# Daily Delirium Nursing Care plan

(label)
Patient name: Date:

Date of birth: Time:

Patient number: Signed:

This care plan is to be used alongside the PINCH ME delirium assessment tool for patients with suspected delirium. Care plan does not remove the need for nursing clinical assessment

**PLEASE FILE IN NURSING NOTES NOT MEDICAL NOTES AS THIS IS A TRIAL, THANK YOU**

## General referrals

Please use your clinical judgement for all referrals

| | Date / Initials | |
|---|---|---|
| **Planned care** | **Commenced** | **Discontinued** |
| Mental Health Liaison Service – for advice for diagnosis for delirium/dementia and medication | | |
| Dementia Nurses – for advice for patients diagnosed with dementia | | |
| DME – for medical team to consider | | |

## Pain

Please refer to Care Plan 11 of the *UHDB Patient Assessment and Care Record*

## Chest infection

| | Date / Initials | |
|---|---|---|
| **Planned care** | **Commenced** | **Discontinued** |
| Encourage deep breathing and coughing every hour for sputum clearance refer for chest therapy if required | | |
| Use supplemental oxygen to obtain target saturations.<br>Provide appropriate mouth care as per Oral Assessment Tool in 'UHDB Assessment and Care Record' | | |
| Ensure the patient is sat up or out if possible to promote chest expansion | | |
| Ensure adequate use of nebulisers for sputum clearance – remember to use PGD saline nebulisers if required | | |

| | | |
|---|---|---|
| If the patient shows signs of aspiration, refer to SALT and inform medical team | | |

## Urine

| Planned care | Commenced | Discontinued |
|---|---|---|
| Ensure patient has positive diagnosis of Urinary Tract Infection | | |
| Ensure fluids are encouraged and fluid balance is positive to aid recovery | | |
| Assess for urinary retention every 4 hours | | |
| Use analgesia to ease discomfort of symptoms of UTI | | |
| Encourage urination to empty the bladder | | |
| Avoid scented products in genital area and avoid tight clothing | | |
| Consider TWOC where appropriate | | |
| Ensure prescribed antibiotics are given on time. Flush with 50ml 0.9% saline bag after to ensure full dose given if IV. | | |

## Surgical wound

| Planned care | Commenced | Discontinued |
|---|---|---|
| Ensure sterile dressing applied with ANTT remains intact. Redress if dressing has been removed, there is excessive strikethrough or instructed by medical team | | |
| Refer to medical team and TVN if dehiscence is apparent | | |
| Ensure good nutritional intake, refer to dietician if diet is low in protein/fat or the patient is losing weight. Encourage snacking | | |
| Ensure fluid balance is positive to aid recovery | | |
| Encourage good hygiene practices with patient and assist when confused e.g. washing hands regularly | | |
| Ensure prescribed antibiotics are given on time. Flush with 50ml 0.9% saline bag after to ensure full dose given if IV. | | |

## Nutrition

Please refer to Care Plan 9 of the *UHDB Patient Assessment and Care Record*

## Constipation

Please refer to Care Plan 13 on Elimination of the *UHDB Patient Assessment and Care Record*

## Hydration

Please refer to Care Plan 9 of the *UHDB Patient Assessment and Care Record*

## Medication

| Planned care | Commenced | Discontinued |
|---|---|---|
| If medications for Mental Health have been less effective or causing unpleasant side effects, refer the MHLT and medical team | | |
| Consider referral to Specialist Parkinson's Nurse and MHLT if the patient has a positive diagnosis of Parkinson's | | |
| Ensure analgesics are given for pain but consider reducing opiate/NSAID use to prevent further confusion if appropriate | | |
| If there is uncertainty if a medication is causing delirium, refer to your ward pharmacist on bleep: ____ | | |
| Medical communication sticker used in medical notes | | |

## Environmental

| Planned care | Commenced | Discontinued |
|---|---|---|
| Ensure the fewest number of bed moves occur to reduce disorientation | | |
| Refer to Enhanced Care Team or Dementia Key Worker if struggling to re-orientate or distract in the ward environment | | |
| Refer to Mental Health Liaison Team and medical team for<br>- Long term confusion with no diagnosis/poor 4AT score<br>- Previous/current excessive alcohol use<br>- Previous/current illicit drug use | | |



*Please document in UHDB Care Plan for any implementations*