Delirium – demystifying the confusion

Dr Claire Copeland
Consultant Physician in Stroke and Elderly Medicine
What does delirium mean to you?
Learning objectives

• What is delirium?
• Why is it important?
• Screening
• Treatment & real life
Older people in Acute hospital

• Older people occupy 2/3 of NHS beds

• Approximately 60% have, or will develop mental disorder
  – Depression mean prevalence = 29%
  – Dementia mean prevalence = 31%
  – Delirium mean prevalence = 20%

Who cares wins, RCPSYCH, 2005
- Acute confusional state
- Acute organic syndrome
  - Toxic psychosis
- Post operative psychosis
  - ‘not quite right’
  - ‘poor historian’
  - ‘away with the fairies’
    - ‘off feet’
Why is delirium bad?
### Mortality (NICE 2010)

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>log(Odds Ratio)</th>
<th>SE</th>
<th>Odds Ratio 95% CI</th>
<th>Odds Ratio 95% CI</th>
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</thead>
<tbody>
<tr>
<td><strong>1.5.1 In hospital</strong></td>
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<tr>
<td>Inouye 1998</td>
<td>-0.35667</td>
<td>0.65</td>
<td>0.70 [0.20, 2.50]</td>
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<tr>
<td>O’Keeffe 1997</td>
<td>0.95551145</td>
<td>0.556435</td>
<td>2.50 [0.87, 7.74]</td>
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<td><strong>1.5.2 In ICU</strong></td>
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<tr>
<td>Lin 2004</td>
<td>2.56494936</td>
<td>0.804123</td>
<td>13.00 [2.69, 62.87]</td>
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<td><strong>1.5.3 In ICU &amp; hospital</strong></td>
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<tr>
<td>Lin 2008 HR</td>
<td>0.989541</td>
<td>0.327972</td>
<td>2.89 [1.41, 5.12]</td>
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<tr>
<td>Thomason 2005 HR</td>
<td>0.2390169</td>
<td>0.435742</td>
<td>1.27 [0.54, 2.98]</td>
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<td><strong>1.5.4 6 weeks</strong></td>
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<td>Drame 2008 HR</td>
<td>0.53062825</td>
<td>0.187237</td>
<td>1.70 [1.18, 2.45]</td>
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<td><strong>1.5.5 3 mo.</strong></td>
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<tr>
<td>Inouye 1998</td>
<td>0.47000363</td>
<td>0.353647</td>
<td>1.60 [0.80, 3.20]</td>
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<td><strong>1.5.6 6 mo.</strong></td>
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<tr>
<td>Ely 2004 HR</td>
<td>1.16315081</td>
<td>0.446</td>
<td>3.20 [1.34, 7.67]</td>
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<td>Francis 1990 RR</td>
<td>0.58778666</td>
<td>0.434</td>
<td>1.80 [0.77, 4.21]</td>
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<tr>
<td>Holmes 2000 RR</td>
<td>1.05779209</td>
<td>0.251657</td>
<td>2.88 [1.76, 4.72]</td>
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<tr>
<td>Levkoff 1992</td>
<td>0.26236426</td>
<td>0.39</td>
<td>1.30 [0.61, 2.79]</td>
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<tr>
<td>Marcantonio 2000</td>
<td>0.09531018</td>
<td>0.654324</td>
<td>1.10 [0.31, 3.97]</td>
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<tr>
<td>O’Keeffe 1997</td>
<td>0.33647224</td>
<td>0.353647</td>
<td>1.40 [0.70, 2.80]</td>
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<td><strong>1.5.7 1 year</strong></td>
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<tr>
<td>Leslie 2005 HR</td>
<td>0.48242615</td>
<td>0.184605</td>
<td>1.62 [1.13, 2.33]</td>
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<tr>
<td>Pitkala 2005</td>
<td>0.62057649</td>
<td>0.264309</td>
<td>1.86 [1.11, 3.12]</td>
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<tr>
<td><strong>1.5.8 2 years</strong></td>
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<tr>
<td>Francis 1992 RR</td>
<td>0.33647224</td>
<td>0.290672</td>
<td>1.40 [0.79, 2.47]</td>
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<tr>
<td>Nightingale 2001 HR</td>
<td>0.87713402</td>
<td>0.16024</td>
<td>2.40 [1.76, 3.29]</td>
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<tr>
<td>Pitkala 2005</td>
<td>0.56531381</td>
<td>0.238344</td>
<td>1.76 [1.10, 2.81]</td>
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<td><strong>1.5.9 3 years</strong></td>
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<tr>
<td>Rockwood 1999 HR</td>
<td>0.53649337</td>
<td>0.263905</td>
<td>1.71 [1.02, 2.87]</td>
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</tr>
</tbody>
</table>

