DANISH HEALTH AUTHORITY

NATIONAL CLINICAL GUIDELINE FOR PREVENTION AND TREATMENT OF ORGANIC DELIRIUM

Quick Guide

It is good practice to consider screening high-risk patients with a psychometric tool

Good practice (consensus)

It was not considered necessary to update the recommendation in 2020.

Training/instruction of staff in using the selected psychometric test is recommended to achieve sufficiently high sensibility and specificity. As delirium is a fluctuating condition, repeated testing after hours or days is recommended, as well as in connection with mental changes in patients with one or more risk factors.
Risk factors:

- High age (min. 65 years)
- Dementia or cognitive dysfunction (both current and previous, for example previous delirium and brain damage)
- Functional impairment
- Acute disease

Consider non-pharmacological multicomponent prevention for all patients aged above 65 at risk of delirium.

Weak recommendation

It was not considered necessary to update the recommendation in 2020.

It is recommended that, as a general rule, non-pharmacological multicomponent therapy be initiated in all patients in connection with a risk of delirium. In practice, the interventions may consist of:

- Sensory optimisation: Ensure that there is enough light in the room for the patient to orient himself/herself. In case of impaired vision or hearing, the patient's glasses or hearing aid must be obtained, and assistance with use must be provided if required. Alternatively, a communicator can be used with hearing-impaired patients.
- Orientation and cognitive stimulation: Visible clock and calendar and possibly board with a daily schedule in the ward. Avoid changing staff, repeat presentation of staff involved in the care and repeat place and reason for hospitalisation. Based on an individual assessment, a conversation can be conducted on current topics. If possible, obtain known objects (pictures, etc.). A few changes to the arrangement of the ward, for example, a bedside table on the patient's usual side of the bed, can help the patient feel more at home.
- Mobilisation: The patient should be mobilised several times daily, as a minimum in connection with meals. The patient should himself/herself perform or assist with parts of his or her personal hygiene. A walker must be made available if needed.
- Nutrition: Assess the patient's nutritional condition and any problems with food ingestion due to the acute condition and remedy this if possible, for example through assessment by a specialist.
- Rehydration: Assess hydration level and fluid intake and supplement with appropriate fluid therapy, if necessary.
- Circadian rhythm: Support the patient's natural circadian rhythm.

Consider non-pharmacological multicomponent therapy for all delirious patients

Weak recommendation

It was not considered necessary to update the recommendation in 2020.

As a general rule, non-pharmacological multicomponent therapy should be initiated in all delirious patients.

In practice, the interventions may consist of:

- Sensory optimisation: Ensure that there is enough light in the room for the patient to orient himself/herself. In case of impaired vision or hearing, the patient's glasses or hearing aid must be obtained, and assistance with use must be provided. Alternatively, a communicator can be used with hearing-impaired patients.
- Orientation and cognitive stimulation: Visible clock and calendar and possibly board with a daily schedule in the ward. Avoid changing staff, repeat presentation of staff involved in the care and repeat place and reason for hospitalisation. Based on an individual assessment, a conversation can be conducted on current topics. If possible, obtain known objects (pictures, etc.). A few changes to the arrangement of the ward, for example a bedside table on the patient's usual side of the bed, can help the patient feel more at home.
- Mobilisation: The patient should be mobilised several times daily, as a minimum in connection with meals. The patient should himself/herself perform or assist with parts of his or her personal hygiene. A walker must be made available if needed.
- Nutrition: Assess the patient's nutritional condition and any problems with food ingestion due to the acute condition. Remedy this, for example through assessment by a specialist.
- Rehydration: Assess hydration level and fluid intake, supplement with appropriate fluid therapy, if necessary.
- Circadian rhythm: Support the patient's natural circadian rhythm.

It is good practice to consider placing delirious patients in a protected environment.

Good practice

It was not considered necessary to update the recommendation in 2020

Practical advice and special patient considerations

- Avoid irrelevant and inappropriate stimuli.
- If possible, schedule medication and examinations so that the patient's sleep is not disturbed.
- Present one stimulus, one piece of information or one task at a time.
- All delirious patients should be given relevant mobilisation and stimulation. Especially in patients with hypoactive delirium, it is important that staff initiate activities.

Consider actively involving relatives in the treatment of patients with delirium

Weak recommendation

It was not considered necessary to update the recommendation in 2020.

Inform the patient's relatives about the condition and risk factors, preferably with written material describing the importance of quiet presence, clear, concise communication, appropriate stimulation, calm and undisturbed sleep. The relatives can be encouraged to bring, if possible, known small objects, for example pictures, for the patient. The relatives can also help describe the patient's preferences, routines and interests. In addition, let the relatives help with reorientation, i.e. correcting the patient calmly concerning time and place and lack of recognition.

In the post-treatment course, a review of the process can be offered with the patient and relatives.

