File within 3rd spine

NHS number: _____
Name: _____
Address: _____
_____
Date of birth: _____
CR number: _____

Affix patient label

NHS
Royal Cornwall Hospitals
NHS Trust

Delirium Care Plan - Eldercare

Care Plan commencement date	Care Plan completion date

Problem

Specific care needs due to suspected or confirmed delirium.

Goals

- To provide a safe and supportive environment.
- To provide care for the patient that encompasses their specific and personalised needs.
- To engage with the patient, carer and family and involve them with this plan of care.

Other individual goals	Sign, Designation Date and Time

Other individual interventions	Sign, Designation Date and Time

Interventions

Nursing management

- Screen for signs of sepsis - (Please refer to RCHT Clinical guidelines for sepsis in adults)
- Check blood glucose for hyper / hypoglycaemia. If capillary blood glucose < 4 refer to clinical guidelines for the management of hypoglycaemia in adults. If ≥ 12 refer to clinical team. If ≥15 urgent medical review.
- Assess for urinary retention
- Treat and avoid constipation
- Ensure regular medications are administered
  - Assess pain by using a NEWS pain score or PAINAD and treat by offering regular analgesia

affix patient label

Interventions cont...

Nursing actions

- Consider is their swallow safe.
- Record and encourage diet and fluid intake.
- Approach the patient in a calm manner and handle gently.
- Maintain and encourage mobility.
- Avoid interventions that are unnecessary

Communication

- Use short unambiguous sentences.
- Use non-confrontational and empathetic de-escalation techniques.
- Provide reassurance and explanations to the patient and carers
- Ensure hearing aids are working and spectacles are available.

Engagement

- Involve family and carers when care/discharge planning.
- Ask family/carers for collateral history.
- Encourage visits from family and friends.
- Consider using a carer's passport.
- Provide frequent orientation of who they are and to the environment.
- Nurse in a calm quiet place that can be observed by nursing staff.
- Ensure good lighting levels.
- Promote a sleeping environment that is free from noise.

Safety and observation

- If patient presents with paranoid or psychotic symptoms and or behaviours that challenge, please consider referral to the complex care and dementia team.
- If a patient requires observation for their own or others safety please refer to hospital policies and guidelines: RCHT Enhanced Care and Meaningful Activity Policy, RCHT Guidelines for the Management of Delirium in Adults, RCHT Restrictive Practice Policy, RCHT Management of Violence and Aggression Policy and RCHT Mental Capacity Act Policy.
- Assess and document mental capacity relevant to decision needing to be made. At this time does the patient have capacity to consent to the care and treatment plan offered? Where indicated medical/ nursing team to assess and document capacity. Assess capacity using the Trust approved assessment and record forms (please refer to the Trusts Mental Capacity Act Policy).
- Consider a DOLs application.
- Avoid ward or bay transfers particularly out of hours.

Care Plan activated by	Sign Print Designation	Care Plan shared with patient	Sign Print Designation