Delirium awareness workshop: session plan

Delirium: diagnosis, prevention and management

2010

NICE clinical guideline 103
**Introduction**

Delirium can have serious consequences, including increased:

- risk of dementia (at 3-year follow-up)
- risk of death
- length of stay for people in hospital
- in-hospital complications (falls, pressure sores and incontinence)
- risk of admission to long-term care for people in hospital.

**Incidence of delirium**

- Up to 33% of people admitted to a general medical ward in hospital have delirium when they first present (prevalent delirium).
- Up to 18% of people on a general medical ward will develop delirium during their stay (incident delirium).
- There are currently 450,000 people in long-term residential care homes and care homes with nursing (NHS Information Centre Community Care Statistics 2008). Expert opinion suggests a high proportion of these people are at risk of delirium.

Delirium is a common but serious condition that is associated with poor outcomes. However, delirium can be prevented and treated if dealt with urgently.

It is therefore essential that all staff who care for people in hospital and the community are aware of how to prevent delirium and how to ensure that someone with suspected delirium receives rapid assessment and appropriate management.

‘Think Delirium’ to ensure you act and intervene early.

This awareness workshop session plan and accompanying slide set are designed to raise this awareness among staff. The workshop should be used alongside ‘Delirium: diagnosis, prevention and management’ (NICE clinical guideline 103).

The case studies cover different clinical settings including critical, acute and elective care in hospitals, as well as the community and long-term care.

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^ Throughout this document long-term care has been taken to mean residential care in a home that may include skilled nursing care and help with everyday activities. This encompasses nursing homes and residential homes.
The aims of the workshop are to:

- promote awareness and understanding of NICE’s recommendations
- increase knowledge of how to apply them as part of routine practice
- practise identifying the risk factors and indicators of delirium
- show how to develop solutions to help prevent delirium.

This resource can be incorporated into existing awareness and assessment training and can be tailored to suit local needs. Relevant local policies and procedures can be inserted into the slide set and additional supporting materials can be provided if needed.
Workshop structure
Two training options are proposed: a full session (up to 3 hours) and a short session (up to 1 hour) that could be fitted in at lunchtime. The slide set can be used to fit either format. You can also adapt the slide set further to meet local needs (for example, by extending the lunchtime session to include more details on how to use the guidance).

Preparation
Send participants the following documents to read before the workshop:

- any documents that are used locally to assess the risk of delirium and prevent and manage delirium (these will be reviewed in the brainstorming section on slide 36)
- the pre-workshop quiz (see page 10).

Exercises 1 and 4 each contain four case studies (please note that the same case studies are used for both exercises). You do not have to use all the case studies. Choose those most relevant to your service setting or client group. Alternatively, if the workshop participants come from a variety of settings, consider dividing them into smaller groups. Ask each group to consider one case study and then feed back to the group.

Short session
Practicalities
- Timing: allow 1 hour.
- Recommended number of participants: 10–30.
- Before the workshop send out the pre-workshop quiz and the materials outlined in the ‘preparation’ section above.
- Pick one of the case studies A–D for exercise 1 and 4 from slides 12–15 or page 14 -15 of this document (choose the most relevant one to your service; note that you won’t need slide 30)
• Print copies of:
  – the answers to the pre-workshop quiz
  – your chosen case study for exercise 1 and 4 and the related questions
    (use the same case study for exercises 1 and 4)
  – exercise 2 question sheet
  – exercise 3 question sheet
  – exercise 5 case study F and answer sheet
  – post-workshop quiz (for participants to take away after the session)
  – evaluation form.

• After the workshop send out the post-workshop quiz answer sheet (timing to be decided locally).
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**Full session**

**Practicalities**
- Timing: allow up to 3 hours (including 30 minutes break).
- Recommended number of participants: 10–30.
- Before the workshop, send out the pre-workshop quiz and the materials outlined in the ‘preparation’ section above.
- Use all the slides.
- Pick at least two of the case studies A–D for exercise 1 and 4 from slides 12–15 or page 14 - 15 of this document (choose the most relevant ones to your service)
- Print copies of:
  - [answers](#) to the pre-workshop quiz
  - your chosen case studies for exercise 1 and 4 and the relevant question sheets
  - exercise 2 question sheet
  - exercise 3 question sheet
  - exercise 5 case studies E and F and the relevant question sheets
  - post-workshop quiz
  - evaluation form.
## Structure

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Pre-workshop quiz

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

1. What does NICE stand for and what does it do? How might this be relevant to your work?

2. NICE has released a clinical guideline, ‘Delirium: diagnosis, prevention and management’. Where can you access this guideline?

3. What is delirium?

4. Can delirium be prevented?

5. What types of delirium are there?

6. What type of people are most at risk of developing delirium?

7. What is the occurrence of delirium on medical wards in hospital and in long-term care?

8. How does delirium affect patients, carers and service providers?

9. Can you think of any people you have cared for who have had delirium?
Pre-workshop quiz – answer sheet

1. What does NICE stand for and what does it do? How might this be relevant to your work?

NICE stands for National Institute for Health and Clinical Excellence. It provides guidance, sets quality standards and manages a national database to improve people’s health and prevent and treat ill health.

NICE makes recommendations to the NHS on:

- new and existing medicines, treatments and procedures
- treating and caring for people with specific diseases and conditions.

NICE also makes recommendations to the NHS, local authorities and other organisations in the public, private, voluntary and community sectors on how to improve people’s health and prevent illness and disease.

NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community sectors, as well as patients and carers, to make recommendations in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

NICE also manages NHS evidence, which:

- has a fast, free and easy to use search engine to help users search for the information they want
- ranks search results from credible medical sources according to relevance and quality
- allows users to personalise a search and register to receive the latest health information
- awards an Accreditation Mark to organisations which meet high quality standards in developing health information (available at www.evidence.nhs.uk).

Using NICE resources can help you care for your patients and may help you to cut costs while at the same time maintaining, and even improving, services.
2. NICE has released a clinical guideline, ‘Delirium: diagnosis, prevention and management’. Where can you access this guideline?

The NICE website: www.nice.org.uk/guidance/CG103

3. What is delirium?
Delirium (sometimes called ‘acute confusional state’) is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually develops over 1–2 days. It is a serious condition that is associated with poor outcomes.

4. Can delirium be prevented?
Yes. Delirium can be prevented. This training document focuses on preventing delirium in people identified to be at risk, using a targeted, multicomponent, non-pharmacological intervention package that addresses a number of modifiable risk factors. If delirium is prevented it should improve outcomes for people at risk of delirium and have cost savings for service providers.

