

# DELIRIUM GUIDELINES

<b>Author</b>	Dementia Steering Group
<b>Lead Director</b>	Dr Rachel Holt, Consultant Physician, Elderly Medicine
<b>Electronic File Reference</b>	
<b>Version Number</b>	3.0
<b>Date of Publication on MY intranet</b>	November 2015
<b>Date Due for Revision</b>	November 2017
<b>Post Responsible for Revision</b>	Trust Dementia Lead
<b>Equality Impact Assessment</b>	Neutral
<b>Circulation</b>	Via staff intranet
<b>Restrictions</b>	Not a restricted document
<b>Total pages</b>	19

## Contents

2. Delirium Care Pathway
3. Checklist
4. Delirium Care Plan
6. Abbey Pain Scale
7. Assessment of Delirium
9. Investigation and Management of Delirium and Distress
14. Delirium information leaflet
18. Equality Impact Assessment

# Delirium Care Pathway Mid Yorkshire Hospitals Trust

**All new admissions**

AMTS on everyone ≥65 years

**Inpatients**

Be alert at all times but at least daily and at every bed move

## ASSESS DELIRIUM RISK

If any of these risk factors is present, the person is at risk of delirium

- **Age 65 years or older**
- **Cognitive impairment** (AMT score <8/10) and/or dementia
- **Current hip fracture**
- **Severe illness** (a clinical condition that is deteriorating or is at risk of deterioration)

NICE Clinical Guideline 103

## THINK DELIRIUM

**Recent changes** (hours or days) in behaviour

- **Social** – lack of cooperation, withdrawn, altered communication
- **Physical function** – reduced mobility, agitation, sleep disturbance, reduced oral intake
- **Cognitive function** – worsened concentration, disorientation, “confused”
- **Perception** – hallucinations (visual or auditory), delusions, paranoia
- **Conscious level** – more sleepy or alert than usual

NICE Clinical Guideline 103

**Known dementia**

**+ Dementia Care Pathway**

**Implement Delirium prevention care plan**

**Assess for delirium** Appendix 2

**Confusion Assessment Method (CAM)**

- 1** Acute onset and fluctuation of abnormal behaviour
- 2** Inattention (e.g. easily distractible, fail 20–1 test or months of year backwards)
- 3** Disorganized thinking (very rambling or irrelevant conversation)
- 4** Altered level of consciousness (drowsy or lethargic or agitated)

**Delirium = 1 + 2 + (3 OR 4)**

Inouye SK 2003

**Investigate and treat causes** (often multiple causes)  
Appendix 3

**Implement Delirium management care plan**

**Management of distress**  
Appendix 3

**Negative**

**Positive**

- Provide patient and family with delirium information leaflet Appendix 4
- **Monitor** delirium with **CAM / AMTS**
- Document diagnosis in notes and on **discharge letter**

## Checklist for Delirium Care

**Tick and date the box if assessed / performed**

**Risk Factor Assessment:** *Was the person assessed for the following on presentation?*

<b>Age 65 years or older</b>	
<b>Cognitive impairment</b> (AMT score <8/10) and/or dementia	
<b>Current hip fracture</b>	
<b>Severe illness</b> (a clinical condition that is deteriorating or is at risk of deterioration)	

**Interventions to Prevent Delirium:** *If the person had 1 or more of the features in the box above on presentation, were they assessed for the following within 24 hours of admission?*

<b>Cognitive impairment or disorientation</b>	
<b>Dehydration or Constipation</b>	
<b>Hypoxia</b>	
<b>Immobility or limited mobility</b>	
<b>Infection</b>	
<b>Multiple medications</b>	
<b>Pain and discomfort</b>	
<b>Poor nutrition</b>	
<b>Hearing and Visual impairment</b>	
<b>Sleep disturbance</b>	

**Indicators of Delirium at Presentation:** *Was the person at risk, assessed on presentation for recent (within hours or days) changes or fluctuations in behaviour?*

<b>Cognitive function:</b> for example, worsened concentration, slow responses, confusion?	
<b>Perception:</b> for example, visual or auditory hallucinations?	
<b>Physical function:</b> for example, reduced mobility, reduced movement, restlessness, agitation, changes in appetite, sleep disturbance?	
<b>Social behaviour:</b> for example, lack of cooperation with reasonable requests, withdrawal, or alterations in communication, mood and/or attitude?	

