NHQI Nursing Home Quality Initiative

DELIRIUM
Acute Intervention Checklist

Resident Name: ________________________________ **Date:** _______________

Date	Interventions	Completed By
	1. Nursing Assessment:	
	Temperature	
	Pulse/heart sounds	
	Respirations/breath sounds	
	Blood pressure	
	Neuro status	
	Intake & output	
	Weight	
	Pulse oximeter	
	Rectal exam	
	Bladder palpation	
	Pain	
	Mobility status	
	Sleep patterns	
	2. Medication regimen review	
	3. Physician notified	
	4. Orders obtained for laboratory/other diagnostic tests	
	5. Family notified	
	6. Underlying medical condition(s) identified & treated as appropriate	
	7. Delirium risk factor modification guide reassessed to determine non-medical causes	

_______ initials _______________ signature

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MO-03-02-NHD April 2003
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with the Centers for Medicare & Medicaid Services (CMS).
The contents presented do not necessarily reflect CMS policy.
Version 04/03/2003

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