Mersey and West Lancashire Teaching Hospitals NHS Trust

Delirium Guideline

Version No: 1

Document Summary:
The Purpose of this guideline is to help all clinical staff to identify and treat delirium amongst the hospital inpatient population.

Document status	Approved	
Document type	Guideline	**Trust wide**
Document number	PD2471	
Approving body	Patient safety council	
Date approved	12/12/2024	
Date implemented	12/12/2024	
Review date	**31/12/2027**	
Accountable Director	Director of Nursing, Midwifery & Governance	
Policy Author	Consultant, Consultant Geriatrician, Dementia and delirium team	
Target audience	Clinical staff	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information		
Title	Delirium guideline	
Directorate	Medical	
Brief Description of amendments		
Cognitive screening templates, delirium pathway, short term sedation updated ***Please state if a document has been superseded. yes***		
Does the document follow the Trust agreed format?		Yes
Are all mandatory headings complete?		Yes
Does the document outline clearly the monitoring compliance and performance management?		Yes
Equality Analysis completed?		Yes
Data Protection Impact Analysis completed?		Yes

Section 2 – Consultation Information*			
*Please remember to consult with all services provided by the Trust, including Community & Primary Care			
Consultation Completed	☑ Trust wide ☐ Local ☐ Specific staff group		
Consultation start date	03/09/2023	**Consultation end date**	03/12/2024

Section 3 – Version Control		
Version	**Date Approved**	**Brief Summary of Changes**
1 PD	12/12/2024	Cognitive screening templates, delirium pathway, short term sedation updated
	Click here to enter a date.	
	Click here to enter a date.	
	Click here to enter a date.	

Section 4 – Approval *– To be completed by Document Control*			
Document approved	☑ Approved ☐ Approved with minor amendments		
Assurance provided by author & Chair	☒ Minutes of meeting ☐ E-mail with Chair's approval		
Date approved	12/12/2024	**Review date**	31/12/2027

Section 5 – Withdrawal *– To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval
Date Withdrawn:	Click here to enter a date.

Contents

1. Scope

Head of Services / Clinical Leads (Heads of Nursing, Head of Therapies, Associate Medical Directors, Clinical Directors)

Responsible for ensuring that policies are produced in relation to clinical procedures and recorded in an appropriate way, ensuring adherence to local and national initiatives and targets, setting trust specific targets accordingly.

Matrons, Clinical Therapy Managers, Senior Doctors

Responsible for ensuring that the clinical guidelines are produced and updated, and that they are available for staff to read, copy and refer to when assessing and treating patients.

All Employees

Responsible for taking ownership of their development and learning and reading the clinical guidelines. They must use these alongside their own clinical reasoning and judgement, to provide the best care for patients with delirium.

2. Introduction

Delirium is a common neuropsychiatric syndrome amongst the over 65s. It accounts for up to 10-31% of all hospital admissions and occurs in between 10-42% of all over 65s during a hospital admission (1). Delirium is associated with both a significantly increased risk of mortality both in hospital and up to 12 months post discharge (1,2) and a significant increase in morbidity with protracted hospital admissions and functional decline (1,3). Furthermore, the failure to diagnose delirium can lead to an eightfold increase in mortality (4). Age is a risk factor for delirium therefore with an increasing aging population, excellent management of patients with Delirium is a priority.

3. Statement of Intent

The Purpose of this guideline is to help all clinical staff to identify and treat delirium amongst the hospital inpatient population.

4. Definitions

Term	Definition/meaning
NICE	National institute for health and clinical excellence
CXR	Chest X-ray
ECG	Electrocardiogram
FBC	Full blood count
NOF	Neck of femur
U&E	Urea and electrolytes
LFT	Liver function tests

5. Duties, Accountabilities and Responsibilities

Head of Services / Clinical Leads (Heads of Nursing, Head of Therapies, Associate Medical Directors, Clinical Directors)

Responsible for ensuring that policies are produced in relation to clinical procedures and recorded in an appropriate way, ensuring adherence to local and national initiatives and targets, setting trust specific targets accordingly.

Matrons, Clinical Therapy Managers, Senior Doctors

Responsible for ensuring that the clinical guidelines are produced and updated, and that they are available for staff to read, copy and refer to when assessing and treating patients.

All Employees

Responsible for taking ownership of their development and learning and reading the clinical guidelines. They must use these alongside their own clinical reasoning and judgement, to provide the best care for patients with delirium.

6. Process

Best Available Evidence

NICE: Delirium: diagnosis, prevention and management (clinical guideline 103—updated 2019)

SIGN 157: Risk reduction and management of delirium (2019).

Overview of Delirium Assessment Tools

Tool	Time taken (min)	Training Required	Staff	Settings	Reported Sensitivity %	Reported Specificity %	Delirium severity rating	Suitable for monitoring	Suitable for detecting DSD
4AT[20,24,26,27,30,32]	<2	No	Any	Multiple	86-100	65-82	No	No	Yes
AMT[20,26]	2	No	Any	Medical	75-87	61-64	No	No	No
CAM and variants[18,20,22,24,30,33]	3-10	Yes	Any	Multiple	46-94	63-100	No†	No	Yes
CAM-ICU[19,22,30,31]	<5	Yes	Any	ICU	28-100	53-99	No	Yes	No
DOS (13-item)*[28-30]	5	Minimal	Any	Multiple	89-100	87-97	Yes	Yes	No
DRS- R-98[30,34,35]	20	Yes	Psychiatry	Multiple	57-93	82-98	Yes	No	Yes
ICDSC[19,31]	7-10	Minimal	Any	ICU	73-97	69-97	Yes	Yes	No
MMSE[36]	5	Minimal	Any	Multiple	76-91	51-84	Yes	No	No
Nu-DESC[30]	<5	No	Any	Multiple	32-96	69-92	No	No	No
RADAR[37]	<1	No	Any	Multiple	43-84	64-78	No	Yes	No
mRASS[33,38]	1	No	Any	Multiple	65-75	82-90	Yes	Yes	Yes
SQiD[20]	<1	No	Any	Medical	77-91	56-71	No	Yes	No

Suitability for monitoring refers to the use of a tool daily or more for screening for incident delirium.

