NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Delirium Diagnosis, Risk Reduction, and Management in Acute Services

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Acute Services Division Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

GGC Acute Sector Guidelines on the Risk Reduction, Diagnosis and Management of Delirium

"THINK DELIRIUM"

Key Points

- Be aware that people in hospital may be at risk of delirium. This can have serious consequences (such as increased risk of dementia and/or death), may increase their length of stay in hospital and their risk of new admission to long-term care.
- The TIME checklist should be used to prompt good delirium risk reduction, diagnosis and management – it consists of a 4AT and the 4 steps: Think, Investigate, Manage and Explain & Explore
- It's use is described in this guideline

	Triggers, Investigate, Manage and Engage	Date	Date	Date	Date	Date
Triggers	**Think possible triggers for delirium**	Tick box	Tick box	Tick box	Tick box	Tick box
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes/ No/ Unsure) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	**Investigate**					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	**Management: Diagnose causes & initiate treatment**					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	**Engage and Explore**					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/ No/ Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print initials of assessor					

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1) Applicability of this guideline

This guideline can be used in all acute areas managing adult patients with the exception of Anaesthetics and Intensive Care where although the principles are the same there are differing practical implications. Practitioners in these areas should refer to local policies or to SIGN 157. This guideline. does not cover primary care (including care homes), children and young people (under 18 years), people receiving end of life care, people with intoxication and/or withdrawing from drugs or alcohol or with delirium associated with these states.
Medical, Nursing and Allied Health Professionals (AHPs) who work in areas where people are at risk of delirium should familiarise themselves with the guideline. Key points are presented at the top of the sections, with background explanation and further details below.

2) Introduction

This guideline is based on the recommendations issued in "SIGN 157 Risk reduction and management of delirium, "NICE CG103 Delirium", the Scottish Delirium Association "Delirium Management Comprehensive Pathway" and the Healthcare Improvement Scotland "THINK DELIRIUM" workstream.

- Delirium is a clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which usually has an acute onset and fluctuating course
- It is a common but serious and complex clinical syndrome associated with poor outcomes including a doubling of mortality and the subsequent development of dementia
- Delirium may be present when a person presents to hospital or may develop during a hospital admission
- People with dementia are particularly vulnerable to delirium (Delirium Superimposed on Dementia) which confers the same set of problems
- 1/3 of cases can be prevented with a multi component intervention
- Delirium can be hypoactive (withdrawn, quiet and sleepy), hyperactive (too alert, agitated and often paranoid) or mixed. Hypoactive and mixed delirium can be more difficult to recognize
- As delirium is often poorly recognized it is important to keep a high clinical suspicion and **THINK DELIRIUM**

2.1) Person Centered Care

Key Points

- Use Getting to Know Me Document/ What Matters to Me board to help personalise care
- Assess capacity of the person to give consent and use Adults With Incapacity (Scotland) Act 2000 where needed

Treatment and care should take into account peoples individual needs and preferences – this can be facilitated by the "Getting to Know Me" Document and "What Matters to Me" boards. Good communication is essential to allow people to reach informed decisions about their care.

For every patient with cognitive impairment, including those with delirium, an assessment of capacity to consent to medical, nursing and AHP treatment should be made (as described in the Adults with Incapacity (Scotland) Act 2000). Where capacity is not present a Section 47 form should be completed. Every effort should be made to ascertain if the individual has a welfare attorney or welfare guardian and to discuss the individual's treatment with them if possible – if there is no legal proxy then the next of kin should be consulted. If the person retains capacity, families and carers should still have the opportunity to be involved in decisions about treatment and care should the individual agree.

3) Reducing Risk of Delirium

Key Points

- People aged 65 or older OR of any age with cognitive impairment OR hip fracture OR severe illness are at high risk of delirium in hospital
- The TIME checklist should be used for these individuals on admission and at every transition of care.
- They should have 4AT and TIME part T, along with an assessment as to whether or not they have delirium
- Together with Care Rounds this prompts a comprehensive delirium risk reduction strategy
- If they develop new high risk features they should have repeat 4AT and TIME part T
- Access to familiar people should be promoted and where possible these people should be invited to assist in risk reduction.