**Delirium Diagnosis:** *If any of these indicators were present, did a healthcare professional carry out a clinical assessment to confirm the diagnosis, using one of the following?*

<b>CAM</b> (4 point short CAM)	
<b>DSM IV criteria</b>	
<b>CAM-ICU</b>	

# Delirium Prevention and Management Care Plan

*Guidance based on NICE Clinical Guideline 103*

For each individual patient, the clinical factors contributing to the risk of, or the episode of, delirium will vary. The same clinical factors act as a risk factor before an episode and as a cause of delirium during an episode.

**Within 24 hours of admission identify which clinical factors from the table below are present in the individual and manage as described. Reassess at least weekly and every bed move.**

Patient name: \_\_\_\_\_

Unit number/sticker: \_\_\_\_\_

Please complete for patient with <u>ANY ONE OF</u> :	<b>Tick</b>
<b>Age 65 years or older</b>	
<b>Dementia or AMT score &lt;8/10</b>	
<b>Current hip fracture</b>	
<b>Severe illness</b> (a clinical condition that is deteriorating or is at risk of deterioration)	
<b>Delirium present</b>	

Clinical Factor	Date Present	Intervention Suggested	Interventions Actioned
<b>Cognitive impairment or disorientation</b>		<ul style="list-style-type: none"> <li>▪ <b>Avoid bed moves</b> – only if agreed with senior medic</li> <li>▪ Provide appropriate lighting and clear signage. A clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk</li> <li>▪ Familiarise patient with yourself when caring for them</li> <li>▪ <b>Reorientate</b> the person by explaining where they are, when it is, who you are, what your role is and what is happening to them – <b>Person-centered communication</b></li> <li>▪ Introduce cognitively stimulating activities (for example, reminiscence)</li> <li>▪ <b>Facilitate regular visits from family and friends – consider Forget-Me-Not and Carer Passport</b></li> </ul>	
<b>Dehydration or Constipation</b>		<ul style="list-style-type: none"> <li>▪ <b>Encourage the person to drink</b> at least hourly. Consider offering subcutaneous or intravenous fluids if necessary</li> <li>▪ Seek advice if necessary when managing fluid balance in people with comorbidities (for example, heart failure or chronic kidney disease)</li> <li>▪ Start a <b>bowel chart</b>. Highlight and treat constipation</li> <li>▪ Perform post-micturition <b>bladder scan</b></li> </ul>	
<b>Hypoxia</b>		<ul style="list-style-type: none"> <li>▪ Assess for hypoxia and <b>optimise oxygen saturation</b> if necessary</li> </ul>	

