**Greater Manchester**

**hospital delirium management and engagement guidance – for medical teams**

Key document 4a

Note: this is a working document and will be updated on the dementia united website: [www.dementia-united.org.uk](http://www.dementia-united.org.uk)

**For those over the age of 18 and not under the**

**Influence of drugs and/or alcohol**

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This document and the other key documents and optional resources listed below can be accessed via the Dementia United website (<https://dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit>)

This guidance forms part of the **M**anagement and **E**ngagement component of the TIME bundle; within the Greater Manchester Hospital Delirium Toolkit. It is not intended to be exhaustive of all medical management and engagement aspects, when supporting someone with delirium. We recognise that not all the guidance will apply. It sits alongside the Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[1]](#endnote-2) which has a more nursing and person-centred care focus.

We anticipate that you will be using this as a guide as a point of reference to consider and return to. This will assist with systematically considering and eliminating aspects and will help to formulate a standardised approach to management.

**Medical management**

Management of delirium begins with the identification and assessment for delirium. **Complete the 4AT which is a delirium screening requirement (NICE 2023).**

1. 4 A’s Test for delirium screening (see **key document 2** of the [hospital toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[2]](#endnote-3)

The 4AT is recommended for use for identification of patients with probable delirium. It requires little training and is quick and easy to use. A score of 4 or above suggests delirium +/- underlying dementia

1. A score of 1-3 suggests possible cognitive impairment (unspecified)
2. A score of 0 suggests cognitive impairment is unlikely to be present

Pay attention to the 4AT guidance notes.

1. Testing attention is the key e.g., the months of the year backwards, or count 20 to 1.
2. Altered arousal. How sleepy are they? Not holding string of conversation together?
3. Liaise with someone who knows the person well to determine if they have become suddenly more confused – family, care home staff, care provider.
4. The 4AT has been translated in to 20 different languages and therefore we suggest using these with a translator - accessible [via the link](https://www.the4at.com/4at-translations) [[3]](#endnote-4)

Please note that despite updated guidance on how to assess for new confusion as part of NEWS2, the scoring as currently implemented cannot be relied upon for delirium detection (Vardy et al 2022). The recommendation from NHS England (2023) of the triple assessment using the 4AT, NEWS2 and Clinical Frailty Scale recommended by the Getting It Right First Time (GIRFT) geriatric medicine report may be a meaningful way forward for older patients.

The next step in the medical management is **identifying the cause or causes of delirium**. It is worth noting that other complications may arise which can exacerbate the delirium or relapse an improving delirium.

Always return to use the PINCH ME Triggers and build in regular reviews, document the frequency of the review and when to bring forward or indications of improvement.

The PINCH ME infographic (shown below) acts as a quick reminder of delirium triggers. It is vitally important that you work through all possible triggers. Please see the[Greater Manchester hospital delirium TIME Bundle (Triggers, Investigations, Management, Engagement) (Key Document 3 of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[4]](#endnote-5)](https://dementia-united.org.uk/wp-content/uploads/sites/4/2021/07/Hospital-Delirium-TIME-Bundle-.docx).



British Geriatric Society 2021

The next step in the medical management is **focusing on ongoing management of delirium principles**.

**Review medications** the person is taking for other conditions, as these may need to be reduced or stopped, if it is felt that they may contribute to sustaining the person’s delirium.

* Review any new medications that may have caused delirium. For example, steroids, or opiates, those with anticholinergic properties – refer to [Hints and tips for anticholinergic burden (ACB) medication reviews](https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1491&checksum=226d1f15ecd35f784d2a20c3ecf56d7f)[[5]](#endnote-6).
* Accurate quantification of anticholinergic burden is important in assessing relative risks versus benefits of prescribing anticholinergic medications. In this review, the Anticholinergic Drug Scale and the Anticholinergic Cognitive Burden scale and the average daily dose and cumulative dose measures, were determined to be well suited for the quantification of anticholinergic exposure Lozano-Ortego et al (2019)
* [ACB Calculator](https://www.acbcalc.com/) [[6]](#endnote-7)
* Consider discontinuing any medication if it is medically appropriate.
	+ Do not stop long-term benzodiazepines or other psychotropic medications.
* Careful titrating of any prescribed opiates, being mindful of side effects, and minimising these where appropriate e.g., prescribing laxatives.

Consider the use of nicotine replacement therapy as needed. Ask about alcohol intake and consider prescribing for withdrawal as per your hospital guidelines.

Consider if the person requires ear plugs where increased noise on the ward impacts their sleep.

In those **people who are drowsy and sleepy** with hypoactive delirium **particular attention needs to be paid** to pressure area relief, nutrition and hydration and vigilance for hypostatic pneumonia.

