Delirium at WDMH

Past, Present & Future

What We Need From You…

- CAM and Delirium Screening Tool?
- Decision re: delirium in ED/ICU
  - Research?
  - Tools?
  - Leads?
- Where does palliative and delirium fit in?
- End product?

Interpretation of Evidence

Levels of Evidence

Ia - Evidence obtained from meta-analysis or systematic review of randomized controlled trials.

Ib - Evidence obtained from at least one randomized controlled trial.

IIa - Evidence obtained from at least one well-designed controlled study without randomization.

IIb - Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.

III - Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies.

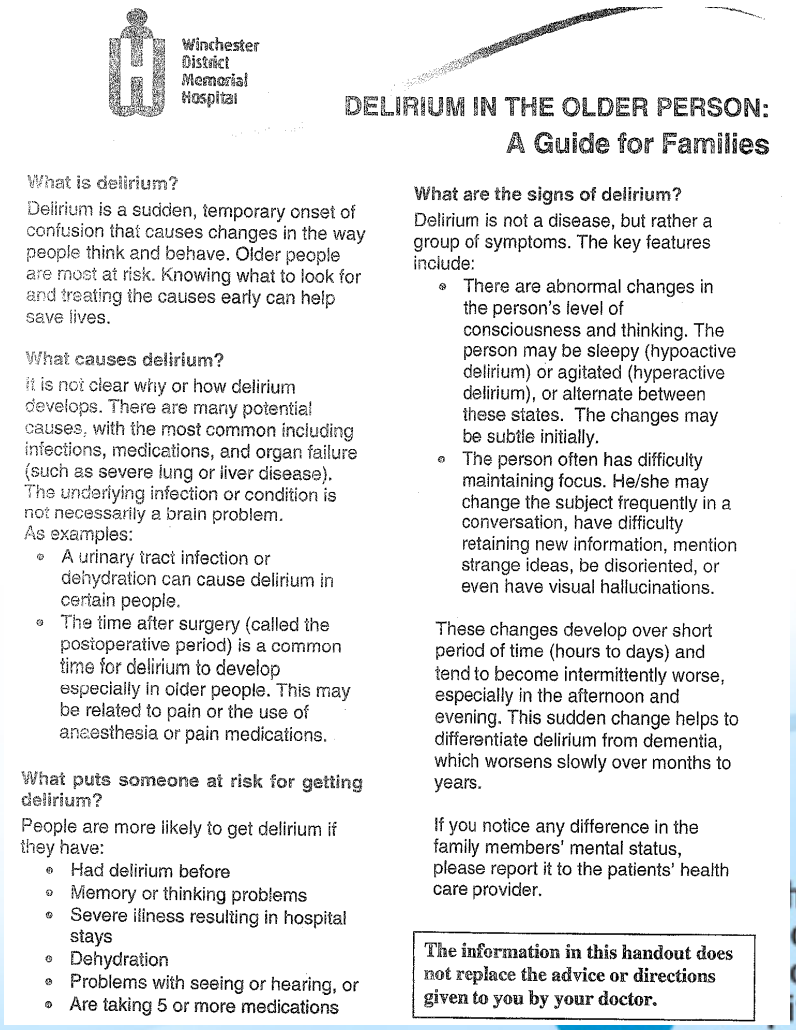
IV - Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities

Recommendation 1.5.5 Nurses should maintain current knowledge of delirium and provide delirium education to the older adult & family (III)

Training on:

- Delirium
- CAM
- Screening Tool
- Decision Tree
- Patient/Family Handout

	CCCU	MS	ER	ECU	Charge
2013	75%	89%	28%	75%	50%
2014	40%	43%	0%	50%	50%



Winchester District Memorial Hospital

DELIRIUM IN THE OLDER PERSON:
A Guide for Families

What is delirium?

Delirium is a sudden, temporary onset of confusion that causes changes in the way people think and behave. Older people are most at risk. Knowing what to look for and treating the causes early can help save lives.

What causes delirium?

It is not clear why or how delirium develops. There are many potential causes, with the most common including infections, medications, and organ failure (such as severe lung or liver disease). The underlying infection or condition is not necessarily a brain problem. As examples:

- A urinary tract infection or dehydration can cause delirium in certain people.
- The time after surgery (called the postoperative period) is a common time for delirium to develop especially in older people. This may be related to pain or the use of anaesthesia or pain medications.

