Early Identification and Initial Management of Delirium in the Emergency Department / Acute Medical Assessment Unit

OLDER PEOPLE | EMERGENCY MEDICINE | ACUTE MEDICINE | NCPS National Clinical Programme in Surgery

Introduction: **Delirium** is an acute change in cognitive function that has an organic cause and is likely to be reversible or preventable. All patients **aged ≥65 years** require screening for delirium on arrival to hospital. Whenever possible get a collateral history.
If cognitive impairment is new - **AWAYS THINK DELIRIUM**

Older Adult (>65) presents to ED/AMAU

Nurse Assessment after Triage: Perform "4AT" Delirium Screen

Result of 4AT

≥4	Possible Delirium: Assign Triage 2
1-3	Possible Cognitive Impairment
0	Delirium or severe cognitive impairment unlikely (but delirium still possible if information incomplete - use clinical judgment)

No evidence of delirium

Proceed with admission/ discharge plan, **as per assessment**

Ensure documentation of cognitive status on ED/AMAU Notes

If any concerns about cognitive impairment consider arranging follow-up via GP

Possible Delirium is a Medical Emergency*

Flag for ADMISSION

1. Discuss diagnosis with senior doctor and nurse in ED/AMAU
2. Discuss diagnosis with carer/relative
3. Start search for causes of delirium

(Remember there is frequently more than one -see Checklist Box on right)

Ensure admitting team know that Delirium is suspected

**Delirium has a high mortality and the vast majority of these patients will need admission. Exceptionally and only after senior discussion should a patient with delirium be discharged.*

Patient Flow to source Urgent Bed

This patient will require enhanced supervision while in ED e.g. increased falls risk, wandering

Reduce Delirium in ED

Avoid sedatives, unless distressed and/or combative and felt to be a threat to themselves or others
Avoid physical restraints and use of urinary catheters, if possible
Ensure adequate fluids/ nutrition (ensure accessible drinks/snacks, if appropriate)
Avoid constipation
Promote relaxation and sufficient sleep in a quiet area
Early and regular mobilisation
Regular reality orientation using visual and auditory aids
Encourage independence with Activities of Daily Living
Manage any pain, using dementia friendly pain score e.g. PAINAD
Medication review

Managing someone with delirium who is **distressed and/or combative and felt to be a threat** to themselves or to others

1. **ALWAYS try to deescalate the situation** first**.** Explain gently what is happening, re-orientate. Try to nurse in a quiet area and consider the need for 'one to one' care.

2. If **medication** is needed for **behavioural issues** (only if patient or others are at risk OR essential care is compromised) use **small doses and increase gradually**. Try **ORAL** therapies first e.g. lorazepam 0.5-1mg. Consider an antipsychotic agent in those with *psychotic* symptoms e.g. haloperidol, olanzapine (avoid in those with Lewy Body Dementia or Parkinson's Disease).

3. If oral therapies fail consider IM or IV sedation. This decision must be made by a **senior doctor** (i.e. Middle Grade Registrar/ Consultant). As with any sedation this should be administered in an area where the patient can be properly monitored and where airway support is available (Resuscitation Room in the ED).

4AT

Validated rapid assessment tool for delirium/cognitive impairment screening at first contact with patient: incorporates AMT4

1. Alertness

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

2. AMT4 (*4-item Abbreviated Mental Test)*
Age, Date of Birth, Place (name of hospital/building), Current Year

No mistakes	**0**
1 mistake	**1**
≥2 mistakes/untestable	**2**

3. Attention - Months of the year Backward

Achieves 7 months or more correctly	**0**
Starts but scores <7 months / refuses to start	**1**
Untestable (cannot start because unwell, drowsy, inattentive)	**2**

4. Acute Change or fluctuating symptoms?

NO	**0**
YES	**4**

Total ____

Initial Check list for Potential Causes of Delirium

- Check for hypoxia/ hypotension/ hypoglycaemia
- Check if patient has pain
- Check for visual or hearing impairment
- Check for urinary retention (consider ultrasound)
- Check for constipation
- Check for recent addition or withdrawal of medication. Especially benzodiazepines or opiates
- Check for major electrolyte disturbance
- Check for an infection- e.g. UTI/ LRTI
- If infection is suspected refer to Sepsis Screening Tool (links overleaf)
- Check if alcohol withdrawal syndrome is possible
- Check for pre-existing cognitive impairment or prior history of delirium
- Check for history of depression

Further work up by admitting team as indicated

References:

NICE CG 103 (delirium) https://www.nice.org.uk/guidance/cg103

NICE CG 10 (Violence) https://www.nice.org.uk/guidance/ng10

Bellelli G, Morandi A, Davis DH, Mazzola P, Turco R, Gentile S, Ryan T, Cash H, Guerini F, Torpilliesi T, Del Santo F, Trabucchi M, Annoni G, Maclullich AM. Validation of the 4AT, a new instrument for rapid delirium screening: a study in 234 hospitalised older people. Age Ageing. 2014 Jul; 43(4):496-502.

Lees R, Corbet S, Johnston C, Moffitt E, Shaw G, Quinn TJ. Test accuracy of short screening tests for diagnosis of delirium or cognitive impairment in an acute stroke unit setting. Stroke. 2013 Nov; 44(11):3078-83.

O'Regan NA, Ryan DJ, Boland E, Connolly W, McGlade C, Leonard M, Clare J, Eustace JA, Meagher D, Timmons S. Attention! A good bedside test for delirium? J Neurol Neurosurg Psychiatry. 2014 Oct; 85(10):1122-3

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. J Am Med Dir Assoc. 2003 Jan-Feb; 4(1):9-15.

Sepsis Pathway Links

http://www.hse.ie/eng/about/Who/clinical/natclinprog/sepsis/sepsis%20management.pdf

http://www.hse.ie/eng/about/Who/clinical/natclinprog/sepsis/EDSepsisPathway.pdf

http://www.hse.ie/eng/about/Who/clinical/natclinprog/sepsis/Adult%20Sepsis%20In-Patient%20Screening%20Form.pdf

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