Fareham and Gosport NHS
Primary Care Trust

FAO: Justina Jeffs

Dr Dowd has amended the flow chart at the end of the Guidelines for the Management of Confusion in the Elderly. I would be grateful if you could amend in copies in your possession

Many thanks

Regards:

Code A

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With compliments

Fareham and Gosport NHS
Primary Care Trust

MANAGEMENT OF CONFUSION (ELDERLY MEDICINE)
(To be used in conjunction with full guidelines)

History from patient and third party

↓

EXAMINATION

↓

MEDICAL SCREEN/INVESTIGATION

↓

USE ENVIRONMNENTAL STRATEGIES TO MINIMISE EFFECT OF CONFUSION

↓

IF CONFUSION IS CAUSING BEHAVIOURAL PROBLEMS

↓

Consider other causes eg. PAIN, DEPRESSION, CONSTIPATION RETENTION, WITHDRAWAL

↓

CONSIDER PSYCHIATRY REFERRAL

↓

If there are still behavioural problems

If the patient is psychotic/ paranoid/hallucinating

↓

Try Risperidone 0.5mg up to 1mg bd
or
Haloperidol 0.5mg bd oral up to 0.5mg qds
(not in Parkinson's/Lewy Body Disease)

If the patient is agitated but not psychotic

↓

Try oral Lorazepam 0.5mg od
or bd up to 0.5mg qds

<u>If all strategies have failed and patient is a risk</u>
to themselves and others

↓

<u>RAPID TRANQUILLIZATION with LORAZEPAM 0.5mg-1mg im stat</u>
(dose may be repeated after 30 mins up to a maximum of 3 doses)

↓

Document and monitor as per Care Pathway

↓

Prescribe regular oral sedation to follow

↓

Consider need for Section 5(2) of Mental Health Act and urgent Psychiatry opinion

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GUIDELINES ON THE MANAGEMENT OF ACUTE CONFUSION AND AGGRESSION IN THE ELDERLY

The following provides guidance on the management of acutely confused and possibly aggressive patients. In all cases it is important to obtain as much information as possible on pre-morbid psychiatric and medical history, personal details, details of onset of illness and medication .

A multi-disciplinary approach is necessary and advice may be needed from the Department of Elderly Mental Health:

Ext 4328 for Saint James' based Consultants,
tel. 02392 471551 for Consultants in Havant during normal working hours,
265 / 266 for Consultants based at Saint Christopher's, and
2289 / 2299 / 2292 / 2295 for those at the Gosport War Memorial, or
via switchboard for the duty psychiatrist out of hours.

REMEMBER – CONFUSION IS A SYMPTOM, NOT A DIAGNOSIS

IN ALL PATIENTS

- A medical screen (Appendix A) should be done to identify the cause of acute confusion
- If confusion is causing behavioural problems then a graded approach should be followed.

  Before sedation is used the following should have been tried:
  - Environmental or general management (see Appendix B).
  - Advice – help from the family
  - Person centred nursing.

If the above fails consider medication.

Consider the underlying conditions that may be causing the behavioural problems as identified on the medical screen.

PAIN	Patients may articulate this poorly but need regular analgesia.
DEPRESSION	Particularly in somebody with dementia may manifest as shouting and calling for attention, consider a trial of an SSRI antidepressant.
CONSTIPATION	A rectal examination should be performed whenever possible, constipation treated appropriately and bowel habit monitored.

URINARY RETENTION

ALCOHOL/ NICOTINE/ DRUG WITHDRAWAL

Some patients with brain damage/dementia call out for no apparent reason, in which case sedation should be limited to night time to promote a "normal" sleep pattern. Drugs which may be tried are:

- Temazepam 10-20mgs,
- Chlormethiazole 1-3 capsules,
- Chloral Betaine 2 tablets (preferably for short term use).

IF ACUTE CONFUSION IS CAUSING BEHAVIOURAL PROBLEMS AND THE PREVIOUSLY STATED GRADUATED APPROACH HAS FAILED TO MANAGE THE SITUATION, CONSIDER THE FOLLOWING:

1. **Is the patient psychotic/hallucinating?** In this case the following oral medication may be used:

- Risperidone 0.5mg once daily/twice daily up to 1mg bd
  or
- Haloperidol 0.5mg bd up to 0.5mg qds orally
  (do not use Haloperidol in Lewy Body disease. This may be suspected in patients with Parkinsonism, visual hallucinations etc).

2. **Is the patient agitated without psychosis/hallucination?** In this case: Lorazepam orally 0.5mg once or twice daily, up to a maximum of 0.5 mg qds may be tried.

SEEK ADVICE OF PSYCHIATRIST OR MENTAL HEALTH NURSE ADVISOR if behaviour is a management problem or not improving.

