Delirium Management
COMMUNITY CARE PATHWAY

THINK DELIRIUM

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

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 ]

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 O2 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
  Risperidone 0.25 mg daily, maximum 1mg in 24 hours
  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)

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