Applying Evidenced-Based Best Practices to Prevent, Mitigate and Manage Delirium Across Care Settings: Part 2

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!

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Applying Evidenced-Based Best Practices to Prevent, Mitigate and Manage Delirium Across Care Settings: Part 2

Event Hosts:
Carolyn Kazdan, MHSA, LNHA
Christine Waszynski, DNP, APRN, GNP-BCFAAN

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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.

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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

https://youtu.be/gpN_kY-7A2c

- 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).

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

AND

Element 2

Inattention

AND either

Element 3

Altered level of consciousness Rass ≠ 0

OR

Element 4

Disorganized thinking

⊕ Positive = 1 + 2 + 3 OR 4

Unable to assess = *RASS or mRASS -4 or -5*

Modified Richmond Agitation Sedation Scale (mRASS)

+4	Combative	No attention, overly combative, violent, immediate danger to staff
+3	Very Agitated	Pulls tube(s) or catheter(s); fights environment/not people, difficult to get patient to pay or sustain attention
+2	Agitated	Frequent non-purposeful movement, uncooperative, loses attention rapidly
+1	Restless	Anxious but movements not aggressive or vigorous, cooperative, pays attention most of the time
0	Alert and Calm	Pays attention, makes eye contact, responds immediately
-1	Wakens Easily	Not fully alert, but has sustained awakening > 10 sec. Slightly drowsy
-2	Wakens Slowly	Briefly awakens with eye contact to voice < 10 sec. Very drowsy
-3	Difficult to Awaken	Movement or eye opening to voice but no eye contact
-4	Can't Stay Awake	No response to voice but displays movement or eye opening to physical stimulation. Arousable but no attention
-5	Unarousable	No response to voice or physical stimulation

(Chester, Harrington & Rudolph, 2012)

Potential Etiologies of Delirium

Drugs
Eyes, ears, environment, emotions
Liver failure, low PO_2 (MI, PE, anemia, CVA)
Infection, immobility
Restraints, respiratory
Injury, ictal state
Unfamiliar surroundings, under hydration
Metabolic

Deliriogenic Drugs to Limit/Avoid

Diphenhydramine *(Benadryl)*	*Alternative for allergic Rx is Claritin (Loratadine)*
Lorazepam *(Ativan)*	*Use only in patients dependent upon benzodiazepines or with potential ETOH withdrawal or terminal delirium*
Zolpidem *(Ambien)*	*Use 2.5 mg at bedtime if nonpharmacological measures fail*
Metaclopramide Promethazine Prochlorperazine *(Reglan, Phenergan, Compazine)*	*Alternative is Ondansetron (Zofran)*
Famotidine *(Pepcid)*	*Alternative is PPI except with Plavix, or Pantoprazole (Protonix)*
Fentanyl	*Alternative is Hydromorphone (Dilaudid), Acetaminophen (Tylenol), or Tramadol (Ultram)*

Medications to Not Stop Abruptly

- Acetylcholinesterase inhibitors
- Antiepiletics
- Benzodiazepines
- Opioids/narcotics
- Sedatives/hypnotics
- SSRIs
- Steroids

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

Delirium & Acute Encephalopathy Care Pathway

Save a Brain

Sponsored by ADAPT
Actions for Delirium Assessment Prevention & 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/