THE USE OF I.M. MEDICATION SHOULD NOT BE INSTITUTED WITHOUT FOLLOWING THE RAPID TRANQUILLISATION PATHWAY (unless the patient is dysphagic and unable to take oral medication).

Also see page 12 for flow chart.

RAPID TRANQUILLISATION

This is an emergency procedure to be employed in the event of behaviour:

- which has failed to respond to other measures,
- which has arisen too quickly to respond to other measures,
- where a patient is a danger to themselves or others.

It should only be employed in situations where the necessary monitoring can be carried out. The senior nurse on duty may consider requesting that the patient is transferred to the nearest accident and emergency department if, in their opinion, the following guidance cannot be implemented due to resource constraints. The 'on call' manager should be informed.

- CONSIDER OTHER MEASURES FIRST (See Care Pathway - Appendix C).

- RESTRAIN PATIENT (See Appendix B) – This is permitted under common law. Additional staff should be called for to safely physically restrain the patient and administer adequate sedation.

- **Lorazepam 0.5mg to 1mg i.m.** stat is suggested and a dose may be repeated after 30 minutes.
  (should be diluted with an equal volume of water for injection or saline)
  If three doses of i.m. Lorazepam have been ineffective, seek urgent psychiatric advice.

- WRITE UP REGULAR ORAL SEDATION - To start when the patient wakes up to avoid the need for repeated rapid tranquillisation e.g.
  - Lorazepam 0.5mg bd up to 0.5mg qds,
  - Risperidone 0.5mg bd or
  - Haloperidol 0.5mg bd up to 0.5mg qds
    (Haloperidol is not to be given to Parkinsonian patients or those with Lewy Body dementia).

- Nurse on a one-to-one basis with adequate pressure relief.

- Hydrate using subcutaneous or intravenous fluids if necessary.

- Inform next of kin about what is happening as this group of patients have a high mortality.

- **Monitor closely including blood pressure, pulse, oxygen saturation as per the Care Pathway (Appendix C).**

- Medical screen.

- Prescribe prn Flumazenil (emergency drug cupboard) to be used if the respiratory rate drops below 10 per minute.

- Consider the need for Section 5(2) of the Mental Health Act.

Dr A Dowd, Consultant,
Jane Marshall, Directorate Pharmacist, Elderly Care,
Andy Tysoe, Mental Health Nurse,
Yvonne Middlewick, Elderly Care Sister, manage this guideline (ext 5412)
See Trust Policy for the Production of Drug Therapy Guidelines
Approved by:
Portsmouth & South East Hampshire Guidelines and Medicines Management Group Date: Nov 2003
Ratified by: Date:
Review date:

Fareham and Gosport NHS
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SECTION 5(2) MENTAL HEALTH ACT 1983

Definition

This section allows for the ***detention*** of an informal in-patient, against their will, for ***up to 72 hours.*** It is designed for use as an ***emergency holding order,*** allowing time for a ***further assessment by a Responsible Medical Officer*** as defined under Section 12(2) of the act, to take place.

Scenario

The patient appears to be suffering from a ***mental disorder and wishes to leave hospital.*** Allowing the patient to leave hospital would present a ***significant risk*** to their ***health and safety, or that of others.***

Process

One medical recommendation is required. ***The doctor in charge of the patient, or their nominated deputy*** (Consultant/Duty Consultant out of hours, or junior doctor who has discussed the patient with the Consultant), completes a ***Medical Report on Hospital Inpatient (form 12).*** This is then handed to the unit bleep holder who receives the report on behalf of the hospital managers.

The doctor completing the medical report does not have to be recognised under Section 12(2) of the Act.

The unit bleep holder will then formally acknowledge receipt of this report by completing the ***Record of Receipt of Medical Recommendation(s) and formal admission to hospital (form 14).***

In accordance with ***Section 132*** of the Act, the patient must be given written information (leaflet 3) and an ***explanation of their rights*** immediately, or as soon as practicable, after the Section 5(2) had been applied.

An ***urgent contact*** with the ***duty psychiatrist*** must be made, as the section should not be allowed to run for the full 72 hours. The section is rescinded by the arrival of, and subsequent assessment by, the psychiatrist.

Treatment

Treatment ***cannot be forced*** on a patient under this section. It can only be administered with the patient's consent or as an emergency, under common law. The patient can, however, be ***legally stopped*** from leaving the ward.

APPENDIX A

Medical Assessment of the Acutely Confused Patient

A full history of the presenting problem and premorbid mental and physical function should be obtained.

A medication review is necessary as polypharmacy or inappropriate prescribing may worsen confusion.

A full examination should be carried out including assessment of sensory functions, e.g. vision and hearing as disabilities in these areas may worsen confusion.

A rectal examination should be done to exclude constipation (wherever possible).

