NHS Tayside

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CLINICAL GUIDELINES

THE MANAGEMENT OF DELIRIUM IN ADULT and OLDER IN-PATIENTS

Author: Short Life Work Group	Review Group: Delirium Forum
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UNCONTROLLED WHEN PRINTED

Signed: _____ Executive Lead Officer
(Authorised Signatory)

CONTENTS

APPENDICES

1. INTRODUCTION

1.1 The following guidelines apply to all NHS Tayside (NHST) staff working in adult and older people's services. These guidelines have been adapted from the November 2004 TUHT policy entitled "The Pharmacological Management Of Acute Confusion In Adult In-Patients"

The aim of these guidelines is:

- To set out the specific actions and pharmacological treatment of delirious patients who may present risk to themselves or others when suffering from delirium.
- To set out the actions and treatments that staff will take to anticipate and prevent or recognise and treat delirium that, if unrecognised and unmanaged, may escalate.

1.2 Delirium (acute confusional state) is often undetected and poorly managed (Siddiqi 2006). It is characterised by a disturbance of consciousness and a change in cognition that can develop rapidly and, within a 24-hour period, can fluctuate widely. There is evidence from the history, examination and investigations that delirium is a direct consequence of a general medical condition, drug withdrawal or intoxication (British Geriatrics Society and Royal College of Physicians 2006). Delirium is a serious medical problem requiring urgent management geared towards the following:

- A good sensory environment with a reality orientation approach
- Identifying and treating the underlying cause
- Managing symptoms
- Addressing environmental and supportive measures
- Clinical review and follow up

2 PREVENTION, DIAGNOSIS & MANAGEMENT OF DELIRIUM

2.1 Delirium can be subdivided into three clinical subtypes;

Hypoactive: Patients with hypoactive delirium (quiet delirium) have symptoms which include unawareness, slow speech, staring and apathy.

Hyperactive: Patients with hyperactive delirium have symptoms which include wandering, fast or loud speech, irritability and euphoria.(Liptzin 1992) Many patients with delirium have hypoactive delirium (quiet delirium) and do not require sedation (O'Keefe 2005) . Therefore the use of sedation should be kept to a minimum.

Mixed : A combination of the above.

Sedatives and major tranquillisers may cause delirium, especially those with anticholinergic side effects. Early identification of delirium and prompt treatment of the underlying cause may reduce the severity and duration of delirium (Lundstrom 2005) The main aim of drug treatment is to treat distressing or dangerous behavioural disturbance e.g. hallucinations or agitation.

The use of sedation in the management of delirium should be kept to a minimum. It should only be used when all other methods have failed. Sedation may be required to prevent a patient from endangering themselves or others or to relieve the distress of a highly agitated or distressed patient.

Only 1 drug should be used at a time. The lowest possible starting dose should be used and should be reviewed regularly. The dose can be increased in increments of 2 hours with all medication being reviewed regularly and at least once daily.

The drug of choice in the management of delirium is Haloperidol. A dose of 0.5mg orally should be used initially and can be given up to 2 hourly. A maximum dose of 5mg (orally or IM) in 24 hours should be used but in exceptional circumstances this may be exceeded depending on the severity of the individual patient. Haloperidol may be given IM in those unable to take medication orally at a dose of 1-2mg.

For those patients suffering with Dementia with Lewy Bodies or Parkinson's Disease antipsychotic use to treatment delirium may worsen their clinical state. In these circumstances it may be necessary to use Lorazepam 0.5-1 mg orally, IV, IM (dilute up to 2ml with normal saline or water) up to 2 hourly up to a maximum dose of 3 mg by any route in 24 hours. In most situations oral is the first choice of route. IM is safer than IV administration. Benzodiazepines can worsen delirium and so should be used with caution.

One to one care is often required and should be provided by the ward staff while the dose of psychotropic medication is titrated upward in a controlled and safe manner.

