



Aneurin Bevan University Health Board

Identifying & Managing Acute Confusion (Delirium)

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1 Scope

This guidance is applicable for all employees of the Aneurin Bevan University Health Board and applies to all health settings involved in the direct care and assessment of **adult patients at risk of acute confusion**.

This guidance aims to raise staff awareness regarding the potential for patients to experience **acute confusion** within a broad range of services and settings.

Its purpose is to assist staff to be able to identify acute confusion and instigate the most suitable plan of care within inpatient and community settings.

The guidance does not apply to children.

The risk factors associated with acute confusional states known as **delirium**, suggest that all staff working in all roles in the following health settings should be **delirium and dementia aware**.

- Settings delivering care to people predominantly (but not exclusively) over the age of 65 (40% of older patients become delirious in hospital)
- Any health setting delivering healthcare to patients who have or likely to experience depression or other mental health disorders (1 in 4 people have a mental health problem and 1 in 14 people over the age of 65 are diagnosed with dementia).
- Surgical wards or surgical aftercare services, providing care to patients following surgery, especially hip or heart surgery and aftercare, (NICE guidelines [CG103]).
- Clinical staff and prescribers who work with patients who take certain high risk medications which cause toxicity or withdrawal.
- Clinical services providing health care for people likely to have an underlying cerebrovascular disease such as previous strokes or TIA's

2 Introduction

Being in a state of **confusion** means not being able to think clearly or quickly, feeling disorientated, and struggling to pay attention, to make decisions, remember things or accurately answer questions.

A simple test for confusion is to ask the person their name, age and today's date, and see if they seem unsure or answer incorrectly. If the onset of confusion was over a short period of time, this is referred to as **acute** confusion.

Delirium is a term used to describe a condition of **acute confusion** which usually starts suddenly, is temporary and associated with physical ill health.

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V), delirium is a disturbance in attention and awareness with associated disturbance in cognition, not explained by another pre-existing, established or evolving neurocognitive disorder or coma.

Whenever the degree of confusion means a person is unable to recount accurate health information, it is extremely important to investigate further and collect a **corroborating history** from suitable sources. This can be professional and family sources who know the person well. Baseline information regarding day to day functioning is extremely important for assessment and care planning, encouraging a person's usual independence and ensuring that all health and wellbeing needs are met, especially in an inpatient setting.

The combination of a physical examination, the medical and clinical history and the case chronology can enable the assessor to determine whether the onset of confusion was acute and typical of physical illness seen causing delirium or a more chronic confusion, manifesting over months and years and more typical of a dementia. Delirium is not the same as **dementia** although confusion is a symptom common to both conditions.

Dementia is an umbrella term and not a diagnosis in itself. It is most important to understand that any type of dementia is caused by diseases that affect the brain. A familiar type of dementia is Alzheimer's disease, but there are also several other types of dementias. The symptoms associated with types of dementia, such as short term memory loss, can come about gradually and may go unnoticed for several years. The age of onset and the disease progression will vary depending upon type of dementia and its effect on the person. The effects on daily living and wellbeing will also vary considerably and these depend on many individualised personal factors such as personality and support networks. Specialist skills are required for accurate diagnosis of dementia. Specialist services aim to pinpoint the actual type of dementia, provide support and counselling regarding what to expect and how to prepare one's personal affairs as the condition progresses and what type of support can be foreseen and planned for.

People with a dementia and people who are frail are more likely to develop delirium when they fall ill, when compared to general population. Therefore dementia is a risk factor for developing delirium. This may be clearly and previously diagnosed or the dementia has gone undiagnosed or is underlying and will eventually emerge over time.

Having a solid understanding of the risk factors and presenting symptoms associated with delirium are key, to initiating the required levels of medical and nursing care and support. Skilled history taking, screening and physical examination are all essential skills involved in the compiling the whole clinical picture, finding the source of delirium, identifying and treating infection and making the correct diagnosis's and treatment plan.

3 The Incidence and Consequence of Delirium

Delirium occurs in approximately 30% of older medical patients at some time during hospitalisation. Among older surgical patients, the risk for delirium varies from 10% to over 50%. In general, delirium can be found wherever there are sick patients, including. fractured neck of femur and post-operative surgical patients. High rates of delirium have been demonstrated in intensive care units (70%), emergency departments (10%), hospice units (42%), and post-acute care settings (16%), (NICE guidelines [CG103]).