https://americandeliriumsociety.org/ags-cocare-cam-and-help-tools/

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

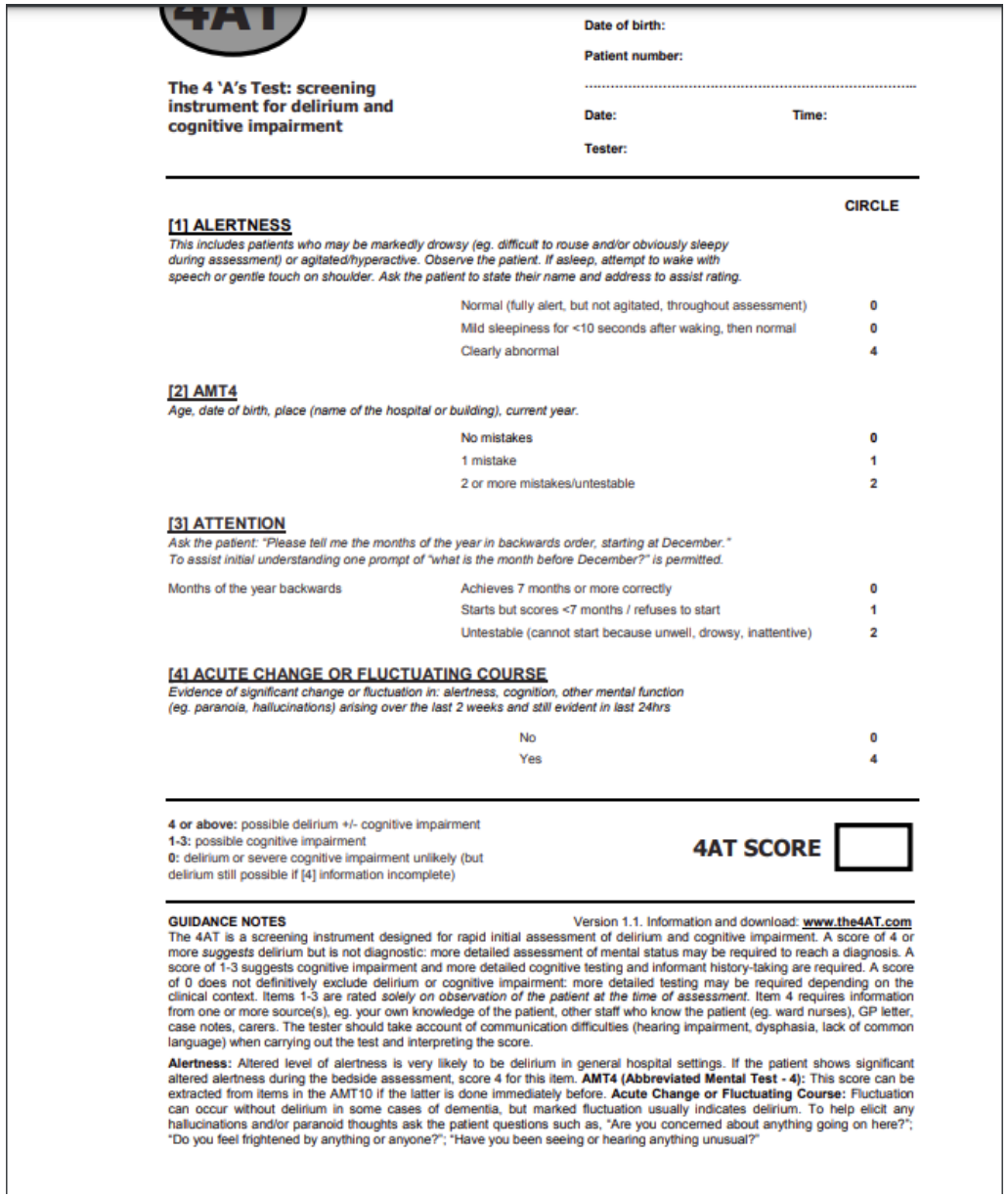
#3: Altered LOC (RASS Score)

#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*



4AT

Date of birth:

Patient number:

The 4 'A's Test: screening instrument for delirium and cognitive impairment

Date: Time:

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	0
Mild sleepiness for <10 seconds after waking, then normal	0
Clearly abnormal	4

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	0
1 mistake	1
2 or more mistakes/untestable	2

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores <7 months / refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	0
Yes	4

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE

GUIDANCE NOTES Version 1.1. Information and download: **www.the4AT.com**

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment*. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

- 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.

