Early Identification and Management of Delirium in the Emergency Department/ Acute Medical Assessment Unit

DELIRIUM is an acute change in cognitive function that has an organic cause and is likely to be reversible or preventable.

All Older Adults (≥ 65) presenting to ED/AMAU: screen for delirium using 4AT at triage or first contact after triage

Result of 4AT (Collateral history necessary)

≥ 4 : Probable delirium +/- cognitive impairment
1-3 : Possible cognitive impairment
0 : Delirium or severe cognitive impairment unlikely

No evidence of delirium (4AT 0-3)

NB Collateral history necessary to derive this score
- Proceed with admission/discharge
- If 4AT score is 1-3: ensure documentation of cognitive status. Person may have undiagnosed dementia
- See reverse side for dementia/ cognitive vulnerability pathway for ED / AMAU
- Assess for delirium risks: those with any risk factors should have regular screening for delirium.

Suspected Delirium (4AT ≥4):

Flag for Urgent Medical Review
- Discuss diagnosis with senior doctor and/or nurse in ED/AMAU
- Discuss diagnosis with carer/ relative and patient as appropriate
- Assess for possible causes of delirium

Ensure admitting team know that delirium is suspected
Delirium has a high mortality. Most patients will need admission. Only discharge after discussion with a senior colleague.

Strategies for delirium prevention/management in ED/AMAU

- 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
- Promote relaxation and sufficient sleep in a quiet area
- Encourage and assist early and regular mobilisation
- Provide own hearing aids and glasses
- Encourage/ allow family members/ carers to stay with the patient
- Encourage independence with activities of daily living (toileting/washing)
- Assess for and manage any pain; use dementia friendly pain score where applicable e.g. PAINAD/ Abbey Pain Scale
- Medication review

Managing someone with delirium who is distressed and/or combative, and felt to be a threat to themselves or others

The management of delirium is primarily NON PHARMACOLOGICAL.

ALWAYS try to de-escalate the situation first. Explain what is happening, re orientate, try to nurse in a quiet area, consider need for one to one care.

1. The evidence for the benefit of antipsychotics in treating delirium is very weak. If emergency treatment with medication is needed because the patient or others are at immediate risk and/or urgent care is compromised, low dose ORAL antipsychotic medication is preferred. Small doses should be given e.g. Haloperidol (0.5 - 1mg), Quetiapine (12.5 - 25mg), Olanzapine (2.5mg), Risperidone (0.5mg).
   - Avoid antipsychotics in those with Lewy body dementia or Parkinson’s disease
   - Get an ECG and check QTc before using antipsychotic agents.

2. Benzodiazepines worsen delirium and are reserved for alcohol or benzodiazepine withdrawal (follow withdrawal protocols); or where emergency treatment is required (as per 1, but antipsychotics are contraindicated: e.g. consider lorazepam (0.5-1mg).

3. A decision to use IM or IV sedation must be made by a senior doctor (i.e. Registrar/ Consultant). This should be administered in an area where the patient can be properly monitored and where airway support is available. Flumazenil should be available if using lorazepam. Propofol/ Benztpine should be available if using antipsychotic agents.

Identify the patient at risk of delirium

Age over 65 years or any one of the following:
- Pre-existing cognitive impairment (e.g. mild cognitive impairment or dementia)
- Previous delirium
- Other brain disorders (e.g. head injury, str Parkinson's Disease)
- Functional dependence or frailty
- Poor mobility
- Poor nutrition
- Visual or hearing impairment
- Depression
- Major trauma/Hip fracture
- Multiple co-morbid illnesses
- Severe medical illness or infection (INEWS ≥4 or ≥5 on oxygen)
- Urea and electrolyte imbalance
- Alcohol or substance misuse
- Polypharmacy and/or high risk medications (e.g. benzodiazepines)

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Assess 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 sepisis pathway as appropriate (link overleaf)
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

NOTE: Clinical algorithms are for reference only and do not replace clinical judgement.

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Proceed with admission/discharge

Assess for and manage any pain; use dementia friendly pain score where applicable e.g. PAINAD/ Abbey Pain Scale

Encourage and assist early and regular mobilisation

Multiple co-morbid illnesses

Previous delirium

A decision to use IM or IV sedation must be made by a senior doctor

If 4AT score is 1-3: ensure

Ensure adequate fluids/nutrition and access to drinks/snacks

Poor mobility

Promote relaxation and sufficient sleep in a quiet area

Visual or hearing impairment

4AT Rapid Clinical Test for Delirium

1. Alertness
Normal (fully alert, but not agitated throughout assessment) 0
Mild sleepiness for <10 seconds after waking but then normal 0
Clearly abnormal 4
2. AMT4 (Age, date of birth, place (name of hospital), current year)
No mistakes 0
1 mistake 1
≥ 2 mistakes/ untestable 2
3. Attention (months of year backwards)
Achieves 7 months or more correctly 0
Starts but scores <7 1
Untestable (too unwell, drowsy, inattentive) 2
4. Acute Change or Fluctuating Symptoms (need collateral history)
No 0
Yes 4
Total