Despite its frequency, delirium is under-recognised given the fluctuating nature of symptoms and there is generally an under-appreciation of its significance by healthcare providers. Moreover, delirium has also been associated with elevated risks for functional and cognitive decline, poor rehabilitation potential, institutionalisation, re- hospitalisation and increased mortality (30 – 40%). While delirium is generally considered to be reversible, recent studies suggest that delirium symptoms can last for weeks to months following onset.

4 Causes of Delirium

Delirium can occur as a result of a number of conditions that disturb brain physiology, including infection, brain tumour, poisoning, drug toxicity or withdrawal, seizures, head trauma, and metabolic disturbances such as fluid, electrolyte, or acid-base imbalance, hypoxia, hypoglycaemia, or hepatic or renal failure.

There is often more than one cause of delirium present at any one time and sometimes no specific cause can be found. The most commonly identified risk factors are underlying brain diseases such as dementia, stroke, or Parkinson's disease; these are present in nearly one-half of older patients with delirium. Often, the dementia goes unrecognized prior to the onset of delirium. Other factors that increase the vulnerability to delirium include advanced age and sensory impairment.

Whenever the diagnoses are uncertain, i.e. whether a patient may have a dementia, a delirium or both; ***it is important to treat delirium first*** whilst

continuing to establish whether a dementia may be emerging or already diagnosed.

5 The 4 Characteristics of Delirium

1. Disturbance of consciousness with reduced ability to focus, sustain, or shift attention
2. Change in cognition or the development of a perceptual disturbance, not accounted for by a pre-existing, established, or evolving dementia
3. Disturbance developing over a short period of time (usually hours to days) and tending to fluctuate during the course of the day
4. Evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication, or medication side effect or combination of multiple factors (American Psychiatric Association's Diagnostic and Statistical Manual, 5th edition (DSM-V)).

6 'Find and Treat'

Two memorable key principles whenever delirium is suspected: -

1. Find The Cause(s)
2. Treat the Underlying cause(s)

7 The 3 Sub Types of Delirium

1. 50% of cases of delirium diagnosed relate to **Hyperactive Delirium**: This can be the most easily recognised type of delirium because of the symptoms of restlessness, agitation, rapid mood changes or hallucinations.
2. 40% relate to **Hypoactive Delirium**: Is characterised by lethargy, reduced motor activity, incoherent speech and lack of interest, delirium may be less obvious.
3. 10% relate to **Mixed Delirium**

8 Delirium Risk Factors

- Age over 65 years (40% of older patients become delirious in hospital)
- Following surgery, especially hip or heart surgery and aftercare, (NICE Guidelines [CG103]).
- Depression or other mental health disorders (1 in 4 mental health problem, 1 in 14 people over the age of 65 are diagnosed with dementia.)
- Take certain high risk medications that cause toxicity and withdrawal.
- Underlying cerebrovascular disease such as previous strokes or TIA's

- A history of alcohol dependence or withdrawal
- Patients who show signs of physical health deterioration should be assessed and managed in accordance with the ABUHB Deteriorating Patient(NEWS)Policy:
<http://howis.wales.nhs.uk/sitesplus/866/document/230101>

8.1 Prevention of Delirium

It is important to identify people with increased risk of developing delirium which is most of frail older people admitted to hospital. The risk of delirium is also high in patients who have recovered from an episode of delirium but in hospital awaiting discharge planning. These patients should have good care to reduce the risk of developing delirium .The following intervention should be part of basic care for any hospitalised patient.

Risk Reduction:

- Orientation and ensuring patients have their sensory aids including glasses and hearing aids
- Early mobilisation
- Review for pain control
- Maintaining optimal hydration and nutrition
 - Regulation of bladder and bowel function
- Provision of supplementary oxygen, if appropriate
- Prevention, early identification and treatment of postoperative complications
- Medication review for all patients at risk
- Avoid unnecessary ward moves (SIGN guidelines)

9 Delirium Assessment List

- Assess for Dehydration (not drinking enough)
- Infection – for example urinary tract or chest infection. Patients with suspected sepsis should be assessed and treated as per NICE guidance on sepsis:
<http://howis.wales.nhs.uk/sitesplus/866/document/434987>
- Drugs, Alcohol toxicity and withdrawal symptoms
- Medicines side effects
- Effects following hip or heart surgery
- Heart disease
- Cerebrovascular disease, stroke or TIA's Lung disease Low oxygen saturation levels Stroke or Transient Ischaemic Attacks (TIA's)
- Seizures (Fits)
- An imbalance of natural chemicals in the body such as sodium or calcium

- Delirium can be made worse by poor eyesight or hearing, constipation, pain or poor nutrition.