†with the exception of CAM-S

*DOS requires assessment over three shifts so time to detection is three days. It is geared towards assessment of hyperactive delirium.

Abbreviations: AMT - Abbreviated Mental Test; CAM - Confusion Assessment Method; DSD - delirium superimposed on dementia; DRS-98-R - Delirium Rating Scale; DOS - Delirium Observation Screening Scale; ICDSC - Intensive Care Delirium Screening Checklist; Nu-DESC - Nursing Delirium Screening Scale; MMSE - Mini Mental State Examination; RADAR - Recognising Acute Delirium As part of your Routine; mRASS - Modified Richmond Agitation-Sedation Scale; SQiD - Single Question to Identify Delirium

Scottish Intercollegiate Guidelines Network (SIGN). Risk reduction and management of delirium, 2019) (8)

When should the Guideline be applied?

Following publication, the above guidelines will be highlighted to all relevant medical staff through direct email and where possible formal educational meetings and through the use of laminated delirium pathway flowcharts being visible in the Trust (see appendix 2 & 3).

The Guideline will be published in the Trust Brief after upload onto intranet.

The Guideline will be disseminated via the Heads of Nursing and Therapies to the whole workforce in addition to training on Delirium being offered via Dementia tier 2 training and bespoke training.

All staff are invited to take a copy of the guideline and must take responsibility for ensuring that they fully understand the guideline and procedure, in order provide excellent care for patients with delirium or knowing what action to take if a patient is found to have a cognitive impairment/confusion. It is the responsibility of each member of staff to ensure that they are following the most recent clinical guideline. The guideline will also be available for staff to view on share-point / the intranet.

Delirium can be further classified into sub-types, and these can present with different clinical features:

Hyperactive Delirium – Characterised by heightened arousal. Patients can be restless, agitated or aggressive.

Hypoactive Delirium – Characterised by withdrawal. Patients can be quiet or sleepy.

Mixed Delirium – Features of both hyperactive and hypoactive delirium may be present.

Delirium screening and assessment

There are no definitive diagnostic tests for delirium, however the 4AT Assessment (p14) is a brief validated tool for use in non-Intensive Care settings, which does not require specific training (22, 23).

4AT screening needs to be completed within 8 hours of admission to hospital for people with positive risk factors of delirium (P8). This should be completed on the Vital Pac system by a qualified member of staff (band 4 or above). Staff who are not band 4 or above who use the 4AT as part of their role should be appropriately delegated by a registered practitioner. It is essential that screening forms part of on-going assessment by nurses and medical staff. Interpretation of scores and any actions rests with the clinical team using the 4AT. The presence or emergence of delirium signifies a need for urgent medical attention. Parental teams must be informed of patients with a positive 4AT score for prompt assessment. 4AT scoring and actions are documented.

The Delirium Pathway (p20) or time bundle (p21) needs completing by a qualified member of staff (band 4 or above) as early as possible, either when they arrive in AED, or when they are admitted to a ward, the timeline is demonstrated on page 14. This indicates the process from assessment, to alerting a doctor and strategies to employ which will best inform the investigation of cause, management, care considerations and will maximise the persons chance of recovery. The pathway and timeline demonstrate best practice and are evidence based which we must adhere to within service provision.

Diagnosis can be further improved by taking a history from a carer or relative to help distinguish between dementia and delirium and further assessment can be required for up to 12 weeks in order for a delirium to have had the opportunity to resolve before making a diagnosis of dementia which would be done after a person has been discharged.

Please see Standard operating procedure (SOP) for delirium risk factor and 4AT screening for further information.

Common Causes

Delirium can be caused by a number of factors. When identifying a patient with delirium there should be an assessment for reversible causes, and these should be addressed where appropriate. (13)

Potentially reversible causes of delirium	
• Pain • Biochemical abnormalities e.g. hypercalcaemia, uraemia • Cardiovascular causes • Cerebral pathology • Constipation • Dehydration • Hypoxia • Polypharmacy • Infection • Sensory impairment	• Infections • Medications • Nutritional deficiencies • Withdrawal from alcohol/nicotine • Withdrawal from drugs e.g. antipsychotics, benzodiazepines, opioids • Exhaustion

Prevention

Delirium is preventable in up to one third of all patients who develop the disorder (8,9,10). Attention should be placed on identifying high risk patients and where possible avoiding high risk precipitants.

Risk Factors	High risk precipitants
Old age (>65)	Urinary catheter
Severe illness	Malnutrition
Cognitive impairment/ confusion	Psychotropic medications
Learning disability	Illness
Current hip fracture	Dehydration
Infection or dehydration	Physical restraint
Diagnosis of dementia	Immobility
Excess alcohol / drug consumption	Substance misuse

(Adapted from British Geriatrics Society and Royal College of Physicians. Guidelines for the prevention, diagnosis and management of delirium in older people. Concise guidance to good practice series, No 6. London: RCP, 2006.)

