Guidelines to Prevent and Treat Delirium in Hospital

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Delirium is a medical emergency. It is a serious condition that is often poorly managed in the acute hospital setting, with significant associated morbidity and mortality. As our population ages, its prevalence is increasing and understanding how to appropriately care for patients with delirium is relevant to all adult specialities. It can be seen in 20% of all general medical inpatients, 10%-50% of patients admitted for surgery and up to 75% of patients admitted to intensive care.

Patients who develop delirium have double the risk of death, an increased risk of falls, pressure ulcers; hospital acquired infection, malnutrition and subsequently, an increased length of stay and risk of institutionalisation and development of Hospital Acquired Functional Decline (HAFD). The condition also has a significant psychological burden with many patients remembering the experience long after it has passed.

Health care professionals should always be alert to the possibility of delirium when patients present to hospital with ‘acute confusion’ or become confused during their admission. It can be difficult to distinguish between delirium and dementia and some people may have both conditions. If clinical uncertainty exists over the diagnosis, the person should be managed initially for delirium.

This clinical guideline describes methods of preventing, diagnosing and managing delirium in accordance with the Mental Capacity Act 2005. It does **not** relate to alcohol or substance misuse. If this is suspected use appropriate clinical guidance.

This guideline is for use by the following staff groups:

This guideline is relevant to all clinical staff involved with older adults entering the Trust.

Lead Clinician(s)

Susan Powell	Consultant Geriatrician, WRH
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Donna Kruckow	Lead Nurse Dementia and Older Adults

Approved by DMB on: 21st May 2024

Approved by Medicines Safety Committee on: 8th May 2024

Review Date: 21st May 2027
This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
May 2024	Changed to 4AT instead of CAM Changes to sedation – maximum dose reduced to 2mg of lorazepam or haloperidol over 24 hours, making risperidone 3rd line New flowsheet	S Powell
January 2024	Full review	S. Powell
August 2016	Full review and amendment	R.Dutta
March 2012	Amendment	R.Dutta
November	Full review	R.Dutta

Delirium in Hospital: Guidelines to diagnose, treat and prevent

Background

Delirium is an acute deterioration in cognition arising over hours or days that is mainly caused by acute illness, surgery, trauma or medication. Historically the condition has been known by terms such as 'acute confusional state', 'acute-on-chronic confusion' or 'acute brain failure'. For clarity, delirium is now the preferred term for use in clinical practice.

The condition usually develops over 1-2 days and has a fluctuating course that can last days or even months. Sadly, in some cases patients never return to their baseline cognition. Up to 60% of patients suffer persistent cognitive impairment following delirium and are also three times more likely to develop dementia in their lifetime. Therefore, where possible, it should be prevented and considered as a medical emergency when it does develop. Delirium can also last for a significant amount of time, in some cases up to 6 months. A multi-disciplinary, holistic approach is key in managing delirium successfully and where possible supporting the patient to return home to their normal environment as quickly as able. Those patients at-risk should be identified promptly as a third of cases can be prevented with intervention.

Clinical presentation

A patient may already have delirium when they present to hospital or may develop delirium during hospital admission. Delirium can be ***hypoactive***, ***hyperactive***, or ***mixed***.

- Patients with ***hyperactive delirium*** have heightened arousal and can be restless, agitated, distressed or aggressive. They often have '***positive features'*** – i.e. visual/auditory hallucinations, delusions. Often these are the most obvious cases and whilst can be physically challenging to manage often improve with supportive measures.
- ***Hypoactive*** delirium patients become withdrawn, quiet and sleepy. These patients are often hard to identify as these are commonly seen as 'less troublesome'. They often present with '***negative features***' - Lethargy, tiredness, immobility, reduced appetite and slow responses. Be aware of patients who are not at their functional baseline.
- Patients with a ***mixed*** delirium exhibit features of both types and need careful monitoring and support to ensure their fluctuating needs are being met.

Delirium can relapse and remit throughout the course of the day. It can be difficult to distinguish between delirium and dementia and some patients may have both. Where there is clinical uncertainty, the patient should be initially managed as if they have delirium.

