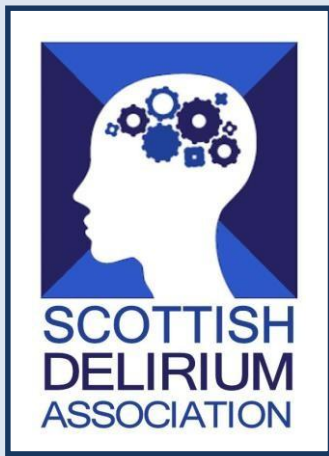




DELIRIUM MANAGEMENT SUMMARY PATHWAY

Developed in collaboration with



THINK DELIRIUM

History of acute change in mental status
Change in cognition, behaviour, physical condition, ability to perform ADLs
**See comprehensive pathway for high risk groups*

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

Clinical suspicion of delirium or "local tool" positive
[e.g. 4AT or CAM]

Act on acute, severe causes
e.g. infection/sepsis, hypoxia, hypoglycaemia, medicine intoxication

This pathway is appropriate for adult patients (18 years & over)

Clinical team should take informant history and assess capacity
(e.g. is AWI Section 47 needed for basic care?) [IQCODE AD8]

General observations, arousal level, neurology, constipation (PR), bladder and skin
**see comprehensive pathway*

Use local tool(s) to record baseline cognition/arousal level
[MOCA GPCOG AMT10 AMT4 AVPU]
Clinical assessment and full physical examination

Medication review
See comprehensive pathway

Investigation
See comprehensive pathway

Optimise management of co-morbidity
See comprehensive pathway

Management

Treat all underlying causes
N.B. In up to 30% of cases no cause is found.
Even if no clear causes, uphold the diagnosis of delirium and manage as follows:

Medical & Nursing 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 O₂ saturation > 95% (caution if COPD/Type 2 resp failure)
- Avoid or treat constipation
- Avoid catheterisation if possible
- Use local person centred care documentation e.g. "Getting to Know Me"
- Consider if swallow is safe

Environmental & General Measures

- Ensure glasses available and hearing aids are working (check for ear wax)
- Sleep chart (*see comprehensive pathway*)
- Aim for regular mobilisation
- Ensure adequate diet taken, keep daily food & fluid charts
- Reduce stress to patient (*see comprehensive pathway*)
- Avoid bed moves & ensure orientation
- Avoid unnecessary interventions

Treatment of Delirium Symptoms

- Encourage frequent 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** (**see comprehensive pathway*) (start low - go slow method) and review drug use at least every 24 hours (**see local pathway*).
- Inform next of kin of medication changes
- Assess capacity (AWI Act & Mental Health Act)

The comprehensive pathway provides more detailed information.

Repeat delirium assessment when clinically indicated until two successive daily negatives

Triggers for Referral to Liaison Psychiatry

- 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 any new anti-agitation drugs
- Repeat cognitive tool

Patient NOT Improving

after 5-7 days or if severe delirium, refer to a geriatrician

Ongoing Cognitive Impairment

- Note delirium and inform patient's GP
- Follow local 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 causes are treated

The SDA pathways are not exhaustive. Additional or alternative assessments, investigations, management strategies or treatments may be necessary for individuals. **Clinical judgement & decisions should be made by the appropriate responsible healthcare professional.**

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