Delirium: Prevention Plan of Care for High-Risk Residents

Key Steps

Resident identified high-risk for delirium on screening

Develop a prevention care plan

Implement the care plan

Reassess cognitive status and the plan of care

Identification of delirium; initiate delirium care plan

Key Elements

- Establish standard prevention protocols for residents identified at high risk
- Documentation and flagging of high risk status in assessment chart and MAR by all professionals involved with documentation
- Utilize quick identification methods to identify high risk residents: color coded wrist bands, flagged chart
- Train staff regarding the normal aging process, delirium risk factors predisposing and precipitating factors, signs and symptoms of delirium (including hyperactive and hypoactive) and the distinguishing differences between, delirium, depression and dementia. (Refer to Common Underlying Medical Conditions and Signs and Symptoms of Delirium)
- Initiate resident and family education protocols (refer to Support Measure Guide)
- Establish schedule for conducting cognitive assessments for high risk residents with ideal as daily monitoring. (refer to Cognitive Assessment Tools)
- Establish mechanism to track high risk residents
- Ensure that the care plan adheres to accepted clinical guidelines (Refer to American psychiatric Association Publication: Delirium: A patient & Family Guide at www.psych.org

During the care plan meeting consider the following areas:
- Routine care issues
- Documentation and tracking of cognitive changes
- Psychosocial support
- Environmental support
- Health maintenance

Go to “Delirium Care Plan” flow diagram