Consider reviewing and reorganising medication for all elderly people at risk of delirium

Weak recommendation

It was not considered necessary to update the recommendation in 2020.

The evidence on which this recommendation is based concerns nursing home residents, but intervention should be considered in all elderly patients who are being treated with multiple drugs and elderly patients with multiple chronic diseases, dementia disorder and/or low functional level.

In delirious patients, intensifying pharmacological treatment may be relevant to treating triggering/persistent causes (for example, antibiotics, heart failure treatment, analgesics, laxatives).

The screening tool START/STOP version 2 on the Danish Geriatric Society's website can be used to identify risky drugs for elderly patients. Reference is also made to the discontinuation list.

It is good practice to review medication for all delirious patients and to consider adjusting, including pausing, non-essential medication

Good practice

It was not considered necessary to update the recommendation in 2020.

The screening tool START/STOP version 2 on the Danish Geriatric Society's website can be used to identify risky drugs for elderly patients. Reference is also made to the *discontinuation list*.

Pay special attention to opioids, benzodiazepines, antipsychotics and antidepressants as well as other anticholinergic drugs, as these may trigger or aggravate delirium. Pay special attention to any need for tapering of addictive drugs.

Do not routinely use treatment with antipsychotics for all patients with delirium, as antipsychotics may not reduce the duration of delirium or mitigate agitation.

Weak recommendation **AGAINST**

The recommendation was updated and changed in 2020.

Routine use of antipsychotic treatment in all patients with delirium is not recommended, but it may be considered when non-pharmacological measures are insufficient for:

- Patients who constitute a risk to themselves or others
- Patients where delirium prevents sufficient diagnostics and treatment
- Patients who are distressed by, for example, hallucinations and delusions
- Terminal patients during their last days/hours

It is essential to treat the underlying cause(s) and to continue multicomponent non-pharmacological treatment concurrently with antipsychotic therapy. The patient's delirious condition and whether the patient remains distressed or agitated should be assessed daily.

Treatment with antipsychotics must therefore depend on an assessment of the patient's mental condition and whether the patient can receive care and treatment. The treatment should be reviewed and adjusted daily.

If treatment with an antipsychotic is required, the choice of drug must be made with due consideration for the best suitable profile of adverse drug reactions in relation to the somatic condition (for example QT), other prescribed medication and route of administration.

It is good practice not to use benzodiazepines and benzodiazepine-like substances for the treatment of delirium

Good practice

It was not considered necessary to update the recommendation in 2020.

Treatment with benzodiazepine and benzodiazepine-like substances may exceptionally be considered in the following patient groups:

- Palliative patients with agitation and restlessness or terminal delirium
- Patients in intensive care units where respiratory support and monitoring can be provided

Treatment should be reserved for cases that are difficult to treat and where antipsychotics have been tried. Benzodiazepines may in themselves trigger delirium.

In elderly patients, paradoxical reactions (the opposite effect to that expected) to benzodiazepines and benzodiazepine-like agents may cause patients to become hyperactive, motor agitated and outward reacting.

Abrupt discontinuation should be avoided in patients who already have long-term use of these drugs due to the risk of withdrawal symptoms.

It is good practice to avoid using melatonin for the treatment of delirium, since there is no documentation of efficacy

Good practice (consensus)

It was not considered necessary to update the recommendation in 2020.

It has not been documented that melatonin can ensure a natural circadian rhythm in delirious patients.

It is good practice to consider offering ECT in refractory delirium, where other treatment options have been exhausted.

Good practice (consensus)

It was not considered necessary to update the recommendation in 2020.

The attending physician must reconsider whether all triggering causes have been correctly identified and corrected and possibly repeat the assessment before considering ECT treatment in treatment-refractory delirium.

As long as the patient is temporarily incompetent, treatment may be provided in accordance with section 19 of the Danish Health Act (*Sundhedsloven*). Adequate information to the patient and the patient's relatives is essential. See section 20 of the Danish Health Act.

DANISH HEALTH AUTHORITY

About the Quick Guide

This Quick Guide contains the key recommendations from the national clinical guideline for the prevention and treatment of organic delirium. The guideline was prepared under the auspices of the Danish Health Authority.

The purpose of this guideline is to ensure relevant detection, prevention and treatment of organic delirium.

The national clinical guideline contains recommendations regarding selected parts of the field, and it cannot stand alone, but must be seen in conjunction with other guidelines, recommendations, process descriptions etc.

Further information at www.sst.dk
A full-length version of the national clinical guideline is available at the Danish Health Authority's website (www.sst.dk), including a detailed review of the underlying evidence for the recommendations.

About the national clinical guidelines
This national clinical guideline is one of the national clinical guidelines prepared by the Danish Health Authority in the period 2017-2020.

Further information about the choice of subjects, method and process is available at www.sst.dk

National clinical guideline for prevention and treatment of organic delirium
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