What puts someone at risk for getting delirium?

People are more likely to get delirium if they have:

- Had delirium before
- Memory or thinking problems
- Severe illness resulting in hospital stays
- Dehydration
- Problems with seeing or hearing, or
- Are taking 5 or more medications

What are the signs of delirium?

Delirium is not a disease, but rather a group of symptoms. The key features include:

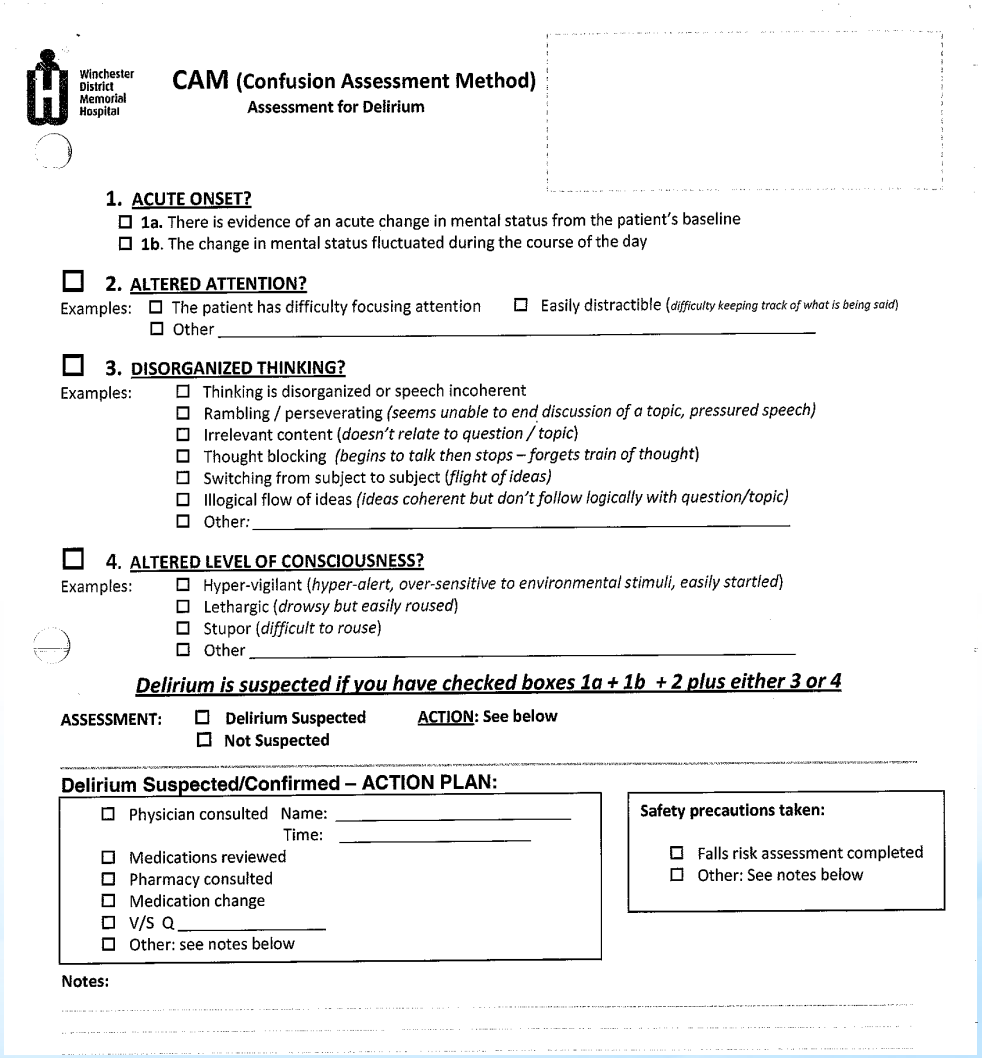
- There are abnormal changes in the person's level of consciousness and thinking. The person may be sleepy (hypoactive delirium) or agitated (hyperactive delirium), or alternate between these states. The changes may be subtle initially.
- The person often has difficulty maintaining focus. He/she may change the subject frequently in a conversation, have difficulty retaining new information, mention strange ideas, be disoriented, or even have visual hallucinations.

