# Acute Delirium

## Preparation for Care Activity

**Recognizing Clinical Relationships**

Review the medical history and home medications of this patient. For each home medication, identify the pharm. classification and expected outcome for this patient its most common side effect (SE). Finally, draw a line to determine which medication treats what condition.

| Medical History | Home Meds | Pharm. Classification | Expected Outcome | Common SE |
|---|---|---|---|---|
| • Osteoarthritis<br>• Asthma<br>• Dementia<br>• Heart failure | • diclofenac sodium 50 mg BID<br>• montelukast 10mg once daily<br>• albuterol inhaler 2 puffs PRN Q 4 H for SOB<br>• donepezil 10 mg once daily<br>• furosemide 40 mg BID<br>• Carvedilol 6.25 mg BID | - NSAID<br>- Leukotriene receptor antagonists<br>- Beta 2 agonists<br>- Acetylcholinesterase inhibitor<br>- Loop diuretic<br>- Beta-adrenergic blocking agent | - Relief of signs and symptoms for osteoarthritis and rheumatoid arthritis<br>- Prevents wheezing and shortness of breath caused asthma<br>- bronchodilator - prevents asthma symptoms and inflammation<br>- Slows down the process of dementia<br>- Pull fluid off body<br>- Treat heart failure, hypertension, | -abdominal pain, gas, constipation, dizzines, indigestion, swelling<br>-Sore throat, wheezing, abdominal pain, dental pain<br>-tremor, increased blood pressure, headache, vomiting, cough<br>- nausea, diarrhea, insomnia, infection, vomiting, cramping<br>- anemia, diarrhea, dizziness, hives, hearing impairment<br>-dizziness, fatigue, weight gain, high blood sugar |



KEITHRN UNFOLDING Reasoning Simulation

# Part I: Developing Noticing and Interpreting Skills

1. Which findings from the *present problem* are **most important** and noticed by the nurse as clinically significant?

| Most Important Findings | Clinical Significance |
|---|---|
| The most important finding is that he has dementia | This is clinical significant because with his altered mental status he is at high risk of hurting himself for example he pulled out his catheter and he is at high risk for hurting others |

2. Which data from the *social history* is **most important** and noticed by the nurse as clinically significant?

| Most Important Findings | Clinical Significance |
|---|---|
| That he drinks wine every night | With his diagnosis it is not appropriate for him to be drinking every night because it can make his diagnosis worse and he already has dementia so with drinking it will impair his mind even more |

3. To provide compassionate holistic care for this patient, answer the following questions.

| | |
|---|---|
| What is the patient likely experiencing/feeling right now in this situation? | The pt is probably feeling agitated and overwhelmed along with some confusion in this situation. |
| What can you do to engage yourself with this patient's experience and show that they matter to you as a person? | Providing therapeutic communication with this pt and showing him that we are there to help him and not harm him is important and making him feel comfortable and to trust the medical team |

4. Which findings from the *contextual factors* are **most important** and noticed by the nurse as clinically significant?

| Most Important Findings | Clinical Significance |
|---|---|
| Being an EMT | This is significant because the nurse is more used to having the confused combative pt and being on the resume squad they have the characteristic to think actively and quick |

# Patient Care Begins

5. Which vital sign findings are most important and noticed by the nurse as clinically significant?

| Most Important Data | Clinical Significance |
|---|---|

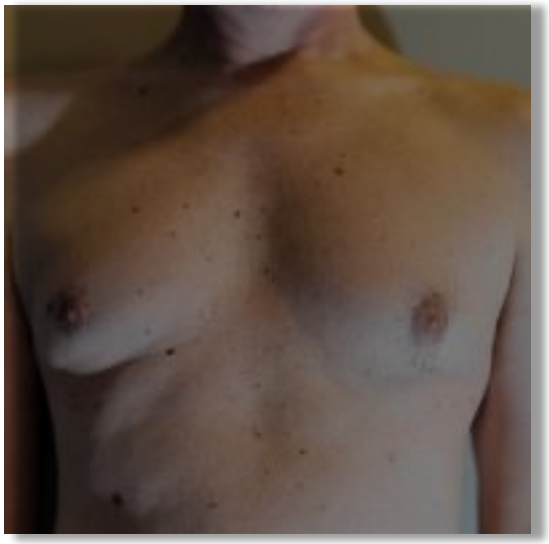
| | |
|---|---|
| The bp and pulse rate | The pt is having high bp and pulse rate can send the pt into arrhythmias that could be life threatening and make his conditions worse |





