Delirium Care Pathway
Mid Yorkshire Hospitals Trust

All new admissions → ASSESS DELIRIUM RISK

Known dementia

Implement Delirium prevention care plan Appendix 1

Assess for delirium Appendix 2

Recent changes (hours or days) in behaviour
- Social – lack of cooperation, withdrawn, altered communication
- Physical function – reduced mobility, agitation, sleep disturbance, reduced oral intake
- Cognitive function – worsened concentration, disorientation, “confused”
- Perception – hallucinations (visual or auditory), delusions, paranoia
- Conscious level – more sleepy or alert than usual

NICE Clinical Guideline 103

Positive

- Monitor delirium with CAM / AMTS
- Discharge Planning (see Dementia Care Pathway)
- See Appendix 3 for Critical Care Delirium

Management of distress See Appendix 1

Confusion Assessment Method (CAM)
1 Acute onset and fluctuating course of abnormal behaviour
2 Inattention (e.g. easily distractible, fail 20–1 test or months of year backwards)
3 Disorganized thinking (very rambling or irrelevant conversation)
4 Altered level of consciousness (drowsy or lethargic or agitated)

Delirium = 1 + 2 + (3 OR 4)

Inouye SK 2003

NICE Clinical Guideline 103

Negative

Implement Delirium management care plan Appendix 1

Assess for delirium Appendix 2

Known dementia

Investigate and treat causes (often multiple causes) Appendix 1

Delirium Care Pathway

Inpatients
Checklist for Delirium Care Pathway:
Tick the box if assessed / performed

Risk Factor Assessment: Was the person assessed for the following on presentation?

<table>
<thead>
<tr>
<th>Risk Factor</th>
</tr>
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<tbody>
<tr>
<td>Age 65 years or older</td>
</tr>
<tr>
<td>Cognitive impairment (AMT score &lt;8/10) and/or dementia</td>
</tr>
<tr>
<td>Current hip fracture</td>
</tr>
<tr>
<td>Severe illness (a clinical condition that is deteriorating or is at risk of deterioration)</td>
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</tbody>
</table>

Interventions to Prevent Delirium: If the person had 1 or more of the features in the box above on presentation, were they assessed for the following within 24 hours of admission?

<table>
<thead>
<tr>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive impairment or disorientation</td>
</tr>
<tr>
<td>Dehydration or Constipation</td>
</tr>
<tr>
<td>Hypoxia</td>
</tr>
<tr>
<td>Immobility or limited mobility</td>
</tr>
<tr>
<td>Infection</td>
</tr>
<tr>
<td>Multiple medications</td>
</tr>
<tr>
<td>Pain and discomfort</td>
</tr>
<tr>
<td>Poor nutrition</td>
</tr>
<tr>
<td>Hearing and Visual impairment</td>
</tr>
<tr>
<td>Sleep disturbance</td>
</tr>
</tbody>
</table>

Indicators of Delirium at Presentation: Was the person at risk, assessed on presentation for recent (within hours or days) changes or fluctuations in behaviour?

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive function: for example, worsened concentration, slow responses, confusion?</td>
</tr>
<tr>
<td>Perception: for example, visual or auditory hallucinations?</td>
</tr>
<tr>
<td>Physical function: for example, reduced mobility, reduced movement, restlessness, agitation, changes in appetite, sleep disturbance?</td>
</tr>
<tr>
<td>Social behaviour: for example, lack of cooperation with reasonable requests, withdrawal, or alterations in communication, mood and/or attitude?</td>
</tr>
</tbody>
</table>

Delirium Diagnosis: If any of these indicators were present, did a healthcare professional carry out a clinical assessment to confirm the diagnosis, using one of the following?

<table>
<thead>
<tr>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAM (4 point short CAM)</td>
</tr>
<tr>
<td>DSM IV criteria</td>
</tr>
<tr>
<td>CAM-ICU</td>
</tr>
</tbody>
</table>
Appendix 1: Delirium Prevention and Management Care Plan
Guidance based on NICE Clinical Guideline 103

For each individual patient, the clinical factors contributing to the risk of, or the episode of, delirium will vary. The same clinical factors act as a risk factor before an episode and as a cause of delirium during an episode.

Within 24 hours of admission identify which clinical factors from the table below are present in the individual and manage as described.