Causes of Delirium

The commonest causes of delirium in the hospital population are listed below:

Pain	Constipation
Electrolyte abnormalities • Hypo/hypercalcaemia • Hypo/hypernatraemia • Hypo/hypermagnesaemia	Hypoglycaemia
Hypothyroidism	Respiratory failure
Dehydration	Cardiac failure
Drugs and drug withdrawal	Renal failure
Sensory impairment	Sleep deprivation
Urinary retention	Pulmonary embolism/ACS
Malnutrition	Infection

The underlying cause of delirium is often ***multifactorial*** and there may be many contributing factors to an acute presentation. Patients with prior cognitive impairment are more vulnerable to developing delirium, but in up to 30% of patients a reason is never identified. Given the wide number of causes a standardised and consistent approach to history taking, investigation and examination are of vital importance.

Prevention and identification of Patients with Delirium

Earlier identification of patients with delirium allows for early treatment and earlier resolution of their clinical symptoms. All patients presenting to hospital who would be considered 'high-risk' for developing delirium should undergo an appropriate screening test. Patient groups considered as 'high risk' are listed below:

1) Age >65
2) Current or past cognitive impairment, or known dementia
3) Current hip fracture

4) Severe illness – defined as a clinical condition that is deteriorating or at risk of deterioration

In practice, this represents the vast majority of adult patients admitted to hospital and therefore most patients will be screened for the symptoms of delirium as part of the acute 'clerk-in'. Patient who are identified as 'at risk' of delirium (even if not displaying symptoms) should still have the same level of care as those currently symptomatic, including early supported discharge to their usual residence where possible.

Staff should be aware that a patient may develop symptoms of delirium at any time during their hospital stay. Any person involved in the direct care of adult patients should consider the 'Single Question in Delirium (SQID)' when performing their clinical duties: ***Do you feel this patient is more confused than usual?*** If the answer to this question is 'Yes', they too should undergo a formal screening assessment for delirium. New confusion in a hospitalised patient scores a '3' on the National Early Warning Score 2 (NEWS2) chart and should prompt staff to escalate the patient for a medical review.

A variety of tests have been devised to assess delirium. However, the following have the best ease-of-use and sensitivity as assessed by NICE. Of note, clinicians who performed these tests should be trained to administer them, and only in their respective clinical area.

A&E / Ward Patients	**ITU / Theatre Recovery Patients**
4AT • Alertness • AMT 4 • Attention • Acute change or fluctuating course *(See appendix 2)*	***CAM – ICU*** • Acute change or fluctuating course • Inattention • Altered level of consciousness • Disorganised thinking *(See appendix 3)*

Whilst these questionnaires can add weight to a diagnosis of delirium, there may be situations where there is still diagnostic uncertainty. Specialist input from the Mental Health Liaison Team may help with the diagnosis if doubt remains.

Assessment following Identification of Delirium

The following should also be considered as part of the assessment of the delirious patient. Whilst not exhaustive, this will help identify any of the wide range of causes for delirium in a holistic way.

1. **History**:

   History taking from the patient's relative or carer is essential to distinguish between delirium and dementia or other disorders of the brain. This should include:

   - Details of the onset and course of the confusion.
   - Previous intellectual function (e.g. ability to manage household affairs, pay bills, compliance with medication, use of telephone and transport)
   - Complete mental capacity assessment and if appropriate apply for DOLS
   - Full drug history including non-prescribed drugs and recent drug changes (especially benzodiazepines)
   - Functional status (e.g. activities of daily living)
   - Sources of chronic pain (e.g. arthritis)
   - Mobility and falls
   - Alcohol history
   - History of diet and food intake
   - History of bladder voiding
   - History of bowel movements
   - Previous episodes of acute or chronic confusion
   - Symptoms suggestive of underlying cause (e.g. infection)
   - Sensory deficits
   - Aids used (e.g. hearing aid, glasses etc.)
   - Pre-admission social circumstances and care package
   - Comorbid illness
   - Mood

