westhealth

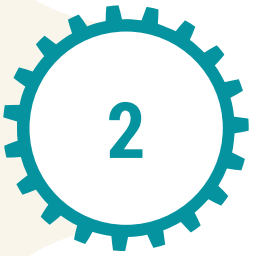
GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Example Delirium Screening Workflow in the ED

Note: Your workflow may differ

Stepwise workflow for using two evidence-based scales to improve screening for delirium in the ED: The **Richmond Agitation-Sedation Scale** (RASS) and the **Brief Confusion Assessment Method** (BCAM)

The primary nurse will open the Primary Assessment tab in Epic and complete the delirium screening along with the rest of the necessary documentation for new ED patients 65 years and older. The first step in screening will be documentation of altered level of consciousness using the RASS.



2a. If the RASS is anything but 0, you will be prompted to complete the bCAM (see 3a). If the patient receives a RASS of 0, the next step is to ask the patient to spell the word 'LUNCH' backwards to test for inattention. (Note: This can only be done for patients who speak English.) If the patient successfully spells lunch backwards, delirium screening is negative.

2b. If the patient cannot spell lunch backwards, this is a sign of inattention. You then move on to completion of the bCAM.

3a. When completing the bCAM, first answer Feature 1: Is there altered mental status of fluctuating course?

3b. In Feature 2, you assess inattention by asking the patient to name the months of the year backwards between December and July. If the patient makes <1 error, screening is negative.

3c. If the patient makes >1 error, the nurse will be prompted to re-document the RASS score in Feature 3.

In Feature 4, the patient is screened for disorganized thinking using the following questions:
- Will a stone float on water?
- Are there fish in the sea?
- Does one pound weigh more than two pounds?
- Can you use a hammer to pound a nail?

If the patient makes any errors, the delirium screening is positive. The nurse will be prompted to notify the attending and a delirium workup will follow with use of an order set in Epic.

The expectation is that the delirium screening will be completed Q4 hours by the RN on all patients at the same time as vital signs (2am, 6am, etc.) to screen for changes in mental status. This delirium screening can also be found in the ED navigator under Suggested Documentation > Delirium Screening.

This screening will only populate for patients 65 years and older.