

Delirium Prevention, Identification and Management Clinical Guideline

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CLINICAL GUIDELINE SUMMARY
This clinical guideline provides practical guidance to clinicians within EPUT on the identification, assessment, diagnosis and management of delirium. We aim to have a consistent approach to delirium across the service that links with the localised delirium policies within the acute trusts.
The Trust monitors the implementation of and compliance with this clinical guideline in the following ways;
Executive Physical Health Sub-Committee Clinical Supervision Record keeping audits

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Nurse

**Delirium Prevention, Identification and Management
Clinical Guideline**

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DELIRIUM PREVENTION, IDENTIFICATION AND MANAGEMENT

1. INTRODUCTION AND SCOPE

The purpose of the guidance is to improve awareness of delirium among EPUT staff and to support Trust staff to recognise, assess and manage delirium in all Trust service users.

Delirium can present in patients across any of our services including in inpatient and community settings, and within physical healthcare and mental health services. The hospital environment often precipitates or exacerbates episodes of delirium and so inpatient settings are a particular priority area.

This document should be read in conjunction with the following:

- Clinical Guideline on Physical Healthcare (CG55)
- Service Operational Policies
- Slips, Trips and Falls Clinical Guidelines (CG58)
- Mental Capacity Act and Deprivation of Liberty Safeguards (MCP2)
- Consent to Examination or Treatment Policy (CLP16)
- Local hospitals and partners delirium policies, such as Basildon Hospital, Southend Hospital, Princess Alexandra Hospital, Colchester General Hospital, Broomfield Hospital, etc.

2. AWARENESS OF DELIRIUM

Delirium is a **sudden** change in mental state, which may present as confusion, agitation, personality change, and difficulties with understanding and memory. Delirium can be very distressing and frightening for patients and their families, and can be challenging for staff to provide even basic care.

Delirium is sometimes mistaken for dementia or depression but, unlike dementia, delirium develops quickly and is usually temporary. Around half get better within six days but it can last several weeks and in some cases months.

Delirium can develop in people with dementia, mental illness or learning disability, and the contribution of family members and carers to the assessment process is critical to recognise the rapid onset of delirium symptoms against the backdrop of the person's usual state of health.

Delirium is often caused by treatable physical conditions but this may not be easy to identify, especially among mental health service users where confusion or agitation are common presenting symptoms, or among elderly patients who may not develop obvious symptoms of infection or illness.

Causes of delirium include infection, electrolyte imbalance, medication, alcohol or drug withdrawal, acute or chronic physical illness, fractures, and surgery.

3. IDENTIFYING DELIRIUM

Staff should ensure that all patients over 65 years and those under 65 who present with confusion or a sudden change in mental state are assessed and reviewed for delirium as this is under-recognised and under-diagnosed.

Delirium can occur in people of any age and in any part of the service, but the risk is higher in people over the age of 65 years and in those with existing dementia, brain injury, poor hearing or eyesight, or terminal illness. The hospital environment often precipitates or exacerbates episodes of delirium.

Staff must be alert to Diagnostic Overshadowing, where symptoms of delirium are misdiagnosed as mental illness or are wrongly attributed to an existing mental illness or learning disability, delaying a clinical response.

NICE Guidance is clear that *'If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia, treat for delirium first.'* (NICE, 2010)

Symptoms of Delirium

- **A sudden change** or worsening of mental state and behaviour over a short period.
- **Fluctuation** – symptoms of delirium can change within the space of a day. People may be delirious, then appear normal, then be delirious again. Often symptoms are worse at night.
- **Disorientation.** People may not know where they are, or what time of day it is.
- **Unusual thoughts.** People may become paranoid and distrustful of the people around them. These thoughts can sometimes become quite hurtful and distressing for the people around them.
- **Cognitive function.** Poor concentration, slow responses and confusion. People may find it difficult to follow what is being said to them.
- **Memory loss.** Short term memory in particular. People with delirium may not remember what has happened or where they are.
- **Sleepiness,** which can be excessive or disturbed sleep.
- **Agitation, restlessness or lethargy** – people may become hyperactive and aggressive, or hypoactive and lethargic. They may get out of bed unexpectedly, increasing the risk of falling.
- **Hallucinations** – for example seeing and hearing things that are not there.
- **Physical changes** such as reduced appetite, mobility or swallowing.
- **Social changes** such as lack of cooperation with reasonable requests, withdrawal, alterations in communication and/or mood.

Any of these symptoms should trigger an assessment and investigations for underlying causes.

4. DELIRIUM ASSESSMENT

A clinical assessment should be carried out by a healthcare professional trained and competent in the diagnosis of delirium. The CAM tool is a validated algorithm with full descriptors of four diagnostic features of delirium (Box).

BOX 1:

The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset or Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions:

- Is there evidence of an acute change in mental status from the patient's baseline?
- Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question:

- Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized thinking

This feature is shown by a positive response to the following question:

- Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of consciousness

This feature is shown by any answer other than "alert" to the following question:

- Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4

Local acute Trusts use either the Confusion Assessment Method (CAM – Appendix 1) or the 4AT Test: screening instrument for cognitive impairment and delirium (Appendix 2) to assess for delirium.