5. What types of delirium are there?
Delirium can be hypoactive or hyperactive but some people show signs of both (mixed). People with hyperactive delirium have heightened arousal and can be restless, agitated and aggressive. People with hypoactive delirium become withdrawn, quiet and sleepy. Hypoactive and mixed delirium can be more difficult to recognise.

6. What type of people are most at risk of developing delirium?
Older people (aged 65 and over) and people with cognitive impairment¹ (past or present) and/or dementia², severe illness³ or a current hip fracture are more at risk of delirium.

7. What is the occurrence of delirium on medical wards in hospital and in long-term care?
The occurrence of delirium in people on medical wards in hospital is about 20% to 30%, and 10% to 50% of people having surgery develop delirium. In long-term care the occurrence rate is 16%. But reporting of delirium is poor, indicating that awareness and reporting procedures need to be improved.
8. **How does delirium affect patients, carers and service providers?**

There is a significant burden associated with this condition. Compared with people who do not develop delirium, people who develop delirium are more likely to:

- need to stay longer in hospital or in critical care
- have dementia at 3-year follow-up
- have more hospital-acquired complications, such as falls and pressure sores
- need to be admitted to long-term care if they are in hospital
- die.

9. **Can you think of any people you have cared for who have had delirium?**

There is no correct answer to this – it is designed to start people thinking about this condition and its occurrence in their workplace.

The answers to the questions can be found on slides 5–6 and in the pre-workshop quiz answer sheet.
**Case studies**

**Case study A**
Harold is 82 years old and has been living at your care home for 5 years. He has been diagnosed with Alzheimer’s disease and has a catheter. Harold does not wear a hearing aid, but over the past day or two you have noticed that he has been asking you to repeat what you have said, and sometimes he seems to mishear you completely. He is otherwise normal for himself.

**Case study B**
George is 81 years old and has mild-to-moderate dementia. He has been on your ward for a few days following a fall and has a painful hip for which he has been taking regular analgesia. He has been reluctant to walk because he says his hip hurts. He tells you that he has been finding it difficult to sleep because of pain and that he has not had his bowels open recently.

**Case study C**
Barbara is 63 years old. She has been admitted to the intermediate care facility in your care home, 7 days after a fall that caused a fractured hip. She had this repaired 4 days ago. Her family report that previously she was independent. After her operation, she was found to have developed an infection in her wound site and was given antibiotics to treat this. She is finding it difficult to mobilise, which she says is because of pain in her hip. It was therefore agreed that she would be transferred to your care home for rehabilitation before discharge home.

**Case study D**
Charles is 66 years old and has been admitted to your ITU/coronary care unit after a heart attack for which he received a coronary artery bypass graft. He is currently stable but the doctors have asked the nursing staff to monitor his vital signs closely.
**Case study E**

Aariz, who is 81, has been a resident in your care home for the last 2 years. He has been diagnosed with Alzheimer’s disease. He is usually quite talkative, although he often shifts the conversation to his days as an electrician’s apprentice and frequently seems to think that it is the 1960s. Increasingly often he asks where he is, and has been wandering at night. This has been going on for several months. In the last few days Aariz has been incontinent of urine (unusual for him), and has been shouting out, especially at night. Last night you found him trying to dismantle a plug in his bedroom. One of his visitors mentions to you that he has said he believes the staff are trying to poison him.

**Case study F**

Gladys is 75 years old and has been admitted to your ward having been found lying on the floor by home care staff. She appears to be talking to herself, sometimes loudly, but it is hard to understand what she is saying. She seems anxious and repeatedly pulls at her bedclothes. She argues with the nursing staff and has refused, in an angry, snappy fashion, to have a blood sample taken. Nursing home staff say that she has recently moved rooms in the care home because of deterioration in her mobility.
Exercise 1: risk factors for delirium

When people first present to hospital or long-term care, it is important to assess them for risk factors for delirium. (Recommendation 1.1.1)

Please read alongside the case study descriptions on pages 14–15 of this session plan.

The following exercise will help you identify the risk factors for delirium.

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

**Exercise 1: risk factors for delirium – questions**

**Case study A**

*Does Harold have any risk factors for delirium? If so what are they?*

**Case study B**

*Does George have any risk factors for delirium? If so what are they?*

**Case study C**

*Does Barbara have any risk factors for delirium? If so what are they?*

**Case study D**

*Does Charles have any risk factors for delirium? If so what are they?*
**Exercise 1: risk factors for delirium – answers**

When people first present to hospital or long-term care, it is important to assess them for risk factors for delirium. (Recommendation 1.1.1)

Please read alongside the case study descriptions on pages 14–15 of this session plan.

The following exercise will help you identify the risk factors for delirium.

**Case study A**

*Does Harold have any risk factors for delirium? If so what are they?*

Yes: age, dementia.

**Case study B**

*Does George have any risk factors for delirium? If so what are they?*

Yes: age, possible current hip fracture, dementia.

**Case study C**

*Does Barbara have any risk factors for delirium? If so what are they?*

Yes: current hip fracture. It is acknowledged that because Barbara has had her hip fracture repaired it may not be defined as ‘current’; however it is beneficial that workshop participants are able to identify this as a risk area.

**Case study D**

*Does Charles have any risk factors for delirium? If so what are they?*

Yes: age over 65, severe illness³.
**Exercise 2: indicators of delirium**

After the initial risk assessment it is important to assess people for indicators of delirium. This is because before you can put in place interventions to prevent delirium in people at risk you need to make sure the person does not already have delirium.

At presentation, assess people at risk for recent (within hours or days) changes or fluctuations in behaviour. (Recommendation 1.2.1)

Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations in usual behaviour. These may be reported by the person at risk, or a carer or relative. (Recommendation 1.4.1)

**Exercise 2: indicators of delirium – questions**

This exercise has been designed to help you identify the indicators of delirium.

