Royal Cornwall Hospitals NHS
NHS Trust

Clinical Guidelines for the Management of Delirium in Adults.

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	Hospital Care and the Safe Use of Bedrails with Adult Patients RCHT Adult Discharge and Transfer Policy Safe and Supportive Observation Policy
Suggested Keywords:	Delirium,, acute confusion, Eldercare
Training Need Identified?	Yes

This document is only valid on the day of printing

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This document is to be retained for 10 years from the date of expiry.

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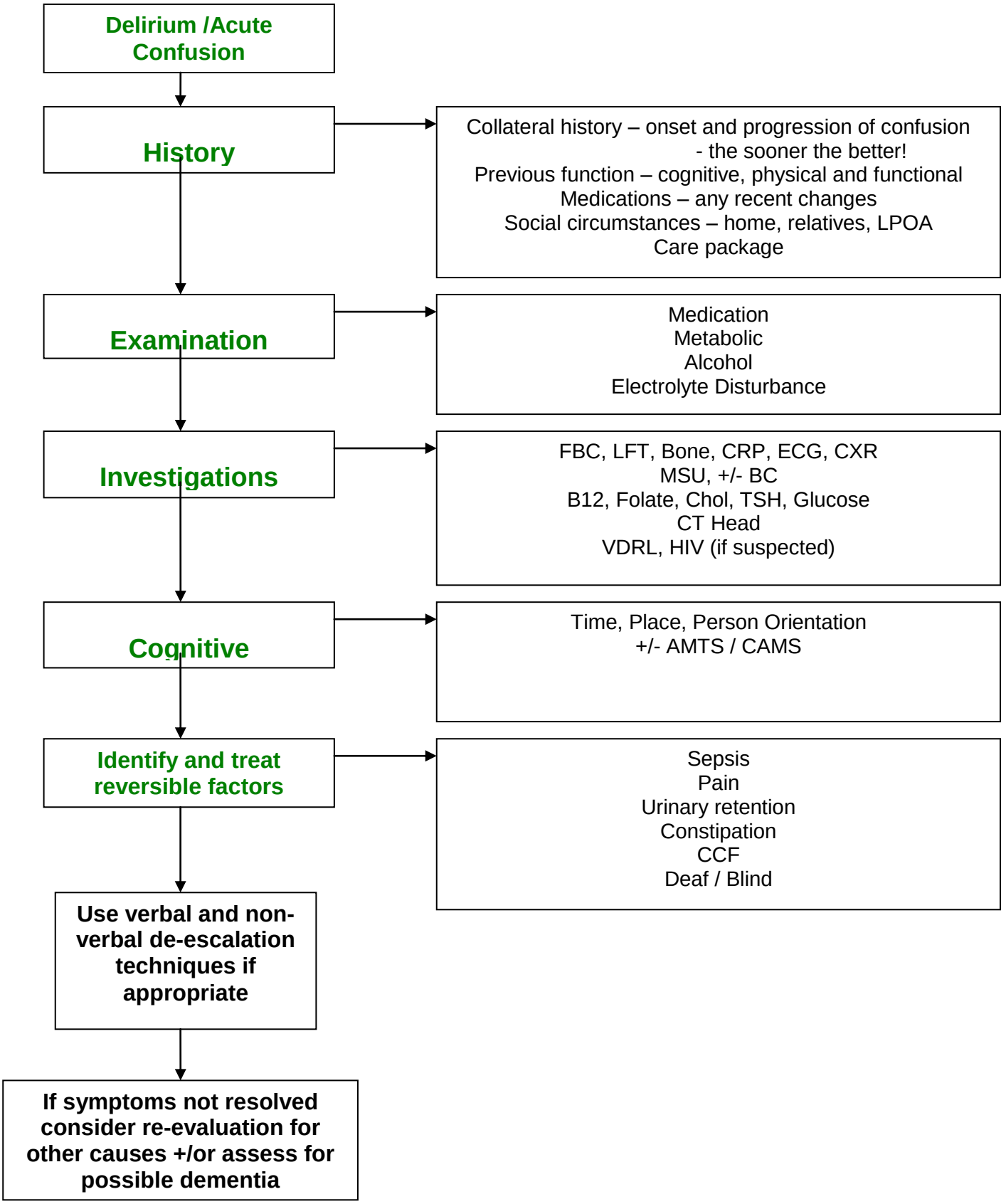
Acute Change in Cognition – Delirium /Acute Confusion Pathway