- Sleep hygiene should be promoted and room moves and use of intravenous lines and catheters should be minimised

When people first present to hospital they should be assessed for the following risk factors. If any of these risk factors is present the person is at risk of delirium

- Age 65 years or older
- Cognitive impairment (past or present, including previous delirium) and/or dementia
- Current hip fracture
- Severe illness (people identified as severely unwell, including those who require level 2 or level 3 care)

On admission, patients at risk of delirium should be assessed using the 4AT and have part T of TIME completed, with the checklist being used to guide management and care planning. They also require a clinical assessment as to whether or not they already have delirium (this is prompted by TIME). If they do not have delirium then part T of the TIME checklist together with Care Rounds prompts a multi component risk reduction strategy (as fully described in appendix 3).

4AT, part T of TIME and decision as to the presence or absence of delirium require to be repeated at every transition of care (ie ward move), as these are high risk times to develop delirium. If at any time an inpatient's condition changes such as they develop new high risk features then the same procedure should be followed.

Where there is a significant risk of delirium (for instance before surgery or other procedures) then the person and their carers should be told in advance so they can institute risk reduction measures and look out for it developing.

Orientation is important in reducing delirium and movement of people at risk within and between rooms and wards should be avoided unless absolutely necessary. If move required consider replicating geographical position within ward or room. Access to familiar people (such as carers and families) should be promoted wherever possible, including outside of visiting times. Where possible these people should be invited to become involved in delivering risk reduction care (see appendices 3 and 4). Intravenous lines and urinary catheters should be avoided if possible. Sleep hygiene should be promoted wherever possible with noise and light levels overnight being reduced as far as is safely practicable. Consideration should be given as to whether it is safe to avoid monitors which make noise, minimize checking of observations and avoid giving medications overnight.

Areas with patients who have a high risk of delirium such as orthopedic trauma wards should have protocols for first line use of commonly required medications designed to reduce delirium risk. (see appendix 6)

4) Detection of delirium

Key Points

- All people at high risk should have an assessment for delirium on admission and on every transition of care. This will be prompted by TIME checklist
- 4AT is a screening test and clinical assessment is needed to diagnose delirium
- The mental state of all inpatients regardless of risk factors for delirium should be monitored using the Single Question in Delirium and if there is any change repeat 4AT and TIME should be carried out

Any abnormality in mental state is a possible indicator of delirium – this applies to all patients and not just those with high risk features. This may include confusion, hallucinations, sleepiness, restlessness, withdrawal or change in personality. It may be noticed by the person, their family or carer or the hospital staff caring for them. Families concerns must be taken seriously as they may pick up on subtle changes. Healthcare Support Workers and Allied Health Professionals (including Physiotherapists, Occupational Therapists, Dieticians and Speech and Language therapists) may be well placed to notice these changes – they should be delirium aware, Complete a 4AT and report findings immediately to medical or nursing staff.

On admission high risk individuals should have these factors asked about, with particular emphasis on a change from baseline, and a 4AT carried out. As prompted by the TIME checklist, a healthcare professional who is trained and competent in diagnosing delirium should carry out a clinical assessment. This process should be repeated at every transfer of care.

Throughout a hospital stay a person's mental state should be monitored using the Single Question in Delirium (SQiD) – "Is the person more confused or drowsy than normal"? If there is any concern of change then a 4AT and part T of TIME checklist with a further delirium assessment should be carried out. This is described in appendix 2.

The presence or absence of delirium should be noted in the person's medical record. If the assessor is unsure then a diagnosis of "possible delirium" can be made, and it may be useful for the procedure for management of delirium to be followed until the diagnosis can be confirmed or refuted.

People with a 4AT of 1,2 or 3 may still have cognitive impairment and require further investigation and follow up.

5) Initial management of delirium

Key Points

- If delirium is diagnosed, then parts I, M and E of TIME should be completed
- The entire TIME checklist will prompt good initial management, including identifying and managing all causes and contributors, communication and consideration of capacity for ongoing treatment
- Delirium should be seen as "brain failure" and dealt with immediately and thoroughly
-
- Be aware of the increased risk of complications such as falls and pressure damage and take steps to prevent themDischarge should be considered if can be achieved safely

Delirium should be seen as a medical emergency. Remember that delirium may be caused by critical illness – this is especially likely in previously fit people though can also be the case in the frail. However in up to 30% of cases no cause is found. Good immediate management of delirium can be triggered by using the TIME checklist – all four parts T, I, M and E should be completed where delirium is diagnosed.
A full history (including collateral history), medications review and examination including neurological examination and assessment of pain should be performed.