**In the word search find the 15 indicators of delirium.** All indicators are in the vertical or horizontal plane. There are no indicators written diagonally.

| W | O | R | S | E | N | E | D | C | O | N | C | E | N | T | R | A | T | I | O | N | L | T | I | L |
| S | R | M | Q | Y | A | P | U | Q | S | G | M | Z | X | N | C | N | B | C | A | L | D | K | F | A |
| L | P | O | L | R | L | Q | F | L | S | P | Y | R | Q | V | B | M | G | O | S | T | F | C | D | C |
| E | L | B | P | U | S | H | A | L | L | U | C | I | N | A | T | I | O | N | S | G | T | L | G | K |
| E | Y | I | A | R | K | L | O | G | O | D | E | G | H | N | K | F | D | F | R | H | U | B | D | O |
| P | B | L | Z | I | D | A | W | N | W | A | Q | T | H | M | L | D | B | U | I | W | U | A | L | F |
| I | S | T | N | O | F | K | L | P | E | U | C | I | N | A | T | I | N | I | S | G | T | L | M | O |
| S | L | Y | K | W | H | L | T | L | S | D | E | G | H | N | K | F | L | O | R | H | U | B | O | O |
| T | O | Q | G | P | G | D | Q | T | P | A | Q | T | H | M | L | D | S | N | I | W | U | A | O | P |
| U | W | T | T | Q | Z | Q | G | Y | O | P | T | T | L | L | P | N | A | T | I | T | U | D | E |
| R | C | H | A | N | G | E | S | I | N | A | P | P | E | T | I | T | E | E | P | I | O | N | L | R |
| B | A | K | P | R | M | A | L | L | S | K | R | M | O | I | L | S | D | E | T | C | A | L | D |
| A | F | G | Y | Q | X | G | A | U | E | T | Y | O | E | T | T | P | A | Q | N | O | S | T | F | T |
| N | G | F | R | E | S | T | L | E | S | S | N | E | S | S | Y | O | P | T | Y | N | S | G | T | I |
| C | Z | W | A | G | I | T | A | T | I | N | W | I | N | A | P | P | F | R | H | U | O |
| E | C | S | R | E | N | U | T | I | L | R | W | G | Y | L | L | S | K | R | T | U | I | W | U | N |
| M | O | V | E | M | E | N | T | O | A | R | E | L | D | P | L | M | N | Q | P | S | S | T | F | A |
| N | X | N | U | R | C | E | P | Q | X | W | I | T | H | D | R | A | W | A | L | I | S | G | T | N |
| M | P | L | I | K | B | R | R | D | W | L | M | L | A | Q | P | W | B | Y | B | O | R | H | U | T |
| Q | C | O | M | M | U | N | I | C | A | T | I | O | N | B | L | D | M | L | Q | M | E | L | T | P |

Which of these indicators suggest hypoactive delirium?

Do any of the people in exercise 1 have indicators of delirium?
Exercise 2: indicators of delirium – answers

The 15 indicators (words in brackets are not in the word search) are: worsened concentration, slow responses, hallucinations (visual or auditory), (reduced) mobility, (reduced) movement, restlessness, agitation, changes in appetite, sleep disturbance, lack of cooperation (with reasonable requests), withdrawal, (alterations in) communication, mood (and/or) attitude, confusion

Which of these indicators suggest hypoactive delirium?

Worsened concentration, slow responses, reduced mobility, reduced movement, changes in appetite, withdrawal.

Do any of the people in exercise 1 have indicators of delirium?

No. However, in case study A, Harold is asking people to repeat what has been said. This poor attention could be an indicator of delirium; however, for the purpose of this case study Harold does not have any indicators of delirium – he has an onset of a hearing problem.
Exercise 3: preventing delirium

Certain clinical factors can contribute to delirium developing in people at risk. Intervening to address these clinical factors can prevent delirium. This exercise will help raise your awareness of interventions that can help to prevent delirium in people at risk. Document which intervention should be assigned to which clinical factor from the risk / intervention diagram on page 21.

Exercise 3: preventing delirium – questions

A =
B =
C =
D =
E =
F =
G =
H =
I =
J =
K =
## Risk / intervention diagram

<table>
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<tr>
<th>Risk status and clinical factors</th>
<th>Intervention</th>
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<tr>
<td>Person is at risk of delirium</td>
<td>A  • Carry out a medication review for people taking multiple drugs, taking into account both the type and number of medications.</td>
</tr>
<tr>
<td>Person has cognitive impairment and/or disorientation</td>
<td>B  • Assess for hypoxia and optimise oxygen saturation if necessary, as clinically appropriate.</td>
</tr>
<tr>
<td>Person is dehydrated and/or constipated</td>
<td>C  • Encourage people to:  - mobilise soon after surgery  - walk (provide appropriate walking aids if needed – these should be accessible at all times).  • Encourage all people, including those unable to walk, to carry out active range-of-motion exercises.</td>
</tr>
<tr>
<td>Person may be hypoxic</td>
<td>D  • Avoid nursing or medical procedures during sleeping hours, if possible.  • Schedule medication rounds to avoid disturbing sleep.  • Reduce noise to a minimum during sleep periods.</td>
</tr>
<tr>
<td>Person has an infection</td>
<td>E  • Provide appropriate lighting and clear signage; a clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk.  • Talk to the person to reorientate them by explaining where they are, who they are, and what your role is.  • Introduce cognitively stimulating activities (for example, reminiscence).  • Facilitate regular visits from family and friends.</td>
</tr>
<tr>
<td>Person is immobile or has limited mobility</td>
<td>F  • Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk.  • Avoid moving people within and between wards or rooms unless absolutely necessary.  • Assess person for clinical factors contributing to delirium.  • Observe people, at least daily, for recent changes or fluctuations in usual behaviour.</td>
</tr>
<tr>
<td>Person is or could be in pain</td>
<td>G  • Follow the advice given on nutrition in ‘Nutrition support in adults’ (NICE clinical guideline 32).  • If people have dentures, ensure they fit properly.</td>
</tr>
<tr>
<td>Person is receiving multiple medications</td>
<td>H  • Resolve any reversible cause of the impairment, such as impacted ear wax.  • Ensure hearing and visual aids are available to, and used by, people who need them, and that they are in good working order.</td>
</tr>
<tr>
<td>Person is poorly nourished</td>
<td>I  • Ensure adequate fluid intake to prevent dehydration by encouraging the person to drink – consider offering subcutaneous or intravenous fluids if necessary.  • Take advice if necessary when managing fluid balance in people with comorbidities (for example heart failure or chronic kidney disease).</td>
</tr>
<tr>
<td>Person has sensory impairment</td>
<td>J  • Assess for pain.  • Look for non-verbal signs of pain, particularly in those with communication difficulties (for example, people with learning difficulties or dementia, or people on a ventilator or who have a tracheostomy).  • Start and review appropriate pain management in any person in whom pain is identified or suspected.</td>
</tr>
<tr>
<td>Person has a poor sleep pattern (for more information on good sleep hygiene, see NICE clinical guideline 35).</td>
<td>K  • Look for and treat infection.  • Avoid unnecessary catheterisation.  • Implement infection control procedures in line with ‘Infection control’ (NICE clinical guideline 2).</td>
</tr>
</tbody>
</table>
Exercise 3: preventing delirium – answers

A = 6
B = 5
C = 9
D = 2
E = 11
F = 3
G = 10
H = 1
I = 7
J = 8
K = 4
Exercise 4: preventing delirium

As we have already identified, delirium can be prevented in at-risk people through interventions to address the clinical factors that contribute to delirium.

