A foundation doctor's guide to clerking the confused older patient

Confusion is a common cause of acute admissions, encompassing dementia, delirium and depression (Bostwick, 2000). Because of this diagnostic challenge, acute confusion is often misdiagnosed and undertreated; one study found this to be the case in 94% of older people in hospitals (Ski and O'Connell, 2006). For a foundation doctor it can be difficult to know where to start with such a patient and yet this type of admission is extremely common. This article raises awareness of the appropriate management of a patient with confusion as part of good medical practice and thus improve the quality of care for patients with dementia and delirium in hospitals.

Key facts

Essentially, the key facts that need to be established are:

1. Is this old or new confusion?
2. How bad is it?
3. What part of the memory is most affected?
4. What could the diagnosis be?

Old or new confusion?

The British Geriatric Society's (2006) guidelines on delirium can help focus on these principles. First, is the confusion an acute phenomenon or part of a progressive memory decline over months or years? The differentials are very different depending on the answer to this question. A collateral history from a carer, friend or GP is invaluable. It should include:

- What is the current problem?
- What memory problems are there, i.e. forgetfulness, change in personality or behaviour, safety concerns, insight?
- Duration and fluctuation of memory loss
- Is the memory impairment interfering with the patient's activities of daily living?
- Who is at home?

How bad is it?

An abbreviated mini-mental test on admission helps identify those patients with cognitive impairment and aims to quantify the severity. It is often surprising how some patients can appear very lucid and yet score extremely badly. The abbreviated mini-mental test also enables serial measurements in patients to detect the new development of delirium or its resolution.

What part of memory?

Later, a thirty-point mini mental state examination can be performed to break down memory into its components: orientation, registration, attention and calculation, recall and language. This is more sensitive for subtle cognitive impairment, enabling earlier detection and is a useful tool when communicating with mental health services.

What could the diagnosis be?

Finally, start by focusing on the simple diagnoses: do an electrocardiogram, urinalysis and chest X-ray. Blood tests should include full blood count, renal, liver and thyroid function, vitamin B_{12}, folate and C-reactive protein. Beware of those patients who have a receptive dysphasia. Delirium can be prevented in a third of patients, often using simple measures (Siddiqi et al, 2007). Therefore try nursing the patient in a quiet, well lit room with a familiar face if possible. Try to avoid sedation.

Local findings

During an audit of 60 patients admitted with confusion at a teaching hospital in the East Midlands, only 35% had a collateral history taken at the time of the initial clerking. A further 18% were completed on the admissions ward (an average of 13 hours later) and an additional 25% on the geriatric ward. Abbreviated mini-mental test assessment was performed on 48% of confused patients on the admission clerking. By more rapidly assessing a patient's background, one could help reduce mortality, morbidity and length of hospital stay (Siddiqi et al, 2007).

Conclusions

Delirium is a common mental disorder with serious adverse outcomes. The key messages are to recognize the confused patient and to formulate a differential diagnosis. If the patient cannot give a reliable account, seek another source to tell the story. BJHM

Conflict of interest: none.

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Dr Laura Winstanley *is Core Medical Trainee Year 2 in Health Care of the Older Person, Queen's Medical Centre, Nottingham NG7 2UH,* **Dr Simon Glew** *is Foundation Year 2 Doctor in the Department of Medicine, Pilgrim Hospital, Boston, Lincs and* **Professor Rowan Harwood** *is Professor of Geriatrics, Queen's Medical Centre, Nottingham*

Correspondence to: Dr L Winstanley

KEY POINTS

- A collateral history is vitally important when managing a patient with confusion.
- Perform an abbreviated mini mental test on every patient who appears confused, and repeat it throughout the admission.
- Ensure simple investigations are ordered, including a urine sample.