Comprehensive Care

Think about the link

Nursing flow chart for delirium screening and management

Delirium Risk Factors

- ☐ Age 65 and over
- ☐ Hip fracture
- ☐ Known cognitive impairment/dementia
- ☐ Cognitive concerns raised by others
- ☐ Severe illness/risk of dying
- ☐ > Age 45 for ATSI population

Screen all patients over the age of 18 years using the 4AT on admission

New delirium suspected in a current inpatient

Complete 4AT

≥ 4 Possible delirium

1-3 possible cognitive impairment

0 Delirium or cognitive impairment unlikely (still possible)

If ≥ 4 complete a Set of vital signs and GCS - Report new changes

Possible Delirium

- Page treating team for medical review
- Develop and implement care plan and start non-pharmacological/behavioural management strategies
- Refer to WH Delirium Guidelines section on Non Pharmalogical Delirium Prevention and Management Strategies on the intranet
- Consider SNAP Referral in EMR

No evidence of Delirium

- Monitor cognitive function TDS for a change in behaviour or thinking
- Document screening results in nursing notes

DELIRIUM PREVENTION AND MANAGEMENT GOALS

SEE WH DELIRIUM GUIDELINES FOR MORE COMPREHENSIVE INFORMATION

1. **Identify risks**
2. **Identify and address any underlying cause(s) or precipitant(s)**
3. **Manage the symptoms**
   - **Non-pharmacological management** – provide a supportive environment (psychological, physical and sensory)
   - **Pharmacological management** – avoid psychoactive medications. Use only when non-pharmacological measures are ineffective and for distressing symptoms (highly agitated or hallucinating) or if patient at risk of harm to self or others
4. **Prevent complications**
5. **Support and educate the patient and their family/carers**
6. **Provide appropriate discharge planning and follow-up**

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Domain	Strategy
Hydration and nutrition	» Food chart » Fluid balance chart » Assist with oral intake (red dome)
Orientation	» 4AT » Avoid room changes » Orientation aids (clock, orientation board) » Encourage family / carer involvement and visits
Behaviours	» Behaviour chart » Consider the use of special » NO mechanical restraints
Bowel and bladder	» Bowel chart » Bladder scan » Full Ward Urine Test » Toileting regime
Falls prevention	» Falls risk assessment tool » Encourage mobility » Referral to PT » Low bed if appropriate
Pain	» Pain assessment (numerical score for alert patients, Abbey Pain Score for patients unable to communicate)
Sensory	» Check for glasses, hearing aids, dentures
Pressure care	» Pressure injury prevention strategies as per risk assessment » Wound chart (if wound present)
Environment	» Bed in visible area » Lighting appropriate to time of day » Encourage family visiting » Minimise noise and disruption at night
Communication	» Introduce yourself » Keep information/explanations simple » Involve family/carers » Provide the family with an information sheet » Minimise the number of staff involved » Use interpreters or communication cards if patient from culturally and linguistically diverse (CALD) background
Sleep-Wake	» Aim for a normal sleep-wake cycle » Avoid nursing or medical procedures and medication administration during sleep » Reduce noise to a minimum during sleep periods

See Western Health Delirium Guidelines for more comprehensive information