Investigations should be dictated by the history and examination findings, but as a minimum would usually include NEWS, baseline blood screen including Glucose, calcium and TFT's, ECG, urinalysis/culture and blood/sputum/stool culture as appropriate. Further CNS investigations are not required routinely in delirium, CT brain should be considered if there is head injury, focal neurological signs or decreased level of consciousness, persistent symptoms or if the person is anti-coagulated. EEG should only be considered if there is specific concern about non convulsive status epilepticus and Lumbar Puncture only if specific concern about CNS infection or inflammation.

In people diagnosed with delirium, identify and manage all possible underlying causes.

Contributory factors such as constipation, dehydration, pain, sensory impairment, background noise and sleep disturbance should be proactively addressed. Mobility should be supported if at all possible. A well lit environment should be provided, people should be regularly re orientated and bed moves (within and between wards) should be avoided unless absolutely necessary for the individuals care. Care Rounds should usually be carried out at least 2 hourly initially. People with delirium are at high risk of its complications such as immobility, falls, pressure ulcers ,dehydration, malnourishment and isolation and particular care should be given to risk assessing and preventing these.

Ensure that the diagnosis is documented in the notes and discussed with the patient or their proxy. An information leaflet should be offered.

Ensure effective communication and reorientation (for example explaining where the person is, who they are and what your role is) and provide reassurance – this should be done by all involved members of medical, nursing and AHP staff. The Welcoming Ward project recognises the important role carers and family have in the care team and they should be invited to be involved wherever possible, not just during visiting times. Ask them how they wish to participate in the persons care, including ascertaining if they would like to be supported to stay or to be contacted if the person becomes distressed. (see appendix 4)

Delirium often settles more quickly at home, and if a person's clinical and social situation is such that this can be achieved safely, discharge should be considered.

6) Treatment of delirium symptoms

Key Points

- Specifically detect agitation and distress and assess for the causes
- Initial management of symptoms should be aimed at causative and contributory factors
- Use person centred approach and utilise family and Getting To Know Me document
- If despite these measures there is severe distress or risk to the person or others, drug treatment may be used
- First line treatment **if no contraindications** is
  - Haloperidol 0.5-1mg PO (max 2 mg/24 hours) or only if oral route not possible
  - Haloperidol 0.5mg IM (max 2 mg/24 hours)

QTc interval should be monitored. See Drugs and Therapeutics handbook for details

- Medications should be regularly reviewed and weaned as soon as possible

People with delirium can develop agitation or distress, which may or may not be associated with hallucinations or delusions. Distress should be specifically looked for and the underlying cause(s) assessed for. The TIME checklist

prompts this assessment including physical causes such as pain, thirst or toileting needs (part T) and psychological and social causes (part E). Managing underlying and contributory factors, and using a person centred approach, including use of the Getting To Know Me document and allowing families to reassure and support care, may help symptoms. The Patient Behaviour Monitoring Chart and associated guidance may be useful if there is stressed or distressed behaviours, as may the GGC restraint policy. People may require increased nursing observation as described in "Guidelines for the observation of patients with acute behavioural disturbance in acute division wards". http://www.staffnet.ggc.scot.nhs.uk/Applications/PM/Policy%20Documents/Guidelines%20for%20the%20Observation%20of%20Patients%20with%20Acute%20Behavioural%20Disturbance%20in%20Acute%20Division%20Wards.pdf

However if despite these measures there are psychotic symptoms causing significant distress, or symptoms which threaten the safety of the patient (including their ability to accept necessary medical or nursing care) or of others, low dose medication can be considered. A doctor of FY2 grade or higher should always be involved in the decision to start sedation.

Emergency sedation can be given under common law. More routine sedation requires assessment of the persons capacity to consent (usually not present) and normally can be administered under Section 47 of the Adults with Incapacity Act – see Drugs and Therapeutics Handbook for further details.

Pharmaceutical treatment of delirium is outlined in the Diagnostics and Therapeutics Handbook. First line treatments if there are no signs of Parkinson's disease, Lewy Body Dementia, QTc prolongation or other drugs that can cause QTc prolongation are

- Haloperidol 0.5-1mg orally (max 2 mg/24 hours) or, only if oral route not possible
- Haloperidol 0.5mg IM (max 2 mg/24 hours)

If Haloperidol can not be used because the person is already on drugs that can prolong QTc but cannot be stopped, consider

- Oral Risperidone 250 to 500mcg (up to a maximum of 2mg in 24 hours)
  Use lower dose range in frail or elderly patients

An ECG should be recorded to check the QT interval prior to treatment with antipsychotics or as soon as possible afterwards if the patient is too agitated. QTc interval should be rechecked during the period of treatment. Ensure modifiable risk factors for QTc prolongation are minimised e.g. electrolyte abnormalities (hypokalaemia, hypomagnesaemia, hypocalcaemia), discontinue other drugs know to prolong QTc if possible.

