Maidstone and Tunbridge Wells
NHS Trust

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NHS Trust

Ref: FOI/GS/ID 5089

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20 December 2018

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Delirium protocols.

You Asked:
Could you send me a copy of your protocol/guidelines for the treatment of delirium in adults

Trust Response:

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Delirium Policy and Procedure

Target audience:	All staff who are directly or indirectly involved in the identification, management and care of people with delirium, their carers and families admitted to the Trust.
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Executive lead:	Chief Nurse
Directorate:	Nursing
Specialty:	Nursing (Dementia)

Supersedes: N/A - new document.

Approved by: Dementia Strategy Group, 4th July 2017

Ratified by: Policy Ratification Committee, 2nd October 2017

Review date: October 2020

Disclaimer: Printed copies of this document may not be the most recent version.
The master copy is held on Q-Pulse Document Management System
This copy – REV1.1

Document history

Requirement for document:	The purpose of this document is to outline the operational policy and procedure for Maidstone and Tunbridge Wells NHS Trust in order to improve the care and experience for people admitted with delirium. It also forms part of the requirements for the National Audit of Inpatient Falls and links with the Dementia Strategy.
Cross references (external):	1. Delirium: prevention, diagnosis and management. NICE clinical guideline, published 28th July 2010 (CG103). 2. Tomlinson E. (2016) Delirium. Australian nursing and midwifery journal. Vol. 24, issue 3, pages 22-25. 2. National Audit of Inpatient Falls. Audit report. Royal College of Physicians (2015). 3. Mental Capacity Act Code of Practice (2013). 4. Mental Capacity Act, Policy and Procedure (2009). 5. Borthwick M, Bourne R et al (2006) Detection, Prevention and Treatment of delirium in Critically Ill Patients. United Kingdom Clinical Pharmacy Association.
Associated documents (internal):	• Restraint Policy and Procedure. (RWF-OPPPCS-C-NUR4) • Safeguarding Adults at Risk of Harm Policy and Procedure (RWF-OPPPCS-C-NUR5) • Mental capacity act and deprivation of liberty safeguarding policy and procedure. (RWF-OPPPCS-C-NUR1) • Policy and procedure for consent to examination or treatment. (RWF-OPPPES-C-SM5) • Delirium [STANDARD PRINT LEAFLET](RWF-OPLF-PC46) • Delirium [LARGE PRINT LEAFLET] (RWF-OPLF-PC47) • Dementia Operational Policy and Procedure. (RWF-OPPPCS-C-NUR10) • Enhanced care to adult inpatients (use of Nurse 'Specials' 1:1 nursing), Policy and procedure for the provision of (RWF-OPPPCS-NC-NUR4) • Dementia Strategy (RWF-OPPPCS-NC-NUR6) • Management of Slips, Trips and Falls Policy and Procedure (RWF-OPPPCS-NC-CG20)

Keywords:	Delirium		

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	New policy	October 2017
1.1	Delirium Pathway appendix added (amendment approved by Dementia Strategy Group 06/03/18); ratified at PRC on 21/06/18)	June 2018

Policy statement for

Delirium Policy

This policy and procedure is intended to ensure that adult patients who are investigated, diagnosed and treated for delirium, receive best practice in their care and treatment whilst an inpatient at Maidstone and Tunbridge Wells NHS Trust.

This document applies to all staff who are directly or indirectly involved in the identification, management and care of people with delirium, their carers and families admitted to the Trust.

