8.0 Delirium

Definition: Delirium is sudden severe confusion and rapid changes in brain function that occur with physical or mental illness. Delirium can last for weeks and even months in older people. See the Royal College of Psychiatrist's website at https://www.rcpsych.ac.uk/mental-health/problems-disorders/delirium for more information on delirium

8.1 What is a patient like with delirium?

- Less aware of what is going on around them
- Disorientated to time and place
- Unable to follow a conversation or to speak clearly
- Has vivid dreams, which are often frightening and may carry on when they wake up
- Hearing noises or voices when there is nothing or no one to cause them.
- Seeing people or things which aren't there
- Worry that other people are trying to harm them
- Very agitated or restless, unable to sit still and wandering about
- Very slow or sleepy
- Sleep during the day, but wake up at night
- Have moods that change quickly. They can be frightened, anxious, depressed or irritable
- More confused at sometimes than at others – often in the evening or at night

8.2 The most common causes of delirium are:

- A urine or chest infection
- Side-effects of medicine like pain killers and steroids
- Dehydration, electrolytes abnormality, anaemia
- Liver or kidney failure
- Suddenly stopping drugs or alcohol
- Major surgery
- Brain injury or infection
- Terminal illness
- Constipation
- Lack of Sleep
- Being in an unfamiliar place

8.3 Assessment of Delirium

- **History:** often need collateral history from relatives /carer
- Full medical examination looking for signs of medical illness
- Investigations:

    - Blood Images, urine tests
    - Complete AMTS and CAM assessment

8.4 Follow E care Delirium assessment including Behavioural indicators of Delirium and 4AT delirium assessment

8.5 Other conditions that mimic Delirium

Always consider other conditions that may mimic Delirium

	DELIRIUM	DEMENTIA	DEPRESSION
Onset	Sudden (hours to days)	Usually gradual (over months)	Gradual (over weeks to months)
Alertness	Fluctuates - Sleepy or agitated	Generally normal	Generally normal
Attention	Fluctuates – difficulty concentrating, easily distractible	Generally normal	May have difficulty concentrating, easily distractible
Sleep	Change in sleeping pattern (often more confused at night)	Can be disturbed –night time wandering and confusion possible	Early morning wakening
Thinking	Disorganised - jumping from one idea to another	Problems with thinking and memory, may have problems finding right word	Slower, preoccupied with negative thoughts of hopelessness, helplessness or self-depreciation
Perception	Illusions, delusions and hallucinations common.	Generally normal	Generally normal

Think of PINCH ME

- **P**ain
- **I**nfection
- **N**utrition
- **C**onstipation
- **H**ydration
- **M**edicine
- **E**nvironment

8.6 Management of violence and aggression in patients living with Dementia

Immediate management should take place in a safe, low-stimulation environment, separate from other service users, preferably with people close to the patient such as relatives or carers around. **Consider with carers their approach to managing the patient's difficult behaviour**

8.7 Non-Pharmacological Management

Improve Communication

Verbal Communication

Do not confront the person

Use VERA and refer to "This is Me" for cues and topics to prevent anxiety

Non-verbal Communication

- Non-verbal cues such as your posture and facial expression will override verbal communication
- Use open hand gestures
- Approach from the front slightly off centre~~s~~
- Maintain eye contact and keep 3 feet so as not to invade personal space
- Be at their eye level

Involve and inform significant others

- Explain the cause of confusion to the relatives/carers
- Assess if the patient prefers to have close people around
- Ask the relatives/carers to bring in familiar objects/pictures/activities into hospital
- Consider with carers their approach to managing the patient's difficult behaviour

Sleep

Promote good non-pharmacological sleep with noise reduction, use of low level light and maintenance of normal sleep/wake cycle

Limit sensory overload

Screen for hearing or visual impairment and offer/provide aids to support/improve sight/hearing

Ensure the patient is not located in a windowless area

Promote a low-stimulation environment e.g. pump alarms/mattress alarms

Nutrition

Avoid malnutrition. To avoid constipation, ensure a good diet, adequate fluid intake and mobilisation are maintained.

Favour mobilisation

Avoid restrictions to mobilisation e.g. catheters/IV infusions

Avoid immobilisation

Check the physical needs of the person

Do they need to use the toilet, are they hungry or thirsty, are they in pain? (PINCH ME)

8.8 Pharmacological Management of Non-Cognitive Symptoms (agitation, aggression, distress, and psychosis)

NB. If giving a person living with dementia sedatives for challenging behavior this must be done alongside a Mental Capacity Assessment (MCA) and if lacking capacity a DOLS (Deprivation of Liberty Safeguards

Antipsychotic medications should be used at the lowest possible dose for the lowest possible time to avoid unnecessary side effects Haloperidol is the preferred option Acute delirium [when non-pharmacological treatments ineffective] Dose: 0.5 mg orally stat can be given then every 2 hourly PRN. Maximum dose :5 mg per 24 hours If the oral route is not possible 0.5mg IM then every 2 hourly PRN maximum 5 mg per 24 hours **Persistent** aggression and psychotic symptoms in moderate to severe Alzheimer's dementia and vascular dementia [when non-pharmacological treatments ineffective and there is a risk of harm to self or others] By mouth • **For Adult** 0.5–5 mg daily in 1–2 divided doses, dose adjusted according to response at intervals of 1–3 days. Reassess treatment after no more than 6 weeks. • **For Elderly** 500 micrograms daily, reassess treatment after no more than 6 weeks	Special populations Avoid in Lewy Body Dementia Parkinson's Disease Known QTc interval prolongation or congenital long QT syndrome In combination with medications which prolong QTc Interval Monitor for extrapyramidal side effects (tremor, rigidity, hypersalivation, bradykinesia, akathisia, acute dystonia. Anti-Parkinson's medications (Procyclidine) may be prescribed as required to manage extrapyramidal symptoms, but it is recommended that they are not prescribed routinely as a preventive measure. Always check BNF for cautions/contra-indications/interactions/dose. Should not be used for more than 5 days
(in combination with Haloperidol) Lorazepam (0.5 mg-1mg) orally- 0.5-1mg PO PRN 4 hourly Maximum 4mg in 24 hours If IM route required, try 0.5-1.0 mg IM maximum dose 4 mg in 24 hours	Flumazenil to hand in case of benzodiazepine-induced respiratory depression

IM diazepam and IM chlorpromazine are not recommended for the management of violence and aggression in Elderly people with dementia.

If rapid tranquillisation is needed, a combination of IM haloperidol and IM lorazepam should be considered.	If the patient is drowsy Vital signs to be monitored every 30 minutes Blood pressure, Pulse, Temperature Respiratory rate Until the patient is fully recovered