

Pharmacological treatment

There is insufficient evidence to support a recommendation for the use of antipsychotics, dexmedetomidine, acetylcholinesterase inhibitors or benzodiazepines in the treatment of patients with delirium. Expert opinion supports a role for medication in specific situations such as in patients in intractable distress, and where the safety of the patient and others is compromised.

Follow up

- R** Healthcare professionals should be aware that older people may have pre-existing cognitive impairment which may have been undetected, or exacerbated in the context of delirium. Appropriate cognitive and functional assessment should be considered. Timing of this assessment must take into account persistent delirium.
- R** In patients who have experienced delirium in ICU consideration should be given to follow up for psychological sequelae including cognitive impairment.
- ✓ Patient records should be coded to highlight a previous episode of delirium so that hospital staff are aware of the increased risk on readmission.
- ✓ Ensure that delirium is noted in the discharge letter for the primary care team.
- ✓ All patients who have had delirium should be reviewed by the primary care team.

Sources of further information

Scottish Delirium Association

www.scottishdeliriumassociation.com

THINK Delirium

[www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4052742/20141007%20Delirium%20leaflet%20\(web\).pdf](http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4052742/20141007%20Delirium%20leaflet%20(web).pdf)

“Getting to Know Me” form

www.alzscot.org/information_and_resources/information_sheet/3472_getting_to_know_me

The “Getting to Know Me” form was designed for patients with dementia. It is completed with information about the person’s likes and dislikes and needs and is held with the patient notes to allow staff to provide the best care possible.

Provision of information

If a patient is at risk of delirium

Identify the family and/or main carer of the patient.

Explain to the patient and the family/carer about delirium.

Ask family/carers to alert medical staff if they notice any change to their relative’s normal behaviour.

Ask the patient and family/carers to complete a ‘Getting to know me’ form or similar, to help healthcare staff to take care of the person’s specific needs.

Ask family/carers to help, if they feel able to do so, to reduce the risk of delirium developing.

If a patient develops delirium

Explain delirium is a change in mental state that often starts suddenly but usually improves when the physical condition improves.

Discuss treatment options and possible side effects with the patient and/or carer.

Provide the family/carer with appropriate information leaflets.

Let the family/carer know how to help someone with delirium.

At discharge following an acute episode of delirium

Liaise with the family/carers regarding discharge arrangements and discuss whether they need extra support.

Inform carers of their right to have a new or updated adult carer support plan.

Ensure that support is in place before the patient is discharged to their home.

If there are concerns about cognitive impairment in the following months, advise the patient/carers to see their general practitioner.

SIGN 157

Risk reduction and management of delirium

Quick reference guide

March 2019

This Quick Reference Guide provides a summary of the main recommendations in **SIGN 157 Risk reduction and management of delirium**.

Recommendations **R** are worded to indicate the strength of the supporting evidence. Good practice points ✓ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

This QRG is also available as part of the SIGN Guidelines app.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk.

Detecting delirium

Tools for detection and assessment

- R** | The 4AT tool should be used for identifying patients with probable delirium in emergency department and acute hospital settings.
- R** | Use of the 4AT tool could be considered for use in community or other settings for identifying patients with probable delirium.
- R** | For intensive care unit settings, CAM-ICU or ICDSC should be considered to help identify patients with probable delirium.
- ✓ | A formal assessment and diagnosis must be made by a suitably trained clinician whenever patients with probable delirium are identified.
- ✓ | Where delirium is detected, patients and their family/carers should be informed of the diagnosis.
- ✓ | Where delirium is detected, the diagnosis of delirium should be clearly documented to aid transfers of care (eg handover notes, referral and discharge letters).

Clinical investigations

- R** | CT brain scan should not be used routinely but should be considered in patients presenting to hospital with delirium in the presence of:
 - new focal neurological signs
 - a reduced level of consciousness (not adequately explained by another cause)
 - a history of recent falls
 - a head injury (patients of any age)
 - anticoagulation therapy.
- ✓ | Consideration should be given to imaging patients with non-resolving delirium where no clear cause is identified or there are features to suggest primary central nervous system pathology.
- R** | Electroencephalogram should be considered when there is a suspicion of epileptic activity or non-convulsive status epilepticus as a cause of a patient's delirium.
- ✓ | Lumbar puncture should not be performed routinely on patients presenting with delirium.

Non-pharmacological risk reduction

- R** | The following components should be considered as part of a package of care for patients at risk of developing delirium:
 - orientation and ensuring patients have their glasses and hearing aids
 - promoting sleep hygiene
 - early mobilisation
 - pain control
 - prevention, early identification and treatment of postoperative complications
 - maintaining optimal hydration and nutrition
 - regulation of bladder and bowel function
 - provision of supplementary oxygen, if appropriate.
- ✓ | Ward moves should be avoided wherever possible for patients at risk of delirium.
- ✓ | Prior to surgery patients and carers should be advised of the risk of developing delirium, to alleviate distress and help with management if it does occur.
- ✓ | Where possible, assistance should be sought from a patient's relatives and carers to deliver care to reduce the risk of delirium developing.

Anaesthetic management

- R** | Depth of anaesthesia should be monitored in all patients aged over 60 years under general anaesthesia for surgery expected to last for more than one hour, with the aim of avoiding excessively deep anaesthesia.

Intensive care

- R** | The use of earplugs should be considered as part of a sleep-promotion strategy in intensive care.

Pharmacological risk reduction

- R** | All patients at risk of delirium should have a medication review conducted by an experienced healthcare professional.
- ✓ | Areas with patients at high risk of delirium, such as trauma orthopaedic wards, should have protocols for commonly required medication (eg analgesia and anti-emesis) that contain choices for first-line treatments which minimise the risk of causing delirium.

There is insufficient evidence of benefit to recommend the use of antipsychotic prophylaxis in patients at risk of developing delirium.

It is unclear if dexmedetomidine can inherently reduce delirium or merely reduce the need for delirogenic drugs (see section 5.3 of the full guideline). No recommendation can be made on the use of dexmedetomidine for the prevention of delirium.

Non-pharmacological treatment

- R** | Healthcare professionals should follow established pathways of good care to manage patients with delirium.
 - First consider acute, life-threatening causes of delirium, including low oxygen level, low blood pressure, low glucose level, and drug intoxication or withdrawal.
 - Systematically identify and treat potential causes (medications, acute illness, etc), noting that multiple causes are common.
 - Optimise physiology, management of concurrent conditions, environment (reduce noise), medications, and natural sleep, to promote brain recovery.
 - Specifically detect, assess causes of, and treat agitation and/or distress, using non-pharmacological means only, if possible.
 - Communicate the diagnosis to patients and carers, encourage involvement of carers, and provide ongoing engagement and support.
 - Aim to prevent complications of delirium such as immobility, falls, pressure sores, dehydration, malnourishment, isolation.
 - Monitor for recovery and consider specialist referral if not recovering.
 - Consider follow up.
- ✓ | Promote cognitive engagement, mobilisation, and other rehabilitation strategies.