Drugs commonly causing Delirium (Alagiakrishnan 2004)

Benzodiazepines
Opiate analgesics
Steroids
Tricyclic antidepressants
Anticonvulsants
Antiparkinsonian Agents
Digoxin
Plus drugs with anticholinergic effects e.g. hyoscine, cyclizine, oxybutynin (Mintzer 2000)

Delirium may result from a variety of causes including:

- Polypharmacy
- Infection
- Electrolyte disturbance
- Anaesthesia
- Dehydration
- Constipation
- Symptoms of another illness
- Alcohol or drug withdrawal
- Intoxification.

2.2 Dementia is a major risk factor for delirium increasing the risk for delirium by a factor of five, and may co-exist with depression, which is common in the older person (Royal College of Psychiatrists 2005). All three conditions of dementia, delirium and depression can have similar symptoms and often older people may be suffering from more than one condition making diagnosis much more difficult. The features and characteristics of each of the three conditions are detailed in Appendix 2, "Clinical features of dementia, depression and delirium"

2.4 **Aids to diagnosis**

The diagnosis of delirium can be made by non-psychiatrically trained clinicians quickly and accurately using Appendix 3, "The Confusion Assessment Method (CAM) screening instrument" (Inoyue 1990). Cognitive assessment should be carried out on all older people admitted to hospital (O'Keefe et al, 2005; Foreman and Milisen, 2004) and the consistent use of a recognised tool such as Appendix 5, "the Mini Mental State Examination"(MMSE) (Folstein 1975) in patients at risk may help detect the development of delirium and assist in its resolution. When confusion is suspected, the use of a serial measurement such as the MMSE may increase the recognition of delirium present on admission. However, this tool alone cannot distinguish between delirium and other causes of cognitive impairment (Antony 1982). A history from a relative or carer regarding the onset or course of the confusion is also essential to help distinguish between delirium and dementia.

2.5 Environmental intervention will be considered where appropriate, recorded in the nursing records

and should incorporate:

- A good sensory environment with a reality orientation approach
- Lighting levels appropriate for the level of the day
- Regular and repeated (at least 3 times daily) cues to personal orientation
- Use of clocks and calendars to improve orientation
- Hearing aids and spectacles should be available as appropriate and in good working order
- Continuity of care from, where possible, familiar staff
- Encouragement of mobility and engagement in activities and with other people
- Quiet and gentle handling
- Elimination of unexpected and irritating noise (e.g. pump alarms)
- Regular analgesia
- Encouragement of visits from family and friends who may be able to calm the patient
- Prevention of dehydration
- Prevention of constipation
- Adequate oxygen delivery
- Promote good sleep pattern

(British Geriatrics Society and Royal College of Physicians 2006)

2.6 The most important approach to the management of delirium is the identification and treatment of the underlying cause. Many patients with delirium are unable to provide an accurate history therefore corroboration should be sought through the carer, GP or any source that knows the patient well. In addition, treatment will also be aimed at alleviating the specific symptoms of delirium while the underlying cause is being investigated or treated, (See Appendix 1, "Assessment & Management of Delirium in Adult & Older People")

2.7 Delirium will not deter health care professionals from communicating with the patient, obtaining consent and explaining the diagnosis and reasons for the delirium. The management plan and

patient/carer discussions will be recorded in the patient's records including:

- The patients behaviour
- Why drug therapy was necessitated
- Outcomes of interventions
- Management strategy
- Review dates

3 ROLES AND RESPONSIBILITIES

3.1 Staff Training and Education

Education has been shown to be effective in recognising and preventing delirium on an acute medical ward (Tabet 2005). Academic establishments should ensure that doctors and nurses in training are able to recognise and treat delirium. An educational programme will be made available for the multi-disciplinary team on the recognition and management of delirium in hospitalised patients.

Undergraduate Education

Students on the Adult Nursing Undergraduate Programme are taught the signs, symptoms, assessment and management of delirium in Year 3 Semester 1.