These changes develop over short period of time (hours to days) and tend to become intermittently worse, especially in the afternoon and evening. This sudden change helps to differentiate delirium from dementia, which worsens slowly over months to years.

If you notice any difference in the family members' mental status, please report it to the patients' health care provider.

The information in this handout does not replace the advice or directions given to you by your doctor.

Recommendation 6.7 Brief screening questions for delirium should be incorporated into nursing histories and/or pt contact documents with opportunities to implement care strategies (IV)



Winchester District Memorial Hospital

CAM (Confusion Assessment Method)
Assessment for Delirium

1. ACUTE ONSET?
- ☐ **1a.** There is evidence of an acute change in mental status from the patient's baseline
- ☐ **1b.** The change in mental status fluctuated during the course of the day

☐ **2. ALTERED ATTENTION?**

Examples:
- ☐ The patient has difficulty focusing attention
- ☐ Easily distractible (*difficulty keeping track of what is being said*)
- ☐ Other _____

☐ **3. DISORGANIZED THINKING?**

Examples:
- ☐ Thinking is disorganized or speech incoherent
- ☐ Rambling / perseverating *(seems unable to end discussion of a topic, pressured speech)*
- ☐ Irrelevant content (*doesn't relate to question / topic*)
- ☐ Thought blocking *(begins to talk then stops – forgets train of thought)*
- ☐ Switching from subject to subject (*flight of ideas)*
- ☐ Illogical flow of ideas *(ideas coherent but don't follow logically with question/topic)*
- ☐ Other: _____

☐ **4. ALTERED LEVEL OF CONSCIOUSNESS?**

Examples:
- ☐ Hyper-vigilant (*hyper-alert, over-sensitive to environmental stimuli, easily startled*)
- ☐ Lethargic (*drowsy but easily roused*)
- ☐ Stupor (*difficult to rouse*)
- ☐ Other _____

Delirium is suspected if you have checked boxes 1a + 1b + 2 plus either 3 or 4

ASSESSMENT: ☐ **Delirium Suspected** ☐ **Not Suspected** **ACTION: See below**

Delirium Suspected/Confirmed – ACTION PLAN:
- ☐ Physician consulted Name: _____ Time: _____
- ☐ Medications reviewed
- ☐ Pharmacy consulted
- ☐ Medication change
- ☐ V/S Q _____
- ☐ Other: see notes below

Safety precautions taken:
- ☐ Falls risk assessment completed
- ☐ Other: See notes below

Notes:

Winchester District Memorial Hospital

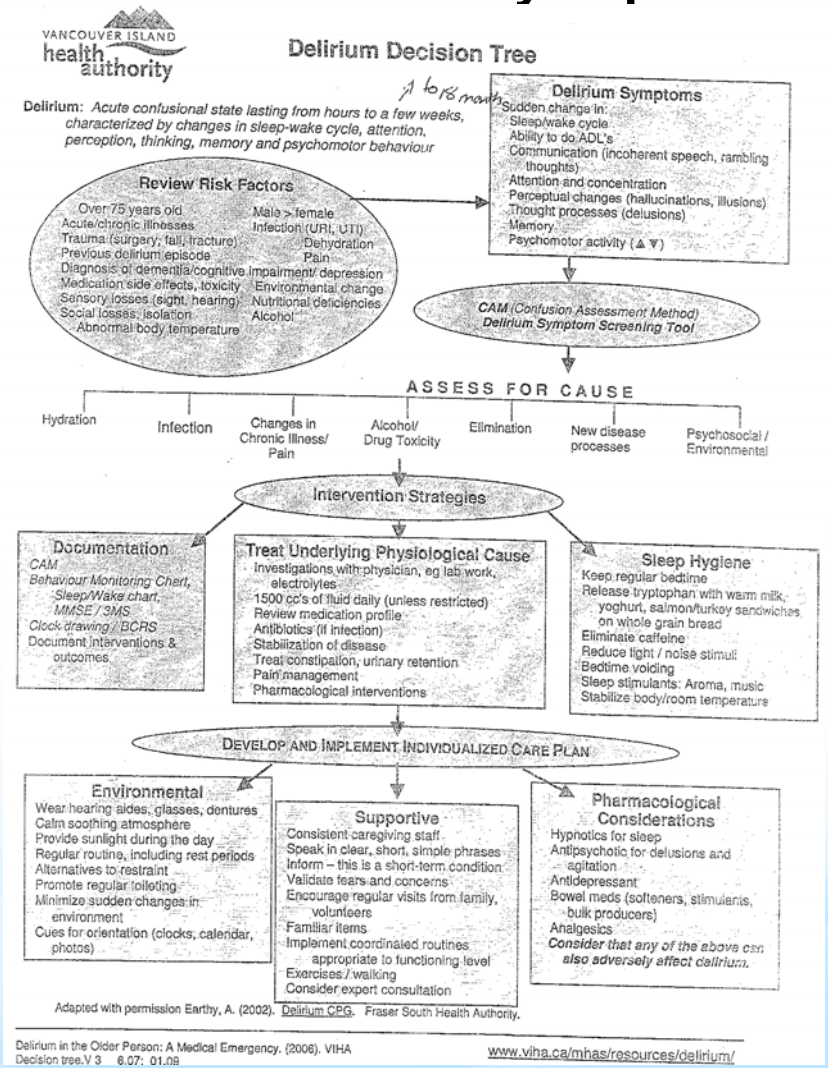
Delirium Screening Tool

Complete within 24 hrs of a SUDDEN CHANGE in behavior

Indicators	Behaviour before sudden change	SUDDEN CHANGES IN BEHAVIOUR (Describe)	Date/ Time/ Initial
SLEEP / AWAKE CYCLE	Wake time _____ Sleep time _____ Rest time _____ Toilet times _____		
ACTIVITIES OF DAILY LIVING (ADL)	☐ Total Care ☐ Needs assistance ☐ Independent		
COMMUNICATION	☐ Understands others ☐ Can be understood ☐ Dentures fit ☐ Can hear ☐ Can see		
ATTENTION/ CONCENTRATION	☐ Can focus during conversation/activity ☐ Easily directed ☐ Can complete a task		
PERCEPTIONS	☐ No misperceptions occur ☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Other _____		
MEMORY	☐ Good ☐ Fluctuates ☐ Poor short term ☐ Poor long term		
PSYCHOMOTOR	☐ Normal activity level ☐ Hyperactive ☐ Hypoactive ☐ Easily distracted Demeanor : ☐ calm ☐ irritable ☐ agitated		
NUTRITION	<table><tr><td></td><td>fluids</td><td>food</td></tr><tr><td>adequate</td><td></td><td></td></tr><tr><td>resists</td><td></td><td></td></tr><tr><td>poor</td><td></td><td></td></tr></table>		

Winchester District Memorial Hospital

Recommendation 1.5 Nurses, working with other disciplines, must select and record multi-component care strategies and implement them simultaneously to prevent delirium (III)



Winchester District Memorial Hospital

Future BPG Recommendations Implementation?

Winchester District Memorial Hospital

Recommendation 1.3 Nurses should initiate standard screening methods to identify risk factors for delirium in initial and ongoing assessments. (IIa)

At a minimum:

- Is there an acute change in mental status with a fluctuating course?
- Is there inattention (difficulty focusing)?
- Is there disorganized thinking? (rambling, disjointed)
- Is there an altered level of consciousness (coma, somnolent, drowsiness, hypervigilence)?

Winchester District Memorial Hospital

Recommendation 1.4 Nurses have a role in presentation of delirium and should target prevention efforts to each pts individual risk factors. (Ib)

The Hospital Elder Life Program (HELP) is a patient-care program that is designed to prevent delirium among hospitalized older patients. HELP does this by keeping hospitalized older people oriented to their surroundings, meeting their needs for nutrition, fluids, and sleep and keeping them mobile within the limitations of their physical condition.