2. **Examination:** think 'PINCHES ME'
    - Look for and act on acute, severe causes such as sepsis, hypoxia, hypoglycaemia and medication intoxication
    - Conscious level (Glasgow Coma Score)
    - Cognitive function
    - Look for evidence of alcohol abuse or withdrawal (e.g. tremor)
    - Look for signs of constipation and consider PR
    - Neurological examination (including speech assessment)
    - Identify source of infection (lungs, urine, abdomen, skin, wounds, CNS)

Memory Aid – PINCHES ME

Pain

Infection

Nutrition

Constipation

Hydration/Hypoxia/ Hypo/hyper states

Electrolytes

Sleep deprivation

Medication

Environmental

3. **Investigations/screening**
    - FBC; CRP; LFT; U & E's, bone profile, thyroid function, B12 and folate
    - Blood glucose
    - Chest x-ray
    - ECG
    - Pulse-oximetry
    - Urinalysis
    - Blood, sputum, stool culture as appropriate
    - CT brain if indicated

4. **Medication review**
    - Avoid abrupt withdrawal of medications that have potential for dependency or likely side effects of withdrawal
    - Consider compliance/concordance issues
    - Recent changes to medication list or doses
    - Review use of high-risk factor drugs e.g. opioids, benzodiazepines, antipsychotics, antispasmodics, anti-epileptics, anti-histamines, anti-hypertensives, cortico-steroids, anti-cholinergic, tricyclic antidepressants, digoxin, and anti-parkinsonian medication
    - An anti-cholinergic calculator can be used to asses if medications may be contributing to confusion - https://www.acbcalc.com/
    - Ensure regular pain relief (use Abbey Pain Scale)

- Consider age appropriateness for all medications
- Consider renal function and other co-morbidities when starting new medications
- Consider nutritional supplements and refer to identification and management of re-feeding syndrome guidance (WAHT-NUT-006) for malnourished patients

Principles of the management of delirium

- Treat reversible causes e.g. electrolyte imbalance, sepsis, constipation, pain, urinary retention, dehydration, hypoxia, hypoglycaemia
- Optimise co-morbid conditions e.g. PD, COPD, DM
- Use Abbey Pain Scale to assess and monitor pain
- Implement “About Me” booklet
- Communicate with patient and carer
- Ensure patient has glasses and hearing aids if needed
- Keep food and fluid diaries
- Remove peripheral devices e.g. cannulas, catheters, oxygen tubing if not required
- Regularly reassure and re-orientate patient – clocks and calendars are useful for this
- Ensure call bell is in the patient’s reach
- Encourage mobility and engagement in activity
- Relax visiting times and allow family and carer involvement
- Avoid inappropriate inter and intra-ward transfers
- Record diagnosis of delirium on EDS to ensure GP is informed and aware of risk of dementia if an older patient
- Where possible support the patient to return to their usual residence. This may require support from Onward Care Team (OCT), Occupational Therapists (OTs) or Physiotherapy (PT) colleagues
- Please provide family members with the Trust’s patient information leaflet for delirium

Managing Challenging Behaviours

Wandering: Patients who wander require close observation within a safe and reasonably closed environment. The least restrictive option should always be used when acting in the best interests of the patient to keep them safe. In the first instance attempts should be made to identify and remedy any possible cause of agitation - e.g.

pain, thirst or need for the toilet. If no source of agitation is found or the cause of the agitation cannot be remedied, the next least restrictive option is to try distracting the patient. Relatives could be encouraged to assist as they will have information about the person which may offer meaningful distraction. The use of restraints or sedation should only be used as a final option. It must be clearly documented in this instance that the intervention was the only option to act in the patients' best interests to prevent harm to themselves or others. If managing delirium well, it is rare that either restraint or sedation is necessary.

Rambling speech: Patients with delirium often exhibit confused and rambling speech; it is usually preferable not to agree with rambling talk, but to adopt one of the following strategies, depending on the circumstance:

- Tactfully disagree (if the topic is not sensitive).
- Change the subject.
- Acknowledge the feelings expressed but distract from the subject if distressing to the patient

The use of sedation in the management of delirium

The use of sedative medication should be **a last and final resort** for patients with delirium**.** There is a significant risk that sedatives may further worsen delirium, especially those with anticholinergic effects. The risk of inpatient falls and resulting injury due to drowsiness/unsteadiness is also significant. Many elderly patients with delirium have hypoactive delirium (quiet delirium) and do not require sedation. The main aim of drug treatment is to treat distressing or dangerous behavioural disturbance (e.g. agitation and hallucination) which may be seen in those with hyperactive delirium.

