Delirium Management
CARE HOME SUMMARY PATHWAY

**THINK DELIRIUM**

- History of acute change
  - Change in alertness, mood, behaviour, thinking, function
    - *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
  - carry out relevant investigations

- Key worker to clarify background history of change in symptoms and consider AWI section 47 if not already in place

- Use local tool to obtain a baseline measure of cognition
  - [GPCog AMT10 MOCA]
  - Assessment and initial investigations

**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:
   - (For UTI please refer to Antibiotic Use In Carehomes pack)

**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**
- Ensure glasses and hearing aids working (ear wax)
- Sleep chart
  - *see comprehensive pathway*
- Ensure regular mobilisation
- Ensure good diet taken, keep daily food & fluid charts
- Consider if swallow safe
- Reduce stress to patient
  - *see comprehensive pathway*
- Ensure orientation
- Avoid unnecessary interventions

**Repeat delirium screening daily**
- until two successive negatives
  - Improvement in sleep pattern, behaviour and cognition can signal recovery from delirium

**Patient Improving**
- Reduce and discontinue anti-psychotic treatment
- Repeat cognitive tool

**Ongoing Cognitive Impairment**
- Note delirium and inform patient's GP
- Follow Cognitive Impairment Pathway

**Patient NOT Improving**
- Re-assess
  - Delirium can persist for weeks or months after the cause is treated

**No Ongoing Cognitive Impairment**
- Inform patient’s GP of delirium and the risk of dementia in the future if an older patient

**Treatment of Delirium Symptoms**
- Encourage regular 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
  - (start low and go slow method) & review every 24 hours
  - Haloperidol 0.25mg bd, maximum of 1mg in 24 hours or Risperidone 0.25mg daily, maximum of 1mg in 24 hours
  - (avoid in PD/ Lewy Body dementia)
- Lorazepam 0.5mg up to 1mg maximum 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 Care Home Liaison Nurse/CPN**
- Severe agitation or distress not responding to standard measures
- Doubt about diagnosis
- If detention under the Mental Health Act is being considered

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