Investigations

Whilst at all times an individualised approach should be made the most commonly recommended basic investigations to ascertain the causes of delirium are (12,13):

· FBC, U&E, LFT, Glucose, Thyroid function tests, B12 and Folate, Bone Profile

· CXR
· ECG
· Blood cultures
· Urinalysis
· Pulse oximetry

Further investigations may be warranted on an individual basis, these include:

· ABG
· Lumbar puncture
· CT Head:

This should be considered in those patients suspected of having underlying intracranial pathology such as: Focal neurology, Raised ICP signs, confusion-post head injury or fall, Concurrent use of anticoagulation or suspicion of underlying mitotic process.

Treatment

Both identifying and treating any underlying cause should underpin the management of all patients with delirium. In addition, efforts must be made to support patients with the symptoms that often manifest as a result of delirium including confusion, hallucinations and agitation.

Non-pharmacological management of Delirium

Due to the risks of adverse side effects from medications used in the treatment of delirium (including drowsiness, decline in cognition, extra-pyramidal side effects and the small risk of neuroleptic malignant syndrome), non-pharmacological interventions should be optimized prior to commencing a pharmacological treatment if possible.

It should be recognised that the types of non-pharmacological measures used should be tailored to the patient in the context of their clinical situation. For example, it may not be in the patient's best interests to keep them in a bay to help orientate them.

Discussion with the patient (where possible) and those close to the patient at an appropriate time should be undertaken when a diagnosis of delirium is reached and should include an explanation of the diagnosis.

Effective communication, reorientation and reassurance is vital. Also, involvement of friends and family may help calm patient.

Environment plays a vital role in dealing with these patients and can often be overlooked. Consider environmental factors that may be distressing such as lighting levels and

reducing noise where possible. Hearing aids and glasses should be available as appropriate so to avoid sensory impairment. Good nursing care is integral in dealing with all patients with confusion, and where possible employ good continuity of nursing care. Consider supplementary care such as bay tagging or 1-1 care when required.

Inter and intra ward transfers should be avoided if at all possible (14). Consider “keep me here” proforma to avoid inappropriate hospital bed moves.

Avoid anticholinergic medications and urinary catheterisation where possible.

Non-pharmacological management strategies

Non-pharmacological management	
• Familiar environment • Familiar healthcare team • Adequate lighting • Visible clock and calendar • Sensory impairment aids • Mobility aids • Maintain good sleep hygiene. • Cognitively stimulating activities	• Effective communication • Re-orientation • Reassurance • Consider involving family/friends/carers to help with this. • Verbal/non-verbal techniques to manage distress

For further information on non-pharmaceutical interventions please see short term sedation guideline.

Pharmacological management of Delirium

- Where possible implement non-pharmacological measures (verbal and non-verbal techniques) to try and calm patient.
- Ensure causes of agitation have been ruled out/treated e.g. pain, urinary retention.
- Sedation should only be used in patients with delirium in order to carry out essential investigations or treatment that cannot be delayed, or in patients endangering themselves or others despite attempting to use non-pharmaceutical interventions (12,13). Drug sedation can also be used in highly agitated or hallucinating patients in whom all other measures have failed.
- The first line choice of drug is *haloperidol (12,13,15,16). Oral 500 microgram to 1mg twice daily with additional doses every 4 hours as needed (peak effect 4-6 hours). In severe agitation intramuscular haloperidol can be given at a dose of 500 microgram to 1mg, observe for 30-60 minutes and repeat if necessary (peak effect 20-40 minutes) (17). Use lower dose in elderly up to a maximum dose of 2mg daily (18).

- Benzodiazepines in delirium can be used alongside antipsychotics for managing symptoms of agitation without increasing the risk of treatment failure (19). However, benzodiazepines ***would not*** routinely be used as monotherapy in delirium unless directed by a specialist or senior doctor or contraindications being present to haloperidol.

Avoid haloperidol in patients with Parkinson's disease/parkinsonism or in patients with Lewy body dementia – use lorazepam in these patients – where possible discuss with senior doctor* (12)

- Haloperidol should be avoided, if possible, when there is a history of Parkinson's disease, CNS depression or clinically significant cardiac disorders e.g. recent acute myocardial infarction, uncompensated heart failure, arrhythmias treated with class IA and III antiarrhythmic medicinal products, QTc interval prolongation, history of ventricular arrhythmia or torsades de pointes clinically significant bradycardia, second or third degree heart block and uncorrected hypokalaemia. If initiating Haloperidol an ECG should be done as soon as is practicable.
- Lorazepam is recommended if there is a contraindication to haloperidol.
- In certain circumstances where agitation is a predominant feature Lorazepam may be used 0.5mg to 1mg orally, IM or IV **(follow local guidelines on how to prepare medication).** This however should be discussed with ST3 doctor or above before initiating.
- If regular sedation is required for patients with delirium this must be reviewed by a senior doctor and this guidance would recommend consideration of the involvement of psychiatry liaison team or consultant geriatrician.
- In patients with parkinsonism, quetiapine may in certain circumstances be used however this guideline would strongly recommend involvement of a consultant geriatrician or psychiatrist before initiation. (17, 20, 21).

For further information on pharmacological interventions please see:

Short term sedation guideline - For older people who are experiencing BPSD, delirium and other disorders of mind or brain.

Violence and aggression guideline - For adults showing severe acute violence, aggression, or severe behavioural disturbance.

Medications for use in delirium

Antipsychotic medication is associated with a number of adverse effects. Therefore, it should only be considered as a short-term treatment option for Delirium (less than a week) and the prescription reviewed on a daily basis.

