Alberta Health Services

Form Title **Delirium Prevention Orders**

Form Number **frm-21015bond**

Alberta Health Services

Last Name	
First Name	
PHN#	MRN#
Birthdate *(dd-Mon-yyyy)*	Physician

Delirium Prevention Orders

Select orders by replacing a (✓) in the associated box

For more information, see Clinical Knowledge Topic ***Delirium, Senior - Inpatient***
http://insite.albertahealthservices.ca/klink/14163.asp

Patient Care

Diet Order

☑ Regular Diet
If significant weight loss, consider liberalizing diet and consult dietitian

☐ High Protein High Calorie Diet

Order modifications for signs or symptoms of possible dysphagia and consider swallowing assessment by Speech Language Pathology or other site appropriate service.

☐ Pureed Diet

☐ Thick Fluids: Honey

☐ Other _____

Nutrition Communication

☑ Eating:

- Assist as needed
- Goal: out of bed for meal
- If less than 50% of meals eaten times 24 hours notify physician/nurse practitioner
- Offer fluids with every patient interaction. Goal:1.5-2 L/day
- Ensure patient is upright and fully alert during all oral intake and for 30 minutes afterwards

☑ Notify physician/nurse practitioner if level of consciousness is limiting oral intake or medication administration

☐ Swallowing Screen – Nursing

☐ Other _____

Activity

☑ Weight bearing as tolerated

☑ Ambulate at least daily, progressing to at least _____ times daily (recommended three times per day) in hallway. Goal is to maintain pre-hospital mobility.

☐ Encourage range of motion exercises

Other Orders

☐ _____

☐ _____

☐ _____

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Patient Care

Monitoring and Fall Prevention

****AVOID restraint use whenever possible ****

Fall Risk Assessment and Fall Prevention

☑ Fall Prevention Risk Assessment. Complete ON ADMISSION, after a fall and with status change.

☑ Fall Risk Monitoring every 4 hours

- Bed in low position
- Minimize rail use
- Call bell/personal items/walking aids/footwear in reach
- Remind patient to call for help verbally and by writing on patient's white board if available
- Comfort rounds every 2-3 hours: toilet; reposition, drink/snack. Pain? Warm enough?
- AVOID RESTRAINTS – use bed alarm

Weigh patient

☑ On admission

☐ Daily

☑ Weekly

☐ Notify physician/nurse practitioner if weight loss greater than 5% within the last 6 months including during hospital admission

Vital Signs

(including respiratory rate, pulse, blood pressure, temperature, and oxygen saturation) **as much as possible, please try to avoid ordering vital signs that disrupt patient sleep at night**

☐ TID while awake and PRN

☐ Daily and PRN

☐ every _____ hour(s) and PRN; call physician/nurse practitioner to re-evaluate after _____ hours

Intake and Output

☐ Monitor Intake - Oral (including amount of fluids and percentage of meals consumed) every shift

Bladder assessment and management

☑ Toileting/ Elimination. Goal: Maintain patient's pre-hospital toileting function. Scheduled toileting every 2 to 3 hours to keep bladder empty. Bedside commode only if necessary. Up to bathroom preferred

Indwelling catheters are only recommended for patients with obstruction AND difficulty catheterizing, strict ins and outs, to protect serious perineal/sacral wound and for patient comfort at end of life.

☑ Discontinue indwelling catheter.

☐ Bladder scan if no urine output in 8 hours. Notify physician/nurse practitioner of results.

☐ Bladder Scan-Post Void Residual until 3 consecutive scans are less than 250 mL. Perform within 30 minutes of voiding to determine residual volume.

☐ In-and-Out Catheter if bladder scan shows volume great than 250 mL and notify physician/nurse practitioner

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Patient Care

Delirium monitoring and preventative measures

☑ Confusion Assessment Method (CAM) every shift and PRN. If CAM positive, notify physician/nurse practitioner and discontinue regular CAM.