6. What assessment data needs to be noticed as **most important**? Interpret its clinical significance.

| **Most Important Data** | **Clinical Significance** |
|---|---|
| The pt is agitated and not easily redirected | This is significant because the pt is at risk for harming himself further than he has or harming the medical team. The pt does not understand what is going on |

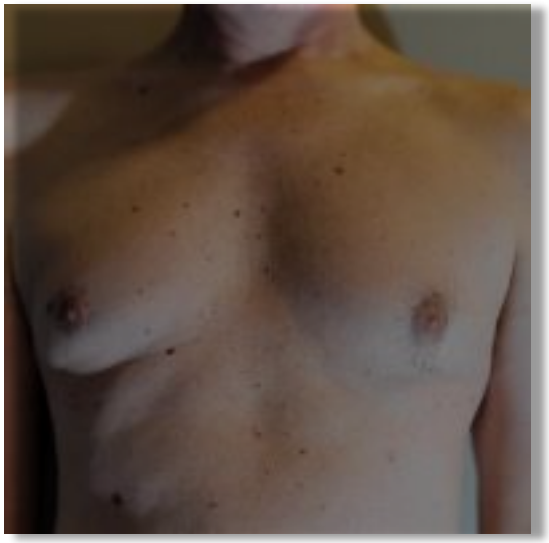


## Auscultate Breath Sounds

Place a circle on the chest where the nurse would place the stethoscope to auscultate the left upper lobe.

**Click this link to listen.** Identify what type of breath sounds are heard, and interpret their clinical significance.

| **Breath Sounds** | **Clinical Significance** |
|---|---|
| | |



## Auscultate Heart Sounds

Place a circle on the chest where the nurse would place the stethoscope to auscultate the tricuspid valvular landmark.

**Click this link** to hear heart tones. Identify what type of heart sounds are heard, and interpret their clinical significance.

| Heart Sounds | Clinical Significance |
|---|---|
| | |





As you complete your room assessment, you notice this container in the drawer of his nightstand next to his bed. It is half full and smells like ETOH.

7. What room assessment data needs to be noticed as most important?
- That he has alcohol at his bed side and needs to be assessed for intoxication
Interpret its clinical significance and determine how the nurse should immediately respond.

| Most Important Data | Clinical Significance | Nurse Response |
|---|---|---|
| The alcohol container | The pt has been consuming alcohol while being treated along with probably consuming more alcohol than he had said | Can you tell me what is in this container? We are just trying to help and need to know if you have been consuming alcohol |

## Radiology Reports: CT Head

What radiology findings are **most important** and noticed by the nurse as clinically significant?

| Radiology: Chest X-Ray | | |
|---|---|---|
| **Results** | **Most Important Data** | **Clinical Significance** |
| No evidence of acute infarction, intracranial hemorrhage, or mass effect was seen. | The pt head ct is okay | This is important because we know that he does not have a head injury and can continue to focus on what the pt needs |

## Lab Results:

| Hematology: Complete Blood Count (CBC) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **WBC** | **HGB** | **PLTS** | **% Neuts** | **% Lymphs** | **% Monos** | **% Eosin** | **Bands** |
| | | **10.5** | **278** | **71** | **22** | | | |

Which diagnostic findings are **most important** and noticed by the nurse as clinically significant?

| Most Important Data | Clinical Significance | TREND Improved/Declined/No Change |
|---|---|---|
| Hgb and Neutrophils | The clinical significance is that the pt is losing blood and there is infection that may be present | **declined** |





| Metabolic Panel | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Na | K | Cl | CO2 | AG | Gluc | Ca | BUN | Creat | GFR |

Which diagnostic findings are **most important** and noticed by the nurse as clinically significant?

| Most Important Data | Clinical Significance | TREND Improved/Declined/No Change |
|---|---|---|
| Na | His Na is low and is not retaining fluid but this could be because of the diuretic | No change |

| Liver Panel | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Albumin 2.8 | Ammonia | Total Bili | Direct Bili | InDirect Bili | Alk Phos | ALT | AST |

Which diagnostic findings are **most important** and noticed by the nurse as clinically significant?