Key considerations:

- Drug sedation may only be considered in the following circumstances:
  - in order to perform essential investigations or treatment
  - to prevent patients endangering themselves or others
  - to relieve distress in a highly agitated or hallucinating patient
- The rationale for requiring sedation **must be documented** in Sunrise alongside the assessment by the prescribing clinician.
- All other reasonable efforts should have been made to help the patient and documented (See above: managing challenging behaviours).

- 1-to-1 nursing should be considered. Out-of-hours this may need discussion with on-call Site Manager if staffing levels are limited.
- It is essential that Mental Capacity has been assessed using MCA 1 and 2 forms if sedative medication is being considered. These can be found on all wards and are available on the Trust Intranet.
- A Deprivation of Liberty Safeguards (DoLs) application can then be made to the local authority by the nursing staff on the ward. The application can be made at the following website: ***https://capublic.worcestershire.gov.uk/DOLS/***
- A DoLs application ***can*** be made retrospectively in an emergency situation but should be completed at the earliest possible opportunity.
- The least restrictive option should always be used. This should be the lowest dose given in the best tolerated route. Oral is preferable to IM injection; however patient compliance may prevent this.
- Use **one drug only**, starting at the lowest possible dose and increasing in increments if necessary after an interval of 30 minutes. *Start low and go slow.*
- Out-of-hours, sedation should only be given as ***STAT doses*** with reassessment after each dose. If further doses are required, this should prompt re-assessment of the patient by the prescribing clinician.
- The use of benzodiazepines can cause significant side effects including paradoxically worsening delirium. Their use should be considered second-line when other medications fail or are contraindicated. Special consideration should be given to the risks of oversedation. The patient's GCS should be regularly monitored and staff should be aware of the reversal agent ***flumazenil***. Please consult Toxbase (https://www.toxbase.org) if considering its use and involve senior clinicians early with the patient ideally in a monitored bed.
- In 2021 an MHRA safety alert was issued around the use of haloperidol in elderly patients: Haloperidol (Haldol): reminder of risks when used in elderly patients for the acute treatment of delirium - GOV.UK (www.gov.uk). Patients living with frailty are at higher risk of developing complications of sedative medicines. In particular, extrapyramidal side effects and sudden cardiac events related to prolonged QT interval. Consider the use of sedation especially carefully in this group. All admitted patients should have an up-to-date ECG. If none available, please ensure the patient has an ECG performed at the earliest opportunity.

