Acute management of delirium

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- Recognition of delirium
  - What to do at the beginning
  - Types of delirium
- Management of delirium
  - What to do next
  - Spotting the signs of trouble
  - When to medicate
  - What not to do

Prompt recognition of delirium

Delirium increases mortality and morbidity

- Acute confusion/behavioural change
- Alertness
- Orientation
- Attention/distractability

History taking and observation

Documenting delirium as a problem

The CAM score
Confusion Assessment Method

- A - Acute onset and fluctuating course
- B – Inattention

- C – Disorganised thinking
- D – Altered level of consciousness

Must have A and B and one of either C of D

Types of delirium

Hyperactive delirium

- Restless, agitated, aggressive
- Less likely to be missed
- Risks:
  - Falls and inhury to themselves
  - Difficult to examine and diagnose medical illness
  - Poor intake of fluids and food
  - Non-compliance with treatment
  - Injury to staff and other patients

Hypoactive delirium

- Withdrawn, reduced movement, drowsy
- Much more dangerous than the hyperactive type
- Risks:
  - Failure to recognise delirium
  - Failure to recognise causative physical illness or new physical illness worsening the delirium
  - Poor intake of fluids and food

Management

- Treat the cause AND treat the delirium
- Delirium is the default diagnosis – avoid psychiatric diagnosis until delirum has been excluded

- The cause:
  - Full examination including PR
  - Septic screen: WCC, urine dip, CXR, blood cultures
  - Metabolic: electrolytes, renal function, Ca+
  - Hypoglycaemia
  - Hypoxia and hypercapnoea
  - Intracranial and post-ictal
  - Cardiac

Treat the delirium

- Non pharmacological methods should always be tried first
  - Relieve pain
  - Reassure
  - Time to settle
  - Involve family (with guidance)
    - Collateral
    - Knowing me – dietary preferences, fears, interests
  - Nurse special / bay buddy
  - Dementia specialist nurse

  - [OPMH]

Pharmacological methods

- Only when non-pharmacological treatment has failed

- Antipsychotics: treatment vs sedation
- Aim:
  - to relieve distress and suffering
  - To enable the patient to comply with physical assessment and treatment

- Treatment of symptoms:
  - Anxiety and distress
  - Psychotic phenomena – hallucinations and delusions

- NICE guidelines: haloperidol and olanzipine

When to give medication? Significant risks

- No exact right answer and OPMH is not the answer
- When physical assessment and investigation Is needed – how urgent? 1 day to settle ?
- Removing cannulae for vital treatment even with nurse present, no oral alternative
- Immediate risk to themselves
- Immediate risk to others
  - Assaulting
  - Threatening to assault for 10 mins
- No oral intake for 2 days
- Chaotic distressing thoughts for 2 days
- Behavioural disturbance including sexual disinhibition

Antipsychotic medication

- Haloperidol – 0.5 mg
- Lorazepam in PD and LBD – 0.5 mg
- [Olanzipine 2.5 mg]

- Principle of least restrictive
  - Oral – tablets or liquid, keep offering
  - IM – beware haematoma
  - Avoid giving more than 2 doses in 24 hrs
  - 2 hours to work: do not repeat too quickly
    - Slow oral absorption
    - Poor blood supply to muscle

How long?

- Longer than you think!
- Fluctuation
- If after 1 dose, patient is not completely back to normal the following day, then a longer course is required
- 2 – 4 weeks
- Mechanism for weaning off

- Don’t forget:
  - Orientating and reasuring the patient
  - managing the family

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Questions ?