| Most Important Data | Clinical Significance | TREND Improved/Declined/No Change |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ALT/AST are high along with bili ammonia and has low albumin | The pt liver is not functioning properly and not filtering correctly and this could be from alcohol induced liver cirrhosis. | Declined |

## Lab Planning Activity

A care plan can be developed around a relevant, abnormal lab value. With each lab, record the normal range, critical or red flag value, physiologic significance, and priority nursing assessments/interventions to respond appropriately.





| Lab Name | Physiologic Significance | Priority Nursing Assessments/Interventions |
|---|---|---|
| **AST**<br><br>Normal Range 5-30<br><br>**Lab Value 145-high**<br><br>**High/Low/Normal** | AST is measured to see if there is any liver damage that is occurring | Weight management, dietary modifications, alcohol cessation, maintain blood sugars - look at vitals, palpate the pt abdomen |

| Lab Name | Physiologic Significance | Priority Nursing Assessments/Interventions |
|---|---|---|
| **ALT**<br><br>Normal Range 5-30<br><br>Lab Value 120-high | Protein in a cell that acts as a catalyst and allows certain bodily process to happen and is found in the liver - released in blood when liver cells are damged | Monitor the pt for any signs of cirrhosis perform blood test and weight management, dietary modifications, alcohol cessation, watchign vitals |

| | | |
|---|---|---|
| **High/Low/Normal** | | |

# Part II: Developing Responding Skills

1. Interpreting clinical data collected, list at least two problems that are possible for this patient? Which problem is the priority?

| Possible Problems | Priority Problem | Pathophysiology of Priority Problem |
|---|---|---|
| Liver failure,<br>Infection<br>Hemorrhaging<br>Kidney failure<br>Arrhythmias<br>shock | Priority problem would be maintaining blood pressure and adequate circulation to the heart | The higher the blood pressure the more at risk the pt is for organ damage, and with his past history of alcohol drinking his liver is probably already failing and with the risk of organ damage it can become worse. Also, this could put pt in arrhythmias that could be life-threatening |

2. What body system(s) will you assess most thoroughly based on the primary problem? What specific assessments will you implement?

| Priority Body System(s) | Priority Assessments |
|---|---|
| Liver<br>Kidney<br>Cardiovascular<br>Neuro | The priority assessment for this pt would be his neuro because we need to know what his competency level is. The pt is a high risk pt and it is important to know what his normal is and out of normal. The pt may have had alcohol and could have an increased ALOC. |





## Medical Management of Care

3. Identify the rationale for each provider order and its expected outcome.

| Care Provider Orders: | Rationale: | Expected Outcome: |
|---|---|---|
| Discontinue urinary catheter Reinsert IV and saline lock<br><br>Haloperidol 1-2 mg IV PRN every 4 hours<br><br>Quetiapine 50 mg PO at bedtime<br><br>Acetaminophen 500 mg PO every 4 hours PRN pain<br><br>12 lead EKG<br><br>One to one sitter<br><br>Thiamine 250 mg daily | Discontinuing the urinary cath would help the pt move and become mobilize- he is also at risk for pulling out his cath<br><br>Catheter reinsert IV and saline lock because the pt ripped out his IV and it is needed in case of emergency's or if there is any drug the pt is going to need through his IV<br><br>Haloperidol will calm the pt down because he is confused and overwhelmed<br><br>Quetiapine is used an antipsychotic drug that can be used to treat sudden episodes of mania or depression<br><br>Acetaminophen is for pain<br><br>The 12 lead EKG is used to monitor the pt heart rate and rhythms<br><br>One to one sitter because he is at risk for hurting himself or someone else<br><br>Thiamine is a used to boost mood | The expected outcome for this pt is that they become calm and episodes of mania and depression are controlled. The pt stops pulling out IV and heart rate is monitored frequently and the pt is able to get adequate rest. |

