SCOPE: National

Inclusion Criteria	Exclusion Criteria
Meet Confusion Assessment Method (CAM) criteria for diagnosis of delirium (see below). Must have: 1 Acute onset and fluctuation of cognition 2 Inattention (distractible and/or difficulty keeping track). For example, can't repeat the months of the year backwards or count backwards from 30 to 1; And either 3 Disorganised thinking (rambling and/or unclear and/or irrelevant conversations); **or** 4 Altered level of consciousness (may range from hyper alert through to coma).	• Known chronic confusion (without acute onset) • Psychiatric diagnosis (eg mania/psychosis) • Simple sleep deprivation

Considerations when Seeking Cause of Delirium

- Endeavour to obtain accurate history from carers/family/hospital records/case notes.
- Nursing clues to possible development of delirium
  - Transiently more confused than before
  - Unexpected episode of incontinence, eg UTI
  - Sleep less well
  - More anxiety
  - Off food and not participating
- Obtain baseline vital signs, if possible (Temperature, Blood Pressure, Mini-Mental State Examination and Blood Sugar Level).
- Patients with delirium rarely offer easy examination
- Perform gentle physical examination (dependant on history) with a particular focus on:
  - Looking and listening first
  - Noting colour, respiratory rate, sweating and limb movements.
  - Only do invasive tests if it will alter management (may need to guess and treat without final proof), for example:
    - Positive u/a without culture
- Participating factors
- Any acute insults?
  - **Medical**
    - Usually are at least three new factors
    - They are linked, for example UTI/fever/dehydration/constipation/renal failure. All contribute
  - **Iatrogenic**
    - Any drugs! Beware of any drug and/or alcohol withdrawals
    - Attachments/invasions, eg IV lines, indwelling catheter

Treatment

Development of delirium may be an end of life presentation in individuals with life limiting disease. The focus of treatment in these individuals will be focussed on symptom control to maximise quality of life (refer to reference list regarding evidence based clinical guidelines for adults in the terminal phase) (6).

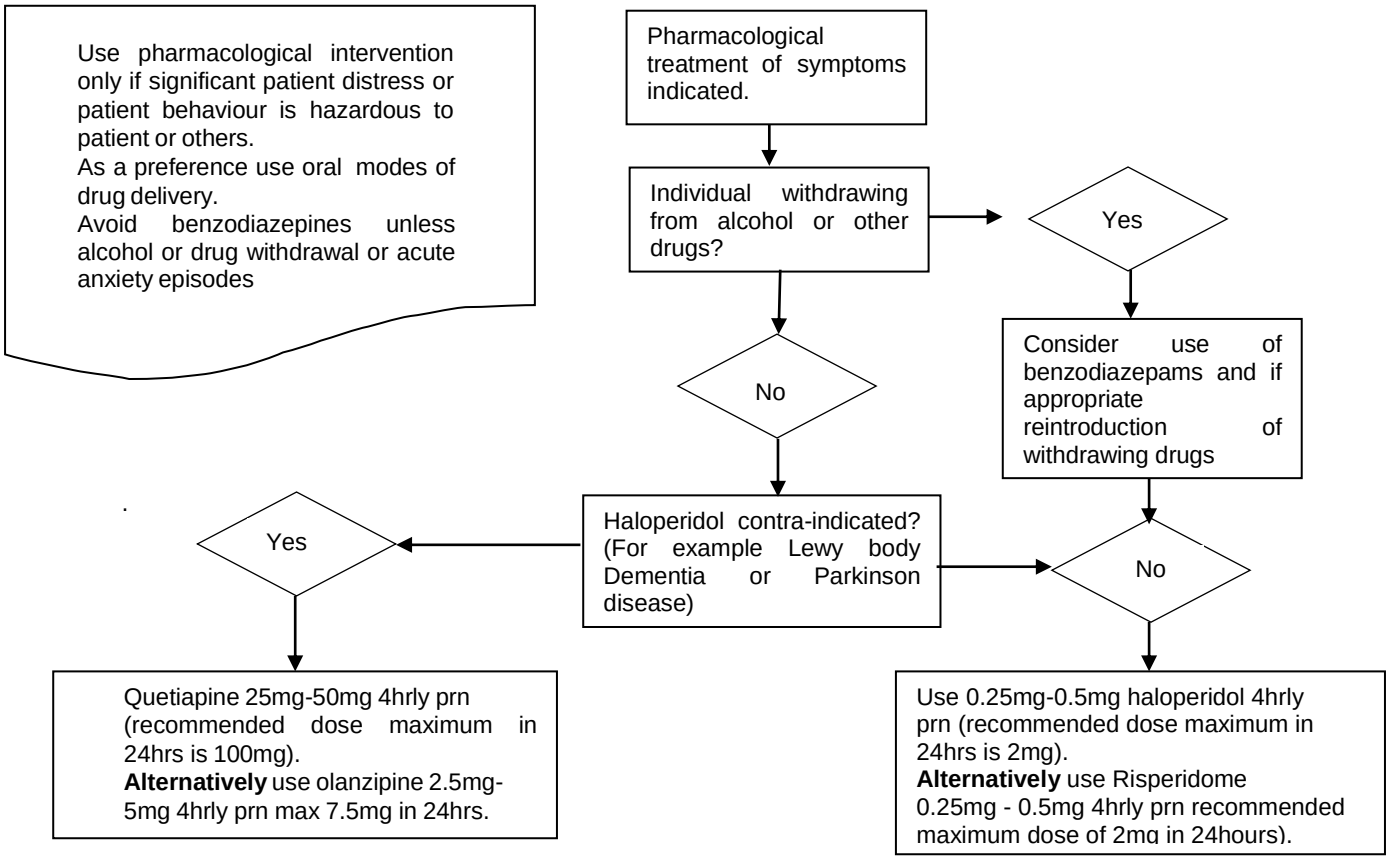
Active treatment of delirium may involve both non-pharmacological and pharmacological treatment strategies. A non-pharmacological approach is the first approach, however, in the case of severe agitation with subsequent physical risk of injury to the patient and or carer pharmacological treatment strategies are useful as a short term strategy.