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*Note: SE = Standard Error, Odds Ratio = Relative Risk*
Cognition

- Accelerates cognitive decline (Fong 2009)
- Associated with developing dementia in non-demented (Lundstrom 2003)
- Dementia is a risk factor for delirium (Inouye 1993)
Institutionalization (NICE 2010)

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>log(Odds Ratio)</th>
<th>SE</th>
<th>Odds Ratio IV, Fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1 at discharge</td>
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<tr>
<td>Balas 2009</td>
<td>1.974081</td>
<td>0.671334</td>
<td>7.20 [1.93, 26.84]</td>
</tr>
<tr>
<td>Bourdel-M 2004 [prevalent]</td>
<td>1.160021</td>
<td>0.445974</td>
<td>3.19 [1.33, 7.65]</td>
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<tr>
<td>Bourdel-M2004 [incident]</td>
<td>0.970779</td>
<td>0.591963</td>
<td>2.64 [0.83, 8.42]</td>
</tr>
<tr>
<td>Inouye 1998</td>
<td>1.09861229</td>
<td>0.379611</td>
<td>3.00 [1.43, 6.31]</td>
</tr>
<tr>
<td>Levkoff 1992</td>
<td>1.98787435</td>
<td>0.526764</td>
<td>7.30 [2.60, 20.50]</td>
</tr>
<tr>
<td>1.2.2 3 months</td>
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<tr>
<td>Inouye 1998 3 months</td>
<td>1.09861229</td>
<td>0.353847</td>
<td>3.00 [1.50, 6.00]</td>
</tr>
<tr>
<td>1.2.3 6 months</td>
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</tr>
<tr>
<td>O'Keeffe 1997</td>
<td>1.02961942</td>
<td>0.394388</td>
<td>2.80 [1.29, 6.07]</td>
</tr>
<tr>
<td>1.2.4 2 years</td>
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<tr>
<td>Pitkala 2005</td>
<td>0.89608802</td>
<td>0.358234</td>
<td>2.45 [1.21, 4.94]</td>
</tr>
</tbody>
</table>
Why is delirium bad?

• Increased length of stay
• Post traumatic stress
DSM IV criteria

- Disturbance of *consciousness* (i.e. reduced clarity of awareness of the environment) occurs, with reduced ability to focus, sustain, or shift *attention*.

- Change in *cognition* or the development of a *perceptual disturbance* that is not better accounted for by a pre-existing, established, or evolving dementia.

- The disturbance *develops over a short period* (usually hours to days) and tends to *fluctuate* during the course of the day.

- Evidence from the history, physical examination, or laboratory findings is present that indicates the disturbance is caused by a direct physiologic consequence of a general medical condition, an intoxicating substance, medication use, or more than one cause.
What’s actually reported....

• ‘This isn’t my Mum’
• ‘Something has changed’
• ‘He was really confused last night but seems ok now.’
• ‘You need to do something – she’s trying to leave the ward!!!’
It’s an acute medical disorder manifesting as a psychiatric illness i.e. behaviourally
Delirium vs Dementia

**DELIRIUM**
- Acute
- Inattention
- Clouding of consciousness
- Fluctuations/minutes
- Reversible
- Hallucinations common

**DEMENTIA**
- Gradual
- Memory disturbance
- Clear consciousness
- None/days
- Irreversible
- Hallucinations common only in advanced disease

*It is common for Delirium to be superimposed on Dementia!*
Pathogenesis

Not sure

• Prob neuroinflammmatory – peripheral conditions causing an acute brain dysfunction

• Direct brain insults eg infection, drugs, stroke

• ‘aberrant stress response’ to mild insult ie over reaction & exaggerated response
Vulnerable brain

- Age
- Frailty
- Severe illness
- Sensory impairment
- Polypharmacy
- Comorbidity
- Cognitive impairment
Precipitating factors

- Infection
- Pain
- Constipation
- Medications
- Dehydration
- Surgery
- Nutrition
What do I say to families/carers?