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

Are you sure that this is my baseline mental status?

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)

Audience Participation Question

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.

	Severe lethargy or severe altered level of consciousness	Check
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.	☐

	UB-2 Screener	Check if sign positive
2	**Ask both questions**	
	Please tell me the day of the week (F3)	☐
	Please tell me months of the year backwards, say "December" as your first month (F2)	☐

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:

_____

_____

_____

SBAR

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Provider Delirium Note

Asked to see patient due to: _____

Patient presents with: _____

_____

Exam:

Cognitive	Yes	No	
CAM 1+2+either 3 or 4 = delirium	☐	☐	1) Altered mental status from baseline
	☐	☐	2) Inattention (20 ↔ 1; days of the week ↔; "A" test)
	☐	☐	3) Altered LOC (~~hyperalert~~/agitated; drowsy/lethargic) RASS
	☐	☐	4) Disorganized thinking (disoriented, impaired memory, unsure of why in hospital, disjointed thoughts)

Mini Cog	Check appropriate box			
Repeats	☐ 3 words	☐ 2 words	☐ 1 word	☐ 0 words
Recalls	☐ 3 words	☐ 2 words	☐ 1 word	☐ 0 words
Clock Drawing	☐ #'s in correct order and spacing is correct			
	☐ #'s in correct order but incorrectly spaced			
	☐ #'s are incorrect			
	☐ Hands correct	☐ Hands incorrect		

Risk Factors:				CIWA (if ETOH withdrawal is an issue)	
Yes	No	Unk		☐ N/V (0-7)	☐ Tactile disturbance (0-7)
☐	☐	☐	Dementia/pre-existing baseline cognitive impairment	☐ Tremor (0-7)	☐ Auditory disturbance (0-7)
☐	☐	☐	Age 65 or greater	☐ Paroxysmal sweats (0-7)	☐ Visual disturbance (0-7)
☐	☐	☐	Active substance abuse	☐ Anxiety (0-7)	☐ Headache (0-7)
☐	☐	☐	History of delirium	☐ Agitation (0-7)	☐ Disorientation (0-4)
☐	☐	☐	Significant sensory deficit (vision/hearing)	Score = _____	

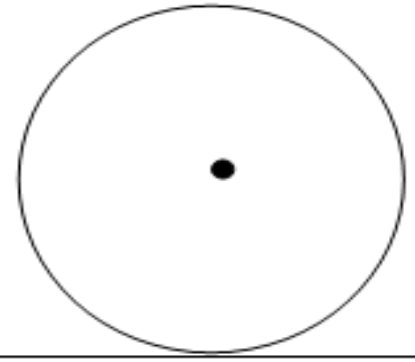
Medication Review:			Acute Medical Issues:		
Yes	No		Yes	No	
☐	☐	Diphenhydramine/Benadryl (or other anticholinergics)	☐	☐	Infection (UTI, Pneumonia, Skin, other)
☐	☐	Ativan/Lorazepam (or other benzodiazepine)	☐	☐	Cardiovascular (MI, CHF, arrhythmia, severe anemia)
☐	☐	Ambien/Zolpidem (or other sedative/hypnotic)	☐	☐	Respiratory (COPD exacerbation, hypoxia, PE)
☐	☐	Reglan/~~Metoclopramide~~ (or other antiemetic)	☐	☐	Electrolyte abnormality (Na, K, ~~Bloos~~, Mg, dehydration)
☐	☐	Pepcid/Famotidine (or other H_2 blocker)	☐	☐	Neuro (head injury, CVA)
☐	☐	Fentanyl, Morphine sulfate (or other narcotic)	☐	☐	Uncontrolled pain
☐	☐	Steroids	☐	☐	Malignancy
☐	☐	Other, specify:	☐	☐	Other, specify:

Physical Exam:

Vital Signs	T: ____	AR: ____	RR: ____	BP: /	Pulse Ox:	% on FIO2:	Last BM:	Last UO:
	Pain:							
Neuro	☐ CN intact	☐ DTR intact	☐ Sensory intact		Abnormalities:			
Cardiac	☐ S_1 S_2 RRR				Abnormalities:			
Chest	☐ Lungs clear				Abnormalities:			
Abdomen	☐ Abdomen non-tender	☐ Bowel sounds present			Abnormalities:			
Other:								

Impression	Delirium ☐ hyperactive ☐ hypoactive ☐ mixed related to:
	☐ Infection
	☐ Pain
	☐ Hypotension/Hypo-perfusion
	☐ _____ Withdrawal
	☐ Hypoxia
	☐ Medication _____
	☐ Metabolic _____
	☐ Other _____
	☐ Unknown_____

Set time to ten minutes after eleven.☐



Plan:

Further Work-Up						
Studies: Standard	☐ CBC	☐ ~~Chem~~ 10	☐ Glucose	☐ UA – reflex to culture		
	☐ TSH	☐ B12	☐ Folate	☐ EKG	☐ Serum drug levels (PRN)	
Additional PRN	☐ RPR	☐ Ammonia	☐ ABG	☐ Albumin	☐ Cardiac enzymes	
	☐ LFTs	☐ Bilirubin	☐ INR	☐ CXR	☐ Ultrasound	
	☐ MRI	☐ Head CT	☐ LP	☐ EEG	☐ ~~Tox~~ Screen (serum or urine)	
	☐ Free T4	☐ ~~Sed~~ Rate	☐ Other, specify:			

- ☐ Fall Precautions
- ☐ Aspiration Precautions
- ☐ Maximum mobilization
- ☐ Bladder Scan for PVR and straight ~~cath~~ if greater than 300mL
- ☐ CIWA at least every 4 hours (if ETOH withdrawal is an issue)
- ☐ Keeping In Touch Volunteers
- ☐ Art Volunteers
- ☐ Meal Mates
- ☐ Pet Therapy
- ☐ Hourly Intentional Rounding
- ☐ Gerontology Consult (if ~~pt~~ is age 65+; not responding to standard interventions)
- ☐ Psychiatry Consult (if pt is < age 65 and not responding to standard interventions or age 65+ with psych co-morbidities)
- ☐ Palliative Medicine Consult
- ☐ Neurology Consult
- ☐ Geriatric RN Consult
- ☐ Pastoral Consult
- ☐ Social Work Consult

Medications:

- ☐ Pain medication: _____
- ☐ Electrolyte replacement: _____
- ☐ Electrolyte replacement: _____
- ☐ Oxygen to keep O_2 sat ≥ 92%
- ☐ Haldol IV
- ☐ Seroquel PO

FOR ETOH WITHDRAWAL: (Follow Alcohol Withdrawal Protocol)

Gabapentin

- ☐ Ativan
- ☐ Folate 1mg oral daily
- ☐ Thiamine 100mg oral daily
- ☐ Multivitamin 1 tab oral daily

☐ **Communication:**

☐ **Attending:** _____

☐ **RN:** _____

☐ **Family:** ☐ **Explained condition** ☐ **Invited to participate in care**

Signature: _____ **Date:** _____ **Time:** _____

Determining the Underlying Etiology of Delirium

Lecturi.com

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:

- 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.