Full blood count, blood sugar, urea and electrolytes, chest Xray and ECG should be done urgently looking for evidence of infection, dehydration, electrolyte imbalance, dysrhythmia or myocardial infarction.

Oxygen saturation should be checked routinely and arterial blood gases done if there is reduced oxygen saturation or signs of respiratory disease.

If there is an elevated white count and/or pyrexia, blood cultures and mid-stream urine should be taken.

In the absence of other causes of acute confusion, if there is any history of significant head injury or a fluctuating conscious level, an urgent brain CT scan should be done to exclude subdural haematoma.

Liver and thyroid function should be checked routinely.

In the sedated patient, hydration should be instituted using subcutaneous fluid unless there is dehydration or antibiotics are needed, in which case intravenous fluids should be given.

All correctable problems should be treated and as soon as this is done, sedation withdrawn gradually over a period of two to three days. The patient should be reassessed at least daily.

APPENDIX B

NURSING INTERVENTIONS AND MANAGEMENT OF ACUTELY CONFUSED PEOPLE

Environment

Bed position – consider: People who wander should have a bed as far as possible, for their own safety, from the entrance/exit of the ward to allow them space to mobilise but reducing the risk of walking off the ward.

Bed rails should be avoided as a way to reduce wandering, as they may serve to place an obstacle in the way of the person, increasing the risk of falls/injury. They are also a form of restraint.

Bed space should be free of clutter.

Lighting – confusion often becomes more marked from late evening onwards (Sundown Syndrome – Laxon et al 1982). Consider timing of medication to pre-empt this. Try to provide adequate lighting for the person, e.g. in a cubicle/day room which will not disturb others. Check if person has/needs glasses.

Noise - try to reduce excessive noise levels: too many radios/ TV's on together or too loud, buzzers left to ring on, staff shouting to each other, drip alarms, trolley and bed movements, visitors, etc. Check if person has/needs a hearing aid and, if so, that it is working properly.

Temperature – Is the person too hot/cold?

Avoid room/bed changes and ward moves where possible, especially at night.

Approach

Verbal – Do not confront. Confused people are more likely to become agitated and aggressive if they feel threatened. Communicate clearly, calmly, simply and express your wish to help with their situation to reduce their distress/confusion.

- Introduce and personalise yourself to the person.
- Listen to the person, observe the behaviour and try to interpret the message, emotion and feelings being communicated.
- Try to avoid commands and the words 'don't' and 'why'.
- Explain to the person what you want them to do – not what not to do.
- Acknowledge their feelings and show concern.
- More than one member of staff talking to the person at the same time will add to the confusion and lose the thread of intervention. It may also serve to make the person feel threatened.
- Try to orientate the person and highlight visual clues for them to acknowledge. If the patient insists they are somewhere else, e.g.

- validate/ acknowledge their feelings and do not proceed with reality orientation as this could provoke a confrontation.
- Explain unfamiliar noises/equipment/personnel to the person to avoid misinterpretation.
- Do not label a person or their behaviour in a negative way to others.

Non-verbal – Open-handed gestures are seen as non-threatening, whereas pointed gestures are invariably seen as aggressive. Offering a handshake will be recognised by a confused person as a friendly gesture. If a person refuses to shake hands, this may indicate to the nurse that hostility and potential aggression are likely.

- Approach the person from the front, slightly off-centre to avoid feelings of confrontation.
- Maintain good eye contact and initial distance of approx. three feet, so as not to invade personal space.
- If the person is in bed or seated, avoid standing over them and, where possible, crouch down to their eye level.
- Non-verbal clues such as facial expression, body posture and eye contact will be taken on board by the patient and will override verbal communication.

Strategies

Identify cause – Acute confusion is a symptom and not a diagnosis. Involve the multidisciplinary team.

Diversion – Try to engage the person in meaningful activities e.g. offer to accompany a person who is wandering for a walk around. Offer food, drink, newspapers, TV and use of the toilet where appropriate; or simply initiate some social conversation.

One-to-one nursing - People who shout out for help constantly may benefit from one-to-one nursing. Giving quality time to the person when they are not shouting out will help to reduce the frequency of this behaviour and the distress it causes to others. This needs to be a managed intervention and not on an 'ad-hoc' basis. Other situations that might benefit from one-to-one nursing include:

- Wandering people who are at risk of falls or walking off the ward.
- Restless people consistently trying to get out of bed.

An individual nurse should only participate in one-to-one nursing on a rotation basis for a maximum of one hour at a time and ideally should know the person.

Psychosocial – Encourage relatives/friends to be involved, if appropriate, in assisting with a confused person. Their presence on the ward will help to orientate the person and they could offer personalised and workable interventions. For example:

- Pictures from home and/or small ornaments will help to orientate a person.
- Clues about things that are important and pleasurable to the person and boost self-esteem.