☑ Notify physician/nurse practitioner if patient has acute change in their level of consciousness or arousal and/or cognition and/or behaviour.

☑ Delirium prevention measures:

- Orient patient to place/time each morning and PRN (as appropriate to baseline cognition); ensure updated calendar visible; glasses on, hearing aids in while awake. Optimize environment (low noise, light during the day, low light at night)
- Encourage patient to do own self-care (hygiene, grooming) to maintain independence.
- Ensure patients have access to sensory aids (glasses, hearing aids, dentures)
- Implement non-pharmacological sleep promotion measures (warm milk; warm blankets; hand rub; low light/minimize noise; calm approach; avoid caffeinated beverages)

Consider behaviour mapping in patients with dementia or delirium who have concerning behaviours.

☐ Clinical Communication: Complete Behaviour Mapping Tool

*****Best practice and AHS policy is to avoid physical restraints as they increase the risk of morbidity and mortality. Restraints should NEVER be ordered PRN (see AHS Restraint as a Last Resort policy). Consider close supervision/ 1:1 staff ratio for safety instead.*

☐ Monitor patient with 1:1 nursing to patient ratio

Allied Health Referrals

Consider Pharmacy referral for medication review, paper bag test where home medication use/adherence uncertain, assistance with deprescribing if high risk medications.

☐ Pharmacy Referral. Reason for referral _____

☐ Speech Language Pathology. Reason for referral _____

Consider a dietitian referral and notify physician/nurse practitioner when there has been unintentional weight loss in last 6 months AND eating less than usual for more than a week pre-admission or patient is eating less than 50% of meals for greater than 24 hours in hospital.

☐ Dietitian Referral. Reason for referral _____

Consider Physical Therapy referral for maintaining mobility and/or concerns about gait, endurance, balance or recurrent falls

☐ Physical Therapy Referral. Reason for referral _____

Consider delaying Occupational Therapy referrals for cognitive assessments until after patient has had sufficient opportunity to adequately recover/plateau from acute issues; note: delirium can take weeks to months to completely resolve

☐ Occupational Therapy Referral. Reason for referral _____

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Physician Consults

Avoid unnecessary duplication of services. In most cases, geriatric medicine and general internal medicine, and/or (geriatric) psychiatry are not needed simultaneously.

☐ Consult Geriatric Medicine. Reason for referral _____

☐ Consult Psychiatry (Geriatric if available). Reason for referral _____

☐ Consult General Internal Medicine. Reason for referral _____

☐ Consult Neurology. Reason for referral _____

☐ Consult Pain service. Reason for referral _____

☐ Consult Palliative care. Reason for referral _____

☐ Consult Other service. Reason for referral _____.

Infusions

☐ Saline lock between medications

☐ IV Bolus: 0.9% NaCl IV _____ mL over _____ hour(s)

☐ IV Bolus *(other)*: _____ IV _____ mL over _____ hour(s)

☐ IV Maintenance: 0.9% NaCl IV _____ mL/hour, to stop on _____ (date) at _____ (time)

☐ IV Fluids *(other)*: _____ IV at _____ mL/hour, to stop on _____ (date) at _____ (time)

If IV not an option:

☐ Subcutaneous Cannula (Hypodermoclysis)- Insert

☐ dextrose 5% in water - 0.9% sodium chloride subcutaneous infusion at 60 mL/hour, to stop on _____ (date) at _____ (time) **OR**

☐ Other _____ subcutaneous infusion at _____ mL/hour, to stop on _____ (date) at _____ (time) **OR**

☐ 0.45% NaCl subcutaneous infusion at _____ mL/hour, to stop on _____ (date) at _____ (time)

Medications

Vitamins and Minerals

Consider in patients known or suspected of micronutrient deficiencies e.g. malnutrition, massive unintentional weight loss, alcohol misuse

Choose all that apply →

☐ vitamins multiple with minerals 1 tab PO daily

If history of B12 deficiency or measured B12 level less than 220

☐ cyanocobalamin 1000 mcg PO daily

For prevention and/or treatment of osteoporosis unless another dose/formulation indicated

