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Delirium Reduction & Recognition: Inpatient Management

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Why Create a Pathway?

- Delirium affects 30-70% of hospital admissions
- Associated with increased morbidity and mortality
- Associated with increased hospital length of stay
- Associated with approximately $60,000 extra cost per delirious patient per year
- ***It is estimated that approximately 30% of hospital associated delirium is preventable***

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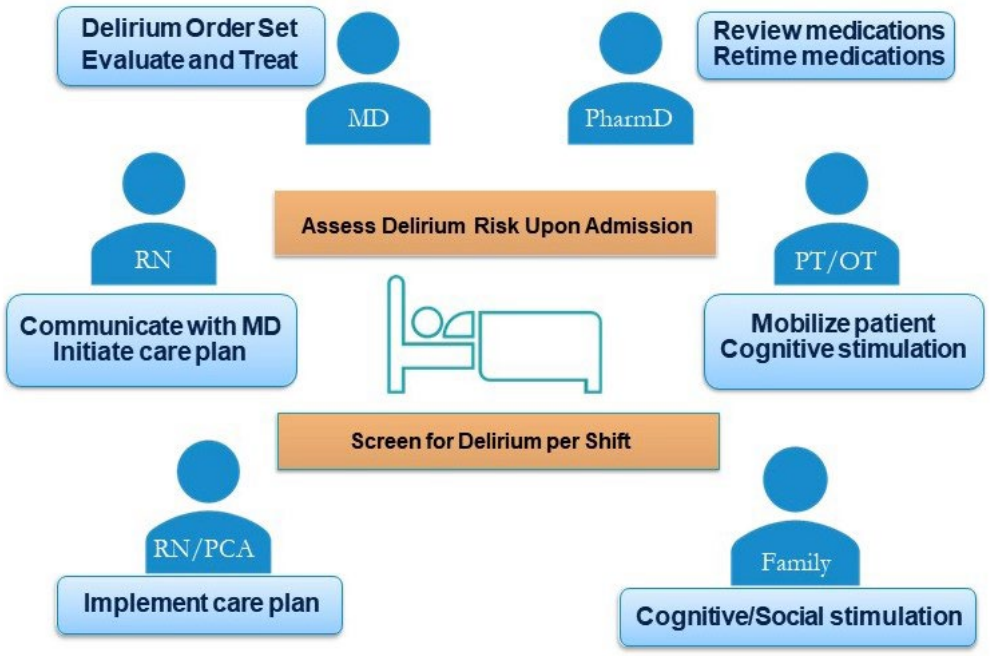
Delirium Reduction and Recognition (DRR)

- The pathway is:
  - Evidence based
  - Multi-component
  - Multidisciplinary
  - Nursing led
- It utilizes a delirium risk screen (AWOL) on admission for all patients ≥65
- It utilizes a standard delirium screening (NuDESC) per shift during hospitalization when indicated



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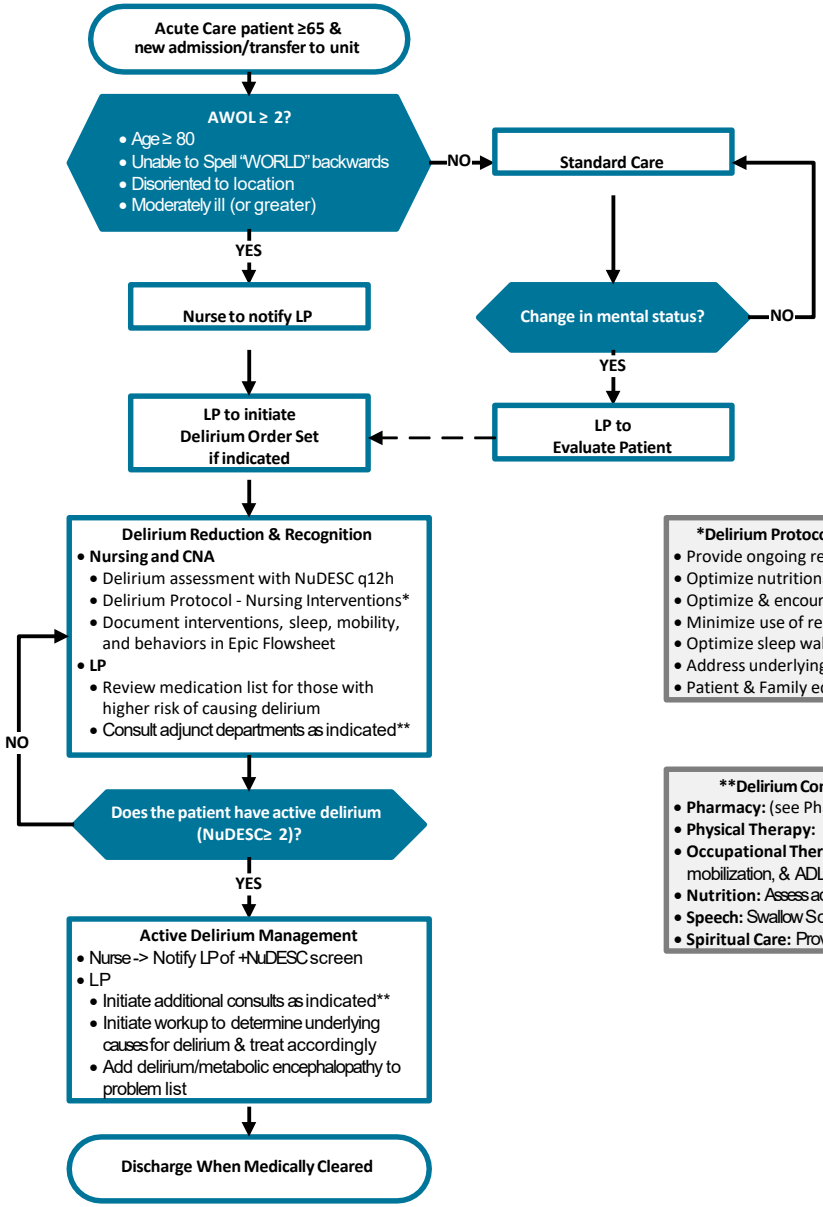
Delirium Reduction & Recognition: Inpatient Management



