PRT01
Prevention, Diagnosis and Management of Delirium in Adult Inpatients

1.0 Procedure Statement (Purpose / Objectives of the Procedure)

The purpose of this protocol is to outline the processes for the prevention, diagnosis and management of delirium in adult inpatients in RWT. The aim of the protocol is to:

1. Promote prevention and early diagnosis of patients with delirium,
2. Promote best practice care of patients with delirium, and
3. Promote discharge review and referral to appropriate services for patients with delirium.

The expected outcome is reduction in rates of delirium, improved quality of care for those suffering a delirium, and improved long term outcomes.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict-of-Interest Policy is to be considered the primary and overriding Policy.

2.0 Accountabilities

Individual directorates and clinical leads have responsibility for this clinical protocol in their individual directorates.

3.0 Procedure/Guidelines Detail / Actions

Background

Delirium is a state of acute confusion. It is very common with a point prevalence ranging between 7% and 25% (1, 2) and incidence of up to 50% (3). It is very distressing for the patient and those looking after them. It increases both morbidity and mortality, it increases length of hospital stay, and it increases the likelihood of entering 24-hour care (4, 5, and 6).

There are several types of delirium: hyperactive, hypoactive and mixed (Appendix 1). Hypoactive delirium has the highest mortality because it is under-recognised, with subsequent delays in treatment.

Delirium often starts suddenly and can fluctuate in its course. It may lead to psychomotor agitation, inattention, disorganised thinking or even increased somnolence. Delirium is more common in those aged over 80, peri-surgery and in people with dementia.

Multidisciplinary intervention is the mainstay of recognition, prevention and management (7).

Identify Risk Factors and Precipitants for Delirium

Patients who experience delirium will often have inherent factors that increase their risk of developing delirium. These are often un-modifiable but need to be recognised.

They will have also often experienced an event that triggers developing the delirium. These are often modifiable and need to be recognised and managed appropriately.

Identifying and acknowledging these risks and precipitants allows for preventative measures to be put in place and higher vigilance to address a developing delirium.

Common Risk Factors for Delirium

- Age over 80,
- Pre-existing cognitive impairment including dementia,
- Pre-existing sensory impairment,
- Previous delirium,
- Pre-existing polypharmacy, and
- Pre-existing multi-morbidity including frailty.

Common Precipitants for Delirium (not exhaustive)

- Acute change in physical wellness
    - Infection (urinary, CNS, bowel, respiratory etc.),
    - Infarction (cardiac, stroke or bowel),
    - Instability (falls; injury including fracture),
    - Iatrogenic (procedures and surgery; or the overdose, withdrawal or initiation of certain medications), and
    - Incontinence (e.g., constipation or retention).

- Acute change in physiological well being
    - Depression,
    - Bereavement, and
    - Psychosis.

- Acute change in social wellness
    - New isolation,
    - New home arrangement (recent move to residential or nursing care),
    - New change in environment (lighting, noise, temperature etc.), and
    - New withdrawal from social drugs (nicotine, alcohol, street drugs etc.).

Delirium is often caused by more than one risk factor and precipitant. A careful history and examination of the patient is required to elucidate the cause(s) and to treat.

Often it is very helpful to obtain collateral history from a relative or carer and this is an opportunity to give information about what is happening.

- IQCODE (8) can be a useful tool in assessing a patient's premorbid function and cognitive function and teasing out delirium from dementia.

Prevention of delirium

Prevention of delirium is often possible, and simple implementations can be crucial in achieving this. In patients who have high risk characteristics or potential precipitants, the following steps can be taken to reduce the chance of developing a delirium.