Identification, diagnosis and management of delirium – procedure

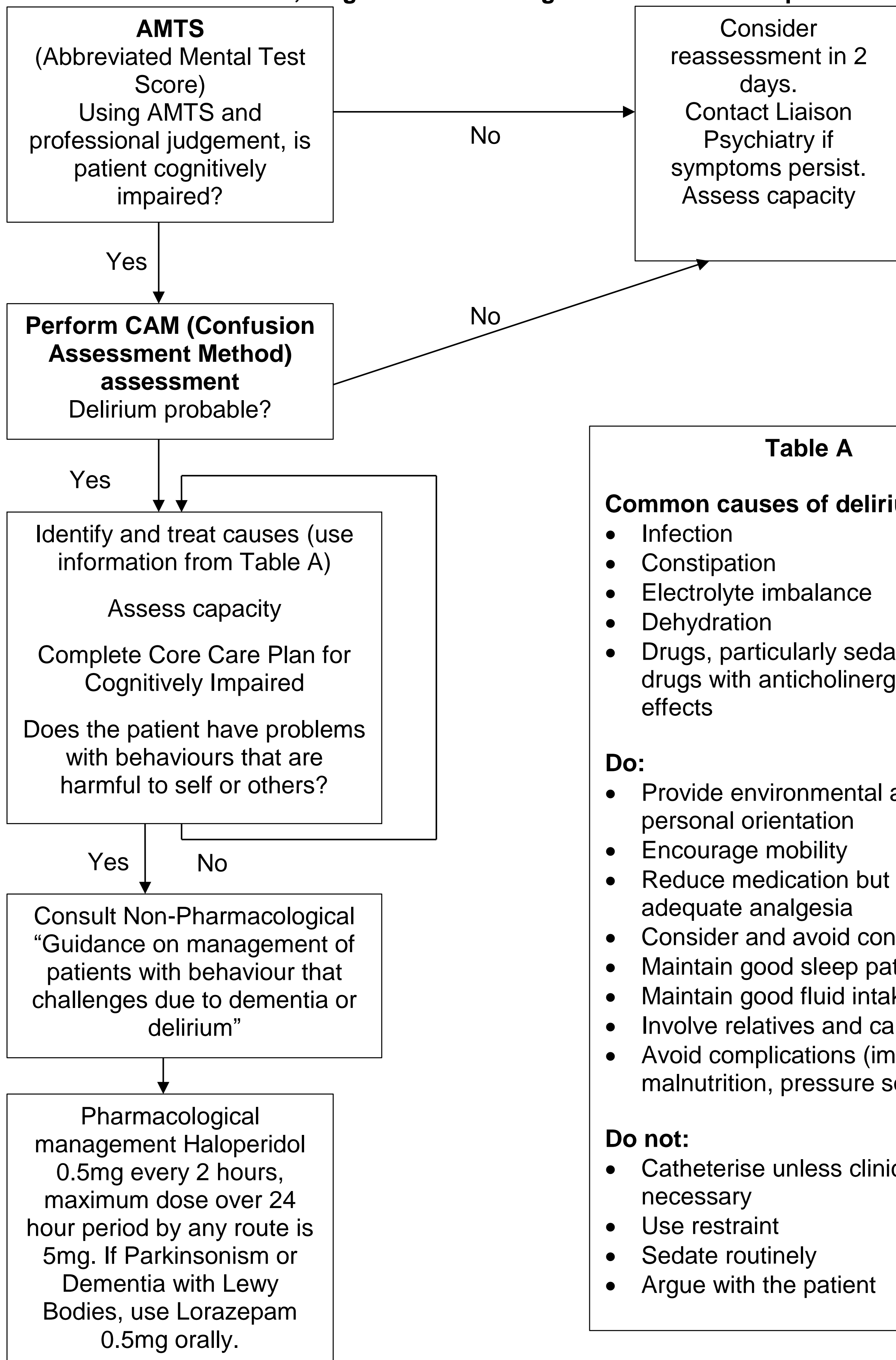

Table A

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 unless clinically necessary
- Use restraint
- Sedate routinely
- Argue with the patient

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1.0 Introduction and scope

This policy and procedure is intended to ensure that adult patients who are investigated, diagnosed and treated for delirium, receive best practice in their care and treatment whilst an inpatient at MTW. For patients attending outpatients or day care areas please seek advice from the doctor caring for the patient at that time. This policy does not cover assessment and treatment of children with delirium, for help and advice in this instance please speak to the doctor caring for the child.