***Delirium Protocol / Nursing Interventions**

- Provide ongoing reorientation
- Optimize nutritional & fluid status
- Optimize & encourage mobilization
- Minimize use of restraints, lines, & devices
- Optimize sleep wake cycle
- Address underlying sensory impairment(s)
- Patient & Family education on delirium

****Delirium Consultations**

- **Pharmacy:** (see Pharmacy Tip Sheet)
- **Physical Therapy:** Mobility Plan
- **Occupational Therapy:** Cognitive therapy, mobilization, & ADL participation
- **Nutrition:** Assess adequacy of oral intake
- **Speech:** Swallow Screen
- **Spiritual Care:** Provide social interaction

For questions please contact:
CarePathways@ValleyMed.org

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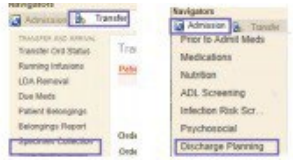
Delirium Screening

AWOL — *Determines risk of delirium*

Patients ≥65 get AWOL screening once upon arrival to the floor by their primary RN.



Scoring

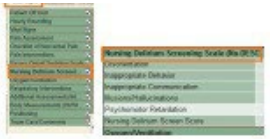
A	W	O	L
Age ≥ 80 years	Unable to correctly spell 'WORLD' backwards	Not oriented to city, state, county, hospital name and floor	Nursing illness severity assessment of moderately ill, severely ill or moribund
1 point	**1 point**	**1 point**	**1 point**

AWOL Score	Delirium Risk
0	2%
1	4%
2	14%
3	20%
4	64%

≥ 2 = High risk for developing delirium

NuDESC (Nursing Delirium Screening Scale) — *Screens for active delirium*

Patients with + AWOL are screened for active delirium Q shift by primary RN.



Scoring

If behavior is present at any point during your shift

0 (no symptoms) | **1** (mild) | **2** (prounounced) for each behavior

BEHAVIORS		
Disorientation	**Inappropriate behavior**	**Inappropriate communication**
Illusions/ Hallucinations	**Psychomotor retardation**	

Overall Score **≥ 2** = Positive Screen

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AWOL Documentation & Scoring

Done on Admission for Patients ≥65 Years of Age

Risk determination using the AWOL is based on the following (1 point assigned to each item):

- Patient **a**ge is ≥80 years.
- Patient cannot spell **W**ORLD backwards..
  - If patient is unable to correctly spell, assign 1 point.
- Patient is not fully **o**riented to (and can name): city, state, county, hospital, floor.
  - If patient cannot name all five correctly, assign 1 point.
- **L**evel of illness severity (mild, moderate, severe)
  - Use clinical judgement to assess.
  - Assign 1 point to 'moderate' and 'severe' levels.

A	W	O	L
Age ≥80 years	Unable to spell "**W**ORLD" backwards	Not **o**riented to city, state, county, hospital name and floor	Nursing illness severity **l**evel assessment of moderately ill, severely ill, or moribund
1 point	**1 point**	**1 point**	**1 point**

A total AWOL score of ≥2 indicates the patient is at high-risk for developing delirium during their hospital stay.

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NuDESC Documentation & Scoring

Done Q Shift When + AWOL or When Concerns for Active Delirium

Completed toward the end of the shift to allow sufficient time for observation of any behavior changes in the patient and note frequency and severity of behaviors.

