Delirium Prevention and Management Care Plan

Guidance based on NICE Clinical Guideline 103

Patient name: _____

Unit no: _____

Please complete for patient with ANY **ONE** OF:	**Tick**
Age 65 years or older	
Dementia or AMT score <8/10	
Current hip fracture	
Severe illness (a clinical condition that is deteriorating or is at risk of deterioration)	
Delirium present	

For each individual patient, the clinical factors contributing to the risk of, or the episode of, delirium will vary. The same clinical factors act as risk factors which you can act on to prevent an episode, and as a cause of delirium in an episode.

Clinical Factor	**Intervention**	**Tick if Present**
Cognitive impairment or disorientation	▪ **Avoid bed moves** ▪ Provide appropriate lighting and clear signage. A clock (consider providing a 24-hour clock in critical care) and a calendar should also be easily visible to the person at risk ▪ **Reorientate** the person by explaining where they are, when it is, who you are, what your role is and what is happening to them ▪ Introduce cognitively stimulating activities (for example, reminiscence) ▪ **Facilitate regular visits from family and friends**	
Dehydration or Constipation	▪ **Encourage the person to drink**. Consider offering subcutaneous or intravenous fluids if necessary ▪ Seek advice if necessary when managing fluid balance in people with comorbidities (for example, heart failure or chronic kidney disease) ▪ Start a **bowel chart**. Highlight and treat constipation	
Hypoxia	▪ Assess for hypoxia and **optimise oxygen saturation** if necessary	
Immobility or limited mobility	▪ Encourage all people, including those unable to walk, to carry out **active range-of-motion exercises** ▪ Encourage the person to: – mobilise soon after surgery – **walk frequently** (even short distance to toilet, walking aids should be accessible at all times)	
Infection	▪ Look for and treat infection ▪ Avoid unnecessary catheterisation ▪ Implement infection control procedures	
Multiple medications	▪ Carry out a **medication review** and stop or reduce dosages of unnecessary drugs	
Pain and discomfort	▪ Assess for pain. **Look for non-verbal signs of pain**, particularly in people with communication difficulties or dementia (use Abbey Pain Scale) ▪ Start and review for adequate pain management in any person in whom pain is identified or suspected ▪ Avoid unnecessary invasive devices (urinary catheter, cannula etc.)	
Poor nutrition	▪ Follow the Trust guidance for nutritional assessment and management ▪ If the person has **dentures**, ensure they fit properly	
Hearing and Visual impairment	▪ Resolve any reversible cause of the impairment (such as impacted **ear wax**) ▪ Ensure **working hearing aids and spectacles are available** to and used by people who need them	
Sleep disturbance	▪ Aim for a normal sleep-wake cycle ▪ Avoid nursing or medical procedures and medications during sleep ▪ Reduce noise to a minimum during sleep periods	

Agitation	▪ See Guidelines for management of distress and agitation ▪ Consider one-to-one observation if patient non-compliant with cares or high risk of falls or high risk of harm to themselves or others

Delirium Prevention and Management Care Plan

Patient details
(Affix patient label)

Date and Time	Specific Clinical Factors identified and actions to be taken Communication with patient / relatives / multidisciplinary team	Signed Title

Delirium Daily Intervention

For patients identified as having delirium
See also Delirium Prevention and Management Care Plan and Delirium Guidelines

Patient details
(Affix patient label)

Date & Time							
Signature and Title in boxes below when actions achieved							
Patient reviewed by doctor regarding delirium							
Medication review by doctor performed							
Observations frequency reviewed and increased as necessary							
Plan to avoid further bed moves recorded in nursing and medical notes							
Blood glucose done							
Bloods done including CRP							
Urine dipstick obtained and recorded							
MSU/CSU obtained							
Bladder scan performed and recorded							
Bowels opened within last 2 days							
Patient assessed for pain - Abbey Pain score may be required - see Delirium Guidelines							
Analgesia prescribed appropriate to pain							
Hearing aids and spectacles been obtained from home if applicable							
Hearing aids and/or spectacles working, labelled and on patient							
Staff aware that regular reorientation and person-centered communication is required							
Patient can see calendar and clock with correct date and time							
Oral hydration encouraged at least hourly if able to drink orally							
Nutrition score performed (MUST)							
Dentures available to patient							
Patient mobilized or performed bed exercises							
Risk assessment and need for one-to-one observation / specialling assessed and escalated if required							
Family / carers given delirium leaflet							

Delirium Daily Intervention

Patient details
(Affix patient label)

Date and Time	Specific issues identified and actions to be taken Communication with patient / relatives / multidisciplinary team	Signed Title