Delirium Management Clinical Guideline

V3.0

January 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 AMTS

Acute onset / change in cognition

No change from baseline

History

Look for cause of delirium

Electrolyte disturbance
Infection
Medication
Head injury
Retention/constipation
Pain
Perioperative

Possible Dementia

B12, folate
TSH

Treat any reversible cause

Bloods – FBC, CRP, UE, Bone, LFT, glu
ECG
Sepsis screen – CXR, MSU, +/- BCs
+/- CTH

Management of confused patient

Orientation – lighting, consistent staff, hearing aids, glasses, family if appropriate
Calm patient down - verbal/non-verbal techniques
Medication is last resort:
Olanzapine 2.5 mg / low dose lorazepam (0.5 to 1 mg) / haloperidol 0.5mg -1 mg (if olanzapine not available)

Remember medication (e.g. lorazepam) can exacerbate delirium and increase the risk of falls. Please warn relatives of a small risk of excess mortality with any antipsychotic medications
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 **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.

The DPA18 covers how the Trust obtains, hold, record, use and store all personal and special category (e.g. Health) information in a secure and confidential manner. This Act covers all data and information whether held electronically or on paper and extends to databases, videos and other automated media about living individuals including but not limited to Human Resources and payroll records, medical records, other manual files, microfilm/fiche, pathology results, images and other sensitive data.

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.infogov@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 elderly, 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).
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 Please note: CAM (Confusion assessment Method) in the Medical Admission Proforma.

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 You must get a **collateral** history from relative/ carer, and/or other persons involved in the patient’s recent care. Pick up the phone if necessary.

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

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

2.4.2 **Cognitive** assessment – AMTS (tick box list available in the medical admission proforma).

2.4.3 Or 4-AT (assessment test for delirium and cognitive impairment).

<table>
<thead>
<tr>
<th>AMTS (the Abbreviated Mental test score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
</tr>
<tr>
<td>2. Date of Birth</td>
</tr>
<tr>
<td>3. Time (to nearest hour)</td>
</tr>
<tr>
<td>4. Year</td>
</tr>
<tr>
<td>5. Place – Hospital + name of hospital/city</td>
</tr>
<tr>
<td>6. Address for recall at end of test (42 West Street)</td>
</tr>
<tr>
<td>7. Recognition of roles of 2 people (eg Dr, nurse)</td>
</tr>
<tr>
<td>8. Year of 1st World War</td>
</tr>
<tr>
<td>9. Name of the present Monarch</td>
</tr>
<tr>
<td>10. Count backwards from 20-1</td>
</tr>
</tbody>
</table>
**4AT** (assessment test for delirium and cognitive impairment)

### [1] ALERTNESS
*Drowsy* (e.g. difficult to rouse and/or obviously sleepy) or *agitated/hyperactive.* Observe the patient. If asleep, attempt to wake. Ask the patient to state their name and address to assist rating.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal (fully alert, but not agitated, throughout assessment)</td>
<td>0</td>
</tr>
<tr>
<td>Mild sleepiness for &lt;10 seconds after waking, then normal</td>
<td>0</td>
</tr>
<tr>
<td>Clearly abnormal</td>
<td>4</td>
</tr>
</tbody>
</table>

### [2] AMT4
*Age, date of birth, place (name of the hospital or building), current year.*

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No mistakes</td>
<td>0</td>
</tr>
<tr>
<td>1 mistake</td>
<td>1</td>
</tr>
<tr>
<td>2 or more mistakes/untestable</td>
<td>2</td>
</tr>
</tbody>
</table>

### [3] ATTENTION
*Months of the year backwards*
*One prompt of “what is the month before December?” is permitted.*

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieves 7 months or more correctly</td>
<td>0</td>
</tr>
<tr>
<td>Starts but scores &lt;7 months / refuses to start</td>
<td>1</td>
</tr>
<tr>
<td>Untestable (cannot start because unwell, drowsy, inattentive)</td>
<td>2</td>
</tr>
</tbody>
</table>

### [4] ACUTE CHANGE OR FLUCTUATING COURSE
*Evidence of significant change or fluctuation arising over the last 2 weeks*

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
</tr>
</tbody>
</table>

**4AT SCORE**
- **4 or above:** possible delirium +/- cognitive impairment
- **1-3:** possible cognitive impairment
- **0:** delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)
2.5 Investigations

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

2.5.2 Other investigations to consider:
- CTH
- 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 ‘specializing’
- Maintain/restore normal sleeping patterns if possible

2.6.2 Sedation

2.6.2.1 Sedation can worsen/prolong delirium as 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.

2.6.3 Which Medication:

- Olanzepine 2.5-5 mg
- Lorazepam 0.5-1 mg orally - maximum 2 mg per day
- Haloperidol 0.5-1 mg orally (tablets or liquid) - if olanzapine not available

Do not give Haloperidol to patients with a history of Parkinson’s Disease.