- Recommended to complete the screen along with 4pm/am vitals, to fit with standard workflow.
- EXCEPTION to end of shift documentation: If it is clear the patient is delirious, assess and document the NuDESC right away so that the pathway is initiated.

Presence and severity of delirium is screened for with the NuDESC based on the following guidelines:

- **0** | No alteration in behavior throughout shift
- **1** | Mild alteration in behavior throughout shift
- **2** | Pronounced alteration in behavior

BEHAVIOR	SCORE		
	0	**1**	**2**
Disorientation	Fully oriented	Disoriented x1; easily re-oriented	Disoriented x2-4; not easily re-oriented
Inappropriate Behavior	Calm, cooperative	Restless, uncooperative	Agitated, pulling at lines/devices; climbing out of bed
Inappropriate Communication	Appropriate	Unclear or rambling speech	Incoherent, nonsensical or unintelligible speech
Illusions/Hallucinations	None noted	Paranoia	Hallucinations; distortions of visual/auditory objects/stimuli
Psychomotor Retardation	Normal speed of movement and response time to questions	Delayed responses; slow to respond to verbal or physical stimulation	Excessive sleeping; somnolent, lethargic; reaction time is slow when prodded; difficult to motivate

A total NuDESC score of ≥2 indicates the patient is positive for active delirium.

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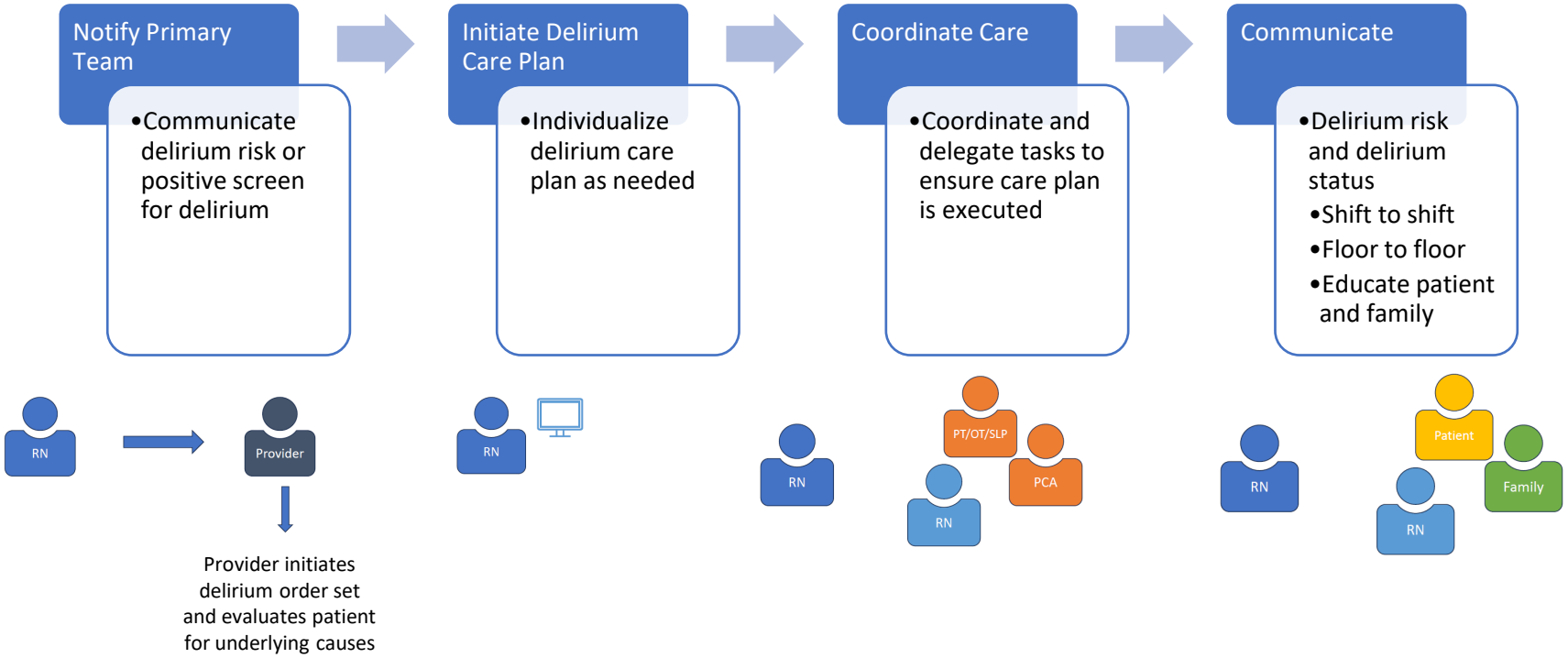
Positive Screen Triggers

