Health
Justice Health and
Forensic Mental Health Network

Guidelines for the Management of Delirium

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Introduction

Delirium is a medical emergency and a sign of clinical deterioration. It is serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment. The onset of delirium is usually rapid — within hours or a few days. It usually only lasts for a few days but some symptoms may persist for weeks.

Delirium can often be traced to one or more contributing factors, such as a severe or chronic illness, changes in metabolic balance (such as low sodium), medication side effects, infection, surgery, or alcohol or drug intoxication or withdrawal.

Because symptoms of delirium and dementia can be similar, input from a family member or caregiver may be important for a doctor to make an accurate diagnosis.

Patients with suspected acute delirium should be sent to hospital for an urgent assessment and management until recovered. Patients who require a high level of monitoring are best managed within a hospital setting. If patients are not admitted to a tertiary hospital, they may be transferred to the Medical Subacute Unit (MSU), Long Bay Hospital (LBH) if appropriate until the delirium is resolved. These management principles are multidisciplinary and apply to all clinical streams across the Network. Please refer to Policy *1.037 Long Bay Hospital Admission Policy*.

In rural and regional areas, every effort should be made to ensure that patients are managed in a setting with 24 hour nursing care, which, in general, will be the local hospital.

Symptoms

1. Reduced awareness of the environment. This may result in:
   - An inability to stay focused on a topic or to switch topics
   - Getting stuck on an idea rather than responding to questions or conversation
   - Being easily distracted by unimportant things
   - Being withdrawn, with little or no activity or little response to the environment

2. Cognitive impairment (poor thinking skills).This may appear as:
   - Poor memory, particularly of recent events
   - Disorientation — for example, not knowing where they are or who they are
   - Difficulty speaking or recalling words
   - Rambling or nonsense speech
   - Trouble understanding speech
   - Difficulty reading or writing

3. Behavior changes. These may include:
   - Seeing things that don't exist (hallucinations)
   - Restlessness, agitation or combative behavior
   - Calling out, moaning or making other sounds
   - Being quiet and withdrawn — especially in older adults
   - Slowed movement or lethargy
   - Disturbed sleep habits
   - Reversal of night-day sleep-wake cycle

4. Emotional disturbances. These may appear as:
    - Anxiety, fear or paranoia
    - Depression
    - Irritability or anger
    - A sense of feeling elated (euphoria)
    - Apathy
    - Rapid and unpredictable mood shifts
    - Personality changes

Types of delirium

1. Hyperactive delirium - may include restlessness (for example, pacing), agitation, rapid mood changes or hallucinations, and refusal to cooperate with care.

2. Hypoactive delirium - may include inactivity or reduced motor activity, sluggishness, abnormal drowsiness, or seeming to be in a daze.

3. Mixed delirium - includes both hyperactive and hypoactive signs and symptoms. The person may quickly switch back and forth from hyperactive to hypoactive states.

Suspicion of Delirium

Clinicians should suspect delirium when there is a disturbance of behaviour, thinking, sleep, or orientation. Some factors associated with delirium include substance intoxication, sepsis, hypoxia, medication interaction, intracranial pathology, age>55 years, head injury, pain, acute or severe medical illnesses such as urinary retention and metabolic disturbances.

History

A thorough history should be taken from the patient, including onset of behavioural fluctuations. This must be collaborated by staff or carers as the patient may not be able to give a history. Appropriate handover from the night nurse (in centres where there is a night duty position) or Corrective Services NSW (CSNSW) officer/ Youth Justice NSW (YJNSW) will give further clues regarding the onset of delirium. A history of alcohol and substance abuse, sleep disturbances and nocturnal exacerbation of any of these behaviours may result in delirium.

Confusion Assessment Method (CAM)

The *Confusion Assessment Method (CAM)* Diagnostic Algorithm can be used to assist diagnosis of delirium. The algorithm is also located on the back of the CAM form:

Feature 1: Acute Onset and Fluctuating Course

This feature is usually obtained from a CSNSW/YJNSW officer or nurse and is shown by positive responses to the following questions:

Is there evidence of an acute change in mental status from the patient's baseline?

Did the (abnormal) behaviour fluctuate during the day; that is, did it tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question:

Did the patient have difficulty focusing attention; for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganised Thinking

This feature is shown by a positive response to the following question:

Was the patient's thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of Consciousness

This feature is shown by any answer other than "alert" to the following question:

Overall, how would you rate this patient's level of consciousness?