See rapid initial assessment of delirium and cognitive assessment using the 4AT tool-page 9 (© 2011-2014 MacLulich, Ryan, Cash)



**Assessment test
for delirium &
cognitive impairment**

Patient name:

(label)

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

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?"

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10 History Taking

It is not unusual for other common diagnoses to be mistaken for delirium. These are dementia, depression, mania, schizophrenia, dysphasia, hysteria, non-convulsive epilepsy or learning disability.

The **medical case history** is essential information which can be gathered from a number of sources and by asking specific interview questions to the patient or to other people who know the person and can give the information. This is useful in planning the right screen and tests and combined with the physical exam diagnosing and planning the correct treatment.

Professional staff reports from care homes, primary care records, memory assessment services and community mental health teams are all sources of essential preadmission assessment or baseline information.

Preadmission information and baseline information is essential to the assessment process. Likewise the chronology of the onset and progression of symptoms are extremely important assessment factors.

Alcohol

It is important to take an alcohol history as delirium as a result of complicated withdrawal (such as delirium tremens or Wernicke's encephalopathy). Complicated alcohol withdrawal has a significant mortality rate if not recognised early and correct management plan put in place.

In addition, poorly managed alcohol withdrawal can lead to Brain Damage.

11 Involving Carers

Close family members and carers play a considerable role in checking the assessment process information and in improving the wellbeing of a loved one. Families should be asked routinely to report existing diagnosis, changes in usual behaviours as well as any improvement noticed following treatment. NICE has written information for the public explaining the guidance on delirium. The Aneurin Bevan University Health Board has produced an [Understanding Delirium - Patients and Carer information leaflet](#). The leaflet is helpful when a patient has recovered from symptoms such as hallucinations in order to assist them to make sense of the delirium experience.

By providing information to people at risk of delirium and their family and/or carers this can assist to:

- Explain that delirium is common and usually temporary.

- Describe people's experience of delirium.
- Encourage people at risk and their families and/or carers to tell their healthcare team about any sudden changes or fluctuations in usual behaviour encourage the person who has had delirium to share their experience of delirium with the healthcare professional during recovery
- Support and monitoring fluids and nutrition
- Advise the person of support

12 Physical Examination and Investigations

The following investigations should be routinely undertaken:

- Urinalysis - Dip Test and MSU
- FBC and ESR
- U&E and Glucose
- Calcium
- LFTs including Gamma GT
- TFTs
- B12 and folate
- ECG
- Chest x-ray
- Brain scan - CT or MRI (when an acute intracerebral cause is suspected including new focal neurological signs or a reduced level of consciousness (not adequately explained by another cause) if there is history of recent falls, head injury or on anticoagulation therapy)
- Electroencephalogram should be considered when there is a suspicion of epileptic activity or non-convulsive status epilepticus as a cause of a patient's delirium.
- Further investigations should be done as indicated from the history and physical examination.

13 The Management of Delirium

13.1 Non Pharmacological Treatment

Good nursing care is paramount in management of Delirium like any other medical illness. It is important to treat the underlying cause or causes of delirium .Consider the following precipitants which can lead to agitation or drowsiness in delirium and plan the management

- Abnormal physiology including hypoxia, hypoglycaemia, dehydration, drug overdose or withdrawal
- Consider Interruption in normal bodily functions including constipation, urinary retention, lack of sleep, sensory impairment loss of glasses or hearing aids.
- Assess for pain, external injury, pressure sores.

- Manage environment – Reduce noise level, involve carers and familiarise the surrounding with e.g.: family photographs, usual pillow or bed spread, 24hour clock etc.
- Close monitoring to prevent complications including falls, injury due to agitation, reduced oral intake.
- Use verbal and nonverbal de-escalation techniques from NICE guideline on violence and aggression (NICE guideline NG10).

It is common in hyperactive delirium to have episodes of agitation if it cannot be managed with non-pharmacological measures then refer to section 13.5 for medications to manage agitation.

13.2 Polypharmacy

Is a major factor affecting delirium; therefore it is advantageous to undertake a medication review and to stop any offending drug(s) whenever possible.

Changes in medications (commencement of new medications, changes in dosage or abrupt withdrawal of medications) could result in delirium.