Delirium /Acute Confusion
History
Collateral history – onset and progression of confusion - the sooner the better!
Previous function – cognitive, physical and functional
Medications – any recent changes
Social circumstances – home, relatives, LPOA
Care package
Examination
Medication
Metabolic
Alcohol
Electrolyte Disturbance
Investigations
FBC, LFT, Bone, CRP, ECG, CXR
MSU, +/- BC
B12, Folate, Chol, TSH, Glucose
CT Head
VDRL, HIV (if suspected)
Cognitive
Time, Place, Person Orientation
+/- AMTS / CAMS
Identify and treat reversible factors
Sepsis
Pain
Urinary retention
Constipation
CCF
Deaf / Blind
Use verbal and non-verbal de-escalation techniques if appropriate
If symptoms not resolved consider re-evaluation for other causes +/or assess for possible dementia

Aim/Purpose of this Guideline

This guideline is provides practical guidance to identify, diagnose and manage delirium and covers all adult patients within RCHT services.

This guideline applies to all Trust staff directly involved in the care of patients. It should be read in conjunction with the RCHT Dementia Care Policy.

They are *not* intended to be used to management of patients with delirium due to alcohol withdrawal or the effects of drugs of abuse.

Scope

This guideline is relevant for all staff who first encounter patients and families entering the Trust. Clinical staff will be at the forefront of delivering this guideline and depending on their clinical role, they may have varied experience. All staff should be supported by their Line Manager to receive the education and training required to fulfil their role.

Definitions /Glossary

Delirium (acute confusion state) is a neuropsychiatric syndrome characterised by acute onset of fluctuating cognition and inattention linked to triggering factors

Prevalence and Hospital Incidence

It is very commonly encountered in hospital medicine and complicates at least 10% of all medical admissions

- 20-30% prevalence on medical wards
- 15-53% of patients postoperatively
- 70-87% of those in intensive care

Outcome and Prognosis

Delirium is a medical emergency independently associated with serious adverse outcomes including:

- Increased mortality in older people - 35-40% at one year
- Longer length of stay in hospital
- Increased risk of institutional placement
- Increased risk of in-hospital complications such as pressure sores and falls. 5
- Up to 60% of individuals suffer persistent cognitive impairment following delirium and they are also three times more likely to develop dementia.1,4

Delirium is preventable in up to 1/3 of cases and is treatable if identified and managed appropriately and urgently.
Delirium is everybody's business. We all need to know how to prevent delirium and make sure that someone with suspected delirium receives rapid assessment and appropriate management. Patients with delirium are often disruptive to usual routines for staff and other patients which affect the delivery of best care and impact on levels of risk to patient and others.

Delirium is characterised by:

- disturbance of consciousness
- change in cognition that develop over a short period of time.

The disorder has a tendency to fluctuate during the course of the day, and there is evidence from the history, examination and investigations that the delirium is a direct consequence of a general medical condition, drug withdrawal or intoxication.

