure 'forget-me not' card is completed and accessible at bedside.			
	Explain diagnosis of delirium to patient and family/carers (use delirium leaflet which is available on intranet dementia/delirium page).			

Top tips

Bed moves should be avoided unless absolutely necessary. This should be documented in the patients' case notes.

Patients should be cared for by a team of staff familiar to them whenever possible, and who are trained and competent in delirium prevention and management – **consider referral to geriatricians if delirium is not resolving FAX: 1142**

Remember delirium can be hypoactive or hyperactive but some people show signs of both (mixed). People with hyperactive delirium have heightened arousal and can be restless, agitated and aggressive. People with hypoactive delirium become withdrawn, quiet and sleepy. Hypoactive and mixed delirium can be more difficult to recognise.

Utilise orientation aids/prompts i.e. appropriate light levels for the time of day, calendars, clocks and daily newspapers.

It may help to involve people familiar to the patient in the delivery of care – inform carers of John's Campaign.

Patients with faecal impaction will require rectal as well as oral treatment.

If patient is diagnosed with delirium include on ICE discharge

People at risk to themselves or others

- If a person with delirium is distressed or considered a risk to themselves or others, first use verbal and non-verbal techniques to de-escalate the situation. Use interventions that are least restrictive to the patient.
- People at risk of harming themselves or others may require close observation (see Supplementary Care Policy). In these cases obtain specialist advice at the earliest opportunity from them Mental Health liaison team. Monitor using nursing observation therapeutic chart. If the restrictions amount to a deprivation of liberty staff should ensure safeguards are in place to ensure that the deprivation of liberty is lawful. Please see further guidance on the Mental Capacity Act on the Trust intranet page.
- If a person with delirium is distressed or considered a risk to themselves or others and verbal and non-verbal de-escalation techniques are ineffective or inappropriate, consider giving short-term (usually for 1 week or less) haloperidol or lorazepam if haloperidol contraindicated. Do not prescribe p.r.n. medication routinely or automatically on admission.
- **Remember to START LOW & GO SLOW** - Start at the lowest clinically appropriate dose and titrate cautiously according to symptoms. Ensure there is clarity about the rationale and circumstances in which medication may be used and that these are included in the care plan.
- Refer to BNF for drug information; ECG is recommended prior to use of haloperidol as prolonged QTc-interval is a contra-indication.

If treatment is required for more than one IM dose or more than 24 hours of a new oral prescription then seek specialist advice from the Mental Health liaison team

Tel: 0151 290 4999 **Available:** 24 hours a day

Sedation - recommended doses for patients 65 and over

ORAL MEDICATION SHOULD BE FIRST LINE TREATMENT UNLESS SYMPTOMS SEVERE.

Drug	Initial Dose	Frequency and maximum dose	Range	Comment
Drug of first choice				
Haloperidol oral	0.5mg	4 to 6 hourly (max 2mg in 24 hours)	0.25 to 1mg	Contraindicated in Parkinson's disease and Lewy body dementia
Haloperidol I.M.	0.5mg to 1mg	4 hourly (max 2mg in 24 hours)	0.5 to 2.5mg	
If Haloperidol contraindicated				
Lorazepam Oral	0.5 to 1mg	2 to 4 hourly (max 2mg in 24hours)	0.5 to 1mg	Lorazepam injection stored in fridge Contact Pharmacy if unavailable
Lorazepam I.M.	1mg (dilute with equal volume water for injections or normal saline)	6 hourly (max 2mg in 24hours)	0.5 to 1mg	

Sedation should be reviewed every 24 hours and reduced or discontinued once agitation has settled and the underlying cause has been identified and treated.