If antipsychotics are contraindicated then consider

- Lorazepam 0.5-1mg orally (max 2 mg/24 hours) or, only if oral route not possible
- Midazolam 2 mg IM (max 6 mg/24 hours)

NOTE: benzodiazepines such as Lorazepam can worsen delirium and so should be used with caution.

Pharmaceutical treatment should be started at the lowest clinically appropriate dose and titrated cautiously. It should usually be given regularly (once or twice daily) for short periods of time rather than purely as required.

If the person's symptoms are not controlled despite the above measures consult senior medical staff. Psychiatry advice may be required.

7) Ongoing management of delirium

Key Points

Delirium should be regularly reassessed

- If delirium fails to settle despite appropriate management refer to local specialist (Geriatrician or Psychiatrist)

- Refer psychiatry at any stage if
  * doubt about diagnosis,
  *severe agitation or distress unresponsive to standard measures
  *consideration of detention under Mental Health Act

- Functional and cognitive assessment should be considered pre discharge.
- If there is persistent cognitive impairment on discharge, appropriate community follow up should be arranged
- On discharge diagnosis should be documented on the Immediate Discharge Letter

Once delirium (or possible delirium) has been diagnosed the individual should be assessed regularly for resolution, which should be documented.

If the delirium improves, sedatives should be reviewed and discontinued as appropriate. Post delirium distress (ie recall of delusional states) should be enquired about. The person's mental state should be monitored for the rest of their admission using the Single Question in Delirium (SQiD) ie is the patient more confused or drowsy .

If delirium fails to improve despite appropriate management as above, or if the delirium is severe, then the patient should be referred to the appropriate local specialist (usually Liaison Psychiatrist or Geriatrician). Delirium can persist for weeks or months after the cause is treated, and occasionally never fully resolve.

Referral to Liaison Psychiatry should be considered at any time if there is

- Severe agitation or distress not responding to standard measures
- Doubt about diagnosis
- Consideration of detention under the Mental Health Act

In all cases of delirium staff need to be aware that there may be persistent or underlying cognitive or functional impairment and appropriate assessment should be considered. If at the time of discharge there is persistent cognitive impairment then appropriate community follow up should be arranged.

The diagnosis of delirium should be made explicit on the discharge summary, which will also allow the episode to be coded.

8) For further information please see

- SIGN 157 Risk reduction and management of delirium
- The Scottish Delirium Association Comprehensive pathway
- NES: Delirium Learn Pro module

- Delirium Learning Education App – available free on Android platform and App Store

PLEASE SEE THE DELIRIUM PAGE ON STAFFNET FOR THE FULL TOOLKIT TO SUPPORT IMPLEMENTATION OF THIS GUIDELINE.

It is accessed via the Acute Services Dementia Page at
http://www.staffnet.ggc.scot.nhs.uk/Acute/Dementia/Pages/PD_Delirium_ASH_171214.aspx

Appendix 1 – TIME and 4AT sheet

4AT and TIME for Detection, Management and Prevention of Delirium

Affix ID Label

NHS Greater Glasgow and Clyde

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

4AT					
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. **Ask the patient to state their name and address to assist rating**	Ward ____ Date & Time _____ _____	Ward ____ Date & Time _____ _____	Ward ____ Date & Time _____ _____	Ward ____ Date & Time _____ _____	Ward ____ Date & Time _____ _____
Normal (fully alert, but not agitated, throughout the assessment)	**0**	**0**	**0**	**0**	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**	**0**	**0**	**0**	**0**
Clearly abnormal	**4**	**4**	**4**	**4**	**4**
(2) AMT4 Ask the patient their **Age**, **Date of Birth**, **Place** (name of hospital) **Current Year**					
No mistakes	**0**	**0**	**0**	**0**	**0**
1 mistake	**1**	**1**	**1**	**1**	**1**
2 or more mistakes	**2**	**2**	**2**	**2**	**2**
(3) Attention Ask the patient **"Please tell me the months of the year in backward order**, starting at **December"**. To assist, one prompt of **"What is the month before December"** is permitted.					
Achieves 7 months or more correctly	**0**	**0**	**0**	**0**	**0**
Starts but scores < 7 months or refuses to start	**1**	**1**	**1**	**1**	**1**
Untestable (cannot participate because too drowsy or inattentive)	**2**	**2**	**2**	**2**	**2**
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	**0**	**0**	**0**	**0**	**0**
Yes	**4**	**4**	**4**	**4**	**4**
4AT TOTAL SCORE					
Print initials of assessor					

Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	**Score 1-3** This is a possible COGNITIVE IMPAIRMENT, and requires further assessment	**Score 0** DELIRIUM or SEVERE COGNITIVE impairment unlikely

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking '**Is the patient more confused or drowsy?**' This is the single question in delirium (SQiD)

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

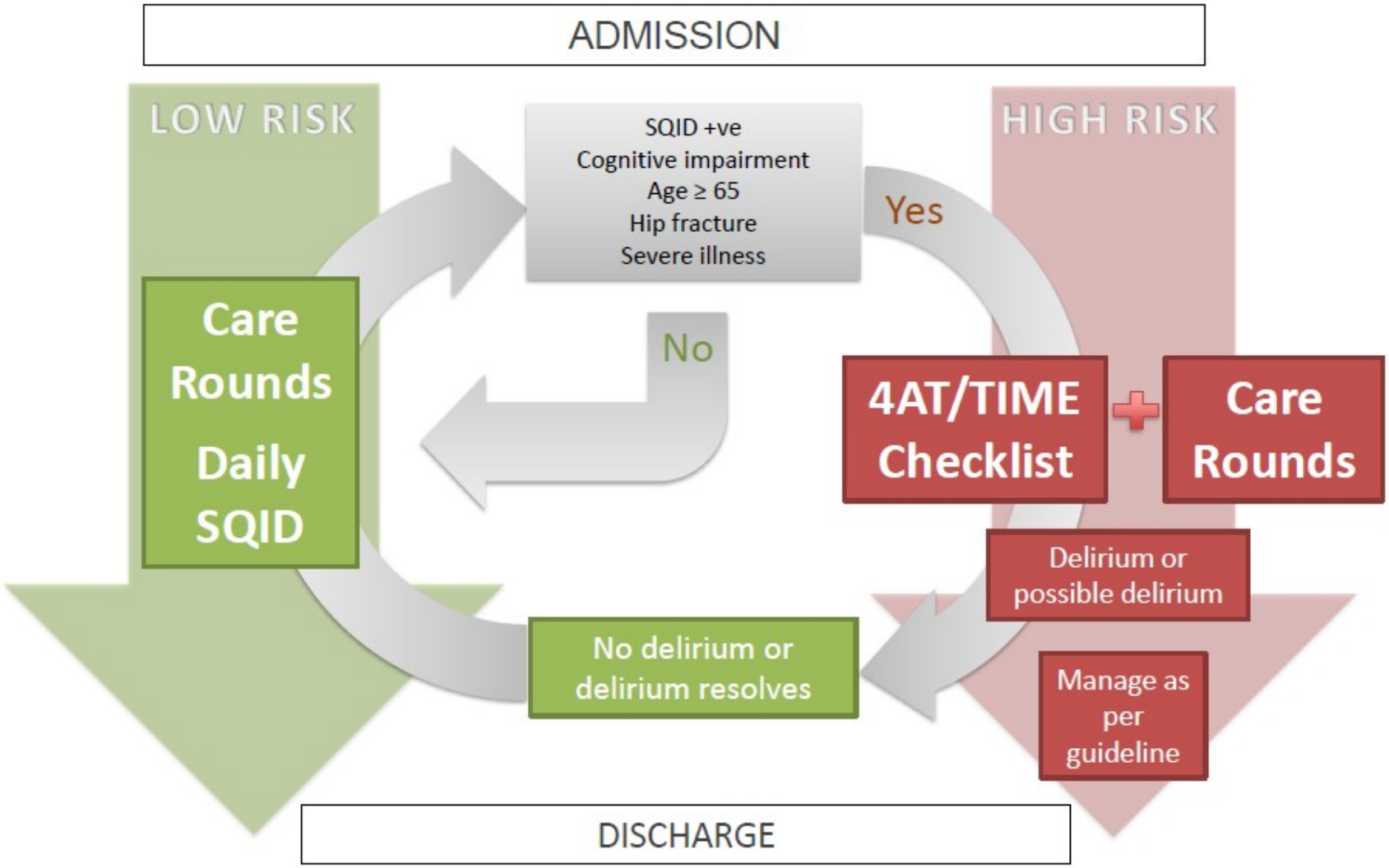
Affix ID Label

NHS Greater Glasgow and Clyde

	Triggers, Investigate, Manage and Engage	Date	Date	Date	Date	Date
	Think possible triggers for delirium	Tick box	Tick box	Tick box	Tick box	Tick box
