NHS Western Isles Delirium Pathway

(Adapted from the Scottish Delirium Society Delirium Pathway)

For use on admission and/or during hospital stay if change in mental state

AMT screening tool +ve or clinical suspicion of delirium

Clinical team responsible for patient to asses whether patient able to consent to treatment.
To have capacity to consent to treatment an individual must be able to:

1. Understand
   a) What treatment is and why needed
   b) The benefits and risks of treatment
   c) That there are other options and can decide between these options
   d) What happens if no treatment given
2. Remember information for long enough to make a decision
3. Be able to communicate the decision to health care professional

If the above cannot be fulfilled the patient will require an AWI Section 47 (consent to treatment) form and treatment plan.

The treatment plan should in preference be discussed with the individual holding Power of Attorney or Welfare Guardian. If this individual is not contactable this should be documented in pts notes and treatment plan should be discussed with NOK/ family member/carer.

ASSESSMENT
Identity underlying causes of delirium (ABCD)

A: Confusion Screen

a) FBC/U&E/LFT/
b) Glucose/CRP
c) TFTS/Calcium/phosphate
d) ECG/CXR
e) O2 Saturation
f) Urinalysis/MSU
g) CT head / MRI (if head injury or focal neurological signs or if persisting delirium after 5 days)

Others dependent on clinical picture

B: Medication review

The role of anti-cholinergic agents in cognitive decline is well recognized. Additionally other groups of medication can provoke cognitive problems in the elderly. In patients with cognitive impairment/delirium the following should be avoided wherever possible or reduced in dose if clinically necessary.

a) Opiates
b) Benzodiazepines
c) Antipsychotics
d) Amitriptyline
e) Anti-spasmodics eg oxybutinin, buscopan
f) Anti-epileptics when not used for epilepsy eg carbamazepine, gabapentin
g) Antihistamines eg citirizine
h) Anti-hypertensives (when causing hypotension

C: Optimise management of co-morbidity eg diabetes, respiratory disease, thyroid disease, constipation etc

D: Informant History

An informant should be contacted to provide information about the nature of the i) cognitive impairment and ii) functional ability

a) Duration (days, weeks, months or years)
b) Onset (rapid or gradual decline)
c) Time course (constant or fluctuating)
d) Character (disturbed, lethargic, restlessness, withdrawn, hallucinations etc)

The informant should also be asked to clarify and quantify alcohol and drugs use

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