Confused older person in ED – Clinical Guide

>65 y.o. (>45 ATSI) confused patient arrives to ED
Risk of delirium[1]

Triage minimum Category 3 assigned
If patient requires resus, transfer to resus area & evaluate mental status when stable
Patient to ED acute area for clinical handover

Is the patient agitated?

NO

- Assessment by ED clinician in clinically recommended timeframe
- Risk of delirium[1]
- Assess for reversible causes
- Structured examination (*1)
- Check collateral history, including baseline cognitive / behavioural function & recent changes to medication
- Investigations (*2)
- Non pharmacological comfort cares

YES

- Rapid assessment by ED clinician
- Assume delirium[1]
- Assess for reversible causes
- Structured examination (*1)
- Check collateral history, including baseline cognitive / behavioural function & recent changes to medication
- Investigations (*2)
- Non pharmacological comfort cares
- +/- pharmacological management (*3)

Agitation improves and is manageable?

YES

NO

Rapid inpatient review
+/- pharmacological management (*3)
Rural sites liaise with RSQ or seek telemed support

Discharge to usual care setting possible?

YES

Discharge to usual care setting if:
- Allied health review reveals no change from usual functional level
- Medical issue treated and medications reviewed
- 24 hour competent supervision available at home or facility (consider carer stress, capacity and capability)
- Discharge care plan and follow-up arranged

NO

Prioritise for admission to Delirium / General Medicine wards
Interim management plan (*3)

Inpatient management (*4)
General medicine / geriatrician / psychogeriatric or mental health consult
Consider Confusion Assessment Method (CAM) upon admission

[1] **Delirium**: Disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours or days), and tends to fluctuate during the course of the day. Delirium may be a life-threatening and potentially reversible condition.
Delirium care pathways, Department of Health and Ageing, 2011
[2]**Severe behavioural Disturbance**: Imminent risk of harm to self or others particularly arising from aggression

(*1) Structured examination
Primary
Vital signs, BSL
GCS / MSQ[3]
Hydration
Assess for underlying/reversible cause(s)
Check for signs of stroke (dysphasia, reflex changes)
Assess for source of pain and provide adequate analgesia
Urinary retention
Fecal impaction
Pressure injuries
Source of infection

(*2) Investigations
ED baseline (all patients)
WTU (MSU)
ECG
UEC, Calcium, LFT, FBE
Blood cultures if infection considered
CXR
Inpatient investigations (if clinically indicated)
CT head
Lumbar puncture
Cardiac enzymes, Troponin
Toxicology
Blood gas (venous/arterial)
TFTs, B12, folate, HIV, syphilis, calcium, MRI, EEG

(*3) ED management
Interim management plan (4 hours)
Medication / pain relief / IV infusion orders
Observation / BSL frequency / parameters
Fluid orders (IV/Subcut) including thiamine
Plan for nursing staff
Inpatient & ED team contact
Document delirium diagnosis in EDIS
Pharmacological management in ED (If clinically indicated)
Haloperidol / Droperidol / Midazolam
Ensure doses are adjusted based on patient age, weight and physiological reserve.
Minimum monitoring – continuous O2 saturations, respiratory rate, sedation score / GCS, blood pressure, pulse rate

(*4) Inpatient management
Holistic cares
Non-pharmacological comfort cares
Care coordination
Orientation assistance
Attend to sensory deficits (glasses, hearing aids)
Nutrition / Hydration
Falls prevention measures
Supervised mobility and transfers
Pressure injury prevention
Monitoring of IDC if present / regular prompted toileting
Reduce sensory stimulation
Mouth cares
Skin care and monitoring
Bowel/bladder record and cares
Communication with family / carers
Community support referral for family / carers
Pharmacological management of agitation
Oral agents
Haloperidol 0.25-2mg orally q 4hrly (max. of 5mg in 24hrs). Consider a STAT dose if no observed effect after 60mins.
Parenteral Agents (if oral route not possible)
- Haloperidol 0.125 to 1.5mg IM q 4hrly (max. of 5mg in 24hrs). Consider a STAT dose if no observed effect & severe behavioural disturbance[2] after 30mins.
- Midazolam 2.5 mg IV/Subcut starting dose (max of 7.5 mg in 24hrs). Consider a STAT dose if no observed effect & severe behavioural disturbance after 30mins.

If considering commencement of regular oral antipsychotic medication, start with low-dose such as
- Haloperidol 0.25 to 0.5mg bd (max 1mg bd) or
- Risperidone 0.25 to 0.5mg (max 1 mg bd)
- Olanzapine 2.5mg starting dose (max 7.5mg in 24hrs if Parkinsonised or Lewy Body disease suspected)

*4 (Pesiah C et al IMJ 2011 41: 651□7)
[3] Kahn et al Am J Psychiatry 1960