- All staff must introduce themselves clearly, stating their roles, what they are doing, and constantly provide reassurances.
- Keep day and night times distinct:
  - Soft overhead lighting at night and
  - Minimal disruption at night.
- Multiple intra- and inter-ward transfers must be kept to absolute minimum and avoided wherever possible.
- Re-orientate patients on the ward with visual and verbal aids.
- Minimise ward disruption and keep routine:
  - Ensure patients who are able are dressed and sat out in mornings,
  - Answer call bells in timely manner,
  - Keep protected mealtimes, and
  - Provide regular drinks for hydration.
- Monitor toileting habits and provide toileting regime if necessary:
  - Treat constipation early and
  - Monitor for urinary retention
- Avoid physical restraint or restriction.
  - Use distraction techniques to combat repetitive or demanding Behaviour.

Detection of Delirium

If delirium does develop, early detection and treatment of the underlying cause can reduce the severity. A high clinical suspicion and alertness are key. (Appendix 2 – Algorithm for Assessment of Acute Delirium and Confusion)

Patients with risk factors and, or potential precipitants should be assessed on admission to hospital.

At risk patients should be assessed daily or even every shift for variations in behaviour.

Patients should be assessed if there is a change in behaviour or a concern raised by family or staff.

Clinicians (medical and nursing) should use a ratified assessment method such as the 4AT (www.the4at.com) to aid diagnosis (Appendix 3).

Clinicians should be particularly vigilant for hypoactive delirium where patient behaviour might not attract attention.

Investigations

Investigations should be based on history and clinical examination but suggested:

- FBC, U+E, bone profile, LFTs and glucose,

- Bladder scan,
- ECG and
- Septic screen with CXR, MSU and blood cultures.

Other investigations to be considered in appropriate setting include:

- CT Head, EEG, lumbar puncture and TFTs.

Treatment and Management of Delirium

The primary aim of management of acute delirium is to identify and address any underlying cause or precipitant. In doing this, the majority of deliriums will resolve.

Patients will require support during this time to prevent relapse and hasten recovery. Relatives may find it equally difficult and should be fully informed. Providing them with a delirium leaflet may help (Appendix 4).

Sedation must be only reserved for high-risk cases once all non-pharmacological options have been exhausted/deemed inappropriate.

Provide reassurance as to what is happening to the patient and why they are in hospital.

In cases of severe/acute agitation

Use non-confrontational techniques

- Distraction and de-escalation techniques with gentle reassurance often work best.
- Aim for minimal physical intervention or contact.
- Allow relatives and carers to be present to be reassuring and calming to the patient.
- Avoid unnecessary iatrogenic intervention.
- One to one staffing levels with a patient who is very distressed from their delirium may be necessary. This is preferable to physical restraint or to sedation (this must be a specially trained member of staff).
- There must be continuity in terms of staff members to provide the patient with less variation.
- Staff members should be acceptable to the patient.
- Staff must try to understand the patient and their personality and pre-morbid life (i.e., previous job, attitudes) to help them to relate to the patient and aid in engagement.

Assess regularly for pain

- Ask about pain and use repeatable assessment tools (Visual Analogue Scale or the Abbey Pain Scale in those patients in whom verbal communication is not possible).
- Provide appropriate analgesia using WHO analgesic ladder.
- Ensure any side effects of analgesia (such as constipation) are monitored and pre-emptively managed.

Review Medications

- Regular (daily) review of medications to ensure that all are appropriate.
- Ensure essential medications are prescribed in a form/preparation which can be taken by the patient.
- Reduce or stop likely precipitants (benzodiazepines, opioids, antipsychotics, and drugs with anticholinergic effects) or other unnecessary medications.
- Involve local ward pharmacist or Older Adult Medicine team if specialist advice required.

Ensure patient is well hydrated

- Make sure the patient is drinking appropriate volumes and use fluid charts to record this.
- Use appropriate physical aids (cups appropriate to patient's physical ability) to facilitate this.
- Provide appropriate parenteral hydration if own intake is suboptimal – subcutaneous fluids often most appropriate.

Ensure patient is receiving adequate nutrition

- Make sure the patient is eating appropriate amounts and use diet charts to record this.
- Ensure food is acceptable to the patient.
- Consider appropriate parenteral feeding in appropriate circumstances.