NON-PHARMACOLOGICAL TREATMENT STRATEGIES INCLUDE

- Try and identify and manage precipitants
- Communicate in straightforward manner using family or known carers to assist
- Non-pharmacological best
- Good nursing care
- Re-orientate
- Rehydrate-fluids/food regularly
- Encourage sleep - try and be quiet
- Properly fitting glasses/hearing aids

PHARMACOLOGICAL TREATMENT STRATEGIES

Pharmacological treatment of delirium symptoms should only be considered if the individual is a danger to themselves or others or if the symptoms are causing the individual considerable distress.



PBS PRESCRIBING ADVICE

- Haloperidol available as unrestricted PBS item.
- Risperidone as authority PBS script.
- Quetiapine, and olanzapine (PBS authority item, **not available** for treatment of delirium).
- These medications will be available through the Priority Response Assessment service.

MEDICAL GOVERNANCE

Client has access to medical governance support twenty four (24) hours per day, seven (7) days a week. Care delivery is planned and provided in consultation with the client, medical practitioner/specialist holding medical governance and nursing staff. Medical specialists may retain medical governance with treatment interventions delivered by Silver Chain. When governance is retained by a Silver Chain medical practitioner the client will have a medical review within twenty four (24) hours of admission and scheduled follow-up up as required. In the instance when a client's condition deteriorates the Silver Chain medical practitioner or nursing staff will confer with an emergency department medical practitioner. All Silver Chain medical practitioners are formally credentialed. Medical practitioner holding governance will determine when the client can be discharged and a summary is sent to the referrer or client's general practitioner.

REFERENCES

1 Inouye, K. van Dyck, C. Alessi, C. Balkin, S. Siegal, A. Horwitz, R. Clarifying confusion: the confusion assessment method A new method detection of delirium. Annals of Internal Medical 1990 113 941-948.

2 Inouye, K. Charpentier, P. Precipitating factors for delirium in hospitalised elderly persons: predictive model and inter-relationship with baseline vulnerability. JAMA 1996; 275: 852-7

3 Rolfson, D. The causes of delirium. In: Lindesay J, Rockwood K, Macdonald A, eds. Delirium in the elderly. Oxford: Oxford University Press, 2002: 101-22.

4 Flacker, J. Marcantonio, E. Delirium in the elderly: optimal management. Drugs Ageing 1998;13: 119-30

5 Australian Society for Geriatric Medicine position statement number 13 Delirium in Older People Dr Sean Maher - 14 September 2005.

6 Government of Western Australia Department of Health. (2010). Management of Terminal Restlessness/Agitation. WA Cancer and Palliative Care Network Evidence based clinical guideline for adults in the terminal phase.

APPENDIX A

Predisposing Factors

Old age
Multiple diseases
Frailty
Dementia
Severe illness
Admission to hospital with infection or dehydration
Visual impairment
Deafness
Renal impairment
Malnutrition
Polypharmacy
Alcohol excess

Precipitating Factors

- Infections (Chest/urinary)
- Constipation/Urinary retention
- Electrolyte disturbance
- Organ failure
- Hypoxia
- Alcohol withdrawal
- Uncontrolled pain
- Neurological insults
- Sleep deprivation
- Surgery
- Restraint use and malnutrition each quadruple the risk of delirium.
- Adding three (3) medications and use of bladder catheter each treble the risk of delirium
- Medications contribute to about 40% of the causes of delirium
- Psychoactives and those that cross the Blood Brain Barrier are most likely
- Common classes of drugs implicated are:
    - Anti-Cholinergic drugs are particularly likely to cause delirium
    - Anti-Parkinson's/benzodiazepines/lithium/anti-
    - Depressants/antipsychotics/anti-convulsants
    - Anti-arrhythmics/anti Hypertensives/histamine antagonists
    - Corticosteroids/opiate analgesics/NSAIDS/OTC and herbal preps
    - Antihistamines and antispasmodics