The prevention, diagnosis and management of delirium in older people

Summary of guidelines

Aids to diagnosis

- Cognitive testing should be carried out on all elderly patients admitted to hospital.[34,36]   **C**

- Serial measurements in patients at risk help to detect the new development of delirium or its resolution.[33,34]   **B**

- A history from a relative or carer about the onset and course of the confusion is essential to help distinguish between delirium and dementia.[36,53]   **C**

- The diagnosis of delirium can be made by non-psychiatrically trained clinicians quickly and accurately using the Confusion Assessment Method (CAM) screening instrument.[29,31]   **B**

Prevention

- Patients at high risk should be identified at admission and prevention strategies incorporated into their care plan.[3,4]   **A**

History

- Many patients with delirium are unable to provide an accurate history. Wherever possible, corroboration should be sought from the carer, general practitioner or any source with good knowledge of them.[36]   **C**

Management

- The most important action for the management of delirium is the identification and treatment of the underlying cause.[38,56]   **C**

- The patient should be nursed in a good sensory environment and with a reality orientation approach, and with involvement of the multidisciplinary team.[55]   **C**

- Keep the use of sedatives and major tranquillisers to a minimum.[56]   **C**

- Use one drug only – haloperidol is currently recommended – starting at the lowest possible dose and increasing in increments if necessary after an interval of 2 hours.[70,71]   **D**

- Review all medication at least every 24 hours.[71]   **D**

- One-to-one care of the patient is often required and should be provided while the dose of psychotropic medication is titrated upward in a controlled and safe manner.[71]   **D**

Staff training, education audit

- Senior doctors and nurses should ensure that doctors in training and nurses are able to recognise and treat delirium.[56,73]   **C**

- Regular audit should be undertaken to assess the processes and outcomes of care of patients with delirium, eg use of cognitive scores, ward moves, length of stay, complications and mortality.   **(GPP)**

- The results of audit should be used as feedback on the performance of doctors and nurses in order to target educational programmes.   **(GPP)**

GPP = Good Practice Point.

Steps in the prevention, diagnosis and mangement of delirium

STEP 1

Identify all older patients (over 65 years) with cognitive impairment using the AMT or MMSE on admission

STEP 2

Consider delirium in all patients with cognitive impairment and at high risk (severe illness, dementia, fracture neck of femur, visual and hearing impairment). Use the CAM screening instrument

STEP 3

Identify the cause of delirium if present from the history – obtained from relatives/carers – examination and investigations. Treat underlying cause or causes – commonly drugs or drug withdrawal, infection, electrolyte disturbance, dehydration or constipation

STEP 4

In patients with delirium *and* patients at high risk of delirium:

Do:
- provide environmental and personal orientation
- ensure continuity of care
- encourage mobility
- reduce medication but ensure adequate analgesia
- ensure hearing aids and spectacles are available and in good working order
- avoid constipation
- maintain a good sleep pattern
- maintain good fluid intake
- involve relatives and carers (carers leaflet)
- avoid complications (immobility, malnutrition, pressure sores, over-sedation, falls, incontinence)
- liaise with old age psychiatry service

Do not:
- catheterise
- use restraint
- sedate routinely
- argue with the patient

STEP 5

If sedation has to be used, use one drug only starting at the lowest possible dose (haloperidol 0.5 mg currently recommended) and increasing in increments if necessary after an interval of two hours

STEP 6

Ensure a safe discharge and consider follow-up with old age psychiatry team. Provide family/carer education and support

AMT = Abbreviated Mental Test; CAM = Confusion Assessment Method; MMSE = Mini Mental State Examination.