Delirium Pathway For use in over 65 years and all patients, patients who present with confusion and/or a sudden change in mental state

Essex Partnership University NHS Foundation Trust

Confusion? Altered mental state? Consider **??DELIRIUM??**

Is there a 'This is me' form? Is there already a diagnosis of dementia?

Use CAM or 4AT screening tool to confirm diagnosis of delirium

- Complete full history
- Consider Physical cause e.g. UTI, constipation, post-operative? Acute episode of chronic condition?
- Consider Sepsis
- Consider Medication induced? Acute withdrawal alcohol or illicit drugs?
- Complete baseline assessment of cognitive state e.g. AMT, MMSE, BEHAVE

Complete Delirium Screen if / as clinically indicated

FBC, B12, Folate, U&E, Glucose, LFT, Serum Calcium, TFT, CRP,
Gamma GT (if history of/or suspected harmful alcohol use) MSU if indicated – CT

Physical Cause Identified?

YES

- Refer to Delirium Guidance
- Treat underlying condition, review meds if indicated
- 1st line supportive care interventions, consider pain or discomfort, noise levels, diet & fluids, specific conditions – 'This is me' form, personal items/visitors for familiarity, communication style, hearing/ sight aids
- Ask relative/carer to complete 'This is me' form, give Delirium information

Complex or severe Delirium unresponsive to supportive care interventions

Things you can do

- Identify & treat the underlying physical cause
- Communicate clearly, calmly & concisely
- Check basic needs e.g. hunger, thirst, pain, tiredness
- Talk to relatives about comfort items / likes / dislikes
- Use personal items & photographs at the person's bedside
- Use clocks, calendars & prompts to improve orientation
- Provide continuity of caregivers
- Ensure the person has spectacles/hearing aids/dentures
- Encourage mobility & cognitive stimulation activity
- Ensure adequate fluids & pain management

NO

Continue with individual mental health care and treatment plan
Or refer to local MH services if treated within community services

Recommended medications for use with agitation & aggression not hypoactive delirium

Haloperidol* 500mcg up to BD
Or
Risperidone* 500mcg OD up to maximum 1mg in 24 hours
Or
Lorazepam* 500mcg up to maximum 2mg in 24 hours in divided doses for 48 hours max

Recommended Protocol

- Monotherapy
- Stat dose – reassess
- Prescribe regularly
- Start low – titrate
- Avoid PRN
- Review regularly – stop ASAP

Post Delirium support and follow up
Review of mental state – review MMSE
Review medication prescribed for Delirium - discontinue or arrange follow up by Liaison Nurse
Provide post Delirium information

* Avoid with Parkinson's or Lewy Body Dementia
* Use with caution, see NICE guidance for further details