Delirium on General Hospital Wards: Identifying Patients at Risk, Delirium Screening and Next Steps

National Dementia Office · Feidhmeannacht na Seirbhíse Sláinte Health Service Executive · Older People · Royal College of Physicians of Ireland

Identify the patient at risk of delirium

Age over 65 years or any one of:

- **Pre-existing cognitive impairment** e.g. mild cognitive impairment 4-AT 1-3, or dementia. (*also follow dementia pathway)
- **Previous delirium**
- Other brain disorders (e.g. head injury, stroke, Parkinson's Disease)
- Functional dependence or frailty
- Poor mobility
- Poor nutrition
- Visual or hearing impairment
- Depression
- Major trauma; hip fracture; post-operative
- Multiple co-morbid illnesses
- Severe medical illness or infection (INEWS ≥4 or ≥5 on oxygen)
- Urea and electrolyte imbalance
- Alcohol or substance misuse
- Polypharmacy; high risk medications (e.g. benzodiazepines); medication withdrawal

Patient is admitted to your ward

Check ED/AMAU 4-AT score; Has this patient possible delirium?

No

Yes

Patient is already diagnosed as having delirium in ED/AMAU

Screening for Delirium

1. Complete 4-AT on admission to the ward for all patients at risk of delirium.

2. Screen at risk patients daily for delirium. The screening tool used will vary per local protocol. Recommended screening tools include:

- **4-AT** (www.the4at.com)
- **RADAR** (Recognising Acute Delirium As part of your Routine)
- **SQID** (Single Question in Delirium)

3. Document delirium status each day in the care plan or specific delirium recording tool (e.g. end-of-bed file).

Delirium Screening is Positive

- **Document result**
- **Contact the treating team for a formal delirium assessment today**

- Assess for possible causes of delirium (see **PINCH ME** box)
- Identify and treat all possible risks/precipitants
- **Reassess** for resolution/persistence every 24-48 hours
- Monitor symptoms using behaviour chart (as per local protocol)
- Once resolved, **resume daily screening** for reoccurrence
- Follow local protocol for accessing expert delirium assessment

Assessing for Potential Causes of Delirium: 'PINCH ME'

P – **Is the person in pain?** Has urinary retention been excluded?
IN – Infection: is there a possible infection? Refer to sepsis pathway as appropriate.
C – Constipation: When was the last bowel movement?
H – Hydration/Nutrition: is there major electrolyte imbalance? Has **h**ypoxia, **h**ypotension, **h**ypoglycaemia been considered?
M – Medication: omission of regular medication or addition of new medication?
E – Environment: change of environment, noise or activity levels impacting sleep/ rest?

Delirium screening negative

- Daily screening, see box above
- Continue to address risk factors

Strategies for delirium prevention & management

- Avoid new sedatives
- Avoid restraint (physical and chemical)
- Avoid use of urinary catheters where possible
- Ensure adequate fluids/nutrition and access to drinks/snacks
- Avoid constipation
- Provide own hearing aids and glasses
- Promote relaxation and sufficient sleep in a quiet area
- Regular re-orientation
- Encourage and assist early and regular mobilisation
- Encourage/ allow family members/carers to stay with the patient where possible
- Encourage independence with activities of daily living
- Assess for and manage any pain; use dementia friendly pain score where applicable e.g. PAINAD/Abbey Pain Scale
- Medication review by team

Extra tips for caring for the patient with possible or proven delirium

- Explain gently what is happening
- Smile and make eye contact to reassure
- Consider enhanced care (i.e. 'special') by a staff member trained in dementia/delirium support
- Encourage familiar faces – staff and family
- Limit ward and bed moves
- Use medications to manage symptoms of delirium rarely and always with senior decision-maker input
- Communicate with family and carers, offer patient information leaflet, discuss reason for 'special'

Record delirium on the discharge letter to the GP and follow-up according to local protocol.

Note: Clinical algorithms are for reference only and do not replace clinical judgement. This algorithm is not intended for delirium due to alcohol or drug intoxication/withdrawal.

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