Ensure adequate excretion

- Monitor bowel health and address constipation or diarrhoea in a timely manner.
- Ensure toileting methods are acceptable to the patient and use the method most familiar to the patient even if this is more labour intensive.
- Monitor voiding habits and ensure retention does not go unnoticed with regular bladder scans in those at risk: constipation, neurological diagnosis, poor mobility, previous uro-gynaecological surgery, BPH.
- Avoid catheters for unnecessary reasons.

Ensure adequate sleep and rest

- Provide settled nighttime routine to aid sleep at night rather than day.
- Delirious patients will often have night day reversal so will require gentle encouragement back to a normal routine.
- Provide a settled environment wherever possible.
- Use gently lit rooms at night with well-marked toileting facilities.
- Ensure disruption to night routine is minimal with minimal observations and tests wherever possible.
- Avoid using sleeping medications and tablets – including benzodiazepines and "Z" drugs.
- Use melatonin only under specialist (Older Adult Medicine/Psychiatry) guidance.

Maximise sensory input

- Assess for any undiagnosed sensory impairment.
- Ensure patients with visual impairment have correct glasses and visual aids available and that they are in working order.
- Ensure patients with hearing impairment have correct hearing aids available and are in working order.

Promote cognition and orientation

- Provide verbal and visual reassurance and orientation.

Use least amount of iatrogenic intervention as possible

- Ensure drips and cannulas are removed as early as possible.
- Avoid invasive monitoring and continuous monitoring unless absolutely necessary.
- Minimise invasive tests (bloods etc.) unless absolutely necessary.
- Ensure catheters are only placed for appropriate reasons and are removed as early as possible.

PHARMACOLOGICAL MANAGEMENT OF DELIRIUM

Sedative medications can make delirium worse in terms of severity and length so must therefore be used as a last resort.

Reasons for using sedative medication must be **written clearly in the medical notes**. Appropriate reasons for using sedation in patients with delirium include the following.

- A patient who is very agitated or distressed and is thus at risk of harm to themselves or others – where non-pharmacological attempts have failed.
- A patient who is very agitated or distressed and is thus at risk of harm to themselves or others – where the clinician deems that non-pharmacological attempts will not resolve the issue in a timely manner or are otherwise deemed unsuitable.
- A patient who is withdrawing from alcohol or drugs, including benzodiazepines.
- To aid investigation or treatment of a patient – short acting medication must be used. Consider if conscious sedation with anaesthetic support more appropriate