<table>
<thead>
<tr>
<th>Clinical Factor</th>
<th>Intervention</th>
<th>Tick if Present</th>
</tr>
</thead>
</table>
| Cognitive impairment or disorientation |  Avoid bed moves  
    Provide appropriate lighting and clear signage. A clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk  
    Reorientate the person by explaining where they are, when it is, who you are, what your role is and what is happening to them  
    Introduce cognitively stimulating activities (for example, reminiscence)  
    Facilitate regular visits from family and friends |                |
| Dehydration or Constipation            |  Encourage the person to drink. Consider offering subcutaneous or intravenous fluids if necessary  
    Seek advice if necessary when managing fluid balance in people with comorbidities (for example, heart failure or chronic kidney disease)  
    Start a bowel chart. Highlight and treat constipation |                |
| Hypoxia                                |  Assess for hypoxia and optimise oxygen saturation if necessary |                |
| Immobility or limited mobility         |  Encourage all people, including those unable to walk, to carry out active range-of-motion exercises  
    Encourage the person to:  
   -- mobilise soon after surgery  
   -- walk frequently (even short distance to toilet, walking aids should be accessible at all times) |                |
| Infection                              |  Look for and treat infection  
    Avoid unnecessary catheterisation  
    Implement infection control procedures |                |
| Multiple medications                   |  Carry out a medication review and stop or reduce dosages of unnecessary drugs |                |
| Pain and discomfort                    |  Assess for pain. Look for non-verbal signs of pain, particularly in people with communication difficulties or dementia (use Abbey Pain Scale)  
    Start and review for adequate pain management in any person in whom pain is identified or suspected  
    Avoid unnecessary invasive devices (urinary catheter, cannula etc.) |                |
| Poor nutrition                         |  Follow the Trust guidance for nutritional assessment and management  
    If the person has dentures, ensure they fit properly |                |
| Hearing and Visual impairment          |  Resolve any reversible cause of the impairment (such as impacted ear wax)  
    Ensure working hearing aids and spectacles are available to and used by people who need them |                |
| Sleep disturbance                      |  Aim for a normal sleep-wake cycle  
    Avoid nursing or medical procedures and medications during sleep  
    Reduce noise to a minimum during sleep periods |                |
**Investigation of Delirium:** Assume delirium initially if there is difficulty distinguishing between delirium, dementia or dementia + delirium

1. **History**
   - Collateral from family, friends, carers, other health professionals: usual cognitive function, alcohol/drug intake, possession of spectacles and hearing aids, course of episode, symptoms of underlying causes, previous episodes of delirium
   - Patient: symptoms, fears, ask about hallucinations and delusions

2. **Examination**
   - Full clinical examination
   - Must include neurological examination and rectal examination for constipation and assessment for possible urine retention
   - Assess cognition (AMTS / 6CIT)
   - Assess nutrition and hydration

3. **Essential Investigations**
   - Blood tests: FBC, U&E, LFT, Calcium, Glucose, CRP
   - Oxygen saturations
   - Urine dipstick: in older patients it is common for uninfected urine samples to test positive for protein, blood and leucocytes - do not treat on the basis of this alone. Ensure a sample is sent to the microbiology laboratory
   - CXR
   - ECG

4. **Additional investigations** (if cause not apparent or delirium not improving with treatment)
   - Blood cultures
   - Abdominal X-ray &/or other imaging
   - CT head
   - Thyroid function, vitamin B12 and folate levels
   - Lumbar puncture for encephalitis or other CNS infection
   - Toxicology / drug levels
   - EEG for non-convulsive status epilepticus or recurrent seizures, and for delirium diagnosis

**Treatment of Delirium:**

1. Treat all Causes and Contributory Clinical Factors *(see tables above and below)*

2. **Non-pharmacological Management**
   - Bed moves should be avoided unless *absolutely* necessary
   - Patients are cared for by a team of staff familiar to them whenever possible, and who are trained and competent in delirium prevention and management
   - Communication is person-centered, sympathetic and effective, uses short sentences, and includes reorientation and reassurance for people diagnosed with delirium
   - Involvement of family and friends: provide information leaflet on delirium
   - Environment is quiet and well-lit

3. **Management of Distress and Agitation**
   - Acknowledge the feelings and experiences of the patient (they may be experiencing frightening hallucinations and delusions). The delusions in delirium often involve a belief that staff are trying to harm them.
- People with delirium are frequently unable to express their care needs, and challenging behaviors may also occur as a result of unmet needs. Because of the increased cognitive impairment and lack of insight which can occur in delirium, patients may be less able to assess the risk of their behaviour. Therefore patients may be at greater risk of exhibiting challenging behaviour and injuring themselves or others.