## Priority Setting

4. Determine the order of priority the nurse will implement each order and the rationale for the order you chose.

| Care Provider Orders: | Order of Priority: | Rationale: |
|---|---|---|
| • Quetiapine 50 mg PO at bedtime<br>• 12 lead EKG<br>• One-to-one sitter<br>• Reinsert IV and saline lock • Haloperidol 1-2 mg IV PRN every 4 hours<br>• Acetaminophen 500 mg PO every 4 hours PRN pain<br>• Thiamine 250 mg one tablet daily | EKG<br>Haloperidol<br>Reset IV<br>Acetaminophen<br>Thiamine<br>One to one<br>Quetiapine | The first priority would be getting the EKG on the pt to monitor their heart rate and rhythm for monitoring of dysthymias. Haloperidol would be a priority to call the pt down and be able to reinsert and IV the next would be giving acetaminophen and thiamine for meds a one on one would need to be with the pt at all times and the quetiapine is not given until night time |

For the order of haloperidol, complete the table below.

| Mechanism of Action | Most Common Side Effects | Priority Assessments | Pt. Education |
|---|---|---|---|
| First gen typical antipsychotic which exerts its antipsychotic action by blocking dopamine D2 receptors in the brain | Drowsiness, headache, dizziness, uncontrolled restless movements, feeling anxious | Monitor the pt neuro and cognitive function | Symptoms may not improve for several weeks, you may have withdrawal symptoms if sudden stopped, store away from moisture, heat and light Take medicine as soon as you can do not take two doses at once |

For the new order of quetiapine, complete the table below.

| Mechanism of Action | Most Common Side Effects | Priority Assessments | Pt. Education |
|---|---|---|---|
| Mechanism of action is unknown- could occur from the antagonism of dopamine type 2 and serotonin receptors | Uncontrolled muscle movements in your face, breast swelling and tenderness, trouble swallowing, painful or difficult urination, high blood pressure, light headed | Nervous system reactions, signs of infection, blood sugar and thyroid lab values | Swallow the tablet whole do not crush, chew or break it, blood |

## Dosage Calculation: IV Push/ Haloperidol 1-2 mg IV PRN every 4 hours

| Medication | Time frame to Administer | Show Work | Volume to Administer |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
|  | **Diluted or Undiluted: Undiluted** | **-5mg for immediate use** | |





## Nursing Management of Care

5. After interpreting clinical data collected, identify the current nursing priority and which action(s) the nurse should take. List appropriate interventions, rationale, and expected outcomes.

| **Nursing Priority** | | |
|---|---|---|
| **Priority Intervention(s)** | **Rationale** | **Expected Outcome** |
| | | |

6. Based on the social history, which findings are noted as most important then identify the psychosocial/holistic care priority? List appropriate interventions, rationale, and expected outcome.

| **Psychosocial Nursing Priority** | Increased risk of anxiety and agitation due to ALOC | |
|---|---|---|
| **Priority Interventions** | **Rationale** | **Expected Outcome** |

| | | |
|---|---|---|
| Reorient the pt<br>Provide familiar objects<br>Remian calm and comforting<br>Treat underlying cause | The pt will need to be reoriented so they are able to calm themselves down providing familiar objects can help reorient the pt and remain calm shows the pt that you are not a threat to them and you are there to help them and not hurt them and treating the underlying cause will help the pt because the underlying disease may be causing ALOC | The expected outcome would be that the pt will become oriented and become calm and doing so the pt will be at a decreased risk of harming themselves or others |

7. What is a CAM assessment, and how will it help assess delirium in this patient?

Confusion Assessment Method. This is a standardized evidence-based tool that allows clinicians to identify and recognize delirium quickly and accurately. Aute onset and fluctuating course/ B inattention/ C disorganized thinking/ D ALOC/.

8. Using the CAM assessment tool, does Johnathan meet diagnostic criteria for acute delirium?

Yes I believe the pt meets this criteria. He has abnormal behavior throughout the day and has difficulty focusing he is becoming disorganized and has unpredictable switching of subjects the pt is alert but can become vigilant.

9. If the nursing intervention(s) were effective, which findings are expected?

| **Expected Findings** |
|---|
| If the nursing interventions are effective the pt will be able to relax and the underlying disease/ illness can be treated and the pt can become at baseline again |