Triggers	**Is the patient in pain?** Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes/No/Unsure) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	**Investigate**					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	**Management: Diagnose causes & initiate treatment**					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	**Engage and Explore**					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print initials of assessor					

Appendix 2

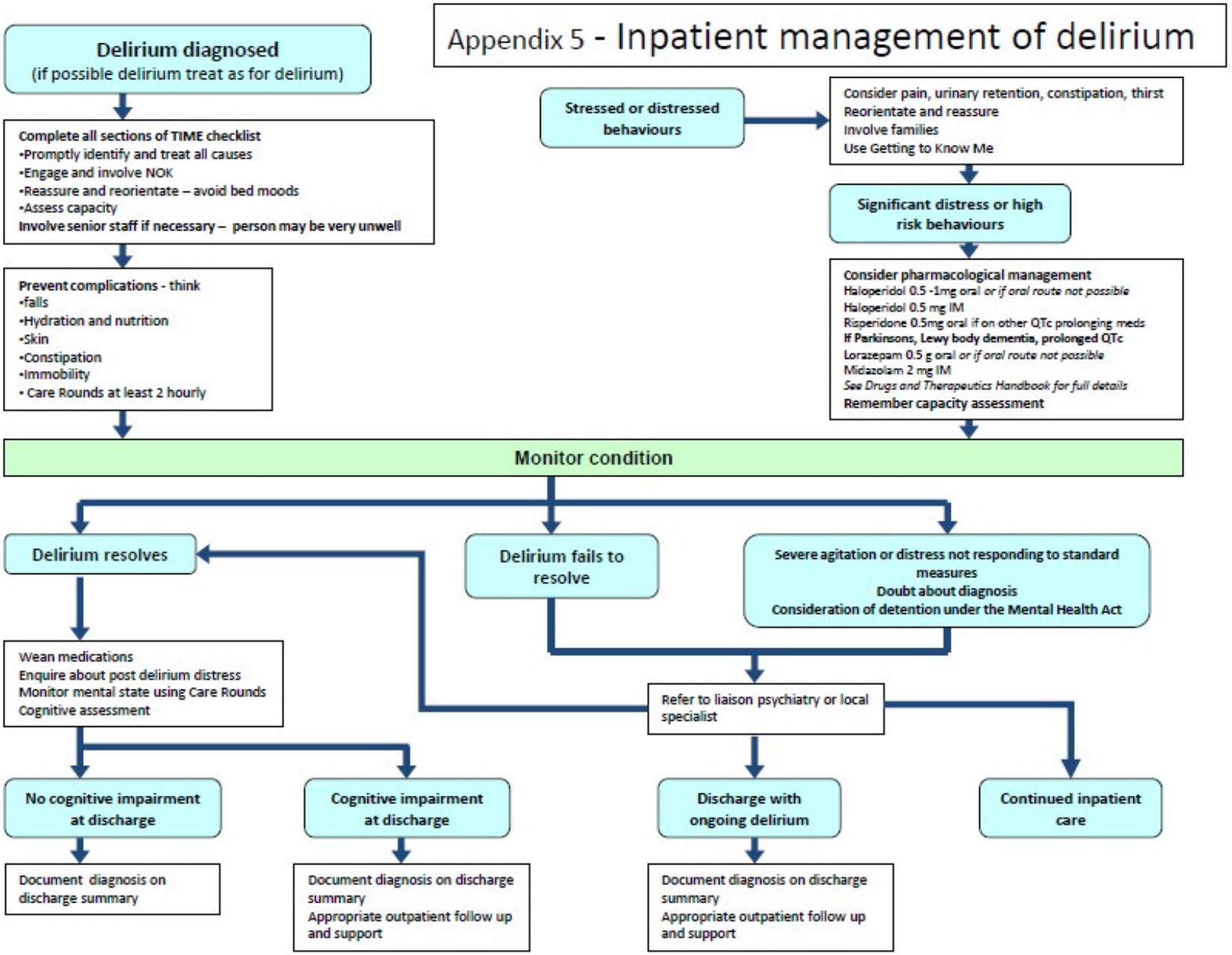
Reducing Risk of and Detecting Delirium using 4AT, TIME and Care Rounds



