Rapid Series Manual

Nursing Interventions for Disorientation – Series 29

What is this series about?

Disorientation is a common problem for people receiving care in hospitals and other facilities. Influencing factors include unfamiliarity of the environment, sensory impairment, prior cognitive impairment, and the impacts of physical illness and medical treatment on a person's awareness and cognition. Despite clinical guideline recommendations for orientation strategies for disoriented persons, there is a lack of evidence that such strategies are effective or even acceptable to them. Your assistance with completing this CRF will contribute to our understanding about whether nurses' use of orientation strategies for disorientated persons in their care are effective and acceptable, and is greatly appreciated. Thank you for your time and efforts in participating in this Rapid series.

Patient tracking

A log or spreadsheet should be developed in order track the patient medical record number and the study ID number allocated to each patient when medication/intervention is commenced. This spreadsheet will be the only link between the data collected and the identity of the patient and remains the property of the participating site. This information should not be shared with the Palliative Care Clinical Studies Collaborative (PaCCSC). The spreadsheet should also contain the date and time of the data entry at each time point.

Patient PID	Patient name	Patient medical record number	Date of initial data entry	Time of data entry

Allocating Patient ID number

The ID number for each set of data collected is a composite number built up using a series of three codes:

1. **Site identifier**
   This is the number allocated to each participating site as a two or three digit number
2. **Medication/intervention number**
   The number for the nursing intervention – Disorientation series is **29.**
3. **Patient number**
   This is usually a three digit number e.g. **001**

Therefore the full patient ID number will be:

Site identifier/medication number/patient number e.g. 01/29/001

Time points

There are 3 main time points where data collection is required;

1. Commencement of the nursing intervention (baseline) (T_0)
2. 30 – 60 minutes after baseline interventions (T_1)
3. 4 hours after baseline interventions (T_2)

Other data collection point:

Date and time of death

- Enter the date and time of death when known.
- If the date of death is entered during the data collection period, the investigator will no longer receive prompts to complete the remaining data.

Each medication/intervention of interest will have different time points for clinical benefit and harms. Time points are determined by each Series subcommittee and are based on clinical experience and published product information/clinical guidelines.

For example: the Cyclizine Series

- Harm is assessed at both days 1 and 3
- Clinical benefit is assessed at both days 1 and 3

Adverse events/Harm assessment

Adverse events (or harms) are assessed using a standard scale from the National Cancer Institute Criteria for Adverse Events (NCI CTCAE). The NCI uses a scale between 1 and 5 ranging from mild to serious (resulting in death) symptoms or sequelae. The NCI criteria are provided as a reference within the CRF to assist with grading of expected harms. A full copy of the NCI CTCAE document is also available on the RAPID webpage **https://uts.edu.au/RAPID** and should be referred to for any events recorded in association with the patient's clinical course.

Each medication/intervention has a number of pre-populated expected symptoms/harms. These are listed at each time point and a grade should be provided for each listed symptom/harm event.

Data entry

Login can be acquired by emailing RAPID@uts.edu.au and requesting the login to the series that is applicable to you.