Antipsychotic medication may be inappropriate in a number of circumstances, for example:

- If reversible conditions such as urinary retention or pain have not been treated or excluded.
- If barriers to effective communication have not been overcome.
- For people with specific conditions such as dementia with Lewy bodies or Parkinson's disease.

The use of sedative medications in Delirium

The use of medication in delirium should be avoided unless absolutely essential and is a last resort after supportive measures and de-escalation techniques have been attempted.

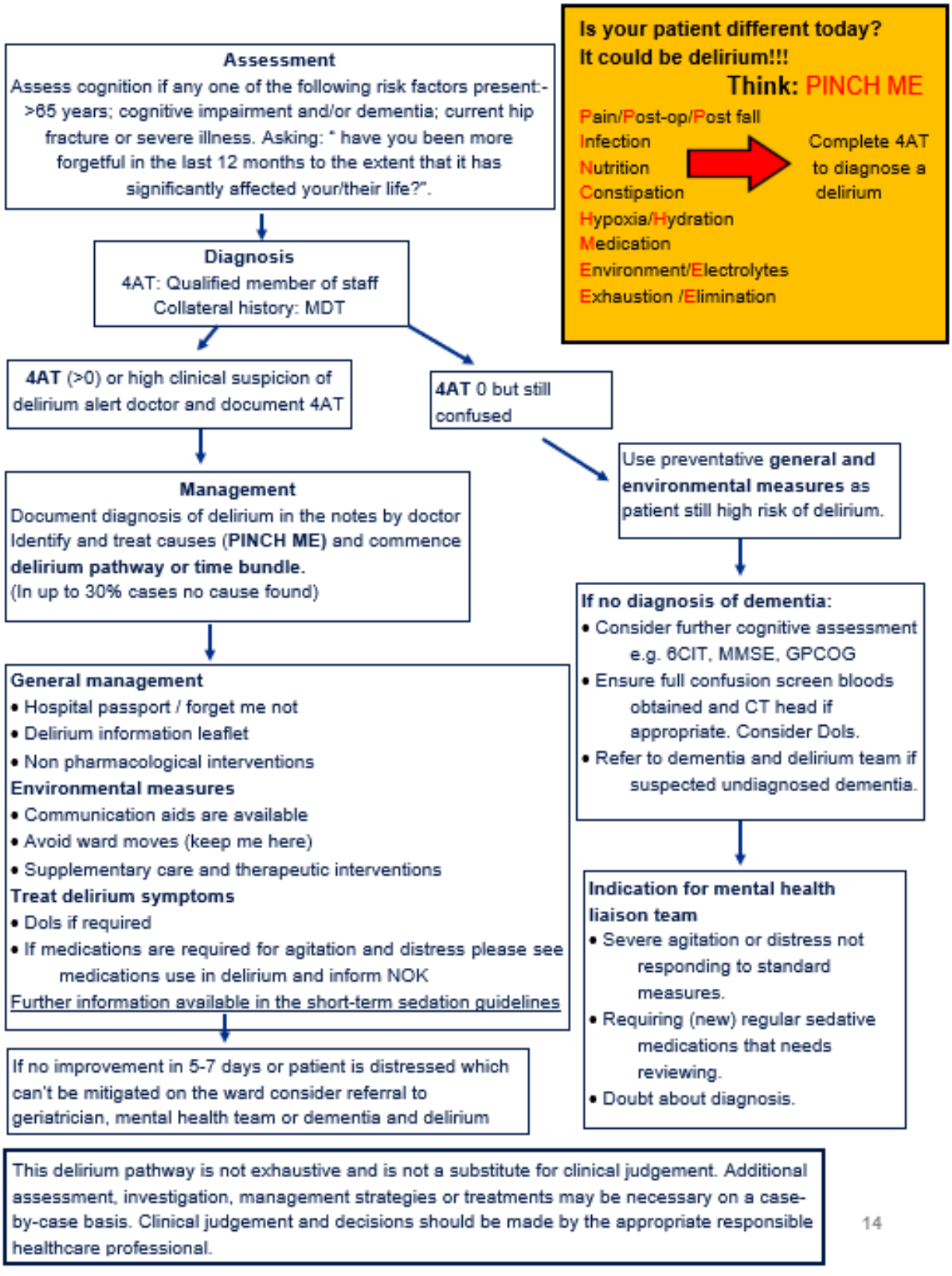
- Use should be restricted to patients who are considered to be a danger to themselves or others.
- The need for medication should be reviewed every 24 hours.
- Very occasionally sedating medication may be indicated if the patient is becoming very distressed by their symptoms of delirium e.g. frightening hallucinations. The use of medication may also be carefully considered to enable urgent tests and investigations to be carried out, if it is felt that these cannot wait until the patient has settled with non-pharmacological intervention.
- "Wandering" is not an indication for using sedating medication and pharmacological intervention may cause an increase in confusion in this patient group. Sedating medication also increases the risk of falls.
- If a patient is started acutely on sedative medications, you must consider the need for a DOLS.
- Commence daily diary to monitor reactions and interventions.
- Consider supplementary care.