Appendix 3 Interventions to reduce risk of delirium

Clinical Factor	Preventative Intervention
Cognitive impairment or disorientation	• Provide appropriate lighting and clear signage. A clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk. • Reorientate the person by explaining where they are, who they are, and what your role is. • Introduce cognitively stimulating activities (e.g., reminiscence). • Facilitate regular visits from family and friends.
Dehydration or constipation	• Encourage the person to drink. Consider offering subcutaneous or intravenous fluids if necessary. • Seek advice if necessary when managing fluid balance in people with co morbidities (for example, heart failure or chronic kidney disease).
Hypoxia	• Asses for hypoxia and optimise oxygen saturation if necessary.
Immobility or limited mobility	• Encourage the person to: Mobilise soon after surgery Walk (provide walking aids if needed-these should be accessible at all times) • Encourage all people, including those unable to walk, to carry out active range of motion exercises.
Infection	• Look for and treat infection • Avoid unnecessary catheterisation. • Implement infection control procedures in line with “NHS GG&C on line Infection Control Policy”.
Multiple medications	• All people at risk of delirium should have a medication review conducted by an experienced health professional, taking into account both the type and number of medications.
Pain	• Assess for pain. Look for non-verbal signs of pain, particularly in people with communication difficulties, consider use of the Abbey Pain Tool. • Start and review appropriate pain management in any person in whom pain is identified or suspected.
Poor nutrition	• Follow the NHSGG&C Food, Fluid and Nutritional Care Policy. • If the person has dentures, ensure they fit properly.
Sensory impairment	• Resolve any reversible cause of the impairment (such as impacted ear wax). • Ensure working hearing and visual aids are available and used by the people who need them.
Sleep disturbance	• Avoid nursing or medical procedures during sleeping hours, if possible. • Schedule medication rounds to avoid disturbing sleep. • Reduce noise to a minimum during sleep periods
Prevention, early identification and treatment of postoperative complications	• All the above if done well will help reduce post operative complications • Consideration can also be given to anaesthetic and pain control techniques and programmes to enhance recovery after surgery, though these are outside the scope of this guideline.

Appendix 5 - Inpatient management of delirium



Appendix 4 - Checklist for provision of information taken from SIGN 157

This section gives examples of the information patients/carers may find helpful at the key stages of the patient journey. The checklist was designed by members of the guideline development group based on their experience and their understanding of the evidence base. The checklist is neither exhaustive nor exclusive.

If a patient is at risk of delirium

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

- Ensure that the patient's contact details are on file. If the patient lacks capacity, ascertain whether a family member or carer has Power of Attorney/Guardianship over welfare.

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

- Delirium is common amongst hospitalised patients especially following an operation.
- Acute triggers of delirium include:
  - infection, dehydration, severe constipation, urinary retention, and pain
  - critical illness
  - surgery especially heart and hip operations
  - side effects of new medicines or medicines withdrawal.
- Those most at risk are:
  - older people
  - older people on multiple medicines
  - people with dementia, Parkinson's disease, stroke or pre-existing cognitive impairment
  - people who are hearing or visually impaired.

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 *(see section 9.3.2)*, 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 by doing the following:

- ensure hearing aids, glasses and dentures are available at all times
- talk to and keep the patient informed in short, simple sentences
- check that the patient has understood you and be prepared to repeat if necessary
- keep a calendar and/or clock within view
- bring in some familiar objects from home to the hospital to keep next to the bed side
- if required, encourage the patient to eat and drink.

If a patient develops delirium

Explain to the patient and family/carers that delirium is a change in mental state that often starts suddenly but usually improves when the physical condition improves and the underlying cause gets better.

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

Provide the family/carer with appropriate information leaflets.

It is important for carers and relatives to participate and work together with the clinical team in hospital or home to clear delirium and give the affected person the best chance of getting back to good health.