Students in Abertay University do a two-hour session in Year 3 for Adult and Mental Health Nurses. The aim of the session is to help students identify the signs and symptoms of delirium and the key interventions required in terms of management.

Students attending the level 9 Fitness for Practice Module; Care of Older People in the Acute Setting are also taught the signs, symptoms, assessment and management of patients with delirium.

Medical students attend a lecture on delirium during Ageing Week in their 3rd year, and this is followed by clinical skills sessions on cognitive tests and their limitations. They also attend seminar sessions with scenarios on “confusion”.

3.2 Psychiatric Liaison Service

The Psychiatric Liaison Service is supportive of the management of people with delirium. The Psychiatry Liaison Service is one of consultation and proactive collaboration and is designed to compliment the care given within the acute wards. The service aims to provide a focus on education and training to improve the mental health skills of general hospital staff (Royal College of Psychiatrists 2005).

The Psychiatry Liaison Service, although not an emergency service, will provide prompt consultation advice on the management of psychiatric illness. Within NHST, local arrangements are in place for staff to contact the Psychiatry Liaison Service for advice.

4 Discharge

Care must be taken to ensure the delirium has been properly investigated and implementation of treatment before discharge and should be planned in conjunction with all appropriate disciplines involved in caring for the patient, both in hospital and in the community (including informal carers). Practical arrangements should be in place prior to discharge for activities such as washing, dressing, administering medication etc. In addition, the following should be carried out:

- Communication with all parties, including family and carers, involved in the patients care is vital.
- Involve the General Practitioner (GP) and Community Pharmacist in the planning of discharge particularly when there are issues of polypharmacy, concordance and previous medication compliance aids with clear plans for collection agreed.
- Prior to discharge the patient should be reassessed for their cognitive and functional status

- Discharge summaries should be completed promptly and should specifically note the presence of delirium and/or dementia. This should be communicated to the GP prior to discharge.

5 Follow up

Referral may be required to a Geriatrician, Psychiatrist of Old Age, Community Psychiatric Nurse, Occupational Therapist or Social Worker for Older People for further assessment and follow up. The follow up would normally be co-ordinated by the GP. Delirium is a common first presentation of an patients underlying dementing process. It may also be a marker of severe illness and comorbidity. It is recognised in some patients with delirium, that they may benefit from more intensive support post discharge. (Rahkonen 2001)

6 PROCESS TO PREVENT AND TREAT DELIRIUM IN HOSPTIAL

Step 1

Identify cognitive impairment using a recognised tool such as MMSE on admission.

Step 2

Consider delirium in all patients with cognitive impairment and at high risk (dementia, severe illness, traumas, visual and hearing impairment). Use of CAM screening instrument.

Step 3.

Identify the cause of delirium if present from accurate history, examination and investigations and treat underlying cause or cause. The common causes are: alcohol or drug withdrawal, infection, electrolyte disturbance, dehydration or constipation.

Step 4

In patients with delirium **and** patients at high risk of delirium.

Do

- Provide environmental & personal orientation
- Encourage mobility
- Reduce medication but ensure adequate analgesia
- Ensure hearing aids and spectacles are available and in good working order
- Avoid constipation
- Maintain good sleep pattern
- Maintain good fluid intake
- Involve relatives and carers
- Avoid complications (immobility, malnutrition, pressure sores, over sedation, falls, incontinence)

Do not

- Catheterise
- Use restraints
- Sedate Routinely
- Argue with the patient

Step 5

With the GP as the co-ordinator of the follow up, assist in ensuring a safe discharge and consider follow-up with appropriate professionals e.g. Old Age Psychiatry, Community Pharmacist, Geriatricians. Provide family/carer education and support.