- Epic Best Practice Advisory
  - Prompts nursing to alert provider of finding and to initiate DRR order set
- Nursing
  - Initiation of delirium nursing care orders (if not done already)
  - Working with LP and colleagues on individualizing nursing care plan specific for the patient
- LP (MD, APP)
  - Initiate DRR order set (if not done already)
  - Assessment of patient and underlying causes
  - Any work-up needed (labs, imaging, etc.)
  - Consideration for consultations as appropriate

Nursing Care Guidelines



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Delirium Nursing Care

"Sunrise Service"

- **Lights on in pt room**
- **Blinds open (>50%) in pt room**
- **OOB (GOAL: minimum = w meals; amb ≥3x/day)**
- **Water w/in reach**
- **Pt awake – prevent/minimize daytime napping (<1 hr)**
- Sensory aids at bedside/in use (e.g., hearing aids, glasses)
- Remove/avoid tethers when possible, ASAP
- Cognitive/social stimulation
- Orientation aids (e.g., (re-)introductions; whiteboard info – date, location, names/contacts)

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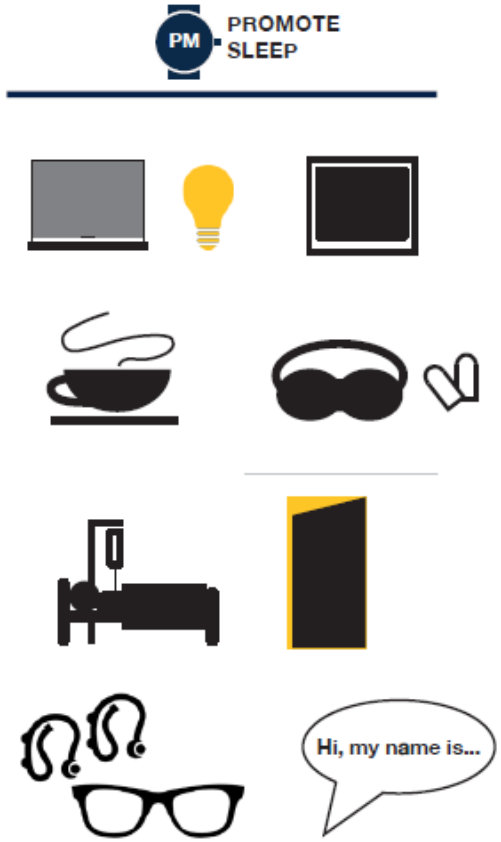
Delirium Nursing Care

"Turndown Service"

- Lights off in pt room
- Blinds closed
- TV off
- Computer monitor off
- Area around pt room quiet
- Pt sleeping by ~2300
- No/minimal caffeine after 1200; liquids after 2000
- Minimal interruptions (bundle care items; no/minimal VSs ~2200-0500 (when safely possible in stable pts))



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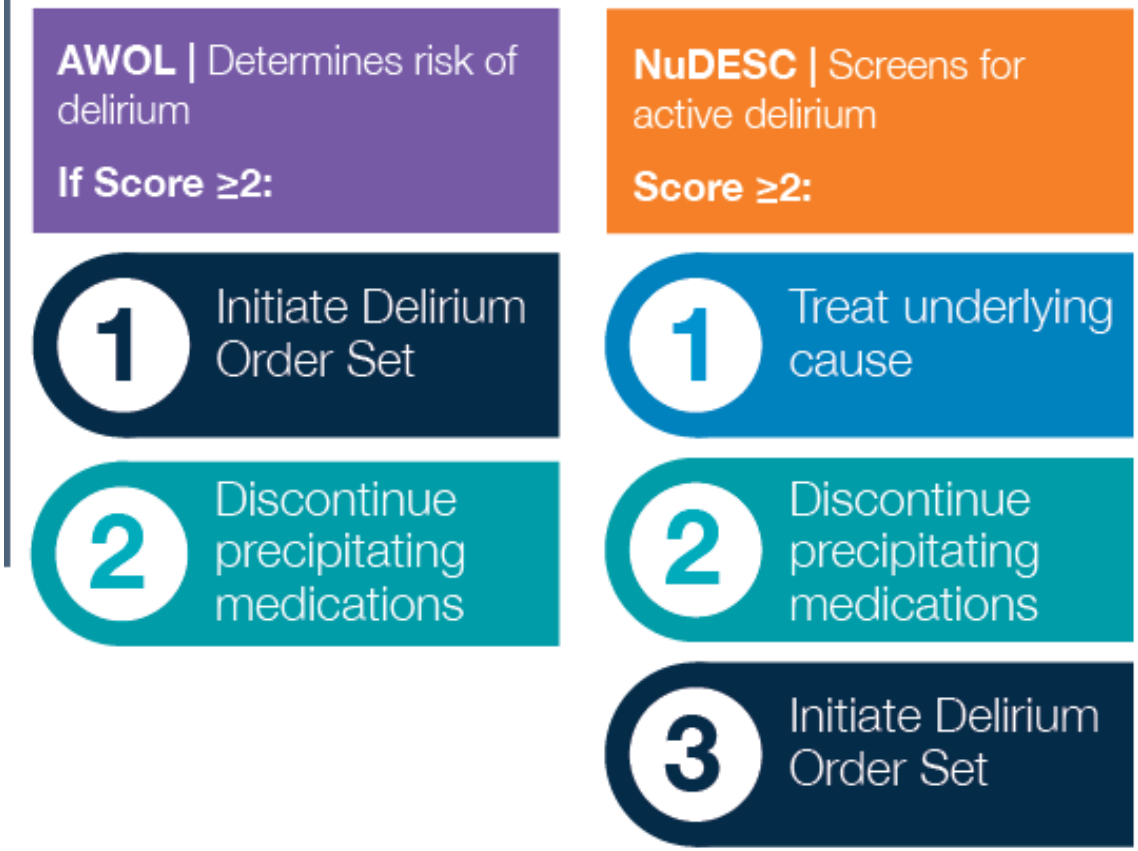
LP (MD, APP) Care Guidelines