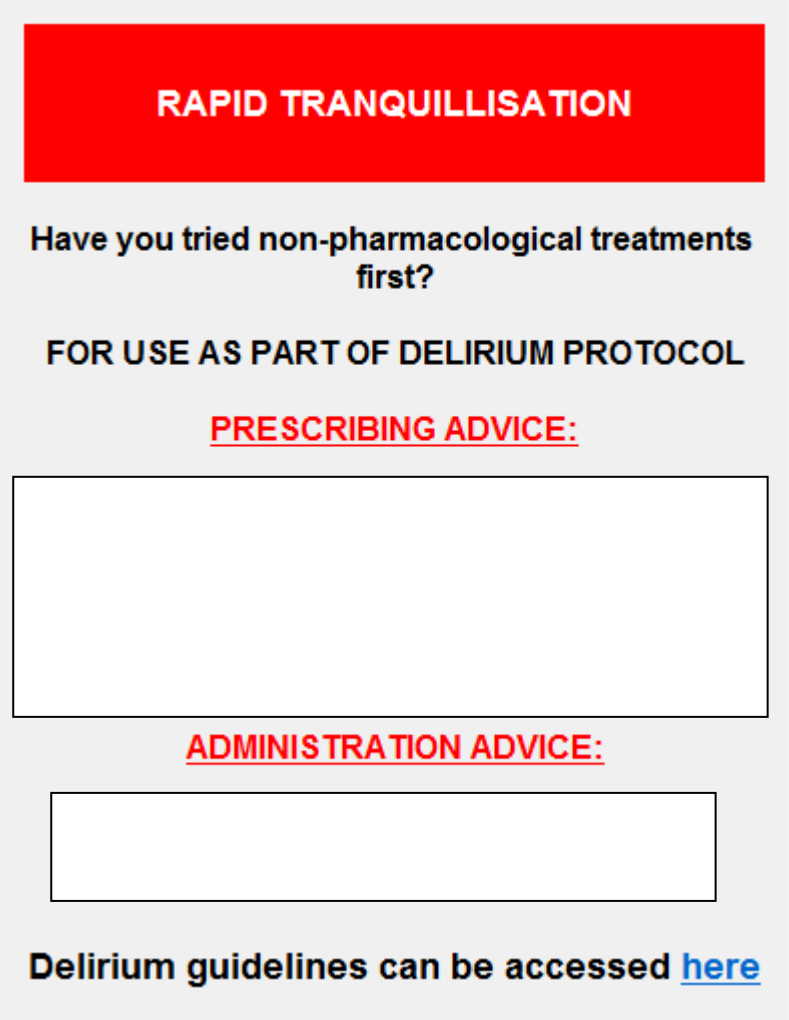
If sedative medication is required, haloperidol or lorazepam are the most commonly prescribed drugs. Haloperidol is first line and is recommended in the NICE Guidance (3), but the treatment of delirium is an unlicensed indication.

It is noted that lorazepam and other benzodiazepines are not part of the NICE guidance, but local expert opinion is that these retain a clinical role.

For patients with Delirium Tremens and Alcohol Withdrawal please refer to Management of Agitated/Delirious Alcohol Patients.

For ITU Patients please refer to the ICCU Delirium Guideline.

There is a delirium template on EPMA that will guide your management of delirium. When sedation is required you can type delirium into ePMA and this protocol will appear :



The prompts will help guide your management and offer safe dosing of haloperidol or lorazepam.

Haloperidol

DO NOT USE IN PARKINSON'S DISEASE, PARKINSONISM OR DEMENTIA WITH LEWY BODIES.

Dose:

- 0.5mg orally;
- 1mg intramuscularly.

The dose can be repeated every two to four hours if necessary.

A maximum of 5mg (PO or IM) can be given in 24 hours but may need to be exceeded depending on severity of distress or presence of psychotic symptoms, weight and sex.

Side Effects: QT Prolongation (avoid concomitant administration with drugs which

prolong QT interval); extra-pyramidal side effects more likely with doses > 3mg in 24 hours.

NOTE: Well absorbed from IM sites but elimination half-life is approximately 20 hours (4).

Lorazepam

TO BE USED IN CASES OF SEVERE AGITATION WHERE HALLUCINATIONS OR DELUSIONS ARE NOT PREVALENT.

MAY ALSO BE USED IN PARKINSON'S DISEASE, PARKINSONISM OR DEMENTIA WITH LEWY BODIES.

Dose:

- 0.5-1mg orally;
- 0.5-1mg can be given intramuscularly.

The dose can be repeated every two to four hours if necessary.

A maximum of 3mg can be given in 24 hours by either route.

Caution if any of these is present give a maximum of 2mg in 24 hours by either route:

- Frail,
- Older age,
- Low BMI patients:

Side Effects: high risk for respiratory depression and may require airway support.

NOTE: absorption from GI tract takes 2 hours and elimination half-life is 12 hours. (5).

Administration Guidance

The oral route is preferred and must be used over other routes as it is the least invasive and restrictive.

Watch and monitor for signs of over-sedation. The lowest dose for the shortest amount of time must be prescribed. Titrate dose to patient response and review daily.

Older, frail or low BMI patients require smaller doses for the same clinical effect.

