AMERICAN DELIRIUM SOCIETY

Delirium Order Sets

For all patients at risk for or experiencing delirium / acute encephalopathy unrelated to alcohol withdrawal.

Consult pharmacist for any patient with parkinsonism, Lewy body dementia or QTC prolongation.

TO BE USED BY

PROVIDERS

Nonpharmacological Interventions

Activity

- Mobilize to full potential: ambulate 3x/day ; bed/chair exercise 3x/day x 10 min
- Up in chair for meals

Eliminations

- Discontinue indwelling urinary catheter (per protocol)
- Scan bladder post void x1 and straight catheterize if >300 ml residual
- Bowel regimen
- Digital rectal exam for fecal impaction
- Scheduled toileting individualized to patient needs

Orientation

- Orient patient to the day, time, location, and circumstance at each encounter
- Provide visual orientation cues (clock, calendar, updated whiteboard)

Communication

- Hearing aid/amplifier
- Eyeglasses
- Dentures
- Picture board
- Interpreter

Comfort

- Proper room temperature
- Massage (back, feet) BID and prn
- Personalized music
- Meditation
- Clergy visit

Consistency of Routine

- Familiar items from home
- Family presence/involvement in care
- Consistent nursing staff
- Avoid unnecessary room changes

Sleep/Rest

- Shades up and lights on during the day
- Dim lights and shades down at night with bathroom light on
- Limit daytime sleeping
- Consolidate care during nighttime sleeping hours to minimize awakenings
- Eye mask at night
- Earplugs at night
- Avoid excess noise

Nutrition/Hydration

- Assist with meals
- Offer fluids every 2 hours while awake
- Offer liquid nutritional supplements during medication administration
- Monitor intake and output every 8 hours
- Dentures secured as appropriate
- Confirm need for any NPO order > 24 hours
- Bolus IV fluids if IV dislodgement is a threat

Cognitive Stimulation/Socialization

- Volunteer visits
- Personalized activities (individualized vs guided) to fit the patient's abilities and interests
- Pet therapy
- Art therapy
- Music therapy
- Integrative medicine

Safety

- Hourly intentional rounding
- Fall risk precautions
- Low bed
- Room close to nursing station
- Reminders (self-release Velcro belt, call before you fall)
- Video monitoring
- One-to-one supervision
- Apparatus disguiser (arm sleeves or long sleeve shirts to conceal IV tubing, busy apron)

Laboratory

Basic work-up

- Comprehensive metabolic panel
- Complete blood count
- Urinalysis

Additional tests to consider based upon individualized symptoms or suspected etiologies.

- Cardiac enzymes: troponin, creatine kinase, creatine kinase MB
- Erythrocyte sedimentation rate and C-reactive protein
- Blood cultures
- Urine culture
- Wound culture
- Sputum culture
- Thyroid stimulating hormone and free T4
- Vitamin B12 and folate
- Arterial blood gas
- Toxicology panel (includes levels of prescribed and non-prescribed substances)
- Rapid plasma reagin
- HIV test
- Ammonia
- Cerebral spinal fluid studies

Imaging/Diagnostic Studies

Basic work-up

- Chest X-ray
- Electrocardiogram

Additional tests to consider based upon individualized symptoms or suspected etiologies.

- CT brain
- MRI brain
- EEG
- Abdominal X-ray (“KUB”)

Pharmacy

Review all medications and taper/discontinue potentially inappropriate deliriogenic meds as appropriate (anticholinergics, antispasmodics, benzodiazepines, sedative/hypnotics)

For discomfort, consider:

- Acetaminophen 650 mg PO every 8 hours while awake for comfort (except in liver failure)

For bowel management, consider:

- Docusate sodium 100 mg PO bid
- Bisacodyl suppository 10 mg rectally if no BM x 3 days

In cases of severe agitation that is distressing to the patient and interferes with care, consider one of the following scheduled regimens:

- Quetiapine 12.5 mg PO every 8 hours x 24 hours (hold for lethargy, dysphagia, hypotension). Provider may titrate up if ineffective in relieving severe restlessness
- Haloperidol 0.25 mg IM or IV every 4 hours x 24 hours (hold for lethargy, dysphagia, hypotension). Provider may titrate up if ineffective in relieving severe restlessness
- Olanzapine 2.5 mg PO every 12 hours x 24 hours (hold for lethargy, dysphagia, hypotension)
- Risperidone orally disintegrating tablet 0.5 mg every 12 hours x 24 hours (hold for lethargy, dysphagia, hypotension)
- 12-lead EKG daily to monitor QTC interval when receiving scheduled antipsychotics for > 24 hours. Notify provider if QTC greater than 500 ms or 20% greater than baseline.

Patients in ICU settings may require more assertive medication dosing to achieve a calm state. The goal is to use the lowest dose possible for the shortest amount of time. Be aware of new-onset hypoactive delirium related to oversedation.

Consults

- Pharmacy (for overall medication review or for assistance with any patient with Parkinsonism, Lewy Body Dementia or QTC prolongation requiring antipsychotics)
- Physical therapy
- Occupational therapy
- Speech therapy
- Geriatrics (for patients age 65+ with delirium not improving after 24 hours)
- Psychiatry (for patients with a significant pre-existing mental health disorder or patients < age 65 with delirium not improving after 24 hours)
- Palliative care
- Integrated medicine
- Nutrition

FOR MORE INFORMATION VISIT

American Delirium Society