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

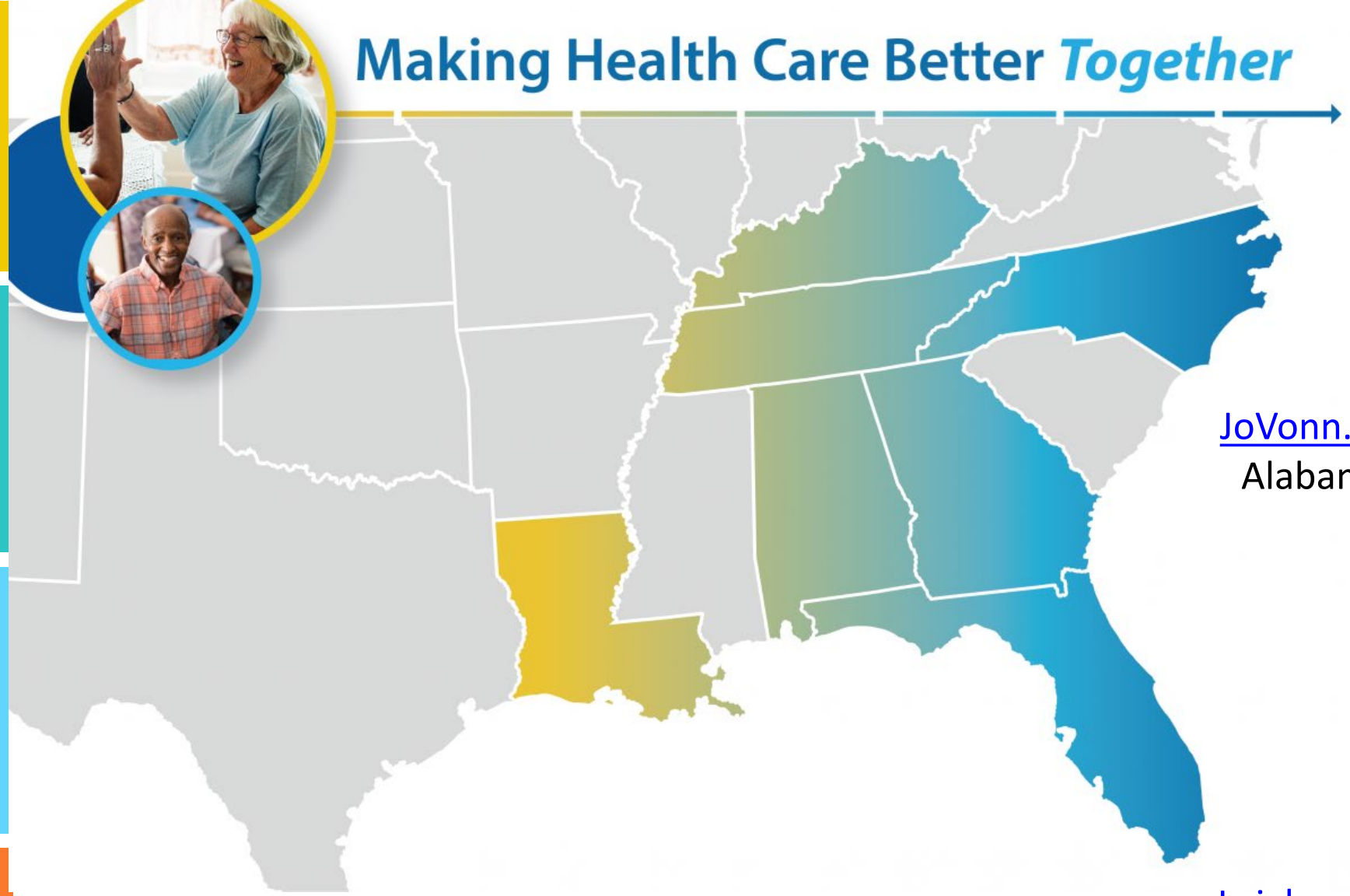
- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve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



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Upcoming Events

Learning and Action Webinars

March 15, 2022: Combined Community Coalition & Nursing Home LAN: Applying evidenced-based best practices to prevent, mitigate and manage delirium across care settings: Part 3
April 19, 2022: Combined Community Coalition & Nursing Home LAN: Applying evidenced-based best practices to prevent, mitigate and manage delirium across care settings: Part 4
Stay tuned for more events! https://quality.allianthealth.org/virtual-educational-events/

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