Quick Reference Guideline: Delirium in Older People

For the management of patients in ED or EAU with delirium. This guideline does not cover delirium due to alcohol withdrawal – see separate guideline.
This quick reference guide has been adapted for local use and is based on the NICE Clinical Guideline 103: delirium – diagnosis, prevention and management (Jul 2010)
www.nice.org.uk/cg103

ADMISSION TO HOSPITAL

Risk factors? Age over 65; cognitive impairment/dementia; hip fracture; severe illness

YES

AT RISK

NO

NOT AT RISK

Change in risk factors?

Are there any indicators of delirium? – NB carers or relatives may report these: RECENT changes in cognitive function, behaviour, perception or physical function?

YES

NO

Are there any indicators of delirium?

Daily observations for indicators of delirium

DELIRIUM PREVENTION STRATEGIES (see notes)

Clinical assessment: short CAM and AMT

Delirium diagnosed?

YES

Record in hospital and primary care notes

MANAGEMENT

The management of delirium has 3 parts:

1. Investigate and treat the underlying cause (in 20% of cases none is found), and review medications.
2. General measures – see the delirium prevention and management checklist
3. Drug treatment should only be used as a last resort.

The diagnosis of delirium should be explained to the relatives/carers.
Quick Reference Guideline: Delirium in Older People – notes

1. Delirium affects 20-30% of medical in-patients and is the most common complication of hospital admission in older people.

2. Delirium is characterised by an acute decline in cognition and attention that fluctuates throughout the course of a day. It is an acute medical condition, not a psychiatric disorder.

3. There are 3 sub-types of delirium: hyperactive (restless, agitated, aggressive), hypoactive (withdrawn, quiet and sleepy) and mixed. Delirium is grossly under-diagnosed. In studies at least half of all cases go unrecoind by doctors and nurses. Delirium is important because a) it is preventable and b) people who develop delirium have longer lengths of stay in hospital, more complications (eg pressure ulcers, falls) and are more likely to die.

4. In a frail older person even a minor insult, such as one dose of a sleeping tablet, could cause delirium. In younger, fitter patients, delirium may only be caused after surgery or admission to ICU. Delirium is characterised by neuro-transmitter disturbances, and there is diffuse slowing of cortical background activity on the EEG with generalised disruption of higher cortical functioning on neuro-psychological and imaging studies.

5. All older people admitted to hospital should be screened for delirium using this flow chart. The short CAM is shown below. AMT = abbreviated mental test (10 validated questions).

6. Any acute medical or surgical problem or medications can cause delirium. Opioids, psychoactive medications and drugs with anti-cholinergic side effects should be avoided in delirium. Please note that bacteruria can be a normal finding in old age, especially in women. This will manifest as leucocytes and nitrates in the urine. So never assume the person has a UTI causing delirium based only on a urine dipstick result. Delirium often has more than one cause, and in 20% of cases no cause is found.

7. As well as treating the underlying cause(s), there are important general measures that should be employed in the prevention and management of delirium – see the checklist on the next page. Drug treatment is a last resort and should be reserved for patients who are at risk of harming themselves due to severe agitation. The most studied drug in delirium is haloperidol eg 0.5mg orally each evening for the shortest possible period.

The Short Confusion Assessment Method (Short CAM)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute onset and fluctuating course?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>(Is there an acute change in mental state? Did this fluctuate during the past day?)</td>
<td></td>
</tr>
<tr>
<td>2. Inattention?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>(Is the patient easily distracted or does he have difficulty keeping track of what is being said? Inattention can also be detected by asking for the days of the week to be recited backwards)</td>
<td></td>
</tr>
<tr>
<td>3. Disorganised thinking?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>(Is the patient’s speech disorganised, incoherent, rambling, irrelevant, unclear/illogical or unpredictably switching between subjects?)</td>
<td></td>
</tr>
<tr>
<td>4. Altered level of consciousness?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>(Is the patient vigilant (hyper-alert) or lethargic/drowsy?)</td>
<td></td>
</tr>
</tbody>
</table>

1 + 2 + either 3 or 4 is required to make a diagnosis of delirium.
DELIRIUM PREVENTION AND MANAGEMENT CHECKLIST

1. Each time you see the patient, provide regular gentle orientation: explain where they are, who you are and what your role is.

2. Introduce cognitively stimulating activity (eg reminiscence) during care. Friends and relatives can help with this.

3. Go through this checklist daily. If the answer is NO to any question, attempt to address the issue (eg moving a very confused patient to a side room as soon as possible).

ORIENTATION
Is the lighting appropriate? YES / NO
Are signs (eg for the toilet) clearly visible? YES / NO
Is there a clock and a calendar visible? YES / NO
Is the patient wearing their glasses? YES / NO
Is the patient wearing their hearing aids? YES / NO
Is the environment quiet and calm (not over-stimulating)? YES / NO

ADDRESS DEHYDRATION AND/OR CONSTIPATION
Is the patient drinking enough fluid? YES / NO
Are the patient’s bowels working normally? YES / NO
Is the patient’s bladder working normally, without a catheter? YES / NO
(remove urinary catheters as soon as possible)

IS MOBILITY BEING ENCOURAGED? YES / NO

OPTIMISE MEDICAL CONDITIONS
Is pain well controlled? YES / NO
Are the oxygen saturations within target range? YES / NO
Are infections being treated? YES / NO
Is the patient getting adequate nutrition? YES / NO

PROMOTE SLEEP
Is activity and mobility being encouraged during the day? YES / NO
Have you checked whether the patient drinks caffeine in the evenings? YES / NO
(avoid caffeinated drinks after tea-time)
Authors:
Dr Nicola Cooper, consultant in acute medicine
Dr xxx, consultant geriatrician

Date:
9 September 2013

Revision date:
9 September 2015

Signed off by the Salford Healthcare Divisional Governance Committee on: [date]