☑ vitamin D tab 2000 units PO daily

Choose one (if applicable) →

For chronically malnourished alcoholics to prevent Wernicke's

☐ thiamine 200 mg IV every 24 hours **OR**

☐ thiamine 100 mg IV/PO every 24 hours *(may give orally once patient tolerating regular diet)*

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Medication Continued

Analgesia/Pain Management

☑ Assess for "discomfort" at rest and with ACTIVITY; assess body language especially if patient confused or agitated. Use appropriate pain assessment tools (e.g. visual, numerical, Edmonton Symptom assessment system (ESAS) or PAINAD for non-communicative/ severely cognitively impaired patients)

☑ Clinical Communication: Optimize non-pharmacologic pain management, including use of cold or heat, massage, positive distraction and repositioning.

☑ Monitor and document response to pharmacological/ non-pharmacological strategies for pain; use appropriate pain assessment tool. Notify physician/ nurse practitioner if pain control sub-optimal or adverse effects noted.

Order non-oral routes if difficulty administering orally BUT be careful to adjust for increased potency as appropriate (e.g. parenteral HYDROmorphone can be up to 5 times as potent as the equivalent oral dose).
Consider scheduled dose (with parameters to hold or delay scheduled dose if sedated) if significant cognitive impairment or communication barrier may prevent patient from asking for PRN dose

Choose one (if applicable) →

☐ acetaminophen 650 mg PO every 4 times a day for pain (maximum dose 3 g per 24 hours for seniors over age 65, and 4 g for generally healthy individuals under age 65)

OR

☐ acetaminophen 325-650 mg PO every 4 hours PRN for pain (maximum dose 3 g per 24 hours for seniors over age 65, and 4 g for generally healthy individuals under age 65)

☐ diclofenac gel 2.32% BID PRN to affected area specify _____

*Caution with opioids as a potential precipitating factor of delirium, cognitive and other side effects however untreated pain is also a precipitating factor of delirium. Avoid morphine in older adults; caution with codeine in renal insufficiency. Use lower starting doses in older adults, particularly if opioid naïve and/or vulnerable brain***

☐ HYDROmorphone 0.25mg PO every 8 hours PRN for pain

☐ Other _____

Bowel Routine

☐ Stool chart

☑ Clinical communication: Maintain usual bowel habits. If no routine, aim for bowel movement daily/every other day. If no bowel movement on Day 1 then give PRN laxative at bedtime; Day 2 escalate use of laxatives (increase frequency or add suppository)

☐ Notify physician/nurse practitioner if patient has not had a bowel movement for 48 hours

☐ polyethylene glycol 3350 powder for oral solution 17 g PO daily

☐ sennosides 1-2 tab PO QHS PRN

☐ lactulose liquid 15-30 mL PO TID PRN

☐ glycerin adult 1 supp RECTALLY daily PRN

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Medication Continued

Bowel Routine

☐ Notify physician/nurse practitioner if diarrhea develops and hold bowel routine. *Consider seepage or overflow diarrhea may occur with severe constipation.*

***avoid use of mineral oil and phosphate enema (FLEET) in older adults given increased risk of adverse effects; if an enema is required, try a tap water enema as a safer alternative*

☐ tap water enema RECTALLY daily PRN until adequate elimination if glycerin suppository ineffective after 24 hours

Antinausea Management

☐ Clinical Communication: Use non-pharmacologic approaches to manage nausea: small meals throughout the day, bland foods, avoid acidic, fatty and spicy foods, consider peppermint tea or (diet) ginger ale; dimnehyDRINATE is contraindicated in the older patient – ondansetron is best practice and cost-effective for antinausea treatment, particularly post-operatively

☐ ondansetron 4mg PO/IV every 8 hours PRN

Other Medication

☐ _____

☐ _____

☐ _____

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