Delirium Management

CARE HOME SUMMARY PATHWAY

Developed in collaboration with Healthcare Improvement Scotland

SCOTTISH DELIRIUM ASSOCIATION

THINK DELIRIUM

History of acute change
Change in alertness, mood, behaviour, thinking, function
**See comprehensive pathway for high risk groups*

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

Clinical suspicion of delirium or "local tool" positive
[the 4AT or CAM]

Consider life-threatening illness
e.g. infection/sepsis, hypoxia, hypoglycaemia, medicine intoxication
carry out relevant investigations

Key worker to clarify background history of change in symptoms and consider AWI section 47 if not already in place

Use local tool to obtain a baseline measure of cognition
[GPCog AMT10 MOCA]
Assessment and initial investigations

General observations - (P,BP,Temp,Resp)
Arousal level
Constipation (PR)
Bladder and skin
Dipstix + mssu,
Bloods – including U&E, FBC, CRP
Recent medication changes
Initiate behaviour chart and sleep chart
**see comprehensive pathway*

Medication review
**see comprehensive pathway*

Further Investigation if indicated
**see comprehensive pathway*

Optimise management of co-morbidity
**see comprehensive pathway*

Management
Treat underlying causes
N.B. In up to 30% of cases no cause is found.
Delirium diagnosis should be upheld and managed as follows:
(For UTI please refer to Antibiotic Use In Carehomes pack)

Medical Management

- Document delirium, explain to patient & carer and provide information leaflet
- Assess and treat pain (e.g. by using the Abbey Pain Scale or similar)
- Ensure O_2 sats are greater than 95% (except in COPD with Type 2 respiratory failure)
- **Avoid constipation and catheterisation**
- Use Butterfly scheme / "This is me" / "Forget me not" / "Getting to know me" (if available)

Environmental & General Measures

- Ensure glasses and hearing aids working (ear wax)
- Sleep chart (*see comprehensive pathway*)
- Ensure regular mobilisation
- Ensure good diet taken, keep daily food & fluid charts
- Consider if swallow safe
- Reduce stress to patient (*see comprehensive pathway*)
- Ensure orientation
- Avoid unnecessary interventions

Treatment of Delirium Symptoms

- Encourage regular family visits to reassure & support care
- Consider additional staff
- Assess for psychotic symptoms and treat if distressing
- If patient symptoms threaten their safety or the safety of others use low dose of **one medication** (start low and go slow method) & review every 24 hours
  Haloperidol 0.25mg bd, maximum 1mg in 24 hours or
  Risperidone 0.25mg daily, maximum of 1mg in 24 hours (avoid in PD/ Lewy Body dementia)
  Lorazepam 0.5mg up to 1mg maximum in 24 hours if antipsychotics contraindicated as above
- Inform next of kin of medication changes
- Consider capacity (AWI section 47 if appropriate)

Repeat delirium screening daily until two successive negatives
Improvement in sleep pattern, behaviour and cognition can signal recovery from delirium

Triggers for Referral to Care Home Liaison Nurse/CPN

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

Patient Improving

- Reduce and discontinue anti-psychotic treatment
- Repeat cognitive tool

Patient NOT Improving Re-assess

Ongoing Cognitive Impairment

- Note delirium and inform patient's GP
- Follow Cognitive Impairment Pathway

No Ongoing Cognitive Impairment

- Inform patient's GP of delirium and the risk of dementia in the future if an older patient

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

The Comprehensive Pathway provides further information to this pathway - *version 1.0 Aug 2016, Review date Aug 2018.*