KEY DOCUMENT 1
OVERVIEW

HOW TO IDENTIFY AND MANAGE DELIRIUM IN THE COMMUNITY
VERSION 1 FEBRUARY 2021
This document and the optional resources listed below can be downloaded on the Dementia United website.

(For those over the age of 18 and not under the influence of drugs and/or alcohol)

Please note this is a guide only and clinical judgement should be exercised particularly regarding any red flags e.g. delirium following a fall or head injury, new neurology or patients taking anti-coagulation medication.

TIME FRAMES
Delirium is a medical emergency. As part of the NHS Long Term Plan for out of hospital care, urgent community response should aim to be given within two hours in a crisis with a two-day referral for reablement care.

1. Single Question Delirium SQiD
New confusion should be identified using the SQiD, single question to identify delirium (Sands et al, 2010). That is ‘Do you think (the patient) has been more confused lately’ and or seemed more drowsy. If the answer is yes it should prompt further assessment as below.

2. Complete 4AT Assessment (Key Document 2)
The 4AT is recommended for use for identification of patients with probable delirium. It is quick and easy to use. Pay attention to the 4AT guidance notes.
   - A score of 4 or above suggests delirium +/- underlying dementia
   - A score of 1-3 suggests possible cognitive impairment (unspecified)
   - A score of 0 suggests cognitive impairment is unlikely to be present

   • Testing attention is the key e.g. the months of the year backwards, or counting backwards from 20 down to 1
   • Altered arousal. How sleepy are they? Not holding a string of conversation together?
   • Liaise with someone who knows the person well to determine if they have become suddenly more confused – family, care home staff, care provider

RESTORE2 (5) (Recognise Early Soft Signs, Take Observations, Respond, Escalate) may be useful to refer to if used in the care home setting. This is only a suggested example, as you may have other suitable tools, already in use in your organisation.
3. Confirm whether the person has delirium

If delirium is suspected based on the 4AT assessment, **someone appropriately qualified** should confirm whether or not the person has a delirium diagnosis and record in the patient notes.

This is important as those who experience delirium are more likely to experience it again in the future, and those over the age of 65 are more likely to develop dementia.

**What is delirium?**

**Definition** Delirium is defined as “a disturbance of consciousness that is accompanied by a change in cognition that cannot be better accounted for by a pre-existing or evolving dementia”

**Characteristics of delirium** defined by the DSM-V criteria:

- Disturbance in attention (reduced ability to direct, focus, sustain, and shift attention) and awareness
- The disturbance develops over a short period of time (usually hours to days), represents a change from baseline, and tends to fluctuate during the course of the day
- An additional disturbance in cognition (memory deficit, disorientation, language, visuospatial ability, or perception)
- The disturbances are not better explained by another pre-existing, evolving or established neurocognitive disorder, and do not occur in the context of a severely reduced level of arousal, such as coma
- There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication or withdrawal, or medication side effect

Additional features that may accompany delirium and confusion include:

- Psychomotor behavioural disturbances such as hypoactivity, hyperactivity with increased sympathetic activity, and impairment in sleep duration and architecture
- Variable emotional disturbances, including fear, depression, euphoria, or perplexity

**Delirium subtypes**

Delirium has been classified into subtypes depending on the changes in level of consciousness:

- Hyperactive (restlessness, agitation, non-purposeful walking, insomnia)
- Hypoactive (drowsiness, somnolence, withdrawn)
- Mixed: alternating hyperactive and hypoactive subtypes
The table below provides information on how delirium, dementia and depression differ, which we hope will assist with making the diagnosis.

The three D’s – delirium, dementia and depression

<table>
<thead>
<tr>
<th></th>
<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
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<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Sudden (hours/days)</td>
<td>Usually gradual and progressive (months and years)</td>
<td>Gradual (weeks/months)</td>
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<tr>
<td><strong>Duration</strong></td>
<td>Usually less than a month</td>
<td>Years to decades</td>
<td>Months, can be chronic</td>
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<tr>
<td><strong>Course</strong></td>
<td>Reversible, when causes identified</td>
<td>Not reversible, progressive deterioration</td>
<td>Recovers within months, can relapse</td>
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<tr>
<td><strong>Alertness, levels of consciousness</strong></td>
<td>Fluctuates (sleepy/agitated) known as hyper or hypo types</td>
<td>Generally normal or slowed</td>
<td>Generally normal</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td>Fluctuates, difficulty concentrating, easily distracts</td>
<td>Generally normal</td>
<td>May have difficulty concentrating</td>
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<tr>
<td><strong>Sleep</strong></td>
<td>Change in pattern, often awake through the night and more confused</td>
<td>Can be disturbed / night time wandering and confusion possible as disease progresses-</td>
<td>May experience early morning wakening, or difficulty in getting off to sleep</td>
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<tr>
<td><strong>Thinking</strong></td>
<td>Disorganised – jumping from one idea to another</td>
<td>Abstract thought problems, poor judgement, sometimes problems word finding</td>
<td>Slower, preoccupied with negative thoughts e.g. hopelessness/ helplessness/ self-depreciation</td>
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<tr>
<td><strong>Perception</strong></td>
<td>Illusions, delusions and hallucinations common</td>
<td>Generally normal in early stages</td>
<td>Generally normal</td>
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If delirium is diagnosed, continue with steps outline below. If delirium is not diagnosed, manage as appropriate.

