# Delirium: It Isn't Just a Phase

## Guidelines for Recognition and Care of Older Adults at Risk for Delirium

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## Phase 1: Incidence of Delirium on Two Units, Q4 of 2014

### Identification of Problem:

Delirium is a common syndrome in hospitalized older adults and is associated with increased mortality, hospital costs, and long-term cognitive and functional impairment (Siddiqi et al., 2006). Delirium can sometimes be prevented with the recognition of high-risk patients and implementation of a standardized delirium-reduction protocol (Bruera et al., 2009). Proactive nursing interventions are the first priority. Pharmacological agents appropriate for the geriatric patient should be the last resort of treatment. Recognition of risk factors and routine screening for delirium should be part of the older comprehensive nursing care of the adult (Milisen et al.,m 2005).

### Areas of Improvement:

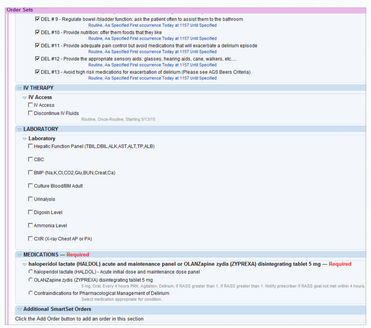
- TriHealth had 347 cases of delirium in 150 patients in the 4Q- 2014:
  - 56 patients experienced a secondary complication
  - 99 out of 150 patients received Lorazepam as the first line of treatment
  - 95 out of 150 patients were placed in restraints
  - 12 patients prolonged their discharge an average of 4 days
  - 14 out of 27 patients discharged to a nursing home came from independent living

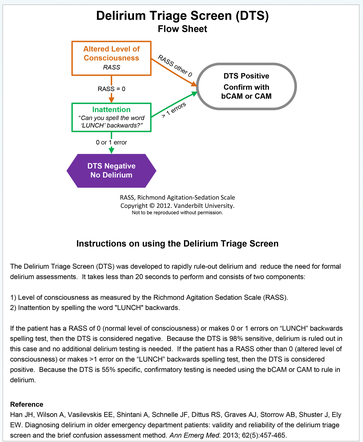
## Phase 2: Delirium Patient Care Guidelines:

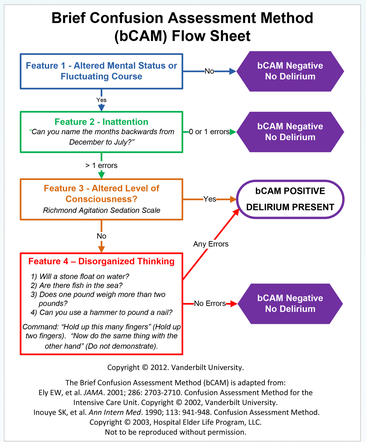
### Goals:

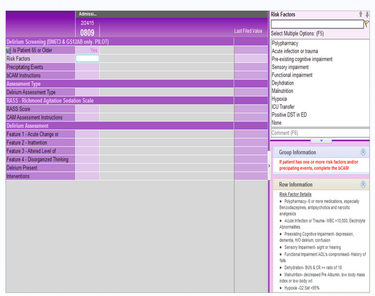
- Reduce the length of stay of a patient experiencing delirium
- Reduce the use of restraints
- Reduce the amount of benzodiazepines used on patients with delirium
- Increase support for the nurses treating a patient with delirium

### Overview:




## Phase 3: Implementation:

### Identification of Problem:

- Pilot on two Med-Surg units
- Re-evaluation of the workflow for the nurses and then rollout system wide once trial is complete
- Using geriatric resource nurses to serve as a resource for staff on the floor and to help evaluate the workflow
- Evaluate using an audit tool to determine the success of the goals being measured.
- Survey to the staff, nurse, and physician satisfaction.

### Education:

- ED staff - 30 min. live in service education, and the development of an SBAR tool to communicate risk factors.
- Med-Surg Staff- 1 ½ hour instructor led education for all RN's and PCA's using video scenarios.
- Physicians- treatment of delirium education in Medical grand rounds and in each section meeting.

Special thanks to the Bethesda North Geriatric Committee.

### Communication to staff about patient's at high risk or experiencing delirium:

- FLYING JAY- is placed outside the door for awareness
- Serves as a reminder for the nurses and patient care assistants to perform prevention interventions
- A way to communicate with environmental services that this patient is at high risk for delirium.

## Phase 4: Results

| | Baseline for Q4 2014 | March '15 | April '15 | May '15 | June '15 |
|---|---|---|---|---|---|
| # of Delirium Cases | 10-14 | 20/201 | 20/218 | 18/240 | 11/186 |
| Resolved with Nursing Interventions | NA | 15 | 10 | 8 | 4 |
| Restraint Usage | 57-69% | 9% | 10% | 0% | 0% |
| Physician Utilization of Order Set | NA | 50% | 75% | 100% | 90% |
| Lorazepam Usage | 88% | 0% | 25% | 0% | 18% |

### Outcome Improvements:

- Reduced average length of stay from 7 to 5 days
- Reduced prolonged length of stays from 4 to 2 days

### Nursing Evaluation:

- 67% of the nurses that did the evaluation, stated the guidelines added resources and provided better management for patients experiencing a delirium episode.
- 12% of the nurses that did the evaluation, felt it was a duplicate assessment.
- Overall, 78% of the nurses that did the evaluation, agreed that the delirium assessment and the delirium order set allowed them to provide competent care for the patient at risk for or experiencing delirium to improve the patient's outcomes.

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