Delirium Management Clinical Guideline

V3.1

September 2019
Summary
This guideline aims to provide advice and information for all staff involved in the care and management of confused and delirious patients.

**Confused patient**
Assess Cognition

- **Acute change** in cognition
- **No change** from baseline

### History
- Look for cause of DELIRIUM
  - Electrolyte disturbance
  - Infection
  - Medication
  - Head injury
  - Retention/constipation
  - Pain

- **Routine Tests**
  - FBC, CRP, UE, Calcium, LFT, Glucose
  - ECG
  - Sepsis screen – CXR, MSU, +/- BCs
  - Consider CT Head (esp if on anticoagulant)

### Treat any reversible cause

#### Management of confused patient

- **Orientation** – lighting, quiet/calm, consistent staff, hearing aids, glasses, family if appropriate
- **Calm patient down** – verbal / non-verbal techniques, move to calmer setting.
- Move to a setting/ward most suited to their needs. Do not move again unless in their interests.
- **Medication** (last resort): Olanzapine 2.5 mg is 1st line.
  - Haloperidol 0.5mg -1 mg is 2nd line.
  - Lorazepam 0.5 to 1 mg is 3rd line.

Remember medication such as Lorazepam can exacerbate delirium and increase the risk of falls.

*Please warn relatives of a small risk of excess mortality with any sedating or antipsychotic medication.*
1. Aim/Purpose of this Guideline

1.1 This guideline aims to provide advice and information for all staff involved in the care and management of confused and delirious patients.

1.2 This guideline translates the NICE Clinical Guideline 103 - Delirium: prevention, diagnosis and management into Practice at Royal Cornwall Hospitals NHS Trust.

1.3 Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.info.gov@nhs.net

2. The Guidance

2.1 Introduction

2.1.1 Delirium is a state of mental confusion that can happen if a person becomes unwell, characterised by acute onset. It is therefore also known as ‘Acute Confusional State’.

2.1.2 Delirium is a non-specific sign of illness which usually occurs in vulnerable patients – the frail, the oldest-old and those with comorbidities.

2.1.3 Delirium affects around 20-30% of patients at any one time in hospital.

2.1.4 It is often poorly recognised – in particular the hypoactive delirium subtype (lethargic patient, not engaging with staff). Hyperactive delirium is usually more noticeable (agitated, delusional, sometimes disruptive). A mixed picture is not uncommon.

2.1.5 Delirium is associated with:
- increased complications (falls, pressure sores)
- increased length of stay
- increased institutionalisation on discharge
- increased readmission
- increased mortality (up to 35-40% at one year)
2.2 Diagnosis of Delirium

2.2.1 Delirium is characterised by:
- **Acute onset** of confusion
- **Alteration of conscious level**: fluctuating course, inattention, disorganised thinking.

2.2.2 The Trust principally uses the CAM (Confusion assessment Method) in the Medical Admission Proforma and on Maxims to diagnose delirium.

The Trauma Unit use 4AT (Assessment Test for delirium and cognitive impairment) linked to national fractured neck of femur pathway requirements.

2.2.3 The main differential diagnoses are:
- Dementia
- Depression (sometimes referred to as ‘pseudodementia’)
- Dysphasia

2.2.4 Patients can have both Delirium and one or more of the differential diagnoses.

2.3 History

2.3.1 Obtain a **collateral** history from relative/ carer, and/or other persons involved in the patient’s recent care. Use the **dementia question** “has this person become more forgetful in the last 12 months?”

2.3.2 Ask specifically about:
- previous function (cognitive and functional)
- onset /course of symptoms
- previous episodes of delirium
- full drug history
- Alcohol history

2.3.3 Think about the most common causes of delirium as you take a history. Use the mnemonic **PINCH ME**:

P - Pain (and unable to sleep or move around )
In - Infection (chest, urine, skin etc)
C - Constipation (or unable to pass urine properly)
H - Hydration (dehydration and malnutrition)
M - Medication (sudden stopping or starting drugs)
E - Environment (being in an unfamiliar place)

2.4 Examination

2.4.1 **Full** examination, looking for potential causes of delirium.