Alert {normal}, vigilant {hyperalert}, lethargic {drowsy, easily aroused}, stupor {difficult to arouse}, or coma {unarousable}.

CAM diagnosis of Delirium requires presence of features (1) and (2) plus either (3) or (4).

Examination

A clinical assessment must be performed by the nurse. This includes:

- Observations
- eProgress notes in JHeHS
- *Alcohol Withdrawal Score (AWS)* (Paper form JUS110.200), where appropriate.
- *Confusion Assessment Method* assessment.

Patient Management by Nurse

If delirium is suspected, contact appropriate onsite Medical Officer (MO)/Nurse Practitioner (NP) or the most appropriate Remote Offsite After-Hours Medical Service (ROAMS) MO or NP based on the clinical assessment (Primary Care, Mental Health or Drug and Alcohol) and if appropriate send the patient out to hospital as soon as possible. The After-Hours Nurse Manager must also be notified.

Clinical Lead

- The MO/NP must contact their Clinical Director (CD).
- The CD will convene a meeting/teleconference/group email as soon as possible with the other two CDs where a management plan and the Clinical Lead will be decided.
- The Clinical Lead must document the assessment and management plan in the patient's eProgress notes in JHeHS and handover to the Nursing Unit Manager (NUM) and other relevant clinicians.
- The NUM or representative will be responsible for coordination of case management meetings and patient care.

After Hours

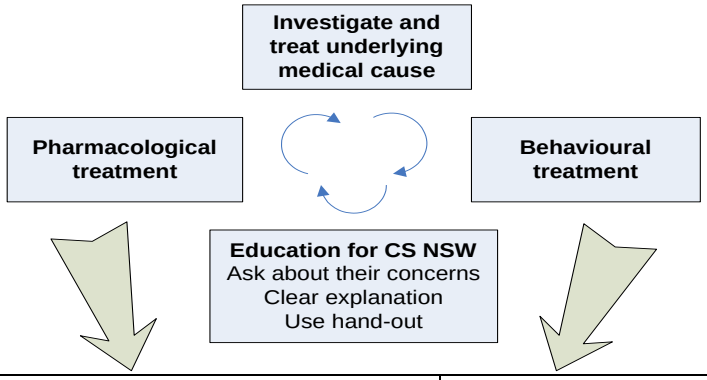
- In addition to actions above, the nurse must contact the After Hours Nurse Manager (AHNM) in accord with *Remote Off-site and After Hours Clinical Services Policy*
- If the patient is sent back to the Health Centre after hours from the external hospital the Health Centre must contact the AHNM.

- The patient may be placed in a 24 hour observation cell in the Health Centre if clinically indicated. The AHNM may organise transfer to the Long Bay Hospital if appropriate utilising the criteria for LBH admission in accord with *Long Bay Hospital Admission Policy 1.037* .

