Welcome!

- All lines are muted, so please ask your questions in Q&A.
- For technical issues, initiate chat with the Technical Support panelist.
- Please actively participate in polling questions that will appear on the lower right-hand side of your screen.

We will get started shortly!
Applying Evidenced-Based Best Practices to Prevent, Mitigate and Manage Delirium Across Care Settings: Part 2

February 24, 2022

Event Hosts:
Carolyn Kazdan, MHSA, LNHA
Christine Waszynski, DNP, APRN, GNP-BCFAAN
Making Health Care Better *Together*
Carolyn Kazdan, MHSA, NHA

SENIOR DIRECTOR, CARE COORDINATION AND NURSING HOME

Ms. Kazdan currently holds the position of senior director, health care quality improvement for IPRO, the Medicare Quality Improvement Organization for New York State. Ms. Kazdan leads IPRO’s work with Project ECHO® and serves as the care transitions lead for Alliant Quality. Ms. Kazdan previously led the IPRO’s work with the NYS Partnership for Patients and the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project on Transforming End of Life Care in Nassau and Suffolk County Region of New York State. Prior to joining IPRO, Ms. Kazdan served as a licensed nursing home administrator and interim regional director of operations in skilled nursing facilities and continuing care retirement communities in New York, Pennsylvania, Ohio and Maryland. In addition, Ms. Kazdan served as a senior examiner for the American Healthcare Association’s National Quality Award Program. Currently, she serves on the MOLST Statewide Implementation Team and Executive Committee. Ms. Kazdan was awarded a master’s degree in health services administration by The George Washington University.

Carolyn enjoys visiting her grandchildren, photography, crocheting, needlepoint, reading and being at the beach!

“Taking on a challenge is a lot like riding a horse, isn't it? If you're comfortable while you're doing it, you're probably doing it wrong.”
- Ted Lasso

Contact: ckazdan@ipro.org
Christine Waszynski, DNP, APRN, GNP-BCFAAN

COORDINATOR OF INPATIENT GERIATRIC SERVICES HARTFORD HOSPITAL HARTFORD CT

Christine is currently the coordinator of Inpatient Geriatric Services, ADAPT (Actions for Delirium Assessment, Prevention and Treatment), Age Friendly Health Systems inpatient project, the Hartford HealthCare Systemwide Fall Prevention Committee, and NICHE (Nurses Improving Care for Health system Elders) programs at Hartford Hospital in Hartford, Connecticut, where she functions in the role of geriatric nurse practitioner and clinical nurse specialist.

She received several awards for her innovative work in gerontological nursing and has published a book and numerous articles.

She is the principal investigator or co-investigator of several research studies focusing on interventions to improve the care of hospitalized older adults. In addition, she is a sought-after presenter at the local, regional, national and international levels on topics involving geriatric nursing, delirium and fall prevention.

She is the immediate past president of the American Delirium Society and serves on their Governance Committee and Board of Directors.

Contact: Christine.Waszynski@hhchealth.org
Objectives

Learn Today:
• Screening for delirium will increase early recognition.
• Delirium is a medical emergency that requires an interprofessional plan of care to identify the cause, maintain safety and prevent iatrogenic complications.

Use Tomorrow:
• Choose a screening tool that fits the care setting.
• Assemble an interprofessional team to role model delirium screening and prompt assessment and attention to etiology with supportive care.
Recap From Session #1

• Delirium is common (20% hospitalized pts; 20% post acute).

• Delirium is under-recognized (60% missed).

• Delirium is different from dementia (delirium = sudden change from baseline mental status + inattention).

• Hypoactive delirium is more common and harmful than hyperactive delirium.

• Delirium is harmful in the short- and long-term (mortality, permanent cognitive impairment, future dementia, falls, skin breakdown, prolonged hospitalization, hospital readmission, higher levels of care, PTSD, costs).

• Up to 40% of delirium is caused by missteps taken by the health care team (actions or lack of action).

• Some risk factors for delirium are modifiable (immobility, dehydration, inadequate nutrition, tethers, deliriogenic meds, sleep disruption, sensory loss).