In exercise 1, four people were introduced to you. You identified that they were all at risk of delirium. In exercise 2 you identified that these people did not have any indicators of delirium. To prevent delirium in these people, the NICE guideline recommends that a multidisciplinary team who are trained and competent in delirium prevention should first assess at-risk people within 24 hours of admission for clinical factors contributing to delirium and, on the basis of this, provide a multicomponent intervention tailored to each person’s individual needs and care setting. (Recommendations 1.3.2 and 1.3.3)

This exercise will help you to practise designing a tailored multicomponent intervention package aimed at preventing delirium in people at risk.

Please read alongside the case study descriptions on pages 14–15 of this session plan.

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Throughout this document, multidisciplinary team has been taken to mean a team of healthcare professionals with the different clinical skills needed to offer complete care to people with complex problems such as delirium.
Exercise 4: case study A – questions

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

You have already identified that Harold has risk factors for delirium but does not have any indicators of delirium. What should you assess next? And what are the possible results of the assessment?

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting. (Recommendation 1.3.2) What interventions would you propose for Harold?

What should you continue to observe in all people in hospital or long-term care?
Exercise 4: case study A – answers

You have already identified that Harold has risk factors for delirium but does not have any indicators of delirium. What should you assess next? And what are the possible results of the assessment?

Within 24 hours of admission, assess people at risk for clinical factors contributing to delirium. (Recommendation 1.3.2)

Clinical factors that could contribute to delirium in this person are:

- Harold has dementia and therefore has cognitive impairment.
- Harold has a catheter, which can be a source of infection.
- Although he does not wear a hearing aid, he might have hearing impairment.

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting. (Recommendation 1.3.2)

What interventions would you propose for Harold?

NICE recommendation 1.3.1 states:

- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk.
- Avoid moving people within and between wards or rooms unless absolutely necessary.

NICE recommendation 1.3.3.1 states:

Address cognitive impairment or disorientation by:

- providing appropriate lighting and clear signage; a clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk
- talking to the person to reorientate them by explaining where they are, who they are, and what your role is
- introducing cognitively stimulating activities (for example, reminiscence)
- facilitating regular visits from family and friends.
NICE recommendation 1.3.3.4 states:

Address infection by:

- looking for and treating infection
- avoiding unnecessary catheterisation
- implementing infection control procedures in line with ‘Infection control’ (NICE clinical guideline 2).

NICE recommendation 1.3.3.9 states:

Address sensory impairment by:

- resolving any reversible cause of the impairment, such as impacted ear wax
- ensuring hearing and visual aids are available to and used by people who need them, and that they are in good working order.

**What should you continue to observe in all people in hospital or long-term care?**

The NICE guideline recommends:

- Observe people at every opportunity for any changes in the risk factors for delirium. (Recommendation 1.1.2)
- Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations in usual behaviour. (Recommendation 1.4.1)

Part of NICE recommendation 1.7.1 states:

- Encourage people at risk and their families and/or carers to tell their healthcare team about any sudden changes or fluctuations in behaviour.

(See the NICE guideline for the full recommendation.)
**Exercise 4: case study B – questions**

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

You have already identified that George has risk factors for delirium but does not have any indicators of delirium. What should you assess next? And what are the possible results of the assessment?

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person's individual needs and care setting. (Recommendation 1.3.2)

What interventions would you propose for George?
**Exercise 4: case study B – answers**

You have already identified that George has risk factors for delirium but does not have any indicators of delirium. What should you assess next? And what are the possible results of the assessment?

Within 24 hours of admission, assess people at risk for clinical factors contributing to delirium. (Recommendation 1.3.2)

Clinical factors that could contribute to delirium in this person are:

- George has a history of dementia and therefore has **cognitive impairment**.
- He has suspected **constipation** (perhaps related to the analgesia or **poor dietary intake**) and/or **dehydration**, both of which are common in unwell older people.
- He reports that his reluctance to **walk** and his **sleep disturbance** are attributable to **pain**.

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting. (Recommendation 1.3.2)

**What interventions would you propose for George?**

NICE recommendation 1.3.1 states:

- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk.
- Avoid moving people within and between wards or rooms unless absolutely necessary.

NICE recommendation 1.3.3.1 states:

Address cognitive impairment or disorientation by:

- providing appropriate lighting and clear signage; a clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk
- talking to the person to reorientate them by explaining where they are, who they are, and what your role is
• introducing cognitively stimulating activities (for example, reminiscence)
• facilitating regular visits from family and friends.

NICE recommendation 1.3.3.2 states:

Address dehydration and/or constipation by:

• ensuring adequate fluid intake to prevent dehydration by encouraging the person to drink – consider offering subcutaneous or intravenous fluids if necessary
• taking advice if necessary when managing fluid balance in people with comorbidities (for example heart failure or chronic kidney disease).

NICE recommendation 1.3.3.8 states:

Address poor nutrition by:

• following the advice given on nutrition in ‘Nutrition support in adults’ (NICE clinical guideline 32)
• if people have dentures, ensuring they fit properly.

NICE recommendation 1.3.3.5 states:

Address immobility or limited mobility through the following actions:

• Encourage people to mobilise soon after surgery and walk (provide appropriate walking aids if needed – these should be accessible at all times)
• Encourage all people, including those unable to walk, to carry out active range-of-motion exercises.

NICE recommendation 1.3.3.10 states:

Promote good patterns and sleep hygiene\(^4\) by:

• avoiding nursing or medical procedures during sleeping hours, if possible
• scheduling medication rounds to avoid disturbing sleep
• reducing noise to a minimum during sleep periods.

NICE recommendation 1.3.3.6 states:
Address pain by:

- assessing for pain
- looking for non-verbal signs of pain, particularly in those with communication difficulties (for example, people with learning difficulties or dementia, or people on a ventilator or who have a tracheostomy)
- starting and reviewing appropriate pain management.

NICE recommendation 1.4.1 states:

- Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations in usual behaviour. These may be reported by the person at risk, or a carer or relative.

Part of NICE recommendation 1.7.1 states:

- Encourage people at risk and their families and/or carers to tell their healthcare team about any sudden changes or fluctuations in behaviour.