It is frequently under recognised and may commonly present in one of 2 ways:

- **Hyperactive delirium** – restless, agitated, delusional, risk of harm
- **Hypoactive delirium** – lethargic, monosyllabic, often overlooked

Risk Factors

A number of risk factors are associated with an increased probability of developing delirium, shown in Table 3.1. Those highlighted in bold have the greatest impact and when any of these risk factors is present, the person is at risk of delirium. When people first present to hospital, documented assessment should be carried out for: 6

Age 65 years or older
Current hip fracture
Cognitive impairment or dementia
Severe illness (a condition deteriorating or at risk of deterioration)

Co-existing medical conditions	**Severe illness** **Current hip fracture** Significant co-morbidity Chronic renal or hepatic impairment History of stroke Infection with HIV	**Drugs**	Polypharmacy (>3 drugs) Treatment with multiple psychoactive drugs Alcohol/recreational drug dependency
Cognitive status	**Dementia** **Cognitive impairment** History of delirium Depression	**Functional status**	Functional dependence Immobility Low level of activity History of falls Incontinence
Demographics	**Age > 65 years old**	**Sensory Impairment**	Visual and hearing
Decreased oral intake	Dehydration Malnutrition	**Metabolic abnormalities**	Hepatic failure Renal failure Thiamine deficiency

Precipitant factors (triggers)

The cause of delirium is almost invariably multi-factorial and there are numerous potential precipitants. These include any condition that can induce disordered body chemistry; any

illness that compromises the body's circulation and oxygenation; any medication that affects the central nervous system; any infection when the patient is in a high-risk group or is severe. A careful assessment must be made to exclude all common causes. Delirium may be the only manifestation of severe disease (eg myocardial infarction) in an older Person

Common precipitating factors:			
Environmental factors	Change of environment Loss of spectacles or hearing aid Inappropriate noise and lighting Immobility Sleep deprivation Catheters and lines Change of staff and ward Falls Physical restraint	Drugs	Alcohol or sedative withdrawal Sedative hypnotics Opioids Anticholinergics Antiparkinsonian drugs Antidepressants Anticonvulsants Corticosteroids Acute recreational drug toxicity or withdrawal
Fluid and electrolyte abnormality	Hypo/ hypernatraemia Hypercalcaemia Renal failure Dehydration	Infections	Chest Urine (do urinalysis) Skin / ulcers Abdominal CNS
Neurological illness	Stroke Seizures Subdural haematoma	Surgery	Orthopaedic Vascular/cardiac Gastro-intestinal
Pain	Acute pain Acute on chronic pain	Urinary and faecal retention	Specifically examine to exclude, history is unreliable
Respiratory/ Cardiovascular	Hypoxia e.g. Pulmonary embolus, pneumonia Hypercapnia Cardiac failure Myocardial infarction Organ/tissue ischaemia	Endocrine/ metabolic	Thiamine deficiency Hypo/ hyperthyroidism Hypo/ hyperglycaemia Liver failure

.

Memory aid for delirium precipitants – think DELIRIUM

Drugs (withdrawal/toxicity, anticholinergics)/**D**ehydration
Electrolyte imbalance
Level of pain
Infection/**I**nflammation (post surgery)
Respiratory failure (hypoxia, hypercapnia)
Impaction of faeces
Urinary retention
Metabolic disorder (liver/renal failure, hypoglycaemia)/**M**yocardial infarction

Diagnosis

In those patients with clinical indicators of delirium, diagnosis should be confirmed using the **Confusion Assessment Method (CAM).** CAM should be used by a person competent in identifying delirium.
Requires point 1 ***and*** 2 ***and either*** 3 ***or*** 4
1) **Acute onset and fluctuating course** (use collateral history and consider serial AMTS/MMSE) *and*
2) **Inattention** (distractible, can't focus, can't follow a conversation, playing with bedclothes) *and either*
3) **Disorganised thinking** (rambling, illogical flow of ideas, switching of subjects)
4) **Altered level of consciousness** (vigilant, lethargic / drowsy, stupor, coma)

Memory aid mnemonic for CAM - think CA2MS:
Delirium diagnosis requires **CA2** *and either* **M** *or* **S**
Changeable course
Acute onset + **A**ttention poor
Muddled thinking
Shifting consciousness

