

Acute Confusion (Delirium)

Assessment	Diagnosis	Outcomes	Interventions	Rationales	Evaluation
<p>Subjective Data: Client reports confusion, disorientation to time and place, difficulty recognizing family members.</p> <p>Objective Data:</p> <ul style="list-style-type: none"> (+) Fluctuating level of consciousness (+) Impaired attention span (+) Misperceptions and visual hallucinations (+) Increased agitation in late afternoon (sundowning) (+) Restlessness and fluctuating psychomotor activity <p>Recent UTI diagnosed 2 days ago</p>	Acute Confusion related to urinary tract infection affecting cerebral metabolism as evidenced by disorientation to time and place, impaired attention span, visual hallucinations, and fluctuating level of consciousness.	<p>After 24-48 hours of nurse-patient interventions, the client will:</p> <ol style="list-style-type: none"> 1. Demonstrate diminished episodes of confusion and delirium. 2. Regain normal reality orientation and improved level of consciousness. 3. Verbalize understanding of causative factors when known. 4. Participate in ADLs with minimal confusion. 	<ol style="list-style-type: none"> 1. Orient client to surroundings, staff, and necessary activities. Present reality concisely. 2. Provide calm environment; eliminate extraneous noise and stimuli. Use earplugs at night if needed. 3. Encourage family participation in reorientation. Place familiar objects in sight (photos, calendar, clock). 4. Monitor for physiological changes (infection status, vital signs, lab values, hydration status). 5. Ensure client uses vision and hearing aids appropriately. 6. Avoid use of restraints. Provide constant observation if needed. 7. Establish toileting schedule every 2 hours while awake. 	<p>1. Increased orientation ensures greater safety. Reorientation techniques and memory cues help confused clients navigate unfamiliar hospital environment.</p> <p>2. Increased sensory stimulation can be misinterpreted by confused clients. Studies show reducing noise with earplugs decreases delirium risk by 53%.</p> <p>3. Family presence enhances comfort and provides ongoing input about current events, helping maintain connection to reality.</p> <p>4. UTI and other infections are common causes of acute confusion in older adults and must be treated to resolve delirium.</p> <p>5. Sensory deficits contribute to confusion. Clients must adequately perceive environment to communicate effectively.</p> <p>6. Restraints worsen confusion and increase risk of injury. Constant observation is safer and more effective.</p> <p>7. Confused clients may not remember to use call light. Regular toileting prevents falls and maintains dignity.</p>	<p>After 24-48 hours of interventions:</p> <p>Client demonstrated decreased confusion episodes, correctly identified day and location 70% of the time.</p> <p>Client recognized family members consistently.</p> <p>Agitation decreased significantly, no sundowning episodes observed.</p> <p>UTI treatment initiated, symptoms improving.</p> <p>Client participated in basic ADLs with minimal prompting.</p> <p>Continue current interventions and reassess in 24 hours.</p>