**Introduction:** Delirium is an acute change in cognitive function that has an organic cause and is likely to be reversible or preventable. All patients aged 65 years require screening for delirium on arrival to hospital. Whenever possible get a collateral history. If cognitive impairment is new - ALWAYS THINK DELIRIUM

### Older Adult (>65) presents to ED/AMAU
Nurse Assessment after Triage: Perform “4AT” Delirium Screen

- **Result of 4AT**
  - ≥4: Possible Delirium: Assign Triage 2
  - 1-3: Possible Cognitive Impairment
  - 0: Delirium or severe cognitive impairment unlikely (but delirium still possible if information incomplete - use clinical judgment)

### No evidence of delirium
Proceed with admission/discharge plan, as per assessment
Ensure documentation of cognitive status on ED/AMAU Notes
If any concerns about cognitive impairment consider arranging follow-up via GP

### Possible Delirium is a Medical Emergency*
Flag for ADMISSION
1. Discuss diagnosis with senior doctor and nurse in ED/AMAU
2. Discuss diagnosis with carer/relative
3. Start search for causes of delirium (Remember there is frequently more than one - see Checklist Box on right)

Ensure admitting team know that Delirium is suspected
*Delirium has a high mortality and the vast majority of these patients will need admission. Exceptionally and only after senior discussion should a patient with delirium be discharged.

### Patient Flow to source Urgent Bed
This patient will require enhanced supervision while in ED e.g. increased falls risk, wandering

### Reduce Delirium in ED
Avoid sedatives, unless distressed and/or combative and felt to be a threat to themselves or others
Avoid physical restraints and use of urinary catheters, if possible
Ensure adequate fluids/nutrition (ensure accessible drinks/snacks, if appropriate)
Avoid constipation
Promote relaxation and sufficient sleep in a quiet area
Early and regular mobilisation
Regular reality orientation using visual and auditory aids
Encourage independence with Activities of Daily Living
Manage any pain, using dementia friendly pain score e.g. PAINAD
Medication review

### Managing someone with delirium who is distressed and/or combative and felt to be a threat to themselves or to others
1. **ALWAYS try to deescalate the situation** first. Explain gently what is happening, re-orientate. Try to nurse in a quiet area and consider the need for ‘one to one’ care.

2. **If restraint with medication** is needed (only if patient or others are at risk OR essential care is compromised) use small doses and increase gradually. Try ORAL therapies first e.g. Lorazepam 0.5-1mg pm, max 2mgs in 24 hours. Should not exceeded 2mgs without discussing with senior clinician or Old Age Psychiatry/Geriatrician where available. Consider an antipsychotic agent in those with psychotic symptoms e.g. Risperidone as 1st line antipsychotic, or Olanzapine as 2nd line alternative.

3. **If oral therapies fail consider IM or IV sedation.** This decision must be made by a senior doctor (i.e. Middle Grade Registrar/Consultant) and following discussion with Old Age Psychiatry/Geriatrician where available. As with any sedation this should be administered in an area where the patient can be properly monitored and where airway support is available (Resuscitation Room in the ED).

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**4AT** Validated rapid assessment tool for delirium/cognitive impairment screening at first contact with patient: incorporates AMT4

**Initial Check list for Potential Causes of Delirium**
- Check for hypoxia/hypotension/hypoglycaemia
- Check if patient has pain
- Check for visual or hearing impairment
- Check for urinary retention (consider ultrasound)
- Check for constipation
- Check for recent addition or withdrawal of medication, including patches especially benzodiazepines or opiates
- Check for major electrolyte disturbance
- Check for an infection - e.g. UTI/LRTI
- If infection is suspected refer to Sepsis Screening Tool (links overleaf)
- Consider if alcohol withdrawal syndrome is possible
- Check for pre-existing cognitive impairment or prior history of delirium
- Check for history of depression

**Further work up by admitting team as indicated**

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**Pathways cannot cover all clinical scenarios. Ultimate responsibility for the interpretation and application of these guidelines, the use of current information and a patient’s overall care and wellbeing resides with the treating clinician.**
References:
NICE CG 103 (delirium) https://www.nice.org.uk/guidance/cg103

NICE CG 10 (Violence) https://www.nice.org.uk/guidance/ng10


Sepsis Pathway Links


http://www.hse.ie/eng/about/Who/clinical/natclinprog/sepsis/Adult%20Sepsis%20In Patient%20Screening%20Form.pdf

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