- People with delirium are frequently unable to comprehend what staff are saying to them:
  - **Speak slowly** and clearly using short sentences and words
  - **Make eye contact** with the patient
  - **Explain** what you are about to do before you do it
  - **Do not argue** with the patient, even if they are illogical or uncooperative

- Consider one to one observation (this could be done discretely or openly, and can be continuous or a fixed frequency) and is important if the patient is a high risk to themselves or others

- **Use verbal and non-verbal de-escalation techniques** *(from NICE Clinical Guideline 25: Violence Section 1.6 De-escalation techniques)*
  - De-escalation should be employed early on in any escalating situation
  - Staff should accept that in a crisis situation they are responsible for avoiding provocation. It is not realistic to expect the person exhibiting distressed or agitated behaviour to simply calm down
  - Staff should learn to recognise what generally and specifically upsets and calms people. This will involve listening to individual patient’s and carer’s reports of what upsets the patient, and this should be reflected in the care plan
  - Staff should be aware of, and learn to monitor and control, their own verbal and non-verbal behaviour, such as body posture and eye contact etc.
  - Where weapons are involved a staff member should ask for the weapon to be placed in a neutral location rather than handed over.

- **One staff member should assume control of a potentially violent situation.** This staff member should consider which de-escalation techniques are appropriate for the situation, manage others in the environment, for example enlisting the help of colleagues and creating space, explain to the service user and others in the immediate vicinity what they intend to do, give clear, brief, assertive instructions, and move towards a safe place without potential weapons and avoid being trapped in a corner. The staff member who has taken control should ensure that their own non-verbal communication is non-threatening and not provocative. This will involve paying attention to non-verbal cues, such as eye contact and allowing greater body space than normal, adopting a non-threatening but safe posture and appearing calm, self-controlled and confident without being dismissive or over-bearing. The staff member who has taken control should attempt to establish a rapport and emphasise cooperation, offer and negotiate realistic options and avoid threats to the patient, ask open questions and inquire about the reason for the distress, for example ‘What has caused you to feel upset/angry?’ Show concern and attentiveness through non-verbal and verbal responses, listen carefully and show empathy, acknowledging any grievances or frustrations, and not being patronising.

- **Distraction techniques** can be more effective in patients with delirium because delirium causes inattention. If the patient’s attention can easily be distracted from the source of distress by verbal and non-verbal techniques, then this should be the main way of dealing with challenging behaviour. To be most effective it requires one-to-one nursing, from a small number of staff members or family to increase the development of trust. Staff should allow
supervised wandering and activities such as making a bed or playing a game, where it does not pose a major risk to the patient or others.

- If it has not been possible to prevent the escalation of the challenging behaviour, and the behaviour is putting the individual or others at imminent risk of harm, then interventions involving restraint may be appropriate. It should be said that these interventions are used:
  - as a last resort
  - following risk assessment and care planning if possible
  - for only as long as absolutely necessary
  - by staff who have received the appropriate training
  - not for punitive reasons
  - in a way that respects people and protects dignity and human rights
  - in the best interests of the recipient of the restraint

- Situations in which restraint can be justified include where staff have a professional duty of care to restrain a patient to protect that patient from a greater risk of harm, or to avoid a foreseeable risk of harm occurring to others. In a situation where a staff member is being attacked or is at risk of physical harm, it is possible to justify the use of restraint as self defence.

- The restraints that are most appropriate in our clinical settings are **physical holding** and **pharmacological management**.

- ‘Physical holding’ can include blocking the patient’s movement to stop them leaving, gentle but firm pressure on a patient’s arm to prevent them from removing medical equipment to which they are attached, through to the patient being held in a seated or prone position by several people. The latter is sometimes referred to as ‘control and restraint’, and only staff who have received appropriate ‘Control and Restraint’ training should attempt to do this. ‘Control and restraint’ should in general be avoided in older, frailer patients with delirium, because of the significant physical risks to them. Efforts should be made to identify someone of the same gender to undertake the physical holding. Security officers on our premises are the only staff who have undertaken this training.