Differential Diagnosis

Common diagnoses that can be mistaken for delirium are dementia, depression, schizophrenia, dysphasia, hysteria/mania, non convulsive epilepsy. Your patient may have dementia, delirium or both. ***If uncertain treat for delirium first.***

SIGNS / SYMPTOMS	DEMENTIA	DELIRIUM	DEPRESSION
DURATION OF	Months, years	Minutes, hours, days	Weeks, months
ONSET	Insidious	Abrupt	Recent or recurrent
PROGRESSION	Irreversible	Reversible if treated	Reversible i/c relapse
MEMORY LOSS	Short-term	Global	Islands of loss (s/t, l/t)
CONFUSION	Chronic	Acute	Variable
CONSCIOUSNESS	Alert	Fluctuating	Alert, ?withdrawn
THOUGHTS	Slow, perseveration	Paranoid, bizarre	Preoccupied, slow
LANGUAGE	Usually preserved	Abnormal	Preserved
SLEEP	Disturbed with wandering	Disturbed with confusion	Early wakening
ACTIVITIES OF DAILY LIVING	Poor performance	Fluctuates	Variable
PERCEPTION	Visual hallucinations	Visual / auditory hallucinations	Uncommon
RESPONSE TO QUESTIONS	Tries but fails	Misinterprets	"I don't know"
CONCERN RE:SYMPTOMS	Minimal	Ignored	Exaggerated

History (usually including collateral history)

If it is not possible to obtain a history from the patient, a collateral history should be sought from a relative / carer. In addition to standard questions in the history, the following information should be specifically sought:

- Previous intellectual function
- Functional status (e.g. Mobility, transfers, toileting/bathing, aids used)
- Onset and course of confusion
- Previous episodes of acute or chronic confusion
- Sensory deficits – hearing, sight, speech
- Symptoms suggestive of underlying cause (eg. infection)
- pre-admission social circumstances / care package
- Full drug history including non-prescribed drugs
- Alcohol history

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Physical Examination

A full clinical examination should be carried out, in particular the following areas:

- Neurological examination (however, if they can comply with a full neurological examination, delirium is unlikely!)
- Conscious level (Glasgow Coma Scale)
- Signs on infection
- Evidence of alcohol abuse or withdrawal
- Rectal examination
- Check for pressure sores and **DON'T FORGET PAIN**
- Blood glucose bedside test
- Assess AMST – a score of 7 or less should prompt further cognitive assessment

Abbreviated Mental Test Score (AMTS)

1. Age (exact only)
2. Date of birth (date and month)
3. Time (to nearest hour)
4. Year (exact only)
5. Name of hospital
6. Address for recall at end of test (e.g. 42 West street)
7. Recognition of 2 persons (e.g. doctor, nurse)
8. Year of 1st world war
9. Name of present monarch
10. Count backwards 20-1

Score out of 10

Helpful Initial Investigations

The following investigations are almost always indicated in patients with acute confusion in order to identify the underlying cause:

- Full Blood Count, CRP
- Calcium
- Urea and electrolytes
- Liver function tests
- Glucose
- Thyroid function tests
- Chest Xray
- ECG
- Blood cultures
- Urinalysis / MSU

Other investigations may be indicated according to the findings from the history and examination:

- CT scan (e.g. if focal neurological signs, confusion developing after head injury or fall, raised ICP)
- B12 and folate
- Arterial blood gases
- Specific cultures (MSU, sputum)
- Lumbar Puncture (if meningism or headache and fever)

Documentation

Ensure that the diagnosis of delirium is documented in the patient's medical notes and document the treatment plan. Include the diagnosis in the patient's discharge letter/summary as well as the discharge AMTS.

