Delirium assessment protocol

Complete for all patients who are delirious or confused when admitted, or who become so during their stay

Apathetic delirium *or* **Agitated delirium**

- 'drowsy', 'unmotivated', 'withdrawn'
- 'restless', 'aggressive', 'paranoid', 'hallucinating', 'disorientated'

Concern	*Intervention*	*By whom?*	*Comments/variance*
Background	Clarify prior mental state, memory problems, mood and psychiatric history	Nurse ☐	
	Check for any recent deliberate or inadvertent change in medication Seek	Nurse ☐	
	pointers to head injury, or to alcohol or drug dependency	Nurse ☐	
Communication	Discuss delirium management and prognosis with patient, relatives and carers	Nurse ☐	
	Check for language problems, and that any hearing aid or spectacles available, working and being worn	Nurse ☐	
Environment	Nurse patient in quiet, well lit and supervised area	Nurse ☐	
	Consider if any venflon, ivi, catheter or other equipment could be removed	Nurse ☐	
Observations	Temp., pulse, BP, O_2 sats., resp. rate, bladder/bowel chart, send MSU, ECG	Nurse ☐	
	Review pain control, bladder function and bowel chart/rectal examination	Nurse ☐	
	Draw a 10cm circle for the patient, and ask that they 'draw a clock face with the hands pointing to 3 o'clock' – as a record of their baseline performance	Nurse ☐	
Examination	Infection - chest, wound, drip sites, urine/catheter	Doctor ☐	
	Fluid status - ?dehydration, JVP, pulmonary oedema, ?retention	Doctor ☐	
	If recent results are not already available then arrange for a 'delirium screen' - FBC, B12/folate, CRP, U&E, LFT, Ca^{2+}, TnT, blood cultures, MSU, ECG, CXR	Doctor ☐	
Risk reduction	If agitation/restlessness is an issue – then manage using 'Falls pathway'	Nurse ☐	
	If continued concern – discuss need for 'special observation' with ward team		
Referral	Request medical review once all this completed – they will consider CT brain scan – if unexplained, new, persistent, significant change in mental state	Doctor ☐	