Other drugs

The atypical antipsychotics can also be used but are not first line and must only be given with specialist (Older Adult Medicine or Psychiatry) supervision due to their added risks.

They are only available in oral preparations:

- Olanzapine (Second line as per NICE Guidance (3)) 2.5mg to 5mg daily,

- Risperidone 0.25mg to 0.5mg twice daily, or
- Quetiapine 12.5mg to 25mg twice daily.

Discharge planning

As delirium can be a very distressing experience for the patient, sometimes with frightening memories and flashbacks, it may be helpful to talk about this with the patient to allow them to understand what has happened and why. This may help in their recovery.

Occasionally delirium does not settle, and underlying memory problems may become apparent. Ensure it is explained to the family or carers that this does not necessarily mean a diagnosis of dementia and that it will require follow up. Provide the delirium leaflet (Appendix 4) to help explain diagnosis.

If, at discharge the delirium is on-going, this must be clearly recorded on the discharge summary to the GP. Classification of delirium, risks, precipitants, length and treatment received must be recorded.

Advice on future management may be appropriate.

Refer for further assessment in the community once the delirium has had time to settle. This may be the GP, a specialist memory clinic (via mental health services) or local cognition clinic (only via referral to Older Adult Medicine prior to discharge).

4.0 Equipment Required

Nil.

5.0 Training

Training to junior medical staff will be provided by the Older Adult Medicine directorate via existing training programs (FY1, FY2, CMT etc.). Training to nursing and allied health professional staff will be through usual channels with support from Older Adult Medicine Delirium Protocol August 2020 Page 11 directorate. The protocol will be available on the intranet and publicized via Staff Communication email.

6.0 Financial Risk Assessment

1	Does the implementation of this document require any additional Capital resources	~~Yes –~~ No
2	Does the implementation of this document require additional revenue resources	~~Yes –~~ No
3	Does the implementation of this document require additional manpower	~~Yes –~~ No
4	Does the implementation of this document release any manpower costs through a change in practice	~~Yes –~~ No

5	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programs or allocated training times for staff.	~~Yes –~~ No
	Other comments	

7.0 Equality Impact Assessment

An initial equality analysis has been carried out and it indicates that there is no likely adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

8.0 Maintenance

This document will be kept up to date by the Consultant Geriatrician.

9.0 Communication and Training

This protocol will be communicated and circulated via the individual clinical directorates. It will be available on the Trust intranet.

10.0 References - Legal, professional or national guidelines

1. Farmer S, Magnúsdóttir H, Skjelbo E. [Incidence of delirium in a geriatric ward of a university hospital]. Ugeskrift For Laeger (2006, Aug 28), 168(35): 2906-2910.
2. Bellelli G, Morandi A, Di Santo S, Mazzone A, Cherubini A, Trabucchi M, et al. "Delirium Day": a nationwide point prevalence study of delirium in older hospitalized patients using an easy standardized diagnostic tool. BMC Medicine. (2016, July 18)
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4. NICE CG 103; Delirium; prevention, diagnosis and management, July 2010, reviewed 2015
5. RCP Guideline Number 6: The Prevention, Diagnosis and Management of delirium in Older People, National Guidelines, June 2006 (http://www.bgs.org.uk/clinicalguides/resources/catclinguidelines/clinguidedeliriumtr eat ment accessed 04 January 2017)
6. Inouye S, Rushing J, Foreman M, Palmer R, Pompei P. Does delirium contribute to poor hospital outcomes? A three-site epidemiologic study. Journal of General Internal Medicine (1998, Apr),13(4): 234-242.
7. Siddiqi N, Harrison JK, Clegg A, Teale EA, Young J, Taylor J, Simpkins SA. Interventions for preventing delirium in hospitalised non-ICU patients. Cochrane Database of Systematic Reviews 2016, Issue 3. Art. No.: CD005563. DOI: 10.1002/14651858.CD005563.pub3
8. Jackson T, MacLullich A, Gladman J, Lord J, Sheehan B. Diagnostic test accuracy of informant-based tools to diagnose dementia in older hospital

patients with delirium: a prospective cohort study. Age And Ageing (2016, July), 45(4): 505-511.

9. Summary of Product Characteristics: Haloperidol http://www.medicines.org.uk/emc/medicine/23005 accessed 04 January 2017

10. Summary of Product Characteristics: Lorazepam http://www.medicines.org.uk/emc/medicine/26011/SPC/Lorazepam+1mg+Tablets/ accessed 04 January 2017

11.0 Appendices

Appendix 1 – Definitions

Delirium: (sometimes called 'acute confusional state') is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It is often a sign that someone is physically unwell. (2)

Hyperactive delirium: a subtype of delirium characterised by heightened arousal; the patient may be restless, agitated or aggressive. (2)

Hypoactive delirium: a subtype of delirium in which people become withdrawn, quiet and sleepy. (2)

Prolonged delirium: Delirium persisting at the time of discharge. It may continue for weeks to months and may reveal other cognitive issues.

Appendix 2 –Algorithm for Assessment of Acute Delirium and Confusion (Adult Medical Guidelines

Appendix 3 - The 4AT

4AT

Assessment test for delirium & cognitive impairment

(label)

Patient name:

Date of birth:

Patient number:

Date: **Time:**

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December."
To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

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4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE ☐

GUIDANCE NOTES Version 1.2. Information and download: **www.the4AT.com**

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment*. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

Document Control

Procedure/ Guidelines number and version	Prevention, Diagnosis and Management of Delirium in Adult Inpatients	**Status:** Final		**Author:** Older Adult Medicine Consultant **Director Sponsor:** Chief Medical Officer
Version / Amend ment History	**Version**	**Date**	**Author**	**Reason**
	1.0	May 2017	Dr Mark Whitsey Dr Elizabeth King	Introduction of Protocol
	1.1	Aug 2020	Dr Mark Whitsey Dr Elizabeth King	Extension to policy approved.
	1.2	Aug 2020	Dr Mark Whitsey Dr Elizabeth King	Extension to policy approved.
	1.3	Feb 21	Dr Mark Whitsey Dr Elizabeth King	Extension to policy approved.
	2.0	Jan 22	Dr Mark Whitsey Dr Sureena Janagal	Policy review and re-submission
	2.1	October 2022	Dr Mark Whitsey Dr Sureena Janagal	Details of prescribing template on EPMA specifically for delirium added to protocol (page 6).
	2.1	March 2025	Dr Natalie McNeela	Extension to policy approved until September 2025.
	2.2	March 2025	Dr Natalie McNeela	Policy review and re-submission
	3.0	Sept. 2025	Older Adult Medicine Consultant	Full review
Intended Recipients: All staff looking after Older People in the Trust				
Consultation Group / Role Titles and Date: Older Adult Medicine and Rehabilitation Governance Group				
Name and date of group where reviewed	Older Adult Medicine Governance Group – March 2025 Trust Policy Group – September 2025			
Name and date of final approval committee (if trust-wide document)/ Directorate or other locally approved committee (if local document)	Trust Policy Group – September 2025			
Date of Procedure/Guidelines issue	September 2025			

Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	September 2025 - 3 yearly
Training and Dissemination: Directorates to present at governance. Available on Trust intranet in conjunction with delirium leaflet and delirium guideline for staff	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes ~~/ No~~** If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.	
To be read in conjunction with: 1) Restraint Policy 2) Falls Policy 3) Delirium leaflet 4) Delirium guideline 5) Enhanced Care Assessment Tool 6) Mental capacity act and assessment	
Initial Equality Impact Assessment: Completed Yes **Full Equality Impact assessment (as required): Completed Yes** If you require this document in an alternative format e.g., larger print please contact Policy Administrator for Trust- wide documents or your line manager or Divisional Management office for Local documents.	
Contact for Review	Older Adult Medicine Consultant

Document summary/key issues covered.

