DELIRIUM WHAT NOT TO DO

Don't think delirium is a benign condition

Don't just write "pleasantly confused". Delirium is bad news: it carries a higher risk of death, institutionalisation, prolonged hospital stays, pressure sores, prolonged cognitive impairment (and is associated with an increased likelihood of dementia)

Don't keep waking patients up at night

- Avoid loud noises & bright lights at night
- Don't ask for/do night time observations unless absolutely necessary (and document this in the notes)
- Don't change bays/wards (especially at night)

Don't stick tubes into patients that they don't need

Don't catheterise or cannulate unless you really have to!

Don't base your entire diagnosis on a +ve urine dipstick: you shouldn't be dipping urine in patients over 65 anyway!

Don't order tests you don't need

CT head, EEG & ABG are not "routinely" needed in delirium: do only if indicated

Don't laugh at (or argue with) patients who have delirium

You'll just make them (and you) frustrated and angry. Delirium is often terrifying for the patient

Don't use antipsychotic meds unless all other interventions have failed (and definitely not to stop patients shouting out or walking around)

Antipsychotics are a last resort, for risk to self/others, needed to allow treatment, or extreme agitation and distress. Do not use them in Lewy Body dementia, PD, or patients with prolonged QT.

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This is a #FOAMed production: please share it far & wide!

PDF for printing can be downloaded at www.lindadykes.org/downloads

This is our 2nd Delirium infographic. Did you see #1?