Be alert to the possibility of alcohol or benzodiazepine withdrawal syndrome especially if the confusion arises within days of admission. If excessive alcohol consumption is possible (suspected or confirmed) then parenteral Thiamine therapy should be considered at the earliest opportunity as well as appropriate management of withdrawal (see ABUHB document "Non-specialist Guidelines for the Pharmacological Support of Detoxification in Individuals with Alcohol Misuse Disorder" <http://howis.wales.nhs.uk/sitesplus/866/opensdoc/244556/&E5A19F45-CA14-8FC6291966A94D4FDD31>)

The following table represents examples of drugs which can cause or exacerbate confusion and which should always be reviewed and either reduced or discontinued whenever a patient is acutely confused.

Benzodiazepines may require a long withdrawal period.

Benzodiazepines	Especially long acting (diazepam, Nitrazepam) and ultra short acting (due to withdrawal) e.g. Lorazepam
Antidepressants	especially tricyclics, like Amitriptyline
Antihistamines	e.g. Diphenhydramine (in Nytol)
Anticholinergics	e.g. Oxybutynin, Procyclidine. Check anticholinergic cognitive burden (ACB) or anticholinergic effect on cognition (AEC) scales
Opioid analgesics	e.g. Pethidine, Tramadol, Codeine
Antipsychotics	especially low potency anticholinergic agents e.g. Chlorpromazine

Anticonvulsants	e.g. Phenytoin
H2 blocking agents	e.g. Ranitidine
Anti-Parkinsonism agents	L Dopa, dopamine agonists

13.3 Sedatives and Delirium

All sedatives may cause delirium, especially those with anticholinergic side effects. The use of sedatives and antipsychotics should therefore be kept to a minimum. Many older patients with delirium have hypoactive delirium and do not require sedation. Early identification of delirium and prompt treatment of the underlying cause may reduce the severity and duration of delirium.

Sedation is likely to significantly increase length of stay and risk of complications. Hence one to one nursing is often not only more effective and appropriate, but more cost effective in the long run.

The aim of tranquillisation should be to help alleviate patient distress but without over sedation. Every effort should be made to provide the appropriate care without the prescription of high doses or combinations of sedative drugs, especially for people with dementia, or older people with frailty, e.g. by involving close family members to help calm and reassure.

Patients with vascular dementia, mixed dementia or Alzheimer's disease have an increased risk of cerebrovascular adverse events and death when given anti-psychotic medication. Patients with Lewy Body dementia also have an increased risk of severe adverse reactions. They have a particular sensitivity to anti-psychotic medication which can lead to profound adverse events and death. These risks should be taken into account and explained to the family as part of care planning and prescribing.

13.4 Pharmacological Management of Hyperactive Delirium (not hypoactive)

Pharmacological treatment for delirium should be used as last resort if all other modalities of treatment have failed.

Medicine regimes should be tailored to an individual's needs.

Refer to the BNF for maximum doses and/or seek advice and record any need to give higher doses than those suggested below.

