DELIRIUM CLINICAL DECISION MAKING GUIDE (CDMG)

Establish the patient's pre-admission functional and cognitive baseline per family or caregiver and document in 48/6 Care Plan.

NUAS

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Identification	Assessment	Interventions
P	**Pain** • Regular pain assessment &monitoring • Use consistent pain scale **Poor Nutrition / Dehydration** • Review Patient Screening Questionnaire (PSQ) • Swallowing difficulties • Electrolyte/glucose imbalance • Dry mouth, low urine output, low BP, dizziness	**Pain** • Regular scheduled analgesia (not PRN, e.g. QID for 48-72 hrs) • Start Low Go Slow • Document effect of analgesia **Poor Nutrition / Dehydration** • Record weight on admission and weekly. • If eating <50% of meals x 3 days, refer to dietitian • If patient fails the Swallowing Screening Tool (SST) for reasons other than decreased LOC or has pre-existing dysphagia, refer to SLP. • Normalize feeding patterns, i.e., daytime enteral feeding, sitting upright on a chair during meals when possible.
R	**Retention** • Determine premorbid continence ability • Assess for urinary retention • Palpate abdomen for distention • Evaluate fluid balance/output **Restraints** • Explore alternatives to restraints whenever possible, to maximize both the patient's functional status and safety	**Retention** • PVR with bladder scanner if suspect retention • Obtain order to remove Foley within 48 hours or ASAP • Check bowels if NEW urinary incontinence occurs. Consider bowel protocol and maintain DAILY bowel movement records. • Regular toileting schedule (minimize use of briefs) **Restraints** • Avoid restraints as these can worsen delirium. Use soft restraints only if patient is a danger to him/herself or others. • Involve family members/support persons. Provide 1:1 constant. Note: remember all behaviour has meaning
I	**Infection / Illness** • VS BID and compare to baseline (note as normal process of aging, temperature may remain normal) • Ongoing monitoring for UTI, chest infection, wound infection, diarrhea • Refer to MEWS re VS concerns as appropriate. **Immobility** • Determine pre-admission functional abilities (PSQ)	**Infection / Illness** • Monitor VS and 0_2 Sats • Measure postural BP • Notify MRP if concerned. **Immobility** • Encourage mobility incl ambulation, sitting up in chair, & participation in personal care • If unable to safely mobilize using ambulation and transfer algorithms, consult PT and consider bed/chair alarms. • Encourage self care with ADLs, involve OT as needed.
S	**Sleep** • Assess for altered sleep/wake cycles • Assess reaction to stimulation (noise, light, activity etc.) **Skin** • Assess for areas of skin breakdown • Use Braden Scale. **Sensory** • Assess for sensory deficits	**Sleep** • Document changes in sleep pattern - day/night reversal. • Implement sleep promotion measures (e.g. warm milk, toileting, back rub, familiar pillow/blanket, consider placement near window for lighting) • Minimize noise and activity in room and on unit at night. • Intersperse focused activities during the day with planned rest periods • Ensure adequate pain control **Skin** • Pressure reducing mattress as indicated, develop turning schedule • Mobilize at least BID (see Immobility interventions) • Refer to Wound Care Clinicians, if wound present **Sensory** • Ensure glasses, hearing aids & dentures are functional & in use • Use Pocket talker to assist with communication/assessments
M	**Mental Status** • CAM every shift (see page 2). • Get their story • Get to know your patient including cognitive baseline **Medications** • Polypharmacy especially >5 meds • Medication side effects/interactions esp anti-cholinergics **Metabolic** • Monitor for abnormal lab results/hemodynamic status	**Mental Status** • Call patients by their preferred name. • Provide frequent gentle reorientation and reassurance. • Give simple, direct instructions in a calm and non-hurried manner. • Provide stimulation activities as available during the day, e.g. crosswords, colouring, fidget aids, reading materials etc. • Ensure the bedside white board is complete and up to date and a clock is visible. • Encourage family involvement and to bring pictures, favorite books, favorite activities and having visits when appropriate. • Use companions as needed. **Medication** • Review med profile with pharmacist for recent changes, adverse effects, toxicity, drug interactions • Start Low, Go Slow. • Reassess psychotropic medication response after each administration for effectiveness • Monitor and immediately report any medication side effects **Metabolic** • Evaluate lab results and notify MRP of abnormalities
E	**Elimination** • Maintain DAILY Bowel Movement Record • Constipation/impaction • (see retention) **Environment** • Unfamiliar surroundings & people • Hot/cold; noisy/too quiet	**Elimination** • Determine normal bowel patterns, last BM • Check for impaction • Consider Bowel protocol **Environment** • Provide calm, safe environment; limit room/unit transfers • Promote normal ADL routines e.g. sit up for meals, own clothes • Encourage family/support persons to participate in care

Sample Form - for Educational Purposes Only

The Confusion Assessment Method (CAM)

		BOX 1
(1) Acute Onset and Fluctuating Course		
Is there evidence of an acute change in mental status from the patient's baseline?	No___	Yes___
Did this behaviour fluctuate during the past day, that is, tend to come and go or increase and decrease in severity?	No___	Yes___
(2) Inattention		
Does the patient have difficulty focusing attention, for example, being easily distractible. or having difficulty keeping track of what was being said?	No___	Yes___

		BOX 2
(3) Disorganized Thinking		
Is the patient's speech disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?	No___	Yes ___
(4) Altered Level of Consciousness		
Overall, how would you rate this patient's level of consciousness?		
Alert (normal) ___		
Vigilant (hyperalert) ___		
Lethargic (drowsy easily aroused)___		
Stupor (difficult to arouse)___		
Coma (unarousable)___		
Do any checks appear in the grey box above?	No ___	Yes ___

Adapted from : Inouye SK, vanDyck CH Allessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. An Intern Med. 1990: 113-641-948. Confusion Assessment Method: Training Manual and Coding Guide. Copyright 2003, Hospital Elder Life Program, LLC.

Are all items in Box 1 checked?	No ___	Yes ___
Is at least one item in Box 2 checked?	No ___	Yes ___
If all items in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested		
Is a diagnosis of delirium suggested?	No ___	Yes ___

Sample Form - for Educational Purposes Only

Delirium Subtypes	Description
Hypoactive	Most common; lethargic, drowsy, sluggish, apathetic & quiet
Hyperactive	Restless, agitated, hyper-alert, psychotic features
Mixed	Presence of hyperactive and hypoactive subtypes

Care Provider:___________________________ / _____ Signature: _________________________ Date: ___________

Printed Name *Designation* *(dd/mmm/yyyy)*