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

National Dementia Office | HSE | Older People | Emergency Medicine | Acute Medicine | NCPS

This algorithm is for use only in adults, and is not intended for delirium due to alcohol or drug intoxication/ withdrawal.

DELIRIUM is an acute change in cognitive function that has an organic cause and is likely to be reversible or preventable.

All Older Adults (≥ 65) presenting to ED/AMAU:
screen for delirium using 4AT at triage or first contact after triage

Result of 4AT (Collateral history necessary)

≥ 4 : Probable delirium +/- cognitive impairment
1-3 : Possible cognitive impairment
0 : Delirium or severe cognitive impairment unlikely

No evidence of delirium (4AT 0-3)

NB Collateral history necessary to derive this score

- Proceed with admission/discharge
- If 4AT score is 1-3: ensure documentation of cognitive status. **Person may have undiagnosed dementia**
- See reverse side for dementia/ cognitive vulnerability pathway for ED / AMAU
- Assess for delirium risks: those with any risk factors should have regular screening for delirium.

Suspected Delirium (4AT ≥4):

This is a medical emergency

Flag for Urgent Medical Review

- Discuss diagnosis with senior doctor and/or nurse in ED/AMAU
- Discuss diagnosis with carer/ relative and patient as appropriate
- Assess for possible causes of delirium

Ensure admitting team know that delirium is suspected

Delirium has a high mortality. Most patients will need admission. Only discharge after discussion with a senior colleague.

Highlight to shift leader/ patient flow liaison to source urgent bed
This patient will require enhanced supervision while in ED, due to increased risk of falls, dehydration, and medication error.

Strategies for delirium prevention/management in ED/AMAU

- Avoid new sedatives
- Avoid restraint (physical and chemical)
- Avoid use of urinary catheters where possible
- Ensure adequate fluids/nutrition and access to drinks/snacks
- Avoid constipation
- Promote relaxation and sufficient sleep in a quiet area
- Encourage and assist early and regular mobilisation
- Provide own hearing aids and glasses
- Encourage/ allow family members/ carers to stay with the patient
- Encourage independence with activities of daily living (toileting/washing)
- Assess for and manage any pain; use dementia friendly pain score where applicable e.g. PAINAD/ Abbey Pain Scale
- Medication review

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

The management of delirium is primarily NON PHARMACOLOGICAL.

ALWAYS try to de-escalate the situation first. Explain what is happening, re orientate, try to nurse in a quiet area, consider need for one to one care.

1. **The evidence for the benefit of antipsychotics in treating delirium is very weak.** If emergency treatment with medication is needed because the patient or others are at immediate risk and/or urgent care is compromised, low dose ORAL antipsychotic medication is preferred. Small doses should be given e.g. Haloperidal (0.5 -1mg), Quetiapine (12.5 - 25mg), Olanzapine (2.5mg), Risperidone (0.5mg)
   - Avoid antipsychotics in those with Lewy body dementia or Parkinson's disease
   - Get an ECG and check QTc before using antipsychotic agents.
2. **Benzodiazepines worsen delirium** and are reserved for alcohol or benzodiazepine withdrawal (follow withdrawal protocols); or where emergency treatment is required (as per 1, but antipsychotics are contraindicated: e.g. consider lorazepam (0.5-1mg).
3. **A decision to use IM or IV sedation must be made by a senior doctor** (i.e. Registrar/ Consultant). This should be administrated in an area where the patient can be properly monitored and where airway support is available. Flumazenil should be available if using lorazepam. Procyclidine/ Benztropine should be available if using antipsychotic agents.

4AT Rapid Clinical Test for Delirium

1. Alertness	
Normal (fully alert, but not agitated throughout assessment)	0
Mild sleepiness for <10 seconds after waking but then normal	0
Clearly abnormal	4
2. AMT4 (Age, date of birth, place (name of hospital), current year)	
No mistakes	0
1 mistake	1
≥ 2 mistakes/ untestable	2
3. Attention (months of year backwards)	
Achieves 7 months or more correctly	0
Starts but scores <7	1
Untestable (too unwell, drowsy, inattentive)	2
4. Acute Change or Fluctuating Symptoms (need collateral history)	
No	0
Yes	4
Total	______

Identify the patient at risk of delirium

Age over 65 years or any one of the following:

- **Pre-existing cognitive impairment** (e.g. mild cognitive impairment or dementia)
- **Previous delirium**
- Other brain disorders (e.g. head injury, str Parkinson's Disease)
- Functional dependence or frailty
- Poor mobility
- Poor nutrition
- Visual or hearing impairment
- Depression
- Major trauma/Hip fracture
- Multiple co-morbid illnesses
- Severe medical illness or infection (INEWS ≥4 or ≥5 on oxygen)
- Urea and electrolyte imbalance
- Alcohol or substance misuse
- Polypharmacy and/or or high risk medications (e.g. benzodiazepines)

Assess for Potential Causes of Delirium: 'PINCH ME'

P – Is the person in pain? Has urinary retention been excluded?

IN – Infection: is there a possible infection? Refer to sepsis pathway as appropriate (link overleaf)

C – Constipation: When was the last bowel movement?

H – Hydration/nutrition: is there major electrolyte imbalance? Has hypoxia, hypotension, hypoglycaemia been considered?

M – Medication: omission of regular medication or addition of new medication

E – Environment: change of environment, noise or activity levels impacting sleep/ rest

NOTE: Clinical algorithms are for reference only and do not replace clinical judgement

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