

**Emergency Department Preprinted Order Set
 for Symptoms Suggestive of Delirium in
 Patients 65 years of age or older.**

600 University Avenue, Toronto, Ontario, Canada M5G 1X5

Label Clearly

Write firmly for two legible carbon copies	
Allergies:	<input type="checkbox"/> None known
Date	

Item	Order	Transcribed
1	<p>Clinical Assessment (Confusion Assessment Method – CAM) Patient 65 years of age or older presents with:</p> <p><input type="checkbox"/> 1) Acute change in mental status from baseline <u>and</u> behaviour fluctuates during the day</p> <p><input type="checkbox"/> 2) Difficulty focusing attention/easily distractible/difficulty keeping track of what is being said</p> <p><input type="checkbox"/> 3) Disorganized/incoherent thinking or rambling/irrelevant/illogical conversation</p> <p><input type="checkbox"/> 4) Altered Level of Consciousness (hyper-alert, lethargic, difficult/unable to arouse)</p> <p>POSITIVE IF – 1), 2), AND at least 3) OR 4) are present. If POSITIVE, proceed with order set.</p>	
2	<p>Clinical Diagnostics</p> <p><input type="checkbox"/> CBC, Electrolytes, Urea, Creatinine, Glucose <input type="checkbox"/> INR, PT, aPTT <input type="checkbox"/> Ca, Mg, PO4 <input type="checkbox"/> TSH</p> <p><input type="checkbox"/> LFTs, Total and Direct Bilirubin, Albumin, Amylase <input type="checkbox"/> Etoh Level <input type="checkbox"/> ECG</p> <p><input type="checkbox"/> Blood Cultures x2 <input type="checkbox"/> Urine R&M <input type="checkbox"/> Urine Culture <input type="checkbox"/> Urine Toxicology</p> <p><input type="checkbox"/> Lactate <input type="checkbox"/> Venous blood gas <input type="checkbox"/> Troponin <input type="checkbox"/> CXR <input type="checkbox"/> CT Brain</p> <p><input type="checkbox"/> Other: _____</p>	
3	<p>Clinical Interventions</p> <p><input type="checkbox"/> Insert and maintain saline lock. Encourage food/drink frequently unless actively vomiting</p> <p><input type="checkbox"/> Initiate IV therapy with 0.9% NS. Bolus _____mL over _____ minutes then _____mL/hr</p> <p><input type="checkbox"/> Initiate IV therapy with 0.9% NS @ _____mL/hr</p> <p><input type="checkbox"/> Other: _____</p>	
4	<p>Clinical Monitoring</p> <ul style="list-style-type: none"> • Document Glasgow Coma Scale (GCS) Q4H and with any change in mental status • Document CAM score every shift and with any change in mental status/behaviour • Document ISAR score • Continuous cardiac monitoring ONLY if evidence of cardiac instability • Document any behavioural issues (please see reverse) • Assess integumentary system and document any existing wounds or pressure ulcers • Have patient and/or family complete Baseline Functional Assessment Tool (BFAT) 	
5	<p>Medications (Avoid use of benzodiazepines) <i>*First-line management of agitation or patient distress in delirium is non-pharmacological (please see reverse for strategies in working with delirious patients). If non-pharmacological strategies have been ineffective, then consider the following:</i></p> <p><input type="checkbox"/> Haloperidol 0.5mg-1.0mg PO/SC/IM/IV Q1H PRN. Note: Reassess after 3 doses. Use PO route first, if possible.</p> <p><input type="checkbox"/> Other: _____</p>	
6	<p>Consults</p> <p><input type="checkbox"/> Social Work <input type="checkbox"/> GEM <input type="checkbox"/> PT/OT <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other _____</p>	

Date: _____ Time _____ Print Name: _____ Signature _____ MD
 Date: _____ Time _____ Print Name: _____ Signature _____ RN

Non-pharmacological strategies to manage patients with delirium

Psychiatric medication interventions for delirium are typically reserved for patients with severe agitation which is: causing interruption of essential medical therapies, contributing to safety hazards to patient/staff, or causing extreme patient distress/restlessness due to agitation or psychotic symptoms.

Non-pharmacological strategies for delirium management:

Communication

- Language and sensory barriers can worsen behaviour: Ensure patients have glasses, hearing aids in place if possible
- Use clear and simple communication. Avoid confrontation or disputing delusions
- Explain all activities in simple terms prior to initiating the activity
- Use distraction to minimize agitation

Safety

- If patient becomes agitated with care, stop, ensure patient is safe and approach at a later time
- Avoid or minimize the use of restraints, consistent with MSH's Restraint Policy
- Modify environment to promote safety (stretcher at lowest level, remove potential hazards in room)

Care Strategies

- Promote Orientation: Orient the patient every shift to place and time, encourage family presence, avoid unnecessary room changes, attempt to remove patient from hallway
- Promote sleep at night-time: When possible, group medication administration and procedure times to allow for uninterrupted sleep. Provide warm blanket. Try to avoid sedative-hypnotics and benzodiazepines.
- Maintain adequate nutrition and hydration: Offer fluids frequently (if not contraindicated), ensure proper use of dentures, positioning, assist with feeding
- Promote comfort/manage discomfort or pain
- Promote function and mobilization, assist patient to chair for meals and to commode or bathroom for toileting
- Monitor for urinary retention
- Reassess need for invasive devices regularly (IVs, tubes)
- Avoid under/over-stimulation which can worsen delirium

Documentation Tips:

- Describe behaviour using objective language
- Describe effect on patient/family/staff
- Identify possible triggers/antecedents
- Document interventions and their effect

Do not chart: "Patient aggressive and agitated with RN"

Instead Chart: "Patient began to strike RN when attempting to take BP. RN offered urinal to void and reoriented patient to location, with good effect. After voiding, pt calmer and allowed BP to be measured."