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



Yes









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?

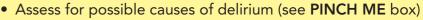
Screening for Delirium

- 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. endof-bed file).

Patient is already <u>diagnosed</u> as having delirium in ED/AMAU

Delirium Screening is Positive

- Document result
- Contact the treating team for a formal delirium assessment <u>today</u>



- 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 hypoxia, hypotension, hypoglycaemia 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?

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

Delirium screening negativeDaily screening, see box above

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

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.