- In many cases of restraint, the patient will not have consented to the intervention. In nearly all of these cases, the patient will not have the capacity to consent to the intervention. The **Mental Capacity Act (2005)** sets out the conditions in which an act may be planned that would constitute restraint of a patient who lacks capacity. The legal authority to restrain a patient is allowed only if the following three conditions are satisfied:
  1. Patient lacks capacity in relation to the matter in question
  2. Staff reasonably believe that it is necessary to do the act in order to prevent harm to the patient
  3. The act is a proportionate response to the likelihood of the patient suffering harm and the seriousness of that harm

  There is further guidance on assessing capacity and determining whether the action is in the ‘best interests’ of the patient on the Trust intranet.  
  *(Click on: Dept → Nursing → Safeguarding Adults → MCA → Aids to Assessment)*

- Some restraint interventions are a restriction of the liberty of the patient, one of their Human Rights. Some interventions are for short periods, though others such as continuous
observation or preventing the patient from leaving the hospital could go on for an extended period. Such a restriction, either on its own or combined with other restrictions (e.g. limited visiting allowed), could amount to a deprivation of liberty. In such cases staff should ensure ‘safeguards’ are in place to ensure that the deprivation of liberty is lawful – it should be appropriate and proportionate. The ‘safeguards’ are considering the use of either the Mental Health Act or the Mental Capacity Act (Deprivation of Liberty Safeguards-DOLS). There is further guidance on use of DOLS on the Trust Intranet (Click on: Dept → Nursing → Safeguarding Adults → Deprivation of Liberty →DOL flowchart).

- All decisions and actions taken by staff should be documented in accordance with agreed best practice. This requires detailed risk assessment and care planning prior to the intervention if possible, and a factual description of decisions and actions taken during the intervention. This will include a description of the interaction with the patient and relatives, if available, detailing the information provided to them. Following the restraint the recipient and those involved in the restraint should be assessed for signs of injury and any emotional/psychological impact. The notes should be signed, timed and dated.

- Arrangements to support staff, who have suffered a violent or aggressive incident will be actioned by the Trust’s Occupational Health Department. This department monitors on a Trustwide basis developing trends and concerns. Such monitoring is reported to appropriate managers and/or committees, which may include the Trust’s Local Security Management Specialists (LSMS). Support for staff involved or affected in an incident is detailed in the policy ‘Supporting Staff involved in Incidents, Complaints and Claims (2008)’.

4. Pharmacological Management

In patients with delirium short courses of low dose haloperidol or olanzapine may reduce severity of the delirium. They should only be used to control challenging behaviour as a last resort.

- consider short-term (≤ 1 week) use of haloperidol (0.5mg PO/IM usually bd, with maximum dosing frequency every 30 minutes and maximum dose in 24 hours 2mg). ECG should be checked for QTc immediately prior to and at least once during use OR olanzapine 2.5 or 5mg (PO orodispersible Velotab once daily maximum) as a last resort.

N.B. Haloperidol and olanzapine do not have UK marketing authorisation for this indication.

- Use lorazepam 0.5mg PO /IM (if available)/sublingual where antipsychotics contraindicated - e.g. Lewy body dementia, Parkinson’s disease, prolonged QTc on ECG, bradycardia and phaeochromocytoma.

N.B. This is an unlicensed use.

Rapid tranquillisation should be avoided due to various risks, including “underlying coincidental physical disorders” (NICE Clinical Guideline 25: Violence, Section 8.1.8.4) which are usually present in cases of delirium.
**Common Causes of Delirium:** usually multiple causes. Assess for Clinical Factors (see table Appendix 1)