2.4.2 **Cognitive** assessment – **AMTS** and **CAM** (tick box list available in the Medical Admission Proforma)
2.4.3 Or **4-AT** (assessment test for delirium and cognitive impairment).

**AMTS** (the Abbreviated Mental test score)

1. Age
2. Date of Birth
3. Time (to nearest hour)
4. Year
5. Place – Hospital + name of hospital/city
6. Address for recall at end of test (42 West Street)
7. Recognition of roles of 2 people (eg Dr, nurse)
8. Year of 1st World War
9. Name of the present Monarch
10. Count backwards from 20-1

**CAM Criteria**
- Acute onset and fluctuating course
- Inattention
- Disorganised thinking
- Altered level of consciousness

A diagnose indicated if positive for the **first and second** criteria and having **one of the other** criteria present

**4AT**
- Alertness – Normal, Sleepy or Clearly abnormal
  - 0, 1 or 4
- AMT4 – Age, Date of Birth, Place, Current Year
  - 0, 1 or 2
- Attention – Months of the Year Backwards
  - 0 if >7 correct, 1 if <7 correct, 2 if untestable
- Acute change or fluctuating course – yes or No
  - 0 or 4

**4AT score**
- 4 or above: possible delirium +/- cognitive impairment
- 1-3: possible cognitive impairment
- 0: delirium or severe cognitive impairment unlikely

**2.5 Investigations**

**2.5.1** All patients should have the following done:
- FBC
- CRP, UE, Calcium, LFTs
- Glucose, TFT
- CXR
- MSU

**2.5.2** Other investigations to consider:
- CT Head (especially if on anticoagulants)
- MRI – especially in younger patients with no other clear cause
• B12, folate
• Lumbar puncture

2.6 Management

2.6.1 Calm the patient down
• Quiet environment, good lighting
• Non-confrontational body language
• Reassurance – use family and friends if possible
• Repeated orientation
• Consistent staff – consider ‘specialing’ (enhanced staffing)
• Maintain/restore normal sleeping patterns if possible

2.6.2 Sedation

2.6.2.1 Sedation can worsen/prolong delirium at it puts patients at risk of complications such as falls, and should be a last resort. There is also a small risk of increased mortality with antipsychotic treatment. It should be reserved for patients whose symptoms would threaten their own safety or that of others, or to carry out essential investigations/treatment.

2.6.2.2 Principles are: use the lowest dose needed, review regularly, discontinue as soon as possible, and document rationale in the Medical Notes. Wandering is not an indication for drug treatment.

2.6.2.3 Medication used in delirium management:

• Olanzapine 2.5 - 5 mg (first line)
• Haloperidol 0.5 - 1 mg (used only if Olanzapine not available or contraindicated)
• Lorazepam 0.5 - 1 mg maximum 2 mg per day (third-line drug, only used if Olanzapine or Haloperidol are contraindicated)

Do not give Haloperidol or Olanzapine to patients with a history of Parkinson’s Disease or Lewy Body Dementia, unless supported by a specialist assessment from a Geriatrician or the Complex Care and Dementia Team.

An RCH patient information leaflet is available for patients and families on medicines used in delirium care.

2.6.3 Nutrition and Hydration
It is important to monitor food, fluid, nutrition and bowel care in these patients. Patients forget to eat or drink and can decondition/become unwell from unnoticed poor oral intake.

Encourage patients to drink when attending to patient care, offer snacks and finger food. Encourage families to attend to assist at meal times or bring in their favourite foods.

There is an RCH patient information leaflet available for patients and relatives on eating and drinking with dementia and delirium.
2.6.4 **Ward moves**
Any move can be detrimental to patient’s suffering with delirium and dementia. It is recommended to minimise moves within bays, within wards, between wards and between hospitals. Ideally all moves should be in the patients’ best interests since they cannot always consent and relatives informed of the move. It is recommended to restrict out-of-hours transfers in hospital and between hospitals for people with delirium or dementia symptoms - restriction between 8pm and 8am. This is supported in our [RCHT Dementia Care Policy](#).  

2.7 **Documentation and Legislation**  

2.7.1 When providing care and treatment for confused patients, it is important to consider assessing their **mental capacity**. See [RCHT Mental Capacity Act Policy](#).  

