GEDA Executive Summary Care Processes Template – Level 1 or 2

Care Process

Select the care process this corresponds to from this dropdown menu:
D.1 Delirium screening

Your care process name:
Geriatric delirium screening in the ED

Date care process approved by your EM Department/Division:
10/4/2022

Description

Rationale: Provide any background or rationale for this process.
Delirium is defined as a neurologic syndrome primarily involving disturbances in attention and awareness, along with changes in cognition. Delirium is characterized by acute onset, and fluctuating course. The brief Confusion Assessment Method (bCAM) is a standardized, evidence-based tool validated tool for screening and assessing patients with potential delirium. The bCAM allows for differentiation of delirium from other types of cognitive impairment (i.e. dementia). Recognition and treatment of delirium can help identify patients who may require more focused attention and treatment, and hopefully improve patient outcomes. Early recognition can provide coordination of care, with special attention to directing interventions towards improving reversible causes and limiting factors that extend or cause delirium.

We will use a sensitive screening tool, the delirium triage screen, for all patients age 65 and over, and if they screen positive, we will use the bCAM, which is a more specific tool to more accurately identify patients with delirium.

Describe the population that the care process will apply to and any exemptions. For example, it may apply to all patients age 65 and over or a subset based on age, ESI, or another positive screening tool. Patients who are severely ill or intubated may be exempted:
All patients age 65 and over

Hours of the day when the care process will be implemented or available if applicable:
24/7

Describe where in the ED workflow this care process fits in. For example, it may occur in triage, once the patient is roomed, at discharge, after discharge, after admission, during another transition of care, or other time:
The DTS will take place during the initial triage nursing evaluation, and the bCAM will be performed by the bedside nurse after rooming.

Brief description of the care process. If you are using a hospital-wide process, please explain how it is applied specifically in the ED:
Previously published screening tools will be used to identify geriatric patients presenting with delirium. This assessment for delirium will use a two-step process.

This initial screening should take place as part of the triage process.

Step 1. Delirium Triage Screening Instrument. This will be completed at triage by the triage nurse within the Triage Narrator.
A positive DTS will be followed by the bCAM screening.

Step 2.

The brief Confusion Assessment Method (bCAM) will be conducted as a part of the nursing primary assessment after a positive delirium screening at triage has been completed.

The bCAM tool focuses on four criteria: acute onset, inattention, disorganized thinking, and altered level of consciousness. A diagnosis of delirium requires the presence of three of these criteria.

Upon admission to the Emergency Department, those patients who screened positive on the DTS will be screened using bCAM. The CAM is built into our epic EMR platform, with screenshots below.

If it is determined that delirium is present based on a positive bCAM, the nurse will notify the treating provider and provide appropriate nursing care to include:

Establishing an environment that promotes optimal functioning

Facilitating communication with the patient and family

Avoid evoking a stress response

Facilitate the patient's contact with reality

Establish a consistent routine

Promote continuity of care

Encourage adequate food and fluid intake

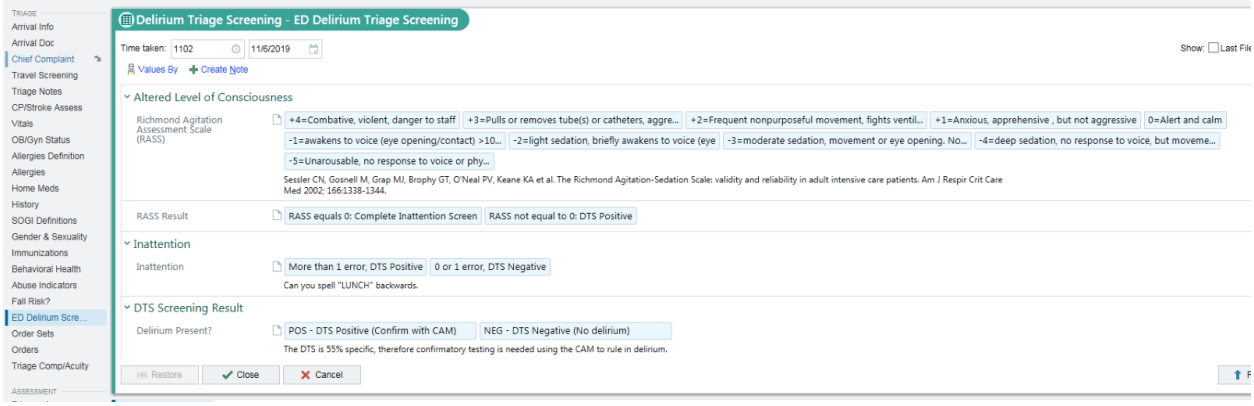
Promote ambulation

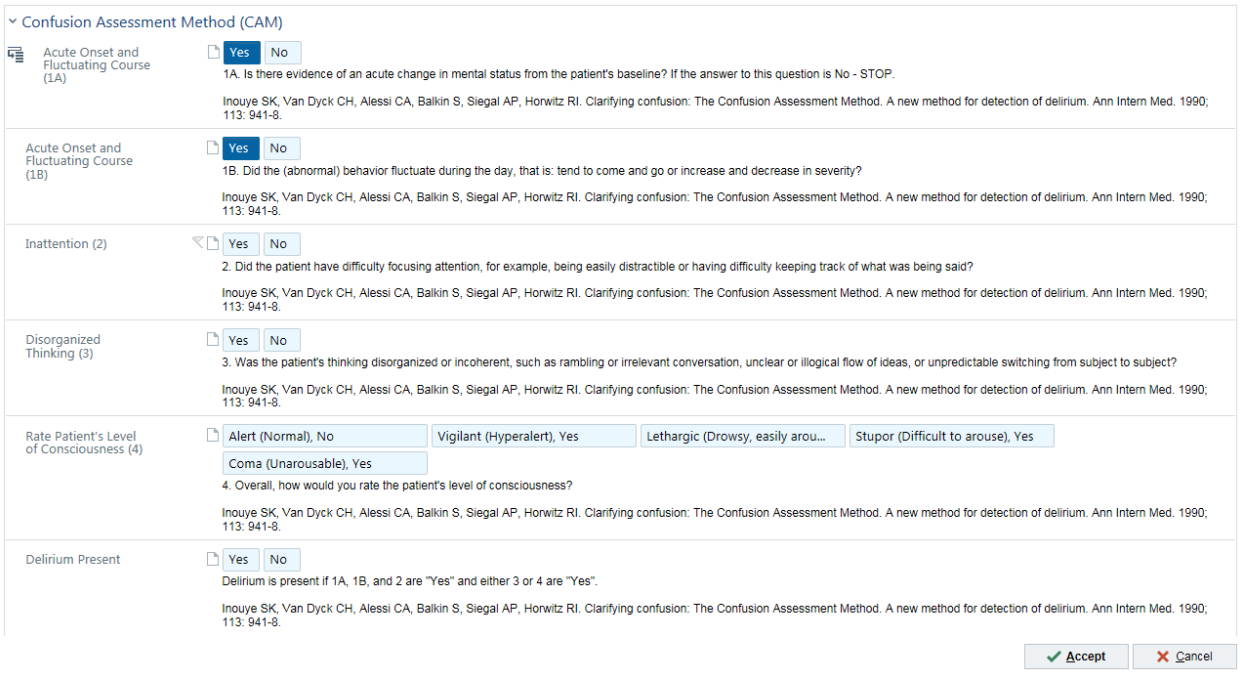
Frequent toileting

Promote safety by avoiding physical restraints, providing adequate supervision, placing patients on falls precautions, and minimizing hazards in the environment

Findings will also be communicated to the inpatient nurse on admission in order to continue

assessing the presence of delirium, and continue processes to mitigate symptoms and reduce progression of delirium.





Who will be responsible for performing the actions in the care process:
Triage RN: DTS
Bedside RN: bCAM
Physician or APC: Evaluate patients with positive bCAM as soon as they are able, and place appropriate orders to help determine the cause of the delirium.

Describe how this care process is geriatric-specific:
This is specifically only used in patients age 65 and over. It uses tools validated in this population.

Describe any further follow-up or interventions involved:
We will track completion rates and also positive screen rates (see below).

Education and Monitoring

Where relevant, describe how you will educate the relevant staff, physicians, or other stakeholders about the care process:
RNs will be trained in this protocol by RN leadership at staff meetings and through in-service training. The Delirium Triage Screening algorithm (pictured above) will be posted in triage for nurse reference, as well as provided in badge card format. A positive screening by the triage nurse will be communicated to the primary nurse through the use of a "sticky note" within the EMR and a bedside CAM screening will then be performed by the primary nurse.

Physicians will be trained by MD leadership on the purpose and utility of delirium screening, and steps to take when delirium is identified.

Describe how you will monitor completion of the care process and its impact, where relevant. The list of GEDA care processes specifies whether each protocol should have validation of its implementation, or whether qualitative metrics are required. For 'validation' please describe the implementation and, if relevant, provide evidence for implementation of the care process. You will have the chance to upload images or files on the web application. For care processes in which 'metrics' are required, you should at least track the percentage of eligible patients who receive the designated intervention. Tracking could be through a live dashboard of screening results, through periodic random chart reviews, or through other tracking methods. Describe how often and by whom this will be performed. You will have a chance to upload metrics on the web application.
On a quarterly basis, we will audit a random sample of 24 hour intervals and track the following:
- Completion and positive rates of DTS screening
- Completion and positive rates of bCAM for patients screening positive on DTS
- Note of delirium by physician or APC in their note.

Please describe how you will help improve the rates of completion or impact of the process if rates are currently low or become low in the future.
If screening rates are under 90% for eligible patients (ie not intubated, trauma activation, or severely ill and unable to obtain), we will meet with nurses and physicians and help identify and mitigate barriers to completion. For example, if it is an awareness or understanding concern, we will work to improve education and dissemination. Also, since the DTS is a built-in, hard stop in Epic, this should increase uptake. We will focus our interventions and education at the step that has low completion rates.

If relevant, please attach the 'validation' or 'metrics' for this care process. For metrics, this should include at least 3 months of tracking data to demonstrate completion rates and any other outcomes that are tracked.
Attach last quarterly dashboard of rates of completion and positive screening.

Please attach your official ED care process policy if present, or other relevant documentation such as order sets, flow charts, etc. Please do not include hospital-wide policies. This policy should be ED-specific.