The main components of the HELP resources comprise five instructional manuals – and accompanying DVDs, guides, and workbooks – which cover business planning, organizational procedures, the clinical program, data collection, and training. The website also provides a large amount of supporting material including clinical information on delirium, materials for patients and caregivers, benchmarking data, and customized tools and resources developed by member hospital sites who have implemented HELP.

Winchester District Memorial Hospital

Recommendation 6.1 Organizations should consider a variety of development opportunities to provide care for delirium

Gentle Persuasive Approach (GPA) Basics:

- An innovative, 4-module dementia-care curriculum based on a person-centred approach to care.
- Designed for interdisciplinary front-line staff across a variety of sectors,
- GPA Basics is delivered by 2 GPA Certified Coaches in a 7.5 hour day.
- The curriculum is evidence-based, interactive, and practical.
- The program guides participants to fully understand responsive behaviours, in order to be able to respond effectively and appropriately in a workplace setting.
- GPA Basics also includes respectful self-protective and gentle redirection techniques for use when catastrophic behaviours do occur.

Winchester District Memorial Hospital

Delirium: Prevention & Tools in ECU?

- http://www.icudelirium.org/delirium/monitoring.html
- Intensive Care delirium Screening Checklist

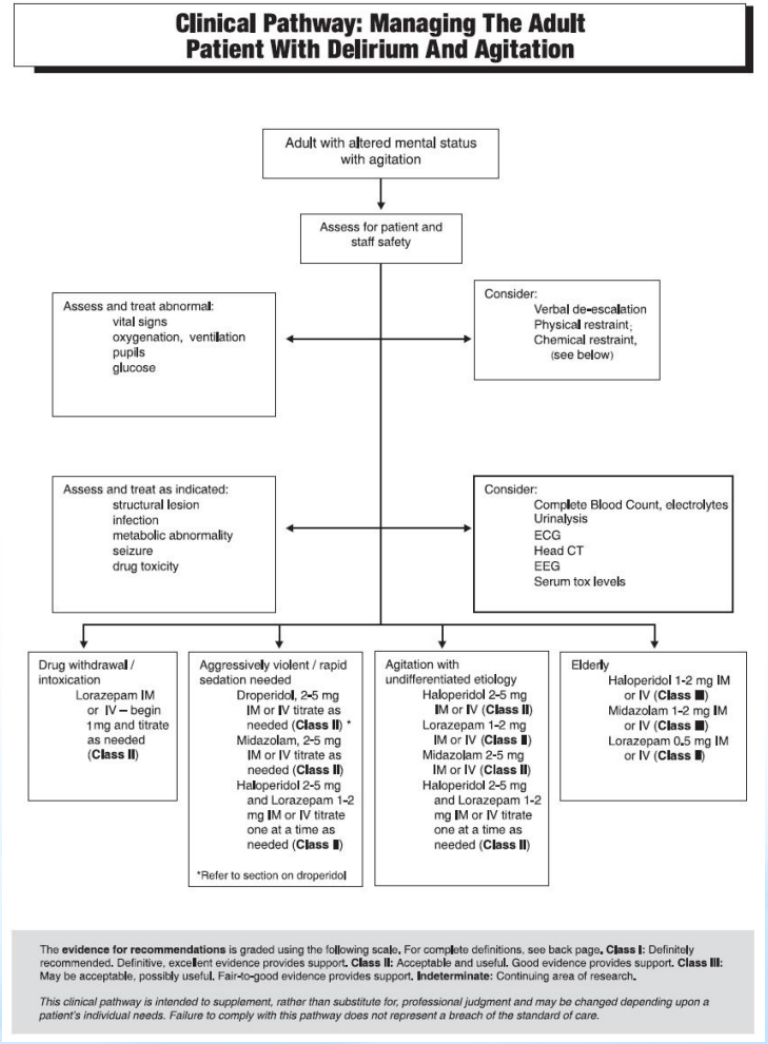
Winchester District Memorial Hospital

Delirium: Prevention & Tools in ED?

- To date, under-recognition of delirium, dementia and depression remains an issue. The
- American College of Emergency Physicians (1999) suggests that 40 % of clients over the age
- of 70 years and presenting to emergencies have altered mental status; 25 % with altered level
- of consciousness; 25 % with delirium; and 50 % with cognitive impairment. Given that
- nurses are providing care to an increasingly complex and older client population, it is
- suggested that best practice guidelines to assist in anticipating and managing delirium,
- dementia and depression be explored.