2.7.2 If a patient is assessed as lacking capacity and needs detaining or covert medications, consider DOLS (Deprivation of Liberty). See [Deprivation of Liberty Safeguards (DoLS) Policy and Procedure](#).  

2.7.3 **Communicate clearly with relatives** and document these conversations. Relatives can find delirium very distressing to watch and concerning for the future.  

*There is an RCH patient information leaflet available to give to patients and relatives about delirium and dementia.*  

2.7.4 **Covert Medication Regimens** In confused patients who are not taking necessary medications, please refer to the Medicines Policy section 6.4.5 Administering Medicines under the Mental Capacity Act (see Appendix). Any patient receiving a covert medication regimen requires to have had a DoLS application made.  

2.8 **Where to ask for help**  
- Complex care and dementia liaison service referral  
- RCH Admiral Nurse  
- Geriatrician referral via MAXIMS  
- Community Psychiatric Team – if the patient is known to them  
- Ward pharmacist  

2.9. **Administering Medicines under the Mental Capacity Act**  
- Covert administration of medicines is the administration of medication in food or drink to people unable to give consent or refuse treatment.  
- The RPS/RCN position statement on the covert administration of medicines (2019) states:  

> “Medicines are administered covertly only to people who actively refuse their medication and who are considered to lack mental capacity in accordance with an agreed management plan. Where deemed necessary, covert administration of medicines takes place within the context of existing legal and best practice frameworks” (see PrescQIPP. (2015).Best practice guidance in covert administration of medicines).
Covert medication can refer to medication given to treat either mental or physical health problems. Covert medication i.e. giving medication without the person’s knowledge should not be confused with forcible medication, where it is given with their full knowledge, but not their consent. This is a complex issue and requires due and repeated consideration of:

- the legal and ethical frameworks for administering medication
- the person’s best interests, where that person lacks capacity
- the need to administer medicines in a safe manner, without loss of efficacy or increased risk of adverse effects.

Where covert administration is needed, in accordance with the Mental Capacity Act 2005, there is a need to request a second opinion in relation to medicines for people detained under the Mental Health Act 1983.

In such situations the Trust lead for Safeguarding Adults should be consulted.

RCHT has adopted the Cornwall Partnership Foundation Trust’s ‘Guidelines for the Covert Administration of Medication – Adult Inpatient Services’. Please refer to their document’s library via their internet site homepage for the most up to date version of this guideline.

### 3. Monitoring compliance and effectiveness

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<thead>
<tr>
<th>Element to be monitored</th>
<th>Documentation of confusion</th>
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<tr>
<td></td>
<td>Prescribing of sedation</td>
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<tr>
<td>Lead</td>
<td>Madeleine Purchas, Consultant Geriatrician</td>
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<td>Laura Wesson, Consultant Geriatrician</td>
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<td>Tool</td>
<td>AMTS and CAM Documentation in the Medical Admission Proforma</td>
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<td>e-prescribing (Olanzapine and Haloperidol)</td>
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<td>Integrated Services for Older People Department</td>
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<td>Madeleine Purchas</td>
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<tr>
<td>Change in practice and lessons to be shared</td>
<td>Implementation of the guideline will be publicized to the Medical Directorate via the Grand Round and the Integrated Services for Older People Meeting.</td>
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<tr>
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<td>Any required changes to practice will be identified and actioned within 6 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
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4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
**Appendix 1. Governance Information**