- Brain fog
- Fluctuations
- Honesty – ‘I’m not sure how long or if it’ll get better’
- Delirium leaflet
Delirium

- **Subtypes**
  - Hyperactive (20%)
  - Hypoactive (50%)
  - Mixed (30%)

- **Persistent**
  - Symptoms may last up over 6 months (6-13%)
  - Associated with greater mortality x 3
How to diagnose it

- CAM
- 4AT
- EEG
- Biomarkers
- RADAR
Confusion Assessment Method (CAM)

1. Acute onset and fluctuating course
2. Inattention
3. Disorganised thinking
4. Altered level of consciousness

Must have presence of 1 & 2 and either 3 or 4
# The 4A Test: Screening Instrument for Cognitive Impairment and Delirium

**Patient name:**

**Date of birth:**

**Patient number:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Tester</th>
</tr>
</thead>
</table>

**4AT Score**

<table>
<thead>
<tr>
<th><strong>[1] ALERTNESS</strong></th>
<th>CIRCLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>This includes patients who may be markedly drowsy (e.g., difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient if asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.</td>
<td></td>
</tr>
<tr>
<td>Normal (fully alert, but not agitated, throughout assessment)</td>
<td>0</td>
</tr>
<tr>
<td>Mild sleepiness for &lt; 10 seconds after waking, then normal</td>
<td>0</td>
</tr>
<tr>
<td>Clearly abnormal</td>
<td>4</td>
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</tbody>
</table>

**[2] AMT4**

Age, date of birth, place (name of the hospital or building), current year.

| No mistakes | 0 |
| 1 mistake | 1 |
| 2 or more mistakes/untestable | 2 |

**[3] ATTENTION**

Ask the patient: “Please tell me the months of the year in backwards order, starting at December.” To assist initial understanding one prompt of “what is the month before December?” is permitted.

<table>
<thead>
<tr>
<th>Months of the year backwards</th>
<th>Achieves 7 months or more correctly</th>
<th>Starts but scores &lt; 7 months / refuses to start</th>
<th>Untestable (cannot start because unwell, drowsy, inattentive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieves 7 months or more correctly</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**[4] ACUTE CHANGE OR FLUCTUATING COURSE**

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g., paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

| No | 4 |
| Yes | 4 |

**4 or above:** possible delirium +/- cognitive impairment

1-3: possible cognitive impairment

0: delirium or cognitive impairment unlikely (but delirium still possible if [4] Information Incomplete)

**Guidance Notes**

Information and download: www.thethe4AT.com

The 4AT is a screening instrument designed for rapid and sensitive initial assessment of cognitive impairment and delirium. A score of 4 or more suggests delirium but is not diagnostic; more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. Items 1-3 are rated solely on observation of the patient at the time of assessment. Item 4 requires information from one or more source(s), e.g., your own knowledge of the patient, other staff who know the patient (e.g., ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

**Alcohol:** Elevated level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4** (Abbreviated Mental Test - 4): This score can be extracted from items in the full 4AT if done immediately before. Acute Change or Fluctuating Course: Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, “Are you concerned about anything going on here?” “Do you feel frightened by anything or anyone?” “Have you been seeing or hearing anything unusual?” in general hospital settings psychotic symptoms most often reflect delirium rather than functional psychosis (such as schizophrenia).
4AT

- Alertness
- AMT 4
- Attention
- Acute & fluctuating change
4AT

- Prof Alasdair MacLullich et al 2011
- 236 patients over 4 months
- Sensitivity 89.7% and specificity 84.1% for delirium
THINK DELIRIUM

What is delirium?

The word 'delirium' is used to describe a severe state of confusion that can happen when someone becomes unwell. Delirium is common and can start suddenly. Some people become very sleepy while others become very agitated.

Delirium can be caused by illness, medication, and surgery or a combination of causes.

