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## Paving the Way to Excellence in Delirium Care

TRIHEALTH  
 BETHESDA NORTH HOSPITAL  
 CINCINNATI, OH

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APRIL 26, 2017

POSTER PRESENTER  
 Crystal Holton, BSN, RN-BC, CMSRN  
 NICHE Coordinator

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### Bethesda North Hospital

- 375 Beds
- Magnet designated
- 67% of admissions are 65 years or older
- NICHE designated since 2014
- Multidisciplinary Geriatric Committee
- Exemplar status
- Top 100 Hospital (Thompson Reuters)
- Part of the Trihealth health system, one of the largest health systems in the Cincinnati area

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### What is Delirium?

Characterized by:

1. Reduced ability to focus
2. Memory impairment, disorientation or illusions
3. Hallucinations
4. Perceptual disturbances or misperceptions of stimuli
5. Hyperactive, hypoactive or mixed

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### Precipitating Factors for Delirium

1. Polypharmacy
2. Malnutrition
3. Physical Restraints
4. Bladder Catheter
5. Untreated pain
6. Relocation

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### Consequences of Delirium

1. Increased Mortality
2. Post-op complications
3. Longer hospital stay
4. New nursing home placement
5. Increased healthcare costs
6. Distress for family, patient and hospital staff

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### Geriatric Committee's Role

1. Identified need for delirium assessment and interventions for patients 65 and older
2. Identified trends in restraint and Ativan usage for confused patients
3. Chose to use DTS and bCAM as assessment tools (CAM already in use in ICU)
4. Pilot unit determined to be orthopedic medical surgical floor due to high geriatric population
5. Education completed hospital-wide through e-learning and classroom instruction
6. Delirium analysis tool developed to track progress

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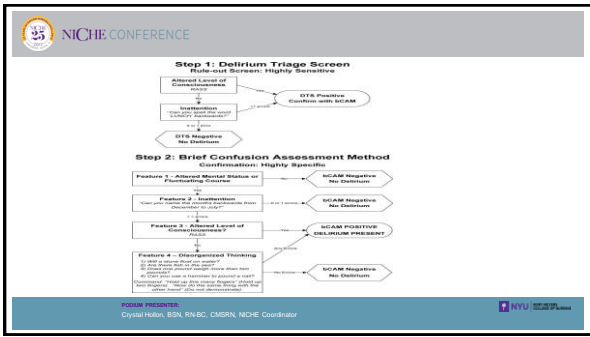
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Visit Signs / Assessment / Intake/Output / IV Assessment / Daily Care/Triage /

**Delirium ED Triage Screening**  
 PATIENTWORK: "Can you spell the  
 Delirium Classification: **ICD-10**  
 Delirium Screening (NRS-17 & GDS-15) only (Pilot)  
 Risk Factors  
 Precipitating Events  
 NCAM Instructions  
 Assessment Type  
 Delirium Assessment Type  
**MASS - Richmond Agitation Sedation Scale**  
 MASS Score: 1  
 CAM Assessment Instructions: Proceed  
**Delirium Assessment:**  
 Feature 1 - Acute Change or  
 Feature 2 - Inattention: Negative  
 Feature 3 - Altered Level of  
 Feature 4 - Disorganized Thinking  
 Delirium Present  
 Interventions

**All patients 65 years or older will have delirium screening done every 12 hours or whenever head to toe assessment is done (at admission, transfer, change of shift or caregiver)**

**If, after doing the assessment there is a message to "proceed to NCAAM" there please complete these rows and load the IP delirium care plan template. And Begin doing this fowsheet every 4 hours until discharge or resolution of delirium**

**FORM PRESENTS:**  
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**Apply Template**  
 Template: THE PATIENT AT RISK FOR EXPERIENCING DELIRIUM (100)

Select check boxes to apply to care plan

Difficulty with Orientation  
 Maintain Orientation X 4  
 Foster orientation by frequently reassuring and reorienting patient

Lack of Familiarity  
 Maintain Orientation, No Confusion or Agitation  
 Foster familiarity by including family in care plan to visit frequently, bring familiar objects from home, maintain consistency of caregivers, minimize room changes

Patient Safety  
 Patient Remains Free From Harm or Injury  
 Maintain safety for patients by avoiding restraints, use coban to cover IV insertions

Sensory Aids Missing

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### How Has Delirium Care Improved?

1. 65% of inpatients found at risk for delirium with only 9.9% experiencing delirium
2. Restraint usage has dropped from 17% to 6.45%
3. Ativan usage has dropped from 16.7% to 6.5%
4. Nurses feel more comfortable caring for patients at risk for or experiencing delirium

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### What's Next?

1. Educational needs identified and additional education provided.
2. The MD order set was reviewed and is currently being revised to address challenges identified by care team.
3. MD notification to be added to flowsheets to encourage better communication amongst care team.
4. Early mobilization plan being developed in collaboration with the falls committee to integrate into our delirium program.

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