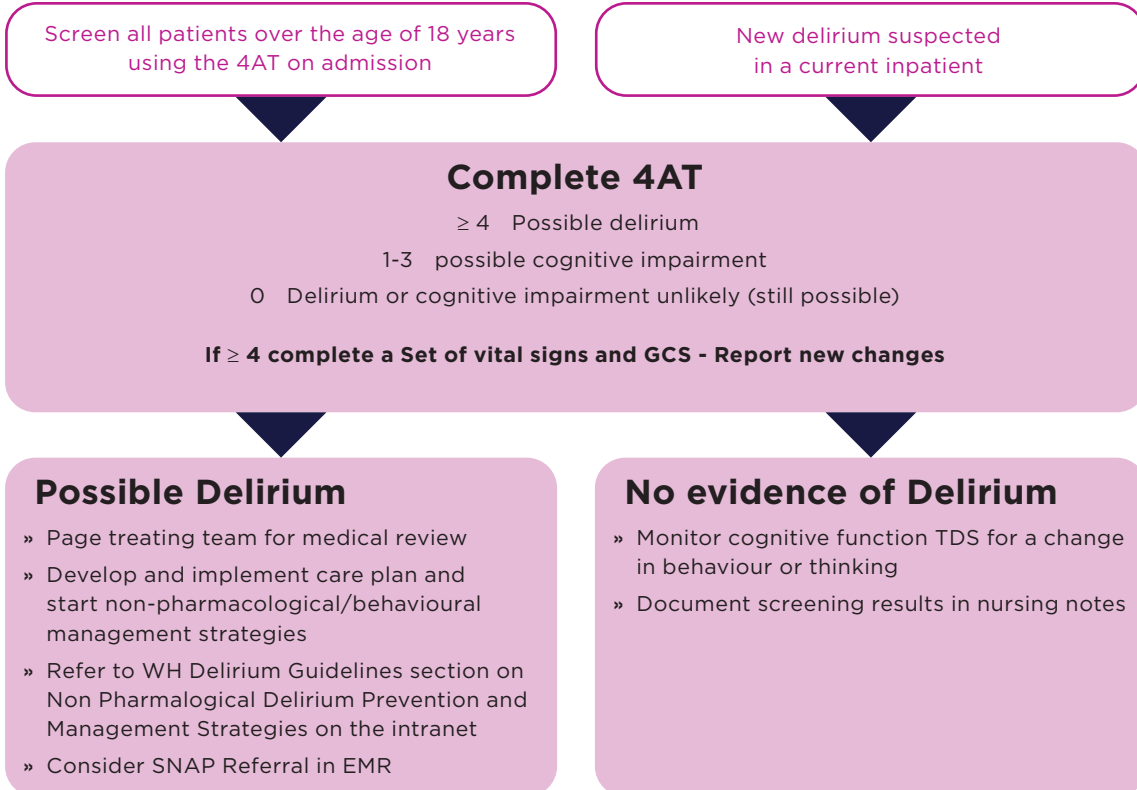




Nursing flow chart for delirium screening and management

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



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



Comprehensive Care

Think about the link

Domain	Strategy
Hydration and nutrition	<ul style="list-style-type: none"> » Food chart » Fluid balance chart » Assist with oral intake (red dome)
Orientation	<ul style="list-style-type: none"> » 4AT » Avoid room changes » Orientation aids (clock, orientation board) » Encourage family / carer involvement and visits
Behaviours	<ul style="list-style-type: none"> » Behaviour chart » Consider the use of special » NO mechanical restraints
Bowel and bladder	<ul style="list-style-type: none"> » Bowel chart » Bladder scan » Full Ward Urine Test » Toileting regime
Falls prevention	<ul style="list-style-type: none"> » Falls risk assessment tool » Encourage mobility » Referral to PT » Low bed if appropriate
Pain	<ul style="list-style-type: none"> » Pain assessment (numerical score for alert patients, Abbey Pain Score for patients unable to communicate)
Sensory	<ul style="list-style-type: none"> » Check for glasses, hearing aids, dentures
Pressure care	<ul style="list-style-type: none"> » Pressure injury prevention strategies as per risk assessment » Wound chart (if wound present)
Environment	<ul style="list-style-type: none"> » Bed in visible area » Lighting appropriate to time of day » Encourage family visiting » Minimise noise and disruption at night
Communication	<ul style="list-style-type: none"> » 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	<ul style="list-style-type: none"> » 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