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ED Quick Delirium Screen

aka: Delirium Triage Screen (DTS)

Altered Level of Consciousness
RASS*

Yes (RASS ≠ 0)

Pre-screen POSITIVE
Confirm with bCAM

No (RASS=0)

Inattention
Can you spell the word "LUNCH" backwards?

>1 errors

0 or 1 error

No Delirium

Where to find in Epic:
RN : Primary Assessment or ED Narrator
MD/PA/NP: Geriatrics Assessment

How often should this be done?
Reassess every 4 hours with vitals

*** Richmond Agitation Sedation Scale (RASS)**

-5	-4	-3	-2	-1	0	+1	+2	+3	+4
Unarousable	Deep Sedation	Moderate Sedation	Light Sedation	Drowsy	ALERT CALM	Restless	Agitated	Very Agitated	Combative
VOICE		TOUCH							

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Brief Confusion Assessment Method (bCAM) Flow Sheet

FEATURE 1
Altered Mental Status or Fluctuating Course

No → **bCAM Negative No Delirium** *

Yes

FEATURE 2
Inattention
"Can you name the months backwards from December to July?"

0 or 1 errors → **bCAM Negative No Delirium** *

> 1 errors

FEATURE 3
Altered Level of Consciousness?
Richmond Agitation Sedation Scale

Yes → **bCAM POSITIVE Delirium Present** **

No

FEATURE 4
Disorganized Thinking

1) Will a stone float in water?
2) Are there fish in the sea?
3) Does one pound weigh more than two pounds?
4) Can you use a hammer to pound a nail?
Command: "Hold up this many fingers" (Hold up two fingers), "Now do the same thing with the other hand" (Do not demonstrate).

Any Errors → **bCAM POSITIVE Delirium Present** **

No Errors → **bCAM Negative No Delirium** *

****Next Steps**
** Notify Attending*
** Use Delirium Order Set for workup*
** Reassess every 4 hours*

***Prevent delirium!**
Address modifiable risk factors (e.g., pain, environment, noise, tethering, etc.)

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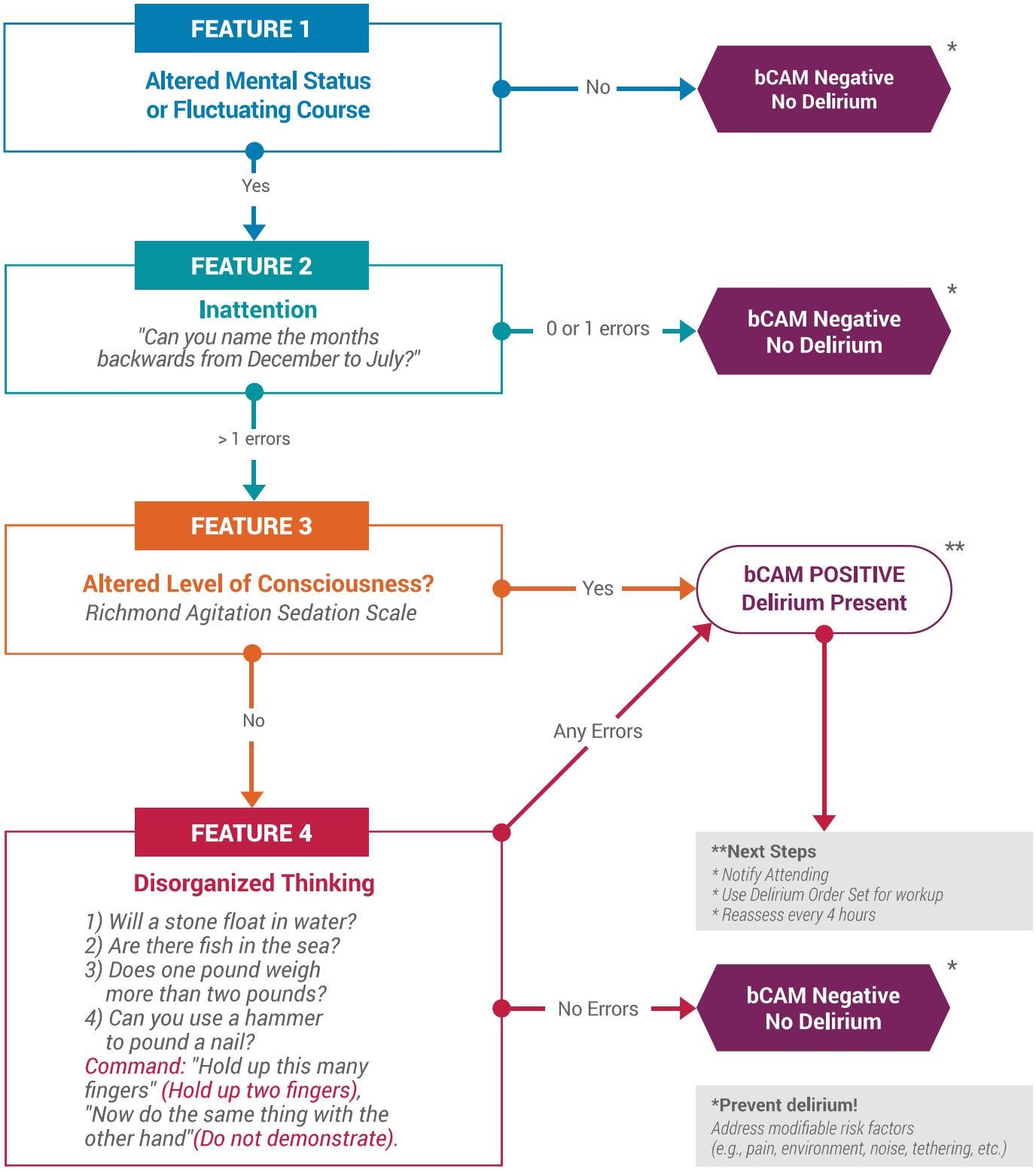
Example of a Brief Confusion Assessment Method (bCAM) Flow Sheet

