Community Coalition Delirium Toolkit:
QUICK REFERENCE GUIDE

This resource is designed to provide a snapshot of key components of delirium management based on the Delirium Education Cards created by the American Delirium Society (https://americandeliriumsociety.org/assets/documents/DeliriumEdCards.pdf). This tool can be used as a framework for evaluating existing programming and the development of new delirium programming. Additional delirium tools and resources and information on prevention, identification and management can be found at (https://quality.allianthealth.org/topic/delirium/).

Recommendations:

- Use as one element of a comprehensive staff education program by incorporating into new staff orientation, annual competency training and competency assessment, and/or individualized staff performance improvement plans.
- Use in developing individualized, person-centered care plans to prevent or manage delirium.
- Use with the Confusion Assessment Method (CAM) (https://americandeliriumsociety.org/ags-cocare-cam-and-help-tools/) to engage families and care partners in the identification and reporting of signs and symptoms, and in the implementation of care plan interventions.
- Engage your Patient and Family Advisory Council in the development and review of materials and programming. Consider the health literacy of the target audience.

  Resources: **CDC Guide for Improving Health Literacy of Older Adult**
  https://www.cdc.gov/healthliteracy/pdf/olderadults-508.pdf
  CMS Outreach and Written Materials Toolkit
  https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit
- Establish a schedule for review and update of this resource as new or revised risk factors, prevention measures or medications are identified, and to ensure alignment with your facility specific clinical pathways and practices.
- Consider utilization as part of an overall strategy to align with the mentation goals of the IHI Age Friendly Health System program. (http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx)

Risk Factors On Admission

- Age ≥ 65 years
- Impaired Cognitive Function
- Vision / Hearing Loss
- Severe Illness
- Fracture
- Infection

Differential Diagnosis

D Drugs
See list of Potentially Toxic Medications
E Electrolytes
Na, Ca, BUN, glucose
L Lack of Drugs
pain, EtOH, Rx meds
I Infection
UTI, Asp PNA
R Reduced Sensory Input
restraint, hearing, vision
I Intracranial (rare)
meds, seizure, stroke
U Urinary Retention
fecal impaction, meds
M Myocardial
PE, MI, CHF

Prevention Measures

IMPROVE ORIENTATION
- Introduce self, role, & location at every patient encounter
- Orientation Board

IMPROVE COGNITIVE STIMULATION
- Vision - Glasses
- Hearing - Portable Amplifier
- Taste – Nutrition
- Touch – Preserve mobility
- Thought - Books, puzzles, games

IMPROVE/PRESERVE MOBILITY
- Reduce foley / IV / restraints
- Encourage ambulation PT/OT

PRESERVE THE SLEEP – WAKE CYCLE
- Minimize nighttime interruptions
- Lights out / Close Doors
- Daytime stimulation

Attention Testing

Months of the year backwards
< perfect = deficit

Serial sevens
< perfect = deficit

Digit span backwards
Say these numbers backwards:

4 – 2

6 – 4 – 9

8 – 5 – 3 – 7

<4 backwards = deficit

Potentially Toxic Medications

- **BENZODIAZEPINES**
  diazepam, lorazepam, ambien
- **ANTIHISTAMINES**
  diphenhydramine, chlorphenhydramine, cimetidine, Anticholinergics, oxybutynin, belladonna, cyclobenzaprine hyocysamine, meclizine, scopolamine
- **PAIN MEDICATIONS**
  meperidine, propoxyphene, opioids, indomethacin
- **ANTIDEPRESSANTS**
  amitriptyline, imipramine, paroxetine
- **ANTIPSYCHOTICS**
  chlorpromazine, thioridazine, olanzapine
- **CARDIAC DRUGS**
  amiodarone, lidocaine, digoxin
- **NEUROLOGIC**
  phenobarbitol, dilantin, carbamazepine, dopamine

Sample Action Steps for Implementation

Recommendation	Next Steps	Process Owner	Target Date
Alignment with facility delirium clinical pathways and practices	*Review with Medical Director* *Schedule for review and approval by QI/QAPI Committee*	*Director of Nursing*	*2 weeks post decision to utilize* *Next QI/QAPI meeting*
Incorporate into staff education	*Review existing staff education programs and identify opportunities for incorporating content* *Identify dissemination strategy:* • *Post on Units* • *Discuss during huddles x 2 weeks*	*Staff Educator*	*1-2 weeks post decision to utilize* *1-3 weeks post QI/QAPI approval*
Utilize in Care Plan Development	*Educate Nurse Managers as train the trainers* *Develop strategy for staff training and use in care plan development and updates*	*TBD*	*TBD*

Delirium Toolkit:
QUICK REFERENCE GUIDE
PRE AND POST LEARNING ASSESSMENT

Recommendations:

- Utilize this learning assessment tool before and after review of the Delirium Quick Reference Guide to document understanding and identify additional learning needs.

Name of Individual completing the Pre-Learning Assessment: _____

Date of Pre-Learning Assessment: _____ ID Number (if required): _____

Pre-Learning Assessment

1. The primary risk factors to identify delirium on admission are: Age > 75, Impaired Cognitive Function, Vision/Hearing Loss, Severe Illness, Fracture, and Infection.	☐ True	☐ False
2. Introducing yourself, your role, and current location with each interaction will help prevention and improve orientation.	☐ True	☐ False
3. It is safer to try to discourage ambulation and movement for a patient/resident with delirium due to an increased risk of falls with injury.	☐ True	☐ False
4. Taste and Nutrition are both cognitive stimulation strategies for delirium prevention.	☐ True	☐ False
5. Cardiac medications are among the classifications of medications that can result in an individual being at greater risk for developing delirium.	☐ True	☐ False
6. The 3 key attention tests for delirium identification are serial 7s, the clock test and months of the year backwards.	☐ True	☐ False

Pre-Learning Assessment Score: _____

Post-Learning Assessment

1. Urinary tract infection but not urinary retention can lead to delirium if not identified and treated.	☐ True	☐ False
2. The primary risk factors to identify delirium on admission are: Age > 65, Impaired Cognitive Function, Vision/Hearing Loss, Severe Illness, Fracture, and Infection.	☐ True	☐ False
3. Providing an individual with glasses, hearing aid or amplifier and/other appliances that are required for appropriate communication can help prevent and reduce the risk for development of delirium by improving cognition and orientation.	☐ True	☐ False
4. It is not necessary to review an individual's co-morbidities, history, or lab work to determine best treatment approach as it does not matter what caused the delirium. It is only important that delirium is identified.	☐ True	☐ False
5. Delirium should be considered as diagnosis for any resident that has sudden onset, and/or fluctuations in their ability to pay attention.	☐ True	☐ False
6. The 3 key attention tests for delirium identification are serial 7s, the clock test and digital span backwards.	☐ True	☐ False

Post-Learning Assessment Score: _____

Pre-Learning Assessment Answer Guide

1. The primary risk factors to identify delirium on admission are: Age > 75, Impaired Cognitive Function, Vision/Hearing Loss, Severe Illness, Fracture, and Infection.	☐ True	☒ False
2. Introducing yourself, your role, and current location with each interaction will help prevention and improve orientation.	☒ True	☐ False
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