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Delirium Order Panel

- Name of order panel:
  - ‘Med IP Delirium Focused’ Med IP Delirium Focused

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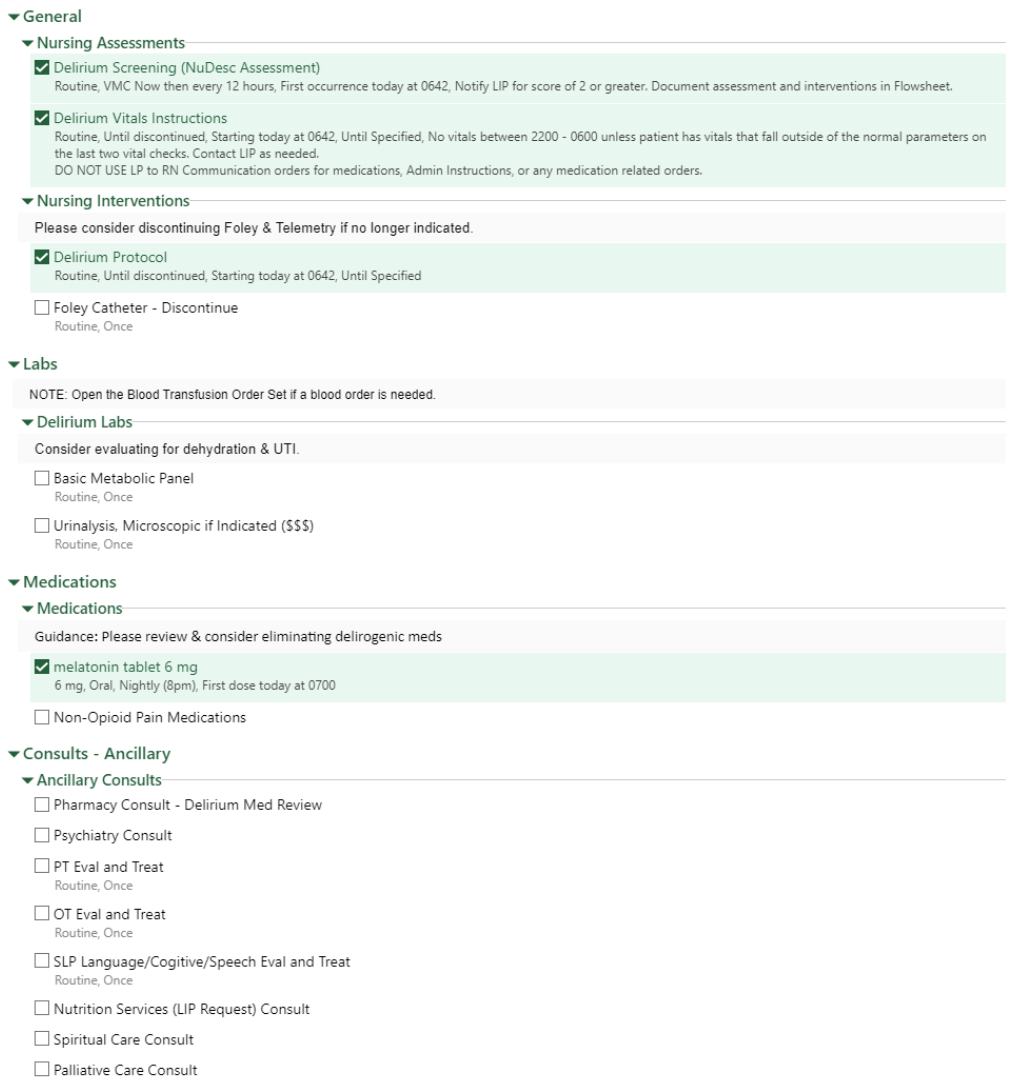
Delirium Order Panel



