Whittington Health NHS

Delirium in the elderly – Assessment and management

Subject:	Delirium in the elderly
Policy Number	N/A
Ratified By:	Clinical Guidelines Committee
Date Ratified:	Original ratified July 2008, update January 2011, minor update October 2012, reviewed Oct 2015
Version:	4.0
Policy Executive Owner:	Dr Celia Bielawski
Designation of Author:	Consultant
Name of Assurance Committee:	As above
Date Issued:	October 2015
Review Date:	October 2016 (post audit)
Target Audience:	All staff dealing with acutely unwell elderly patients, including General Medicine. Surgery, Emergency Medicine and Orthopaedics.
Key Words:	Delirium, acute confusional state, sedation, elderly

Version Control Sheet

Version	Date	Author	Status	Comment
3.0	Oct 2012	Dr C Bielawski	Off line	Midazolam added due to lorazepam shortage
4.0	Oct 2015	Dr C Bielawski	Live	Content reviewed by Dr Celia Bielawski in line with review date. No changes required. One year review date assigned due to forthcoming, planned audit of the guideline.

➢ Criteria for use

This guideline is designed to help clinicians screen for and identify delirium in elderly inpatients and then instigate appropriate management

➢ Background/ introduction

Delirium is defined as a clinical syndrome characterised by disturbed consciousness, cognitive function or perception. It has an acute or subacute onset and may have a fluctuating course. It is sometimes known as 'acute confusional state'.

Delirium is common in the hospitalised elderly and is seen in up to 50% of inpatients aged over 75

Although delirium may present with agitation, many patients actually present with **hypoactivity** and the condition is therefore missed. For this reason, staff caring for the acutely unwell elderly need to **THINK DELIRIUM** and actively assess patients to facilitate timely management.

The following guideline explains how to screen for delirium and then treat it appropriately.

➢ Inclusion/ exclusion criteria

Included: Any hospital inpatient over the age of 65 who is acutely unwell.

Excluded: patients receiving end of life care, patients who are intoxicated or withdrawing from alcohol and/or drugs

	Please see Whittington Hospital NHS Trust Guideline: ***'Alcohol withdrawal and intoxication'***

➢ Clinical management

Diagnosing Delirium

Any patient aged over 65 presenting to hospital should be considered **at risk** of delirium. New NICE guidance considers the following groups at especially high risk:

- Existing cognitive impairment / dementia
- Current hip fracture
- Severe illness

In these circumstances **THINK DELIRIUM** and look for indicators that it may be present.

Delirium is likely if there have been acute (over days to weeks) changes in cognitive function, perception, physical function or social behaviour. A collateral history from a carer or relative is therefore essential. Be particularly vigilant for symptoms and signs suggesting hypoactive delirium.

Finding the cause of Delirium

Any acute or subacute illness in older people can cause delirium and a thorough history and examination, plus simple investigations will reveal most causes of delirium.

Medication is one of commonest causes of delirium- always carefully review the drug history particularly any medications recently started or stopped. Common culprit drugs include opiates, benzodiazepines, antihistamines, H2 antagonists.

Delirium is often multifactorial with pre-existing cognitive impairment (dementia) and sensory impairments contributing to the picture.

Important points in the history that are commonly missed are:

- drug history
- alcohol history
- any hearing or visual problems, plus aids used
- previous episodes of delirium
- history of dementia

Important points in the examination that are commonly missed are:

- documentation of level of consciousness
- documentation of nutritional status
- examination of wound sites and IV line sites
- a full neurological examination including assessment of speech
- a digital rectal examination (DRE) if impaction is suspected

- evidence of alcohol abuse or withdrawal
- an Abbreviated Mental Test Score (AMTS) or Mini Mental State Examination (MMSE)

If a patient has a history and examination suggestive of delirium, the Confusion Assessment Method (CAM) screening tool should be used to help confirm the diagnosis:

Confusion Assessment Method Diagnostic Algorithm

	Symptoms	**Yes or No**
1.	**Acute onset and fluctuating course:** - is there evidence of an acute change in mental status from the patient's baseline? - Does the abnormal behaviour fluctuate during the day	
2.	**Inattention** Did the patient have difficulty focusing attention or keeping track of what was being said	
3.a	**Disorganised thinking** Eg: rambling conversation, illogical flow of ideas, switching from subject to subject	
3b.	**Altered Level of consciousness** Eg: hyper-alert, lethargic,.	
If answer Yes to 1,2 and either 3a or 3b, a diagnosis of delirium can be assumed **(Sensitivity 94%, Specificity 90%)**		

Investigations should be guided by initial assessment but are likely to include:

- FBC, U+E, LFT, Bone profile
- Urine dip
- ECG
- CXR

A CT brain is indicated ONLY if the patient has focal neurological signs or an unexplained decreased level of consciousness.

Treating Delirium

(1) Treat the cause

Identify and treat the underlying cause.

Review the drug chart

Remember there is a high incidence of asymptomatic bacteruria in the elderly- a positive urine dip does not necessarily indicate a UTI. Do not give antibiotics without good evidence of infection.

