
# An Introduction for HCSW

# What is delirium?

When there is a sudden change in someone's alertness and awareness this may be a Delirium and should be reported immediately to Nurse in charge.

Press play to learn more about Delirium in this short video

Bennett & Krishnan (2016)
Tees, Esk and Wear Valleys NHS Foundation Trust

# Delirium prevention

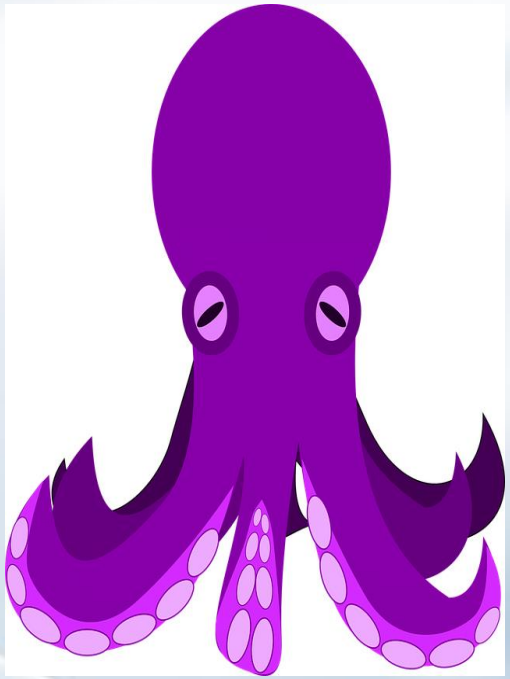
- 1 in 3 of cases of delirium in hospital are preventable and there is good evidence that prevention works
- Prevention includes good nutrition and fluid intake, bowel care, mobilisation and pain control
- You can play a key role

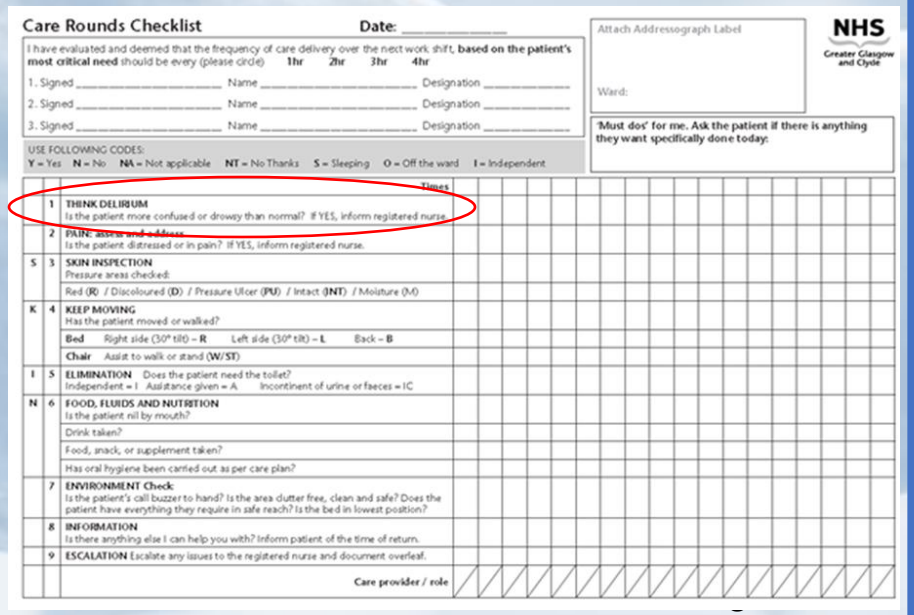
# How do we identify delirium?

On the Care Rounds Checklist a **S**ingle **Q**uestion **i**n **D**elirium (SQiD) asks ‘is the person more confused or drowsy than normal?’

This question is asked at every care round. If the answer is yes, this should always be reported to the nurse in charge of the patient’s care.

The nurse and doctor will review and, if appropriate, start an assessment test for delirium (named 4AT and Time bundle).