(See the NICE guideline for the full recommendation.)
Exercise 4: case study C – questions

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

You have already identified that Barbara has risk factors for delirium but does not have any indicators of delirium. What should you assess next? And what are the possible results of the assessment?

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting. (Recommendation 1.3.2) What interventions would you propose for Barbara?
Exercise 4: case study C – answers

You have already identified that Barbara has risk factors for delirium but does not have any indicators of delirium. What should you assess next? And what are the possible results of the assessment?

Within 24 hours of admission, assess people at risk for clinical factors contributing to delirium. (Recommendation 1.3.2)

Clinical factors that could contribute to delirium in this person are:

- Barbara may be in pain following her operation.
- She is finding it difficult to mobilise.
- She has had an infection in her wound site and the infection may not have responded fully to the antibiotics.
- She has moved locations a lot recently and this may have disorientated her.

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person's individual needs and care setting. (Recommendation 1.3.2)

What interventions would you propose for Barbara?

NICE recommendation 1.3.1 states:

- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk.
- Avoid moving people within and between wards or rooms unless absolutely necessary.

NICE recommendation 1.3.3.6 states:

Address pain by:

- assessing for pain
- looking for non-verbal signs of pain, particularly in those with communication difficulties (for example, people with learning difficulties or dementia, or people on a ventilator or who have a tracheostomy).
• starting and reviewing appropriate pain management.

NICE recommendation 1.3.3.5 states:

Address immobility or limited mobility through the following actions:

• Encourage people to mobilise soon after surgery and walk (provide appropriate walking aids if needed – these should be accessible at all times).
• Encourage all people, including those unable to walk, to carry out active range-of-motion exercises.

NICE recommendation 1.3.3.4 states:

Address infection by:

• looking for and treating infection
• avoiding unnecessary catheterisation
• implementing infection control procedures in line with ‘Infection control’ (NICE clinical guideline 2).

NICE recommendation 1.3.3.1 states:

Address cognitive impairment or disorientation by:

• providing appropriate lighting and clear signage; a clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk
• talking to the person to reorientate them by explaining where they are, who they are, and what your role is
• introducing cognitively stimulating activities (for example, reminiscence)
• facilitating regular visits from family and friends.
NICE recommendation 1.4.1 states:

- Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations in usual behaviour. These may be reported by the person at risk, or a carer or relative.

Part of NICE recommendation 1.7.1 states:

- Encourage people at risk and their families and/or carers to tell their healthcare team about any sudden changes or fluctuations in behaviour.

(See the NICE guideline for the full recommendation.)
Exercise 4: case study D – questions

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

You have already identified that Charles has risk factors for delirium but does not have any indicators of delirium. What should you assess next? What are the possible results of the assessment?

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting. (Recommendation 1.3.2) What interventions would you propose for this person?
Exercise 4: case study D – answers

You have already identified that Charles has risk factors for delirium but does not have any indicators of delirium. What should you assess next? What are the possible results of the assessment?

Within 24 hours of admission, assess people at risk for clinical factors contributing to delirium. (Recommendation 1.3.2)

Clinical factors that could contribute to delirium in this person are:

- Charles may be receiving multiple medications to manage his potentially unstable condition.

To prevent delirium in this person the NICE guideline recommends: based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting. (Recommendation 1.3.2)

What interventions would you propose for this person?

NICE recommendation 1.3.1 states:

- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk.
- Avoid moving people within and between wards or rooms unless absolutely necessary.

NICE recommendation 1.3.3.7 states:

- Carry out a medication review for people taking multiple drugs, taking into account both the type and number of medications.
NICE recommendation 1.4.1 states:

- Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations in usual behaviour. These may be reported by the person at risk, or a carer or relative.

Part of NICE recommendation 1.7.1 states:

- Encourage people at risk and their families and/or carers to tell their healthcare team about any sudden changes or fluctuations in behaviour.

(See the NICE guideline for the full recommendation.)
Exercise 5: diagnosing and treating delirium

We have established how to prevent delirium in people who are at risk but do not have any indicators of delirium. The NICE guideline also addresses diagnosis and treatment of delirium.

This exercise is designed to help you learn how delirium should be diagnosed and what treatment options are recommended. This exercise will also encourage you to reflect upon if and when interventions could have been implemented to prevent delirium.

Please read alongside the case study descriptions on pages 14–15 of this session plan.
Exercise 5: case study E – questions

If you are conducting a short session do not ask participants to complete the questions initially by themselves. Work through the answers with them.

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

When you assess Aariz on admission, you should assess for risk factors for delirium and indicators of delirium. What are the possible results of this assessment for this person?

Risk factors for delirium:

Indicators of delirium:

What makes this case more difficult?

What will you do now with the results of your assessment?

What tools should be used to confirm a diagnosis of delirium?

If Aariz were to be diagnosed with delirium, what information should be offered to Aariz and his family?
Exercise 5: case study E – answers

If you are conducting a short session do not ask participants to complete the questions initially by themselves. Work through the answers with them.

When you assess Aariz on admission, you should assess for risk factors for delirium and indicators of delirium. What are the possible results of this assessment for this person?

Risk factors for delirium:

Age
Dementia (Alzheimer's)

Indicators of delirium:

Cognitive: confusion
Perception: altered perception
Physical: sleep disturbance
Social behaviour: alterations in communication (shouting)

What makes this case more difficult?

Aariz is also showing signs of dementia².

What will you do now with the results of your assessment?

Aariz is showing signs of dementia and possible delirium. The NICE guideline recommends that: if there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia, treat for delirium first. (Recommendation 1.5.1) Therefore you should proceed with the care pathway for delirium.

The NICE guideline recommends that if any delirium indicators are present, a healthcare professional who is trained and competent in diagnosing delirium should carry out a clinical assessment to confirm the diagnosis. (Recommendation 1.2.1) Therefore you would refer this person to the appropriate healthcare professional in your organisation or clinical area for clinical assessment to diagnose delirium.
What tools should be used to confirm a diagnosis of delirium?

If indicators of delirium are identified, carry out a clinical assessment based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria, short Confusion Assessment Method (short CAM) or CAM-ICU (in critical care or in the recovery room after surgery). A healthcare professional who is trained and competent in the diagnosis of delirium should carry out the assessment. (Recommendation 1.5.1)

Please see page 40 of http://www.nice.org.uk/nicemedia/live/13060/49960/49960.pdf (appendix I) for more information about DSM-IV and details about the validated instruments for delirium.

