### Delirium Management Comprehensive Pathway - Acute Hospital

#### General Management
- Document diagnosis of delirium in notes
- Explain to patient & carer
- Use ‘This is Me’ & ‘Butterfly Scheme’
- Assess & monitor pain
- Encourage oral hydration & nutrition wherever possible & document daily intake
- Good pressure area care
- Avoid catheterisation unless absolutely necessary
- Treat constipation
- Consider if swallow safe
- Avoid unnecessary interventions

#### Environmental Measures
- Ensure glasses are clean & worn
- Ensure hearing aid is working and treat ear wax
- Nurse in calm, quiet, well lit area, ensure buzzer is close to patient and respond promptly
- Give regular gentle reassurance & orientation prompts (use clocks & calendars)
- Promote mobility and meaningful activity as much as possible
- Consider an interpreter for language choice of patient
- Treat ear wax
- Encourage family visits, relax visiting times, involve relatives in care
- Consider additional staff if challenging behaviour or wandering
- If symptoms or behaviour threaten the patient or others, use the lowest possible doses of medication, ‘start low, go slow’
- Seek senior advice
- Assess mental capacity and need for deprivation of liberty safeguarding DOLS
- Inform next of kin if medication changes

#### Treat Delirium Symptoms
- Encourage family visits, relax visiting times, involve relatives in care
- Consider additional staff if challenging behaviour or wandering
- If symptoms or behaviour threaten the patient or others, use the lowest possible doses of medication, ‘start low, go slow’
- Seek senior advice
- Assess mental capacity and need for deprivation of liberty safeguarding DOLS
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#### Treat Underlying Causes
- Investigation
- Medication Review
- Optimise Clinical Condition

### Time Bundle
- There’s no time like the present.
- For patients aged 75 and over when clinical history suggests delirium or assessment tool 4AT positive:
  - Initiate all elements of this CARE Bundle within 2 hours

### T THINK
- Think about possible triggers acute illness, pain, trauma

### I INVESTIGATE
- Carry out early warning score
- Start fluid balance chart
- Send routine bloods & appropriate cultures, imaging
- Consider drug withdrawal / intoxication, alcohol

### M MANAGEMENT
- Medication review, infection, hypoxia, hypoglycaemia.

### E ENGAGE
- Triggers referral to Liaison Psychiatry
  - Severe agitation or distress not responding to standard measures above
  - Doubt about diagnosis
  - If formal assessment under Mental Health Act is being considered
- Psychiatric services may also hold useful information on background cognition and mental health.

### Patient Improving
- If no improvement after 5 to 7 days or if cause of delirium not clear, refer to Geriatric services

### Patient NOT Improving
- If no improvement after 5 to 7 days or if cause of delirium not clear, refer to Geriatric services

### Delirium Diagnosis
- Delirium diagnosis must be included in ALL discharge documentation

#### Delirium Management
- **Possible delirium is a Medical Emergency**
  - TIME bundle initiate all elements within 2 hours

#### Act on acute, severe causes & stabilise patient
- e.g. infection / medication toxicity / hypoxia / hypoglycaemia / dehydration / retention / constipation

#### Patient Improving
- Repeat AMT10 cognitive assessment
- Consider post-delirium distress
- Encourage patient to share their experience with healthcare staff
- Reduce & discontinue antipsychotic treatment

#### Patient NOT Improving
- If no improvement after 5 to 7 days or if cause of delirium not clear, refer to Geriatric services

### Delirium can persist for weeks or months after the cause is treated

#### 4AT
- 1. Alertness
  - Normal (fully alert, not agitated throughout assessment) 0
  - Mild sleepiness for < 10 seconds after waking, then normal 0
  - Clearly abnormal 4

- 2. AMT4 (4 item Abbreviated Mental Test)
  - Age, Date of Birth, Place, Year
  - No mistakes 0
  - 1 mistake 1
  - ≥ 2 mistakes / untestable 2

- 3. Attention
  - Months of the year backwards
  - Achieves 7 months or more correctly 0
  - Starts but scores <7 months or refuses to start 1
  - Untestable (cannot start because unwel, drowsy, inattentive) 2

- 4. Acute Change or fluctuating symptoms?
  - No 0
  - Yes 4

**TOTAL:** _______