Appendix I: Prevention and management of delirium

Delirium is a disturbance in attention, awareness (reduced orientation to the environment), and cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception)[1]. It is an acute condition, developing within hours to days, and tends to fluctuate during the day, worsening in the evenings. May present with increased mood lability, agitation, and/or uncooperative behaviour if hyperactive, or poor responsiveness and stupor if hypoactive.

Delirium is a physiological consequence of another medical condition, substance intoxication or withdrawal (including prescription or over the counter medications and recreational substances), exposure to a toxin, or multiple aetiologies.

Risk factors include[2] [3]

- prior cognitive impairment or dementia of any aetiology (e.g. HIV/AIDS, Alzheimer's)
- >65 years of age
- multiple comorbidities
- history of delirium, stroke, neurological disease, falls
- psychoactive substance use
- polypharmacy
- severe illness

Prevention of delirium in at-risk patients is advised;[3] [4] [5] the following measures are recommended:

- Assess new admissions/ quarantined individuals for risk factors of delirium.
- Provide a calm, familiar nursing environment; avoid changes of staff members/ caregivers and avoid moving the patient between rooms or wards wherever possible.
- Repeatedly re-orientate the patient – explain where they are, who they are, who you are, and what your role is at every engagement with the patient. This is particularly important when wearing PPE.
- Orientate to place and time with clear signage, clock, calendar.
- Maintain circadian rhythm: mobilise and provide sensory stimulation (for example, allow time to talk about themselves; use spectacles and/or hearing aids) during day. At night, avoid nursing or medical procedures, dim lights, reduce noise to a minimum.
- Assess for and address dehydration, constipation, hypoxia, infections, pain, and discomfort.
- Avoid abrupt substance withdrawal (see Adult Hospital STGs and EML; Chapter 15: Mental Health conditions, Substance misuse).
- Review all medicines that the person has been taking – optimise doses; gradually wean and stop any unnecessary medication, including sedatives and analgesics.

Treatment of delirium involves treatment of the precipitating acute illness and comorbidities. There is no good evidence to support use of any pharmacological agent vs placebo.[6] [7] [8]

- Continue with all preventative measures – see above.
- As far as possible, avoid benzodiazepines and opioids, unless required for substance withdrawal.
- Avoid anticholinergic medicines.
- If an antipsychotic is deemed clinically necessary for marked agitation not responsive to non-pharmacological measures, use the lowest dose, at night, titrating according to response and adverse effects. Continue short-term if effective; wean and stop once patient improves medically and before hospital discharge.

[1] American Psychiatric Association DSM-5 Task Force. Diagnostic and statistical manual of mental disorders: DSM-5. 5th ed. Washington, D.C.: American Psychiatric Association; 2013. https://www.psychiatry.org/psychiatrists/practice/dsm

[2] Taylor, David; Paton, Carol; Kapur, Shitij. The Maudsley Prescribing Guidelines, Twelfth Edition. London: CRC Press; 2015.

[3] National Institute of Clinical Excellence. Delirium: prevention, diagnosis and management (CG103) 2020 [cited 2020 4 May]. Available from: www.nice.org.uk/guidance/cg103.

[4] Kotfis K, Williams Roberson S, Wilson JE, Dabrowski W, Pun BT, Ely EW. COVID-19: ICU delirium management during SARS-CoV-2 pandemic. Crit Care. 2020;24(1):176. https://www.ncbi.nlm.nih.gov/pubmed/32345343

[5] Pisani MA, D'Ambrosio C. Sleep and Delirium in Adults Who Are Critically Ill: A Contemporary Review. Chest. 2020;157(4):977-84. https://www.ncbi.nlm.nih.gov/pubmed/31874132

[6] Burry L, Hutton B, Williamson DR, Mehta S, Adhikari NK, Cheng W, et al. Pharmacological interventions for the treatment of delirium in critically ill adults. Cochrane Database Syst Rev. 2019;9:CD011749. https://www.ncbi.nlm.nih.gov/pubmed/31479532

[7] Burry L, Mehta S, Perreault MM, Luxenberg JS, Siddiqi N, Hutton B, et al. Antipsychotics for treatment of delirium in hospitalised non-ICU patients. Cochrane Database Syst Rev. 2018;6:CD005594. https://www.ncbi.nlm.nih.gov/pubmed/29920656

[8] Nikooie R, Neufeld KJ, Oh ES, Wilson LM, Zhang A, Robinson KA, et al. Antipsychotics for Treating Delirium in Hospitalized Adults: A Systematic Review. Ann Intern Med. 2019. https://www.ncbi.nlm.nih.gov/pubmed/31476770