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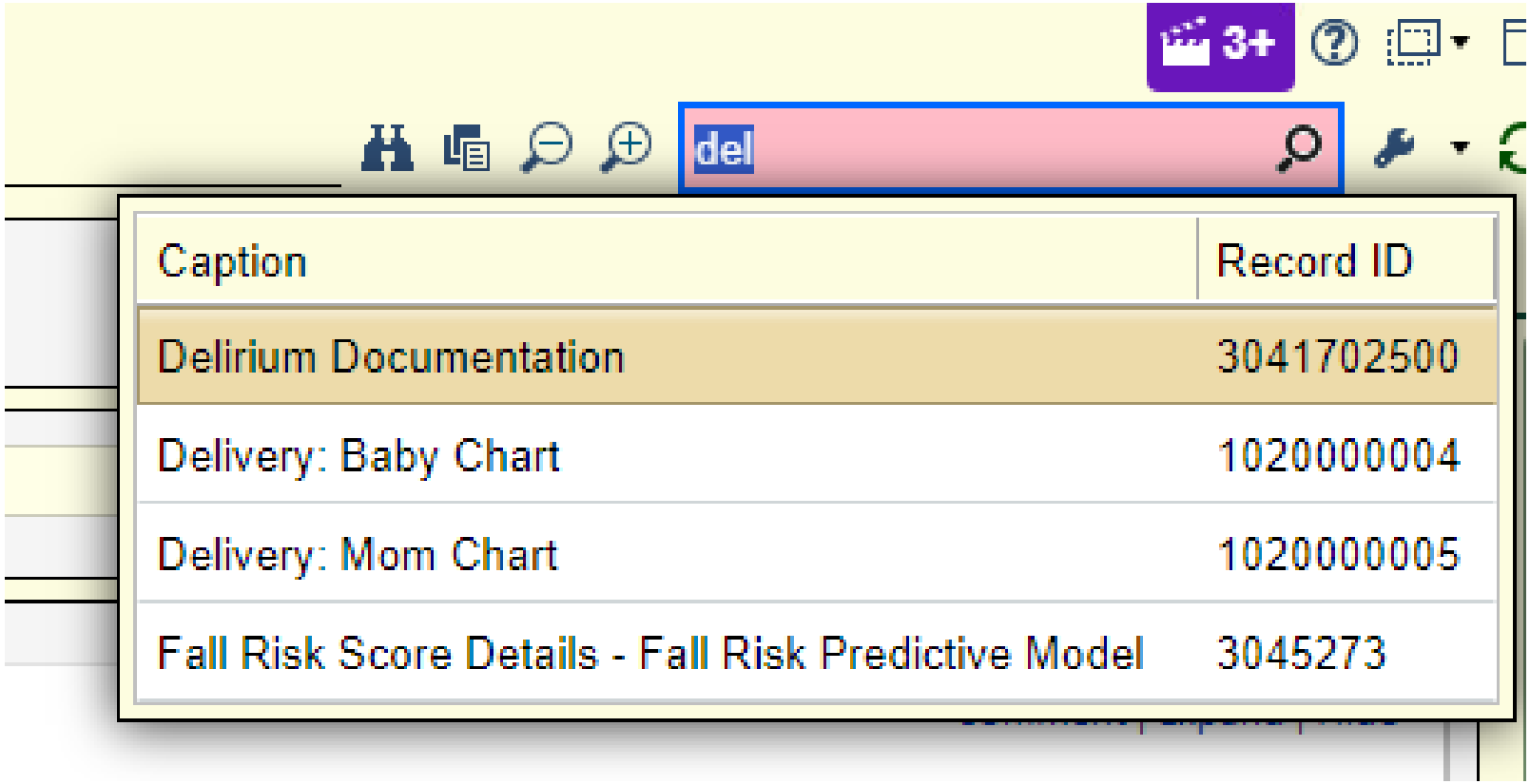
How to View Delirium Documentation Report in Epic

From the Summary activity, start typing “delirium” and hit Enter or the magnifying glass



