TAKING A GOOD IDEA & MAKING IT GREAT:

MOVING TOWARD A HOLISTIC APPROACH TO PREVENT & TREAT DELIRIUM IN THE ACUTE CARE HOSPITAL SETTING

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Why?

- An 84yo female with delirium was administered lorazepam 2mg for getting up to use the bathroom….
- A 70yo male with delirium was administered a total of 17mg of IV or IM haloperidol within 2.5 hours on a night shift, after receiving multiple doses of Lortab….
- A 91yo female, morbidly obese, received 100mcg of IV fentanyl intra-operatively, a total of 20mg of morphine post-operatively, and then lorazepam 5mg for management of her delirium….

Background

Driven by concern identified by the Acute Care for the Elderly (ACE) consultation service and utilizing the Geriatric Subcommittee of the Pharmacy & Therapeutics committee (guides / evaluates policy and practice at the hospital) as a vehicle, we endeavored to improve care with the hospitalized older adult in the medical-surgical setting by standardizing and reorganizing the workflow surrounding the assessment, prevention, and management of delirium. The existing "delirium protocol" was medically driven, with strong emphasis on medication orders and diagnostic studies; the order set lacked the opportunity for individualization and did not promote family/caregiver involvement - the new protocol was intended to be "Nurse-empowered." The Geriatric Subcommittee - consisting of an NP, RNs, MDs, and Pharmacists, with the input of Nutrition, IT, and Nurse Education professionals - developed a new protocol to enhance quality of care and safety, while decreasing delirium prevalence. An educational module was also developed for licensed and unlicensed staff, using a case-based approach.

Method

The policy, procedure, and order set were reviewed by the Geriatric Subcommittee: the originating group (the Delirium Task Force) no longer existed. A literature review was conducted to incorporate the most up-to-date research and validated practice. Aforementioned disciplines (and numerous administrators!) were consulted for feedback at every step, and final drafts of the policy, procedure, and educational module were posted to Blackboard for institution-wide perspective. Lessons were learned regarding navigating the process of implementing change in a multi-tiered administrative model.

Proposed Practice Changes

- Screening Tool: NuDESC to CAM, with assessment per change in caregiver (to correspond with existing documentation and assessment policies), and communication to responsible prescriber if change in mental status from baseline suspected.
- Validated nursing interventions for prevention and management of delirium moved to EPIC workflow, with Row Info incorporating risk factors for delirium development (e.g. advanced age, sex, polypharmacy, etc.) and suggesting strategies to implement.
- Opportunity for free text in work flow to accommodate individual preferences / family preferences.
- Delirium order set was simplified, with redundancies removed, and medication suggestions organized by heading (e.g. Pain, Sleep, Agitation, etc.), appropriate dose selections available, a caution about benzodiazepine use, and a prompt to implement nonpharmacological means prior to administering antipsychotics.

Outcomes

Pending implementation, May 1st, 2017.

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