Explain that the person affected with delirium may show many different types of change. The patient may:

- be less aware of their surroundings
- be unable to speak clearly or follow conversations
- have dreams which can sometimes be frightening and can carry on when they wake up
- hear voices or noises which may not be present (auditory hallucinations)
- see objects or people that are not present or in different context (visual hallucinations)
- get upset that other people are trying to harm them
- be agitated or restless, unable to sit still, and have an increased risk of having a fall
- be sleepy and slow to move and respond
- be reluctant to eat or drink
- have a temporary change in personality
- have all or some of the above and that could quickly change
- have worse symptoms in the evenings or overnight.

Suggest completing a diary so that if the person with delirium cannot remember what has happened the carer can fill in the blanks and help make sense of the experience once the person is starting to feel better.

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

They can help by reassuring and reorienting the patient, eg:

- ensure hearing aids, glasses and dentures are available at all times
- have a gentle and friendly approach, smiling and providing reassurance
- talk and keep the patient informed in short, simple sentences
- check that the patient has understood you and be prepared to repeat if necessary
- familiarity helps, so try to make sure that someone the patient knows well is with them
- try not to agree with any incorrect ideas but disagree with tact and change the subject
- keep a calendar and/or clock within view and give reminders of the surroundings.
- bring in some familiar objects from home to the hospital to keep next to the bed side
- remind the patient to eat and drink and assist if required.

The key is to remain calm and help the affected person feel calm and in control.

At discharge following an acute episode of delirium

Liaise with the family/carers regarding discharge arrangements. Discuss with family/carers whether they need extra support. Some patients may still be recovering, not be entirely themselves or be less able than usual to carry out their daily activities.

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 (GP).

Appendix 6 – Analgesia Protocol

ANALGESIA PROTOCOL
FOR PATIENTS AGED ≥ 65 YRS with FRACTURED NECK OF FEMUR

STEP ONE - From admission prescribe all the medications below:

Regular:

Paracetamol 1g four times daily orally
- *Reduce the dose to 500mg four times daily if the patient weighs<50kg*

Oramorph liquid 2.5 mg four times daily orally (first dose 8hours after FI Block initiated)
- *Morphine 2mg four times daily subcutaneously if unable to take orally*
- *If eGR ≤ 30, reduce Oramorph to 2.5mg twice daily orally or reduce Morphine to 2mg twice daily subcutaneously if unable to take orally*

Laxido 1 sachet orally twice daily

PRN:

Oramorph liquid 2.5mg orally hourly as required
- *Morphine 2mg subcutaneously hourly if unable to take orally*

Buccastem 3mg (placed between upper lip and gum) up to twice daily for nausea

Ondansetron 4 mg intramuscularly / intravenously (over 15mins) up to twice daily for nausea
- *Avoid if QTc interval > 500ms and use Cyclizine 50mg intravenously up to three times daily*

STEP TWO - Review the above prescription after 48hours and alter if required:

- *Assess charted pain score and use of PRN analgesia*
- *Remember pain as a cause of delirium*
- *Consider use of Abbey Pain Chart to assess in cognitive impairment*

Reduce: Regular **Oramorph** liquid orally to **2.5mg twice** daily & leave PRN as before
if the patient is in less pain or is *oversedated (may need to stop if low eGFR. Reduce scut. Morphine to twice daily if nil orally)*

Increase: Regular **Oramorph** liquid orally to **5mg four times** daily
if the patient's pain is inadequately controlled (using PRN analgesia ≥ 4 times daily in addition to the regular analgesia prescription. Increase scut. Morphine to 4mg four times daily if nil orally)

Modify: Consider switch to **Oxynorm** liquid 2mg three times daily orally
if the patient is unable to tolerate Oramorph or has *significant delirium*

STEP THREE - Before discharge home:

Change: **Stop Oramorph or Morphine or Oxynorm** and change to **regular Paracetamol 1g four times** daily orally with **PRN Codeine 15mg** *24 hours before EDD*
- *Reduce the dose of Paracetamol to 500mg four times daily if the patient weighs<50kg*

IMPORTANT NOTES:
- Nefopam, Tramadol, NSAIDs, Co-Codamol and Dihydrocodeine should **be avoided.**
- Known drug sensitivities or medical contra-indications to any of the above medications, should **prevent their prescribing**.
- **Seek senior advice** if clinical prescribing concerns or patient not responding as intended.

Appendix 7 – BGS Coronavirus: Managing delirium in confirmed and suspected cases

https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases