

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> Confirmed diagnosis of delirium. 	<ul style="list-style-type: none"> Co-existing medical condition requiring hospital admission. Chronic confusion without acute onset. Diagnostic features not consistent with diagnosis of delirium (for example psychiatric disorder, agitation due to triggers or simple insomnia). Failure of carer support. Existing Silver Chain Hospice Care patient (refer to Hospice Care Service clinical staff for advice)

Diagnosis of Delirium (1)

Confirm that individual has the following signs and symptoms consistent with the diagnosis of delirium:

- Acute onset and fluctuation of cognition.
- Inattention (distractible and or difficulty keeping track) with **either**:
 - Disorganised thinking (rambling and or unclear and or irrelevant conversations); **or**
 - Altered level of consciousness (may range from hyper alert through to coma).

Screen for Cause of Delirium (2, 3 and 4)

- Endeavour to obtain accurate history from carers/family.
- Obtain baseline vital signs (TPR, BP, SaO2, MMSE and BGL).
- Perform focussed or general physical examination (dependant on history) with a particular focus on:
 - Check for sepsis (eg UTI, LRTI, wound)
 - Hypoxaemia (hypoxia, severe anaemia, low cardiac output)
 - Pain
 - Medication toxicity
 - Alcohol or drug withdrawal
 - Urinary retention
 - Constipation
 - Metabolic disturbances (eg hyperglycaemia, hypoglycaemia, hyponatraemia)
- As part of screening process consider in collaboration with medical governance GP need for diagnostics investigations with a particular focus on:
 - FBP, U&Es, BSL, Ca, cardiac enzymes, MSU, CXR and ECG.

Treatment (5)

Development of delirium may be an end of life presentation in individuals with life limiting disease. The focus of treatment in these individuals will be focussed on symptom control to maximise quality of life (refer to reference list regarding Evidence based clinical guidelines for adults in the terminal phase) (6).

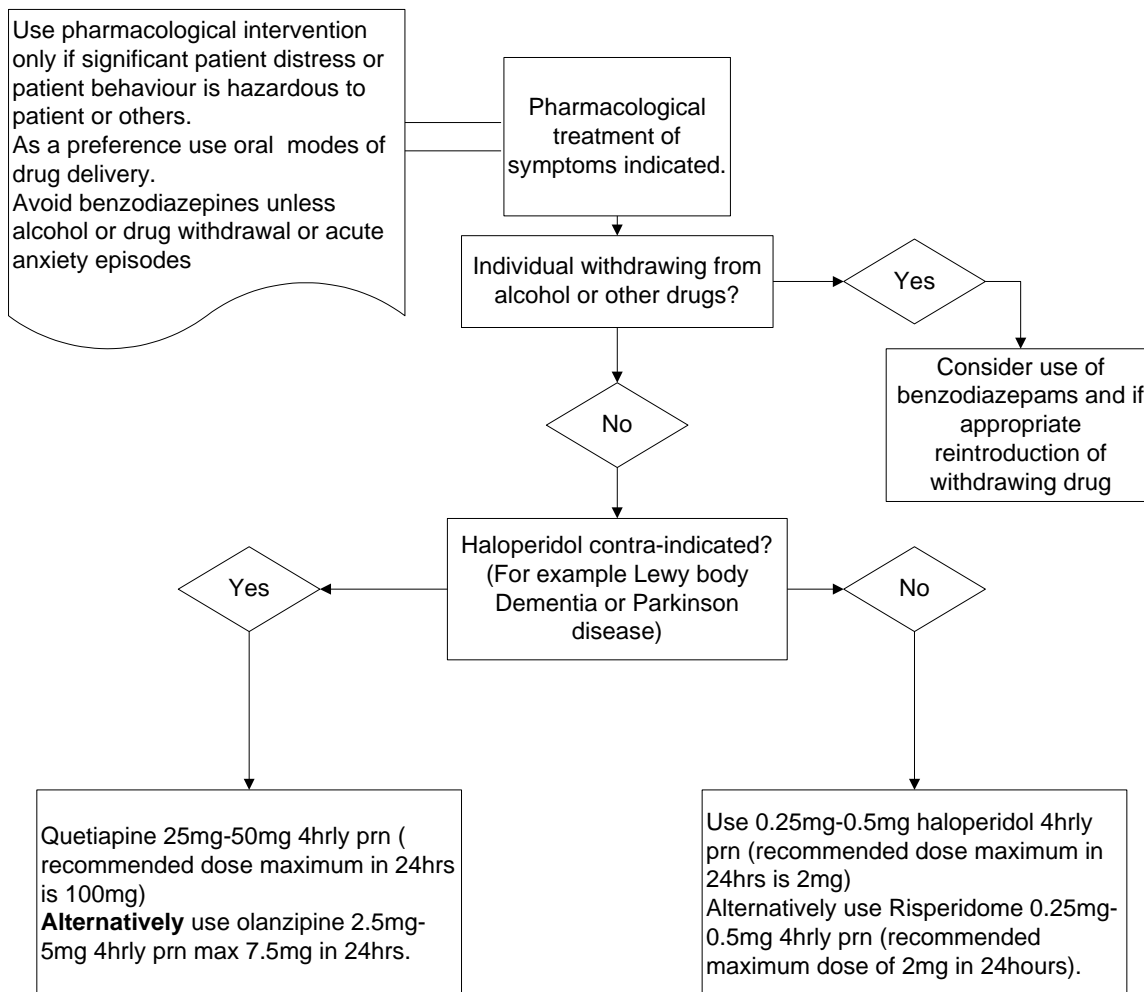
Active treatment of delirium may involve both non-pharmacological and pharmacological treatment strategies. Ideally a non-pharmacological approach is the first approach, however, in the case of severe agitation with subsequent physical risk of injury to the patient and or carer pharmacological treatment strategies are useful as a short term strategy.

Non-pharmacological Treatment Strategies Include

- Identify cause and treat.
- Treat dehydration (oral rehydration or parental fluid replacement).
- Identify and correct sensory deficits (eg sight and hearing).
- Communicate in a straight forward manner using terminology easy for the patient to understand-use family or other carers well known to patient to assist in communication process.
- Re-orientate patient
- Use a quiet light environment.
- Minimise room environment changes.
- Seek to organise an outside environmental view .

Pharmacological Treatment Strategies

Pharmacological treatment of delirium symptoms should only be considered if the individual is a danger to themselves or others or if the symptoms are causing the individual considerable distress.



PBS Prescribing Advice

- Haloperidol available as unrestricted PBS item.
- Risperidone as authority PBS script.
- Quetiapine, and olanzapine (PBS authority item, **not available** for treatment of delirium).
- These medications will be available through the Priority Response Assessment service.

MEDICAL GOVERNANCE

Client has access to medical governance support twenty four (24) hours per day, seven (7) days a week. Care delivery is planned and provided in consultation with the client, medical practitioner/specialist holding medical governance and nursing staff. Medical specialists may retain medical governance with treatment interventions delivered by Silver Chain. When governance is retained by a Silver Chain medical practitioner the client will have a medical review within twenty four (24) hours of admission and scheduled follow-up up as required. In the instance when a client's condition deteriorates the Silver Chain medical practitioner or nursing staff will confer with an emergency department medical practitioner. All Silver Chain medical practitioners are formally credentialed. Medical practitioner holding governance will determine when the client can be discharged and a summary is sent to the referrer or client's general practitioner.

REFERENCES

- 1 Inouye, K. van Dyck, C. Alessi, C. Balkin, S. Siegal, A. Horwitz, R. Clarifying confusion: the confusion assessment method A new method detection of delirium. *Annals of Internal Medical* 1990 113 941-948.
- 2 Inouye, K. Charpentier, P. Precipitating factors for delirium in hospitalised elderly persons: predictive model and inter-relationship with baseline vulnerability. *JAMA* 1996; 275: 852-7
- 3 Rolfson, D. The causes of delirium. In: Lindsay J, Rockwood K, Macdonald A, eds. *Delirium in the elderly*. Oxford: Oxford University Press, 2002: 101-22.
- 4 Flacker, J. Marcantonio, E. Delirium in the elderly: optimal management. *Drugs Ageing* 1998;13: 119-30
- 5 Australian Society for Geriatric Medicine position statement number 13 Delirium in Older People Dr Sean Maher - 14 September 2005.
- 6 Government of Western Australia Department of Health. (2010). Management of Terminal Restlessness/Agitation. WA Cancer and Palliative Care Network Evidence based clinical guideline for adults in the terminal phase.