• Use of evidence-based strategies can improve outcomes (less delirium, less complications, less mortality).

https://youtu.be/gpN_kY-7A2c
Delirium/Acute Encephalopathy Care Pathway

Confusion Assessment Method (CAM® or CAM-ICU®)

Element 1
Acute onset of mental status change from baseline or fluctuating mental status

Element 2
Apathy

Element 3
Altered level of consciousness

Element 4
Disorganized thinking

Potential Etiologies of Delirium
- Drugs
- Eyes, ears, environment, emotions
- Liver failure, low PO2 (MI, PE, anemia, CVA)
- Infection, immobility
- Restrains, respiratory
- Injury, ileal state
- Unfamiliar surroundings, under hydration
- Metabolic

Delirogenic Drugs to Limit/Avoid
- Diphenhydramine (Benadryl)
- Lorazepam (Ativan)
- Zolpidem (Ambien)
- Metoclopramide
- Promethazine
- Promethazine (Reglan, Phenergan, Complan)
- Fentanyl (Pavane)

Modified Richmond Agitation Sedation Scale (mRASS)

Potential Medications to Not Stop Abruptly
- Acetylcholinesterase inhibitors
- Antiepileptics
- Benzodiazepines
- Opioids/narcotics
- Sedatives/hypnotics
- SSRIs
- Steroids

Delirium and Acute Encephalopathy are associated with:
- Death
- Disability
- Deterioration and Discharge Difficulties

Save a Brain

Sponsored by ADAPT
Actions for Delirium Assessment Prevention and Treatment

Hartford Hospital
A Hartford Healthcare Partner
Delirium Screening

Several available tools:

Confusion Assessment Method (CAM); B-CAM; 3D-CAM

NuDESC; 4AT; Proxy test for delirium

Single Question in Delirium (SQID); UB2: Delirium Triage Screen (DTS)

CAM-ICU; Intensive care Delirium Screening Checklist (ICDSC)

4-DSD

https://deliriumnetwork.org/measurement/delirium-info-cards/


Considerations for tool selection:

Most often administered by nursing

Population to screen: all patients versus those at highest risk for delirium; adult versus pediatric

Setting: ICU, general inpatient, ED, post-acute, LTC, ambulatory care

Time to complete

Frequency of screening
Confusion Assessment Method (CAM Tool) – Based on DSM IV Criteria = Gold Standard

#1: Acute change from baseline or fluctuating mental status

#2: Inattention

#3: Altered LOC (RASS Score)

#4: Disorganized thinking
   Delirium = 1+2+3 or 4 (CAM+)

Inouye et al, 1990, Copyright 2003. Hospital Elderlife Program
4AT Delirium Screening *MacLullich et al, 2019, NIHR Journal*

- Alertness
- AMT4 (orientation)
- Attention
- Acute Change or Fluctuating Course
Audience Participation Question

Baseline mental status is:

A. A description of the patient’s cognitive abilities at the beginning of the shift.

B. A description of the patient’s cognitive abilities at the beginning of the hospital or post-acute admission.

C. A description of the patient’s cognitive abilities in the emergency department.

D. A description of the patient’s cognitive abilities in their current living situation when the patient is not ill or injured.
Are you sure that this is my baseline mental status?

Have you documented your patient’s baseline mental status upon admission/encounter?

Baseline mental status = Cognitive performance when the patient is not sick/injured prior to admission/encounter.

- No deficits
- Mild memory problems (misplaces items, needs reminder list)
- Significant memory problems (forgets names, gets lost)
- Difficulty completing complex tasks (cooking, driving, finance)
- Inappropriate behavior (specify)
- Delusions
- Hallucinations (document all that apply to the patient)
A 91-year-old female is an injured passenger in a MVA and is unable to state the date or her address correctly in the ED.

What sources might be available to learn about this patient’s baseline mental status?

A. The driver of the vehicle.
B. The staff at the assisted living where she lives.
C. A note in the EHR from her primary care providers documenting her last Medicare annual wellness visit.
D. A note in the EHR from a hospital admission three months ago.
E. All of the above.
Standardized Cognitive Assessment Screening Tools

Need to administer when the patient is not ill or injured to document baseline mental status.

Can be re-administered routinely over time or during an acute event to detect change.

Mini-Cog©
Quick Screening for Early Dementia Detection

MOCA – Montreal Cognitive Assessment

SLUMS – St. Louis University Mental Status
# Ultra Brief 2 Item Screener for Delirium

**Instructions:** Administer items in order specified. Direct questions of patients are *shown in italics*.
- A positive sign for delirium is any incorrect, don't know, non-response, or non-sensical response.
- CAM features 1-4 are indicated with F1, F2, F3, F4, respectively.