Delirium usually improves when the condition causing it gets better. It can be frightening - not only for the person who is unwell, but also for those around them.

What can I do?

If you notice a sudden change in your relative’s usual behavior as this helps us detect delirium.

Delirium is distressing for everyone, but once the underlying cause for the severe confusion has been treated, the distressing symptoms will usually improve.

We encourage patients, relatives, and carers to talk openly about their experiences following delirium as this may help to speed up the person's recovery.

For more information, please speak to a member of staff.
Delirium Immediate care guidance bundle – TIME

This should be used for all patients aged 65 and over when 4AT score is 4 or above. All elements should be initiated within 24 HOURS.

**DATE:** __________  **TIME INITIATED:** ___________  **4AT SCORE:** ________  **INITIATING DR/NURSE SIGNATURE:** ___________

<table>
<thead>
<tr>
<th>TIME - initiate all elements (INITIAL &amp; WRITE TIME OF COMPLETION)</th>
<th>Date Assessed</th>
<th>Date Abnormality found</th>
<th>Re-assess Date</th>
<th>Re-assess Date</th>
<th>Re-assess Date</th>
<th>Re-assess Date</th>
<th>Re-assess Date</th>
<th>Re-assess Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>T</strong> (Think exclude and treat possible triggers)<strong>(Record any actions over page)</strong></td>
<td>T ick/int</td>
<td>Tick/int</td>
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<td>MEWS (think Sepsis 6)</td>
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<td>Infection (UTI, Chest? other source)</td>
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<td>Assess for constipation</td>
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<td>Assess for hydration/urinary retention/ start fluid balance chart</td>
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<td>Nutrition/recent weight loss</td>
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<td>Medication history (identify new meds/change of dose/ meds recently stopped)</td>
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<td>Pain review (Abbey Pain scale)</td>
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<tr>
<td><strong>T</strong> (Investigate and intervene to correct underlying causes)<strong>(Record results over page)</strong></td>
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<td>Bloods (FBC, U&amp;Es, LFTs, CRP, Mg)</td>
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<td>Urinalysis/CSU</td>
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<td>Consider appropriate cultures/imaging in relation to signs/symptoms of infection</td>
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<td><strong>M</strong> (Management plan)</td>
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<tr>
<td>Initiate treatment of ALL underlying causes found above – consider Sepsis 6</td>
<td>Completed</td>
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<tr>
<td>Implement NHS A &amp; A Delirium Nursing Care Plan</td>
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<tr>
<td>Refer to NHS A &amp; A Psychopharmacological management of delirium</td>
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<tr>
<td>Refer to Scottish Delirium Association (SDA) pathway</td>
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<td><strong>E</strong> (Engage and explore)</td>
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<td>Document diagnosis of delirium in medical and nursing notes</td>
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<tr>
<td>Explain to patient/family (use delirium leaflet)</td>
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<tr>
<td>Access FACE if further information required</td>
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<tr>
<td>Is this is normal behaviour? How would family like to be involved? Complete Getting to know me</td>
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<tr>
<td>Consider AWI form (Section 47) and treatment plan</td>
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</tbody>
</table>

Please date the tick and initial each box when completed

Any abnormality found should be assessed, evaluated and documented on reverse of this sheet.
Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6.

Name of resident: .................................................................

Name and designation of person completing the scale: ........................................

Date: ........................................ Time: .....................................

Latest pain relief given was............................................................ at.............hrs.

Q1. Vocalisation
    eg whimpering, groaning, crying
    Absent 0  Mild 1  Moderate 2  Severe 3

Q2. Facial expression
    eg looking tense, frowning, grimacing, looking frightened
    Absent 0  Mild 1  Moderate 2  Severe 3

Q3. Change in body language
    eg fidgeting, rocking, guarding part of body, withdrawn
    Absent 0  Mild 1  Moderate 2  Severe 3

Q4. Behavioural Change
    eg increased confusion, refusing to eat, alteration in usual patterns
    Absent 0  Mild 1  Moderate 2  Severe 3

Q5. Physiological change
    eg temperature, pulse or blood pressure outside normal limits,
    perspiring, flushing or pallor
    Absent 0  Mild 1  Moderate 2  Severe 3

