Barwon Health Delirium Guideline

Risk Factors for Delirium

Premorbid Risk factors Assessment	Tick	Precipitating factors	Tick
Visual Impairment	❒	Physical Restraint	❒
Severe Illness	❒	Malnutrition	❒
Cognitive screening AMTS (<7/10)	❒	3 medications added in 24 hours	❒
MMSE (<25/30)	❒		
Dehydration	❒	IDC	❒
		Iatrogenic event (eg transfusion, procedure)	❒
1-2 Present medium risk of delirium **>**3 High risk of delirium	**Total**	1-2 Present medium risk of delirium >3 High risk of delirium	**Total**

Prevention of Delirium

Objective: Identify Cause and treat, Keep patient safe : if untreated, mortality is high

Hydration and Nutrition	Preparative hydration – IV fluids Early recognition of dehydration and volume repletion with encouragement of oral intake or IV fluids	**Referral:** Dietitian
Cognitive Impairment	Establish baseline, discuss with family and carers Orientation protocol, diversional therapy Repeat cognitive function tests if change	**Referral:** Occupational therapy Diversional Therapist
Immobility	Ambulation or Active range of movement 3 times daily Avoid immobilising equipment eg restraint or bladder catheters	**Referral:** Volunteers Physiotherapy
Bowel and Bladder	Bowel chart, monitor for constipation	
Sleep	Avoid use of unnecessary hypnotics Non pharmacological sleep protocol Sleep enhancement programme	
Sensory	Be aware elderly patients may have poor hearing and eyesight. Ensure sensory aids are well fitting and in good repair: hearing aids, Glasses, dentures Check Ears for wax	**Referrals:** Speech therapy Audiology
Environment	Familiar objects, natural light/window where possible Stable room temperature: 21°C – 24°C TV or Radio, large face clock, newspapers Consider single room Adequate lighting : 40-60 Watt night light Reduced Noise: <45 decibels (day); <20 decibels (night)	
Language	If English is not primary language	**Referral**: Interpreter

Assessment of patients with Delirium

	Step 1	Step 2	Step 3	Step 4
Physical Assessment	**<u>History</u> (CAM)** • Acute onset • Fluctuating Course • Disorganised thinking • Altered level of consciousness	**<u>Examination</u>** – Physical including vital signs – neurological, PR examination, bladder scan and O_2 Sats	Review of medical records	Medication Review[1] And if >5 medications
Mental Assessment	Interview patient and family	Cognitive Testing • AMTS • MMSE		.
Investigations	FBE, Glucose Electrolytes, LFTs Urinalysis Calcium	Blood Gases if post operative Thyroid Function Test	Chest x-ray	ECG
Additional	CT/MRI brain[2]see criteria Additional EEG if indicated	Urine culture and sensitivity Blood Cultures Lumbar Puncture	Serum levels of medication	

[1] Common medications that may cause or worsen cognitive problems include Tricyclic antidepressants, SSRIs, MAO inhibitors, neuroleptics, anti-Parkinson medication, anticholinergics, Benzodiazepines, antihistamines, Opioid analgesics and Quinolone anitbiotics.

[2] Any sudden or recent change in mental state, unless dementia is well established, recent onset of focal neurological signs, documented fall with significant injury, patient on anticoagulation especially with history of trauma.

Treatment of Patients with Delirium		
Objective: Identify Cause and treat, Keep patient safe		
Hydration and Elimination	Bowels – assess constipation Urinary Output – urine dilute and odourless	
Drug Management ***Adequate Pain Management***	Ensure adequate pain relief without overdose Regular analgesia preferable Pharmacology review	
Benzodiazepine/alcohol withdrawal	Oxazepam /Valium Protocols Consult Psychiatric liaison	
Environmental Factors	As per prevention protocol	
Family	Reassure and educate family, friends and the patient. Encourage family to reassure the patient Fear Reducing Conversation	
Support and Education	Orientate patient, Reassure Patient, Community clearly and concisely, touch	
Management of Confusion		
Behavioural Management	Behavioural Charts for 3 days, then assess with Geriatrician Liase with psychiatrist or Aged Psychiatry Service (Phone 52267044)	
Communication	Documentation and reporting	
Geriatric Assessment	Consultation	Review
Psychiatric assessment and treatment	Consultation	Review
Injury Prevention	Falls prevention Avoid physical restraint	Monitor, review daily
Wandering Agitated and Aggressive Patient	Promote patient safety and self control Staff attitude of calmness and comforting behaviour Calm voice, careful touch. Orientate patient to IV line other tubing. Do not confront arguing patient Careful listening to hallucination – identify item in surrounding that may be misunderstood.	
Management of hypoalert patient	Psychiatric Review Exclude Depression Pressure Care Management and Bowel management Prevent deconditioning, mobilisation or active range of movement	
Intense Rehabilitation	Commence immediately post operative. Develop appropriate activities for mental and physical capacity.	
Drug Management	• **If oral medication tolerated:** – Olanzepine 2.5mg once daily as first line (Can be increased to 5mg once daily) – Risperidone 0.5mg increase up to 1 mg bd (Increase should be slow, ie every two days) – Haloperidol 0.25mg – 4mg orally up to 4 times daily. (max dose 10mg) (Initial dose can be repeated every 4 hours until response is seen, then continue with suitable bd/ tds dose) • **If Parenteral medication required:** – Haloperidol 0.25mg initially in older frailer patients up to 5 mg IM in younger patients (<60 years of age) repeat after 20 mins. If no response after 20 minutes, increase to 0.5mg, 1mg, 2.5mg. 5mg after each 20 minutes up to a total of 10mg) Initial dose can be given as slow I.V. injection in ICU – Benzodiazepine use in alcohol and benzodiazepine withdrawal Sedation may paradoxically increase agitation **PATIENT MUST HAVE DAILY MEDICAL AND MEDICATION REVIEW**	