Adapted from the British Geriatric Society and Royal College of Physicians guidelines for the prevention, diagnosis and management of delirium in older people. (2006)

REFERENCES

Alagiakrishnan, K., Wiens., CA. (2004). An Approach to drug induced delirium in the elderly. Postgraduate Medical Journal (80) 388-393

Antony, J., LeResche, L., Niaz, U., Von Korff, M.R., Folstein, MF. (1982). Limits of the 'Mini Mental State Examination' as a screening test for dementia and delirium among hospital patients. Psychological Medicine (12) 397-408.

British Geriatric Society and Royal College of Physicians. (2006). Guidelines for the prevention, diagnosis and management of delirium in older people. Guidance to good practice series No.6. London RCP.

Folstein, MF., Folstein, SE., McHugh, PR. (1975). 'Mini-Mental State': a practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research. 12. 189 – 198.

Foreman, M., Milisen, K. (2004) Improving recognition of delirium in the elderly. Primary Psychiatry.11. 46-50.

Inoyue, SK., van Dyck, C., Alessie, C.A., Balkin, S., Siegal, A.P., Horowitz, R.I .(1990). Clarifying confusion. : The confusion assessment method. A new method for detection of delirium. Annals of Internal Medicine. 113. 941-8.

Liptzin B., Levkoff, S.E., (1992) An empirical study of delirium subtypes. British Journal of Psychiatry 161: 843-845

Lundstrom, R.N., Edlund, A., Karlsson, S., Brunnstrom, B., Bucht, G., Gustafson., Y. (2005). A multifactorial intervention program reduces the duration of delirium, length of hospitalisation and mortality in delirious patients. Journal of American Geriatric Society. 53. 622-628.

Mintzer, J., Burns, ,A .(2000). Anticholinergic side-effects of drugs in elderly people. Journal of the Royal Society of Medicine. (93) 457-462

O'Keefe, ST., Mulkerrin, EC., Nayeem, K., Varughese, M., Pillay, I. (2005). An empirical study of delirium subtypes. Journal of American Geriatric Society. 53. 867-70.

Rahkonen, T., Eloniemi-Sukava, U., Paanita, S., Halonen, P., Silvenius, J., Sulkava, R. (2001). Systematic intervention for supporting community care of elderly people after a delirium episode. International Psychogeriatrics. 13 (1) 37-49.

Poutney, D. (2007). Dementia, delirium or depression?. Nursing Older People. 19 (5) 12-14.

Royal College of Psychiatrists. (2005). Who Cares Wins. Royal College of Psychiatry. London.

Siddiqi, N., House, AO., Holmes, JD. (2006). Occurrence and outcome of delirium in medical inpatients: a systematic literature review. Age and Ageing. 35 (4) 350-64.

Tabet, N., Hudson, S., Sweeney, V., Sauer, J., Bryant, C., Macdonald, A., Howard, R. (2005). An educational intervention can prevent delirium on acute medical wards**.** Age and Ageing. 34 (2) 152-6.

6. WORKING GROUP MEMBERS

Chairperson: Emma Law, Practice Development Manager Psychiatry of Old Age, Perth and Kinross

Group Members: Donna Morrison, Senior Nurse, Liff Hospital Dundee
Sarah Henderson, Senior Registrar, Medicine for the Elderly, Tayside
Lorna Milton, Practice Development Nurse, MFE and continuing Care, Dundee
Andy Shewan, Psychiatry of Old Age liaison, Dundee
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Ella McLafferty, Senior Lecturer, School of Nursing, Dundee
Kathryn Wood, Lead Clinical Pharmacist, Elderly and Rehabilitation, Tayside

Acknowledgements to the staff group in Angus, the Psychiatry of Old Age Consultants peer group, the Mental Health Prescribing Group, Pam Baxter Liaison Nurse, Perth Royal Infirmary and the Nursing and Midwifery Strategic Group who provided feedback on drafts.

Acknowledgements to the previous working group from 2004 chaired by Mr Greig Murray, Consultant Surgeon & Clinical Director for General Surgery, Perth Royal Infirmary.

Acknowledgements to staff, patients and carers who provided feedback during the consultation process for this document.