START LOW, GO SLOW

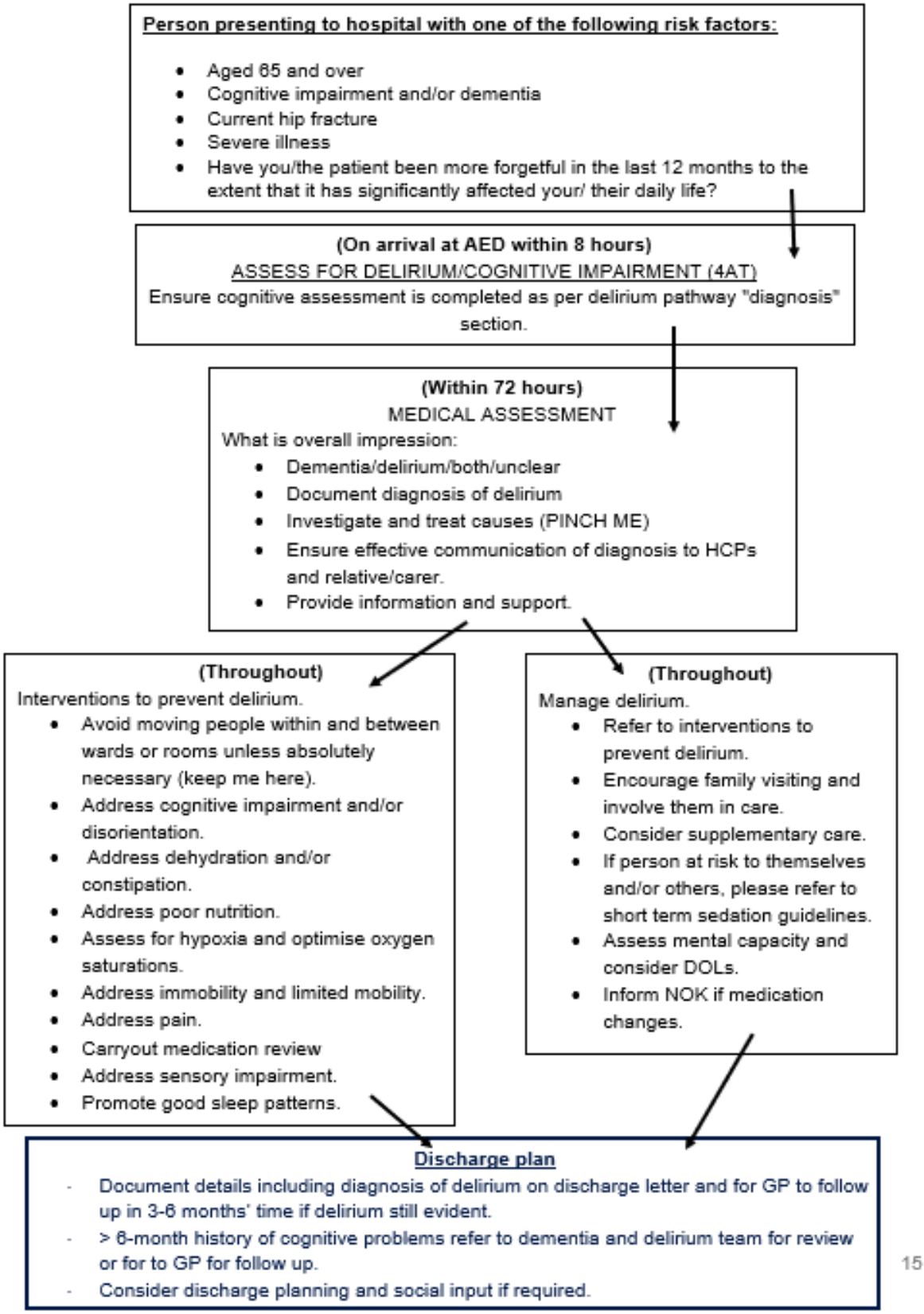
Medication	Route	Dose range (mg)	Daily frequency range	Max dose/24 hours
Haloperidol (First line)	PO/IM (Liquid form available)	0.5-2mg *Start with small doses and increase	OD to 2-4 hourly	5mg max dose In elderly (ideally no more than 2mg/24hours). If using above 2mg refer to the MH team for advice. 10mg if not an older person
Lorazepam (Second line)	PO/IM/IV (IV lorazepam is a last resort and needs senior supervision)	0.5-1mg *Start with small doses and increase	OD to QDS	2mg if elderly 4mg if not
Risperidone	PO (liquid form available)	0.25-0.5mg	OD to BD	2mg
Quetiapine	PO	25mg – 50mg	OD to BD	100mg
Olanzapine	PO/IM	2.5mg – 5mg	OD to BD	10mg

Start with the lowest dose possible and increase cautiously until the desired effect is achieved.

Delirium and Cognitive Impairment Pathway



Delirium timeline



15

4AT

Assessment test for delirium & cognitive impairment

(label)

Patient name:

Date of birth:

Patient number:

Date: **Time:**

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

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)

4AT SCORE ☐

GUIDANCE NOTES Version 1.2. Information and download: **www.the4AT.com**

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment*. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

© 2011-2014 MacLullich, Ryan, Cash

Six Item Cognitive Impairment Test (6CIT)

MindWell

(6CIT - Kingshill Version 2000, Dementia screening tool)

Patients details:

Date: _____

Name of accessor: _____

Question	Score range	Score
1. What year is it?	**0-4** Correct – 0 points Incorrect – 4 points	
2. What month is it?	**0-3** Correct – 0 points Incorrect – 3 points	

Give the patient an address phrase to remember with 5 components,
eg John, Smith, 42, High St, Bedford

3. About what time is it? (within 1 hour)	**0-3** Correct – 0 points Incorrect – 3 points	
4. Count backwards from 20 to 1	**0-4** Correct – 0 points 1 error – 2 points More than 1 error – 4 points	
5. Say the months of the year in reverse	**0-4** Correct – 0 points 1 error – 2 points More than 1 error – 4 points	
6. Repeat the address phrase	**0-10** Correct – 0 points 1 error – 2 points 2 errors – 4 points 3 errors – 6 points 4 errors – 8 points All wrong – 10 points	

Outcome from score:

0-7 = Normal
Referral not necessary at present

8-9 = Mild cognitive impairment
Probably refer

10-28 = Significant cognitive impairment
Refer

Patient name:_____ **Date:** _____

GPCOG Screening Test

Step 1: Patient Examination

Unless specified, each question should only be asked once

Name and Address for subsequent recall test

1. "*I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington.*" (Allow a maximum of 4 attempts).