4. Complete the Greater Manchester community delirium TIME bundle

If delirium is strongly suspected or diagnosed, initiate the Greater Manchester community delirium TIME (Triggers, Investigations, Management, Engage) bundle (Key document 3 Greater Manchester community delirium TIME Bundle).
Please review the below resources to ensure you have everything you need to carry out each element of the TIME bundle

Some Optional Resources are included in this toolkit, but you may have appropriate tools that you already use in your organisation. The links to the Optional Resources are provided in the Toolkit contents document are can be accessed here Greater Manchester Community Delirium Toolkit - Dementia United (dementia-united.org.uk)

TRIGGERS

- Optional Resource 7: Abbey Pain Scale
- Blood pressure monitor
- Thermometer
- Optional Resource 8A: Paper Weight Arm band can be used to indicate malnutrition
- Optional Resource 8B: Monitoring fluid, food intake and oral hygiene
- Optional Resource 9: Health Education England Mouth Care Assessment Guide
- Optional Resource 10: Bristol Stool Chart
- Pulse oximeter
- Glucometer
- Bladder Scanner (may be useful for urinary retention)
- Optional Resource 11: West Essex CCG Anticholinergic side-effects and prescribing guidance

INVESTIGATIONS

- Local organisation blood request forms please stating Urgent Delirium Bloods to be done in 24hrs

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<tr>
<th>FBC</th>
<th>UE</th>
<th>LFT</th>
<th>Calcium Magnesium</th>
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<tr>
<td>CRP</td>
<td>Glucose</td>
<td>Phosphate</td>
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- Optional Resource 12: Bury UTI Assessment Tool
- Catheter Specimen Urine Sample Kit
- Newcastle Urine Collection pack (from Sterisets International for when someone is wearing an incontinence product) - can be purchased via NHS Supply Chain item FSW1451 Browse products in section 'Specimen collectors' - NHS Supply Chain Online Catalogue
- Midstream Specimen of Urine Sample Kit
- ECG (may be useful if indicated)
MANAGEMENT

- GM Delirium Management Guidance (Key document 4)
  - Continuing to treat other conditions
  - Manage medications
  - Monitor and reduce the risk of the person developing pressure ulcers
  - Monitor and reduce the risk of the person experiencing falls
  - Recovery and assessing for returning to baseline

Please refer to the Key document 4 for a more detailed consideration of the following aspects in the Management of delirium

ENGAGEMENT

- GM Delirium Management Guidance (Key document 4)  
  Engagement with family members and informal and formal carers, to assist with supporting and monitoring for signs of improvement or not for person with delirium and in undertaking to:
  - Meet the needs of reassurance, orientation and occupation
  - Meet the needs of physical comfort and well-being
  - Meet the needs to feel safe, secure and receive comfort and reassurance when distressed

  - Optional Resource 13A: Greater Manchester Nutrition and Hydration: Eat, Drink, Live Well
  - Optional Resource 13B: Eating and drinking well – supporting people living with dementia
  - Optional Resource 13C: Keep GM Moving: Moving More at Home
  - Optional Resource 13D: GM COVID-19 specific guide for living well at home
  - Optional Resource 14: Alzheimer’s Society “This is Me” document

- GM Delirium Leaflets (Key documents 5). There are two leaflets, a longer and shorter version. Please go through these with the person with delirium and their family. The longer version has a ‘person centred care plan’ to complete at the end.
  - The briefer version can be accessed via the link here, as well as other resources offering training to support the toolkit Delirium toolkit training resources - Dementia United (dementia-united.org.uk)

Whilst it is understood that a hospital admission can be even more distressing and disorientating for someone with delirium, this is necessary sometimes. Any pre-work completed (eg the 4AT and/or working through the TIME bundle) can be handed to the hospital team to continue the person’s delirium assessment and management.
GET IN TOUCH

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