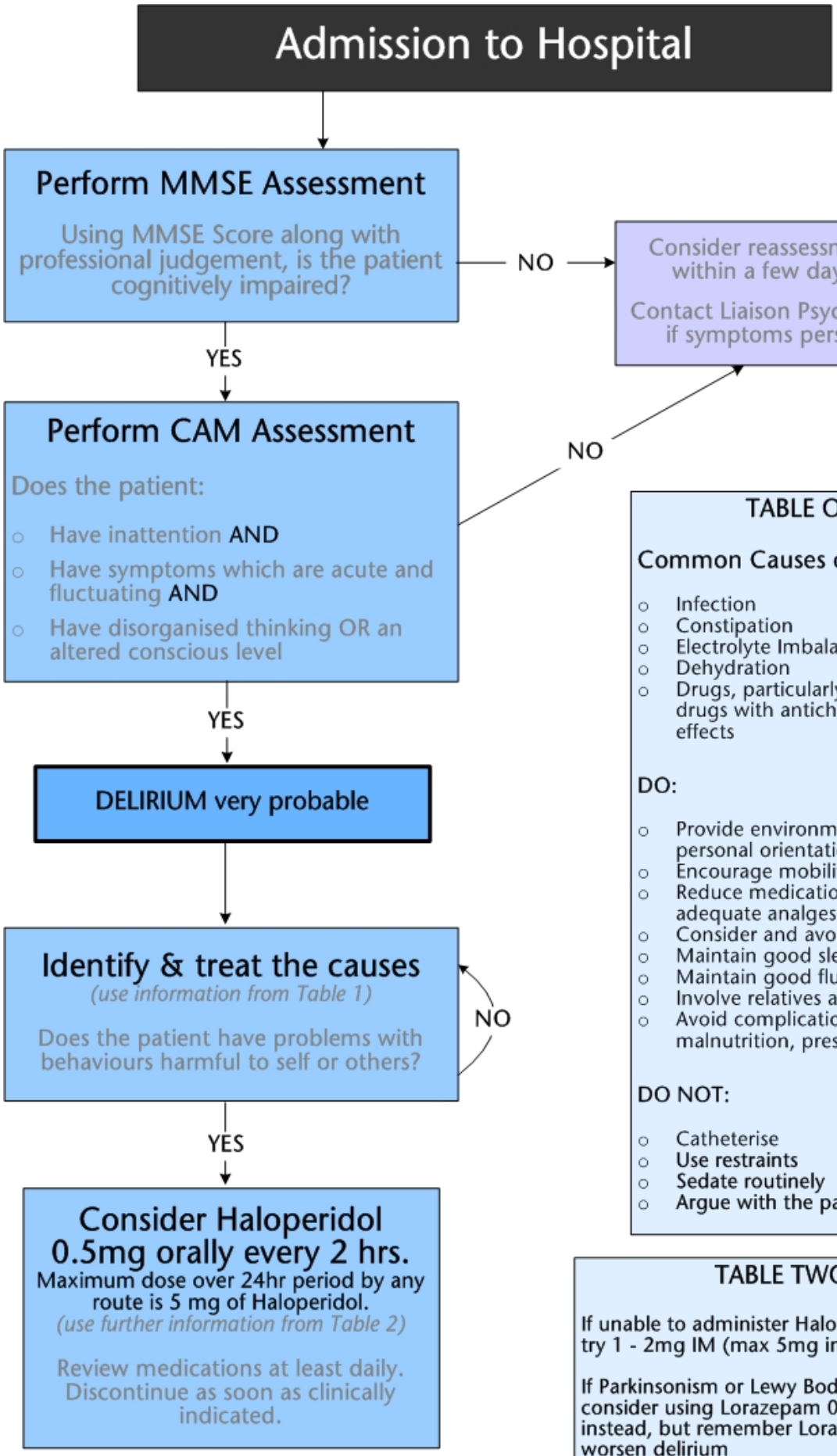


TABLE ONE

Common Causes of Delirium:

- Infection
- Constipation
- Electrolyte Imbalance
- Dehydration
- Drugs, particularly sedatives and drugs with anticholinergic side effects

DO:

- Provide environmental and personal orientation
- Encourage mobility
- Reduce medication but ensure adequate analgesia
- Consider and avoid constipation
- Maintain good sleep pattern
- Maintain good fluid intake
- Involve relatives and carers
- Avoid complications (immobility, malnutrition, pressure sores)

DO NOT:

- Catheterise
- Use restraints
- Sedate routinely
- Argue with the patient

TABLE TWO

If unable to administer Haloperidol orally, try 1 - 2mg IM (max 5mg in 24 hrs)

If Parkinsonism or Lewy Body Dementia, consider using Lorazepam 0.5mg orally instead, but remember Lorazepam can worsen delirium

START LOW - GO SLOW

Appendix 2

Clinical Features of Dementia, Depression and Delirium

Dementia, delirium and depression are the three most prevalent psychiatric disorders in older people. (Poutney 2007). All three conditions can have similar symptoms and older people may often be suffering from more than one of these conditions making diagnosis so much more difficult. Delirium is very common and often treatable in older people, especially in those in hospital or residential care and despite the fact that delirium is a common and serious condition it is frequently unrecognised.

Distinguishing features of delirium, depression and dementia.

Feature	Delirium	Dementia	Depression
Onset	Abrupt and sudden	Slow and insidious	Gradual
Duration	Hours/days	Months/years	Weeks/months
Course	Fluctuating	Progressive	Worse in the morning
Orientation	Severely impaired	Variably impaired	Usually normal
Memory	Impaired	Impaired	May be impaired
Mood	Anxious, fearful, apathetic	Apathetic	Low, sad, irritable
Perception	Visual hallucinations	Visual Hallucinations	Auditory Hallucinations
Sleep-wake	Severe disruption	Nocturnal Wandering	Early morning Wakening
Thinking	Paranoid delusions	Error/delusions	Delusions of guilt/ill health

Appendix 3

The Confusion Assessment Method Instrument:

1. **(Acute onset)** Is there evidence of an acute change in mental status from the patient's baseline?

2a **(In attention)** Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

2b **(If present or abnormal)** Did this behaviour fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?

3. **(Disorganised thinking)** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

4. **(Altered level of consciousness)** Overall, how would you rate this patient's level of consciousness? (Alert (normal); Vigilant (hyperalert, overly sensitive to environmental stimuli, startled very easily), Lethargic (drowsy, easily aroused); Stupor (difficult to arouse); Coma (unarousable) Uncertain.

5. **(Disorientation)** Was the patient disorientated at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?

6. **(Memory impairment)** Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?

7. **(Perceptual disturbances)** Did the patient have any evidence of perceptual disturbances, e.g. hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?

8a. **(Psychomotor agitation)** At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?

8b. **(Psychomotor retardation)** At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?

9. **(Altered sleep-wake cycle)** Did the patient have evidence of disturbance of sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

The Confusion Assessment Method (CAM) Diagnostic Algorithm:

Feature 1: Acute onset and fluctuating course
This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behaviour fluctuate during the day, tend to come and go or increase/decrease in severity?

Feature 2: Inattention
This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, e.g. being easily distracted, or having difficulty keeping track of what was being said?

