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Delirium Transition & follow-up

Mental Health Nursing | Transition & follow-up

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Clinical assessment

Subjective: Family reports sudden change from usual alertness during acute illness.

Objective findings and required checks: Fluctuating attention and disorientation; urgent medical assessment is needed.

Physical examination and investigations: Assess baseline, observations, glucose, oxygenation, medicines, pain, hydration and cause-directed investigations.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Delirium: Acute illness, medicines or physiological disturbance disrupt attention and cognition.

Medical / surgical management

Treat underlying causes, maintain orientation and sensory aids, protect sleep and use least restrictive safety measures.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks

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Medicine / treatment	Purpose	Nursing checks
Medication review	Identify possible contributors	Avoid adding sedating drugs routinely
prescribed cause-specific treatment	Correct the identified trigger	Monitor response and adverse effects.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Check unresolved risks, medicine reconciliation, practical support and follow-up before transition.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about experiences, distress and thoughts of harming self or others directly and respectfully. Assess: Assess orientation, mental state, behaviour and possible medical contributors.	Disturbed interpretation of experiences affecting safety or function. Possible factors: changes in perception, cognition or mood. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Engages in a safe, calm interaction and accepts an agreed support step. Longer-term: Before the clinically approved transition or agreed follow-up: Patient and support team describe relapse signs and the follow-up plan.	1. Use calm, brief communication and acknowledge feelings without reinforcing false beliefs. Rationale: A consistent approach reduces confrontation and distress. 2. Assess immediate risk and possible delirium or substance-related causes; escalate concerns. Rationale: Medical and psychiatric emergencies may present with altered behaviour. 3. Maintain a low-stimulation setting and monitor prescribed treatment effects. Rationale: The environment and treatment response influence safety and recovery. 4. Treat underlying causes, maintain orientation and sensory aids, protect sleep and use least restrictive safety measures. Rationale: Acute illness, medicines or physiological disturbance disrupt attention and cognition. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask directly about safety, self-harm, aggression and access to harmful means. Assess: Assess risk, observation needs and environmental hazards collaboratively.	Immediate safety needs during altered mood, cognition or behaviour. Possible factors: reduced judgment, severe distress or loss of control. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Immediate risks are addressed using the least restrictive appropriate care plan. Longer-term: Before the clinically approved transition or agreed follow-up: A collaborative safety and follow-up plan is documented before transition.	1. Escalate imminent danger immediately and maintain observation according to risk and local policy. Rationale: Timely support protects life and prevents unobserved deterioration. 2. Use de-escalation, respectful communication and proportionate environmental safeguards. Rationale: Dignity and reduced stimulation can support safer engagement. 3. Review risk with the multidisciplinary team and document changes and handover. Rationale: Risk is dynamic and requires continuity across staff and settings.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about usual sleep, current disruption and daytime fatigue. Assess: Record sleep pattern, symptom triggers and environmental disturbance.	Sleep disrupted by symptoms or the care environment. Possible factors: discomfort, anxiety or interrupted routines. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Reports improved rest during the next planned sleep period. Longer-term: Before the clinically approved transition or agreed follow-up: Identifies practical sleep-supporting routines for recovery.	1. Identify pain, breathlessness, anxiety and medicine-related causes of poor sleep. Rationale: Treating contributors is more useful than assuming a single cause. 2. Cluster non-urgent care and reduce light and noise when safe. Rationale: A predictable environment protects opportunities to sleep. 3. Use relaxation strategies and review prescribed sedating medicines carefully. Rationale: Rest should improve without avoidable oversedation or falls.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: Before any clinically approved transition: Explains the most important immediate	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain the fluctuating course to family, encourage familiar support and arrange cognitive review after recovery. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain the fluctuating course to family, encourage familiar support and arrange cognitive review after recovery.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Declining consciousness, focal deficit, shock or uncontrolled danger requires immediate escalation.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Acute illness, medicines or physiological disturbance disrupt attention and cognition.

- Priority concerns: Disturbed interpretation of experiences affecting safety or function; Immediate safety needs during altered mood, cognition or behaviour; Sleep disrupted by symptoms or the care environment; Learning needs about the condition and care plan.

- Declining consciousness, focal deficit, shock or uncontrolled danger requires immediate escalation.

- Explain the fluctuating course to family, encourage familiar support and arrange cognitive review after recovery.

Exam / viva: Which unresolved problem would delay transition, and what information must reach the next care team?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
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