NHS Lanarkshire Care Homes Protocol Group

Guideline for the Management Of Delirium in Care Homes Version 2

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Guideline for the Management of Delirium In Care Homes

Introduction

Delirium is a common serious medical problem. It is associated with complications such as falls, pressure sores and functional impairment and patients with delirium are at increased risk of death.

In the hospital setting, delirium affects 20-30% of patients in medical wards and 10-50% of patients following surgery.

Unfortunately, delirium is often unrecognised and misdiagnosed.

Definition

Delirium is characterised by disturbances of cognition, consciousness and attention. The condition is of acute onset and it follows a fluctuating course.

Delirium may be hyperactive when the patient will show signs of over-arousal, agitation or restlessness or it may be hypoactive when the patient will be subdued and sleepy.

Risk Factors

- Old age
- Severe physical illness
- Recent surgery, especially hip surgery
- Dementia
- Frailty
- Sepsis and dehydration
- Polypharmacy
- Sensory impairment (visual, hearing)
- Alcohol excess

Causes

A variety of causes can trigger delirium and more than one cause may be involved in any individual case. Causes include: -

- Immobility
- Use of a bladder catheter
- Prescription of medications (especially analgesics, psycho-active drugs, those with anticholinergic side-effects)
- Severe intercurrent illness (including stroke, sepsis)
- Withdrawal (including alcohol but also other agents eg benzodiazepines, SSRIs)

Common drug causes of delirium include: -

- Benzodiazepines e.g. Diazepam, Temazepam
- Analgesics e.g. Opioids including Tramadol
- Antiparkinsonian drugs e.g. Levodopa, Selegeline, Benzhexol, Pergolide
- Steroids
- Cardiac drugs e.g. Digoxin
- Major tranquillizers e.g. Chlorpromazine
- Anticholinergic drugs e.g. Atropine, Chlorphenamine
- Antidepressants e.g. Amitriptyline
- Histamine blockers e.g. Cimetidine, Ranitidine
- Anticonvulsants e.g. Primidone, Phenytoin, Valproate
- Lithium
- Respiratory drugs e.g. Theophylline

Prevention

The risk of delirium can be lessened by a number of simple measures, thereby reducing the stress to residents, relatives and carers. Measures which help reduce the risk of delirium are given below.

- Approach patient calmly and gently from the front
    - Non-threatening posture from staff
    - Clear unambiguous communication
- Lighting levels appropriate for time of day
    - Quiet relaxing night environment
- Night light in room
- Regular and repeated cues to improve personal orientation
    - Examples of orientating cues include clocks, calendars, signs
- Hearing aids and spectacles should be available and in good working order.
- Continuity of care from nursing staff
    - Minimal changes of staff and ward
- Encouragement of mobility and engagement in activities and with other people
- Elimination of unexpected and irritating noise (e.g. pump alarms, television, radio).
- Encouragement of visits from family and friends who may be able to help calm the patient
    - Explain the cause of the confusion to relatives
    - Encourage family to bring in familiar objects and pictures from home and participate in rehabilitation
- Good diet, fluid intake and mobility to prevent constipation.
- Good sleep pattern (use milky drinks at bedtime, exercise during the day).
- Regular review of medication
- Optimise oxygen saturation when necessary
- Look for and treat infections promptly
- Avoid catheterisation if possible

Identification of Delirium

Given that delirium is often unrecognised, it is important to bear the possibility of delirium in mind – think delirium

History

The following features will aid diagnosis and management of the confused patient: -

- Onset and course of confusion
- Full drug history including non-prescribed drugs and recent drug cessation (especially benzodiazepines)
- Alcohol history
- Functional status (e.g. activities of daily living)
- Previous episodes of acute or chronic confusion
- Symptoms suggestive of underlying cause (e.g. infection, oxygenation)
- Co-morbid illness

Examination

There are no specific examination findings in delirium. However, the following points should be noted: -

- A full general and detailed physical examination is required by clinician responsible for the patient.
- Localising signs suggestive of sepsis should be sought e.g. of community acquired pneumonia, abdominal discomfort, skin infection
- Serial review is often required
- A neurological examination is essential

4AT Single Assessment Tool

The 4AT tool is a simple useful tool which can be used without the need for formal training. The tool can be used to help diagnose delirium and it can also be used to review the patient with delirium.

The tool is made freely available by Professor Alasdair MacLullich and is embedded below: -

4AT v1:2 Oct 2014.pdf

Investigation

The GP or lead clinician may request the following investigations as dictated by history and examination.

- Routine blood tests include
  - full blood count
  - Inflammatory markers
  - U&E
  - LFT
  - Glucose
  - Calcium
- MSSU (Note that dipstick urinalysis is not reliable in the elderly).
- "Screening" investigations such as TFTs, B12 and folate are also appropriate.

Treatment of Delirium

The mainstay of treatment is to treat the underlying causes.

- Follow local antibiotic guidelines where there is evidence of sepsis
- Review medication
  - Review and potentially stop any drugs which may be contributing
  - Review and reduce analgesics if possible
- Consider pain as a cause of delirium
- Correct biochemical derangements (e.g. hyponatraemia, hypercalcaemia)
- Treat dehydration. Consider subcutaneous fluids where appropriate.

General measures in patient care and environment

The measures described in the Prevention section can equally be applied to the care of a patient suffering from delirium: -

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  - Clear unambiguous communication
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  - Quiet relaxing night environment
- Night light in room
- Regular and repeated cues to improve personal orientation
  - Examples of orientating cues include clocks, calendars, signs
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    - Encourage family to bring in familiar objects and pictures from home and participate in rehabilitation
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<u>Management of wandering and agitation</u>

- Intensive 1:1 support and observation may be required
- Adopt least restrictive approach e.g. allow patient to wander around ward accompanied by a member of staff as opposed to confining in room
- Distraction techniques
    - Divert from content of incoherent and rambling speech and change topic
    - Focus on understanding and empathy of patient's emotions

<u>Drug Treatment of Delirium</u>

Medication should be used only as a last resort - "Start low and go slow"

- Review medication regularly – at least 24 hourly intervals
- Start with low dose and titrate slowly according to tolerance and efficacy
- The lowest possible dose should be used and regularly reviewed to prevent over-sedation.
- Sedatives should be reduced or tailed-off as quickly as possible

If medication is required, antipsychotics would be first choice, except in alcohol withdrawal, where there are signs of parkinsonism and Lewy Body dementia.

The first choice oral drug treatments would be: -

Haloperidol 0.5mg-1mg/24 hours up to a maximum of 2mg/24 hours. There should be at least 4 hours between each dose. The lower end of this dose range should be used in frail or elderly patients. (Please note that consideration should be given to a baseline ECG due to potential QTc prolongation prior to treatment with haloperidol)

Or

Risperidone 0.25mg daily, maximum 1mg in 24 hours
Ensure that antipsychotic medication is reduced and stopped once the patient's condition has settled.

Benzodiazepines should be avoided, except in alcohol withdrawal and Lewy Body dementia.

References

1. Delirium: Prevention, diagnosis and management. NICE clinical guideline CG103. July 2010
2. Improving the care for older people: Delirium Toolkit. Healthcare Improvement Scotland in collaboration with Scottish Delirium Association and NHS Education for Scotland. 2014
3. http://www.the4at.com/
4. Scottish Intercollegiate Guidelines Network (SIGN). Risk reduction and management of delirium. Edinburgh: SIGN. 2019. (SIGN publication no. 157). [October 2020]. Available from URL: http://www.sign.ac.uk.

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