Daily Bedside Delirium Checklist

DATE:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Achieved= A Not Applicable= NA (Document rationale in care plan)							
Has the patient been screened for delirium using confusion assessment method (CAM-ICU) or Intensive Care Delirium Screening Checklist (ICDSC) at least daily and if changes or fluctuations in behaviour occur?							
Is the Richmond Agitation-Sedation Scale (RASS) or Riker sedation agitation scale documented as a minimum of 4 hourly?							
Has pain been assessed as a minimum of 4 hourly using a standardised tool for critical care?							
Has a medical review of risk factors for delirium been completed & documented on admission?							
Is there evidence that written information about Delirium has been offered to the patient (and/or relative)							
Have strategies been implemented & documented to facilitate patient orientation (clear and concise, repeated verbal reminders of day, time, location & identification of individuals.							
Has a daily medication review taken place?							
Is there evidence of a daily (MDT) review of nutrition and hydration status? (eg Ward round)							
Is there documentation that earplugs and/or eye masks been offered to patients at night?							
Is there a 24-hour clock visible to the patient?							
Has the patient been mobilised within the last 24 hours or, documented as to why not if contraindicated?							
Does the patient have communication aids available if required? (Glasses, hearing aids, letter boards, electronic aids)							
Initials							