Continued Care

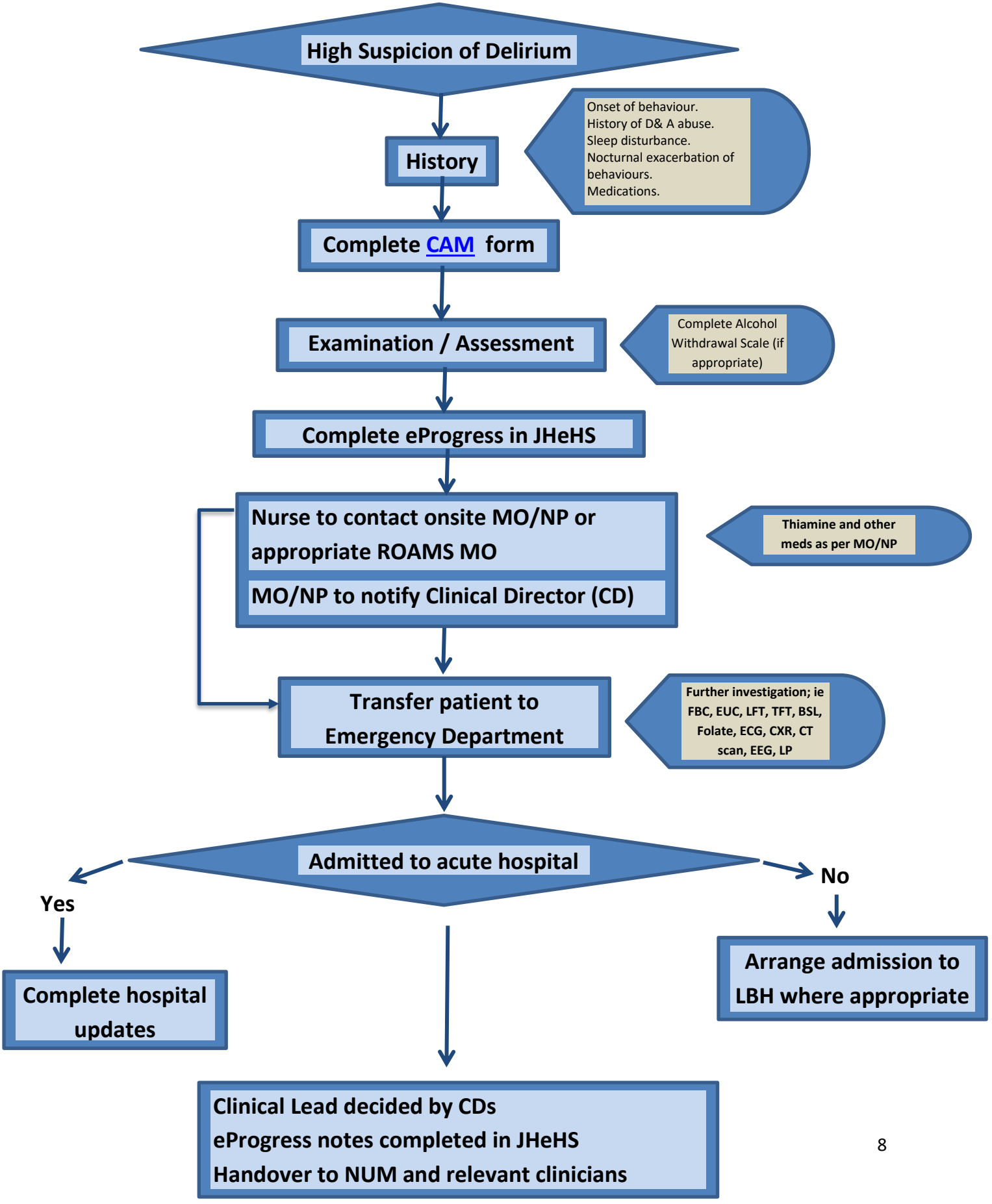
- The Health Centre will continue to get shift by shift updates on the patient in accord with *Policy 1.252 Access to Local Public Hospitals*.
- On discharge from the acute hospital, the Clinical Lead may arrange for the patient to be transferred directly from the external hospital to LBH using the admission criteria in accord with *Policy 1.037 Long Bay Hospital Admission Policy*. Adolescents will generally stay in an acute hospital until well.
- Investigations may include FBC (Full Blood Count), EUC (Electrolytes, Urea, Creatinine), LFT (Liver Function Test), TFT (Thyroid Function Test), BSL (Blood Sugar Level), Urine Drug Screen, MSU, CRP, ECG (Electrocardiography), B12 (Vitamin B12 Deficiency), Folate, CXR (Chest X-Ray), CT scan, EEG (Electroencephalograph), LP (Lumbar Puncture). The tests should be done at the hospital when the patient is sent out. Appropriate follow up may be arranged at the Health Centre or LBH MSU on discharge from the tertiary hospital.

Pharmacological and Behavioural Management



• Use specific medications for known cause, e.g., diazepam in accord with alcohol withdrawal guidelines for medication. • Specific medication regimens: titrate as necessary (see medication guidelines for delirium, alcohol withdrawal and rapid tranquilisation.) • Consider use of antipsychotics as appropriate to aide management of behavioural disturbance. • Consider lower doses in elderly or severely ill. Consider higher doses in young agitated patients. Doses may vary greatly depending on context and comorbidities, e.g., liver disease. • Beware of exacerbating delirium with high doses of antipsychotics and benzodiazepines. • Aim to reduce or rationalise as many medications as possible. Anticipate nocturnal deterioration and adjust time of medication accordingly	• Select appropriate care level, e.g. hospital, 24 hour nursing care in Health Centre. • Maximise behavioural interventions. • Frequent assessment as condition fluctuates. Note agitation and intervene when necessary to prevent build-up of distress. • Gentle, reassuring approach. Regular reassurance, especially regarding safety. Patient may be easily startled. • Keep information/explanation simple. May need repeating. Provide prompts for orientation and memory. • Give Information sheets to Custodial and Network staff as appropriate. • Try to ensure that there is continuity and consistency of staff where possible. • Physical restraint is rarely required.

Delirium Guidelines Flowchart



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