Note: Your workflow may differ



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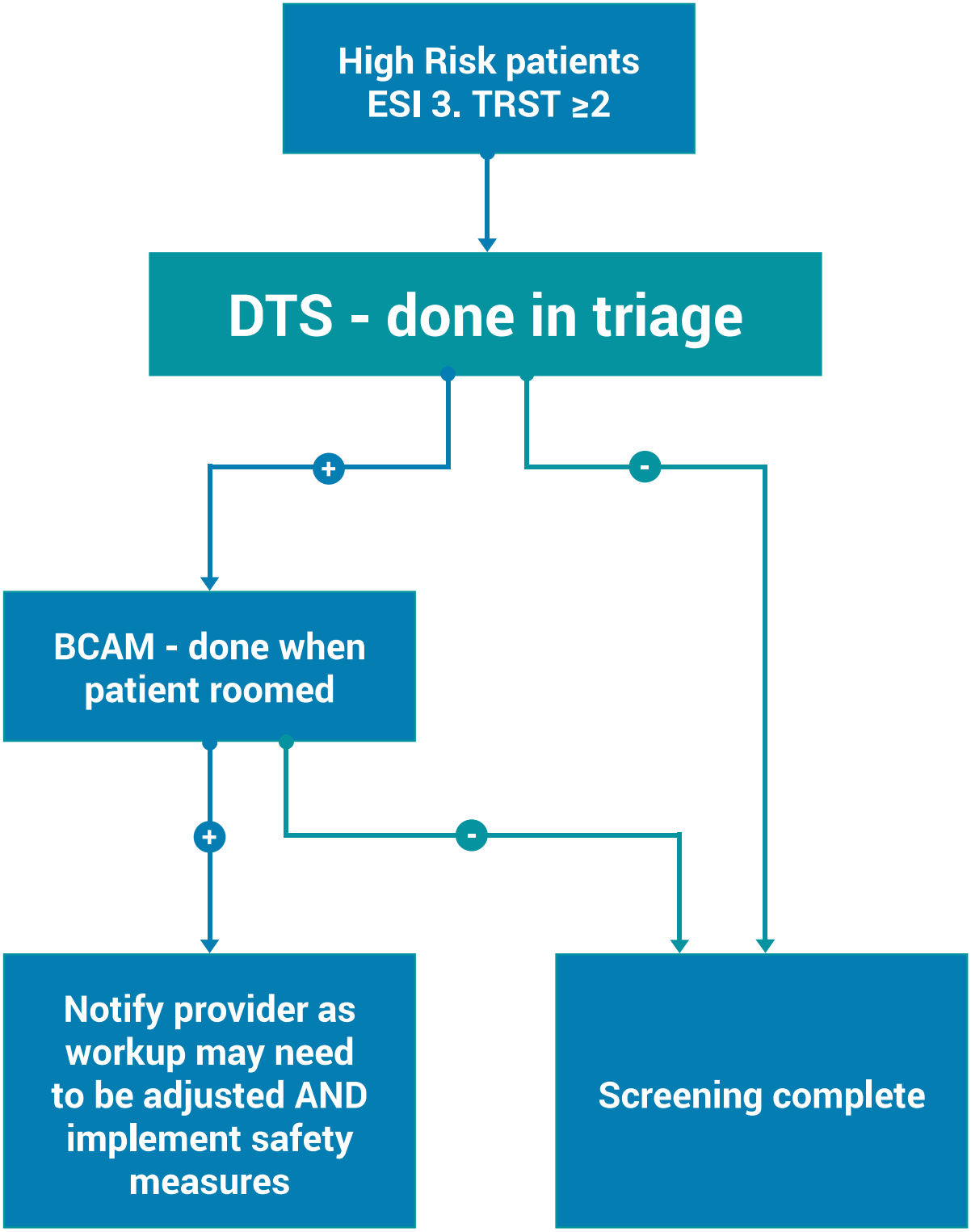
Example Delirium bCAM Workflow

Note: Your workflow may differ



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Suggested Process and Outcome Measures to Track for ED-Delirium Program

Domain	Measure and Definition	Rationale
Process Measures		
Delirium Risk Assessment	Percentage of patients age 65 and older screened for delirium risk during triage or clinical evaluation	Assessment for delirium risk is the essential first step to identify older adults at high risk for delirium and for whom the delirium prevention protocol is indicated.
Delirium Prevention Protocol	Percentage of at-risk patients who had a delirium prevention protocol initiated	Providing prompt nonpharmacologic intervention to patients at high risk reduces the likelihood of adverse delirium outcomes, including functional decline, increased ED LOS, hospital costs, falls, and death.[2]
Mobility	Percentage of at-risk patients who walked at least once per shift in ED	Mobility is a key intervention for prevention and management of delirium
Hydration	Percentage of at-risk patients who received adequate hydration (IV or PO) in ED	Dehydration is a leading risk factor for delirium in the ED. Attending to patient's fluid and nutritional status is key to prevention.
Non-Pharmacologic Management of Delirium	Percentage of patients with delirium who were managed with non-pharmacologic approaches for delirium symptoms or agitation	Non-pharmacologic management for delirium has demonstrated effectiveness for reducing agitation and delirium symptoms.
Use of Beers Criteria medications	Percentage of at-risk patients who received Beers Criteria medications	Goal is to reduce the percentage. Beers criteria medications are potentially inappropriate medications for older adults, and may increase the risk of delirium and other adverse outcomes.
Benzodiazepine Use	Percentage of patients with agitated delirium receiving a benzodiazepine (except in those with active benzodiazepine or alcohol use)	Goal is to reduce. Benzodiazepines increase the risk of delirium, functional/ cognitive decline, falls, and other adverse outcomes in older adults.[4]
Antipsychotic Use	Percentage of patients with agitated delirium receiving an antipsychotic	Goal is to reduce. Antipsychotics are ineffective to treat delirium, may prolong delirium, increase the risk of functional/cognitive decline, falls, and other adverse outcomes in older adults.
Use of Physical Restraints and/or Bed-Chair Alarms	Percentage of patients at-risk or with delirium who were physically restrained or alarmed at any time during ED stay	Goal is to reduce. Use of physical restraints (or bed/chair alarms) is a precipitating factor for delirium.[3]
Outcome Measures		
Emergency Department Length of Stay (LOS)	Number of hours/days spent in emergency department or observation unit	Goal is to reduce. Delirium increases ED LOS, and conversely, ED LOS greater than 10 hours is associated with a higher risk of delirium in older adults.[1]
Emergency Department Discharge Disposition	Proportion of patients transferred to observation unit; transferred to floor; discharged home without services; discharged home with services; discharged to post-acute care or other setting	This measure allows for assessment of patient's status following ED visit.

