Delirium can be a very distressing condition. If the patient is very distressed or any resulting behaviour presents a significant risk, short term medication may be necessary. This should be discussed fully and reviewed regularly.

**Please refer to the Whittington Hospital delirium policy available on the trust intranet.**

## In addition staff should

- Complete with the carer a 'This is me' patient autobiography with the carer. This is so staff better understand the patient, their behaviours, likes, dislikes and what comforts them.
- Ask carers to bring in familiar objects, photos, radios and known comforts to make the environment less alien and help the patient feel more secure.
- Communicate in a clear and simple way with the patient explaining your intentions. Try to be kind, patient and reassuring. You may need to repeat things and reorientate them.
- Fit any hearing aids or glasses to address any sensory impairment.
- Try to stand in the shoes of the patient and think how they might be thinking and feeling. This may help you understand the situation better.
- Suggest family and friends visit regularly and provide support, unless you know this will upset the patient.

Delirium for acute hospital staff

## Additional Information

For more information please visit:

National Institute for Health and Care Excellence:
**www.nice.org.uk**

**www.rcpsych.ac.uk/healthadvice/problemsdisorders/delirium.aspx**

The European Delirium Association:
**www.europeandeliriumassociation.com**

Delirium is more common in dementia, to read more about this visit:
**www.alzheimers.org.uk**

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# Delirium for acute hospital staff

Talk to us

## Introduction

It is common for elderly people when they are physically unwell to become delirious (acutely confused). Delirium effects 25% of patients in hospitals. It is important that the treating team are aware of any increased or new confusion so they can manage it. Delirium can lengthen the stay in hospital.

## What does delirium look like?

Patients present with sudden onset of some of the following

- reduced awareness of the environment
- poor attention and concentration
- disorientation
- poor memory
- disorganised thinking
- misinterpretation of the surroundings, suspiciousness, hallucinations and delusions
- behaviour change such as drowsiness and apathy or restlessness and agitation and sometimes even aggression
- mood change such as anxiety, depression and fear
- sleep/wake disturbance

Often the course of this is fluctuating and changeable.

**The CAM (Confusion Assessment Method) is a useful brief screening tool and should be used.**

*"The treating team must identify the underlying cause and treat this. It is also important that any modifiable factors are identified."*

## Who is more at risk?

Those who have a pre-existing memory impairment or dementia are more susceptible to delirium. Other important risk factors are being frail, being severely ill, having a sensory impairment or substance misuse problem.

## What is it?

Delirium is a state of mental confusion that happens if you become medically unwell. It is a non-specific brain response to inflammation.

## What causes it?

It can be caused by all sorts of medical conditions such as stroke, pneumonia, heart attack or surgery. Often it is caused by several minor factors such as pain, infection, malnutrition, constipation, dehydration or just a change in the environment. Medication can also be an important cause. This includes any medications recently stopped or over the counter prescriptions.

## How long does it last?

Delirium usually resolves quickly. Sometimes however, it can take weeks or even months. Occasionally a degree of confusion persists. If this happens, it is important to ask the patients GP to refer them to a memory assessment clinic for a fuller assessment of the problem. This means they will have timely access to any treatment, support and advice needed.

# Delirium for acute hospital staff

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## How is delirium identified?

- **Patient history should include their understanding of the situation, recent physical symptoms and any underling medical problems.**
- **Mental state examination including MMSE.**
- **Collateral history from carers and GP with attention to timing of symptoms, patients usual baseline and past medical history.**
- **Physical health check - delirium screen bloods (FBC, U&E, LFT, TFT, glucose, CRP, cholesterol, bone profile, B12/folate), urine sample, CT head scan, ECG and CXR where appropriate.**

## How is delirium managed?

- **Identify the underlying cause and treat this**
- **Correct any modifiable factors:**
  **- ensure patient is eating and drinking**
  **- toileting**
  **- mobilising (refer to physiotherapy)**
  **- stimulated (refer to occupational therapy)**
  **- not in pain**
  **- sleeping**
- **Environment should be clearly signposted, quiet and well lit (a side room may be necessary).**
- **Some patients can be helped by having individual nursing staff to support and reassure them**
- **Use of a behaviour chart looking in depth at any problematic behaviour can be helpful.**
- **Avoid unnecessary moves.**
- **Consider the use of a dementia recognition scheme.**