SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Aged Care and Rehabilitation
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SUMMARY	The aim of this document is to provide an evidence based procedure on delirium for LHD staff. This document provides information and tools to assist in the prevention, assessment and management of delirium in older people

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Acknowledgement of Country

South Eastern Sydney Local Health District would like to acknowledge the traditional Custodians on whose land we stand, and the lands our facilities are located on; the lands of the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples. We would like to pay our respects to Elders past, present and those of the future.

Prevention, Assessment and Management of Delirium in Older People

1. PROCEDURE STATEMENT

This procedure describes the actions that South Eastern Sydney Local health District (SESLHD) will undertake to support the prevention, assessment and management of delirium and delirium risk among people admitted to its acute and sub-acute facilities and community teams in accordance with:

- National Safety and Quality Health Service (NSQHS) Standard 1: Governance for safety and quality in health service organisations
- National Safety and Quality Health Service (NSQHS) Standard 2: Partnering with consumers
- National Safety and Quality Health Service (NSQHS) Standard 4: Medication safety
- National Safety and Quality Health Service (NSQHS) Standard 5: Comprehensive care: Actions 5.29 and 5.30
- National Safety and Quality Health Service (NSQHS) Standard 6: Communicating for safety
- National Safety and Quality Health Service (NSQHS) Standard 8: Recognising and Responding to Acute Deterioration
- A better way to care: safe and quality care for patients with cognitive impairment (dementia and delirium) ACSQHC, 2014
- Australian Commission on Safety and Quality in Health Care (ACSQHC) Delirium clinical care standard 2021
- NSW Ministry of Health Policy Directive PD2020_018 – Recognition and management of patients who are deteriorating.

2. BACKGROUND

Delirium is an acute change in mental status that is common among older patients in hospital. Despite being a serious condition that is associated with increased mortality, delirium is poorly recognised, both in Australian hospitals and internationally.

Prevention is the most effective strategy, but outcomes for patients with delirium can also be improved by early intervention. SESLHD is committed to involving patients, carers and their families in the development of care plans that consider their individual needs and preferences.

SESLHD clinicians are also committed to educating older people regarding their risk of developing delirium and addressing their concerns and those of their carers and families. This procedures consistent approach to preventing, assessing and managing delirium in older people integrates the principles of person-centred care.

Benefits of this consistent approach include:

- Improved quality and safety outcomes for older people with delirium
- Enhanced person-centred care
- Reduction in hospitalisation related costs

This procedure should be read in conjunction with local facility pathways for the management of older people with confusion/ delirium:

- Prince of Wales/Sydney/ Sydney-Sydney Eye Hospital *POWH/SSEH CLIN040* - Delirium Assessment, Prevention and Management in the Older Person
- St George Hospital *CLIN366 Clinical Business Rule* Confusion and Delirium - Flowchart for Assessment Management for Older Patients at SGH
- The Sutherland Hospital *CLIN668 Clinical Business Rule* Delirium Screening, Assessment, Prevention and Management - TSH

3. TARGET AUDIENCE

This procedure relates to, but is not limited to, people aged over 65 years, and Aboriginal and Torres Strait Islander people and people with intellectual disabilities aged over 45 years. It is also relevant to other adults who have complex co-morbidities.

Delirium is not isolated to patients in aged care wards and all health professionals should be aware of delirium prevention, assessment and management.

This procedure does not include the management of children, or young people withdrawing from drugs or alcohol and those admitted to Intensive Care Units (ICU).

4. RESPONSIBILITIES

4.1 Medical staff will:

- Familiarise themselves with this procedure
- Ensure their own clinical practice in the prevention, assessment and management of delirium is in line with this procedure and local facility delirium pathways
- Ensure delirium and/ or the risk of delirium is communicated to the multidisciplinary team in team meetings, at handovers and in discharge summaries
- Maintain up to date delirium education available in MHL and site based training opportunities

4.2 Nursing Unit Managers (NUM) will:

- Monitor compliance with this procedure – NUM can monitor compliance using a delirium audit tool in QARS – each facility can determine audit schedule
- Ensure that all nursing staff are trained in the use of a validated delirium assessment tool as determined by local facility pathways
- Ensure all staff a trained in the development and implementation of individualised person centred delirium prevention and management plans
- Support staff in completing mandatory and other relevant training around minimising patient harm. Refer to the six modules assigned to relevant staff

under the My Health Learning pathway: Minimising patient harm – Falls and Delirium.

4.3 Nursing staff will:

- Be aware of their responsibilities outlined in this procedure and local facility pathways to prevent and manage delirium
- Complete relevant validated delirium assessment tool within 24 hours of admission to the ward, or on admission to community based teams and repeat when there is a change in patient condition
- Ensure presence of delirium/ delirium risk is documented in the patients' medical record and is communicated at every transfer of care
- Work collaboratively with the multidisciplinary team to prevent, assess and manage delirium
- Implement person centred delirium management strategies
- Discuss person centred delirium management strategies with patients and families/ carers, use interpreters (face to face or telephone) if necessary for people of culturally and linguistically diverse (CALD) backgrounds
- Complete mandatory and other relevant training around minimising patient harm. Refer to the six modules assigned to relevant staff under the My Health Learning pathway: Minimising patient harm – Falls and Delirium.

4.4 Allied Health staff will:

- Assess for presence of delirium using a validated delirium assessment tool if concerns are noted about an acute change in a patient's cognition or function at any time during their care.
- Work collaboratively with the multidisciplinary team to prevent, assess and manage delirium
- Complete mandatory and other relevant training around minimising patient harm. Refer to the six modules assigned to relevant staff under the My Health Learning pathway: Minimising patient harm – Falls and Delirium.

5. DEFINITIONS

Delirium	A disturbance in attention, awareness and cognition that develops over a short period of time, hours or days. The disturbance may fluctuate in severity throughout the day. Signs and symptoms include: • Acute onset • Difficulty focusing or sustaining attention • Disorganised thinking • Disturbance of sleep/wake cycle • Speech or language disturbance • Disorientation to time or place • Disturbance in psychomotor behaviour - Increased e.g. agitation/ Decreased e.g. lethargy.
The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM5) - Delirium	The five key features that characterise delirium are: • Disturbance in attention (reduced ability to direct, focus, sustain, and shift attention) and awareness. • The disturbance develops over a short period of time (usually hours to days), represents a change from baseline, and tends to fluctuate during the course of the day. • An additional disturbance in cognition (memory deficit, disorientation, language, visuospatial ability, or perception). • The disturbances are not better explained by another preexisting, evolving, or established neurocognitive disorder, and do not occur in the context of a severely reduced level of arousal, such as coma. • There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication or withdrawal, or medication side effect.
Hyperactive Delirium	A subtype of delirium with symptoms of a hyperactive level of psychomotor activity that may be accompanied by strong mood changes, agitation, and/ or refusal to co-operate with medical care. Symptoms include: • Predominately restless and agitated • Increased motor activity • Loss of control of activity • Restlessness and wandering • Hallucinations
Hypoactive Delirium	A subtype of delirium that can often be missed or misdiagnosed as depression.

	Symptoms include: • Quiet, • Withdrawn • Inactive
Mixed Delirium	A subtype of delirium in which symptoms fluctuate between hyper and hypo active.
New Onset Confusion	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days) (PD2020_018).
Behaviour Change	Changes to the way a patient interacts with other people or their environment that deviate from their baseline or their expected response, based on developmental age. Changes may present as shifts in cognitive function, activity/tone, perception, or emotional (PD2020_018).
Deterioration in Mental State	Negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment (PD2020_018).
Person Responsible (In NSW)	An appointed guardian (including an Enduring Guardian) who has the function of consenting to medical, dental and health care treatments or, if there is no guardian, the most recent spouse or de facto spouse (including same sex partner) with whom the person has a close, continuing relationship or, if there is no spouse or de facto spouse, an unpaid carer who is now providing care to the person or arranged/provided this support before the person entered residential care or, if there is no carer, a relative or friend who has a close personal relationship with the person. For further information see Person Responsible Factsheet.

6. PREVENTION OF DELIRIUM

Key Risk Factors	Precipitating Risk Factors
• Age > 65 years or > 45 years for Aboriginal or Torres Strait Islander or people with an intellectual disability • Known cognition impairment or formal diagnosis of dementia (AMTS < 7/ 10 or MMSE < 25/30 or past history of memory or cognitive deficit) • Severe medical illness or risk at dying • History of previous delirium • With a Hip fracture	• Use of physical restraint • Use of indwelling catheter • Adding three or more medications • Multiple bed moves/ change in environment • Pain • Surgery • Anaesthesia and hypoxia • Malnutrition and dehydration • Visual and hearing impairment • Depression • Abnormal sodium, potassium and glucose • Polypharmacy • Alcohol/ Benzodiazepine use

6.1 Early Risk Screening

Clinical Care Standard: A patient presenting to hospital with one or more key risk factors for delirium receives cognitive screening using a validated test.