Keep relatives informed at all times regarding the potential reasons for the person's behaviour and the strategies being used to manage this.

Restraint – Should physical restriction on the person's movements be necessary, to ensure the safety of the individual or others, use gradient holds only until needed and within the competency of the staff present. You should not use these unless you have had training in the techniques.

Maintain the health, safety and dignity of the person at all times and use the minimal force necessary.

Report/review any incidents as per Trust Policy and highlight appropriate early intervention techniques/antecedent behaviours in the person's care plan.

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APPENDIX C
Care Pathway For Patients Requiring Rapid Tranquillisation

Patients name ..... Hospital no. .....

Date of birth ..... Ward .....

Consultant .....

Prior to the use of i.m. rapid tranquillisation please indicate what alternatives have been tried and their outcome.

	Yes/No	Outcome	If not appropriate – reason	Signed by
1.Alteration of environment e.g. remove to quieter area				
Use of distraction technique				
Advice/help from family				
2. One-to-one nursing				
3. Oral medication				

Indicate reason for use of i.m. medication (Please tick those that apply & initial)

	Tick	Initial
Refusing oral medication		
Urgency of situation requires im administration for rapid effect		
Unable to co-operate		
Other – please state		

Indicate reasons for rapid tranquillization. (At least one must be identified). Please tick all that apply.

1. Severe agitation
2. Physical aggression to patients and/or staff
3. Significant risk of harm to self
4. Prolonged overactivity, risk of exhaustion
5. Determined attempts to abscond that cannot be contained by other means

Name ..... Signature .....

Date ..... Time .....

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Patient name ..... Dob .....

Continue hourly observations until the patient is awake.
Inform doctor if
- Pulse <50 or >110 beats/min
- Respiratory rate <10 per min or >20/min
- Diastolic BP >110mmHg
- O_2 Sat <90%
- Temp >38°C
- Sedation persisting for prolonged period

Activity and Record					Reason for change in observation/action taken	Time	Initial
	P	R	BP	O_2 Sat			
Baseline							
15 mins							
30 mins							
45 mins							
1 hr							
2 hrs							
3 hrs							
4 hrs							
5 hrs							
6 hrs							
7 hrs							
8 hrs							
9 hrs							
10 hrs							
11 hrs							
12 hrs							

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APPENDIX D

GUIDELINES ON THERAPEUTIC INTERVENTIONS FOR PEOPLE WITH ACUTE CONFUSION

Behaviour that Challenges/symptoms commonly seen in acute confusion

- **Wandering/trying to leave the ward**
- **Aggression – verbal**
  - Swearing
  - Abusive/derogatory remarks
  - Shouting out/screaming
  - Threats/confrontative language
- **Aggression – physical**
  - Grabbing out at others and their property
  - Kicking
  - Slapping
  - Scratching
  - Spitting
- **Restlessness** – Compounded when the person is unable to weight bear but tries to walk unaided
- **Stripping off clothes in view of others**
- **Inability to co-operate with/participate in care**
- **Sleep disturbance -**
  - Nocturnal wandering
  - Inverted body clock
  - Early waking
  - Calling out for help etc. constantly
- **Refusal to eat or drink**
- **Inappropriate sexual advances**
- **Delusions**
- **Hallucinations**
- **Disorientation –**
  - Time
  - Place
  - Person

- **Paranoid ideation**

These behaviours can be observed on their own or in 'clusters'.

MANAGEMENT OF CONFUSION (ELDERLY MEDICINE)

(To be used in conjunction with full guidelines)

History from patient and third party

↓

EXAMINATION

↓

MEDICAL SCREEN/INVESTIGATION

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USE ENVIRONMNENTAL STRATEGIES TO MINIMISE EFFECT OF CONFUSION

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IF CONFUSION IS CAUSING BEHAVIOURAL PROBLEMS

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Consider other causes eg. PAIN, DEPRESSION, CONSTIPATION RETENTION, WITHDRAWAL

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CONSIDER PSYCHIATRY REFERRAL

↓

If there are still behavioural problems

If the patient is psychotic/ paranoid/hallucinating

Try Risperidone 0.5mg up to 1mg bd
0.5mg od
or Haloperidol 0.5mg bd oral up to 0.5mg qds
qds
(not in Parkinson's/Lewy Body Disease)

If the patient is agitated but not psychotic

Try oral Lorazepam

or bd up to 0.5mg

<u>If all strategies have failed and patient is a risk</u>
to themselves and others

↓

<u>RAPID TRANQUILLIZATION with LORAZEPAM 0.5mg-1mg im stat</u>
(dose may be repeated after 30 mins up to a maximum of 3 doses)

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Document and monitor as per Care Pathway

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Prescribe regular oral sedation to follow

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Consider need for Section 5(2) of Mental Health Act and urgent Psychiatry opinion