Other measures to consider: % with new delirium; transitional care received; discharge with delirium

1. Bo M, et al. Length of Stay in the Emergency Department and Occurrence of Delirium in Older Medical Patients. J Am Geriatr Soc 2016;64(5):1114-9.
2. Josephson SA, et al. Quality Improvement in Neurology: Inpatient and Emergency Care Quality Measure Set: Executive Summary. Neurology 2017;89.
3. Inouye SK, et al. Precipitating Factors for Delirium in Hospitalized Elderly Persons: Predictive Model and Interrelationship with Baseline Vulnerability. JAMA 1996;275(11):852-7.
4. American Geriatrics Society Beers Criteria Update Expert Panel. 2019 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. JAGS 2019;[Epub ahead of print]:1-21.

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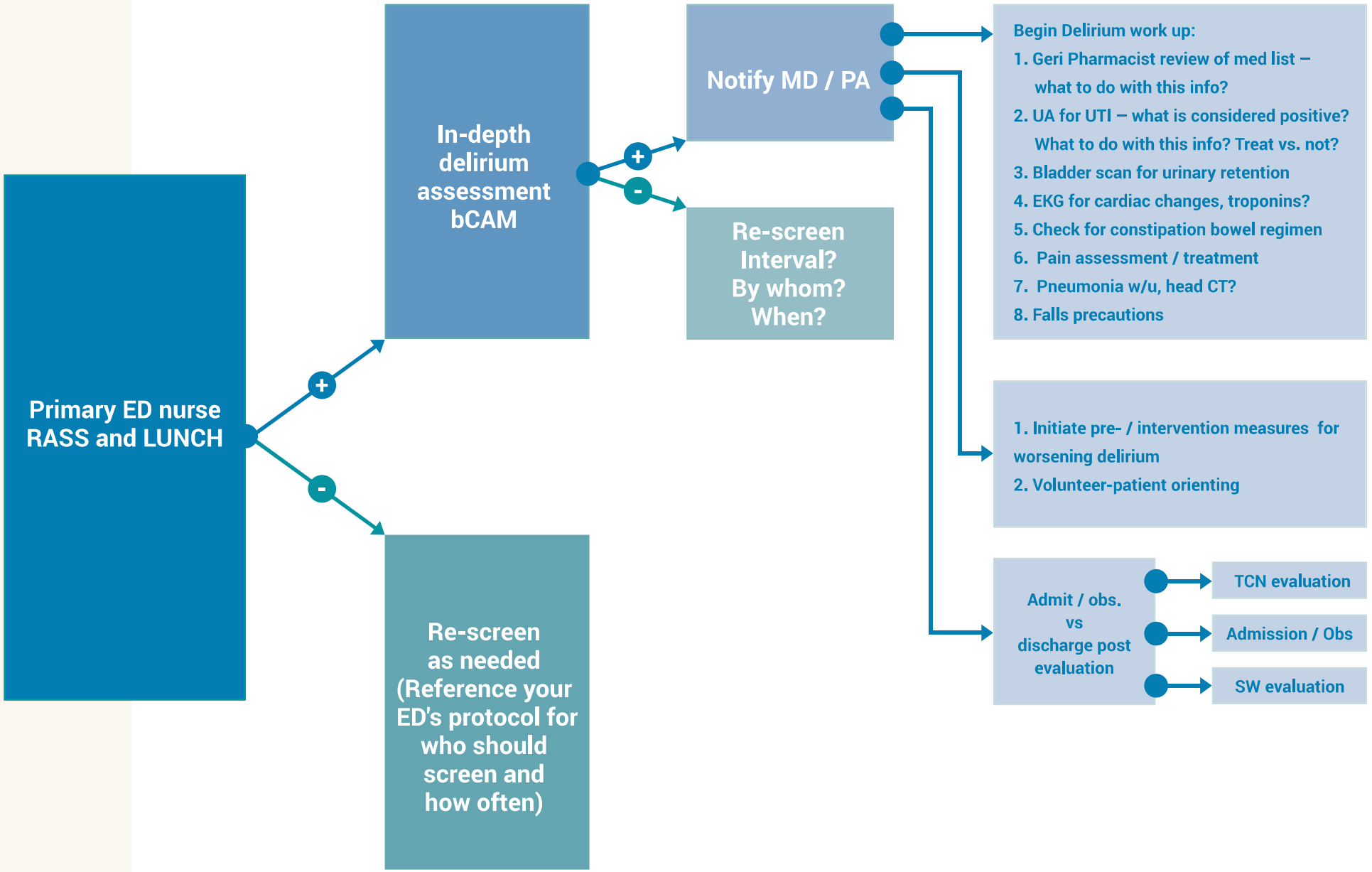
Example Delirium Workflow (Initiating at Bedside)

