In emergency

1. **Carry out CAM**
2. **Address medical cause**
3. **Consider delirium management checklist**
4. **Contact doctor**
5. **Consider short term sedation with**

Haloperidol 500 micrograms orally or IM up to two hourly.

(Dose can be increased according to response) max 10mg/24 hours

Olanzapine 2.5mg orally (max 10mg/24 hr) and monitor

Consider **lorazepam** 0.5 to 1mg up to hourly (max 4mg/24 hours) especially in Parkinson's or Lewy Body Dementia.

However, benzodiazepines should usually be avoided/not used first line

Think SQID
Single Question to Identify Delirium

Has there been a sudden change in behaviour or confusion?

Use I'M A SEA CATCH

I'	INFECTION	e.g. urine/chest infections/ flu/ pressure ulcers
M	METABOLIC	e.g. acidosis/ electrolyte Imbalance vitamin deficiencies
A	ACUTE VASCULAR	e.g. hypertensive crisis/arrhythmias
S	SUBSTANCES	e.g. alcohol/street drugs/prescribed/ OTC meds
E	ENDOCRINE	e.g. thyroid/diabetes/ adrenal
A	ANYTHING ELSE	20% no cause found ?in pain ?immobilised anaesthetic in last 5 days
C	CONSTIPATION	check last time bowels open
A	ANOXIA/HYPOXIA	cardio/respiratory insufficiency or arrest
T	TRAUMA	e.g. falls/head injury/ assault/heamatomas
C	CNS PATHOLOGY	e.g. stroke/TIA/ tumours/ hydrocephalus/ seizures
H	HYDRATION	check for AKI & dehydration

NHS
Weston Area Health
NHS Trust

Let's Talk About Delirium

Information for medical staff

Why is it important to recognise?

1. It is the most common complication of hospital admission for older people
2. Up to ½ of older people suffer from delirium post-operatively
3. Twofold increase in discharge mortality
4. Worse physical and cognitive recovery at 6 and 12 months
5. Increases risk of institutional care post discharge

High risk patients

- Over 65s
- Pre-existing cognitive impairment
- Severe illness
- # NOF
- Visual and hearing impairments
- Polypharmacy
- Alcohol

Core signs of delirium

- Acute onset
- Changed cognition (especially attention—ask days of week or months backwards)
- Fluctuation through the day
- Disturbance of consciousness (hyper alert to stuperose)

Additional symptoms may be:

- Hallucinations / illusions
- Disturbance in the sleep-wake cycle
- Delusions/paranoia

Three types of delirium

Hyperactive

In addition to core symptoms:

- Heightened arousal
- Sensitivity to surroundings
- Threatening or aggressive
- Restless (e.g. *floccillation—picking at bedding/clothes*)
- Wandering

Hypoactive

In addition to core symptoms:

- Intermittent sleepiness
- Less interested in surroundings
- Intermittent incoherence
- Impairment of grasp
- Uncommunicative

Mixed

In addition to core symptoms

Mixed presentation

CAM Confusion Assessment Method

All three features need to be present for diagnosis

1. Presence of acute onset and fluctuating course
2. Inattention *and either*
3. Disorganised thinking (illogical or incoherent/rambling speech)

   And/*or*

   Altered level of consciousness (often lethargic/stuporose/hyperalert)

Management checklist

Please assess for and address the following if present'

Help disorientation	√
Dehydration or constipation	√
Hypoxia	√
Immobility or limited mobility	√
Infection	√
Multiple medications	√
Pain	√
Poor nutrition	√
Sensory impairment	√
Sleep disturbance	√