Care Rounds Checklist

Date: _____

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed _____ Name _____ Designation _____

2. Signed _____ Name _____ Designation _____

3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

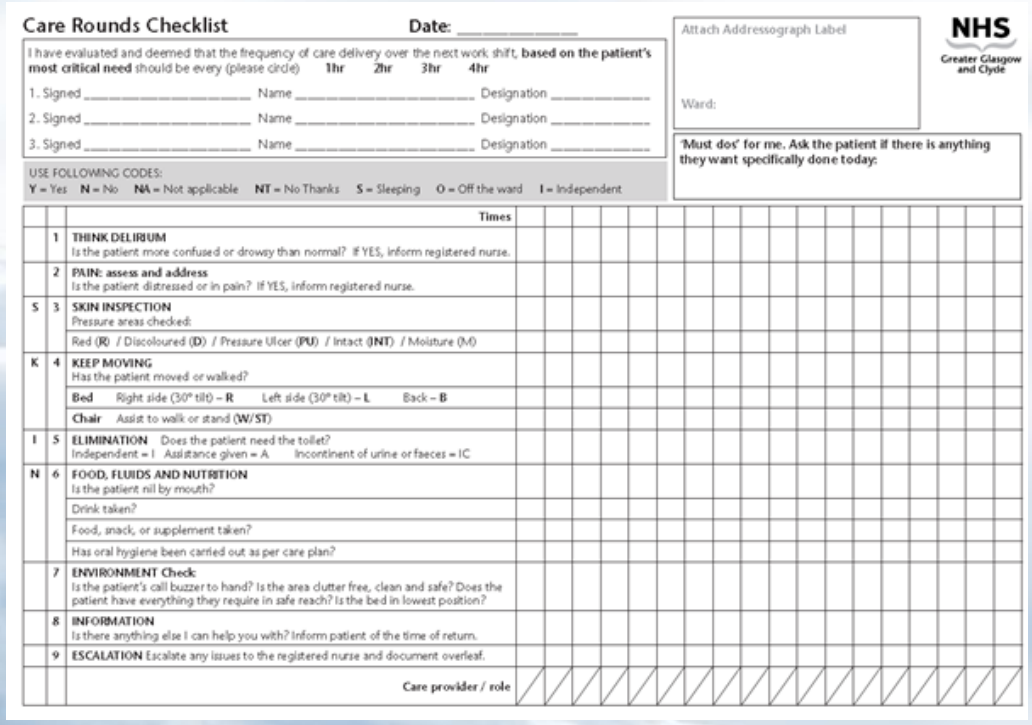
'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

| | | | Times |
|---|---|---|---|
| | 1 | **THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse. | |
| | 2 | **PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse. | |
| S | 3 | **SKIN INSPECTION** Pressure areas checked: Red (**R**) / Discoloured (**D**) / Pressure Ulcer (**PU**) / Intact (**INT**) / Moisture (**M**) | |
| K | 4 | **KEEP MOVING** Has the patient moved or walked? **Bed** Right side (30° tilt) – R Left side (30° tilt) – L Back – B **Chair** Assist to walk or stand (**W/ST**) | |
| I | 5 | **ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC | |
| N | 6 | **FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth? Drink taken? Food, snack, or supplement taken? Has oral hygiene been carried out as per care plan? | |
| | 7 | **ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? | |
| | 8 | **INFORMATION** Is there anything else I can help you with? Inform patient of the time of return. | |
| | 9 | **ESCALATION** Escalate any issues to the registered nurse and document overleaf. | |
| | | **Care provider / role** | |

# How do we prevent delirium?

- Care rounding is really important - as this is the time to ask and assess the impact of known risk factors such as pain, dehydration, constipation and environmental factors and take steps to minimise the impact of these.



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- For example, for the patient in pain, report this to the registered nurse, so painkillers can be given.
- For the patient at risk of dehydration, encourage them to drink

# Your role is key!

- Delirium is very distressing for patients and their family.
- Be alert for any change in the patients mental state – are they more confused, agitated, withdrawn or drowsy?
- Remember Single Question in Delirium (SQID) daily

- “Is the patient more confused or drowsy than normal?”
- If the answer is ‘Yes’ inform the Registered Nurse