<table>
<thead>
<tr>
<th>Possible Cause</th>
<th>Differential Diagnosis / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe illness</td>
<td>Admissions to critical care at high risk of delirium</td>
</tr>
<tr>
<td>Medications</td>
<td>Consider all new medications&lt;br&gt;Eszpecially - low dose opiates giving inadequate pain relief,&lt;br&gt;benzodiazepines, calcium channel blockers, antihistamines, medications with anticholinergic activity, psychoactive medications</td>
</tr>
<tr>
<td>Infection</td>
<td>Don't assume UTI&lt;br&gt;Sepsis</td>
</tr>
<tr>
<td>Constipation / Urine retention</td>
<td>Very common in frail elderly</td>
</tr>
<tr>
<td>Restraint</td>
<td>Physical restraint – urinary catheter, intravenous drip, table in front of chair, cot sides&lt;br&gt;Pharmacological restraint</td>
</tr>
<tr>
<td>Change in environment</td>
<td>Move from a familiar environment&lt;br&gt;Bed moves&lt;br&gt;Carers unfamiliar to patient&lt;br&gt;Routine unfamiliar to patient</td>
</tr>
<tr>
<td>Hypercapnoea</td>
<td>(high pCO2)&lt;br&gt;Respiratory failure&lt;br&gt;Obstructive sleep apnoea</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>Heart failure&lt;br&gt;Anaemia&lt;br&gt;Pneumonia&lt;br&gt;Pulmonary embolus&lt;br&gt;Other causes of respiratory failure</td>
</tr>
<tr>
<td>Neurological</td>
<td>Seizures&lt;br&gt;Stroke&lt;br&gt;Head injuries etc.</td>
</tr>
<tr>
<td>Cardiological</td>
<td>Myocardial infarction&lt;br&gt;Arrhythmia</td>
</tr>
<tr>
<td>Electrolyte imbalance</td>
<td>Dehydration&lt;br&gt;Renal failure&lt;br&gt;Hyponatraemia&lt;br&gt;Hypercalcaemia etc.</td>
</tr>
<tr>
<td>Endocrine / metabolic</td>
<td>Hyperglycaemia / hypoglycaemia&lt;br&gt;Thyroid disease&lt;br&gt;Liver disease</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Alcohol&lt;br&gt;Medications&lt;br&gt;Nicotine&lt;br&gt;Drugs</td>
</tr>
<tr>
<td>Surgical and anaesthetic</td>
<td>Trauma&lt;br&gt;Pain&lt;br&gt;Aesthetic agents</td>
</tr>
</tbody>
</table>
Appendix 2: Assess for Delirium

1. From NICE clinical guideline 103
- Carry out a clinical assessment for delirium e.g. DSM IV criteria or Short CAM to confirm the diagnosis
- In critical care, or in the recovery room after surgery, CAM-ICU should be used
- A healthcare professional who is trained and competent in the diagnosis of delirium should carry out the assessment
- Ensure that the diagnosis of delirium is documented both in the person's hospital record and in their primary care record

2. Confusion Assessment Method (Short CAM)

<table>
<thead>
<tr>
<th>Confusion Assessment Method (CAM)</th>
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<tbody>
<tr>
<td>(Adapted from Inouye et al., 1990)</td>
</tr>
</tbody>
</table>

Patient's Name: ____________________________ Date: ____________________________

**Instructions**: Assess the following factors.

**Acute Onset**
1. Is there evidence of an acute change in mental status from the patient’s baseline?
   - ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

**Inattention**
(The questions listed under this topic are repeated for each topic where applicable.)
2A. Did the patient have difficulty focusing attention (for example, being easily distractible or having difficulty keeping track of what was being said)?
   - ____ Not present at any time during interview
   - ____ Present at some time during interview, but in mild form
   - ____ Present at some time during interview, in marked form
   - ____ Uncertain

2B. **(If present or abnormal)** Did this behavior fluctuate during the interview (that is, tend to come and go or increase and decrease in severity)?
   - ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

2C. **(If present or abnormal)** Please describe this behavior.

   __________________________________________________________

**Disorganized Thinking**
3. Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable, switching from subject to subject?
   - ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

**Altered Level of Consciousness**
4. Overall, how would you rate this patient’s level of consciousness?
   - ____ Alert (normal)
   - ____ Vigilant (hyperalert, overly sensitive to environmental stimuli, startled very easily)
   - ____ Lethargic (drowsy, easily aroused)
   - ____ Stupor (difficult to arouse)
   - ____ Coma (unarousable)
   - ____ Uncertain
Scoring:
For a diagnosis of delirium by CAM, the patient must display:
1. Presence of acute onset and fluctuating discourse
AND
2. Inattention
AND EITHER
3. Disorganized thinking
OR
4. Altered level of consciousness

Source:

3. Additional Features of Delirium

Disorientation
5. Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?
   ___ YES   ___ NO   ___ UNCERTAIN   ___ NOT APPLICABLE