Ensure that the diagnosis of delirium is documented both in the person’s hospital record and in their primary care health record. (Recommendation 1.5.2)

If Aariz were to be diagnosed with delirium, what information should be offered to Aariz and his family?

NICE recommendations 1.7.1 and 1.7.2 state that the information should:

- inform them that delirium is common and usually temporary
- describe people’s experience of delirium
- encourage people at risk and their families and/or carers to tell their healthcare team about any sudden changes or fluctuations in behaviour
- encourage the person who has had delirium to share their experience of delirium with the healthcare professional during recovery
- advise the person of any support groups
- meet the cultural, cognitive and language needs of the person.
**Exercise 5: case study F – questions**

*If you are conducting a short session do not ask participants to complete the questions initially by themselves. Work through the answers with them.*

Please note: the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

You have identified that Gladys has some indicators for delirium; therefore you have referred her for clinical assessment with a healthcare professional who is trained and competent in diagnosing delirium. The diagnosis of delirium is confirmed. What should be the elements of the initial treatment plan for this person?

You feel that Gladys is distressed and possibly a risk to herself or others. What will your next step be?

What would you do if delirium symptoms did not resolve following treatment?

What would you do if delirium symptoms did resolve following treatment?
Gladys is at risk of delirium. Therefore, according to NICE recommendations, nursing home staff should have assessed her for clinical factors and been delivering a multicomponent intervention package tailored to her needs and care setting. When her needs changed (deteriorating mobility meant she had to change rooms), Gladys’s care team should have reassessed the clinical factors contributing to delirium and redesigned her multicomponent intervention. Can you identify any clinical factors contributing to delirium which, if they were addressed earlier, could have prevented delirium?

How would you have addressed these?

How would you ensure you prevented delirium throughout the stay of a person who on admission was not considered at risk of delirium and didn’t have any indicators of delirium?
Exercise 5: case study F – answers

If you are conducting a short session do not ask participants to complete the questions initially by themselves. Work through the answers with them.

You have identified that Gladys has some indicators for delirium; therefore you have referred her for clinical assessment with a healthcare professional who is trained and competent in diagnosing delirium. The diagnosis of delirium is confirmed. What should be the elements of the initial treatment plan for this person?

- In people diagnosed with delirium, identify and manage the possible underlying cause or combination of causes. (Recommendation 1.6.1)
- Ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium. Consider involving family, friends and carers to help with this. Provide a suitable care environment (see recommendation 1.3.1). (Recommendation 1.6.2)
- Ensure that people are cared for by a team of healthcare professionals who are familiar to the person at risk. (Recommendation 1.3.1)
- Avoid moving people within and between wards or rooms unless absolutely necessary. (Recommendation 1.3.1)

You feel that Gladys is distressed and possibly a risk to herself or others. What will your next step be?

NICE recommendation 1.6.3 states:

- If a person with delirium is distressed or considered a risk to themselves or others, first use verbal and non-verbal techniques to de-escalate the situation. For more information on de-escalation techniques, see ‘Violence’ (NICE clinical guideline 25). Distress may be less evident in people with hypoactive delirium, who can still become distressed by, for example, psychotic symptoms.

NICE recommendation 1.6.4 states:
• If verbal and non-verbal techniques are ineffective or inappropriate, consider giving short-term (usually for 1 week or less) haloperidol$^5$ or olanzapine$^5$. Start at the lowest clinically appropriate dose and titrate cautiously according to symptoms. Check contraindications of these medications before administering.

NICE recommendation 1.6.5 states:

• Use antipsychotic drugs with caution or not at all for people with conditions such as Parkinson’s disease or dementia with Lewy bodies$^6$.

What would you do if delirium symptoms did not resolve following treatment?

Re-evaluate for underlying causes.

Follow up and assess for possible dementia$^2$.

What would you do if delirium symptoms did resolve following treatment?

NICE recommendation 1.1.2 states:

• Observe people at every opportunity for any changes in the risk factors for delirium.

NICE recommendation 1.4.1 states:

• Observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations in usual behaviour. These may be reported by the person at risk, or a carer or relative.

Gladys is at risk of delirium. Therefore, according to the NICE recommendations, nursing home staff should have assessed her for clinical factors and been delivering a multicomponent intervention package tailored to her needs and care setting. When her needs changed (deteriorating mobility meant she had to change rooms), Gladys’s care team should have reassessed the clinical factors contributing to delirium and redesigned her multicomponent intervention. Can you identify any clinical factors contributing
to delirium which, if they were addressed earlier, could have prevented delirium?

She may have become disorientated by being moved from her bedroom to another room.

She has reduced mobility.

The cause of her reduced mobility may have been pain.

**How would you have addressed these?**

NICE recommendation 1.3.1 states:

- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk.
- Avoid moving people within and between wards or rooms unless absolutely necessary.

If moving Gladys between rooms was absolutely necessary it would have been important for the care home staff to recognise that this is a clinical factor contributing to delirium, and to take appropriate action to reduce possible disorientation. NICE recommendation 1.3.3.1 states:

Address cognitive impairment or disorientation by:

- providing appropriate lighting and clear signage; a clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk
- talking to the person to reorientate them by explaining where they are, who they are, and what your role is
- introducing cognitively stimulating activities (for example, reminiscence)
- facilitating regular visits from family and friends.

NICE recommendation 1.3.3.5 states:

Address immobility or limited mobility through the following actions:

- Encourage people to mobilise soon after surgery and walk (provide appropriate walking aids if needed – these should be accessible at all times).
• Encourage all people, including those unable to walk, to carry out active range-of-motion exercises.

NICE recommendation 1.3.3.6 states:

Address pain by:

• assessing for pain
• looking for non-verbal signs of pain, particularly in those with communication difficulties (for example, people with learning difficulties or dementia, or people on a ventilator or who have a tracheostomy).
• starting and reviewing appropriate pain management.

How would you ensure you prevented delirium throughout the stay of a person who on admission was not considered at risk of delirium and didn’t have any indicators of delirium?

Observe people at every opportunity for any changes in the risk factors for delirium. (Recommendation 1.1.2) If there is a change in the person’s risk factors during their admission, reassess for clinical factors contributing to delirium. Based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting as described in recommendations 1.3.3.1–1.3.3.10 (see page 7 of the quick reference guide for the algorithm explaining this process).