2nd line - IM if necessary
2.6.4 **Avoid multiple ward moves** as this will only exacerbate confusion.

2.7 **Documentation**

2.7.1 In 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, 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.

2.8 **Where to ask for help**

- Psychogeriatric liaison referral
- Eldercare consultant referral via MAXIMS
- Community Psychiatric Team – if the patient is known to them
- Ward pharmacist

3. **Monitoring compliance and effectiveness**

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Documentation of confusion</th>
<th>Prescribing of sedation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Madeleine Purchas, Consultant in Eldercare</td>
<td></td>
</tr>
<tr>
<td>Tool</td>
<td>AMTS and CAM Documentation in the Medical Admission Proforma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e-prescribing (Lorazepam and Haloperidol)</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>Eldercare Governance meetings (Monthly)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delirium Policy meeting</td>
<td></td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Monthly meetings are minuted</td>
<td></td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Eldercare Department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Madeleine Purchas</td>
<td></td>
</tr>
<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 Eldercare Meeting.</td>
<td></td>
</tr>
<tr>
<td></td>
<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>
<td></td>
</tr>
</tbody>
</table>
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>
<tr>
<th>Document Title</th>
<th>Delirium Management Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>02/11/2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>January 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>January 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Madeleine Purchas – Consultant Eldercare</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 information for all staff involved in the care and management of confused and delirious patients.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Delirium, Acute confusion, Sedation</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT ✓</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director – Mark Daly</td>
</tr>
<tr>
<td>Date revised:</td>
<td>November 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical Guidelines for the Management of Delirium in Adults V2.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Eldercare Governance Group, Divisional Governance Group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Naomi Wakeley</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed} Name: Julia Bell</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy)</td>
<td>Internet &amp; Intranet ✓</td>
</tr>
</tbody>
</table>
Delirium Management Clinical Guideline V3.0

<table>
<thead>
<tr>
<th>Document Library Folder/Sub Folder</th>
<th>Clinical/Elder Care</th>
</tr>
</thead>
</table>

**Links to key external standards**

- Delirium: Prevention, Diagnosis and management NICE July 2010
- Jitapunkul S, Pillay I, Ebrahim S. The abbreviated mental test: its use and validity, Age and Ageing; 1991;20:332-336
- Purchas MA, Pollard N (2005) Guidelines for the Diagnosis and management of Acute Confusion (Delirium) in the Elderly. www.acutemed.co.uk/docs

**Related Documents:**

- RCHT Mental Capacity Act Policy
- RCHT Deprivation of Liberty Safeguards (DOLS) Policy and Procedure

**Training Need Identified?**

No

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### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2009</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Madeleine Purchas</td>
</tr>
<tr>
<td>June 2015</td>
<td>V2.0</td>
<td>Not recorded</td>
<td>Fiona Boyd, Consultant Geriatrician</td>
</tr>
</tbody>
</table>
| November 2018 | V3.0   | 1. Flow chart added for ease of use  
2. Guideline simplified for ease of use  
3. 4AT added as an alternative screening tool for delirium (this is currently used by the orthogeriatricians in particular)  
4. Medication for delirium amended in line with current practice | Madeleine Purchas |

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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**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<thead>
<tr>
<th>Name of strategy / policy / proposal / service function to be assessed</th>
<th>Delirium Management Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Medical/Elder Care</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Madeleine Purchas</td>
</tr>
<tr>
<td>Telephone:</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
   - √
   - √

   **Please record specific names of groups**
   - Delirium Policy Group (RCHT/CPFT)

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.**

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are there concerns that the policy could have differential impact on:

Equality Strands: Yes No Unsure Rationale for Assessment / Existing Evidence
<table>
<thead>
<tr>
<th>Age</th>
<th>Older patients are at higher risk of developing delirium. Implementation of this guideline may improve outcomes for older patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<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>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
</tr>
</tbody>
</table>

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.

Signature of policy developer / lead manager / director Madeleine Purchas  
Date of completion and submission 02/11/2018

Names and signatures of members carrying out the Screening Assessment  1. Madeleine Purchas  
2. Human Rights, Equality & Inclusion Lead
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,
Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the
Human Rights, Equality & Inclusion Lead.

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

Signed __ Madeleine Purchas
Date ____02/11/2018__________