<b>Immobility or limited mobility</b>						<ul style="list-style-type: none"> <li>▪ Encourage all people, including those unable to walk, to carry out <b>active range-of-motion exercises</b></li> <li>▪ Encourage the person to: <ul style="list-style-type: none"> <li>- mobilise soon after admission</li> <li>- <b>walk frequently</b> (even short distance to toilet, walking aids should be accessible if appropriate) <ul style="list-style-type: none"> <li>▪ allow to wander on ward with supervision e.g. safety guardian</li> </ul> </li> </ul> </li> </ul>	
<b>Infection</b>						<ul style="list-style-type: none"> <li>▪ Look for and treat infection</li> <li>▪ <b>Avoid unnecessary catheterisation</b></li> <li>▪ Implement infection control procedures</li> </ul>	
<b>Multiple medications</b>						<ul style="list-style-type: none"> <li>▪ Doctor to carry out a <b>medication review</b> and stop or reduce doses of unnecessary drugs</li> </ul>	
<b>Pain and discomfort</b>						<ul style="list-style-type: none"> <li>▪ Assess for pain. <b>Look for non-verbal signs of pain</b>, particularly in people with communication difficulties or dementia (use <b>Abbey Pain Scale – Appendix 1</b>)</li> <li>▪ Start and review for adequate pain management in any person in whom pain is identified or suspected</li> <li>▪ Avoid unnecessary invasive devices (urinary catheter, cannula etc.)</li> </ul>	
<b>Poor nutrition</b>						<ul style="list-style-type: none"> <li>▪ Follow the Trust guidance for nutritional assessment and management</li> <li>▪ If the person has <b>dentures</b>, ensure they fit properly</li> </ul>	
<b>Hearing and Visual impairment</b>						<ul style="list-style-type: none"> <li>▪ Resolve any reversible cause of the impairment (such as impacted <b>ear wax</b>)</li> <li>▪ Ensure <b>working hearing aids and spectacles are available</b> to and used by people who need them</li> </ul>	
<b>Sleep disturbance</b>						<ul style="list-style-type: none"> <li>▪ Aim for a normal sleep-wake cycle</li> <li>▪ Avoid nursing or medical procedures and medications during sleep, reduce noise to a minimum during sleep periods</li> </ul>	
<b>Agitation</b>						<ul style="list-style-type: none"> <li>▪ See Appendix 3 for management of distress and agitation</li> <li>▪ Consider one-to-one observation if patient high risk of falls or high risk of harm to themselves or others</li> <li>▪ Complete Risk Assessment form if required</li> </ul>	

# Appendix 1: Abbey Pain Scale

## Abbey Pain Scale

*For measurement of pain in people with dementia who cannot verbalise.*

**How to use scale :** While observing the resident, score questions 1 to 6.

**Name of resident :** .....

**Name and designation of person completing the scale :** .....

**Date :** ..... **Time :** .....

**Latest pain relief given was**.....**at**.....**hrs.**

- |   |    |   |
|---|----|---|
| <p><b>Q1. Vocalisation</b><br/>eg whimpering, groaning, crying<br/><i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p>   | Q1 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p><b>Q2. Facial expression</b><br/>eg looking tense, frowning, grimacing, looking frightened<br/><i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p>  | Q2 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p><b>Q3. Change in body language</b><br/>eg fidgeting, rocking, guarding part of body, withdrawn<br/><i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p>                                    | Q3 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p><b>Q4. Behavioural Change</b><br/>eg increased confusion, refusing to eat, alteration in usual patterns<br/><i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p>                           | Q4 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p><b>Q5. Physiological change</b><br/>eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor<br/><i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p> | Q5 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p><b>Q6. Physical changes</b><br/>eg skin tears, pressure areas, arthritis, contractures, previous injuries<br/><i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p>                         | Q6 | <input style="width: 40px; height: 25px;" type="text"/> |

Add scores for 1 - 6 and record here ➔ **Total Pain Score**

Now tick the box that matches the Total Pain Score ➔

0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe
------------------	---------------	--------------------	----------------

Finally, tick the box which matches the type of pain ➔

Chronic	Acute	Acute on Chronic
---------	-------	------------------

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.  
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002  
*(This document may be reproduced with this acknowledgement retained)*

## Appendix 2: Assessment of Delirium

# THINK DELIRIUM – if unsure whether this is dementia or delirium, assume delirium

### 1. From NICE clinical guideline 103

- Carry out a clinical assessment for delirium e.g. DSM IV criteria or Short CAM to confirm the diagnosis
- A healthcare professional who is trained and competent in the diagnosis of delirium should carry out the assessment
- Ensure that the diagnosis of delirium is documented both in the person's hospital record and in their primary care record

### 2. Confusion Assessment Method (Short CAM)

#### Confusion Assessment Method (CAM)

(Adapted from Inouye et al., 1990)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Assess the following factors.