Additionally, NICE recommends observing, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations in usual behaviour (indicators of delirium). These may be reported by the person at risk, or a carer or relative. If any of these behaviour changes is present, a healthcare professional who is trained and competent in the diagnosis of delirium should carry out a clinical assessment to confirm the diagnosis. (Recommendation 1.4.1)
Post-workshop quiz
If you are taking part in a short session, complete this questionnaire after the session. Your facilitator will provide you with the answers at a feedback session in the future.

If you are taking part in a full session, your facilitator may request that you complete this questionnaire during the session.

Without using any versions of the guideline answer the following.

Please note the size of the gaps left for responses does not reflect the anticipated size of the answers. Extra space may be needed by participants to write their answers.

1. What are the risk factors for delirium?
   (Maximum 4 points)

2. If a person is at risk of delirium what should you consider when preparing their care environment?
   (Maximum 2 points)

3. In people at risk what clinical factors can contribute to delirium?
   (Maximum 10 points)

4. When should people at risk be assessed for clinical factors contributing to delirium? What should this information be used for?
   (Maximum 4 points)

5. Who should deliver the multicomponent intervention package?
   (Maximum 1 point)

6. What interventions would you offer to address each of the following clinical factors (tailored multicomponent intervention):
   (Maximum 11 points)
   Address cognitive impairment or disorientation by:
   Address dehydration and/or constipation by:
   Address infection by:
   Address pain by:
   Address sensory impairment by:
7. **What would indicate a person has delirium? Who might report these indicators?**

(1 point for identifying recent change in behaviour; 1 additional point for identifying each area that behaviour change may affect and 3 points for identifying the three groups who may report these changes. Maximum 8 points.)

8. **When would you assess people for these indicators?**

(Maximum 2 points)

9. **What should you do if you believe a person has delirium?**

(Maximum 1 point)

10. **What should trained healthcare professionals base their assessment on to confirm the diagnosis of delirium?**

(Maximum 3 points)

11. **If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia what should be done?**

(Maximum 1 point)

12. **Once a diagnosis of delirium is confirmed what initial steps should you take?**

(Maximum 5 points)

13. **If the person with delirium is distressed or considered a risk to themselves or others, what techniques should you first use to de-escalate the situation?**

(Maximum 2 points)

14. **For people with delirium who are distressed or considered a risk to themselves or others, and in whom the initial approaches are ineffective or inappropriate, what else would you consider doing?**

(Maximum 1 point)

15. **If delirium does not resolve what should you do?**

(Maximum 2 points)
16. What are the key components of the information and support that should be offered to people who are at risk of delirium or who have delirium, and their family and/or carers?

(Maximum 6 points)

Score..................... /63
Post-workshop quiz answers

1. **What are the risk factors for delirium?**
   (Maximum 4 points)
   - Age 65 years or older.
   - Cognitive impairment (past or present) and/or dementia\(^2\). If cognitive impairment is suspected, confirm it using a standardised and validated cognitive impairment measure.
   - Current hip fracture.
   - Severe illness (a clinical condition that is deteriorating or is at risk of deterioration)\(^3\).
   (Recommendation 1.1.1)

2. **If a person is at risk of delirium what should you consider when preparing their care environment?**
   (Maximum 2 points)
   - Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk.
   - Avoid moving people within and between wards or rooms unless absolutely necessary.
   (Recommendation 1.3.1)

3. **In people at risk what clinical factors can contribute to delirium?**
   (Maximum 10 points)
   - Cognitive impairment and/or disorientation
   - Dehydration and/or constipation
   - Hypoxia
   - Infection
   - Immobility or limited mobility
   - Pain
   - Multiple drugs
   - Poor nutrition
   - Sensory impairment
   - Poor sleep patterns and sleep hygiene\(^4\)
(Recommendations 1.3.3.1–1.3.3.10)

4. **When should people at risk be assessed for clinical factors contributing to delirium? What should this information be used for?**

(Maximum 4 points)

- Within 24 hours of admission and at least daily after that.
- Based on the results of this assessment, provide a multicomponent intervention tailored to the person’s individual needs and care setting.

(Recommendation 1.3.2)

5. **Who should deliver the multicomponent intervention package?**

(Maximum 1 point)

- The tailored multicomponent intervention package should be delivered by a multidisciplinary team trained and competent in delirium prevention.

(Recommendation 1.3.3)

6. **What interventions would you offer to address each of the following clinical factors (tailored multicomponent intervention):**

(Maximum 11 points)

**Address cognitive impairment or disorientation by:**

- providing appropriate lighting and clear signage; a clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk
- talking to the person to reorientate them by explaining where they are, who they are, and what your role is
- introducing cognitively stimulating activities (for example, reminiscence)
- facilitating regular visits from family and friends.

**Address dehydration and/or constipation by:**

- ensuring adequate fluid intake to prevent dehydration by encouraging the person to drink – consider offering subcutaneous or intravenous fluids if necessary
- taking advice if necessary when managing fluid balance in people with comorbidities (for example heart failure or chronic kidney disease).
Address infection by:

- looking for and treating infection
- avoiding unnecessary catheterisation
- implementing infection control procedures in line with ‘Infection control’ (NICE clinical guideline 2).

Address pain by:

- assessing for pain
- looking for non-verbal signs of pain, particularly in those with communication difficulties (for example, people with learning difficulties or dementia, or people on a ventilator or who have a tracheostomy)
- starting and reviewing appropriate pain management.

Address sensory impairment by:

- resolving any reversible cause of the impairment, such as impacted ear wax
- ensuring hearing and visual aids are available to and used by people who need them, and that they are in good working order.

7. What would indicate a person has delirium? Who might report these indicators?

(1 point for identifying recent change in behaviour; 1 additional point for identifying each area that behaviour change may affect and 3 points for identifying the three groups who may report these changes. Maximum 8 points.)

