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

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

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

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

NO

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

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

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