The duration of delirium can vary widely, with delirium lasting a few days in most people. Persistent delirium (that is, lasting for weeks or months) is not rare, with 20% of people exhibiting some symptoms of delirium at 6 months (Wilson et al 2020). When managing persistent delirium, it is vitally important that you continue to return to these management guidelines and address any areas where the person requires support.

Wilson et al (2020) noted that consensus guidelines make several recommendations for delirium prevention in various health-care settings, for multicomponent interventions such as:

• Early recognition of high-risk factors (age >65 years, dementia, hip surgery and high acuity)

• Daily screening for delirium

• Environmental orientation (sensory, auditory, dentures, time, events, family visits and music)

• Maintain normal hydration

• Regulation of bladder and bowel function

• Early establishment of normal diet

• Correction of metabolic disorders

• Cardiorespiratory optimization (with provision of oxygen if appropriate)

• Early identification of infection

• Effective treatment of pain

• Daily mobilisation

• Avoidance of antipsychotic drugs

• Avoidance of benzodiazepines

• Reduced nocturnal disturbances to promote sleep

• Sleep promotion (eye mask and earplugs)

People experiencing delirium may present with behaviours that we find challenging. Some people will need to feel safe, secure, and reassured when agitated and distressed, in the context of delirium.

**The message behind the behaviour**

Because of the way delirium affects the brain, the person may have lost some of the inhibitions that would have prevented them from showing their feelings in this way previously. But the feelings being expressed now are important because they represent the person’s way of saying something significant. And we need to understand the message. This could be, for example, ‘I feel like a prisoner’, ‘I’m frightened – I don’t understand what’s going on’, ‘I’m in pain’, or ‘I’m so frustrated’.

Detect, assess, and treat **causes of agitation and/or distress** by treating the underlying cause and using non-pharmacological means wherever possible. Please refer to **Greater Manchester hospital delirium management and engagement guidance –for non-medical** teams (Key **Document 4b of the** [**hospital delirium toolkit**](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit)**)[[7]](#endnote-8)** which provides more detailed information on non-pharmacological approaches, multidimensional person-centred care interventions which evidence suggests will make a difference.

Where non-pharmacological means alone are not reducing the patient’s distress, please refer to your local Trust guidance on the use of medication. Some **general principles to consider in terms of the use of medication for agitation and distress.**

* There is no evidence supporting the use of medication to sedate when delirium is present. If medication is needed, it is so important to be weighing up each patient’s specific risks of using medication (effects, side-effects) versus not using medication.
* This weighing up, needs to include the patient/family including abiding the Mental Capacity Act principles in relation to mental capacity assessment and best interest decision making.
* A formal mental capacity assessment may be needed in relation to care and treatment decisions. [MCA: Assessing capacity | SCIE](https://www.scie.org.uk/mca/practice/assessing-capacity) [[8]](#endnote-9)
* The Mental Capacity Act (MCA) applies to everybody involved in the care, treatment, and support of people aged 16 and over who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity. Anyone caring for or supporting a person who lacks capacity could be involved in assessing capacity.
* Guidance on the MCA and principles to be applying to person centre care decisions can be found on the [DU website](https://dementia-united.org.uk/mental-capacity/) [[9]](#endnote-10) with links to films and key documents to guide clinicians.
* Booklets for staff, the person who is being assessed and their family members on the MCA can be accessed via the links below too.
* [This booklet is for health and social care staff and covers what is mental capacity, how to assess capacity, best interests, providing care and treatment](https://www.ouh.nhs.uk/patient-guide/safeguarding/documents/health-workers-guide.pdf) [[10]](#endnote-11)
* This booklet is in relation to – [Making decisions about your health, welfare or finance. Who decides when you can’t?](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365631/making_decisions-opg601.pdf)[[11]](#endnote-12)
* This booklet is in relation to  [Making decisions A Guide for family, friends and other unpaid carers](https://dementia-united.org.uk/wp-content/uploads/sites/4/2021/10/Making-decisions-A-Guide-for-family-friends-and-other-unpaid-carers.pdf) [[12]](#endnote-13)
* What to **consider when weighing up;** the risks of the person remaining very distressed and the need to introduce medication that may result in increased risks of sedation, resulting in reduced eating and drinking and increased falls.
* Broad principles should be that non-pharmacological treatment should be tried before consulting local guidance for medication.
* A person with delirium will do their best to let others know how they are faring and what they need through their behaviour, if other communication channels begin to fail. Using antipsychotic drugs as an early response to behaviour that challenges others often creates additional problems for the person and effectively silences their message.
* “Antipsychotics are often accompanied by unpleasant and dangerous side effects, and studies have estimated that there are at least 1,800 extra deaths each year among people with dementia as a result of taking antipsychotics” (Department of Health, 2009)
* Agar (2020) “Before the institution of any pharmacological strategy, it is important for a careful assessment of the causes and degree of distress, the patient’s and/or family’s interpretation of the symptoms and signs and have made an assessment of whether the agitation is more distressing than the possible distress caused by the potential sedation and loss of meaningful communication, which could occur from a pharmacological approach. This should be considered both at the time of prescribing, but also re-assessed when administering as needed medications. “
* It is also worth noting that, Wilson et al (2020) found in their systematic review, that data were generally of poor quality with regards to the treatment of delirium with anti-psychotics. Antipsychotic agents had no effect on delirium severity, symptom resolution and reporting of adverse effects was absent or poor.
* **Cautions are needed with the introduction of medication**, with careful monitoring of use and possible side-effects and a written plan to review (frequency/risks to be considered) and to discontinue as soon as is clinically possible. To specify when the medication is being reviewed or discontinued; build in review dates and clear instructions for this.