<table>
<thead>
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<th>Document Title</th>
<th>Delirium Management Clinical Guideline V3.1</th>
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<td>Date Issued/Approved:</td>
<td>03 May 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>September 2019 <em>Partial update</em></td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>January 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible</td>
<td>Madeleine Purchas – Consultant Geriatrician</td>
</tr>
<tr>
<td>(author/owner):</td>
<td></td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252447</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline aims to provide advice and</td>
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<td>information for all staff involved in the</td>
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<td>care and management of confused and</td>
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<td>delirious patients.</td>
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<td>Medical Director – Rob Parry</td>
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<td>Policy:</td>
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<td>Date revised:</td>
<td>March 2019</td>
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<td>This document replaces (exact title of</td>
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<td>previous version):</td>
<td>Delirium in Adults V3.0</td>
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<td>Naomi Wakeley</td>
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<td>signatories</td>
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<td>Name: Neil Pollard</td>
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<td>approval by specialty and divisional</td>
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<td>management meetings</td>
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<td>approval</td>
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Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet | ✓ Intranet Only
---|---
Document Library Folder/Sub Folder | Clinical/Dementia and Eldercare
Links to key external standards | NICE Clinical Guideline 103: Delirium: Prevention, Diagnosis and Management
Related Documents: | RCHT Mental Capacity Act Policy
RCHT Deprivation of Liberty Safeguards (DOLS) Policy and Procedure
Training Need Identified? | No

### Version Control Table

<table>
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<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<td>V1.0</td>
<td>Initial Issue</td>
<td>Madeleine Purchas, Consultant Geriatrician</td>
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<td>June 2015</td>
<td>V2.0</td>
<td>Not recorded</td>
<td>Fiona Boyd, Consultant Geriatrician</td>
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<td>January 2019</td>
<td>V3.0</td>
<td>Updated throughout</td>
<td>Madeleine Purchas, Consultant Geriatrician</td>
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<td>March 2019</td>
<td>V3.1</td>
<td>Changes to reinforce CAM is the Trust’s principle tool to support the diagnosis of</td>
<td>Frazer Underwood, Consultant Nurse / Associate Nurse Director</td>
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<td>delirium (section 2.2.2); Lorazepam recommendations revised; service title update</td>
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<td>from Eldercare to Integrated Services for Older; Covert medications section</td>
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<td>updated in light of Medicine Policy changes</td>
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**All or part of this document can be released under the Freedom of Information Act 2000**

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

**Controlled Document**

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**Appendix 2. Initial Equality Impact Assessment Form**

**Name of Name of the strategy / policy / proposal / service function to be assessed**
Delirium Management Clinical Guideline V3.1

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy?</th>
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<td>Medical/Elder Care</td>
<td>Existing</td>
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<table>
<thead>
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<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
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</thead>
<tbody>
<tr>
<td>Madeleine Purchas</td>
<td>01872 252447</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   - **Who is the strategy / policy / proposal / service function aimed at?**
     
     This guideline aims to provide advice and information for all staff involved in the care and management of confused and delirious patients.

2. **Policy Objectives***
   - Improve and standardise clinical care.
   - Reduce use of sedation in patients with delirium

3. **Policy – intended Outcomes**
   - Improve outcomes for patients with delirium

4. **How will you measure the outcome?**
   - Documentation of delirium (AMTS, CAM assessment method in medical admission proforma)
   - Trends in e-prescribing of sedation medication
   - Use of ‘specialising’ nursing

5. **Who is intended to benefit from the policy?**
   - Patients suffering from delirium.

6a. **Who did you consult with**
   - Workforce
   - Patients
   - Local groups
   - External organisations
   - Other

   √ Workforce

   √ Local groups

   √ External organisations

   Please record specific names of groups

   Delirium Policy Group (RCHT/ CPFT)

7. **What was the outcome of the consultation?**
   - Ratified at Integrated Services for Older People Care Governance Group

7. **The Impact**
   Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.
Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
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<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tr>
<td>Age</td>
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<td>Older patients are at higher risk of developing delirium. Implementation of this guideline may improve outcomes for older patients.</td>
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<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<td>Race / Ethnic communities /groups</td>
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<td>Patients with comorbidities (both pre-existing physical and mental health conditions) are at higher risk of developing delirium. Implementation of this guideline may improve outcomes for this group.</td>
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<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  Yes  No √

9. If you are not recommending a Full Impact assessment please explain why.

No negative impact likely. Implementing this guideline is only likely to improve outcomes for the groups detailed above.

Date of completion and submission 03/05/19
Members approving screening assessment
Policy Review Group (PRG) APPROVED

This EIA will not be uploaded to the Trust website without the approval of the Standard operating procedure Review Group.

A summary of the results will be published on the Trust’s web site.

Delirium Management Clinical Guideline V3.1