



Allergies (also specify reaction) <input type="checkbox"/> None known
Date (YYYY MM DD)

Write firmly for two legible carbon copies

**Emergency Department Preprinted Order Set for
Symptoms Suggestive of Delirium**

Form D 773 (02.2015) Page 1 of 2

Item	Orders	Transcribed
1	Clinical Assessment Complete and document Confusion Assessment Method (CAM) score on Emergency Nursing Care Record (MS 560) with: <ul style="list-style-type: none"> Initial or change of shift nursing assessment Any change in mental status/behaviour 	
2	Clinical Diagnostics <input type="checkbox"/> CBC, Electrolytes, Glucose <input type="checkbox"/> Creatinine <input type="checkbox"/> Urea <input type="checkbox"/> Blood Cultures x2 <input type="checkbox"/> Urine R & M <input type="checkbox"/> LFTs, Total and Direct Bilirubin, Albumin, Amylase <input type="checkbox"/> Venous blood gas <input type="checkbox"/> Urine Culture <input type="checkbox"/> Ca, Mg, PO4 <input type="checkbox"/> Troponin <input type="checkbox"/> Etoh Level <input type="checkbox"/> INR, PT, aPTT <input type="checkbox"/> Urine Toxicology <input type="checkbox"/> TSH <input type="checkbox"/> Lactate <input type="checkbox"/> CXR <input type="checkbox"/> CT Brain <input type="checkbox"/> ECG <input type="checkbox"/> Other: _____	
3	Clinical Interventions <input type="checkbox"/> Insert and maintain saline lock. Encourage food/drink frequently unless actively vomiting <input type="checkbox"/> Initiate IV therapy with 0.9% Normal Saline. Bolus ____ mL over ____ minutes THEN ____ mL/hr <input type="checkbox"/> Initiate IV therapy with 0.9% Normal Saline at ____ mL/hr <input type="checkbox"/> Other: _____	
4	Clinical Monitoring/Documentation <ul style="list-style-type: none"> Document Identification of Seniors at Risk (ISAR) score on Emergency Nursing Care Record (MS 560) if applicable Document challenging behavioural issues (see reverse for documentation tips) Assess for appropriateness for ACE unit and flag in FirstNet accordingly 	
5	Non-Pharmacological Interventions <ul style="list-style-type: none"> First-line management of agitation or patient distress in delirium is non-pharmacological (see reverse for strategies in working with delirious patients). If non-pharmacological strategies have been ineffective, then consider the following: 	
6	Medications (For acute agitation or aggression that impairs care or safety) Avoid use of benzodiazepines unless delirium secondary to ETOH or benzodiazepine withdrawal <input type="checkbox"/> Haloperidol 0.5 mg-1 mg PO/SC/IM/IV q1hr PRN. Note: Reassess after 3 doses. Use PO route first, if possible. <input type="checkbox"/> Other: _____	
7	Consults <input type="checkbox"/> Social Work <input type="checkbox"/> GEM <input type="checkbox"/> PT/OT <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other _____	

Date	Time	Print Name	Signatures
(YYYY MM DD)	(HH : MM)	_____	_____, M.D.
(YYYY MM DD)	(HH : MM)	_____	_____, R.N.



D773

Non-pharmacological strategies to manage patients with Delirium

Note: 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.

Try the following non-pharmacological strategies first:

Communication

- Language and sensory barriers can worsen behaviour: Ensure patients have glasses and hearing aids in place with appropriate language interpretation
- Use clear and simple communication. Avoid confrontation or disputing delusions
- Explain all activities in simple terms prior to initiating the activity

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 (see Least Restraint Management 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, proper patient positioning and assist with feeding if required
- 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/constipation. Obtain post-void residual (PVR) if low urinary output
- Discontinue urinary catheter unless absolutely necessary (see Emergency Department Medical Directives)
- Reassess need for invasive devices regularly (IVs, tubes)
- Avoid under/over-stimulation which can worsen Delirium
- Evaluate and monitor pharmacological measures including rationale for medication use
- Use distraction to minimize agitation
- Educate patient and family about Delirium

Documentation Tips:

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

Documentation example: "Patient began to strike RN when attempting to take blood pressure. RN offered urinal to void and reoriented patient. After voiding, pt calmer and allowed blood pressure to be measured."

Confusion Assessment Method (CAM) Screen for Delirium

If **both items in Box 1** are checked and **at least one item in Box 2** is checked, CAM is positive

Box 1

- 1) Acute change in mental status from baseline and behaviour fluctuates during the day
- 2) Difficulty focusing attention/easily distractible/difficulty keeping track of what is being said

Box 2

- 3) Disorganized/incoherent thinking or rambling/irrelevant/illogical conversation
- 4) Altered Level of Consciousness (hyper-alert, lethargic, difficult/unable to arouse)