Table 1: Pharmacological Management of Delirium

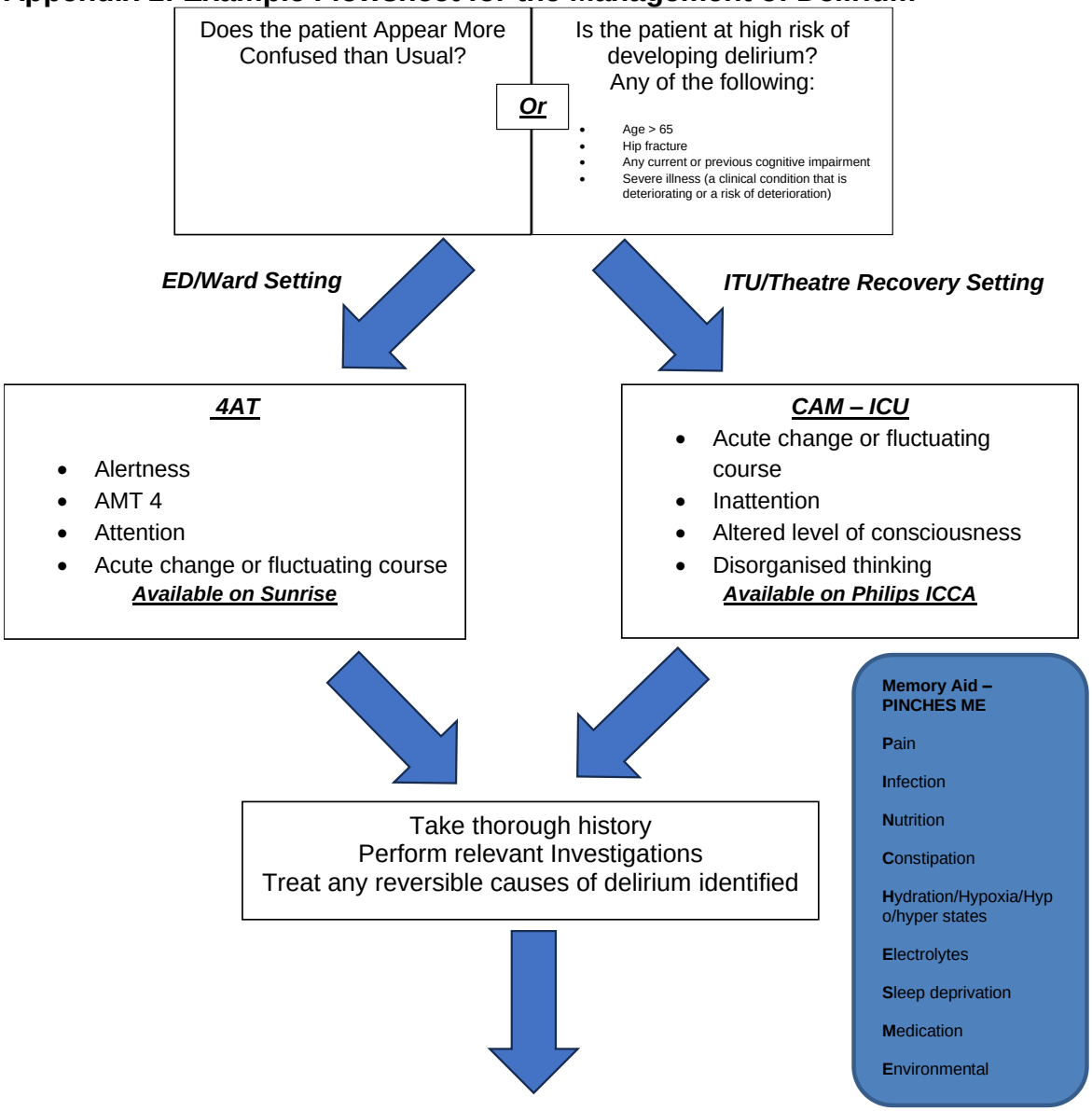
If considering pharmacological treatment, patients must have a valid MCA/DOLS assessment in place

1st Line Choice ***(CONTRA-INDICATED IN PARKINSONISM OR LEWY BODY DEMENTIA)*** **Haloperidol 0.5 – 1.0 mg orally** maximum 2mg/24 hours **Haloperidol 0.5mg IM** maximum 2mg/24 hours ***Ensure the patient has an available up-to-date ECG***
2nd Line Choice *- Where antipsychotics are contra-indicated or not tolerated* **Lorazepam 0.5mg - 1 mg orally/IV/IM** maximum 2mg/24 hours
3rd Line Choice *– Where symptoms are requiring recurrent doses of sedation or Behavioural and Psychological Symptoms of Dementia (BPSD) are present* **Risperidone 0.25 – 0.5mg orally** maximum 0.5mg/24 hours ***Ensure the patient has an available up-to-date ECG***

Training and Education

Delirium e-learning is available on ESR and staff groups working with older adults should be able to actively engage with available training.

