Delirium Management

COMMUNITY CARE PATHWAY

Developed in collaboration with Healthcare Improvement Scotland

SCOTTISH DELIRIUM ASSOCIATION

THINK DELIRIUM

History of acute change
Change in behaviour, physical condition, ability to perform ADLs
**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

Take informant history if available and consider AWI section 47
[IQCODE AD8]

Use local tool to obtain a baseline measure of cognition
[GPCOG AMT10 MOCA]
Clinical assessment and physical examination

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

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

- Glasses and hearing aids working (ear wax?)
- Sleeping well?
- Regular mobilisation?
- Good diet?
- 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 help at home
- 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 0.25 mgs daily, maximum 1mg in 24 hours
  (avoid in PD/ Lewy Body dementia)
  Lorazepam 0.5mg up to 1mg in 24 hours if antipsychotics contraindicated as above
- Inform next of kin of medication changes
- Consider capacity (AWI section 47 if appropriate)

Triggers for Referral to CMHT(E) or Geriatrician

- Severe agitation or distress not responding to standard measures
- Doubt about diagnosis
- Not able to remain at home

Reassess patient as clinically indicated

Improvement in sleep pattern, behaviour and cognition can signal recovery from delirium

Patient Improving

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

Patient NOT Improving Reassess

Ongoing Cognitive Impairment

- Note delirium
- Follow Cognitive Impairment Pathway

No Ongoing Cognitive Impairment

- Note delirium and the potential 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.*