Improving Outcomes Through Delirium Prevention, Treatment & Care Transitions

Hospital-Acquired Delirium Prevention & Treatment Initiative
SESSION LEARNING OBJECTIVES
HOSPITAL ACQUIRED DELIRIUM (HAD)
PREVENTION, TREATMENT & CARE TRANSITIONS

- Develop a basic understanding of Hospital-Acquired Delirium

- Learn why it is important to be aware of HAD and intervene

- Know who is at risk and learn to recognize the signs and symptoms of HAD

- Become familiar with best practices in various healthcare settings

- Recognize how to strengthen care transitions for patients at risk, suspected of, or returning with HAD, to improve outcomes and reduce costs

- Be aware of what family members need to know

- Link to resources
Healthcare Foundation Mission and Funding Priorities

Hospital Conversion Foundation

Serving Greater Newark & the Jewish community of MetroWest
Improving the health of vulnerable children & adults

Focus on Elderly Adults

www.hfnj.org
Visit HFNJ on Facebook!

The Healthcare Foundation of NJ
60 East Willow Street, Millburn, NJ 07041
(973) 921-1210
Planning the Hospital-Acquired Delirium Prevention & Treatment Initiative

I. PROBLEM - AWARENESS & INVESTIGATION

“Risk and Onset in Healthcare Settings - Poor Outcomes for Elderly Hallucinations in Hospitals Pose Risk to Elderly” 6/6/2010 NEW YORK TIMES

II. BEST PRACTICES AND EFFORTS IN THE FIELD

HELP (Hospital Elder Life) Program
DR. SHARON INOUYE, YALE (now at Harvard Medical School)

III. CONVENING LOCAL HOSPITALS

IV. REQUEST FOR PROPOSALS – April 2011
Year 1 Grants – September 2011
Total Funding: $1.2 Million
HAD Programs – Changing Geriatric Care, Culture and Outcomes
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Resources: HOSPITAL-ACQUIRED DELIRIUM

Hospital Elder Life Program
www.hospitalelderlifeprogram.org

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OVERLOOK MEDICAL CENTER
DELIRIUM PROGRAM
Definition

- Acute change in mental status or acute confusion
- A medical emergency
- Reversible and preventable medical illness
- May fluctuate through the day
- Inability to concentrate or change focus
- Only treatment is to eliminate cause(s)
CAM (Confusion Assessment Method)

1. Acute or subacute onset of mental status change often with fluctuating course
2. Affects concentration: inability to focus attention or inability to shift attention
3. Disorganized thinking: rambling, paranoid delusions
4. Change in the level of consciousness: vigilant, lethargic, stuporous, comatose

Positive test: 1+2+ either 3 or 4; or 1+2+3+4
Other common symptoms

• Hallucinations
• Disturbance of sleep-wake cycle
• Disorientation
• Agitation (hyperactive)
• Slow response (hypoactive)
Why should we care?

- Patient’s distress: scary, agitation may result in restraints, inability to communicate
- Consequences: persistent delirium, poor function, cognitive decline, re-hospitalization, institutionalization, death
- Importance of prevention: avoid certain medications, maintain hydration and nutrition, engage in activities, compensate for sensory impairment
<table>
<thead>
<tr>
<th>Predisposing factors</th>
<th>Precipitating risk factors</th>
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<tr>
<td>Age</td>
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<td>Infection</td>
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<td>Poor nutrition/feeding</td>
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<td>Pain</td>
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<td>Diabetes and other co-morbidities</td>
<td>Constipation</td>
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<td>Institutional residence</td>
<td>Change in environment</td>
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History at OMC

• 2008: delirium team formed
• 2009: first medical nursing unit
• 2010-2011: expansion to 4 more units; development of nursing care plan; ED staff trained
• 2012: HFNJ grant and addition of 4 ELS to assist with program; all medical units in program
• 2013: surgical units added to program, integration in geriatric task force
OMC Current Program

• Prevention: care plan, medications, activities, nutrition, hearing amplifiers, elderlife specialist and volunteer visits

• Identification of delirium

• Management program, including physician orders

• Caregiver education incl. brochures

• Care transitions and transfer of information to facilities; delirium education at nursing homes; checklist for caregivers

• Integration in work of Geriatric Task Force
Professional Staff

• Geriatrician
• Geriatric nurse practitioner
• Behavioral health educator
• 4 elder life specialists
• Volunteers
• Nursing staff

Monthly meetings
Care Transitions

• Admission: request information on patient’s baseline, list of medications, recent change
• Discharge to the community: support systems, caregiver education, medication education
• Discharge to a facility: information on diagnosis, medications
Discharge Checklist

- Keep patient engaged in activities to improve concentration (activities vary based on baseline cognition)
- Assist with slow return to normal sleep-wake cycle
- Understand disorganized thinking; no contradiction, just reassurance, calm, and respect
- Ensure hearing and vision are corrected
- Environment: familiar items and routine, temperature, lighting
- Pain and discomfort management
- Maintain mobility
- Medications for delirium (should not be used indefinitely)
- Provide information on baseline status to health care professionals
Outcomes

• Shorter length of stay for patients who do not have delirium
• Few readmissions
• Culture change-nursing staff and medical staff
• Patient satisfaction
• Volunteer satisfaction