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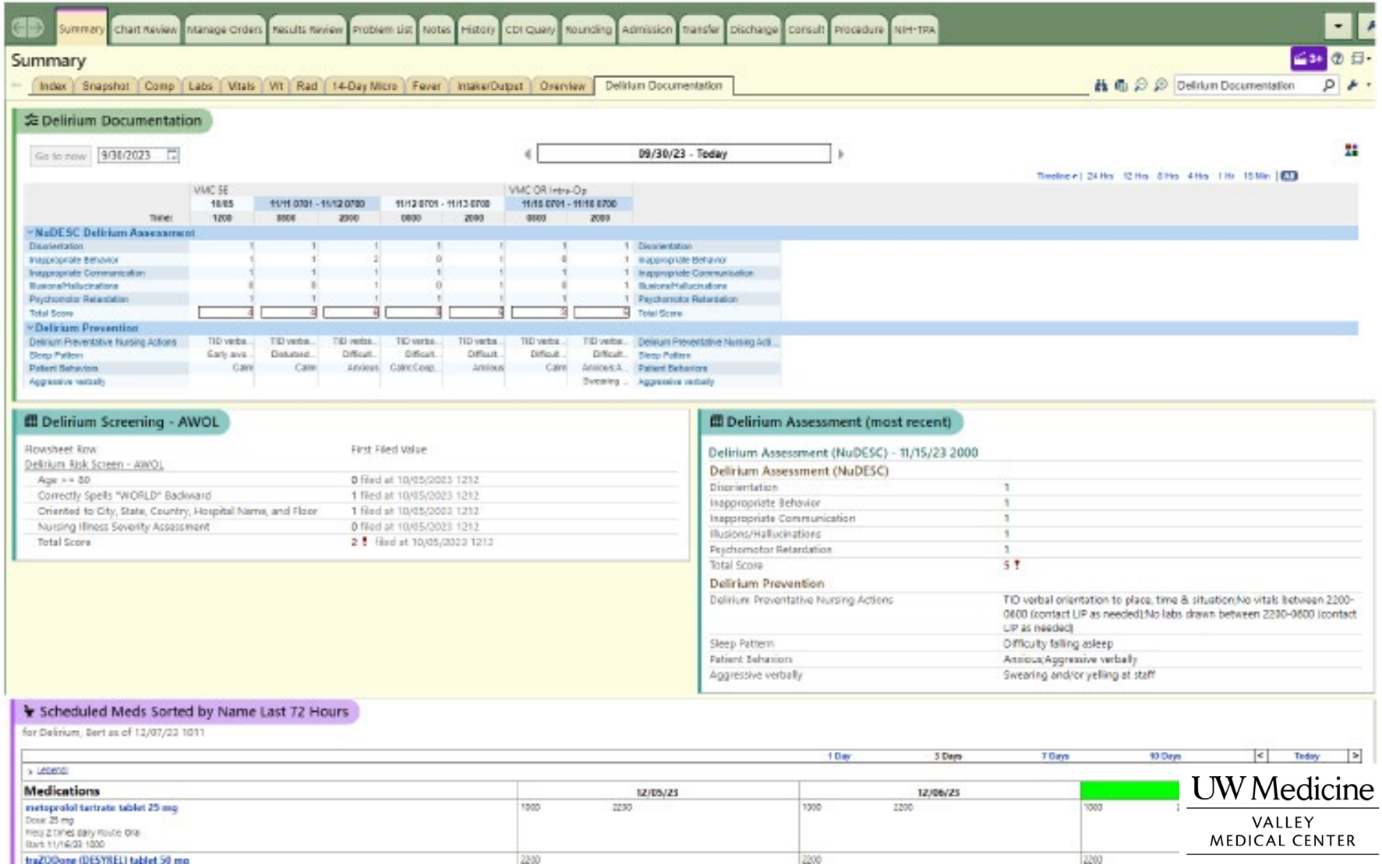
Delirium Documentation Report



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LP (MD, APP) Care Guidelines

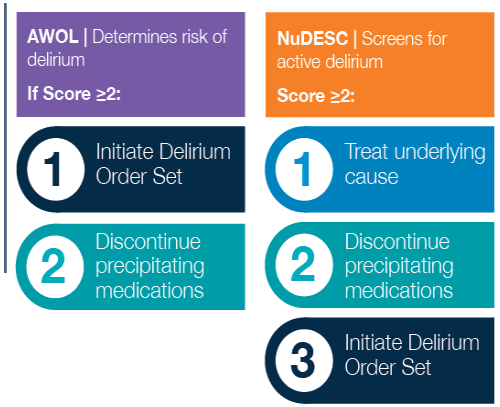
Assess Underlying Causes*

Drugs/medications/polypharmacy
Electrolytes (Na, Ca, CO2), **E**nvironment change
Lack of drugs (withdrawal), **L**ack of sleep
Infection, **I**mmobility (catheters, feeding tubes), **I**atrogenic (e.g.,major surgery)
Restraints, **R**educed sensory input (vision/hearing)
Intracranial (stroke, bleed, seizure, meningitis)
Urinary Retention, constipation, **U**ncontrolled pain
Metabolic (hypoxia, uremia, hepatic encephalopathy, thyroid)

WORKUP

- Physical exam: check surgical wound; check tubes/lines/drains; brief neuro exam
- Vital signs, pulse ox, pain assessment
- Labs: UA, CBC, BMP. Consider TSH, LFTs, UTox, cultures, EKG, Chest X-ray