## Problem Recognition

10. To prevent a complication based on the primary problem, answer each question in the table below.

| Identify the worst possible and | **Worst Possible** | **Most Likely** |
|---|---|---|

| | | |
|---|---|---|
| most likely complication? | ***The pt is aggressive and starts pulling out tubes harming himself and losing blood because of the alcohol that has thinned his blood or he becomes harmful to a staff member*** | The pt will become relaxed from the haloperidol and will with draw from the alcohol and will need education on alcohol abuse |
| What interventions can prevent this complication from developing? | Giving the pt medication to relax and reduce anxiety because with him having delirium he is at higher risk to harm himself or others | The nurse will give therapeutic communication and relax the pt along with giving the proper meds to help with his cognitive state and detox and his medical condition |
| What clinical data/assessments are needed to identify this complication early? | Monitoring his neuro function and address his baseline for cognitive status this is important because we need to know if he is at baseline or still in toxicated | The nurse needs to assess this neuro function/ cognitive state |
| What nursing interventions will the nurse implement if the anticipated complication develops? | The nurse administers haloperidol if the pt starts to become aggressive and agitated and help reorient the pt along with giving the pt medication to help with withdrawals | The intervention the nurse will implement if there is a complication that occurs will obtaining help from other coworkers if help is needed and an incident arises |

## Education/Discharge Planning

11. What educational topics need to be included in a teaching plan to prevent complications and prepare this patient for discharge?

| **Priority Topics** | **Rationale** |
|---|---|
| | |

12. Which interprofessional team member would the nurse need to consult and collaborate with to promote and maintain health after discharge?

| **Team Member** | **Rationale** |
|---|---|

| | |
|---|---|
| | |





# Part III: Developing Evaluation Skills

## Two hours later:

Johnathan is resting comfortably and appears to be sleeping in his bed. He has a sitter at the bedside and his wife has gone home to rest. He received a total of haloperidol 4 mg IV.

He has not voided since his urinary catheter was pulled out. Before falling asleep an hour ago, he received acetaminophen 500 mg PO for pain at the surgical site.

1. The nurse has implemented the medical and nursing plan of care. You collect the following assessment data below. For each finding, make a clinical judgment by placing an "x" in the appropriate column if the patient's condition has improved, has not changed, or has declined.

| Assessment Finding | Improved | No Change | Declined |
|---|---|---|---|
| **T:** 98.8 F/37.1 C (oral) | | | |
| **P:** 74 (regular) | | | |
| **R:** 14 (regular) | | | |
| **BP:** 114/64 | | | |
| **O2 sat:** 93% room air | | | |
| Calm, body relaxed, appears to be resting comfortably | | | |
| Moderate amount of frank bloody drainage from urethra onto the bed sheets | | | |

2. Is the *overall* status of the patient:

    a. Improved

b. No change
c. Decline

3. After evaluating the patient, identify the current nursing priority and which action(s) the nurse should take. List interventions by priority and the expected outcome.

| **Nursing Priority** | | |
|---|---|---|
| **Priority Interventions** | **Rationale** | **Expected Outcome** |
| | | |





4. Write a concise nurse's note using your program's preferred format to document what was most important in the medical record at the end of your shift.

| |
|---|
| |

It is now the end of your shift.
Write out your SBAR report to the oncoming nurse who will be caring for your patient.

| |
|---|
| **S**ituation: |

| |
|---|
| Name/age:<br><br>Concise summary of primary problem:<br><br>Day of admission/postop #: |
| **B**ackground: |
| Primary problem/diagnosis:<br><br>Most important past medical history:<br><br>Most important background data: |
| **A**ssessment: |
| Most important clinical data:<br><br>*Trend* of most important clinical data (stable-increasing/decreasing):<br><br>How have you advanced the plan of care?<br><br>Patient response:<br><br>Current status (stable/unstable/worsening): |
| **R**ecommendation: |
| Suggestions to advance the plan of care: |





## Nurse Reflection

To strengthen your clinical judgment skills, reflect on your knowledge and the decisions made caring for this patient by answering the reflection questions below.

| **Reflection Question** | **Nurse Reflection** |
|---|---|

| | |
|---|---|
| As you worked through this simulation, how did it make you feel? | This scenario made me feel like I was better able to understand delirium and the actions and emotions that come with it |
| What did you already know and do well on this simulation? | What I already knew for this simulation was that many people with delirium are aggravated and can become aggressive. I feel like I did a good on prioritizing the orders |
| What areas do you need to develop/improve? | I could develop my skills in the aspect of how to accurately communicate with someone who has been drinking alcohol while under medical treatment |
| What did you learn? How will you apply what was learned to improve patient care? | I learned that chronic drinking will lead to liver and kidney failure quickly and how drinking every night could hurt the pt faster than they think |