**Delerium Critical Care Nursing Care Guideline 15**

**Clinical Rationale:** Delirium occurs in most critically ill patients and is independently associated with death, prolonged stay, and further complications during hospital stay. Therefore monitoring and treatment of delirium in all critically ill patients is vital.

**Indications:** Patients with any acute changes and/ or fluctuating mental status from baseline assessment or within the previous 24 hours.

If changes apparent, non-sedated patients and sedated patients with a Ramsey Sedation Score (RSS) of 3 and less can be assessed.

**Goal:**

1. All patients displaying signs of delirium will be recognised, assessed and treated appropriately.

**Care:**

**B.** Complete CAM-ICU assessment forms each shift.

**C.** Ensure adequate fluid/nutritional intake to prevent dehydration/malnourishment.

**D.** Assess for hypoxia and optimise oxygen saturation as per daily targets.

**E.** Address all sources of possible infection by actively screening for and treating infection.

**F.** Consider drugs including nicotine and alcohol withdrawal.

**G.** Regular reviews of medications.

**H.** Ensure that the patient receives continuity of care from staff for familiarity.

**I.** Avoid moving people within and between wards or rooms unless absolutely necessary.

**J.** Facilitate regular visits from family and friends whilst protecting/promoting good sleep pattern (See Sleeping NCG) and protecting feeding and rest times.

**K.** Address sensory impairmentby minimizing noise//disturbance and maximizing light during the day/ minimizing light at night.

**L.** Ensure a clock and a calendar are easily visible to the person at risk and appropriate lighting provided.

**M.** Talk to the person to re-orientate them by explaining where they are, who they are, and what your role is. Introduce cognitively stimulating activities.

**N.** Mobilise as soon as possible.

**O.** Haloperidol to be used only in acute situations. Olanzapine- first antipsychotic drug of choice if necessary. Commence Trazadone for night sedation if needed.

**Preferred Outcome: - To ensure all patients at risk of developing delirium are assessed, monitored and treated appropriately.**

**References:**

* *NICE clinical guidelines*
* Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult
* Patients in the Intensive Care Unit – Barr et al - Critical care medicine
* Delirium in the intensive care unit. Girard et al, Crit Care. 2008
* CAM-ICU guidelines 2010.