Comprehensive Care

Think about the link

Medical flow chart for delirium screening and management

Delirium Risk Factors

- ☐ Age 65 and over
- ☐ Hip fracture
- ☐ Known cognitive impairment/dementia
- ☐ Cognitive concerns raised by others
- ☐ Severe illness/risk of dying
- ☐ > Age 45 for ATSI population

Delirium screen positive (4AT ≥4) or clinical suspicion of delirium

Assess for delirium and identify the causes of delirium

Obtain a history of the presenting complaint and collateral history

Clinical assessment, full physical examination and cognitive assessment including Confusion Assessment Method (CAM) for Delirium Diagnosis

Medication review

Consider medications effects, side-effects, interactions, toxicity (including prescription and over the counter)

Investigations

FBE, UEC, CRP, LFT, Calcium, TFT, Glucose, ECG and post void residual bladder volume

Consider CXR, AXR, CT brain, blood cultures, drug levels, cardiac enzymes

See **Delirium Order Set In EMR**

Optimise management of co-morbidities

Treat all underlying causes

Medical and nursing management

- Document delirium and provide education to the patient and family
- Assess and treat the pain
- Treat constipation
- Monitor urinary residual volume
- Review pressure risk and falls risk
- Monitor nutrition and review swallowing if any concerns
- Consider the need for 1:1 special

Behavioural and environmental strategies

- Reduce stimulation / noise
- Avoid room changes
- Aim to remove any medical devices as soon as possible (i.e. IDC, IVC, NGT, etc.)
- Have lighting appropriate to time of day
- Encourage family / carer to bring in personal and familiar objects for patient
- Encourage family / carer involvement and visits
- Use a gentle, reassuring approach
- Keep information/explanations simple
- Provide prompts for orientation and memory
- NO mechanical restraints

Treatment of delirium symptoms

- Optimise non-pharmacological management first
- Consider use of medication for distressing symptoms (highly agitated or hallucinating) or if patient at risk of harm to self or others
- Avoid prescribing medication for wandering or calling out behaviours
- Use lowest effective dose for shortest period of time
- MUST obtain consent prior to using anti-psychotic medication from MDTM or Office of Public Advocate, unless emergency

Consider a referral to SNAP/Delirium CNC for advice or assistance with ward management of a patient with delirium

For further advice on the management of delirium consider a discussion with a Geriatrician or Geriatric Registrar

Refer to the Delirium guidelines, section on acute pharmacological management for delirium

See Western Health Delirium Guidelines for more comprehensive information