WRITE OR ATTACH LABEL Surname: ……..DOB: ……/……/…… Forenames: ……..Hosp No…… NHS Number ……

Insert logo

Care Plan Number : Delirium:	
Problem: …… Is experiencing delirium due to……	**Goal(s)**: To promote safety and recovery

Plan of Nursing Care:	**Date discontinued**
To support good nutrition and hydration • Complete mini nutrition screening tool • Document any assistance required to eat and drink; use red tray • Encourage family caregiver and friends carers to help with eating & drinking at meal times • Ensure dentures are worn and fit correctly • Try finger foods and high calorie options i.e. fortified jelly • Ensure good mouth care given; treat oral thrush promptly • Monitor & record bowel action; do not allow to become constipated • Monitor & record food intake	
To ensure good levels of communication • Ensure hearing aid worn and turned on, batteries working or use listening device • Ensure spectacles worn and clean • Give clear simple information as often as necessary i.e. where they are, who you are, what time of day it is. • Ensure a clock with numbers is visible • Use Abbey Pain Scale to recognise monitor and treat pain • Encourage regular visitors	
To maintain usual levels of activity • Complete falls assessment and intervention plan as outlined in Trust falls policy • Ensure well-fitting footwear or non-slip socks • Consider referral to physiotherapy/occupational therapy • Establish patient's 'norms' from family caregivers or cares from care home and try to recreate this i.e. wash at the sink in the bathroom/shower, eat sitting in a chair not in bed/sleep hygiene. • Encourage patient to sit out of bed and walk around the ward as able • Offer the toilet or a drink if patient wakes during the night they are likely to be frightened • Prevent boredom; offer magazines, discuss interests/past life events	
To maintain usual levels of personal hygiene • Assess levels of assistance required with hygiene needs and record • Assist with washing & dressing as required • Encourage & assist patient to be as independent as possible • Enable patient to follow own pace whenever possible • If refusing personal care consider Mental Capacity Act and assessment of capacity (MCA) – to refuse. If they lack capacity to refuse care and/or medication a best interest meeting with MDT and family to discuss on-going plan must be arranged.	

WRITE OR ATTACH LABEL Surname: ……..DOB: ……/……/…… Forenames: ……..Hosp No…….. NHS Number ……

Insert logo

To maintain safety • Encourage family or friends to remain with the patient as much as they are able and gather as much information about the patient as you can to support care interventions • Assess Waterlow score on admission; review weekly • Consider position in the ward, i.e. visible to staff at all times. • Non-slip socks are worn • Consider 1 to 1 nursing • Consider deprivation of liberty safeguards (DoL's). If lacks capacity to make decisions regarding place of treatment and care and is under constant supervision/control i.e. 1 to 1 supervision and would not be allowed to leave if asked to do so DoI's may apply.	
Management of behaviour due to distress • Ensure adequate pain relief using Abbey Pain Scale, available for the Medicine for the Elderly intranet page • Give prescribed analgesics regularly as preferable to p.r.n. • Avoid urinary catheters and venous cannulation • Accept how the person views reality, validate their feelings and show empathy, for example "you look upset, I'm so sorry this must be very difficult, you're not alone I'm here with you". • Ensure adequate lighting particularly if awake and walking at night • Provide reassurance/explanations in short sentences • Avoid boredom, ask family about usual interests and hobbies, listen to radio etc. • Encourage to walk about as much as possible • Eliminate unexpected noise, doors banging etc. • Try to ensure glasses and hearing aids or listening device are used • Avoid sedation unless risk of harm to themselves or others or they are very distressed. See delirium in older adults policy • Contact Older Adult Assessment Team for further support and guidance 07415634969	
To support family caregivers and friends • Provide copy of delirium information leaflet available to print from the Medicine for the Elderly page on the intranet. • If family caregiver wish please contact the Older Adult Assessment Team to provide further support and information • Discuss with ward sister use of family caregiver passport to enable family to visit out of hours/stay overnight to help support the patients psychological needs	
Additional interventions required: •	

Start Date:	Designation & Name	Signature	NMC