Q6. Physical changes
    eg skin tears, pressure areas, arthritis, contractures,
    previous injuries
    Absent 0  Mild 1  Moderate 2  Severe 3

Add scores for 1 - 6 and record here

Now tick the box that matches the Total Pain Score

<table>
<thead>
<tr>
<th>0 - 2</th>
<th>3 - 7</th>
<th>8 - 13</th>
<th>14+</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
</tbody>
</table>

Finally, tick the box which matches the type of pain

<table>
<thead>
<tr>
<th>Chronic</th>
<th>Acute</th>
<th>Acute on Chronic</th>
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</table>
What do we really know about the treatment of delirium with antipsychotics? ¹

- 28 studies identified
- 75% receiving short course achieve response
- Little difference between delirium subtypes
- Unclear mechanism of action
- Better studies needed vs placebos

¹ Meagher, Am J Ger Psych, 2013 (ahead of print)
Benzodiazepines

- Generally avoided as may WORSEN delirium
- No adequately controlled trials could be found to support the use of benzodiazepines in the treatment of delirium
  
  *Cochrane Database Syst Review, 2009*

- Lorazepam associated with increased side effects and ineffective
  
  *Breitbart, Am J Psychiatry 1996*
Cochrane review 2007

- Meta-analysis compared efficacy and adverse effects (3 trials included)
  - No difference in efficacy or adverse effects between low dose Haloperidol and Risperidone or Olanzapine
  - High dose haloperidol (>4.5mg/day) greater incidence of side effects, mainly EPSE.

Lonergan 2007
‘Do something now!!!’

- Oral Lorazepam (0.5, 1 or 2mg) or Haloperidol (0.5, 1 or 1.5mg)

- IM versions of Lorazepam +/- Haloperidol

  30mins apart to max dose

Take the edge off them...

- Regular low dose haloperidol 05.mg bg

- Olanzapine 2.5mg nocte

- Short course ~1wk

- Must have EMHT f/up
Capacity issues....

- Must remember about this to cover the fluctuations
- Adults with Incapacity Act 2000
- Mental Capacity Act 2005 (England & Wales)
Delirium toolkit

- ‘Hello, my name is...’
- Orientate
- Offer drinks
- Calm
- Music
- Family/open visiting
- ‘This is me...’ document
Jan – June 14:
1611 4AT assessments
(Mon – Fri, 9-5)

<table>
<thead>
<tr>
<th>4AT score</th>
<th>Numbers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;4</td>
<td>1209</td>
<td>75%</td>
</tr>
<tr>
<td>&gt;4</td>
<td>Admit</td>
<td>341</td>
</tr>
<tr>
<td></td>
<td>Home</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>N/home</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Transfer</td>
<td>5</td>
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</tbody>
</table>

~25% scored >4 suggesting delirium

85% of them were admitted
Future considerations....

Using the figures above we can model the potential demand with delirium over the 15 months since the start of FOPP.

- ED presentations when FOPP avail (15 mths) 7553
- 4AT Scoring >=4 1888
- >=4 Admit 1605

- All >=65 presentations (15 mths) 20204
- 4AT Scoring >=4 5051
- >=4 Admit 4293

- Potential Monthly >=65 presentations 1347
- 4AT Scoring >=4 337
- >=4 Admit 286 (65 pts/week, 9 pts/day)*

*32% presentations 09:00-17:00 Mon-Fri, 68% 17:00-09:00 & Sat/Sun
Demographics

• >65yr population will rise by 59%, from 2000 to 2031

• >80yrs will see the greater increase of 79%

*Who cares wins, RSCPSYCH*
Delirium is everyone’s problem....

‘....a healthcare professional who is trained and competent in diagnosing delirium should carry out a clinical assessment to confirm the diagnosis.’

• Empower nursing staff – especially the healthcare assistants

• Care home staff
Locally....

• It’s hard work!

• Collaborative approach

• Education, education, education........