Feature 3: Disorganised thinking
This feature is shown by a positive response to the following question: Was the patient's thinking disorganised or incoherent, such as ramblings or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered level of consciousness
This feature is shown by any answer other than "alert" to the following question:
Overall, how would you rate this patient's level of consciousness (as in number 4 above)

Patient **Current address** **Examiner** **Date** **DOB/CHI**

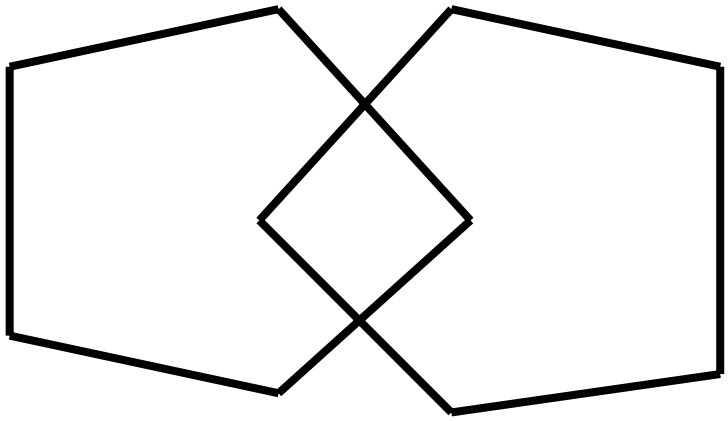
Maximum Score	Score	
5 5	☐ ☐	**ORIENTATION:** What is the (**year**) (**season**) (**month**) (**day**) (**date**) ? Where are we (**country**) (**town**) (**area/** (**street/** (**house no/ scheme**) **hospital**) **ward**)
3	☐	**REGISTRATION:** Name 3 objects: 1 second to name each. (**apple, table, penny)** Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials:=.....
5	☐	**ATTENTION AND CALCULATION:** Serial 7's - ie take 7 away from 100 and continue until 65. 1 point for each correct answer, Then spell 'world' backwards. (30 seconds each) Take best score
3	☐	**RECALL** Ask for the 3 objects repeated above. Give 1 point for each correct.
9	☐ ☐ ☐ ☐ ☐ ☐	**LANGUAGE AND COPYING** Name a pencil and watch (2 points) Repeat the following - "no ifs, ands or buts". (1 point) Follow a 3-stage command: "Take this piece of paper with your right hand, fold it in half and give it back with your left hand (3 points). Read and obey the following: "CLOSE YOUR EYES" (1 point) Write a sentence (including subject and verb) (1 point) Copy design (1 point)
Total Score:	☐	Maximum 30
		Comments on ability to complete MMSE:
		Signature of Assessor:.....

Reading

CLOSE YOUR EYES

Writing

Construction (Two overlapping five-sided shapes)



Instructions on Attention and Calculation

Serial 7's If any subtraction is incorrect next calculation and subsequent calculations marked correct if is subtracted accurately.

World If letters are in appropriate position in word regardless of any mistakes previously a correct score should be recorded.

NHS TAYSIDE - POLICY/STRATEGY APPROVAL CHECKLIST

This checklist must be completed and forwarded with policy to the appropriate forum/committee for approval.
POLICY/STRATEGY AREA: (See Intranet Framework) Clinical _____
POLICY/STRATEGY TITLE: THE MANAGEMENT OF DELIRIUM IN ADULT and OLDER IN-PATIENTS (Guideline) _____
LEAD OFFICER Emma Law, P&K Practice Development Manager _____