Winchester District Memorial Hospital

Delirium: Prevention & Tools in ED?



Clinical Pathway: Managing The Adult Patient With Delirium And Agitation

Adult with altered mental status with agitation

Assess for patient and staff safety

Assess and treat abnormal:
- vital signs
- oxygenation, ventilation
- pupils
- glucose

Consider:
- Verbal de-escalation
- Physical restraint;
- Chemical restraint, (see below)

Assess and treat as indicated:
- structural lesion
- infection
- metabolic abnormality
- seizure
- drug toxicity

Consider:
- Complete Blood Count, electrolytes
- Urinalysis
- ECG
- Head CT
- EEG
- Serum tox levels

Drug withdrawal / intoxication
- Lorazepam IM or IV – begin 1mg and titrate as needed (**Class II**)

Aggressively violent / rapid sedation needed
- Droperidol, 2-5 mg IM or IV titrate as needed (**Class II**) *
- Midazolam, 2-5 mg IM or IV titrate as needed (**Class II**)
- Haloperidol 2-5 mg and Lorazepam 1-2 mg IM or IV titrate one at a time as needed (**Class II**)

*Refer to section on droperidol

Agitation with undifferentiated etiology
- Haloperidol 2-5 mg IM or IV (**Class II**)
- Lorazepam 1-2 mg IM or IV (**Class II**)
- Midazolam 2-5 mg IM or IV (**Class II**)
- Haloperidol 2-5 mg and Lorazepam 1-2 mg IM or IV titrate one at a time as needed (**Class II**)

Elderly
- Haloperidol 1-2 mg IM or IV (**Class III**)
- Midazolam 1-2 mg IM or IV (**Class III**)
- Lorazepam 0.5 mg IM or IV (**Class II**)

The **evidence for recommendations** is graded using the following scale. For complete definitions, see back page. **Class I:** Definitely recommended. Definitive, excellent evidence provides support. **Class II:** Acceptable and useful. Good evidence provides support. **Class III:** May be acceptable, possibly useful. Fair-to-good evidence provides support. **Indeterminate:** Continuing area of research.

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Winchester District Memorial Hospital

What Does “It” Look Like?

- Framework?
- Delirium program?
- P&Ps?
- Packages in each department
- At orientation?

Winchester District Memorial Hospital

Monitoring & Evaluating -Baseline

Process	Rate of Baseline Delirium Screening
Description	**Percentage of patients (65 and older) receiving delirium screening using a validated tool upon admission to hospital**
Numerator	# of patients (65 and older) receiving at least one delirium screen within 48h of admission to hospital
Denominator	# of patients (65 and older) discharged/separated from hospital
Improvement Noted As	An increase in delirium screening rates
Data Source and/or Tool	Inpatient Units: Confusion Assessment Method (CAM) Intensive/Critical Care Units: CAM-ICU or Intensive Care Delirium Screening Checklist (ICDSC)
Exclusions	(1) Patients whose level of consciousness is (a) unresponsive or (b) requiring vigorous stimulation for a response (2) Patients in palliative care

Winchester District Memorial Hospital

Monitoring & Evaluating -Hospital Acquired

Outcome	Rate of Hospital Acquired Delirium
Description	**Incidence of delirium in patients (65 and older) acquired over the course of hospital admission**
Numerator	# of discharged patients (65 and older) who screen positive for delirium at any point during hospitalization after a negative baseline screen on admission
Denominator	# of patients (65 and older) discharged/separated from hospital with a negative baseline screen for delirium on admission
Improvement Noted As	A decrease in delirium incidence
Data Source and/or Tool	Inpatient Units: Confusion Assessment Method (CAM) Intensive/Critical Care Units: CAM-ICU or Intensive Care Delirium Screening Checklist (ICDSC)
Exclusions	(1) Patients whose level of consciousness is (a) unresponsive or (b) requiring vigorous stimulation for a response (2) Patients in palliative care
Considerations	Minimum frequency of screening to capture incidence – at least daily after the initial baseline screen

Winchester District Memorial Hospital