The EPUT electronic record (initial inpatient assessment forms) includes the CAM tool in the following format:

Confusion Assessment Method (CAM) Diagnostic algorithm		
1. Acute onset fluctuating course	Yes	No <i>(Please circle)</i>
2. Inattention, distractibility	Yes	No <i>(Please circle)</i>
3. Disorganised thinking, illogical or unclear ideas	Yes	No <i>(Please circle)</i>
4. Alteration in consciousness	Yes	No <i>(Please circle)</i>
The diagnosis of Delirium requires the presence of both features 1 and 2, plus either feature 3 or 4		

Staff will need to refer to this guideline for full explanation of the descriptors.

5. INVESTIGATION OF DELIRIUM

Delirium may be caused by one or more underlying conditions as set out below. A systematic approach should be taken to investigate and exclude underlying physical health conditions as described in the Clinical Guideline on Physical Healthcare (CG55).

Staff must be especially vigilant for occult triggers such as pain, hypoxia and electrolyte disturbance.

Risk Factors	Precipitating factors for delirium
<ul style="list-style-type: none"> • Older age • Existing chronic cognitive impairment or dementia • Post General Anaesthesia • Pain • Polypharmacy • Renal impairment • Hepatic impairment • Drug/ Alcohol withdrawal • Surgery e.g. fracture neck of femur • Significant environmental change • Multiple co morbidities • Sensory impairment such as deafness, visual problems 	<ul style="list-style-type: none"> • Infection • Drugs (especially psychoactive and anticholinergic drugs) • Immobility, including the use of physical restraint • Urinary catheter • Urinary retention • Constipation • Malnutrition • Dehydration • Electrolyte disturbance • Pain • Metabolic disturbance • Severe or deteriorating illness • Environmental change (ward transfer, lack of clock/watch) • Sensory deprivation (e.g. access to hearing aid and spectacles)

6. MANAGEMENT OF DELIRIUM

Treat underlying causes and reduce risk factors

- For people diagnosed with delirium, identify and manage the underlying cause or combination of causes as identified by observations and investigations.
- Review and manage pain, monitoring with non-verbal signs of pain in those with communication difficulties such as learning disability or dementia.
- Review medication, especially strong painkillers, sedatives and bladder medications. Consider nicotine replacement if relevant.
- Ensure glasses, hearing aids or mobility aids are used, working and maintained.
- Assess sleep hygiene and support a consistent sleep routine.
- Avoid dehydration and constipation with attention to mouth-care, diet, adequate fluid intake and judicious use of laxatives.
- Engage the patient in activities to provide stimulation as well as distraction from any agitation they are experiencing.
- Encourage mobility, involving physiotherapy in the MDT discussions and planning.

Treat the symptoms of delirium

- If there is significant distress, use verbal and non-verbal techniques to de-escalate the situation. Distress may be less evident in people with hypoactive delirium, who can still become distressed by, for example, psychotic symptoms.
- If de-escalation is ineffective or inappropriate, consider giving short-term (1 week or less) haloperidol or olanzapine. Start at the lowest clinically appropriate dose and titrate according to symptoms. Use antipsychotic drugs with caution or not at all for people with conditions such as Parkinson's disease or dementia with Lewy bodies. (NICE, 2010)
- Ensure the plan for care includes effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium

Manage the Environment

- Provide a suitable care environment to reduce confusion (good lighting, low noise levels, signage to toilets, orientate with clocks and calendars)
- Reduce room or ward transitions to maintain a consistent and familiar environment.
- Involve the family to support care planning, communication and reorientation.
- Encourage family members to be present as often as possible; display familiar objects and photos of friends and family.
- Maintain continuity of staff by having a small staff team providing care.

7. RESPONSIBILITIES

The Trust Board has overall responsibility for ensuring:

- That the principles of this guideline and other associated procedures are implemented across the organisation
- The availability for any necessary financial resources to ensure staff are appropriately trained and have access to appropriate pressure relieving equipment.

The Executive Nurse has lead responsibility to ensure:

- Clinical Guidelines are embedded into clinical practice and in ensuring these are updated regularly.
- That any clinical risk issues identified are addressed with relevant line managers
- The implementation of national guidance in relation to the prevention and management of delirium.

Directors and Senior Management are responsible for:

- Disseminating, implementing and monitoring this guideline within their services via clinical audit and supervision
- Ensuring that EPUT policies and procedures are followed

Managers and other Persons in Charge will ensure that:

- The procedures and principles detailed within this guideline are followed, to ensure best practice and that national guidelines are met
- Staff receive appropriate and correct training
- The monitoring the implementation of this policy via clinical audit and supervision

Individuals will ensure:

- Any difficulties relating to carrying out the care of patients with or at risk of developing delirium are reported to their line manager;
- That they adhere to all EPUT policies and guidelines;
- That they are familiar with these guidelines and associated documents and know where to locate them i.e. on the Trust intranet (InPut).

END