Why has this policy/strategy been developed?		These guidelines have been adapted and replace the November 2004 TUHT policy entitled "The Pharmacological Management Of Acute Confusion In Adult In-Patients"	
Has the policy/strategy been developed in accordance with or related to legislation? – Please give details of applicable legislation.		**No legislation impacts upon the scope of this guideline.**	
Has a risk control plan been developed? Who is the owner of the risk?		**No**	
Who has been involved/consulted in the development of the policy/strategy?		**NHST Delirium Forum, staff group in Angus, the Psychiatry of Old Age Consultants peer group, the Mental Health Prescribing Group, PRI Liaison Nurse and the Nursing and Midwifery Strategic Group.** **Other staff, patients and carers provided feedback during the consultation process for this document.**	
Has the policy/strategy been assessed for Equality and Diversity in relation to:-		**Has the policy/strategy been assessed For Equality and Diversity not to disadvantage the following groups:-**	
	Please indicate Yes/No for the following:		**Please indicate Yes/No for the following:**
Race/Ethnicity	**Yes**	**Minority Ethnic Communities**	**Yes**
Gender	**Yes**	**(includes Gypsy/Travellers,**	**Yes**
Age	**Yes**	**Refugees & Asylum Seekers)**	**Yes**
Religion/Faith	**Yes**	**Women and Men**	**Yes**
Disability	**Yes**	**Religious & Faith Groups**	**Yes**
Sexual Orientation	**Yes**	**Disabled People**	**Yes**
		Children and Young People	**Yes**
		Lesbian, Gay, Bisexual &	**Yes**
		Transgender Community	**Yes**
Does the policy/strategy contain evidence of the Equality & Diversity Impact Assessment Process?		**No**	
Is there an implementation plan?		**Yes**	
Which officers are responsible for implementation?		**Emma Law, P&K Practice Development Manager**	
When will the policy/strategy take effect?		**March 2008**	
Who must comply with the policy/strategy?		**The guideline is intended for use by staff who are involved in the care of Adult and Older Inpatients.**	
How will they be informed of their responsibilities?		**Through training and publicity**	
Is any training required?		**Yes**	
If yes, has any been arranged?		**Yes**	
Are there any cost implications?		**Yes**	
If yes, please detail costs and note source of funding		**Printed copy of Delirium flowchart made available to all NHST ward areas. Source of funding unknown at present.**	
Who is responsible for auditing the implementation of the policy/strategy?		**NHST Delirium Forum**	
What is the audit interval?		**There are no plans to audit this guideline.**	
Who will receive the audit reports?		**There are no plans to audit this guideline.**	
When will the policy/strategy be reviewed and by whom? (please give designation)		**Emma Law, P&K Practice Development Manager. First review in March 2009, and annually thereafter.**	

Name: Emma Law, P&K Practice Development Manager Date: 10th April 2008 _____

Rapid Impact Checklist (RIC)

Each policy must include a completed and signed template of assessment

Which groups of the population do you think will be affected by this proposal? • minority ethnic people (incl. gypsy/travellers, refugees & asylum seekers) • women and men • people in religious/faith groups • disabled people • older people, children and young people • lesbian, gay, bisexual and transgender people • people of low income • people with mental health problems • homeless people • people involved in criminal justice system • staff	Other Groups:	This guideline will potentially effect all inpatients apart from those under 16.

N.B. The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed.	What positive and negative impacts do you think there may be? Which groups will be affected by these impacts?
What impact will the proposal have on lifestyles? For example, will the changes affect: • Diet and nutrition? • Exercise and physical activity? • Substance use: tobacco, alcohol or drugs? • Risk taking behaviour? • Education and learning, or skills?	Not applicable
Will the proposal have any impact on the social environment? Things that might be affected include • Social status • Employment (paid or unpaid) • Social/family support • Stress • Income	Not applicable
Will the proposal have any impact on • *Discrimination?* • *Equality of opportunity?* • *Relations between groups?*	Not applicable
Will the proposal have an impact on the physical environment? For example, will there be impacts on: • Living conditions? • Working conditions? • Accidental injuries or public safety? • Transmission of infectious disease?	Not applicable
Will the proposal affect access to and experience of services? For example, • Health care • Transport • Social services • Housing services • Education	Not applicable

Rapid Impact Checklist (RIC): Summary Sheet

Each policy must include a completed and signed template of assessment

1. Positive Impacts (Note the groups affected)	2. Negative Impacts (Note the groups affected)
All adults and older people will have a thorough and robust assessment of their mental state are for early detection of Delirium. This will allow for faster and most effective management and treatment.	There may be a transitional period in which staff take longer to assess until they are familiar with the new process contained within the guideline.

3. Additional Information and Evidence Required

4. Recommendations

That staff use this guideline as appropriate, and that it is reviewed on an annual basis.

5. From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?

NO

Manager's Signature: Emma Kay

Date: 10 April 2008