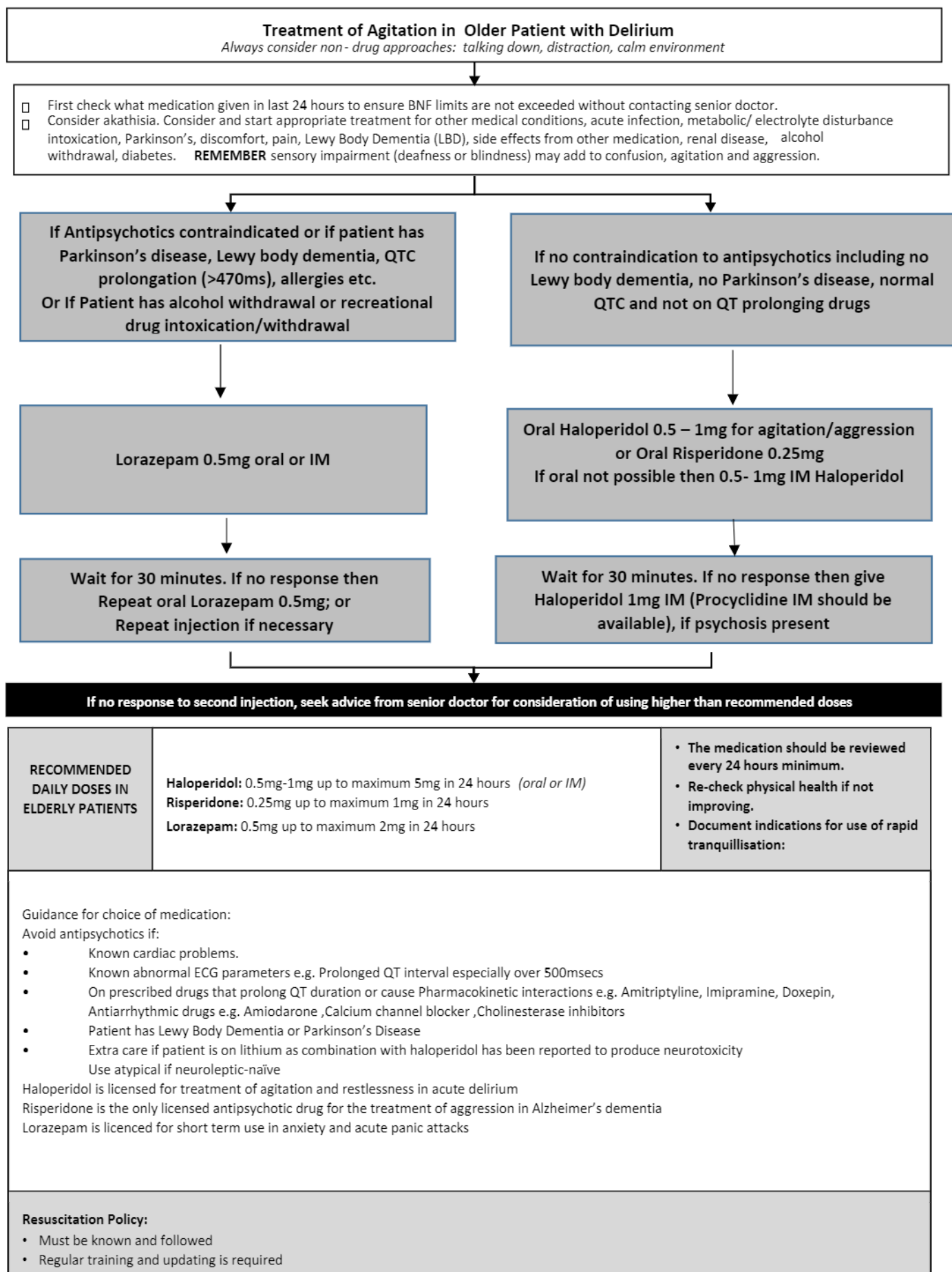
The recommended medications that may be used for agitation and aggression symptoms, are:

1. **Haloperidol** 0.5mg-1mg oral (maximum 5mg in 24 hour). If oral not possible, then Haloperidol 0.5mg-1mg IM (maximum 5mg in 24hours). Use with caution, see NICE guidance, BNF for further details. Alternative for haloperidol or if Haloperidol is contraindicated then for oral option use **Risperidone** 0.25mg (maximum 1mg in 24 hours). If antipsychotics cannot be used due to QTC prolongation or Parkinson's disease or Lewy body dementia or allergies, etc. or if there is evidence of alcohol withdrawal or recreational drug intoxication or drug withdrawal with agitation then use benzodiazepines like Lorazepam.
2. **Lorazepam** 0.5 mg oral or IM (Maximum 2mg in 24 hours). If patient has alcohol withdrawal or substance misuse or withdrawal then Lorazepam will be the first line medication.
3. Once acute episode of agitation is managed decide on prescribing regular antipsychotics if appropriate with clear documentation of duration of treatment (not more than 1 week) and review every 24 hours.

Alternatives which can be considered after discussion with specialist: (i) Quetiapine (ii) Aripiprazole

(Please review individual patient's history, co morbidities, allergies, intolerance before prescribing)

For further advice regarding medication contact psychiatric liaison services for older people please contact the OPAL team. Contact details page 15.