Management should be patient centred, giving patients the opportunity to make informed decisions about their health care and taking into account the individuals needs and wishes. Often patients with delirium lack capacity for some decisions. If this is the case, the code of practice detailed in Mental Capacity Act should be followed (see www.publicguardian.gov.uk or trust link http://gti/clinical/assurance/clinicalgovernance/mentalcapacityact/mentalcapacityact.aspx for more information).

Where a patient is at significant risk do act in the their Best Interest and de-escalate challenging behaviours with appropriate techniques and possible sedation interventions – please refer to hospital policies and guidelines which may include RCHT Policy for the Safe and Supportive Observations of Adults, RCHT Policy on Restraint, and policy on Violence and Aggression, Mental Capacity Act. - Good communication between members of the team caring for the patient is vital. Written communication should be clear and appropriately detailed. Family and carers should have the opportunity to be involved in treatment strategies.

Delirium Prevention

Preventing delirium is the most effective strategy for reducing its frequency and complications.3 Up to one third of cases have been shown to be preventable.11 Patients found to be at risk of delirium as detailed above should be assessed for clinical factors that may contribute to delirium within 24 hours of admission.6 Following the multi-component do's and don'ts intervention

package listed in table 5.1 will provide a framework prevent delirium and interventions should be tailored suit individual's needs. Those highlighted in bold are specifically endorsed by NICE.

Delirium Management

1. Delirium is a medical emergency and often associated with severe underlying illness.
2. Rapid identification and treatment of underlying causes should be the first aim of management.
3. Non-confrontational and empathic de-escalation techniques may be required in a distressed and agitated patient.
4. Pay particular attention to re-orientation and re-assurance, often with the aid of familiar family and friends.
5. A suitable calming and stable care environment is important.
6. Continue to look for new and missed causes – don't forget medication side effects and withdrawal as a precipitant.
7. Using pharmacological treatment to prevent delirium, for example giving haloperidol preoperatively, has not been shown to reduce the incidence of delirium in some circumstance antipsychotic's may reduce the duration of delirium – however must always be used with extreme caution.
8. Pharmacological management should be reserved for patients whose symptoms of delirium would threaten their own safety or the safety of other persons, or would result in the interruption of essential therapy.
9. The common errors in managing delirium are to use medications in excessive doses, give them too late or overuse.

Sedation in Treatment Plans

All sedatives may cause delirium, especially those with anticholinergic side effects. The use of sedatives and major tranquillisers should therefore be kept to a minimum. Prior to giving medication it is necessary to determine that all other non-therapeutic interventions such as calm lighting, appropriate environmental support, toileting, hunger and thirst have been addressed**.**

If these measures fail then medication may be the only option to ensure delivery of safe care.

1. Drug sedation may be necessary in the following circumstances:

    - in order to carry out essential investigations or treatment
    - to prevent patients endangering themselves or others
    - to relieve distress in a highly agitated or hallucinating patient

2. It is essential that a determination of Mental Capacity has been undertaken and MCA level 3 form completed to ensure robust and legally supported framework for intervention is evidenced.
3. The rational for requiring sedation must be documented.
4. It is preferable to use one drug only, starting at the lowest possible dose and increasing in increments if necessary after an interval of 30 minutes.
5. If repeated dosed of medication are required then Application for Deprivation of Liberty (DoL) must be undertaken.
6. If sedatives are prescribed, the prescription should be reviewed regularly and discontinued as soon as possible.

The preferred drugs are:

- **Lorazepam 0.5-1mg** orally in the first instance with consideration for IM injection for those refusing oral medication. *Caution in respiratory disease.*
- **Haloperidol - 0.5mg-2mg** orally as tablets or liquid up to 4 times daily or 2.5 - 5 mg by intramuscular injection (NB the oral and IM doses of haloperidol are not equivalent).

Halperidol may be first line choice for those with respiratory failure.
Warning! Haloperidol should not be used in those patients with signs of Parkinson's

The patient should be offered the option for oral medication first - if this failed then IM sedation may be required.