<table>
<thead>
<tr>
<th>Severe lethargy or severe altered level of consciousness</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Severe lethargy or severe altered level of consciousness (no or minimal response to voice/touch). If present, terminate assessment and ratings. Patient is considered DELIRIOUS. If not present, proceed to UB-2 Screener.</td>
<td>☐</td>
</tr>
</tbody>
</table>

**UB-2 Screener**

<table>
<thead>
<tr>
<th>2 Ask both questions</th>
<th>Check if sign positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please tell me the day of the week (F3)</td>
<td>☐</td>
</tr>
<tr>
<td>Please tell me months of the year backwards, say &quot;December&quot; as your first month (F2)</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Checkpoint:**
- If neither sign is positive/checked, STOP: patient is NOT DELIRIOUS
- If at least one sign is positive/checked, proceed to next section (3) and follow as directed

Positive UB-2 ➔ 3-D CAM
Delirium Is a Medical Emergency
“Acute Brain Failure”

It is the:

- “Heart Attack” of Cardiology
- “Pulmonary Embolism” of Pulmonary
- “Sepsis” of Infectious Disease
- “Perforated Bowel” of GI
- “Diabetic Coma” of Endocrine
- “Hot Joint” of Rheumatology
- “Prostate Cancer” of Urology
Delirium ISBAR

**Introduction:** This is ______________________ calling from ______________________

**Situation:**
I am calling about ______________________ (patient).
He/She has had a change in mental status and is scoring positive on the CAM.
(Describe when this change occurred and what has changed such as symptoms, illness, injury, medical condition)

**Background:**
He/She was admitted on ______________________ (date) for ______________________ (history)
His/Her baseline mental status is ______________________
(alert, oriented, calm, cognitive screen score if available such as BIMS or MMSE score)

**Assessment:**
Vital signs: ______________________
Current mental status: (Use CAM to describe): ______________________
Physical assessment findings: ______________________
Nutrition and hydration: ______________________
Recent labs: ______________________
Pain: ______________________
Medication list, recent changes: ______________________
Potential etiologies of delirium: ______________________ (see delirium pathway)

**Recommendation:**
______________________
Determining the Underlying Etiology of Delirium

Drugs
Eyes, ears, environment, emotional
Liver failure, low PO2 states (MI, PE, anemia, CVA)
Infection, immobility
Restraints, respiratory, retention
Injury, ictal state
Unfamiliar surroundings, underhydration
Metabolic abnormalities
Building Your Team

Members to consider:
✓ Nursing (leadership, educators and bedside nurses and nursing assistants)
✓ Providers (leadership and clinician MDs, APPs)
  - hospitalists/specialists/geriatricians/neurologists/psychiatrists
✓ Rehabilitation (PT, OT, RT, ST)
✓ Physiatrist
✓ Palliative Care
✓ Social Work
✓ Care coordination
✓ Administration
✓ IT
✓ Volunteers
✓ Pastoral Care
✓ Nutritionist
✓ Pharmacist
Contact Information

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Objectives Check In!

Learn Today:

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Use Tomorrow:

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- Assemble an interprofessional team to role model delirium screening and prompt assessment and attention to etiology with supportive care.

How will this change what you do? Please tell us in the poll.
Closing Survey

Help Us Help You!

• Please turn your attention to the poll that has appeared in the lower right-hand side of your screen.
• Completion of this survey will help us ensure our topics cater to your needs.
CMS 12th SOW Goals

**Behavioral Health Outcomes & Opioid Misuse**
- Promote opioid best practices
- Decrease high dose opioid prescribing and opioid adverse events in all settings
- Increase access to behavioral health services

**Patient Safety**
- Reduce risky medication combinations
- Reduce adverse drug events
- Reduce C. diff in all settings

**Chronic Disease Self-Management**
- Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- Identify patients at high-risk for developing kidney disease & improve outcomes
- Identify patients at high risk for diabetes-related complications & improve outcomes

**Quality of Care Transitions**
- Convene community coalitions
- Identify and promote optical care for super utilizers
- Reduce community-based adverse drug events

**Nursing Home Quality**
- Improve the mean total quality score
- Develop national baselines for health care related infections in nursing homes
- Reduce emergency department visits and readmissions of short stay residents
Making Health Care Better Together

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## Upcoming Events

### Learning and Action Webinars

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 15, 2022</td>
<td>Combined Community Coalition &amp; Nursing Home LAN: Applying evidenced-based best practices to prevent, mitigate and manage delirium across care settings: Part 3</td>
</tr>
<tr>
<td>April 19, 2022</td>
<td>Combined Community Coalition &amp; Nursing Home LAN: Applying evidenced-based best practices to prevent, mitigate and manage delirium across care settings: Part 4</td>
</tr>
</tbody>
</table>

Stay tuned for more events!

[https://quality.allianthealth.org/virtual-educational-events/](https://quality.allianthealth.org/virtual-educational-events/)