**Meeting the needs at the end of life**

Delirium is important to consider at the end of life. It may be almost universal in non-sudden death, especially in those with [dementia](https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-dementia)[[13]](#endnote-14). Delirium has a poor prognosis, regardless of how well it is identified, investigated, and treated, especially the hypoactive (drowsy) form. Half of those with delirium on general and geriatric medical wards will die within six months [End of Life Care in Frailty: Delirium | British Geriatrics Society (bgs.org.uk)](https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-delirium)[[14]](#endnote-15) and [End of Life Care in Frailty | British Geriatrics Society (bgs.org.uk)](https://www.bgs.org.uk/resources/resource-series/end-of-life-care-in-frailty)[[15]](#endnote-16)

Distinguishing delirium in the person who is imminently dying with reversible delirium is a key clinical challenge. This can be more challenging too, when the person has an underlying diagnosed dementia or cognitive impairment.

* Symptoms and causes of distress in the person with delirium at end of life are often multifactorial.
* Clear information and shared decision making are needed for all elements of the management plan Davies and Iliffe (2020)
* [This guide](https://dementia-united.org.uk/wp-content/uploads/sites/4/2021/01/03-UCL-Rules-of-Thumb-Guide-v14.0_PRINT-version.pdf)[[16]](#endnote-17) has been created for any healthcare professionals providing care and support for people with dementia at the end of life. It can be used for training, to support decision-making, and help you have discussions with family members and advocates.

Agitation and restlessness

* Look for an underlying cause, as you would do for delirium assessment. Agitation and restlessness may not always be caused by dementia. If there is no identifiable cause, then consider non-drug treatments, e.g., music therapy, massage or aromatherapy, and trial pain relief.
* Towards the end of a person’s life, you should only continue medication or interventions that are likely to maintain their comfort and quality of life. The same goes for starting them on any new medication or interventions. Davies and Iliffe (2020)

**Medical engagement**

**Early explanation to family members and caregivers** about the diagnosis, cause, investigation, management and prognosis of delirium should be undertaken by an experienced clinician.

* Written information should also be provided, such as the [GM Delirium leaflet](https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Long-Version-June-2023.docx)**[[17]](#endnote-18)** This includes going through the longer leaflet with the person and the completion of the person-centred care plan at the end of the leaflet. This will enable the person and family members to have this information and share when needed themselves.

Symptoms such as paranoia/hallucinations, problems with delivery of nutrition and hydration, and legal and ethical complications may need **the input of specialist staff**.

* In these circumstances, advice should be sought from the Mental Health Liaison team or a Geriatrician, or allied health professionals, or colleagues from safeguarding and quality.
* Monitor recovery and consider specialist referral to a geriatrician or mental health liaison if not recovering.

Aim to **prevent the complications** of delirium such as immobility, falls, pressure sores, dehydration, malnourishment, and isolation.

**Recovery from delirium**

During the period of recovery, steps should be taken to avoid a relapse of the delirium (see section below on Delirium prevention).

* Part of preventing delirium includes minimising ward moves. Moving people who have a delirium from one bed area to another will exacerbate the delirium, increasing complications, morbidity, mortality, and length of stay.
* Similarly, even when a person has recovered from delirium, unnecessary ward moves may result in a delirium relapse with the associated consequences and risks of patient harm.

Ensure that you have provided the person and family with the GM Delirium leaflets**[[18]](#endnote-19)** and have spent time explaining the leaflet and consider completing the person-centred care plan, at the end of the leaflet.

Some people will not recall their episode of delirium. Some will experience flashbacks as parts of it return and some will recall of their episode. Encourage the person to talk things through with yourselves or the nursing team.

Following recovery from an episode of delirium, please consider the following:

* Always add the diagnosis of delirium into the patient’s Electronic Patient Record.
* Highlight the presence of delirium in the related section of the discharge summary.

Refer for **follow-up** anyone with **resolving delirium** when considering discharge, or where you consider they would require a formal cognitive assessment when discharged. This includes the need for the involvement of community teams to facilitate review and monitoring of resolving delirium in the community and engagement in relation to short-term increased need for care and support and equipment.