Delirium can affect up to 30% of medical admissions, and up to 50% of surgical patients (1) making it the most common post-operative complication in older people. Delirium is often poorly understood by staff and it is estimated that up to 50-80% of cases go unrecognised (2).

People who develop delirium have high mortality rates, twice that of non-delirious patients. They also have longer lengths of stay in hospital and higher complication rates. Complications include falls, pressure damage, hospital acquired infections, functional impairment, continence problems and malnutrition.

2.0 Definitions / glossary

- **AMTS:** Abbreviated Mental Test Score. A tool for determining the presence of cognitive impairment in a patient. Initially developed to pick up the presence of dementia, now commonly used to identify confusion (acute or chronic).
- **AVPU:** The AVPU scale (an acronym from “alert, voice, pain, unresponsive”) is a system by which you can measure and record a patient’s level of consciousness.
- **CAM:** Confusion Assessment Method. A tool for screening for delirium.
- **Cognitive impairment:** When a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe.
- **CQUIN:** The Commissioning for Quality and Innovation payments framework, which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.
- **Delirium:** Delirium is characterised by a disturbance of consciousness and a change in cognition, such as memory deficit, disorientation and language disturbance that develop over a short period of time, and can fluctuate widely. Delirium is a serious medical problem requiring urgent management.

  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, agitation, restlessness and paranoia.
  - **Mixed:** A combination of the above throughout the day.
- **Dementia**: The term used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. These include Alzheimer’s disease, Vascular Dementia, Dementia with Lewy Bodies and Fronto-temporal Lobe Dementia.
- **DoLS**: Deprivation of Liberty Safeguards. A set of checks that aims to make sure that any care that restricts a person’s liberty is both appropriate and in their best interests

- **eDN**: Electronic discharge notification. Summary of care written by the doctors caring for the patient while in hospital, sent electronically to the patients GP.
- **IMCA**: Independent mental capacity advocate. The IMCA service safeguards the rights of people age 16 years and over who lack capacity to make a specific decision at the time it needs to be made and have nobody else who is willing or able to represent them or be consulted in the process of working out their best interest, other than paid staff.
- **LPA:** Lasting Power of Attorney
- **MCA**: Mental Capacity Assessment
- **MUST:** Malnutrition Universal Screening Tool. A five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
- **Out of Hours:** 10.00pm to 7:00am.

3.0 Duties

3.1 Chief Executive

- The Chief Executive has overall accountability for ensuring that the Trust meets its statutory and non-statutory obligations in respect of appropriate care for patients with delirium. The Chief Executive devolves responsibility for monitoring and compliance to the Medical Director and Chief Nurse.

3.2 Medical Director / Chief Nurse

- Both are responsible for ensuring that the Trust has in place robust governance, assurance and training frameworks to ensure all staff have the knowledge and competence to enable the delivery of a high standard of care to all patients with delirium.
- Responsible for ensuring that appropriate policies and procedures are developed, maintained and communicated through the organisation and adhered to by all relevant staff.

3.3 Clinical Directors / General Managers / Matrons

Are responsible for ensuring that all staff:

- Adhere to Trust policy in relation to patients with delirium.
- Are trained to the appropriate level for the service they provide.
- Follow all appropriate policies and procedures

3.4 Ward Managers/Consultants

- To ensure all staff are familiar with the contents of this policy and that this is reflected in practice.
- To ensure that copies of assessment tools are available and that staff are trained in their use and interpretation.
- To ensure that the core care plan for delirium is used.
- To monitor the use of assessment tools and care plans.
- To monitor patient care delivery in their areas to ensure that it is congruent with the contents of this policy.
- To participate in any related clinical audit activity.
- To be aware of relevant prescribing guidelines.

3.5 Pharmacists

To review the drug regimens of patients and identify those regimens that may precipitate delirium in high risk patients, or might be contributing to an episode of delirium; and if so, to advise on alternatives

3.6 All staff

It is the responsibility of every member of staff to ensure that the delirium policy and procedure is adhered to when caring for someone with delirium.