Time Orientation	**Correct**	**Incorrect**
2. *What is the date?* (exact only)	☐	☐

Clock Drawing – use blank page

3. *Please mark in all the numbers to indicate the hours of a clock* (correct spacing required)	☐	☐
4. *Please mark in hands to show 10 minutes past eleven o'clock* (11.10)	☐	☐

Information

5. *Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).	☐	☐

Recall

6. *What was the name and address I asked you to remember*

John	☐	☐
Brown	☐	☐
42	☐	☐
West (St)	☐	☐
Kensington	☐	☐

(*To get a total score, add the number of items answered correctly*
Total correct (score out of 9) **/9**

If patient scores 9, no significant cognitive impairment and further testing not necessary.
If patient scores 5-8, more information required. Proceed with Step 2, informant section.
If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

© University of New South Wales as represented by the Dementia Collaborative Research Centre – Assessment and Better Care;
Brodaty et al, *JAGS* 2002; 50:530-534

Mersey and West Lancashire Teaching Hospitals NHS Trust

Delirium Care Pathway (This is an MDT document)

Date:_____/_____/_____

Patient label

Recognise

Is your patient different today?

- History of sudden change from usual cognitive baseline ☐
- Less alert, drowsy and less engaged ☐
- Hallucinations ☐
- Agitated/distressed/confused ☐
- Reduced consciousness ☐
- Change in behaviour ☐
- Intoxication/drug misuse ☐

THINK: PINCH MEE

Pain/Post–op/Post fall
Infection
Nutrition
Constipation/Covid-19
Hypoxia/Hydration
Medication
Environment/Electrolytes
Exhaustion/Elimination

Diagnose

4AT Score .....(on vital pac)

- **0** Delirium or severe cognitive impairment unlikely (but still possible if information is incomplete).
- **1-3** possible cognitive impairment
- **4 or above** possible delirium +/- cognitive impairment

4AT score 4 or above — NO → **Continue to monitor at risk patients**

Aged 65 and over, immobility, pain, dementia, sensory impairment, head injury, severely ill, cognitive impairment, excess alcohol and drug consumption, learning disability.

YES ↓

Investigate

Please tick below actions to rule out precipitating factors
(if not clinically indicated please put N/A)

- Obtain collateral history to rule out underlying cognitive impairment ☐
- Complete confusion screen bloods ☐
  (FBC, LFT, U&E,B12, TFT, MG, Folate, Calcium, random glucose)
- Obtain MSU if clinically indicated ☐
- Strict fluid balance chart in place —monitor dietary and fluid intake ☐
- Rule out constipation and urinary retention ☐
- Covid swab in date ☐
- Monitor vital signs and escalate abnormalities ☐
- Medication review— rule out any recent changes that may cause side effects ☐
- Rule out any evidence of pain (change to Abbey pain scale on vitalpac) ☐
- ECG and CXR if clinically indicated ☐
- Neuro imaging if clinically indicated (CT/MRI) ☐

Nurse review: Name:.....Date:.....Time:.....
Medic review: Name:.....Date:.....Time:.....

Management

Considerations

- 2 stage capacity test
- DoLs
- Enhanced levels of care
- My Daily Diary
- Environmental factors

Please see overleaf for more information on the management of delirium

Refer

If your patient is becoming distressed that can't be de-escalated or is showing no signs of improvement between 3-5 days (once investigations completed), then please refer to Dementia and Delirium team via Care flow.

Date:.....Time:.....Initial:.....N/A:.....

If delirium is still evident on discharge, medics to refer to GP for cognitive assessment within 3-6 months

1

Hosp No:

D.O.B.

(TIME bundle)

4AT Score

Practitioner name: ..... Practitioner signature: .....

Designation ..... Date/time score recorded: .....

Initiate TIME bundle within 2 hours (initial and write time of completion)		Assessed / sent	Results seen	Abnormality found
T	Think exclude and treat possible triggers			
	NEWS2 (think sepsis pathway)			
	Capillary blood glucose (BM)			
	Medication history (identify new medications/change of dose/medication recently stopped, alcohol or benzodiazepine withdrawal).			
	Pain assessment			
	Urinary retention – confirm with bladder scan. Urinary retention can be present when someone is passing urine and without a palpable bladder.			
	Assess for constipation - consider rectal examination			
I	Investigate and intervene to correct underlying causes			
	Assess hydration and start fluid balance chart			
	Bloods (Delirium order set on Medway)			
	Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment			
	ECG (ACS)			
M	Management Plan			Completed
	Initiate treatment of ALL underlying causes found above			
E	Engage and Explore (complete within 2 hours or if family/carer not present within 24 hours)			
	Engage with patient/family/carer – explore if this is usual behaviour. Ask: How would you like to be involved? Ensure 'forget-me not' card is completed and accessible at bedside.			
	Explain diagnosis of delirium to patient and family/carers (use delirium leaflet which is available on intranet dementia/delirium page).			