This should be given with clinical team in attendance and the clinical team should not leave until the situation has been made safe and behaviour de-escalated. It may take 15-20 minutes for oral medication to be successful. If it does not achieve the required outcome – a further dose of medication may be required.

For delirium due to alcohol withdrawal (delirium tremens) a benzodiazepine (e.g. diazepam or chlordiazepoxide) or chlormethiazole are preferred in a reducing course. Detailed guidelines for this condition are beyond the scope of this advice sheet.

NB. Wandering is not an indication for drug treatment.

For Night-time disturbance – consider simple hypnotic to aid more restful sleep pattern, if this fails ,only then consider low dose lorazepam.

The Golden Rules:

- Review medication every 24 hours.
- Start with low doses.
- Discontinue sedation as soon as possible.
- Avoid poly-pharmacy.
- If in doubt, ask for advice (Geriatrician on-call, Complex care and dementia liaison service, Eldercare or ward pharmacist)

You may also get additional information about the patient from the community psychiatric nurses, if the patient is known to them.

Nursing Care

Consider:

- Good lighting levels
- Repeated orientation (clocks, calendars, newspapers, familiar objects)
- Repeated reassurance, ideally by the same person (consider 'specialling')
- Sensory aids where necessary (glasses, hearing aids)
- Avoidance of physical, emotional or chemical restraints
- Minimal distractions, calm environment (consider side room)
- Approach and handle gently
- Avoid multiple ward transfers
- Maintenance / restoration of normal sleep patterns

Management • Correct hypoxia (see oxygen prescription guidelines) and hypotension. • Remain vigilant for infection (e.g. urinalysis, bloods, chest). • Correct dehydration (may need SC/IV if oral intake poor). • Monitor bowels and treat constipation. • Identify (including non-verbal signs) and treat pain. • If delirium develops, follow a step by step approach identify and treat the causes • Explain diagnosis of delirium to family. • Ensure diagnosis is documented clearly in the notes • Consider urgent psychiatric review especially if hallucinations or delusions are present. • Consider security involvement • Consider arm length observations at all times including contacting Site team for extra staffing. **Prescribing** • Review appropriateness of all medications (anticholinergic medication ought to be stopped). • Ascertain use of non-prescription/recreational drugs	**Management** • Don't delay attendance – delirium has a high mortality. • Don't catheterise unnecessarily. • Don't use IV lines unnecessarily and follow Trust guidance in use of IV cannulas. • Don't order unnecessary tests (CT, EEG or frequent bloods). • Don't disturb patient's sleep with procedures and medication rounds if possible. • Don't use medication unless other interventions have failed. • Don't use large amounts of medication, particularly in the elderly. • General rule is use less more often. • Don't give antipsychotics to patients with a prolonged QTc, with parkinsonism or with Lewy Body Dementia - use lorazepam instead.

- Encouraging visits from familiar friends / family (and 'distraction therapists')

• Consider medication for patients at risk to self/others with distress or to enable essential investigations as per attached guidance, with maximum dose in 24 hours also clearly documented.	

References

1. Delirium: diagnosis. Prevention and Management. National Institute of Health and Clinical Excellence, NICE Guideline 103. July 2010..
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3. Levkoff S, Cleary P. Epidemiology of delirium: an overview of research issues and findings. Int Psychogeriatrics 1991;3(2):149-167
4. American Psychiatric Association: diagnostic and statistical manual of mental disorders, fourth edition, Washington, D.C., American psychiatric association, 1994
5. Jitapunkul S, Pillay I, Ebrahim S. The abbreviated mental test: its use and validity. Age and ageing; 1991;20:332-336
6. The Prevention, diagnosis and management of delirium in older people, National guidelines, The Royal College of Physicians and British Geriatrics Society, Royal College of Physicians, www.rcplondon.ac.uk, June 2006
7. Rockwood K. Acute confusion in elderly medical patients. JAGS 1989;37:150-154

Monitoring

These guidelines are audited annually with a report being submitted to the RCHT Dementia Action Group.