Appendix 1: Example Flowsheet for the Management of Delirium



Supportive Measures in Delirium

Orientation
- Introduce self and explain what is happening
- Encourage regular visits from familiar faces
- Adequate lighting, clock and calendar

Hydration
- Encourage person to drink

Infection
- Look for and treat any infection. Avoid drips, drains lines or catheters

Pain and constipation
- Use the Abbey Pain Scale to assess non-verbal indicators of pain
- Give appropriate analgesia
- Bowel chart

Sensory Impairment
- Ensure hearing aids and glasses are available

Medication Review
- Review all medications
- Stop any unnecessary medications
- Consider any evidence of medication withdrawal

Hypoxia
- Assess for hypoxia and optimise oxygenation

Mobility
- Encourage mobility. If not mobile consider bed exercises
- Ensure adequate VTE prophylaxis

Sleep Hygiene
- Promote good sleep pattern and hygiene

Nutrition
- Complete nutritional assessment/dietician input

Sedation is a last and final resort. Please see full guidance for further information

Worcestershire Acute Hospitals NHS Trust

Appendix 2 – 4AT Delirium Assessment Tool

4AT

Assessment test for delirium & cognitive impairment

(label)

Patient name:

Date of birth:

Patient number:

Date: **Time:**

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December."
To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

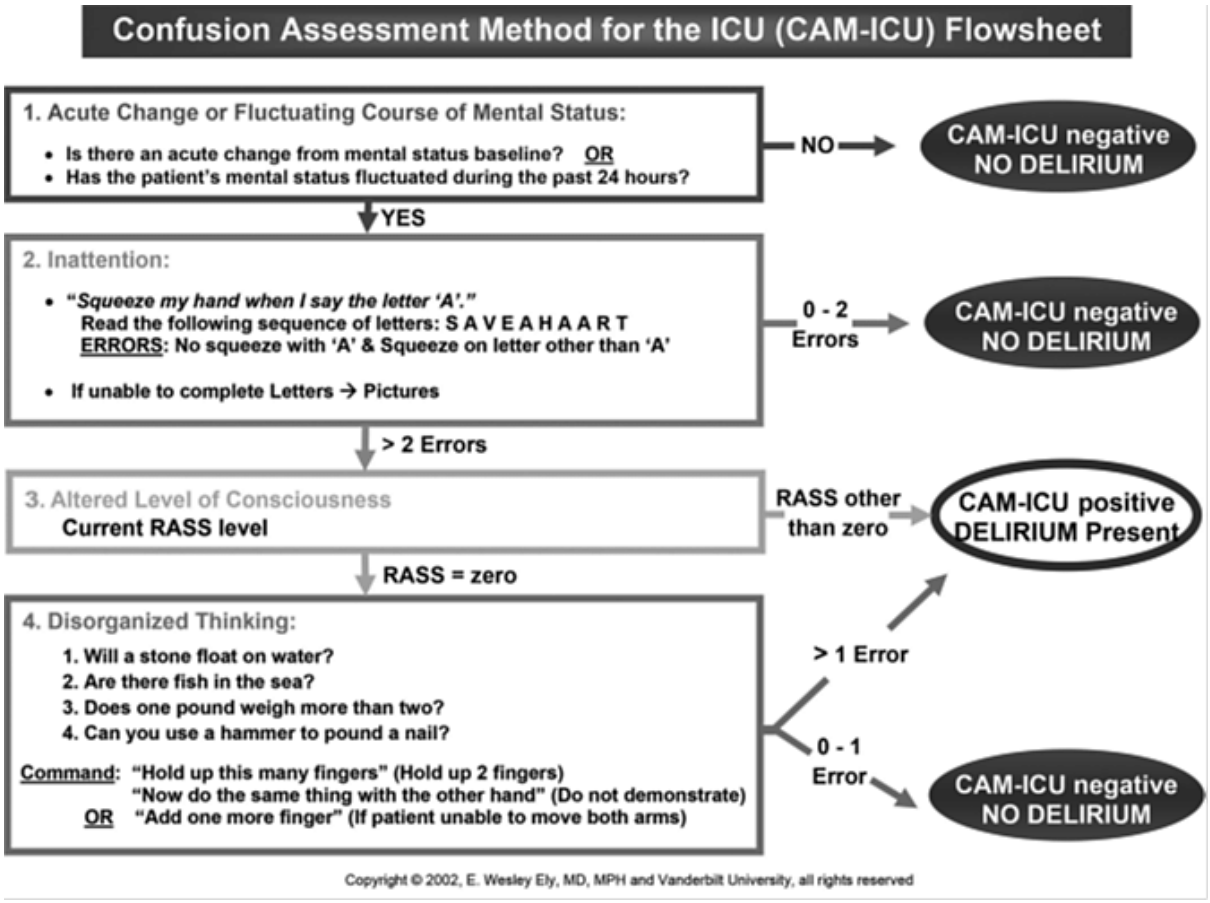
4AT SCORE ☐

GUIDANCE NOTES Version 1.2. Information and download: **www.the4AT.com**

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment.* Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