#### **Acute Onset**

1. Is there evidence of an acute change in mental status from the patient's baseline?  
\_\_\_ YES      \_\_\_ NO      \_\_\_ UNCERTAIN      \_\_\_ NOT APPLICABLE

#### **Inattention**

*(The questions listed under this topic are repeated for each topic where applicable.)*

- 2A. Did the patient have difficulty focusing attention (for example, being easily distractible or having difficulty keeping track of what was being said)?  
\_\_\_\_ Not present at any time during interview  
\_\_\_\_ Present at some time during interview, but in mild form  
\_\_\_\_ Present at some time during interview, in marked form  
\_\_\_\_ Uncertain
- 2B. *(If present or abnormal)* Did this behavior fluctuate during the interview (that is, tend to come and go or increase and decrease in severity)?  
\_\_\_ YES      \_\_\_ NO      \_\_\_ UNCERTAIN      \_\_\_ NOT APPLICABLE
- 2C. *(If present or abnormal)* Please describe this behavior.  
\_\_\_\_\_  
\_\_\_\_\_

#### **Disorganized Thinking**

3. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable, switching from subject to subject?  
\_\_\_ YES      \_\_\_ NO      \_\_\_ UNCERTAIN      \_\_\_ NOT APPLICABLE

#### **Altered Level of Consciousness**

4. Overall, how would you rate this patient's level of consciousness?  
\_\_\_\_ Alert (*normal*)  
\_\_\_\_ Vigilant (*hyperalert, overly sensitive to environmental stimuli, startled very easily*)  
\_\_\_\_ Lethargic (*drowsy, easily aroused*)  
\_\_\_\_ Stupor (*difficult to arouse*)  
\_\_\_\_ Coma (*unarousable*)  
\_\_\_\_ Uncertain

**Scoring:**

For a diagnosis of delirium by CAM, the patient must display:

1. Presence of acute onset and fluctuating discourse

AND

2. Inattention

AND EITHER

3. Disorganized thinking

OR

4. Altered level of consciousness

**Source:**

Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegel AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med.* 1990;113(12):941-948.

**3. Additional Features of Delirium**

**Disorientation**

5. Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?

YES       NO       UNCERTAIN       NOT APPLICABLE

**Memory Impairment**

6. Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?

YES       NO       UNCERTAIN       NOT APPLICABLE

**Perceptual Disturbances**

7. Did the patient have any evidence of perceptual disturbances, such as hallucinations, illusions, or misinterpretations (for example, thinking something was moving when it was not)?

YES       NO       UNCERTAIN       NOT APPLICABLE

**Psychomotor Agitation**

- 8A. At any time during the interview, did the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent, sudden changes in position?

YES       NO       UNCERTAIN       NOT APPLICABLE

**Psychomotor Retardation**

- 8B. At any time during the interview, did the patient have an unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time, or moving very slowly?

YES       NO       UNCERTAIN       NOT APPLICABLE

**Altered Sleep-Wake Cycle**

9. Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

YES       NO       UNCERTAIN       NOT APPLICABLE

## **Appendix 3: Investigation and Management of Delirium and Distress**

### **Investigation of Delirium: Assume delirium initially if there is difficulty distinguishing between delirium, dementia or dementia + delirium**

#### **1. History**

- Collateral from family, friends, carers, other health professionals: usual cognitive function, alcohol/drug intake, possession of spectacles and hearing aids, course of episode, symptoms of underlying causes, previous episodes of delirium
- Patient: symptoms, fears, ask about hallucinations and delusions

#### **2. Examination**

- Full clinical examination
- Should include neurological examination and rectal examination for constipation and assessment for possible urine retention
- Assess cognition (AMTS)
- Assess nutrition and hydration

#### **3. Essential Investigations**

- Blood tests: FBC, U&E, LFT, Calcium, Glucose, CRP
- Oxygen saturations
- Urine dipstick: **in older patients it is common for uninfected urine samples to test positive for protein, blood and leucocytes - do not treat on the basis of this alone. Ensure a sample is sent to the microbiology laboratory**
- CXR
- ECG