Equality and Diversity

This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 1.

Appendix 1.Initial Equality Impact Assessment Screening Form

Name of service, strategy, policy or project (hereafter referred to as *policy)* to be assessed:	
Directorate and service area: *Medical*	Is this a new or existing Procedure*?* **existing**
Name of individual completing assessment: Dr Fiona Boyd	Telephone: 01872 252447
1. Procedure Aim*	Provides practical guidance on the identification and management of adults who have delirium
2. Procedure Objectives*	Improve and standardise care
3. Procedure – intended Outcomes*	Improve patient and carer experience
4. How will you measure the outcome?	Monitor rate and subject matter of Complaints, Datix incident reports, PALS contacts and Compliments. Patient Satisfaction Surveys
5. Who is intended to benefit from the Procedure?	Patients with delirium and their families. Staff across the Trust in terms of confidence in delivery of care, and access to the necessary training and education to support.
6a. Is consultation required with the workforce, equality groups etc. around this procedure? b. If yes, have these groups been consulted? c. Please list any groups who have been consulted about this procedure.	

*Please see Glossary

7. The Impact

Please complete the following table using ticks. You should refer to the EIA guidance notes for areas of possible impact and also the Glossary if needed.

- Where you think that the *policy* could have a **positive** impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, tick the 'Positive impact' box.
- Where you think that the *policy* could have a **negative** impact on any of the equality group(s) i.e. it could disadvantage them, tick the 'Negative impact' box.
- Where you think that the *policy* has **no impact** on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, tick the 'No impact' box.

Equality Group	Positive Impact	Negative Impact	No Impact	Reasons for decision
Age			x	
Disability			x	
Faith and Belief			x	
Gender			x	
Race			x	
Sexual Orientation			x	

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- **A negative impact and**
- **No consultation (this excludes any *policies* which have been identified as not requiring consultation).**

8. If there is no evidence that the *policy* promotes equality, equal opportunities or improved relations - could it be adapted so that it does? How?	Full statement of commitment to policy of equal opportunities is included in the policy

Please sign and date this form.

Keep one copy and send a copy to the Human Resources Team, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Lamorna House, Penventinnie Lane, Truro, Cornwall, TR1 3LJ They will arrange for a summary of the results to be published on the Trust's web site.

Signed _____

Date _____

Appendix 2: Advice for Clinical Staff for use of Sedation in Challenging Behaviour

The following advice is to assist staff in delivering safe and effective medication to de-escalate challenging behaviour that is frequently seen in those persons with delirium and / or dementia.
All sedatives may cause delirium, especially those with anticholinergic side effects. The use of sedatives and major tranquillisers should therefore be kept to a minimum. Prior to giving medication it is necessary to determine that all other non-therapeutic interventions such as calm lighting, appropriate environmental support, toileting, hunger and thirst have been addressed.

If these measures fail then medication may be the only option to ensure delivery of safe care.

1. Drug sedation may be necessary in the following circumstances:
    - **in order to carry out essential investigations or treatment**
    - **to prevent patients endangering themselves or others**
    - **to relieve distress in a highly agitated or hallucinating patient**
2. It is essential that a determination of Mental Capacity has been undertaken and MCA level 3 form completed to ensure robust and legally supported framework for intervention is evidenced.
3. The rational for requiring sedation must be documented.
4. It is preferable to use one drug only, starting at the lowest possible dose and increasing in increments if necessary after an interval of 30 minutes.
5. If repeated dosed of medication are required then Application for Deprivation of Liberty (DoL) must be undertaken.
6. If sedatives are prescribed, the prescription should be reviewed regularly and discontinued as soon as possible.

The preferred drugs are:

- **Lorazepam** 0.5-1mg orally in the first instance with consideration for IM injection for those refusing oral medication. *Caution in respiratory disease.*
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-

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