MONITORING

Baseline observations on admission, or as soon as possible after admission	Temperature	BP	Pulse	Hydration
Before administration of parenteral drugs also record	BP	Pulse	Respiratory rate	
	A Pre-treatment ECG is recommended before giving Haloperidol			
If this is not possible, please document why not and patient is to be subject to close visual observations				
After parenteral drug administration, where possible monitor:	BP every 15 mins for 1 st hour then half-hourly for 4 hours, or until patient is mobile. Temperature ,Pulse Hydration , Oxygen saturation As above or if comatose, continuous until patient mobile			
BLOOD TESTS				
U&Es within 48 hours of drug administration				
Aim for 2 litres of fluid in 24 hours – use fluid monitoring sheet				
After resolution of symptoms, where possible, review episode with patient				

Management of problems occurring during Sedation & Tranquillisation

NB. IV administration by medical staff only

PROBLEM	REMEDIAL MEASURES
1. Acute dystonias (<i>including oculogyric crisis</i>)	Give Procyclidine (See BNF Antimuscarinic drugs) 5-10mg IM or (IV)
2. Reduced respiratory rate (<i><10 breaths/min or oxygen saturation <90%</i>) Phone 2222 if no doctor available in the ward or 999 if no on site Doctor available	Give oxygen, raise legs, ensure patient is not lying face down Give Flumazenil, if Benzodiazepine-induced respiratory depression suspected Initial dose: 200 micrograms IV over 15 secs – if required level of consciousness not achieved after 60 secs then: Subsequent dose: 100 micrograms over 10 secs, repeated after 60 secs as necessary Maximum dose: 1mg in 24 hours (one initial dose and eight subsequent doses) Monitor respiration until rate returns to baseline level Very rarely seizures may occur particularly after long term treatment with benzodiazepine If induced by another agent, patient will require mechanical ventilation – arrange transfer to ITU immediately
3. Irregular or slow pulse (<i><50/minute</i>)	Refer to physicians immediately
4. Fall in blood pressure (<i>orthostatic or <50mmHg diastolic</i>)	Lie patient flat, raise legs if possible, monitor closely, may need a referral to physicians
5. Increase in temperature	Consider Neuroleptic Malignant Syndrome (NMS) if on antipsychotic
NEUROLEPTIC MALIGNANT SYNDROME	
CLINICAL FEATURES	Fever usually above 38°C, sometimes hyperpyrexia over 40°C Muscle rigidity Alteration in consciousness Autonomic disturbance - Tachycardia, Changes in BP, Urinary incontinence Raised creatine kinase levels.
RISK FACTORS	Previous NMS or cerebral compromise Catatonia, agitation, over-activity Rapid tranquillisation, IM therapy, high potency neuroleptics
MANAGEMENT	STOP ANTIPSYCHOTIC – consult medical team, can be FATAL, may need ITU

The DOs & DON'Ts Guide in Delirium

The table depicts some helpful dos and don'ts related to the Management of Delirium. (The bold type are points taken from NICE Guidance for the Management of Delirium, 2010 and updated in 2019)

DOs	DON'Ts
Observe the patient: <ul style="list-style-type: none"> High risk of falls (Falls Risk Assessment - Prevention and Management of Adult In Patient Falls Policy) Patients at high falls risk should be observed closely by a nurse at all times. Consider using a bed close to the nursing station 	Environment and Communication: <ul style="list-style-type: none"> Don't insist on performing unnecessary tasks Don't argue and avoid commands: reasoning is usually impaired in delirium. Don't frequently change nurses, wards or bays. Don't use side rooms if possible. Don't expose patient to disturbances such as sudden noise or bright lights at night.
Environment and Communication: <ul style="list-style-type: none"> Use calm speech and gentle manner Be courteous and polite even if the patient isn't Acknowledge their feelings and show concern 	
Orientate patient frequently: who and where they are and what your role is. <input type="checkbox"/> Explain unfamiliar noises/equipment/personnel	Don't prevent sleep at night: reduce loud bleeps/noises and bright lights. <ul style="list-style-type: none"> Don't ignore ABUHB bedrail policy, avoid bedrails if patient is able and likely to climb over them. Don't physically restrain patients to the bed / chair. Wherever possible mobilise patient instead e.g. take for regular walks to toilet or for washing/shower.
Provide easily visible clocks and calendars, good lighting and signage. Facilitate visits from friends and family. <input type="checkbox"/> Use familiar pictures/items around bed	
Use cognitively stimulating activities such as reminiscence	Management Don't delay attendance – delirium has a high mortality
Optimise any sensory deficit (remove wax, provide hearing aids/spectacles)	Don't catheterise unnecessarily. <ul style="list-style-type: none"> Don't use IV lines unnecessarily and follow trust guidance in use of IV cannulas Don't order unnecessary tests (CT, EEG or frequent bloods)
Hydrate patients, offer drinks when visiting	
Consider nutrition by providing dentures, performing a MUST score and involving dietetics if necessary	Don't disturb patient's sleep with procedures and medication rounds if possible
Encourage early mobility, under supervision if required. Encourage all people, including those unable to walk, to carry out active range of-motion exercises	<input type="checkbox"/> Don't use antipsychotics unless other interventions have failed
Use interventions that are least restrictive to the patient.	<input type="checkbox"/> Don't use large amounts of antipsychotics, particularly in older people. General rule is, use less, more often
Let patients wander within a safe environment.	
Documentation: <input type="checkbox"/> Patient's capacity if absent and how you acted in the patient's best interest. Check need for MCA & DoLS.	<input type="checkbox"/> Don't give antipsychotics to patients with a prolonged QTc, with parkinsonism or with Lewy body dementia - use Lorazepam instead.
Management Correct hypoxia and hypotension	
Remain vigilant for infection (e.g. urinalysis, bloods, chest)	
Correct dehydration (may need SC/IV if oral intake poor)	
Monitor bowels and treat constipation	