Appendix 3 – CAM ICU Assessment Tool



Richmond Agitation-Sedation Scale (RASS)
+4 Combative, violent, immediate danger to staff
+3 Very agitated Pulls or removes tube(s) or catheter(s); aggressive
+2 Agitated Frequent non-purposeful movement, fights ventilator
+1 Restless Anxious, apprehensive but movements are not aggressive or vigorous
0 Alert and calm
-1 Drowsy Not fully alert, but has sustained awakening to voice (eye opening & contact > 10 sec)
-2 Light sedation Briefly awakens to voice (eye opening & contact < 10 sec)
-3 Moderate sedation
Movement or eye opening To voice (but no eye contact)
-4 Deep sedation No response to voice, but movement or eye opening to physical stimulation
-5 Unarousable No response to voice or physical stimulation

Sessler, et al., Am J Repir Crit Care Med 2002, 166: 1338-1344
Ely, et al., JAMA 2003; 286, 2983-2991

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Standards	Percentage	Clinical Exceptions
All patients >65 admitted to hospital should have cognitive assessment (AMT)	**100%**	**Unconscious or aphasic (this must be documented)**
Of patients diagnosed with delirium, care plan initiated	**100%**	
All patients diagnosed with delirium should have diagnosis documented on EDS	**100%**	

References

1. NICE Delirium: Prevention, diagnosis and management in hospital and long-term care. CG103 July 2010 (Updated 2023) Link: https://www.nice.org.uk/guidance/cg103/chapter/recommendations#assessment-and-diagnosis

2. British Geriatrics Society: Silver Book Link https://www.bgs.org.uk/resources/silver-book-ii-geriatric-syndromes#_ENREF_153

3. Innouye SK, Bogurdas ST, Charpentier PA et al. A multicomponent intervention to prevent delirium in hospitalized older patients. *N Eng J Med* 1999; **340**: 669-76.

4. Bogurdas ST Jr., Desai MM, Williams CS et al. The effects of a targeted multicomponent delirium intervention on post discharge outcomes for hospitalized older adults. *Am J Med* 2003; **114**: 383-90.

5. Rockwood K, Cosway S, Carver D et al. The risk of dementia and death after delirium. *Age Aging* 1999; 28: 551-56.

6 George J, Oxford Desk Reference Geriatric Medicine 2015 pg 264

7 Sign 157: Delirium Link https://www.sign.ac.uk/media/1423/sign157.pdf

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Dr C Jackson
Dr C Wilkes
Mr P Goode

This key document has been circulated to the chair(s) of the following committees / groups for comments;

Committee
Sedation Committee
Divisional Governance Group for Speciality Medicine
Medicines Safety Committee

Supporting Document 1 - Equality Impact Assessment Tool

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Susan Powell**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Dr Susan Powell	**Consultant Geriatrician**	**Susan.powell16@nhs.net**
Date assessment completed	**5th April 2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Guidelines to Prevent and Treat Delirium in Hospital			
What is the aim, purpose and/or intended outcomes of this Activity?	To improve identification of delirium in the hospital setting standardise the management.			
Who will be affected by the development & implementation of this activity?	x❑ Service User x❑ Patient ❑ Carers ❑ Visitors		❑ Staff ❑ Communities ❑ Other _____	
Is this:	x❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			

What information and evidence have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc.	Latest NICE guidance.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Discussed with members of the sedation committee and clinical members of the Acute Frailty Team including pharmacy, consultant and nurse consultant members.
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	x			Older people are more likely to develop a delirium and this guideline will improve their clinical care.
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	.		
How will you monitor these actions?				
When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc., and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	S Powell

Date signed	5th April 2024
Comments:	
Signature of person the Leader Person for this activity	S Powell
Date signed	5th April 2024
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	There is current training on delirium and this will be updated with the 4AT

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval