

Delirium in Critical Care Patients. Management guidelines.

Salford Royal 
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Classification: Clinical Guideline
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Unique ID: GSCcrit01(15)
Issue number: 2
Expiry Date: October 2020

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Who should read this document?

- Clinical Staff working in Critical Care (= Intensive Care Unit, Surgical High Dependency and Neuro High Dependency Units).
- This document is NOT intended for use outside of the Critical Care Unit.
- This document does NOT cover the identification of patients potentially suffering from delirium and does NOT cover the prevention of delirium

Key Messages

- **Delirium is a potentially life threatening condition. Once identified it should be managed by the whole Critical Care team including the medical staff.**
- **The management can be summarised as ‘CaECUM’**
- **Ca- Look for the Cause(s) of this patients delirium**
- **E - Environment- control the patient’s environment**
- **C- Communicate with the patient, relatives, the rest of the Critical Care team and other teams, communicate the diagnosis in the patient record**
- **U- Plan for any Unexpected deterioration in the patient’s clinical condition with hyperactive delirium**
- **M - Medications- review drugs that may be causing delirium and potential for delirium caused by the withdrawal of drugs. Consider medicines that may be used to manage symptoms of delirium**

Background & Scope

Delirium is a potentially life-threatening disease.

We should be treating patients in ways that minimise the incidence of delirium and we should be screening patients to identify patients who may have delirium.

This guideline covers only what to do if we identify a patient who may be suffering from delirium.

Guideline

1. What to do if a patient has a positive screen for delirium

If the patient is thought to have delirium this is potentially a major problem that is associated with significant mortality and morbidity [1]. There are several things that should be done which can be summarised with this mnemonic:

CaECUM

Causes- assess for a potential cause for the delirium like symptoms

Environment- control the patient's environment

Communicate- with patient, relatives and other care givers and record in the notes

Unexpected- plan for rapid changes in the patient's condition

Medications if indicated- Sometimes drugs are required to control delirium or pain

These actions are in part suggested by a number of published guidelines [2-4] which can be found on the GM website [5].

2. Causes - Assess what is wrong with the patient (MEDICAL STAFF REVIEW)

The patient may have delirium that is being caused by a potentially treatable medical condition, or they may have another psychiatric disease producing delirium-like symptoms. The patient may also have a physiological imbalance or infection associated with their critical-illness that is causing delirium.

The patient may also have MORE THAN ONE PROBLEM causing delirium or, following the assessment of a patient, it may not be possible to diagnose a specific cause for delirium.

Approach to the problem- The patient MUST have a review by a Doctor capable of assessing the patient and the assessment must be recorded in the notes. Delirium has a high risk of death and disability and to treat it without excluding a treatable cause may cause death or permanent disability to the patient.

As with any assessment the review is based on history and examination followed by investigations. These stages cannot be reviewed in detail in this document but some pointers are:

History- Normal functional state and possible underlying problems; Screening questions for underlying causes; Review of medication/drug history; When has the

delirium presented in the critical care episode? The age of the patient and when in the delirium was first identified in the critical care stay will give clues to the cause.

Examination- Review of the mental state examination and neurological examination to exclude neurological causes for apparent delirium (examine the ears for wax). Review of potential sources of sepsis (urine, chest, wound, lines, abdomen, blood, CNS). Assess hydration and look for stigmata of other diseases that may be causing delirium. Treat pain as appropriate.

Investigations- All patients require: FBC, Blood glucose, U+Es, Calcium, infection screen, TFTs, LFTs, ESR and CRP.

And consider the following: ammonia levels, B12, folate, HIV screen, syphilis screen (these should be discussed with a consultant). The requirement for CT and EEG investigations should be agreed with a consultant due to the low positive rate for these investigations [6]. An ECG (partly to look at Q-T interval) should be reviewed.

The lists of potential causes of delirium given below suggest areas for focus in the history, examination and investigations of the patient.

Help in the review- The patient's referring team should be informed of the problem as an episode of delirium may be associated with a complication of the primary illness which led to critical care admission- for example a leak in a surgical anastomosis.

Examples of diseases that may be confused with delirium or cause delirium like symptoms

Neurological diseases:

CNS infections, CNS trauma, including chronic subdural, CNS tumours, Cerebrovascular diseases, stroke, TIA, Underlying dementia, Epilepsy including non-convulsive seizures, Other CNS diseases- inflammatory and autoimmune

Dementia:

In older patients a period of critical illness may reveal a developing dementia that the patient had been able to cope with at home without the diagnosis having been made prior to hospital admission.

Metabolic and endocrine diseases

Diabetes and hypoglycaemia, Thyroid diseases, Systemic lupus erythematosus, Liver failure, Metabolic diseases of ammonia metabolism, these may be revealed by patients being started on sodium valproate.

Psychiatric diseases

Psychosis due to psychiatric disease- e.g. bipolar disorder or schizophrenia,
Psychosis due to substance abuse, Psychosis due to withdrawal of recreational
drugs, alcohol or prescribed drugs.

Delirium is also more likely to occur in patients with previous psychiatric disease.

For details of how to obtain a psychiatric opinion in Salford Royal NHS Foundation
Trust: Please request an opinion using the EPR order set 'Mental health liaison
team' or bleep 3411.

Examples of other causes of delirium in critical care

A mnemonic for remembering these could be **DIMPLES-** (**D**rugs, **I**nfections,
Metabolic derangement, **P**ain, **L**ong standing diseases (above), **E**xcretion
(constipation), **S**ensory input.)

Drugs

Prescribed and recreational drugs, alcohol taken up to admission or illicitly after
admission

Withdrawal of drugs- commonly: alcohol, benzodiazepines, Nicotine, painkillers
prescribed and recreational, anti-depressant drugs

Drugs started during the critical care episode causing delirium as a side effect, a list
of drugs commonly associated with delirium are [shown here](#).

Infections

Wound, urine, chest, CNS

Metabolic derangement

Abnormal blood glucose, dehydration, abnormal electrolytes

Problems with passing urine/ constipation

Pain

Pain may be difficult to assess in a patient with delirium and patients with pain may
not identify it as such. Abnormal facial and body movement may be due to pain or
conversely distress associated with delirium or something else. Self-reported pain is
most reliable for most patients, but if a patient can't report pain accurately then a
behavioural pain scale may be used [7], see [here for example](#).

Problems with sensory input

Poor eye sight or hearing (ear wax)

FOLLOWING review, if a satisfactory cause or causes cannot be established, then a second opinion should be considered.

3. Sort out the patient's Environment (External, internal and perception of)

Control the patient's External environment-

Ensure quiet and calm (consider risks and benefits of moving to a side room)

Familiar faces and family (Consider open visiting of immediate family, consider limited group of staff caring for the patient). Consider a patient diary to help them in recovery.

Familiar objects and photos (Non-breakable and not upsetting if lost on the unit and not a potential weapon!)

Remove objects that could cause harm if the patient is hyperactive and aggressive

Consider moving to a bed with access to natural light if a disordered sleep/wake cycle is present.

Improve the patient's perception of their environment- provide glasses, hearing aids, treat ear wax.

Control the patient's internal environment- control pain, hydration and biochemistry and Remove medical devices that are not required, give the patient their false teeth.

4. Communicate and record in the notes

Communicate with the patient ([detailed guidance see here](#)) [8]

Communicate with the relatives ([detailed guidance see here](#)) [9] Make sure that they have a copy of the document 'Delirium in critical care- advice for relatives'

Communicate with specialist services, particularly about establishing or treating underlying diagnosis. For details of how to obtain a psychiatric opinion in Salford Royal NHS Foundation Trust (Change if used in another trust) : Please request an opinion using the EPR order set 'Mental health liaison team' or bleep 3411.

Communicate with the patient's referring team

Communicate with the rest of the critical care team

Handover during critical care stay and at transfer from critical care, ensure diagnosis is recorded in notes for coding and payment and for GP to add to patient's record. In Salford Royal NHS Foundation Trust- This should be entered as a diagnosis in health issues. For details of how to do this click on the following link

5. Prepare for unexpected dangerous hyperactive delirium

Patients with severe hyperactive delirium may be a danger to themselves with respect to unplanned removal of essential medical devices or falls or self-harm. The increased metabolic demands of delirium may result in myocardial ischemia and dysrhythmias. Delirious patients may disrupt the care of other patients and put staff at risk from assault or manual handling injuries. Delirium is a fluctuating disease, often worse at night when there are reduced levels of medical cover. A documented management plan should be produced for dangerous hyperactivity in all patients with hyperactive delirium. Issues to address should include the following, presented as a mnemonic **S.E.M.I.N.A.R.** - :

S.taffing- what extra staff may be required, do the security staff need to be contacted, are the senior medical and nursing staff aware of the problem, are a team of nurses going to provide constant care?