Memory Impairment
6. Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?
   ___ YES   ___ NO   ___ UNCERTAIN   ___ NOT APPLICABLE

Perceptual Disturbances
7. Did the patient have any evidence of perceptual disturbances, such as hallucinations, illusions, or misinterpretations (for example, thinking something was moving when it was not)?
   ___ YES   ___ NO   ___ UNCERTAIN   ___ NOT APPLICABLE

Psychomotor Agitation
8A. At any time during the interview, did the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent, sudden changes in position?
   ___ YES   ___ NO   ___ UNCERTAIN   ___ NOT APPLICABLE

Psychomotor Retardation
8B. At any time during the interview, did the patient have an unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time, or moving very slowly?
   ___ YES   ___ NO   ___ UNCERTAIN   ___ NOT APPLICABLE

Altered Sleep-Wake Cycle
9. Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?
   ___ YES   ___ NO   ___ UNCERTAIN   ___ NOT APPLICABLE
Diagnosis: CAM-ICU - twice daily assessments

1. Acute onset or fluctuating course
Is the patient different than his/her baseline mental status?
OR
Has the patient had any fluctuation in mental status in the past 24 hours as evidenced by fluctuation on a sedation scale (i.e., RASS), GCS, or previous delirium assessment?

2. Inattention - greater than 2 errors

Letters Attention Test: Say to the patient, “I am going to read you a series of 10 letters. Whenever you hear the letter ‘A,’ indicate by squeezing my hand.” Read letters from the following letter list in a normal tone 3 seconds apart. S A V E A H A A R T
Errors are counted when patient fails to squeeze on the letter “A” and when the patient squeezes on any letter other than “A.”

3. Disorganised thinking - noted during conversation or:
Yes/No Questions
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?
Errors are counted when the patient incorrectly answers a question.

Command
Say to patient: “Hold up this many fingers” (Hold 2 fingers in front of patient) “Now do the same thing with the other hand” (Do not repeat number of fingers). If pt is unable to move both arms, for 2nd part of command ask patient to “Add one more finger”. An error is counted if patient is unable to complete the entire command.

- Positive if combined number of errors (for Yes/No and Command sections) greater than 1

4. Altered level of consciousness
Present if the Actual RASS score is anything other than alert and calm (zero)

For diagnosis of delirium, features 1 and 2 along with feature 3 or feature 4 must be displayed

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www.icudelirium.org
RASS score:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative</td>
</tr>
<tr>
<td>+3</td>
<td>Very agitated</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated</td>
</tr>
<tr>
<td>+1</td>
<td>Restless</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation</td>
</tr>
<tr>
<td>-5</td>
<td>Unrousable</td>
</tr>
</tbody>
</table>

Immediate danger to staff
Pulls tubes, aggressive
Frequent non-purposeful movements
Anxious, but movements not aggressive
Opens eyes to voice in <10 seconds, (eye contact)
Opens eyes to voice in >10 seconds, (eye contact)
Movement or eye open to voice, (no eye contact)
Movement or eye opening to physical stimulation
No response to voice or physical stimulation

Management

Alcohol withdrawal delirium
LORAZEPAM 1-4mg (IV or IM) (if available) or Chlordiazepoxide
Consider HALOPERIDOL if still agitated / altered perception / disturbed thinking
Consider PROPOFOL

Delirium detected by screening
HALOPERIDOL – low dose regular enterally / IV route, or OLANZAPINE 5mg enterally

Overtly delirious
HALOPERIDOL IV – use titration method or OLANZAPINE (patients with parkinsons) 2.5 – 10 mg IM, repeat if necessary
MIDAZOLAM 5 – 10 mg IV (for dangerous motor activity, repeat as needed), or MIDAZOLAM 5 – 10 mg IM

Night sedation
50mg TRAZADONE enterally qds for seven days or 2-5mg HALOPERIDOL intravenously at night

Notes on Haloperidol
- Do not use in patients with Parkinsons disease
- Start with low dose if any concern over cardiovascular status or if elderly (ie 1-2mg)
- If extra-pyramidal side effects occur, treat with Procyclidine 5-10mg iv
- If using IV titration, (doubling dose every 20-30 minutes until effect achieved) do not exceed 8mg per 24 hours without consultant approval
- For any patient on regular haloperidol, perform daily 12-lead ECG to ascertain QTc value, reduce dose if QTc exceeds 480 ms
- Perform daily measurement of serum magnesium and potassium
- If treatment is effective in controlling delirium, plan to reduce haloperidol (or other drug for delirium) dosing regime gradually over a few days
Appendix 4: Abbey Pain Scale

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6.