* It is therefore vitally important to ensure that the presence of resolved and/or resolving delirium is communicated clearly to all community and primary care colleagues. Plus:
	+ - Inform the GP if follow up is required, in order for this to be actioned.
		- Inform the patient and family, so they can follow this up too.

**Delirium prevention**

Some people are at higher risk of developing delirium than others. For example, people who have experienced delirium previously are at higher risk of developing it again. This highlights the importance of screening for delirium in high-risk groups and adopting delirium prevention strategies. It is vitally important that this information is relayed to the person and family members. The **main risk factors for developing delirium** include:

* Advancing age
* Dementia
* Hip fracture
* Previous history of delirium
* Multiple co-morbidities
* Polypharmacy

In high-risk groups, it is important to take steps to both **prevent delirium** developing in the first place, which include:

* + - * Pain management
			* Management of constipation, avoidance of urinary catheters
			* Support with nutrition and hydration
			* Promoting sleep hygiene
			* Medication review
			* Provision of sensory aids (glasses and hearing aids)
			* Early mobilisation
			* Environmental considerations e.g., noise, consistent staffing, avoid unnecessary ward moves
1. **List of full links to resources**

 **Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b)**

[www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit) [↑](#endnote-ref-2)
2. **4 A’s Test for delirium screening (Key Document 2)**

www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit [↑](#endnote-ref-3)
3. **Translated delirium resources - Dementia United**

[https://dementia-united.org.uk/translated-delirium-resources](https://dementia-united.org.uk/translated-delirium-resources/) [↑](#endnote-ref-4)
4. **Greater Manchester hospital delirium TIME Bundle (Triggers, Investigations, Management, Engagement) (Key Document 3)**

www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit [↑](#endnote-ref-5)
5. **Hints and tips for anticholinergic burden (ACB) medication reviews**<https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1491&checksum=226d1f15ecd35f784d2a20c3ecf56d7f> [↑](#endnote-ref-6)
6. **ACB Calculator**

[www.acbcalc.com](http://www.acbcalc.com) [↑](#endnote-ref-7)
7. **Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b)**

[www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit) [↑](#endnote-ref-8)
8. **MCA: Assessing capacity | SCIE**

[www.scie.org.uk/mca/practice/assessing-capacity](http://www.scie.org.uk/mca/practice/assessing-capacity) [↑](#endnote-ref-9)
9. **Mental Capacity - Dementia United**

[www.dementia-united.org.uk/mental-capacity](http://www.dementia-united.org.uk/mental-capacity) [↑](#endnote-ref-10)
10. **Mental capacity act - Making decisions: a guide for people who work in health and social care** [www.ouh.nhs.uk/patient-guide/safeguarding/documents/health-workers-guide.pdf](http://www.ouh.nhs.uk/patient-guide/safeguarding/documents/health-workers-guide.pdf) [↑](#endnote-ref-11)
11. **Mental capacity act - Making decisions about your health, welfare or finances. Who decides when you can’t** <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365631/making_decisions-opg601.pdf> [↑](#endnote-ref-12)
12. **Making decisions: a guide for family, friends, and other unpaid carers**

<https://dementia-united.org.uk/wp-content/uploads/sites/4/2021/10/Making-decisions-A-Guide-for-family-friends-and-other-unpaid-carers.pdf> [↑](#endnote-ref-13)
13. **BGS - End of Life Care in Frailty: Dementia**

[www.bgs.org.uk/resources/end-of-life-care-in-frailty-dementia](http://www.bgs.org.uk/resources/end-of-life-care-in-frailty-dementia) [↑](#endnote-ref-14)
14. **BGS - End of Life Care in Frailty: Delirium**

[www.bgs.org.uk/resources/end-of-life-care-in-frailty-delirium](http://www.bgs.org.uk/resources/end-of-life-care-in-frailty-delirium) [↑](#endnote-ref-15)
15. **BGS - End of Life Care in Frailty**

<https://www.bgs.org.uk/resources/resource-series/end-of-life-care-in-frailty> [↑](#endnote-ref-16)
16. **UCL: Rules of Thumb** <https://dementia-united.org.uk/wp-content/uploads/sites/4/2021/01/03-UCL-Rules-of-Thumb-Guide-v14.0_PRINT-version.pdf> [↑](#endnote-ref-17)
17. **Greater Manchester delirium leaflet: long version**

<https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Long-Version-June-2023.docx> [↑](#endnote-ref-18)
18. **Greater Manchester delirium leaflet: long version**

<https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Long-Version-June-2023.docx>

**Greater Manchester Delirium Leaflet: Short Version June**

<https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Short-Version-June-2023.docx>

**GET IN TOUCH**

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 [↑](#endnote-ref-19)