4.0 Training / competency requirements

Training on delirium is provided within the basic dementia awareness and intermediate dementia awareness training packages that can be completed online via AT- learning or via face to face teaching sessions, which can be booked with learning and development. Basic dementia awareness and intermediate dementia awareness are mandatory for all clinical staff.

5.0 Procedure

It is important that all people admitted to hospital are screened for features of delirium and that this screening forms part of on-going assessment by nurses and medical staff. Development of delirium in older people is usually a manifestation (sometimes the only one) of a serious medical condition in need of urgent investigation and treatment.

There are a number of pre-disposing and precipitating factors for delirium (see below), and these should inform initial and subsequent assessments.

Predisposing factors		Precipitating factors
Dementia		Medications
Severe underlying illness		Immobilisation
Functional impairment		Use of in-dwelling urinary catheters
Advanced age		Malnutrition
Chronic renal failure		Iatrogenic (caused by healthcare interventions e.g. medicines)
Dehydration		Infections
Sensory deficits		Metabolic disturbance
Physical frailty		Environmental and psychosocial influences

Cognitive testing should be performed, by the admitting doctor as part of the initial clerking on all older people (over 75 years) or those presenting with cognitive impairment using the AMTS.

CAM (Appendix 4) should be used if delirium is suspected. As this tool is not assessing solely for cognition, it is reported to have better specificity and sensitivity for delirium. If the patient tests positively on the AMTS and/or CAM, consider use of mental capacity assessment to support decision making for the individual going forward.

Hypoactive delirium is frequently not recognised and careful attention should be paid to assessing patients who have suddenly become quiet, withdrawn or lethargic. All staff should ensure that mental capacity / best interests and DoLS principles are followed at all times.

Appropriate tools must be used to undertake these assessments and decisions are clearly documented on the appropriate documentation within the patient's healthcare record.

Patient behaviour can be monitored using the behaviour monitoring chart. (Appendix 5).The use of this tool can help staff determine triggers and patterns in behaviour. It is recommended that staff speak to patients' family, friends and carers to determine what is normal behaviour for the individual.

5.1 Management

5.1.1 Investigation and treatment

The presence or emergence of delirium signifies a need for urgent medical attention. Nurses must refer any patients with signs of delirium to the appropriate medical team for assessment. It is useful to use the CAM framework to articulate the characteristics of delirium when discussing symptoms with medical or other clinical colleagues. Please also refer to the Delirium Pathway (Appendix 8) for guidance.

In older people delirium occurs due to the decreased reserve capacity of the ageing brain, therefore a relatively minor insult can lead to the development of delirium especially if there is a pre-existing cognitive deficit.

Indicators of delirium: at presentation
At presentation, assess patients at risk for recent (within hours or days) changes or fluctuations in behaviour. These may be reported by the patient at risk, or a carer or relative. Staff should be particularly vigilant for behaviour indicating hypoactive delirium. Behaviour changes may affect:

- **Cognitive function:** worsened concentration, slow responses, confusion.
- **Perception:** visual or auditory hallucinations.
- **Physical function:** reduced mobility, reduced movement, restlessness, agitation, changes in appetite, sleep disturbance.
- **Social behaviour:** lack of cooperation with reasonable requests, withdrawal or alterations in communication, mood and/or attitude.

If features of delirium are identified, the underlying cause will need prompt investigation. The more common causes are given below and should be given special consideration. Often the cause of delirium is multi-factorial with a number of causes present simultaneously:

- **Infections:** chest, urine, cellulitis and via invasive devices and procedures.
- **Anaesthesia alcohol:** both poisoning and withdrawal.
- **Metabolic disturbance:** of electrolytes, glucose, calcium, thyroid, vitamin deficiencies.
- **Neurological:** stroke, epilepsy, sub-dural haematoma.
- **Respiratory:** causing hypoxaemia, or hypercapnia.
- **Gastrointestinal:** faecal impaction, haemorrhage.
- **Cardiovascular:** myocardial infarction, pulmonary embolism (PE), arrhythmia.
- **Genitourinary:** urinary retention.
- **Medicines:** sedatives, analgesics, steroids, medicine withdrawal.

The drugs commonly causing delirium are:

- Benzodiazepines
- Opiate analgesics
- Steroids
- Tricyclic antidepressants
- Anticonvulsants
- Antiparkinsonian agents
- Digoxin
- Plus drugs with anticholinergic effects e.g. Hyoscine, Cyclizine and Oxybutynin

Medical management is primarily concerned with treatment of the underlying cause of delirium, but attention should be given to the prompt treatment of any pain, hypoxia, anaemia, dehydration or other metabolic disturbance to alleviate distressing symptoms. The care plan for a patient who is cognitively impaired should be used for all patients with a delirium. All patients that develop a delirium should be given the Trust core leaflet, Delirium [STANDARD PRINT LEAFLET] (RWF-OPLF-PC46) or Delirium [LARGE PRINT LEAFLET] (RWF-OPLF-PC47). This leaflet is of benefit to the patient and their family.

Patients with a delirium are at greater risk of falling and as such a falls assessment and care plan should be used to reduce their risk of falling while in hospital. (Care plan for a patient who is at risk of falling RWF-OWP-APP479)

5.1.2 Differential diagnosis

Delirium can be mistaken or occur concurrently with other forms of mental health conditions. Those with dementia are at greater risk of developing concurrent delirium

Dementia is a global and irreversible loss of cognitive and cortical functioning. It is progressive over time. It may involve memory loss, language impairment, disorientation, changes in mood and personality, self-neglect, and impaired judgement.

Depression is a mental health disorder characterised by an all-encompassing low mood accompanied by low self-esteem, and loss of interest or pleasure in normally enjoyable activities. It is under-diagnosed in older people and can be mis-diagnosed as delirium or dementia.

Common diagnoses that can be mistaken for delirium are; dementia, depression, schizophrenia, dysphasia, hysteria/mania, non-convulsive epilepsy. Patients may have dementia, delirium or both. If uncertain treat for delirium first.

Key features of these conditions are summarised below:

Feature	Delirium	Dementia	Depression
Duration	Minutes, hours, days	Months, years	Weeks, months
Onset	Acute, often over hours	Insidious	Variable
Course	Quick and fluctuating	Slow and constantly progressive	Variation during the day
Level of consciousness and orientation	Clouded, disorientated	Lucid until later stages	Usually normal
Attention and memory	Poor short-term memory *and* constant inattention	Poor short-term memory *without* inattention	Poor attention but intact memory
Cognition	Focal cognitive failure	Global cognitive failure	Variable
Sleep	Disturbed with confusion	Disturbed with wandering	Early waking
Psychotic symptoms	Frequent, but ideation usually brief and non-elaborated	Less frequent	Rare, but when occurs ideation is complex and mood related
EEG	Abnormalities in 80-90%	Abnormalities in 80-90%	Normal

Borthwick M, Bourne R et al (2006)

5.4 Behaviours harmful to self or others management

Guidance on the management of patients with behavior that challenges due to dementia or delirium provides initial non-pharmacological interventions should be employed prior to considering pharmacological interventions (Appendix 6).

5.5 Restraint

There may be times when a person who has delirium may not be accepting care and intervention. Clear documentation of mental capacity assessment, process and outcome should be evident in accordance with the Safeguarding Adults at Risk of Harm Policy and Procedure (RWF-OPPPCS-C-NUR5) and Restraint policy and procedure (RWF-OPPPCS-C-NUR4). If a person lacks capacity to make a decision about refusing care or treatment, restraint may be necessary in the best interests of a patient. Decisions about this should be multi-professional and when all other alternatives have been attempted. Next of kin should be informed and consulted if possible. All interventions should be documented appropriately in the patient's healthcare record.

