Bradford Teaching Hospitals NHS
NHS Foundation Trust

A&E Delirium Assessment

Name	**D.O.B.** ..... **NHS No.** .....
General Practitioner	**Consultant** .....
Completed by ..... **Sig** ..... **Date** ..... **Time**	

Delirium Risk Factor Assessment		**Comments**
1. Does the patient have a current hip fracture	**Yes** ❑ **No** ❑	**If any of the factors from 1- 4 are present SQID to be asked.**
2. Is the patient aged 65yrs or above	**Yes** ❑ **No** ❑	
3. Does the patient have cognitive impairment: difficulty with memory, thinking, concentration and ability to read or write, withdrawn / uncommunicative.	**Yes** ❑ **No** ❑	
4. Does the patient have a severe illness; a clinical condition that is deteriorating or is at risk of deterioration	**Yes** ❑ **No** ❑	

Single Question In Delirium (SQID):

Single Question In Delirium (SQID):	**Yes**	**No**
You are required to contact a person who knows the patient and ask the following question: Do you think (the patient).has been more confused in the past three days?		
If the patient does not have anybody who can confirm how they have been in the last three days;	**Yes**	**No**
Test for evidence of inattention by asking them to count backwards from 20-1.		

If you have answered **Yes** to either of the above, inform the doctor who should complete a Delirium Assessment.	If you have answered **No** to both questions continue with the Dementia Assessment.
Dr……..…… Date ……..Time ……..……	(tick if applicable) ❑

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Delirium Assessment: To be completed by the Doctor

Delirium is a rapid onset of fluctuating confusion, disturbed awareness and inattention. Please carry out a clinical assessment to confirm diagnosis and identify possible causes.

Consider the common causes of delirium

P I N C H S /M E **P**ain, **I**nfection, **N**utrition, **C**onstipation, **H**ydration/**H**ypoxia, **S**leep, **M**edication, **E**nvironment.

Remember that there are multiple causes in delirium, e.g. an older person with a chest infection may also be dehydrated, hypoxic, constipated and have altered metabolism of medications such as opioids

First line tests for patients with delirium:

U&E, FBC, LFT, calcium, BM, TTU, CXR, ECG, oxygen saturations

Second line tests based on clinical picture:

B12/folate, TFT, AXR, CT head, CT abdomen, blood cultures, ABG, lumbar puncture.

Please advise nursing staff to commence the delirium monitoring care plan.

Delirium Assessment: To be completed by the nurse

Report any changes in medical condition or adverse behaviour to a doctor immediately and document this.
Commence delirium monitoring (DOS, NEWS, Care and comfort) if a patient is found to have a diagnosis of delirium.

Please document the findings of the delirium assessment in both the medical and nursing notes.