

Delirium Screen

Could your resident be experiencing delirium?

Recent and sudden behavioural changes should prompt consideration of delirium. People with delirium can experience heightened arousal, become restless, agitated and aggressive. Alternately, they may be withdrawn, sleepy, and quiet. This tool is designed to assist health care professionals assess causes of delirium that may be impacting on a person's behaviours.

BLADDER



Look for (if you answer 'yes' to any of the questions below please complete assessments)

Have there been changes in urine colour, frequency, amount (small volumes), odour?	<input type="checkbox"/> Y <input type="checkbox"/> N
Could the person be in urinary retention? (E.g. when was the last time they urinated?)	<input type="checkbox"/> Y <input type="checkbox"/> N
Has the person recently become incontinent (or has this worsened)?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the person displaying genital area discomfort (e.g. scratching)?	<input type="checkbox"/> Y <input type="checkbox"/> N

Assessments to be completed

URINALYSIS COMPLETED

Date ___/___/___

Blood _____ pH _____

Leucocytes _____

If traces of leucocytes please collect MSU and contact GP

BLADDER SCAN/PALPATION

Date ___/___/___

If any signs of distension or retention please contact GP

Comments (including follow-up conducted)

BOWEL



Has there been a change in bowel habit?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is there evidence of abdominal pain/cramps or bloating? E.g. person holding tummy.	<input type="checkbox"/> Y <input type="checkbox"/> N
Does the person have diarrhoea that may be constipation with overflow?	<input type="checkbox"/> Y <input type="checkbox"/> N
Has appetite or oral intake decreased?	<input type="checkbox"/> Y <input type="checkbox"/> N

CHECK BOWEL CHART (7 DAYS)

Bristol Stool Score _____

Last BO ___/___/___ Number of days BNO _____

If over 3 days BNO or Bristol Stool type 1 or 2 refer to Bowel Management plan and/or review current strategies. Refer to Joanna Briggs Institute Management of Constipation (2008).

Comments (including follow-up conducted)

PAIN



Does the person have a history of any conditions that could cause pain? E.g. angina, arthritis, fractures.	<input type="checkbox"/> Y <input type="checkbox"/> N
Are there any changes in gums/teeth, mouth, ears, toenails? E.g. redness, ooze, bleeding?	<input type="checkbox"/> Y <input type="checkbox"/> N
Has the person recently had surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the skin intact? Are there reddened areas or any breaks?	<input type="checkbox"/> Y <input type="checkbox"/> N

ABBEY PAIN SCALE COMPLETED

Abbey pain scale score _____

If Abbey score is over 2 please contact GP to review current prescribed analgesic medication and/or refer to pain management plan. If any signs of infection please consult GP. If any potential pressure areas noted review PAC plan

Comments (including follow-up conducted)

INFECTION



Are there signs of localised infection? E.g. pain, redness, swelling, ooze?	<input type="checkbox"/> Y <input type="checkbox"/> N
Has a physical assessment been conducted? Are there signs of pressure sores, ingrown toenails, mouth ulcers?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is there evidence of chest infection? E.g. increased breathing, runny nose, pale skin, productive cough, wheeze, temperature.	<input type="checkbox"/> Y <input type="checkbox"/> N

INFECTION CHECK COMPLETED

Temp _____ BP _____

Resp _____ SaO2 (if able) _____

If any signs of infection e.g. T above 37.5, BP above normal range and increased respirations please consult GP.

Comments (including follow-up conducted)

MEDICINES



Have there been any changes in the person's medications?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have any of the following recently been commenced? Sedatives, anti-psychotics, anti-depressants, diuretics, steroids or painkillers. Have any of these been suddenly withdrawn?	<input type="checkbox"/> Y <input type="checkbox"/> N

MEDICATION REVIEW WITH GP OR COMMUNITY PHARMACIST

CLINICAL INVESTIGATION COMPLETED, APPROPRIATE CHANGES MADE

Comments (including follow-up conducted)

Date commenced: ___/___/___ Signature: _____



1800 699 799



dsa@dementia.com.au



dementia.com.au

Dementia Support Australia is funded by the Australian Government.