**Patients with more risk factors (old age, cognitive impairment, poor functional status, hearing/vision impairment, depression, alcohol abuse) can develop delirium with minor precipitants.*



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LP (MD, APP) Care Guidelines

AWOL | Determines risk of delirium

If Score ≥2:

1. Initiate Delirium Order Set
2. Discontinue precipitating medications

NuDESC | Screens for active delirium

Score ≥2:

1. Treat underlying cause
2. Discontinue precipitating medications
3. Initiate Delirium Order Set

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LP (MD, APP) Care Guidelines

- Review medication list, esp. those started, dose adjusted, or stopped within last 24 hours
- Assess pain, urinary retention, constipation, electrolytes, vital signs, oxygen saturation, etc
- Consider bladder scan to check for urinary retention
- If no BM in past 48 hours check for fecal impaction
- Foley out as soon as feasible
- Education (patient and family caregiver)

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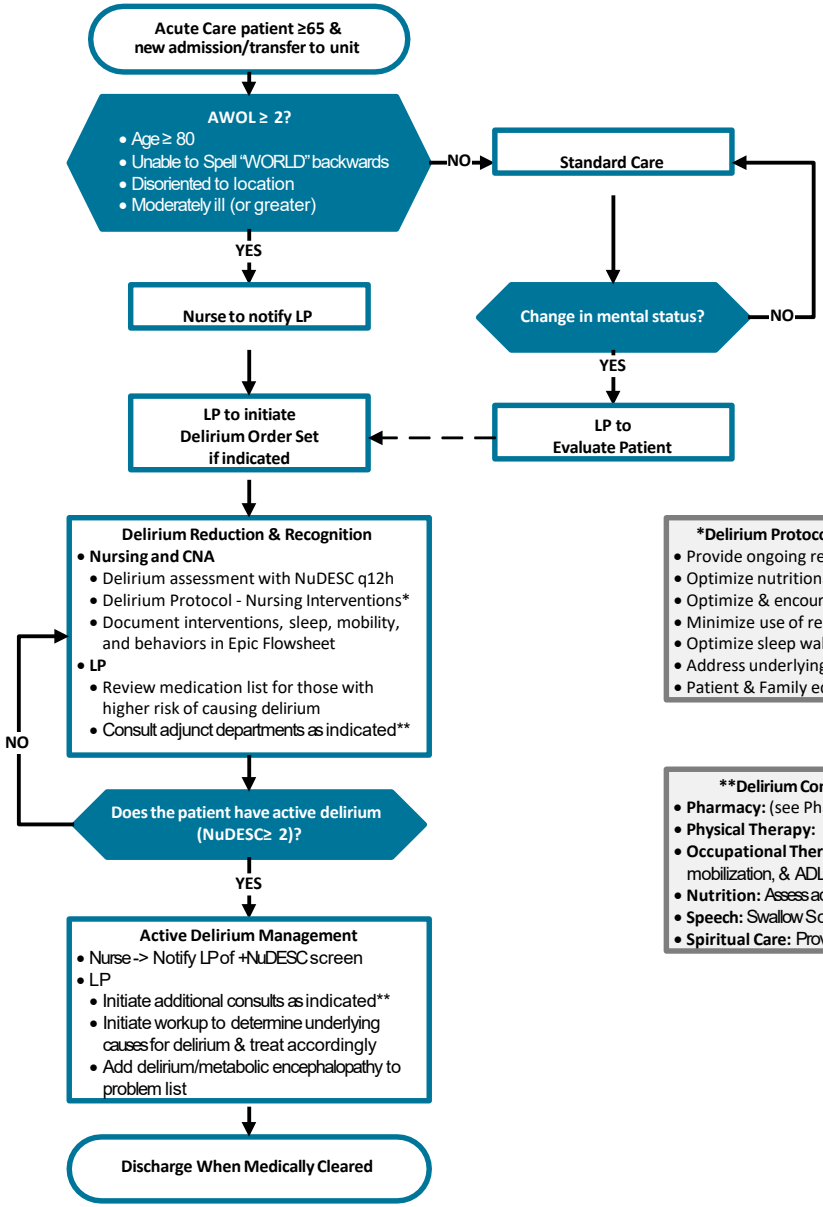

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Delirium Prevention Pathway

- To access the pathway:
  - https://www.valleymed.org/contentassets/dff2ea0e3f5a4184a89d05049d6098ff/delirium_-_inpatient_care_pathway.pdf
- To access the policy:
  - https://valleymed.sharepoint.com/sites/policycentral/PolicyCentral/DELIRIUM%20ASSESSMENT%20AND%20MANAGEMENT%20POLICY.docx

THANK YOU!

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