At a minimum all patients > 65 years or > 45 years for Aboriginal or Torres Strait Islander or people with an intellectual disability, must have a delirium assessment completed within 24 hours of admission to hospital or on admission to community based teams. A delirium assessment must be undertaken using a validated delirium assessment tool as determined by local site pathways.

Patients with precipitating factors should have a delirium assessment repeated using a validated delirium assessment tool as determined by local site pathways, in the following situations:

- New onset of confusion
- Deterioration in mental state
- Change in behaviour, cognition and/ or function
- Patient, carer/ family raise concerns about an acute change.

Preventative strategies should be implemented for all patients considered to be at risk of delirium.

6.2 Interventions to Prevent Delirium

Clinical Care Standard: A patient at risk of delirium is offered a set of interventions to prevent delirium and regular monitoring for changes in behaviour, cognition and physical condition.

Multiple interventions have been shown to assist in the prevention of delirium. They include:

- Medication review – collaborate with local pharmacy/ GP
- Treatment and prevention of dehydration and malnutrition
- Treatment and prevention of constipation and/ or urinary retention
- Regular pain assessment and management using a validated non-verbal pain assessment tool such as the PAINAD or ABBEY pain scales
- Regular reorientation and reassurance – open blinds through the day, use your name throughout the conversation, use of calendars, clocks and newspapers
- Mobility activities – go for a walk in the ward.
- Activities for stimulating cognition, for example listening to music, reading newspapers, completing crosswords
- Non-pharmacological measures to help promote sleep, for example, regular bedtime hours, avoiding caffeine/ soft drinks, relaxation techniques prior to bed, regular exercise throughout the day
- Ensuring patient wears hearing and visual aids if required.

These interventions should be tailored to individual preferences, and implemented for patients at risk of delirium as well as for those with a delirium. Staff should discuss these strategies with the patient and/ or their carer/ family, and document in the medical records.

7. ASSESSMENT FOR DELIRIUM

Clinical Care Standard: A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed for delirium by a clinician trained and competent in delirium diagnosis and in the use of a validated diagnostic tool.

When	Procedure
Emergency Department (ED)	Persons over the age of 65 years or > 45 years for Aboriginal and Torres Strait Islander or people with an intellectual disability, or people with key risk factors are assessed for delirium on arrival. If an admitted person is identified with delirium, then a medical assessment is required and this should be communicated to the ward in advance of the transfer. Non pharmacological strategies are to be implemented for those with delirium as well as those at risk of delirium.
Pre-Admission Clinic/ Day Surgery	Persons over the age of 65 years or > 45 years for Aboriginal and Torres Strait Islander or people with an intellectual disability, or people with key risk factors are assessed for delirium on arrival.
Within 24 hours of admission to ward	Persons over the age of 65 years or > 45 years for Aboriginal and Torres Strait Islander or people with an intellectual disability, or people with key risk factors are assessed for delirium within 24 hours of admission.
Community Teams	Persons over the age of 65 years or > 45 years for Aboriginal and Torres Strait Islander or people with an intellectual disability, or people with key risk factors are assessed for delirium on admission to service.
Change in the patient's condition (New onset confusion, new change in behaviour and/ or function)	The presence of new onset of confusion, and/ or new change in behaviour and/ or function should prompt clinical staff to undertake an A-G assessment (Airway; Breathing; Circulation; Disability; Exposure; Fluids; Glucose). Assessment must also include ACVPU **A**lert; **C**onfusion/ change in behaviour, rousable by **V**oice; rousable only by **P**ain; **U**nresponsive scale).

	If there is a change to 'C' confusion/ change in behaviour, then a clinical review (at minimum) is to be called via the facilities Clinical Emergency Response System (CERS). Once the deterioration has been escalated via the CERS system then a delirium assessment using the local facilities endorsed delirium assessment tool can occur.
Post-operative patients	Patients who have had an anaesthetic should be considered at high risk of delirium. The repeat screen should be within 24 hours.

Delirium Assessment Tools

4AT	The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more suggests delirium and prompts escalation for a detailed assessment of mental status. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. 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.
Abbreviated Mental Test Score (AMTS)	The AMTS is a validated 10 point quick cognition tool for rapidly assessing older patients for cognitive impairment. Completion of the AMTS is required prior to completing the CAM.
Confusion Assessment Method (CAM)	The CAM is an assessment tool based on four cardinal features of delirium: 1) Acute onset and fluctuating course, 2) Inattention, 3) Disorganized thinking 4) Altered level of consciousness. Delirium is likely present is there is the presence of features 1, 2, and either 3 or 4. Completion of the AMTS is required prior to completing the CAM.

A positive 4AT or CAM identifies that delirium is likely present and should prompt action to:

- Notify treating medical team – if it is a new onset, this should be escalated via the Clinical Emergency Response System (CERS)
- Document positive delirium assessment in the patient's medical records
- Commence investigation into the cause/s of the delirium
- Develop and document a delirium management plan incorporating non-pharmacological strategies
- Provide information and education to patient and carer such as the NSW Health/ ACI Delirium brochure (2HACI08) which is available in a range of languages.

A definitive diagnosis of delirium is determined by experienced clinicians using the DSM5 criteria.

8. MANAGEMENT OF DELIRIUM

The underlying cause of delirium is often multi-factorial and requires a comprehensive assessment to identify the underlying causes.

Predisposing factors such as infection (urinary tract infections, pneumonia – aspiration), electrolyte imbalance, constipation and pain are all common causes of delirium, however a rigorous assessment is required to identify the cause or causes of each individual case of delirium so that appropriate treatment can be commenced.

Assessment should be based on a biopsychosocial framework and include a detailed history of the onset and course of the confusion, previous episodes of confusion, sensory deficits, safety issues, drug and alcohol use and social and environmental circumstances. Pre-morbid functional activities of daily living, symptoms of underlying causes and co-morbid illnesses should also be included.

The assessment process should also pay particular attention to the following:

- Baseline mental/ cognitive/ functional status
- Full physical assessment including history and examination
- Clinical investigations
- Medication review
- Pain assessment
- Sleep assessment
- Hydration and nutrition assessment
- Drug and alcohol assessment, with a referral for a Drug and Alcohol consultation if required
- Use of visual/ hearing aids if required.

The comprehensive assessment must be documented in the patient's medical record.

8.1 Recommended Clinical Investigations for Delirium

Common investigations that may be indicated in patients with delirium to identify the underlying cause include:

- Full blood count (FBC)
- Urea and electrolytes (UEC)
- Glucose
- Calcium, magnesium and phosphorus levels
- Albumin and protein
- C-reactive protein (CRP)
- Cardiac enzymes
- Liver function tests (LFT)
- Urine analysis +/- MSU
- Bladder scan
- Chest x-ray
- ECG
- Drug toxicity
- Drug and alcohol screen.

Other tests that may be considered include:

- Blood gases
- Blood cultures
- Thyroid function test (TFT)
- B12 and folate
- Abdominal x-ray
- CT brain
- Lumbar puncture and CSF examination
- EEG
- Venereal disease research laboratory (VDRL).

8.2 Medication Review

Some medications may affect cognitive function and worsen delirium/ cognition including:

- Medications with anticholinergic effects, for example, oxybutynin, solifenacin
- Anticonvulsants, for example, phenytoin, carbamazepine, valproate
- Anti-Parkinson medications, for example levodopa, rotigotine, pramipexole, bromocriptine
- Antipsychotics, for example, haloperidol, olanzapine, quetiapine
- Opioids, for example, codeine, fentanyl, HYDROmorphone
- Benzodiazepines, for example, diazepam, alprazolam
- Corticosteroids (high dose), for example, prednisone
- Cardiovascular medications, for example, digoxin, metoprolol, propranolol
- Some anti-bacterial and antiviral agents, for example aciclovir, trimethoprim with sulfamethoxazole, ciprofloxacin (AMH Aged Care Companion).

8.3 Non- Pharmacological Care Strategies- Preventing complications of care

Clinical Care Standard: A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment

An **individualised care plan** is required for people with cognitive impairment who are at risk of delirium as well as those with delirium. A care plan should include the relevant non-pharmacological strategies detailed below:

Increased Observation

- The confusion associated with delirium can produce behavioural symptoms which may put the patient, staff and others at risk
- A 24 hour Behaviour Monitoring Record (NH700562) assists in identifying potential strategies that maintain the person's comfort, as well as possible triggers for behaviour that places people at risk.

Family/ Carers

- Discuss patient's individual likes and dislikes, social history and usual routine. Information about the person's history and preferences can be documented on a Person-centred Profile SES060.159
- Family members should be encouraged to stay with the older person if practicable, to provide reassurance, orientation and emotional comfort.
- Provide NSW Health/ ACI delirium brochure in the appropriate language to assist family/ carer with an understanding of delirium.
- Include interpreters in clinical discussions and when gathering information and /or providing information to patient/carer or family members.
- "Ask all patients on arrival to hospital if they identify as an 'Aboriginal or Torres Strait Islander person?' If the answer is yes, staff then ask if they would like to see an Aboriginal Health Worker. Staff then contact the Aboriginal Hospital Liaison Officer (AHLO) (POWH, SGH, TSH).

Aboriginal Hospital Liaison Officer:
Offers social, emotional and cultural support to patients and their families. Liaison and advocacy between the patient, family and hospital staff. Provides information about hospital services. Assistance with discharge planning and referrals to Aboriginal and non-Aboriginal organisations and services.

Pain

- A non-verbal pain assessment tool should be implemented for patients with delirium/ cognitive impairment or communication deficits. Both the Abbey Pain Scale and PAINAD tools are available in eMR
- Regular, rather than PRN analgesia should be administered for patients with evidence of pain/ discomfort
- Staff should also identify how the patient expresses pain, for example, grimacing, rubbing the targeted area, aggression, apathy, and document this in the patient's medical record, as well as communicate at handover.

Mobility

Immobility in hospital contributes to poor outcomes, including delirium, pressure injuries, hospital acquired infections (e.g. urinary tract infection and aspiration pneumonia), functional decline, higher risk of injurious falls and longer length of stay. Early mobility is one strategy to help prevent and manage delirium.

The following documents should be used to guide clinical decision making and formulation of a care plan:

- SESLHDPR/380: Falls Prevention and Management for people admitted to acute and sub-acute care
- SESLHDGL/042: Falls Prevention and Management: Guideline for Designated High Risk Observation Room (Adult Inpatient)
- SESLHDGL/054: Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatient)
- SESLHDGL/047: Standardised mobility terminology for use across SESLHD
- CEC information for patients and families: People who are confused may fall in hospital.

Safe mobility includes consideration of:

- Referral to physiotherapy and occupational therapy to support mobility and participation in self-care and activities of daily living
- Ensuring the person has their usual mobility aid
- Ensuring appropriate footwear
- Use of glasses and hearing aids if applicable
- Ensuring a safe environment (e.g. bed brakes on, suitable height of bed and chair, remove clutter and hazards, secure any attachments).
- Appropriate use of bed and chair alarms, noting that these may increase agitation in people with delirium and may not be a suitable strategy
- Providing supervision and, where needed, assistance with mobility.

Hydration and Nutrition

Avoid dehydration

- Ensure regular oral intake by offering regular drinks (avoid caffeinated drinks)
- Maintain a fluid balance chart to monitor input and output.

Encourage adequate nutrition

- Sit patient out of bed for all meals (if not contraindicated)
- Complete Malnutrition risk screen (in eMR)
- Complete Food Chart (SEI110.120). If poor oral intake noted, consider referral to dietician
- Encourage family to visit around meal times
- Set up and open packeted meals

- Provide and have access to regular snacks
- Offer finger food if patient has lost the ability to use utensils
- Provide regular mouth care
- Offer option of weekly menu plan for family/ carers to assist with food choices if patient unable to self-select menu
- Consider a speech pathology referral if swallowing concerns are observed during oral intake
- If the patient is too drowsy to accept oral intake due to a hypoactive delirium, then the patient should be NBM until they are alert enough to recommence oral intake. Once the patient is alert enough their baseline diet can be recommenced, with a referral to speech pathologist only required if concerns with swallowing are observed
- Lengthy pre-operative fasting should be avoided as it is a risk for delirium. Patients should not fast for longer than 6 hours from solid foods (unless contraindicated eg bowel surgery) and 2 hours from fluids. If available provide high CHO drinks two hours prior to surgery.
- Patients should be commenced on fluids and diet as soon as physiologically possible following any procedure. Adequate nutrition will assist in wound healing, stabilisation of blood glucose, prevention of other complications such as VTE, pressure injuries and electrolyte imbalances; all of which can contribute to delirium.

Bladder and Bowels

Bladder

- Identify baseline continence status
- Provide a regular toileting regime
- Monitor urinary output
- Provide identifying signage e.g. toilet/ bathroom
- Bladder scan if clinically indicated
- Consider removal of indwelling catheter (IDC) as early as possible.

Bowels

- Prevent constipation by:
  - Keeping the patient hydrated. Encourage water intake - be aware of fluid restrictions
  - Encouraging mobility at regular intervals
  - Promoting usual daily toileting habits and maintaining that same routine
  - Maintaining a bowel chart, documenting the type and volume of all motions
  - Consider regular aperients.

Sleep

Promote normal circadian rhythms by:

- Ascertaining regular sleep habits and follow the same. e.g. what time does the patient usually go to bed, do they get up throughout the night, what do they do to resettle, what night attire do they wear etc.
- Completing a Sleep Chart (SEI060.123) to identify current sleep/ wake patterns

- Providing natural lighting during the day and dress in daytime clothing
- Providing dim lighting at night
- Decreasing noise
- Avoiding caffeinated drinks
- Limiting day time sleep to less than 90 minutes
- Engaging in meaningful physical and diversional therapies during the day as per patient preferences documented on Person Centred Profile/ TOP 5 form.

Sensory

- Ensure glasses, dentures and hearing aids are in place, if they are usually required.

Environmental

- Remove clutter from the room to avoid misidentification and reduce risk of falls
- Promote a quiet, calming environment
- Provide way finding signage: toilets/bathrooms are sign posted
- Request family provide familiar items i.e. favourite blanket/pillow/photographs etc.
- Encourage regular daily routines with activities of daily living.

Emotional Well-being

- Provide reassurance and support to the patient and family/ carer.
- Assess need for social worker referral.
- Consider referral to chaplaincy service as appropriate.

9. MINIMISING USE OF ANTIPSYCHOTIC MEDICATIONS AND OTHER RESTRICTIVE PRACTICES

Clinical Care Standard: Treatment with an antipsychotic medicine is only considered if a patient with delirium is distressed and the cause of their distress cannot be addressed and non-drug strategies have failed to ease their symptoms.

Antipsychotic medicines have a number of serious adverse effects for older people and can worsen a delirium.

The administration of antipsychotic medication needs careful consideration and only used under “the principle of necessity” if:

- The patient is severely distressed
- There is immediate risk of harm to the patient and/ or others
- Non-pharmacological strategies have been trialled

The administration of antipsychotic medications is considered a restrictive practice and strict adherence to SESLHDPR/483 - Restrictive Practices with Adult Patients is required

The use of psychotropic medications requires informed consent from the patient's 'person responsible'.

Antipsychotic medications are not recommended and are unlikely to be effective in certain symptoms such as wandering, undressing, inappropriate voiding and verbal aggression or screaming.

9.1 Pharmacological Management of Behavioural Symptoms of Delirium

There is limited evidence of the efficacy of medications in the management of behavioural symptoms of delirium, and there is a significant risk of adverse effects.

Antipsychotics and benzodiazepines can worsen delirium.

There are no specific pharmacological treatments and, in particular, medications are not helpful for calling out or wandering behaviours. There is no evidence that the use of antipsychotics or sedatives improve prognosis.

Only consider pharmacological treatment if:

- The person's degree of distress interferes with their (or other people's) ability to receive essential nursing or medical care
- The person's behaviour threatens the safety of self or others
- Anxiety/ delusions/ hallucinations are causing significant distress to the person.
- Non-pharmacological strategies have been trialled and have little effect on minimising the distress.

Prior to administration:

- Discuss with the patient and family/ carer regarding the choice of antipsychotic medication, the risks and benefits, dosage, duration and document in the medical record
- Use a low dose, closely monitor response before considering any dose increases, and limit use for as short a period as possible
- Use antipsychotic medications with caution or not at all for people with Parkinson's disease or dementia with Lewy Bodies.

9.2 Mechanical Restrictive Practice

- It is recognised that mechanical **restrictive practice is a precipitating factor for delirium** and increases morbidity and mortality.
- Restrictive practice should only be used as a last resort to maintain the safety of the patient, staff or others.
- Alternative methods of management should be tried whenever possible before consideration of restrictive practice.
- The following document should be used to guide to clinical decision making: SESLHDPR/483 - Restrictive Practices with Adult Patients.

10. ADVANCE CARE PLANNING

- All advance care planning discussions undertaken should be documented contemporaneously in the patient's electronic medical record to ensure all members of the primary and associated treating teams are aware of the progress of the discussions.
- A 'Record of Advance Care Planning Discussion' documentation area has been built within eMR to record brief advance care planning discussions.
- This area is located in the ad hoc tab and opens to a free text area for medical, nursing or allied health to record discussions prior to completion of the formal SESLHD/ NSW Health ACD or SESLHD ACP.
- This area allows a continuum of discussions to be viewed in the Advance Care Documents tab and assist clinicians to find important advance care planning information that has occurred previously in a timely manner.
- **Aboriginal Palliative Care Coordinator:** is available for cultural support of Aboriginal patients, families and the community during this part of life's journey. Providing a holistic approach to cultural health care needs through liaison, advocacy and linking to health services/programs to ensure access and delivery of culturally appropriate care.
- If the patient is "End of Life" contact the Aboriginal Palliative Care Coordinator 0434 565 833.

11. DISCHARGE PLANNING

Clinical Care Standard: To ensure patients with current or resolved delirium, their carer, and their general practitioner or ongoing clinical provider are informed about the diagnosis of delirium and of the treatment the patient will require after they leave hospital.

Diagnosis of delirium should be included in the medical discharge summary and provided to:

- Patient and their carer before they leave the hospital
- Patient's GP and other ongoing clinical providers within 48 hours of leaving hospital.

General Practitioner (GP) Discharge Information:

- Follow up cognition screen
- Reassess the ongoing need for use antipsychotic medication (if applicable).

Family/ carers discharge information:

- Provide printed information to assist their understanding of delirium and early future recognition of delirium, for example, the NSW Health/ ACI Delirium Brochure (2HACI08) available in multiple languages.

12. DOCUMENTATION

SESLHD tools used:

- 4AT Rapid Assessment Test for Delirium – eMR
- Confusion Assessment Method (CAM) – eMR
- Confusion Assessment Method – ICU (CAM-ICU) – eric
- Abbreviated Mental Test Score (AMTS) – eMR
- Mini Mental Status Examination (MMSE) – SEI060.310
- Rowland Universal Dementia Assessment (RUDAS) - SMR060.925
- 24 Behaviour Monitoring Record – NH700562
- Behaviour Management Plan – SES060.277
- Abbey Pain Scale - eMR
- Pain Assessment in Advanced Dementia (PAINAD) – eMR
- Person-Centred Profile SES606.127
- Sunflower chart ACI Sunflower tool
- NSW Health/ ACI Delirium – Brochure – 2HACI08
- Food Chart – SEI110.120
- Sleep Chart – SEI060.123

13. EDUCATION AND RESOURCES

This procedure will be supported through in-services and workshops by the SESLHD Dementia/ Delirium leads. Workshops are open to all health professionals to attend and are aimed at increasing confidence in delirium screening, assessment and management as part of routine care.

MHL Delirium Stage 1 Course code: 233003664 Duration: 20 minutes	This module is orange pinned for relevant clinical staff. On completion of this module the learner will be able to: • recognise signs and symptoms of delirium • demonstrates effective questioning techniques from appropriate screening tools • implement non-pharmacological treatment • communicate and collaborate with patient, family/carer and multidisciplinary team about management plan including medication.
MHL Delirium Care Course code: 266621954 Duration: 30 minutes	This module is orange pinned for relevant clinical staff. On completion of this module the learner will be able to: • identify patients at risk of delirium and screen for a baseline • assess all patients with a change of behaviour for delirium • treat immediately when diagnosed as delirium and continue to monitor • NOTE: It is recommended that you complete Delirium (Stage 1) before attempting this module.
DETECTING Delirium Course Course code: CSK131136	Site based interactive scenario based learning. See local site continuing education calendar for dates.
Violence prevention and management – Personal safety – face to face workshop. Course code: 45793317	Interactive health-based training program that teaches techniques and interventions on violence prevention and management. See MHL for calendar dates and course pre-requisites. See MHL continuing education calendar for dates and availability.

14. REFERENCES

- Australian Commission on Safety and Quality in Health Care (2016). *Delirium Clinical Care Standard*. Sydney, Australia.
- Australian Commission on Safety and Quality in Health Care (2014). *A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital - Actions for health service managers*. Sydney, Australia.
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed, APA Press, Washington, DC 2013
- CHOPS care of the confused older person. 2021. *Delirium risk factors*. [online] Available at: <https://aci.health.nsw.gov.au/chops/chops-key-principles/delirium-risk-identification-and-preventive-measures/delirium-risk-factors> [Accessed 12 May 2021].
- Gowan, J., & Roller, L. (2019). Disease state management: Pain management in older people in aged care facilities and in the community. AJP: *The Australian Journal of Pharmacy, 100(1186),* 58.
- Inouye, S. K. (2018). Mobility Change Package and Toolkit, Hospital Elder Life Program.
- Therapeutic Guidelines (2013). Psychotropic Expert Group: Psychotropic. Melbourne: Therapeutic Guidelines Limited.
- NSW Ministry of Health Policy Directive PD2020_018 – Recognition and management of patients who are deteriorating.

15. VERSION & APPROVAL HISTORY

Date	Version No.	Version and approval notes
Jan 2009	0	Colleen McKinnon Area Dementia/Delirium CNC. Approved by Executive Sponsor Elizabeth Koff, Director Clinical Operations and Clinical Council 28 January 2009.
Jan 2014	1	Janine Masso District CNC Dementia/Delirium (Acute)
April 2015	2	Converted to procedure and revised by District Policy Officer. Author to continue review as a procedure.
June 2015	2	Janine Masso - Revised as a Procedure
July 2015	2	Updates endorsed by Peter Gonski, Executive Sponsor
August 2015	2	Changes made as requested by SESLHD Drug and Quality Use of Medicines Committee and endorsed by Executive Sponsor – November 2015
April 2018	3	Update approved by Executive Sponsor.
July 2018	3	Processed by Executive Services prior to progression to SELSHD Quality Use of Medicines Committee.
August 2018	3	Endorsed by SESLHD Quality Use of Medicines Committee and SESLHD Clinical and Quality Council
February 2021	4	Kellee Barbuto – SESLHD Dementia and Delirium CNC Updated and Reviewed
April 2021	4	Kellee Barbuto SESLHD CNC Dementia/Delirium and Olivia

		Paulik CNC STG Aged Care.
November 2021	5	Final version approved by Executive Sponsor. To be tabled at Quality Use of Medicines Committee.
December 2021	5	Approved by Quality Use of Medicines Committee with minor amendment. To be tabled at SESLHD Clinical and Quality Council.
March 2022	5	Approved at Clinical and Quality Council.
July 2023	5.1	Minor review to update *Section 13 - Education and Resources Section* only. Change reference of MAPA to Violence Prevention and Management. Review Date to remain as March 2025.

Appendix 1:

Clinical Care Standards

Clinician Fact Sheet:
Delirium

The goal of the Delirium Clinical Care Standard is to improve prevention of delirium in patients at risk and to improve the early diagnosis and treatment of patients with delirium, so as to reduce the severity and duration of delirium. Clinicians and health services can use this Clinical Care Standard to support the delivery of high quality care.

UNDER THIS CLINICAL CARE STANDARD

A patient presenting to hospital with one or more key risk factors for delirium receives cognitive screening using a validated test. In addition, the patient and their carer are asked about any recent changes (within hours or days) in the patient's behaviour or thinking.

A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed for delirium by a clinician trained and competent in delirium diagnosis and in the use of a validated diagnostic tool. The patient and their carer are asked about any recent changes in the patient's behaviour or thinking. The patient's diagnosis is discussed with them and is documented.

A patient at risk of delirium is offered a set of interventions to prevent delirium and regular monitoring for changes in behaviour, cognition and physical condition.

A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment.

A patient with delirium receives care based on their risk of falls and pressure injuries.

Treatment with an antipsychotic medicine is only considered if a patient with delirium is distressed and the cause of their distress cannot be addressed and non-drug strategies have failed to ease their symptoms.

Before a patient with current or resolved delirium leaves hospital, the patient and their carer are involved in the development of an individualised care plan and are provided with information about delirium. The plan is developed collaboratively with the patient's general practitioner and describes the ongoing care that the patient will require after they leave hospital. It includes a summary of any changes in medicines, strategies to help reduce the risk of delirium and prevent complications from it, and any other ongoing treatments. This plan is provided to the patient and their carer before discharge, and to their general practitioner and other ongoing clinical providers within 48 hours of discharge.

More information on the Clinical Care Standards program is available from the Australian Commission on Safety and Quality in Health Care website at **www.safetyandquality.gov.au/ccs**

The Australian Commission on Safety and Quality in Health Care has produced this Clinical Care Standard to support the delivery of appropriate care for a defined condition. The Clinical Care Standard is based on the best evidence available at the time of development. The particular circumstances of each patient should be taken into account by healthcare professionals when applying information in the Clinical Care Standard.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Delirium Clinical Care Standard
Clinician Fact Sheet, July 2016