#### **4. Additional investigations (if cause not apparent or delirium not improving with treatment)**

- Blood cultures
- Abdominal X-ray &/or other imaging
- CT head – focal neurological signs present or new confusion with head injury
- Thyroid function, vitamin B12 and folate levels
- Lumbar puncture for encephalitis or other CNS infection
- Toxicology / drug levels
- EEG for non-convulsive status epilepticus or recurrent seizures, and for delirium diagnosis

### **Treatment of Delirium:**

#### **1. Treat all Causes and Contributory Clinical Factors (see tables above and below)**

**2. Monitor patients with delirium for resolution – use serial AMTS/CAM scores every day/few days.** For people in whom delirium does not resolve, reevaluate for underlying causes and follow up and assess for possible dementia. **Refer to primary care for follow-up of delirium and cognitive impairment – include in discharge letter.**

#### **3. Non-pharmacological Management of Distress and Agitation**

- **Bed moves should be avoided unless absolutely necessary**
- Patients are cared for by a team of staff familiar to them whenever possible, and who are trained and competent in delirium prevention and management
- Environment is quiet and well-lit
- **Communication is person-centered**, sympathetic and effective, uses short sentences, and includes reorientation and reassurance for people diagnosed with delirium

- Involvement of family and friends: **provide Trust information leaflet on delirium**
- Acknowledge the feelings and experiences of the patient (they may be experiencing frightening hallucinations and delusions). The delusions in delirium often involve a belief that staff are trying to harm them.
  
- People with delirium are frequently unable to express their care needs, and challenging behaviors may also occur as a result of unmet needs. Because of the increased cognitive impairment and lack of insight which can occur in delirium, patients may be less able to assess the risk of their behaviour. Therefore patients may be at greater risk of exhibiting challenging behaviour and injuring themselves or others.
  
- People with delirium are frequently unable to comprehend what staff are saying to them:
  - **Speak slowly** and clearly using short sentences and words
  - Make **eye contact** with the patient
  - **Explain** what you are about to do before you do it
  - **Do not argue** with the patient, even if they are illogical or uncooperative
  
- Consider one to one observation (this could be done discretely or openly, and can be continuous or a fixed frequency) and is important if the patient is a high risk to themselves or others. Complete risk assessment -
  
- **Use verbal and non-verbal de-escalation techniques** *(from NICE Clinical Guideline 25: Violence Section 1.6 De-escalation techniques)*
  - De-escalation should be employed early on in any escalating situation
  - Staff should accept that in a crisis situation they are responsible for avoiding provocation. **It is not realistic to expect the person exhibiting distressed or agitated behaviour to simply calm down**
  - Staff should learn to recognise what generally and specifically upsets and calms people. This will involve listening to individual patient's and carer's reports of what upsets the patient, use the Forget-Me-Not documentation if available
  - Staff should be aware of, and learn to monitor and control, their own verbal and non-verbal behaviour – good eye contact and allowing greater body space than normal, adopting a non-threatening but safe posture and appearing calm, self-controlled and confident without being dismissive or over-bearing.
  - Where weapons are involved a staff member should ask for the weapon to be placed in a neutral location rather than handed over.
  - **One staff member should assume control of a potentially violent situation.** This staff member should consider which de-escalation techniques are appropriate for the situation, manage others in the environment, for example enlisting the help of colleagues and creating space, explain to the service user and others in the immediate vicinity what they intend to do, give clear, brief, assertive instructions, and move towards a safe place without potential weapons and avoid being trapped in a corner. The staff member who has taken control should ensure that their own non-verbal communication is non-threatening and not provocative. Show concern and attentiveness through non-verbal and verbal responses, listen carefully and show empathy, acknowledging any grievances or frustrations, and not being patronising. The staff member who has taken control should attempt to establish a rapport and emphasise cooperation, offer and negotiate realistic options and avoid threats to the patient, ask open questions and inquire about the reason for the distress, for example 'What has caused you to feel upset/angry?'
  
- **Distraction techniques** can be more effective in patients with delirium because delirium causes inattention. If the patient's attention can easily be distracted from the source of distress then this

should be the main way of dealing with challenging behaviour. To be most effective it requires one-to-one nursing or from family to increase the development of trust. Staff should allow supervised wandering and activities such as making a bed or playing a game, where it does not pose a major risk to the patient or others.