(2) Non-pharmacological management

- nurse patient in a quiet well lit side room
- provide one to one nursing if necessary
- display the date and time so easily visible to patient
- ask family to bring in familiar objects (eg pictures) to help orientate the patient
- Encourage mobility
- Keep fluid and food charts and encourage good fluid intake
- Keep a stool chart and treat constipation if needed
- Nursing staff should complete a falls risk assessment and appropriate care plan
- Ensure VTE risk has been assessed and appropriate preventative treatment prescribed

TRY TO AVOID:

- **moving the patient between rooms or wards**
- **anticholinergic medication**
- **urinary catheterisation**
- **use of sedating medication**
- **use of physical restraints including cot sides**

	Please see Whittington Hospital NHS Trust Guideline: ***'Using bed side rails safely and effectively'***

(3) Consider pharmacological management

Pharmacological management can be considered to either sedate the patient, or treat any psychotic component to their agitation but ONLY if non pharmacological measures have not worked and the patient is a risk to themselves and/or others.

Sedation is distinct from antipsychotic treatment which should only be used if the patient has distressing psychotic features to their agitation

The majority of elderly patients have hypoactive delirium and simple **sedation or antipsychotic treatment is NOT appropriate.**

Simple sedation may be indicated if the patient is very agitated and at risk of harming themselves or others and fails to improve with non-pharmacological measures. Sedation may also be indicated to allow an essential investigation or intervention to proceed safely.

Antipsychotics should be used with caution as they are associated with serious side effects in the elderly. They should therefore only be used for psychotic symptoms which are causing distress to the patient or those that endanger the patient or others and when other measures have failed.

Antipsychotics should **not** be used for:

- Wandering

- Restlessness
- Unsociability
- Fidgeting
- Nervousness
- Lack of cooperation
- Agitated behaviour without danger to self or others

If either simple sedation or antipsychotic treatment is required, use one drug at the smallest dose and review after the first dose and min. daily thereafter.

Advice on safe sedation

- Prescribe the first dose as a single stat prescription
- **Do not** prescribe PRN sedation until you have had a chance to review the effect of the first dose
- **Review** the PRN prescriptions for sedative medication every day
- **Do not** discharge the patient on the sedating medication
- **Antipyschotics should only be used for extremely distressing psychotic symptoms or those that endanger the patient or others.**

DOSING GUIDE

Able to take oral meds			
Indication	Drug	Dose/Route	Max 24 hour dose
Sedation only	Lorazepam	0.5-1.0mg PO	3mg
Distressing psychotic features	Amisulpride	50-200mg PO BD	400mg
Unable to take oral meds			
Sedation only	Lorazepam OR Midazolam hydrochloride 1mg/ml NB stored in CD cupboard	0.5-1.0mg IM or IV diluted up to 2 mls with 0.9% saline 0.5-1mg iv over 30 secs OR 1-2 mg (1-2 ml) deep im. Can be repeated after 30 mins.	3mg 3mg 4mg
Distressing psychotic features	Haloperidol * **Do not give haloperidol if there is any concern that the patient has Lewy body dementia.** **Do not give Haloperidol until you have seen an ECG from the**	0.5mg IM The patient should be observed for 30-60 minutes as the peak effect occurs after 20-40 minutes.	4mg

	current admission with a normal Qtc interval		

After administration of any of these drugs im or iv, basic observations (temperature, pulse, blood pressure and respiratory rate) should be monitored every 5 – 10 minutes for one hour and then half-hourly until the patient is ambulatory.

(4) Follow up

-Patients should NOT be routinely discharged on sedating or antipsychotic medication.
-Any patient that has required antipsychotic medication during their admission should be considered for review by the relevant mental health team before discharge.
-If the patient is to be discharged on an antipsychotic, clear plans for review of this medication must be made and documented in the medical notes and on the discharge summary.
- if a diagnosis of delirium has been made it should be documented on the discharge summary for coding.

➢ Further information

Care of Older people Department, lead Dr C Bielawski.
0207 288 5462/5324

Old Age Psychiatry Liason team, lead Dr G Rands
0207 288 4219.

➢ References (evidence upon which the guideline is based)

The NICE guidelines on delirium can be found at:
http://guidance.nice.org.uk/CG103/NICEGuidance/pdf/English

with a quick reference version at:
http://guidance.nice.org.uk/CG103/QuickRefGuide/pdf/English

Adherence to this guideline will be monitored by annual case note audit within the division of medicine.

Appendix A

Plan for Dissemination and implementation plan of new Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Acknowledgement: University Hospitals of Leicester NHS Trust

Title of document:	**Delirium in the elderly - Assessment and management (v2)**		
Date finalised:	**January 2011 (re-issue Oct 2012)**	**Dissemination lead: Print name and contact details**	
Previous document already being used?	**Yes** **(Please delete as appropriate)**		
If yes, in what format and where?	**On intranet**		
Proposed action to retrieve out-of-date copies of the document:	**Previous version to be unassigned on intranet**		
To be disseminated to:	**How will it be disseminated/implemented, who will do it and when?**	**Paper or Electronic**	**Comments**
Al relevant staff groups	**Via intranet**	**E**	
Is a training programme required?	**No**		
Who is responsible for the training programme?			

Appendix B

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Impact (= relevance) 1 Low 2 Medium 3 High	Evidence for impact assessment (monitoring, statistics, consultation, research, etc	Evidential gaps (what info do you need but don't have)	Action to take to fill evidential gap	Other issues
Race	**1**			
Disability	**1**			
Gender	**1**			
Age	**1**			
Sexual Orientation	**1**			
Religion and belief	**1**			

Once the initial screening has been completed, a full assessment is only required if:

- The impact is potentially discriminatory under equality or anti-discrimination legislation
- Any of the key equality groups are identified as being potentially disadvantaged or negatively impacted by the policy or service
- The impact is assessed to be of high significance.

If you have identified a potential discriminatory impact of this procedural document, please refer it to relevant Head of Department, together with any suggestions as to the action required to avoid/reduce this impact.