The following are examples of restraint, and should be considered as a potential deprivation of liberty:

Primary restraint:
- Physical restraint – stopping an individual's movement by guiding them, or holding them
- Physical intervention to stop a person from doing what they intend to do
- Environmental restraint – designing the environment to limit the patient's ability to move as they wish
- Administration of medication, chemical restraint
- Preventing a person from leaving
- Electronic tagging systems
- Bandaging of hands or use of soft mitts to prevent an agitated or incapacitated patient from pulling out tubes
- One to one close supervision

Secondary restraint:
- Bed rails
- Lap belts
- Closed doors (but consider whether this amounts to a deprivation of liberty)
- Verbal restraint – continual reinforcement by asking someone to remain where they are, verbal reminders that they will be safe staying in hospital and then having to benignly bring the patient back to the ward should they have wandered off

5.6 One-to-one nursing (enhanced care pathway)

One-to-one care is sometimes indicated to ensure a patients safety especially when there are challenging behaviors present. If one-to-one nursing is felt to be indicated this should be discussed with the relevant Matron (or out of hours, the Clinical Site Manager) who will redeploy resources or authorise the engagement of additional staff via the Bank office. A DoLS will need to be completed in these instances.

Please refer to the documentation for 'Policy and procedure for the provision of Enhanced care to adult inpatients (use of Nurse 'Specials' one-to-one nursing) (RWF-OPPPCS-NC-NUR4).

5.7 Pharmacological management

The use of sedatives and anti-psychotics should be kept to a minimum.

All sedatives may cause delirium, especially those with anti-cholinergic side effects (such as haloperidol, chlorpromazine etc.). Rapid tranquilisation should only be considered once other strategies have failed to calm the patient.

Sedation may be necessary in the following circumstances in delirious patients:
- In order to carry out essential investigations or treatment.
- To prevent patients endangering themselves or others.
- To relieve distress from hallucinations in a highly agitated patient.

Senior advice from a Consultant or Specialist Trainee (grade 4 and above) should be requested before starting patients on sedatives.

The preferred medicines for sedation in delirious patients are Haloperidol 0.5mg every 2 hours – maximum dose over 24 hour period by any route is 5mg.

Haloperidol must not be used for patients with Parkinsonism or dementia with Lewy bodies. For these patients use Lorazepam.

Risperidone and Olanzapine may be used with caution after advice from the psychiatric liaison team. These are the medications suggested in NICE guidance.

It is preferable to use one medicine only, starting at the lowest possible dose and increasing in increments, if necessary, after an interval of 20 to 30 minutes. The maximum daily dose should not be exceeded and prescribers must be aware that medicine accumulation may occur. If the prescription is continued, it must be reviewed regularly (at least every 24 hours) by the medical team and be discontinued as soon as possible.

All patients given rapid sedation should be carefully monitored, especially for:

- Respiratory compromise.
- Over-sedation.
- Aspiration.
- An ECG should be taken if possible prior to commencement of neuroleptics or sedation.

Pulse, blood pressure, respiratory rate and oxygen saturation must be checked every 15 minutes for the first hour, and then hourly. Respiratory rate is frequently overlooked but is the most sensitive indicator that the patient may be compromised. If any vital sign falls within the trigger values as designated on the Trust Observation Chart, then the nurse in charge should review the patient and take action according to their professional judgment. This may include a decision to continue monitoring, advice from senior nursing staff, or routine or urgent review by medical staff.

5.8 Discharge

Care must be taken to ensure the delirium has been properly investigated and implementation of treatment before discharge. Discharge 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). Prior to discharge the patient should be reassessed for their cognitive and functional status; this should be documented on the eDN. The patient’s eDN should be completed promptly and should specifically note the presence of delirium.

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chairman will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under ‘Policies & guidelines’.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under ‘Policies & guidelines’; notification of the posting is included on the intranet “News Feed” and in the Chief Executive’s newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Monitoring compliance with this document

Auditing of documentation completion: Core Care Plan for cognitively impaired / AMTS score / Short CAM, at least twice a year by the Lead Nurse for Dementia and the Dementia Nurse Facilitator. The audit results to be presented at the Dementia Strategy Group.

Annual review of reported incidents relating to patients with delirium, results to be presented at the Dementia Strategy Group, by the Lead Nurse for Dementia.

Carer Survey – surveying carers of people with dementia and delirium monthly and results presented at the Dementia Strategy Group at least twice a year, by the Lead Nurse for Dementia.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 3 years, following the procedure set out in the ‘Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures’ [RWF-OPPPCS-NC-CG25].

If, before the document reaches its review date, changes in legislation or practice occur which require extensive or potentially contentious amendments to be made, a full review, approval and ratification must be undertaken.

If minor amendments are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Minor amendments include changes to job titles, contact details, ward names etc; they are ‘non-contentious’. For a full explanation please see the ‘Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures’ [RWF-OPPPCS-NC-CG25]. The amended document can be emailed to the CGA for activation on the Trust approved document management database on the intranet, under ‘Policies & guidelines’. Similarly, amendments to the appendices between reviews do not need to undergo consultation, approval and ratification.

4.0 Archiving

The Trust approved document management database on the intranet, under ‘Policies & guidelines’, retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Delirium Policy and Procedure
Consultation process – Use this form to ensure your consultation has been adequate for the purpose.
Please return comments to: Dementia Nurse Facilitator
By date: 19/06/17

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Corporate Governance Assistant	25/05/17	19/06/17	Y	Y
Chief Pharmacist and Formulary Pharmacist (if prescribing or medicine is included in the document)	25/05/17			
Formulary Pharmacist (if the document includes antibiotic use)	N/A			
Staff-Side Chair (if Workforce / HR issues are included in the document)	N/A			
Emergency Planning Team (a vast majority of Policies have some form of Emergency Planning aspect, even if this is only minor)	02/10/17	03/10/17	N	
Head of Staff Engagement and Equality (Equality & Diversity agenda must be considered within all policies)	25/05/17			
Health Records Manager (if the document contains any mention of patient record keeping and documentation)	25/05/17			
Complaints & PALS Manager (if the document makes any reference to the Trust's Complaints and/or PALS service)	N/A			
All individuals listed on the front page of this document				
All members of the Dementia Strategy Group	25/05/17			
All members of the approving committee: Safeguarding Committee	25/05/17	14/06/17	Y	Y
Lead Nurse for Dementia Care	25/05/17	08/06/17	Y	Y
Matron for safeguarding	25/05/17			
Deputy Chief Nurse	25/05/17	30/05/17	Y	Y
Consultant Geriatrician	25/06/17	26/05/17	Y	Y
The following staff have given consent for their personal names to be included in this policy and its appendices:				

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Delirium Policy and Procedure
What are the aims of the policy or practice?	The aim of this policy is to ensure that Maidstone and Tunbridge Wells NHS Trust meets strategic and clinical best practice standards in the identification, diagnosis and management of delirium.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines:

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Delirium (acute confusion) Diagnose and treat it. Diagnostic algorithm for delirium-CAM (Confusion Assessment Method)	RWF-OPPM-CORP183	Dementia Operational Policy and Procedure [RWF-OPPPCS-C-NUR10]
5	Behaviour monitoring chart	RWF-NUR-NUR-FOR-7	Dementia Operational Policy and Procedure [RWF-OPPPCS-C-NUR10]
6	Guidance on management of patients with behaviour that challenges due to dementia or delirium	RWF-OPPM-CORP168	Dementia Operational Policy and Procedure [RWF-OPPPCS-C-NUR10]
7	Care plan for a patient at risk of falling.	RWF-OWP-APP479	Management of Slips, Trips and Falls Policy and Procedure (RWF-OPPPCS-NC-CG20)
8	Delirium pathway	RWF-NUR-NUR-GUI-12	This policy