Risk reduction and management of delirium

Delirium Identification

The 4AT tool
The 4AT tool should be used for identifying patients with probable delirium in emergency department and acute hospital settings

Expect it in vulnerable brain
People with dementia are at high risk in hospital, including people with previous delirium. Plan and protect vulnerable people

Speak to family and carers
They will provide you with collateral history to investigate an acute change. Always speak to someone who knows the person

Hyperactive delirium
Can be present on admission or develop in hospital. Easier to spot due to agitated behaviour, confusion and hallucinations always?

Early recognition
For every 48 hours delirium is undetected, mortality increases by 11%

Hypoactive delirium*
Have concern for a newly sleepy, drowsy person with acute illness presenting or developing in hospital. High risk of aspiration and mortality

* Remember delirium can also be mixed hyperactive and hypoactive, look for causes

Delirium Risk Reduction

Sleep in hospital
Promote good environment for restful sleep

Sight and hearing
Helping people with sensory impairment by using glasses and hearing aids in hospital

Hydration
Ensure people at risk have adequate plan for hydration in hospital

Prolonged hospital stay
Work together to plan for discharge, avoiding prolonged stay

Identification
One in five people in acute hospitals can have delirium

Medication
Avoid high risk medication in people at risk of delirium. Think about pain

Promoting mobility and function
Design plan of care to promote mobility and function

Constipation
Optimise bowel health/function in those at risk

Renal function
Preserve renal function ensuring medicine reconciliation is carried out and hydration status is monitored in those at risk

Delirium Management

Educate people and their families
Help families and carers understand what is happening. Help them to be involved in the care of their loved ones. It is important for recognition of potential future episodes

Look for triggers
By taking a thorough history first treat the cause or causes. Think medication change, addition or withdrawal, pain, dehydration, electrolyte disturbance, sepsis, constipation and retention

Use management tool
Ensure safety by using a systematic approach. The TIME Bundle will reduce variation in care.
THINK, INVESTIGATE, MANAGE, ENGAGE & EXPLAIN

Think about follow-up
It is important to write DELIRIUM in the notes, on the discharge letter and refer to appropriate follow-up ensuring safe transition of care. Connect the chain of people caring for the person

It can be fatal
For every FIVE people diagnosed with delirium ONE will be dead within a month

Reduce risk of falling
People with delirium are at great risk of falling. Always consider your plan to reduce in both care domains. 68% of people who fall in hospital have cognitive impairment

Think about Stress and Distress
Remember that people with dementia are at high risk of developing delirium

For more information, visit
http://ihub.scot/delirium-toolkit