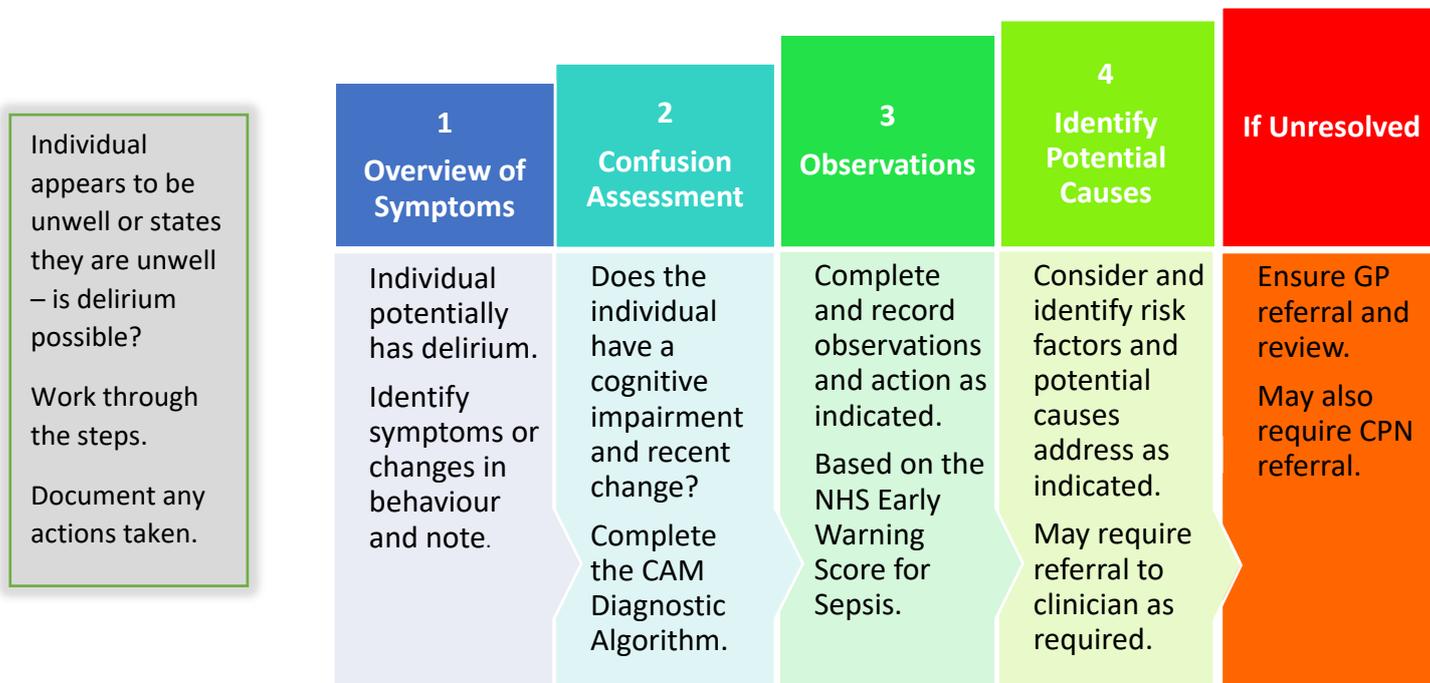


Delirium on Dementia Toolkit

Purpose: to determine if someone with dementia is likely to have delirium, consider possible causes and action guidance. Suggested actions are **NOT** prescriptive, there is no substitute for clinical assessment and judgement.

How to use the Toolkit:



1. Overview of Symptoms		
(How is the individual presenting? Include hypo or hyperactivity, behaviour changes, fatigue, eating and drinking changes.)		
Person completing form:	DATE:	TIME:

2. Confusion Assessment Method (CAM) Diagnostic Algorithm	
1. Acute onset and fluctuating course? (Acute change in mental status from baseline, fluctuating behaviour through the day.)	Yes or No
2. Inattention? (Difficulty focusing attention, easily distracted, difficulty keeping track of what is being said.)	Yes or No
3. Disorganised thinking? (Disorganized or incoherent thinking, rambling or irrelevant conversation, unclear or illogical flow of ideas.)	Yes or No
4. Altered level of consciousness? (This feature is shown by any answer other than “alert”, including: hyper-alert, lethargic, stupor, or coma.)	Yes or No
The diagnosis of delirium by CAM requires the presence of features 1 and 2 AND EITHER 3 or 4	
Delirium detected?	Yes or No

Thank you to our generous funders who have made this toolkit possible.

3. Observations

Physiological Parameters	Scoring (Based on NHS Early Warning Score for Sepsis)							Observations	Score
	3	2	1	0	1	2	3		
Pulse	Less than or equal to 40		41-50	51-90	91-110	111-130	Greater than or equal to 131		
Temperature	Less than or equal to 35.0		35.1-36.0	36.1-38.0	38.1-39	Greater than or equal to 39.1			
Systolic BP (systolic/diastolic)	Less than or equal to 90	91-100	101-110	111-219			Greater than or equal to 220		
Respirations	Less than or equal to 8		9-11	12-20		21-24	Greater than or equal to 25		
Consciousness Level				Alert			Voice Pain Unresponsive		
O2 Saturation	Less than or equal to 91	92-93	94-95	More than or equal to 96					
Oxygen		YES		NO					
COMPLETED BY:								TOTAL	

Aggregate Scores:

0-4 LOW RISK Inform RN who should assess the patient, if delirium present infection/acute disease process may be indicated as cause.

5-6 MEDIUM RISK Inform RN, request medical review and provide information, if delirium present infection/acute disease/exacerbation of existing condition may be a cause. May require increased frequency of observations – attend and document.

7 or more HIGH RISK May require emergency assessment, increase frequency of observations and document.

4. Potential Contributing Factors

Risk Factor	Consider	Suggested Action	Initial & date	
Age 70 or over Underlying conditions Previous delirium	Delirium and/or depression may be superimposed on dementia. Some health conditions increase the risk factor of delirium. Previous delirium increases likelihood of recurrence.	Review medical history for risk factors. Refer to GP if required.		
Hypoxia Infection	On Oxygen/COPD/Lung Ca. Refer to local policy. Chest/UTI/Catheter.	Check observations. Complete chart and action accordingly. Refer to GP if required.		
Organ dysfunction Medication Depression	Kidney/Liver disease Dehydration/AKI. Multiple medications may impact toxicity. High risk medications.	Request bloods (Us&Es, LFTs, FBC, Glucose, Calcium and Cardiac Enzymes +/- toxicity). Refer to GP.		
Constipation Pain Nutrition	Last bowel movement. Current medication that may cause constipation. Are medications being administered as prescribed?	Administer appropriate medication. Review/commence bowel chart. Review/commence pain chart. Review/commence food and fluid chart. Refer to GP if required.		
Sleep pattern disturbed Environmental change Sensory impairment	Has individual moved room/facility/returned from hospital? Are hearing aids/glasses used?	Facilitate orientation (lighting adequate, quiet areas, clock, calendar, utilise family/carers). Promote relaxation and sufficient sleep. Ensure equipment in working order.		

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