E.nvironment- Should the patient be moved- for example into a side room. Is the bed appropriate- can it be lowered, would the patient be better on a mattresses on the floor, are there objects that could be used as a weapon that should be removed from the bed area ?

M.edications- a documented medication plan for escalation should be produced. Giving small doses (e.g. 0.5 to 1.0 mg Haloperidol) as patients start to get increasingly agitated may stop the process escalating, this should also be considered on the night following an episode of severe night time agitation.

I.ntubation and ventilation- if the patient needs to be deeply sedated, are the resources available to safely and rapidly manage this?

N. Are the medical devices **Not** needed? For each medical device in-situ: is it still required or does it present an unnecessary risk?

Are all the other steps in CaECUM already followed?

R.elatives: Do the relatives know and would their presence outside of visiting hours be helpful?

6. Medications: Consider prescribing medications to treat or manage delirium, and stopping those medications that may be causing delirium

There is no benefit to giving prophylactic drugs to prevent delirium [10] and generally the treatment of delirium is supportive, there is little evidence for benefit for medications to treat delirium in the long term [11] but medications may be indicated to treat underlying causes or promote safe nursing:

Pain may be a cause of delirium and should be treated.

Alcohol withdrawal is normally treated with benzodiazepines. Your unit will have protocol for the treatment of the patient withdrawing from alcohol and you should follow this, not forgetting to give thiamine.

Nicotine withdrawal may cause delirium [12], prophylactic nicotine replacement is not routinely indicated but withdrawal should be treated with nicotine replacement [13].

Benzodiazepine withdrawal is a common cause of delirium and may be treated with benzodiazepines in a reducing dose [14], tolerance may have been caused by use started during the critical care stay (more than a week's treatment), this is also true for opiates [15].

Opiate withdrawal may be treated with reducing doses of opiates or clonidine, remember that most patients withdrawing from opiates will be withdrawing from opiates prescribed for chronic pain, follow local guidance about opiate withdrawal.

Abrupt antidepressant withdrawal may cause psychosis and delirium and these drugs should be restarted if possible, there is little advice on what to do if the oral route is not available but benzodiazepines may be helpful [16].

Constipation is described as a cause of delirium [2-4] and can be treated using local unit guidelines.

Hypoactive delirium does not normally require drug treatment [10].

Active delirium can be managed with medications although the long term benefits are unclear [10-11]- A typical protocol for the use of these drugs [is found here.](#)

If you are using anti-psychotics to control active delirium then you should document in the notes that the patient lacks capacity to consent to treatment but that the treatment is in the best interests of the patient. You should also make sure that discussions with relatives are documented and where appropriate the use of the medication has been discussed with them (it may well not be in an acute situation where they are not around). You should also document that proportionate measures

have been taken to give the medication (for example it may be necessary to place a cannula to give the drugs).

These drugs should not be used if the QT interval is prolonged or the patient has another contraindication (for example head injury or epilepsy)

A list of medications that may have been started in the critical care unit that commonly cause delirium can be [found here](#)- the risks and benefits of their continued use in the patient should be considered.

Other treatments for the underlying causes of delirium are outside the scope of this review.

7. Summary

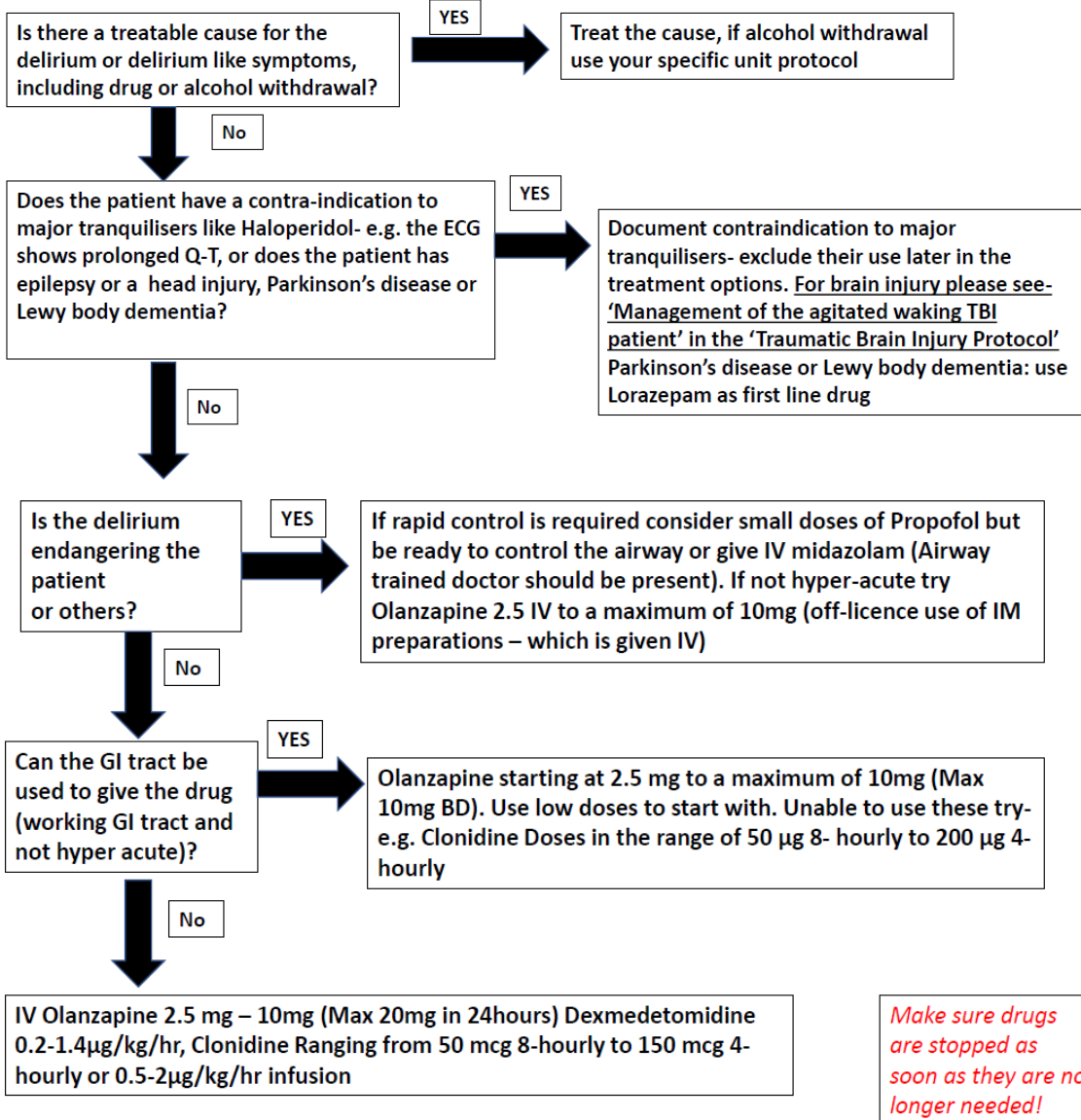
The management of a patient with delirium can be difficult and frustrating, but it's important to go back to the basic steps of history examination and investigations, making sure you get second opinions where you need them. Communication, recording and planning are also important. Most treatment is supportive and dealing with any causes. Drug treatment is sometimes important.

There are other links to information about delirium on the GM Critical Care website- please check them out!

If you have used this protocol please feedback your experiences to tony.thomas@srft.nhs.uk.

Drug Treatment of Hyperactive Delirium

Drug treatment of Hyperactive delirium (Hypoactive does not require drug treatment)- Following an ECG and where the degree of hyperactivity requires drug management.



Standards

NICE quality standard [QS63] Published date: July 2014

Describes the importance of this guidance, particularly establishing and recording the diagnosis

Statement 4. Adults with delirium in hospital or long-term care, and their family members and carers, are given information that explains the condition and describes other people's experiences of delirium.

Statement 5. Adults with current or resolved delirium who are discharged from hospital have their diagnosis of delirium communicated to their GP.

Explanation of terms & Definitions

Terms are described in the guideline

References and Supporting Documents

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3. AMERICAN GERIATRICS SOCIETY Clinical Practice Guideline for Postoperative Delirium in Older Adults. October 10, 2014 American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adult
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15. Cammarano, W. B., J. F. Pittet, S. Weitz, R. M. Schlobohm and J. D. Marks (1998). "Acute withdrawal syndrome related to the administration of analgesic and sedative medications in adult intensive care unit patients." *Critical Care Medicine* 26(4): 676-684.
16. Schatzberg, A. F., P. Blier, P. L. Delgado, M. Fava, P. M. Haddad and R. C. Shelton (2006). "Antidepressant discontinuation syndrome: Consensus panel recommendations for clinical management and additional research." *Journal of Clinical Psychiatry* 67: 27-31

Supporting documentation and additional information can be found on the web site of the Greater Manchester Critical Care Network web site:

<http://gmccn.org.uk/delirium>

Roles and responsibilities

Clinical staff in critical care will be responsible for following the policy.

