Diagnosing Delirium in the Emergency Department

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Introduction

- Baby Boomers are aging, enhancing healthier life-styles, and living longer
- In 2030, 1 in every 5 Americans will be aged 65 and older[1]
- 2009-2010, 19.6 million elders were seen in Emergency Departments[2,3]
- Hospitals need to adapt to the influx of geriatric specialty care
- Increased need to be attuned to needs of this population and inherent complications when ill

Delirium is an insidious syndrome with disturbances in…

- Orientation
- Memory
- Attention
- Thought and behavior
- Affects over 1.5 million elders seen in Emergency Departments annually[4,5]

THE PROBLEM…

- Despite Increased knowledge of the pathophysiology
- Despite knowledge of Risk factors and outcomes related to delirium
- Delirium is Under-diagnosed and modifiable risk factors are neglected

The Emergency Department

No process for delirium screening

Admits 47% of its elderly patients equaling 262 patients per month

79%-90% of undiagnosed delirium patients have increased morbidly and mortality over the next 12 months[6-8]

The Potential Outcomes of Delirium

- Increased mortality
- Reduced functional abilities
- Increased need for ICU admissions
- Increased ICU and hospital LOS
- Increased likelihood of admission to LTCF

Purpose of this Initiative

The problem identified is that the emergency department needs to provide a way to identify and effectively manage geriatric patients with acute agitation and delirium. *The purpose of this initiative is to evaluate elderly pts in the ER for Delirium using the brief Confusion Assessment Method (bCAM) tool.* The value of this innovation is that it is in line with the mission and values of Hurley Medical Center.

The bCAM is automated as tool on EPIC with one touch entry and the entire time needed is approximately 1 minute. This became the geriatric assessment process when the patient, aged 65 years and older, is taken to a room to be seen.

The Process

The patient is placed in an exam room from triage, the admitting nurse opens the patient chart and the first of many best practice acts fires…

Geriatric Assessment Screening
Please Complete the Geriatric Assessment Screening Tools

The only way that this can be overwritten is if the patient is critical

1. Then the Nurse clicks the link to complete…

Add Row | Add Group | Values By | Create Note

bCam ED (Brief Confusion Method) Assessment

Question	Options		
1A. Is the patient different than his/her baseline mental status (obtain from proxy)?	Yes (Positive)	No (Negative)	
1B. Has the patient had any fluctuation in mental status in the past 24 hours (obtain from proxy)?	Yes (Positive)	No (Negative)	
2. Inattention-- Say to patient: "Can you name the months backwards starting from December to July?" Must be done in <15 seconds	Yes (Positive 2 or more errors on Months backwards Dec to July)	No (Negative 1 or less errors)	
Overall ED bCam	Negative	Positive on 1 AND 2 & either positive on 3 OR 4- Go to Orders and place B-CAM order	Unable to assess: RASS is -4 or -5

2. RN needs to evaluate both questions 1A & 1B about mental status change: If both are negative, the pt is negative and does not have delirium if yes to either question,
3. then the nurse goes on to question #2 – Can patient say months backwards from Dec to July without two errors: If <2 errors, nurse marks Overall ED bCAM score Negative and is done; If 2 or more errors, then assessment opens further for question 3 (RASS).
4. The RASS is a way to assess altered level of consciousness. It is a <10 second assessment with a score range -5 (unarousable) to +4 (combative); 0= normal level of consciousness.[12] If RASS is anything but zero (alert & calm)., the bCAM is positive for delirium. If the RASS is zero-
5. The nurse goes on to question 4 parts a and b—both questions need assessed.

Question	Options	
4A. Disorganized Thinking: ASK PT: Will a stone float on water? Are there fish in the sea? Does 1 pound weigh more than 2 pounds? Can you use a hammer to pound a nail? Positive if any errors.	Positive if any errors	Negative errors
4B: Direct pt to "Hold up this many fingers" (hold two fingers up). "Now do the same thing with the other hand" (Do Not Demonstrate). If unable to move both arms, ask patient "Add 1 more finger". Error results if unable to successfully complete.	Positive-if patient makes any errors.	Negative-no errors

If any errors, the bCAM is positive, if no errors the bCAM is negative. Any time the bCAM is negative, the program automatically brings up the bCAM-negative score and no further questions are brought forward and the screening is complete.

bCAM Positive Patient

If positive score, BPA fires for the RN to place bCAM protocol orders.

bCAM Orders consist of two orders:
1. ED Clerk consult order to Notify ACE Nurse of bCAM positive pt by calling Geriatric resource team number (which automatically places the patient on the team list as well).
2. Orders for RN to institute supportive measures.

The geriatric resource team would then follow the patient from admission to discharge, implementing measures to decrease and/or obliterate signs and symptoms of delirium while in the hospital setting.

The positive bCAM also fires another BPA to alert the healthcare provider, upon opening the patient's EMR, that the patient is positive for delirium and requires the diagnosis to be placed on the problem list utilized as an admitting diagnosis

Triage Summary | ED Handoff Widget | Results | All ED Notes | Orders | Report: ED Handoff Widget

Senior, Eric #201066 (Acct:300003312) (66 y.o. M) PCP: None ED A06

B-CAM DELIRIUM SCREENING POSITIVE IN ER

Chief Complaint	Medical History	Surgical History
Croup Cough x 3 days. Becoming more confused, per family. Normally alert and oriented.	Past Medical History Hypertension [I10]	None
ER Sticky Notes — Comment	ER MSW Sticky Notes — Comment	ER Provider Sticky Notes

BestPractice | Disposition | Clinical Impression | Reminder | Orders | Order Sets | OrderRec Sign&Hold | Letters

BestPractice Advisories

This patient has a positive BCAM score. Please add Delirium to the Clinical Impression list.

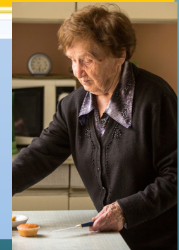
Refresh Last refreshed on 2/4/2016 at 9:12 AM

Implications for Emergency Nurses

- Comprehensive interdisciplinary approach
- Established a delirium protocol where there was none
- This nurse-run protocol had a significant impact on patient outcomes
- Increased quality care and patient safety

References

Available upon request



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