PRESCRIBERS & PHARMACISTS

Medicines and delirium: review, prescribe cautiously, stop promptly

Support a safe medicines review when delirium may be caused or worsened by a medicine, a recent change or abrupt withdrawal, and when medication is being considered for severe distress.

Reconstruct what has changed

- Reconcile prescribed, non-prescription and complementary medicines as accurately as possible.
- Ask about recent starts, stops, dose changes, missed doses and possible withdrawal, including alcohol where relevant.
- Check what the person was actually taking before the change. Use family, carers, care records, pharmacy information and previous prescriptions where available.

Review benefit, burden and current physiology

- Arrange review by an experienced healthcare professional. Consider the type and number of medicines, interactions and cumulative effects.
- Reconsider medicines that may contribute to delirium, while also treating pain and other symptoms adequately. Untreated pain can itself contribute.
- Account for acute illness and changes in renal or hepatic function, hydration and other physiology that may alter medicine effects.

Make changes deliberately

- Continue, pause, reduce or stop a medicine only after considering its indication, current risk, withdrawal potential and the person's clinical state.
- Avoid abrupt withdrawal where this may cause harm. Use an appropriate taper or specialist advice when required.
- Record each change, the reason, intended duration, monitoring plan and who will review it. Follow the current local formulary, national guidance and product information.

If distress creates a medication question

- Treat causes of distress and use verbal and non-verbal de-escalation first where possible.
- Medication may be considered only after an individual clinical assessment when distress is severe or safety is compromised and non-drug measures are ineffective or inappropriate.
- Any prescription should be made by an appropriately qualified prescriber. Review the response and adverse effects frequently, and stop treatment as soon as the clinical situation allows.

Haloperidol safety checks

- Do not use haloperidol in Parkinson's disease or dementia with Lewy bodies. Check other contraindications and interactions in current product information.
- Before starting in an older person, the MHRA recommends a baseline ECG and correction of electrolyte disturbances. Assess QT risk. During treatment, repeat cardiac and electrolyte monitoring; individualise the frequency of further ECGs.
- If haloperidol is used, prescribe the lowest clinically appropriate dose for the shortest possible time. Monitor blood pressure and check for cardiac effects, orthostatic hypotension and extrapyramidal effects, including swallowing difficulty.

Safety box - this sheet contains no regimen: It does not authorise a medicine, dose or route. Check current local and national prescribing guidance, the formulary and product information for the individual person. Haloperidol is contraindicated in Parkinson's disease and dementia with Lewy bodies; QT-related contraindications and interacting medicines also require specific review. Make an explicit stop or early-review plan.

Verified official sources

- NICE CG103: medication review and treatment of distress
- SIGN 157 on Right Decisions: medicines optimisation
- SIGN 157 on Right Decisions: pharmacological treatment
- MHRA: haloperidol risks in older people with delirium
- NHS inform: delirium causes and treatment

Use and review: UK-focused general education. This resource supports but does not replace clinical assessment, individual advice or current local guidance. Prepared from source materials curated by Professor Alasdair MacLullich, University of Edinburgh; AI-assisted production. Professor MacLullich led development of the 4AT and reports no financial interest in its uptake. Final named human clinical approval is required before use in patient care. Independent resource; not an official University of Edinburgh or NHS publication.