Appendices

Appendix 1: Communication with the patient

- Tell the person who you are each time you visit. If you leave the room for even a short time, identify yourself again when you come back. Tell the person where they are and what date and time it is. Remind the patient why they are in the critical care unit.
- Address the patient by name to get their attention- if you are using their first name check this is OK with them first.
- Try to speak to the patient directly facing the patient- confused patients will not cope with you talking from the side or behind; try to be on the same height.
- Speak slowly and don't shout, but make sure you are heard. Use a warm and reassuring tone of voice. Be prepared to repeat phrases several times.
- Keep sentences short and use simple words (try to avoid technical terms). Give the person enough time to absorb the information and to respond.
- Reassure the person that you understand they are having a confusing and frightening experience, but that they will get better.
- Listen carefully. Even if the content of the confused person's conversation makes no sense to you, you may still understand the emotion being expressed. Respond to that emotion. "I'm sorry this is frightening/upsetting for you; there are lots of people here to help you".
- Do not correct or argue with a confused person. This will not reduce confusion and will upset everyone concerned.
- Do not to speak to others about the confused patient as if he or she is not there. Try to include the confused person in all conversations. Make sure they are spoken to on ward-rounds. Humour is OK if NOT in any way possibly perceived to be at the patient's expense.
- Sometimes a confused person may say things that are very hurtful. Although it's hard, try not to take these comments personally. Remember it is the confusion speaking, not the person.
- Questions are a good way of communicating, but need to be simple in the first instance so that a 'Yes' or 'No' answer or a shake or nod are enough, give the patient time to process their response and ask one thing at a time
- This guidance is based on advice from the Geriatric Department in Leicester [8]

Appendix 2: Communication with patient's relatives

- There should be written information to give the relatives on the unit [9]- make sure you have read this.
- Remember that a patient's confusion may be very upsetting for the relatives, particularly if they are saying things that are unkind. Try and make the relatives understand this is the confusion speaking rather than the patient
- The relatives may be helpful in ensuring the episode of confusion is handed over on ward transfer
- They should also be a helpful source of information about the patient's pre-morbid state as well as medication, smoking and illicit-drug histories- make sure these are recorded in the notes so colleagues don't keep asking the relatives about them.

Appendix 3: Deliriogenic drugs

Directly deliriogenic drugs

Drugs that exhibit antimuscarinic or dopaminergic activity are particularly associated with the development of delirium. Increased plasma concentrations and / or increased blood brain barrier permeability (e.g. in renal failure) may make patients particularly prone to the deliriogenic effects of some drugs (e.g. penicillins, quinolones, opioids and linezolid).

Drugs commonly used in critical care that have been shown to be deliriogenic

- ◆ Analgesics –Codeine, Fentanyl, Morphine, Gabapentin. Don't forget Epidural opiates and Opiate withdrawal.
- ◆ Antidepressants and Anticonvulsants –Amitriptyline, Paroxetine. Or following stopping antidepressants or anticonvulsants
- ◆ Antihistamines and antiemetics –Chlorphenamine, Promethazine, Prochlorperazine, Cyclazine.
- ◆ Antipsychotics - including drugs used to treat delirium! Or withdrawal from these drugs
- ◆ Antimuscarinics –Atropine, Hyoscine
- ◆ Cardiovascular agents - β -blockers including atenolol, Digoxin, Dopamine
- ◆ Corticosteroids – Dexamethasone, Hydrocortisone, Prednisolone
- ◆ Hypnotic agents - Benzodiazepines, Zopiclone
- ◆ Miscellaneous agents –Furosemide, Ranitidine

(Based on a list in the ICS guidance on delirium [4])


Appendix 4: Behavioural Pain Scale

Example of a behaviour pain assessment tool:

Behavioral Pain Scale (BPS)		
Item	Description	Score
Facial expression	Relaxed	1
	Partially tightened (e.g., brow lowering)	2
	Fully tightened (e.g., eyelid closing)	3
	Grimacing	4
Upper limb movements	No movement	1
	Partially bent	2
	Fully bent with finger flexion	3
	Permanently retracted	4
Compliance with mechanical ventilation	Tolerating movement	1
	Coughing but tolerating ventilation for the most of time	2
	Fighting ventilator	3
	Unable to control ventilation	4

BPS score ranges from 3 (no pain) to 12 (maximum pain).

Document Control Information

Delirium in Critical Care Patients Management guidelines	Salford Royal  NHS Foundation Trust <i>University Teaching Trust</i> safe • clean • personal
Lead Author: Dr A.N. Thomas Consultant in ICM, Critical Care Directorate Additional authors: N/A Document owner: Dr A.N. Thomas Contact details: tony.thomas@srft.nhs.uk tel 2064718	
Classification: Clinical guideline Scope: Critical care only Applies to: Clinical staff Document for public display: No	
Keywords: Delirium, agitation, confusion, haloperidol, olanzapine, CAM,CAM-ICU, withdrawal	
Associated Documents: <ul style="list-style-type: none">• None	
Unique Identifier: GSCcrit01(15) Issue number: 2 Authorised by: Critical Care Management Committee Authorisation date: 26/09/2017 Next review: October 2020	

Policy Implementation Plan

There will be a link to the policy from the section of the EPR record where the screening tool for delirium is recorded; a positive screen will therefore take the staff to the policy explaining what to do with the positive screen.

Monitoring and Review

The management of delirium will be monitored using a specific audit tool developed in the critical care unit, the audit being completed every 3 months.

Endorsement

Endorsed by:

Name of Lead Clinician/Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Dr J Goodall	CD Critical Care	27/10/15
Tony Thomas	Critical Care Clinical Governance	26/09/2017

Screening Equality Analysis Outcomes

The Trust is required to ensure that all our policies/procedures meet the requirements of its service users, that it is accessible to all relevant groups and **further the aims of the Equality Duty for all protected groups by age, religion/ belief, race, disability, sex, sexual orientation, marital status/ civil partnership, pregnancy/ maternity, gender re-assignment.** Due consideration may also be given to carers & socioeconomic factors.

Have you been trained to carryout this assessment? If 'no' contact Equality Team 62598 for details.	
Name of policy or document: Delirium in Critical Care Patients. Management guidelines	
Key aims/objectives of policy/document: To provide guidance for the safe management of patients who screen positive for delirium in the Critical Care Unit (impact on both staff & service users)	
1) a) Who is this document or policy aimed at?	Clinical staff in critical care
2) a) Is there any evidence to suggest that your 'end users' have different <u>needs</u> in relation to this policy or document; (e.g. health/ employment inequality outcomes) (NB If you do not have any evidence you should put in section 8 how you will start to review this data)	No
3) a) Does the document require any decision to be made which could result in some individuals receiving different treatment, care, outcomes to other groups/individuals?	No
b) If yes, on what basis would this decision be made? (It must be justified objectively)	
4) a) Have you included where you may need to make reasonable adjustments for disabled users or staff to ensure they receive the same outcomes to other groups ?	None required
5) a) Have you undertaken any consultation/ involvement with service users or other groups in relation to this document?	No

b) If yes, what format did this take? Face/face or questionnaire? (please provide details of this)	
c) Have any amendments been made as a result?	
6) a) Are you aware of any complaints from service users in relation to this policy?	No
b) If yes, how was the issue resolved? Has this policy been amended as a result?	NA

7) a) To summarise; is there any evidence to indicate that any groups listed below receive different outcomes in relation to this document?

	Yes		No	unsure
	Positive	Negative*		
Age			X	
Disability			X	
Sex			X	
Race			X	
Religion & Belief			X	
Sexual orientation			X	
Pregnancy & Maternity			X	
Marital status/civil partnership			X	
Gender Reassignment			X	
Carers *1			X	
Socio/economic**2			X	

1: That these two categories are not classed as protected groups under the Equality Act.

2: Care must be taken when giving due consideration to socio/economic group that we do not inadvertently discriminate against groups with protected characteristics

Negative Impacts

*If any negative impacts have been identified you must either a) state below how you have eliminated these within the policy or b) conduct a full impact assessment:

8) How will the future outcomes of this policy be monitored?

Audit of delirium in critical care

9) **If any negative impact has been highlighted by this assessment, you will need to undertake a full equality impact assessment:**

Will this policy require a full impact assessment? No
(if yes please contact Equality Team, 62598/67204, for further guidance)

High/Medium/Low Type/sign A.N. Thomas
date: September 2017