Delirium (also known as 'Acute Confusional State') is common (1, 2), often predictable and a largely preventable condition that affects a large number of inpatients. Up to 50% of patients in hospital can experience delirium at some point (3) and it is often the most older or frail. It is frightening for the patient, increases morbidity and mortality amongst those affected and increases demand on the Trust as it increases bed-days and resources used.

Early assessment to look for, and recognition of, features that predispose a patient to delirium can allow appropriate management of subsequent risk factors to reduce the chances of a delirium developing.

If delirium has occurred, the early detection can reduce severity, length and subsequent sequelae. The use of verified assessment tools such as Cognitive Assessment Method (CAM) and 4AT can aid this.

Management of delirium is often multifaceted and involves all members of the MDT. Simple measures and reassurance are often all that is necessary but usually time is the most important factor. Patients need to be supported through this event, ensuring that hydration, analgesia, continence and comfort are maintained as well as reducing exposure to further exacerbating factors.

Sedation is rarely required.

Delirium may resolve slowly and still be present on discharge. This needs to be communicated to the patient, family and GP to allow ongoing assessment in community and potential referral to more specialist services. Prevention is better than cure.	
Key words for intranet searching purposes	Prevention, Diagnosis and Management of Delirium in Adult Inpatients

Delirium/New Acute Confusion

The Royal Wolverhampton NHS Trust

Algorithm for the Initial Assessment and Management in Older Adults

NEW CONFUSION, FALLS, AGITATION, DROWSINESS, DISORIENTATION

Important Information
Delirium can effect up to 40% of inpatients during their hospital stay

Patients have an increased risk of mortality

Length of stay is increased

STOP! Is this Delirium?

Early Diagnosis reduces morbidity and mortality

Expert advice
9-5pm – Older Adult Medicine Team.
Out of Hours – On Call Medical Team

Clinical Protocol for Prevention, Diagnosis and Management of Delirium in Adult Inpatients(Hyperlink)

Common Risk Factors
- Age> 65 (greater >80)
- Dementia
- Previous Delirium
- Polypharmacy (antiphyschotics, anticholinergics)
- Frailty/Multimorbidity

Common Precipitants are Acute Changes in:
- Physical well being (infection, infarction, surgery, falls, drugs, retention, constipation)
- Psychological well being (depression, bereavement,)
- Social Well being (isolation, new environment)

Assess mental state with 4AT (www.the4AT.com)
Score > 4 Suggests Delirium is present
Record 6CIT and consider IQCODE to assess for other cognitive impairment
Identification of possible cause(s), and treatment of these factors, is most important

Essential Investigations
Clinical examination, Bloods (FBC, U+E, Calcium, LFT), Glucose, ECG, Bladder Scan , Septic Screen

Optional Investigations if Indicated
CT head(consider anticoagulants), EEG (if at risk of Seizures), LP, TFTs, Haematinics

Early appropriate management reduces morbidity and mortality

Essential Management
Treat underlying cause
Non pharmacological supportive treatment:
- Non confrontational & Distraction techniques
- Well lit environment
- Reorientation
- Minimal invasive interventions
- 1:1 Staffing

Specific Management
Ensure adequate pain relief
Ensure adequate hydration and nutrition
Ensure adequate elimination
Ensure adequate rest and sleep

Sedation
NOT routinely required
Consult Clinical Protocol for Prevention, Diagnosis and Management of Delirium in Adult Inpatients(Hyperlink) If used **REVIEW** daily.

Follow up
Monitor clinical progress with daily mental state assessment.
At point of discharge is it fully resolved ?
- YES – no further action
- NO – requires follow up by GP, Memory Clinic or Local Cognition Clinic

V 1.1 Jan 2022 Review Jan 2025