Name of resident: ...............................................................

Name and designation of person completing the scale: .....................

Date: ........................................ Time: ........................................

Latest pain relief given was...................................................... at........hrs.

Q1. Vocalisation
   eg whimpering, groaning, crying
   Absent 0  Mild 1  Moderate 2  Severe 3

Q2. Facial expression
   eg looking tense, frowning, grimacing, looking frightened
   Absent 0  Mild 1  Moderate 2  Severe 3

Q3. Change in body language
   eg fidgeting, rocking, guarding part of body, withdrawn
   Absent 0  Mild 1  Moderate 2  Severe 3

Q4. Behavioural Change
   eg increased confusion, refusing to eat, alteration in usual patterns
   Absent 0  Mild 1  Moderate 2  Severe 3

Q5. Physiological change
   eg temperature, pulse or blood pressure outside normal limits,
   perspiring, flushing or pallor
   Absent 0  Mild 1  Moderate 2  Severe 3

Q6. Physical changes
   eg skin tears, pressure areas, arthritis, contractures,
   previous injuries
   Absent 0  Mild 1  Moderate 2  Severe 3

Add scores for 1 - 6 and record here

Total Pain Score

Now tick the box that matches the Total Pain Score

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 2</td>
<td>No pain</td>
</tr>
<tr>
<td>3 - 7</td>
<td>Mild</td>
</tr>
<tr>
<td>8 - 13</td>
<td>Moderate</td>
</tr>
<tr>
<td>14 +</td>
<td>Severe</td>
</tr>
</tbody>
</table>

Finally, tick the box which matches the type of pain

Chronic  Acute  Acute on Chronic

Abbey, J; De Brilis, A; Pilier, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Quinn Medical Research Foundation 1996 - 2002
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Appendix 5: Delirium Leaflet for Patients and Relatives
Delirium

Prevention and Management

Information for Patients, Relatives and Friends
WHAT IS DELIRIUM?

Delirium is more common in older people. It is also commoner when they are in hospital.

This is because they are more poorly, and because they are in an unfamiliar place.

*Most older people in hospital are at some risk of delirium*
The Mid Yorkshire Hospitals Trust is implementing a programme to prevent and better manage delirium when it occurs.

Staff are being educated about what delirium is and how to prevent and manage it.

In order to prevent delirium the staff will approach patients in order to assess and reduce their risk factors for delirium:

- Disorientation
- Dehydration
- Reduced Vision
- Reduced Hearing
- Pain
- Constipation
- Poor Mobility

They are also monitoring patients for early signs of delirium.
YOU CAN HELP PREVENT YOUR RELATIVE, FRIEND OR YOURSELF DEVELOPING DELIRIUM AND TREAT IT

1. It is important to **tell a member of staff** if you notice that the patient has **become confused** or more confused than usual, as they **may** be developing delirium

2. Unless the patient is Nil by Mouth or on a fluid restriction, **encourage them to drink** plenty of water or squash or tea, this can prevent and treat dehydration and constipation

3. **Try to drink four glasses of water in a day, on top of two to four cups of tea & coffee** = **six to eight drinks per day**

4. **Remind them where they are and what is going on. Remind them of the date and time. Chat to them** about current events. **Bring in photos of the patient and of friends and family**

5. **Inform staff** of what the patient’s memory and behaviour are normally like
Regular contact with familiar people and objects from outside hospital is very important to patients with delirium. This helps to calm and reassure them.

We would suggest that you talk slowly and clearly about familiar, non-worrying topics. Remind them often where they are and what the time and date is. Try to use a calm reassuring tone.

Avoid tiring visits, multiple visitors at any one time and loud chatter and laughter around the patient.

It may be distressing for you to have a relative or friend who is delirious. They may fail to recognize you or may behave out of character.

Despite this it is important to continue visiting if you can and hopefully the patient will improve and respond to your visits.

Dr Rachel Holt, Mid Yorkshire NHS Trust, November 2013