**Delirium Management Comprehensive Pathway**

**History of Acute Change – Think Delirium**

- Acute illness
- Sensory Impairment
- Recent discharge from acute hospital
- Restraint
- Dementia
- Polypharmacy
- Recent anaesthetic/surgery
- Depression
- History of alcohol misuse
- Frailty
- Catheterised
- Hypoglycaemia
- Acute or chronic pain

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

[Screening tools can be negative in the presence of delirium – use clinical judgement]

**Act on acute, severe causes e.g. sepsis, hypoxia, hypoglycemia, medication intoxication**

**This pathway is not exhaustive**

Catheterisation

Dehydration

Interventions

Unnecessary

**Follow Cognitive Impairment**

- Document diagnosis of delirium on discharge letter to GP
- High risk of recurrent delirium requiring prompt treatment
- Follow Cognitive Impairment Pathway

**Ongoing Cognitive Impairment**

- Document diagnosis of delirium on discharge letter to GP
- High risk of recurrent delirium requiring prompt treatment
- Follow Cognitive Impairment Pathway

**No Ongoing Cognitive Impairment**

- Document diagnosis of delirium on discharge letter to GP
- High risk of recurrent delirium requiring prompt treatment
- Increased risk of dementia in the future in older people

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

**Delirium is frequently undetected. Be aware that patients with delirium may have paranoid ideas/delusions; risk assess and manage appropriately.**

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

**Delirium Document Diagnosis of Delirium & Suspected Causes; Revise as appropriate.**

**PATHWAY**

**Diagnosis**

**Document**

**Declaration**

**History**

**Clinical**

**Careful**

**Consent**

**Clinical**

**Pathway**

**Antipsychotics**

**Discharge**

**Detox**

**Drug**

**Environmental & General Measures**

- Approach patient calmly and gently from the front
- Sleep chart; maintain daytime wakefulness with activities
- Allow patients to mobilise as much as possible in an area which has been deemed safe given confusion/ falls risk
- Ensure glasses and hearing aids are working, treat ear wax
- Ensure adequate diet taken, keep daily food & fluid charts
- Regularly reassure and re-orientate (use clocks & calendars)
- Ensure buzzer close to patient and respond promptly to calls
- Listen to the patient’s expression of needs
- Reduce noise (e.g. monitors and alarms) and background noise
- If language or hearing problems, consider an interpreter
- Refer to advocacy as appropriate e.g. if patient detained under Mental Health (Care and Treatment) (Scotland) Act

**Investigation**

- Dialedict by the history and examination findings
- U&A / LFT / FBC / Glucose / CRP
- Calcium / Phosphate
- Thyroid function
- Oxygen saturation / arterial blood gases
- ECG
- Chest X-ray
- Urinalysis / urine culture
- Blood / spu tum / stool culture as appropriate
- CT brain if anti-coagulated (urgent), head injury, focal neurological signs, or persistent symptoms

**Optimise Management of Co-morbidity**

- For example:
  - Respiratory disease
  - Diabetes mellitus
  - Cardiac disease / heart failure
  - Thyroid disease
  - Parkinson’s disease
  - Cerebrovascular disease

**Triggers for Referral to Liaison Psychiatry**

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

Psychiatric services may also hold useful information on background cognition and mental health.

**Treatment of Delirium Symptoms**

- Consider additional staff
- If patient’s symptoms threaten their safety or the safety of others, use low dose of one medication (start low – go slow method) and review every 24 hours
- Consider capacity to consent to treatment (AWI Section 47)
- Medications for unmanageable agitation/distress:
  - Haloperidol 0.5-1mg orally (max 2mg/24hours)
  - Haloperidol 0.5-0.25mg IM (max 2mg/24hours)
  - Haloperidol is contra-indicated in combination with QTc prolonging drugs, which makes it uncommon and local “off label” policy should be followed
- Use atypical antipsychotic at low dose, for example, Risperidone 0.25mg daily, maximum 0.5mg in 24 hours
- Do not use if signs of Parkinsonism or Lewy Body Dementia
- If antipsychotics are contra-indicated (as above), Lorazepam 0.5-1mg orally (max 2mg/24hrs); Midazolam 2.5mg IM (max 7.5mg/24Hours). Younger patients may need higher drug doses

**Patient Improving**

- Reduce and discontinue antipsychotic treatment
- Repeat cognitive assessment
- Consider post-delirium distress (e.g. recall of delusional states)
- Encourage patients to share their experience with healthcare staff

**Medication Review**

- Review age appropriateness
- Any drugs recently started/stopped?
- Dose changes to medication?
- Compliance/concordance issues with medication?
- Carefully consider ongoing needs for:
  - Opioids / benzodiazepines / antipsychotics / antispasmodics / antiepileptics / antihistamines / antihypertensives (especially if hypertension) / corticosteroids / triyclic antidepressants / digoxin / antiarrhythmic medication
- Avoid abrupt withdrawal of drugs with dependence potential or possible discontinuation syndrome.

**Avoid**

- Bed moves
- Unnecessary interventions
- Hypoxia
- Dehydration
- Constipation
- Catheterisation

There are often multiple causes of delirium but in up to 30% of cases no cause is found

**Patient NOT Improving**

After one week or if severe delirium, refer to the appropriate local specialist

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