- If it has not been possible to prevent the escalation of the challenging behaviour, and the behaviour is putting the individual or others at imminent risk of harm, then interventions involving restraint may be appropriate. It should be said that these interventions are used:

- as a last resort
- following risk assessment and care planning if possible
- for only as long as absolutely necessary
- by staff who have received the appropriate training
- not for punitive reasons
- in a way that respects people and protects dignity and human rights
- in the best interests of the recipient of the restraint

- Situations in which restraint can be justified include where staff have a professional duty of care to restrain a patient to protect that patient from a greater risk of harm, or to avoid a foreseeable risk of harm occurring to others. In a situation where a staff member is being attacked or is at risk of physical harm, it is possible to justify the use of restraint as self defence.

- The restraints that are most appropriate in our clinical settings are **physical holding** and **pharmacological management**.

- 'Physical holding' can include blocking the patient's movement to stop them leaving, gentle but firm pressure on a patient's arm to prevent them from removing medical equipment to which they are attached, through to the patient being held in a seated or prone position by several people. The latter is sometimes referred to as 'control and restraint', and only staff who have received appropriate 'Control and Restraint' training should attempt to do this. 'Control and restraint' should in general be avoided in older, frailer patients with delirium, because of the significant physical risks to them. Efforts should be made to identify someone of the same gender to undertake the physical holding. Security officers on our premises are staff who have undertaken this training.

- In many cases of restraint, the patient will not have consented to the intervention. In nearly all of these cases, the patient will not have the capacity to consent to the intervention. The **Mental Capacity Act (2005)** sets out the conditions in which an act may be planned that would constitute restraint of a patient who lacks capacity. The legal authority to restrain a patient is allowed only *if* the following three conditions are satisfied:

1. Patient lacks capacity in relation to the matter in question
2. Staff reasonably believe that it is necessary to do the act in order to prevent harm to the patient
3. The act is a proportionate response to the likelihood of the patient suffering harm and the seriousness of that harm

There is further guidance on assessing capacity and determining whether the action is in the 'best interests' of the patient on the Trust intranet.

(Click on: Dept → Corporate → Nursing → Safeguarding Adults → Mental Capacity Act → Assessment documents)

- Some restraint interventions are a restriction of the liberty of the patient, one of their Human Rights. Some interventions are for short periods, though others such as continuous observation or preventing the patient from leaving the hospital could go on for an extended period. Such a restriction, either on its own or combined with other restrictions (e.g. limited visiting allowed), could amount to a deprivation of liberty. In such cases staff should ensure 'safeguards' are in place to ensure that the deprivation of liberty is lawful – it should be appropriate and proportionate. The 'safeguards' are considering the use of either the Mental Health Act or the Mental Capacity Act (**Deprivation of Liberty Safeguards-DOLS**). There is further guidance on use of DOLS on the Trust Intranet.

- All decisions and actions taken by staff **should be documented** in accordance with agreed best practice. This requires detailed risk assessment and care planning prior to the intervention if possible, and a factual description of decisions and actions taken during the intervention. This will include a description of the interaction with the patient and relatives, if available, detailing the information provided to them. Following the restraint the recipient and those involved in the restraint should be assessed for signs of injury and any emotional/psychological impact. The notes should be signed, timed and dated.

- Arrangements to support **staff** who have suffered a violent or aggressive incident will be actioned by the Trust's Occupational Health Department. This department monitors on a Trustwide basis developing trends and concerns. Such monitoring is reported to appropriate managers and/or committees, which may include the Trust's Local Security Management Specialists (LSMS). Support for staff involved or affected in an incident is detailed in the policy 'Supporting Staff involved in Incidents, Complaints and Claims (2008)'.

#### 4. Pharmacological Management

In patients with delirium short courses of low dose haloperidol or olanzapine *may reduce severity* of the delirium. **They should only be used to control challenging behaviour as a last resort.**

- consider short-term ( $\leq 1$  week) use of **haloperidol** (0.5mg PO/IM usually bd, with maximum dosing frequency every 30 minutes and maximum dose in 24 hours 2mg). Titrate doses cautiously according to symptoms.

**ECG** should be checked for QTc immediately prior to and at least once during use as prolongation of QTc is a relative contraindication to use of Haloperidol.

- **OR olanzapine** 2.5 or 5mg (PO orodispersible Velotab once daily maximum) as a last resort.

*N.B. Haloperidol and olanzapine do not have UK marketing authorisation for this indication.*

- Use **lorazepam** 0.5mg PO /IM (if available)/sublingual where antipsychotics contraindicated - e.g. Lewy body dementia, Parkinson's disease, prolonged QTc on ECG, bradycardia and phaeochromocytoma. Titrate doses cautiously according to symptoms.

*N.B. This is an unlicensed use.*

Rapid tranquillisation should be avoided due to various risks, including "underlying coincidental physical disorders" (NICE Clinical Guideline 25: Violence, Section 8.1.8.4) which are usually present in cases of delirium.

**Common Causes of Delirium: usually multiple causes. Assess for Clinical Factors (see Delirium Care Plan)**

Possible Cause	Differential Diagnosis / Comments
Severe illness	Admissions to critical care at high risk of delirium
Medications	Consider all new medications Especially - low dose opiates giving inadequate pain relief, benzodiazepines, calcium channel blockers, antihistamines, medications with anticholinergic activity, psychoactive medications
Infection	Don't assume UTI Sepsis
Constipation / Urine retention	Very common in frail elderly
Restraint	Physical restraint – urinary catheter, intravenous drip, table in front of chair, cot sides Pharmacological restraint
Change in environment	Move from a familiar environment Bed moves Carers unfamiliar to patient Routine unfamiliar to patient
Hypercapnoea	(high pCO <sub>2</sub> ) Respiratory failure Obstructive sleep apnoea
Hypoxia	Heart failure Anaemia Pneumonia Pulmonary embolus Other causes of respiratory failure
Neurological	Seizures Stroke Head injuries etc.
Cardiological	Myocardial infarction Arrhythmia
Electrolyte imbalance	Dehydration Renal failure Hyponatraemia Hypercalcaemia etc.
Endocrine / metabolic	Hyperglycaemia / hypoglycaemia Thyroid disease Liver disease
Withdrawal	Alcohol Medications Nicotine Drugs
Surgical and anaesthetic	Trauma Pain Anaesthetic agents

## Appendix 4: Delirium Information Leaflet

Copies of the leaflet are available from print room. The sheets fold together to form a booklet

### Contact details

Dr Rachel Holt, Consultant Physician and Trust  
Dementia Lead.

Telephone: 01924 542468/ 541658

### References:

<sup>1</sup>NICE Clinical Guideline Delirium 103 <http://guidance.nice.org.uk/CG103>

<sup>2</sup>NICE delirium quick reference guide <http://guidance.nice.org.uk/CG103/QuickRefGuide/pdf/English>

We are committed to providing high quality care. If you have a suggestion, comment, complaint or appreciation about the care you have received, or if you need this leaflet in another format please contact the Patient Advice and Liaison Service on: 01924 542972 or email: [pals@midyorks.nhs.uk](mailto:pals@midyorks.nhs.uk)

To contact any of our hospitals call: **0844 811 8110**  
To book or change an appointment call: 0844 822 0022

[www.midyorks.nhs.uk](http://www.midyorks.nhs.uk)

1719a  
Published May 2015  
Review Date 2018



SMOKE FREE  
hospital

cleanyourhands<sup>®</sup>  
campaign



Image: The Mid Yorkshire Hospitals NHS Trust - 0807 941 941

The Mid Yorkshire Hospitals   
NHS Trust

## Delirium Prevention and Management

Information for patients, relatives  
and friends

### What are the signs of Delirium?

- New onset of temporary confusion.
- Or worsening of confusion, with
- Disorientation.
- Rambling conversation
- Sometimes hallucinations
- People behave in ways that are unusual for them or say unusual things.
- They become unusually sleepy or agitated
- Comes on quickly
- Varies from hour to hour



Regular contact with familiar people and objects from outside hospital is very important to people with delirium. This helps to calm and reassure them.

We would suggest that you talk slowly and clearly about familiar, non-worrying topics. Remind them often where they are and what the time and date is. Try to use a calm and reassuring tone.

It may be distressing for you to have a relative or friend who is delirious. They may fail to recognise you or may behave out of character.

Despite this it is important to continue visiting if you can and hopefully the patient will improve and respond to your visits.

You can help prevent Delirium developing in your relative, friend or yourself or help to treat it by<sup>2</sup>:

1. Tell a member of staff if you notice that you or the person you know has become confused or more confused than usual, as they may be developing delirium.
2. Unless the person is Nil by Mouth or on a fluid restriction, encourage them to drink plenty of water or squash or tea, this can prevent and treat dehydration and constipation. This includes thickened fluids for those having them. Extra fluids can also be mixed into some foods.
3. Try to drink four glasses of water in a day, on top of two to four cups of tea or coffee.



4

3. Remind the person where they are and what is going on. Remind them of the date and time. Chat to them about current events. Bring in photos of the person and of friends and family.
4. Make sure the person has their **working hearing aid** and **spectacles** with them. Please ask a member of staff if new hearing aid batteries are needed.



5. Inform staff what the person's memory and behaviour are normally like.

5

---

The Mid Yorkshire Hospitals NHS Trust is implementing a programme to prevent and better manage delirium when it occurs.

Staff will be educated about what delirium is and how to prevent and manage it.

If staff identify a person has delirium, they will use a special care pathway to help them care for the person.

In order to prevent delirium the staff will approach patients in order to assess and reduce their risk factors for delirium:

- Disorientation
- Dehydration
- Reduced Vision
- Reduced Hearing
- Pain
- Constipation
- Poor Mobility
- Look out for infections.

6

Delirium is a sign that someone is physically unwell.

Delirium is more common in people who are older, and people who are unwell.

The cause of delirium is not always known.

It is also commoner when people are in hospital. This is because they are more poorly, and because they are in an unfamiliar place.

Most older people in hospital are at some risk of delirium<sup>1</sup>

3

**EQUALITY IMPACT ASSESSMENT  
INITIAL ASSESSMENT/SCREENING**

An impact assessment is a way of finding out whether an existing or proposed policy affects different groups of people in different ways and whether there is adverse impact on a group.

This form is to be used for new and existing policies and service developments, where a question is not applicable to your assessment, please indicate.

<b>Managers Name</b> Dr Rachel Holt	<b>Directorate</b> Medical Directorate
<b>Policy Title</b> Delirium Guidelines	
<b>Policy Statement</b> This policy determines that all Trust procedural documents will comply with the standards described	
Which groups does the policy benefit All staff and patients	
Related polices that may be affected by changes Dementia Care Pathway Policy	
<b>Names of staff and public (if applicable) who participated in the assessment, date of assessment</b> Dr Rachel Holt 14/10/2015	

If the answer to any of the above is 'yes' an Intermediate assessment in the relevant area(s) is required. If not please complete below and then

<b>Indicate either Y or N in each Box below in answer to the following questions/statements (cannot be both Y &amp; N in same box or left blank)</b>										
	Marriage & Civil Partnerships	Pregnancy & Maternity	Sex	Age	Disability	Ethnicity	Religion and belief	Gender/transgender	Sexual Orientation	
Do different groups have different needs, experiences, issues and priorities in relation to the policy or service?	N	N	N	N	N	N	N	N	N	
Is there potential for or evidence that, the policy or service will discriminate against certain groups?	N	N	N	N	N	N	N	N	N	
Is there public concern in the policy area about actual, received or potential discrimination against particular groups?	N	N	N	N	N	N	N	N	N	
Is there doubt about answers to any of the above questions submit to the relevant board/committee for approval.	N	N	N	N	N	N	N	N	N	