• Delirium leads in every ward – tailor to meet the demands of that area
THINK DELIRIUM

TIME bundle

T Think exclude and treat possible triggers
I Investigate and intervene to correct underlying causes
M Management Plan
E Engage and Explore

Delirium is a medical emergency - use 4AT tool to assess for delirium
4AT score of 4 or above suggestive of delirium (see over)
Search for underlying causes and manage promptly

For guidance visit www.the4at.com

4AT assessment tool

[1] Alertness: This includes patients who may be markedly drowsy (e.g., difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

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

[2] AM/n: Age, date of birth, place (name of the hospital or building), current year

- No mistakes
- 1 mistake
- 2 or more mistakes/untestable

[3] Attention: Ask the patient: “Please tell me the months of the year in backwards order, starting at December.” To assist initial understanding one prompt of “What is the month before December?” is permitted.

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

[4] Acute change or fluctuating course: Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g., paranoia, hallucinations) arising over the last 2 weeks and still evident in the last 24 hours.

- No
- Yes

4AT score: 4 or above possible delirium +/- cognitive impairment; 1-3: possible cognitive impairment; 0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

www.healthcareimprovementscotland.org/opac.aspx
General Examination

Temp:          Pulse:          RR:          
SpO₂:          %        FiO₂:          (mask/NP)          
BP - Lying:    /          Standing:(1min): /          
Calves:        

Delirium and Cognitive Assessment

4AT score _____ Use if over 65 or confused
Nursing staff will do this on admission; transcribe from their admission document.

The 4AT score helps distinguish delirium from cognitive impairment. Delirium is more likely in the acute setting.

Score ≥ 4 delirium +/- cognitive impairment
1-3 possible cognitive impairment
0 unlikely delirium or cognitive impairment
If ≥4 then commence Delirium Pathway

Cardiovascular Examination

HS: ____________
Heaves / Thrills
JVP:
Oedema:

Respiratory Examination

Pulses:
Peak flow:

Abdominal Examination

General Neurological Examination
### All Patients

- Blood results reviewed and printed: 
- VTE prophylaxis assessed: 
- Investigations requested: 
- In-patient prescription chart complete:

### Considerations

- Sepsis 6?
- Adults With Incapacity?
- DNA-CPR?
- HIV test?

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<thead>
<tr>
<th>Name &amp; grade (ID stamp):</th>
<th>Page:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Ward:</td>
<td>Time:</td>
</tr>
</tbody>
</table>
Social media
Useful links

- NICE guidelines
- Delirium app
- Scottish Delirium Association
- OPAC
Welcome to the Improving Care for Older People in Acute Care National Workstream.

This Workstream is focussing on improving care for older people in acute care. Clinical leadership is needed to drive forward effective and efficient care for older people. This work will improve the experience of acute care. Caring behaviours and attitudes should underpin the technical aspects of care that older people receive.

Caring for older people in acute care. The majority of patients in hospitals are older people. If we can get the right for older people we have a greater chance of getting it right for everyone.

The Improving Care for Older People in Acute Care Workstream in Scotland, will work with hospital teams across Scotland to identify, spread and sustain good practice and demonstrate improvements in key areas.

- Co-ordination of care.
- Cognitive impairment initially focusing on delirium management.

Healthcare Improvement Scotland is carrying out a programme of inspections of services for older people in hospitals in order to:
- Drive improvement in the quality of care for older people in hospitals.
- Provide public assurance that NHS Scotland treats older people with respect, compassion and dignity.

In addition to the inspection process, Healthcare Improvement Scotland is adding a national Improvement Framework of work to coordinate and support national and local improvements in care for older people in acute hospitals.

Our improvements are made by working with Local Commissioning Groups which are to keep older people in their own homes and in the community as far as possible. Hospital is only part of care for older people and a priority should be to keep people out of hospital if at all possible.

Meet the team
Welcome to our site and thank you for your interest in Improving Care for Older People. We are here to help you achieve our shared goal of improving care for older people.

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Jane Miller
Senior Project Officer
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Healthcare Improvement Scotland
NHS Scotland

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Tel: 0141 227 3270

Follow us on twitter: @opachis @online_his

www.improvingcareforolderpeople.scot.nhs.uk
www.healthcareimprovementscotland.org
Think delirium!

- Has there been a change?
- 4AT/CAM
- Delirium pathway
- Think about capacity issues
- Must engage the families