Recent (within hours or days) changes or fluctuations in usual behaviour. These may be reported by the person at risk, or a carer or relative. The behaviour changes may affect:

- cognitive function: for example, worsened concentration, slow responses, confusion
- perception: for example, visual or auditory hallucinations
- physical function: for example, reduced mobility, reduced movement, restlessness, agitation, changes in appetite, sleep disturbance
• social behaviour: for example, lack of cooperation with reasonable requests, withdrawal, or alterations in communication, mood and/or attitude. (Recommendation 1.2.1)

8. **When would you assess people for these indicators?** (Maximum 2 points)

• People at risk should be assessed at presentation for recent changes or fluctuations in behaviour. (Recommendation 1.2.1)

• All people (those at risk on admission and those who were not) in hospital or long-term care should be observed at least daily for recent changes or fluctuations in usual behaviour. (Recommendation 1.4.1)

9. **What should you do if you believe a person has delirium?** (Maximum 1 point)

If any of these indicators are present, a healthcare professional who is trained and competent in diagnosing delirium should carry out a clinical assessment to confirm the diagnosis. (Recommendation 1.2.1)

10. **What should trained healthcare professionals base their assessment on to confirm the diagnosis of delirium?** (Maximum 3 points)

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria, the short Confusion Assessment Method (short CAM) or (in critical care or in the recovery room after surgery) CAM-ICU. (Recommendation 1.5.1)

11. **If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia what should be done?** (Maximum 1 point)

Treat for delirium first. (Recommendation 1.5.1)
12. **Once a diagnosis of delirium is confirmed what initial steps should you take?**

(Maximum 5 points)

- Ensure that the diagnosis of delirium is documented both in the person’s hospital record and in their primary care health record. (Recommendation 1.5.2)
- Identify and manage the possible underlying cause or combination of causes. (Recommendation 1.6.1)
- Ensure effective communication and reorientation and provide reassurance for people diagnosed with delirium. Consider involving family, friends and carers to help with this. (Recommendation 1.6.2)
- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk. (Recommendation 1.3.1)
- Avoid moving people within and between wards or rooms unless absolutely necessary. (Recommendation 1.3.1)

13. **If the person with delirium is distressed or considered a risk to themselves or others, what techniques should you first use to de-escalate the situation?**

(Maximum 2 points)

Recommendation 1.6.3 says that if a person with delirium is distressed or considered a risk to themselves or others, first use verbal and non-verbal techniques to de-escalate the situation. For more information on de-escalation techniques, see ‘Violence’ (NICE clinical guideline 25). Distress may be less evident in people with hypoactive delirium, who can still become distressed by, for example, psychotic symptoms.

14. **For people with delirium who are distressed or considered a risk to themselves or others, and in whom the initial approaches are ineffective or inappropriate what else would you consider doing?**

(Maximum 1 point)

Giving short-term (usually for 1 week or less) haloperidol or olanzapine (start at the lowest clinically appropriate dose and titrate cautiously according to symptoms),
provided the person does not have dementia with Lewy bodies or Parkinson’s disease\textsuperscript{6}.

(Recommendation 1.6.4)

15. **If delirium does not resolve what should you do?**
(Maximum 2 points)
- Re-evaluate for underlying causes.
- Follow up and assess for possible dementia\textsuperscript{2}.

(Recommendation 1.6.6)

16. **What are the key components of the information and support that should be offered to people who are at risk of delirium or who have delirium, and their family and/or carers?**
(Maximum 6 points)

It should:

- inform them that delirium is common and usually temporary
- describe people’s experience of delirium
- encourage people at risk and their families and/or carers to tell their healthcare team about any sudden changes or fluctuations in behaviour
- encourage the person who has had delirium to share their experience of delirium with the healthcare professional during recovery
- advise the person of any support groups
- meet the cultural, cognitive and language needs of the person.

(Recommendations 1.7.1 and 1.7.2)

Score.......................... /63
Certificate of attendance

........................................................................................................

completed a

Delirium awareness workshop

(based on NICE clinical guideline CG103)

on ..................................................
at ..................................................
1 hour / 3 hour format (delete as applicable)

Signed..............................................................

Designation............................................................

THINK DELIRIUM!
Other resources to support learning

The following versions of NICE clinical guideline 103 are available from www.nice.org.uk/guidance/CG103:

- The NICE guideline – all the recommendations.
- ‘Understanding NICE guidance’ – information for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or ‘Understanding NICE guidance’, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote reference numbers N2224 (quick reference guide) and/or N2225 (‘Understanding NICE guidance’).

Implementation tools

NICE has developed tools to help organisations implement this guideline, available from www.nice.org.uk/guidance/CG103

- Implementation advice – this provides practical suggestions for action to help those responsible for planning and implementing the guideline. In particular it details the ‘whole system’ approach which is required in order to prevent delirium.
- Standard slide set – highlights the key messages from the guideline.
- Costing tools – a costing statement giving an indication of the savings and costs associated with implementation, and a costing template allowing you to estimate the local costs and savings involved.
- Audit support and baseline assessment tool – for monitoring local practice and helping to identify which areas of practice may need more support, decide on clinical audit topics and prioritise implementation activities.
- Delirium awareness workshop slide set – to accompany this session plan.
• Delirium prevention care plan: template – a template care plan for the prevention of delirium in people identified as at risk of delirium.

Related NICE guidance

Acutely ill patients in hospital. NICE clinical guideline 50 (2007).
Dementia. NICE clinical guideline 42 (2006).
Infection control. NICE clinical guideline 2 (2003)

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• members of the National Clinical Guideline Centre
• members of the Guideline Development Group
• attendees of the planning meeting
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• ‘Stop Delirium!’ project for providing some of the case studies for this training pack.

References and endnotes

References


Endnotes

1 Cognitive impairment is taken to mean difficulty with memory, thinking, concentration and ability to read and write.
2 If dementia is suspected, refer to further information on the diagnosis, treatment and care of people with dementia in ‘Dementia: supporting people with dementia and their carers in health and social care’ (NICE clinical guideline 42).
3 For further information on recognising and responding to acute illness in adults in hospital see ‘Acutely ill patients in hospital’ (NICE clinical guideline 50).
4 For more information on good sleep hygiene, see ‘Parkinson’s disease’ (NICE clinical guideline 35).
5 Haloperidol and olanzapine do not have UK marketing authorisation for this indication.
6 For more information on the use of antipsychotics for these conditions, see ‘Parkinson’s disease’ (NICE clinical guideline 35) and ‘Dementia’ (NICE clinical guideline 42).
Evaluation form

Insert date and time of workshop:

Administration
Was the information you received before the workshop
☐ Too much ☐ Just right ☐ Not enough ☐ Don’t know

Did you have enough time to complete the pre-workshop tasks?
☐ Too much ☐ Just right ☐ Not enough ☐ Don’t know

Workshop
Has the session improved your knowledge of the guidance?
☐ Yes ☐ Partly ☐ No ☐ Don’t know

If not why not...........................................................................................................................................................................

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Did the session explain how the guidance should be used?
☐ Yes, completely ☐Partly ☐ No ☐ Don’t know

If not why not...........................................................................................................................................................................

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Were the case studies helpful?
☐ Yes ☐Partly ☐ No ☐ Don’t know

Will areas of your practice change as a result of this session? If so, how and if not why not?
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Any other comments or suggestions for improvement?
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Thank you for your feedback.