Top tips

Bed moves should be avoided unless absolutely necessary. This should be documented in the patients' case notes.

Patients should be cared for by a team of staff familiar to them whenever possible, and who are trained and competent in delirium prevention and management – **consider referral to geriatricians if delirium is not resolving FAX: 1142**

Remember delirium can be hypoactive or hyperactive but some people show signs of both (mixed). People with hyperactive delirium have heightened arousal and can be restless, agitated and aggressive. People with hypoactive delirium become withdrawn, quiet and sleepy. Hypoactive and mixed delirium can be more difficult to recognise.

Utilise orientation aids/prompts i.e. appropriate light levels for the time of day, calendars, clocks and daily newspapers.

It may help to involve people familiar to the patient in the delivery of care – inform carers of John's Campaign.

Patients with faecal impaction will require rectal as well as oral treatment.

If patient is diagnosed with delirium include on ICE discharge

7. Training

[Provide a brief outline of any training requirements. If training is mandatory you must refer to the Trust Induction, Mandatory and Risk Management Training Policy – Training Needs Analysis. If the policy contains mandatory training ensure that this is appropriately monitored in section 8 of the procedural document.]

What aspect/s of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Statutory & Mandatory Training Policy?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
Cognitive screening templates, Delirium pathway, time bundle, awareness of short-term sedation guideline	All clinical staff involved in the caring for patients with delirium	No	Read and sign	none	Once only	Ward managers

8. Monitoring Compliance

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1.	4AT compliance
2.	Investigation of delirium
3.	Assessing delirium
4.	Delirium follow up
5.	
6.	
7.	

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Minimum of thirty patient case notes to be reviewed and audited	Dementia and delirium teams, geriatricians	Review	Yearly	Dementia and delirium strategy group, patient experience Council	Dementia and delirium team, geriatricians

9. References/Bibliography/Relevant Legislation/National Guidelines

1) Siddiqi N, House AO, Holmes JD. Occurrence and outcome of delirium in medical in-patients: a systematic literature review. *Age Ageing* 2006;**35**:350–64.

2) De Lange E, Verhaak PFM, van der Meer K. Prevalence, presentation and prognosis of delirium in older people in the population, at home and in long term care: a review. *Int J Geriatr Psychiatry*2013;**28**:127-34

3) Inouye SK. Delirium in older persons. *N Engl J Med*2006;354:1157-65

4) Kakuma R, du Fort GG, Arsenault L, Perrault A, Platt RW, Monette J, et al. Delirium in older emergency department patients discharged home: effect on survival. *J Am Geriatr Soc*2003;**51**:443-50

5) *Inouye SK, van Dyck CH, Alessi CA et al. Clarifying confusion: the Confusion Assessment Method. A new method for detection of delirium. Ann Intern Med 1990; **113**: 941–948.*

6) McDaniel JS, Brown FW, & Cole SA. Assessment of depression and grief reactions in the medically ill. In: Stoudemire A, Fogel BS, Greenberg DB (eds): Psychiatric Care of the Medical Patient. 2000. New York: Oxford University Press, pp. 149-164

7) Inouye SK. The dilemma of delirium: Clinical and research controversies regarding diagnosis and evaluation of delirium in hospitalized elderly medical patients. Am J Med, 1994; 97: 278-288.

8) Scottish Intercollegiate Guidelines Network (SIGN). Risk reduction and management of delirium. Edinburgh: SIGN; 2019. (SIGN publication no. 157). [March 2019]. Available from URL: http://www.sign.ac.uk

9) Johnson JC, Kerse NM, Gottlieb G, Wanich C, Sullivan E, Chen K. Prospective versus retrospective methods of identifying patients with delirium. *JAGS*1992;**40**:316-319

10) Inouye SK, Bogardus ST, Charpentier PA, Leo-Summers L, Acompora D, Holford TR and Cooney LM. A multi-component intervention to prevent delirium in hospitalised older patients. *NEJM* 1999; **340**:669-676

11) Marcantonio, E.R., Flacker, J.M., Wright, R.J., Resnick, N.M. Reducing delirium after hip fracture: a randomised trial. *JAGS* 2001; **49:** 516-522

12) British Geriatrics Society and Royal College of Physicians. Guidelines for the prevention, diagnosis and management of delirium in older people. Concise guidance to good practice series, No 6. London: RCP, 2006.

13) National Institute for Clinical Excellence (NICE (2010). Delirium: diagnosis, prevention and management. (Clinical guideline 103 - Updated 2019.). London: NICE [Online]. [Accessed 01/05/192018] Available from: [https://www.nice.org.uk/guidance/cg103]

14) Mattice M. Intrahospital room transfers: a potential link to delirium in the elderly. *Perspectives* 1989; **(summer):**10-12.

15) Han, C.S., Kim, Y.K. A double-blind trial of risperidone and haloperidol for the treatment of delirium. *Psychosomatics* 2004; **45**; 297 – 301.

16) American Psychiatric Association. Practice Guideline for the Treatment of Patients with Delirium. 1999. American Psychiatric Association.

17) Taylor, D., 2018. *The Maudsley Prescribing Guidelines in Psychiatry*. 13th ed. West Sussex: Wiley Blackwell. p672-677

18) BNF accessed via www.medicinescomplete.com 28.11.18.