The DOs Guide in Delirium (continued)

Identify (including non-verbal signs) and treat pain

- Use PAIN-AD, pain assessment, A suitable assessment of pain tool suitable for cognitive impairment.
- Explain diagnosis of delirium to family and give patient/carer information leaflet on delirium.
- Ensure diagnosis is documented clearly in the notes.
- Consider urgent psychiatric review especially if hallucinations or delusions are present.

If behavioural disturbance unresolved by above measures:

- Consider security involvement and arm length observations at all times including extra staffing.

Prescribing

- Review appropriateness of all medications (anticholinergic medication ought to be stopped if appropriate).
- Ascertain use of non-prescription/ recreational drugs
- Consider medication for patients at risk to self/others or with distress or to enable essential investigations, with maximum dose in 24 hours also clearly documented.

The following table provides a telephone contact list for the older adult mental health memory services and the older adult psychiatric liaison services OPAL teams. The local memory services will be able to confirm whether a patient has a diagnosis of dementia or is known to the CMHT.

Equally the Liaison teams are able to support local teams with specialist advice, assessment and care planning - [OPAL Information Leaflet](#).

Liaison Services	Hospital Sites Covered	Contact
OPAL South	RGH, St Woolos Hospital, Chepstow	01633 238247
OPAL North	NHH, YAB, YYF	01873 733156

Memory Assessment Services	Base	Contact
Newport	Kemeys Unit, St Cadoc's Hospital	01633 436847
Torfaen	Ty Siriol Unit, County Hospital	01495 768786
Caerphilly	Ysbyty Ystrad Fawr	01443 802396
Blaenau Gwent	Ysbyty Tri Chwm	01495 353208
Monmouth	Maindiff Court Hospital	01873 735553

14 The Legal Framework

It is not unusual for confused patients to refuse staff requests, or misinterpret investigations or attempts to offer support and nursing care. There are many communication strategies which may be employed in this complex situation. It is of paramount importance that staff are aware of the legal safeguards.

15 Mental Capacity Act (MCA) & Deprivation of Liberty Safeguarding (DoLS)

The Deprivation of Liberty safeguards are part of the MCA legal framework for safeguarding people who lack the capacity to consent; to care arrangements, to their place of residence, to being admitted to hospital and/or to receive health care.

The '**acid test**' is a mechanism which clinical and non-clinical staff should apply to assessment and decision making associated with people who are at risk of being deprived of their liberty. This '*acid test*' arose from the case law judgement, *P v Cheshire West et al* [2014]. The test is itemised in the 3 points below.

A person is deprived of their liberty if they meet the acid test:

1. They lack capacity to consent to decide where to reside to receive care **AND**
2. They are subject to continuous supervision and control **AND**
3. They are not free to leave

If a person meets the acid test, a request for urgent and standard DoLS authorisation should be made in order to continue to deprive the patient of his/her liberty.

An example of this is should a person lack capacity in respect of taking medicines, but require sedation, a DoLS referral should be considered. Please refer to the Health board Guidance on the Deprivation of Liberty Safeguards Policy.

The Assessment of Mental Capacity Procedure provides the assessment, process, flow charts and forms required.

MCA Information for Staff and an Easy Read Summary can be found using the following intranet hyperlink:

<http://howis.wales.nhs.uk/sitesplus/866/page/40349>

16 References

This guidance updates Expired Document Gwent Healthcare Guidance for management of Confused Older Patients 2017.

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