19) McDaniel JS, Brown FW, & Cole SA. Assessment of depression and grief reactions in the medically ill. In: Stoudemire A, Fogel BS, Greenberg DB (eds): Psychiatric Care of the Medical Patient. 2000. New York: Oxford University Press, pp. 149-164

20) National Institute for Clinical Excellence (NICE (2017). Parkinson's disease in adults. (Clinical guideline 71). London: NICE [Online]. [Accessed 19 November 2018] Available from: [https://www.nice.org.uk/guidance/ng71]

21) National Institute for Clinical Excellence (NICE (2018). Dementia: assessment, management and support for people living with dementia and their carers. (Clinical guideline 97). London: NICE [Online]. [Accessed 19 November 2018] Available from: [https://www.nice.org.uk/guidance/ng97]

22) De J, Wand AP. Delirium screening: a systematic review of delirium screening tools in hospitalized patients. The Gerontologist 2015;55(6):1079-99.

23) De J, Wand AP, Smerdely PI, Hunt GE. Validating the 4A's test in screening for delirium in a culturally diverse geriatric inpatient population. International Journal of Geriatric Psychiatry. 2017;32(12):1322-9.

10. Related Trust Documents

[List any procedural documents which are referenced within the text.]

No	Related Document
1.	Standard operating procedure (SOP) for delirium risk factor and 4AT screening for further information.
2.	Short term sedation guideline.
3.	Violence and aggression guideline
4.	
5.	

Equality Analysis Screening Tool

The EIA screening must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process. Where the screening identifies that a full EIA needs to be completed, please use the full EIA template.

The completed EIA screening form must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Head of Patient Inclusion and Experience for monitoring purposes via the following email, cheryl.farmer@sthk.nhs.uk. If the assessment is related to workforce a copy should be sent to the workforce Head of Equality, Diversity and Inclusion for workforce equality&diversity@sthk.nhs.uk.
If this screening assessment indicates that discrimination could potentially be introduced then seek advice from either the Head of Patient Inclusion and Experience or Head of Equality, Diversity (Workforce) and Inclusion.

A full equality impact assessment must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Title of function	Delirium guideline
Brief description of function to be assessed	Guideline is to help all clinical staff to identify and treat delirium amongst the hospital inpatient population.
Date of assessment	23/12/24
Lead Executive Director	Acting Director of Nursing, Midwifery and Governance
Name of assessor	Sophie williams
Job title of assessor	Dementia and delirium specialist nurse

Equality, Diversity & Inclusion

Does the policy/proposal:
1) Have the potential to or will in practice, discriminate against equality groups
2) Promote equality of opportunity, or foster good relations between equality groups?
3) Where there is potential unlawful discrimination, is this justifiable?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Age	No	Yes	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation to the specific characteristic Within the guidance, there are three risk factors identified that are more common in older people (age 65+). These factors are old age >65, current hip fracture and diagnosis of dementia. Although a person of any age is able to fracture their hip. Due to these risk factors, the associated measures have also been included in order to reduce the risk of delirium in relation to age and specifically patients aged 65+.
Disability	No	Yes	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation to the specific characteristic Within the guidance, there is one risk factor relating to disability (learning disability). Due to this risk factor, the necessary measures have also been included in order to reduce the risk of delirium in relation to learning disabilities. We will also communicate with patients via a method that meets their needs in relation to disability.
Gender reassignment	No	No	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation to the specific characteristic
Pregnancy or maternity	No	No	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in

	Negative Impact	Positive Impact	Justification/ evidence and data source
			relation to the specific characteristic
Race	No	No	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation to the specific characteristic We will also communicate with patients via a method that meets their needs, such as providing an interpreter for patients whose first language is not English.
Religion or belief	No	No	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation to the specific characteristic
Sex	No	No	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation to the specific characteristic
Sexual orientation	No	No	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation to the specific characteristic

Human Rights

Is the policy/proposal infringing on the Human Rights of individuals or groups?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Right to life	No	No	
Right to be free from inhumane or degrading treatment	No	No	
Right to Liberty/security	No	Yes	Patient may lose capacity to make their own decision under the MCA, therefore a DOLs may need to be implemented to maintain safety and to make decisions in the patient's best interest.

	Negative Impact	Positive Impact	Justification/ evidence and data source
Right to privacy/family life, home and correspondence	No	No	
Right to freedom of Thought/conscience	No	No	
Right to Freedom of expression	No	No	
Right to a fair trial	No	No	

Health Inequalities

Is the policy/proposal addressing health inequalities and are there potential or actual negative impact on health inequality groups, or positive impacts? Where there is potential unlawful impacts is this justifiable.

	Negative Impact	Positive Impact	Justification/ evidence and data source
Deprived Populations	No	No	
Inclusion health groups	No	Yes	This guideline is aimed to prevent, assess and treat delirium in all cases therefore provides a positive impact in relation inclusion health groups Within the guidance risk factors have been identified around excessive alcohol and drug consumption and measures have been identified to reduce the risk of delirium such as referral to medical/support intervention.
5 child clinical areas	No	No	
5 adult clinical areas	No	No	

Outcome

After completing all of the above sections, please review the responses and consider the outcome.

Is a full EIA required?	Yes ☐ No ☒ Please include rationale: No Impact identified

Sign off

Name of approving manager	Ryan Jackson
Job title of approving manager	Patient Equality & Inclusion Manager
Date approved	24/01/25

11. Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		X		
Will the procedural document lead to the collection of new information about individuals?		X		
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		X		
Will the implementation of the procedural document require you to contact individuals in ways which they may find intrusive?		X		
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		X		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		X		
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		X		
Will the implementation of the procedural document compel individuals to provide information about themselves?		X		

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author sophie williams **Date 23/12/24**