Note: Your workflow may differ



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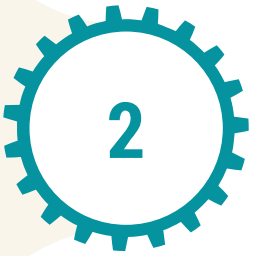
Example Delirium Screening Workflow in the ED

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.

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Delirium Screening Tool: RASS

RICHMOND AGITATION-SEDATION SCALE (RASS)

Scale	Label	Description	
+4	COMBATIVE	Combative, violent, immediate danger to staff	
+3	VERY AGITATED	Pulls to remove tubes or catherers; aggressive	
+2	AGITATED	Frequent non-purposeful movement, fights ventilator	
+1	RESTLESS	Anxious, apprehensive, movements not aggressive	
0	ALERT & CALM	Spontaneously pays attention to caregiver	
-1	DROWSY	Not fully alert, but has sustained awakening to voice (eye opening & contact >10sec)	VOICE
-2	LIGHT SEDATION	Briefly awakens to voice (eyes open & contact <10sec)	VOICE
-3	MODERATE SEDATION	Movement or eye opening to voice (no eye contact)	VOICE
-4	DEEP SEDATION	No response to voice, but movement or eye opening to physical stimulation	TOUCH
-5	UNAROUSABLE	No response to voice or physical stimulation	TOUCH

RASS, Richmond Agitation-Sedation Scale

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Suggested Roles and Responsibilites

TIP
Schedule at least 1 Delirium Champion per ED shift

Delirium Champion

Key Attributes

- Health care professionals (often MD, RN, or SW)
- Committed to quality improvement
- Knowledge of delirium
- Proactive leadership and communication skills

Key Responsibilities

- Educational outreach to team members
- Remind staff to complete delirium protocols and ensure adherence
- Lead meetings regarding delirium
- Offers tools for success including staff recognition and incentives
- Gains support from administration and hospital/ED leadership

Delirium Team Members

Key Attributes

Professionals with a variety of perspectives (physicians, nurses, techs, case managers, social workers, pharmacists, physical therapists, geriatrician, geriatric nurse specialist)

Key Responsibilities

- Determine who will be screened (all patients, high risk patients, etc)
- Decide on a screening tool
- Decide who will perform the screening and where
- Determine follow-up protocol for positive screens
- Determine safety measures to be implemented within the ED following a positive screen.

Administrative Leader

Key Attributes

- Senior member of the management team with substantial decision-making capacity

Key Responsibilities

- Allocate personnel and resources
- Remove barriers
- Provide financial support
- Lay groundwork for staff empowerment

Pharmacist

Key Attributes

- Clinical pharmacist with knowledge of delirium

Key Responsibilities

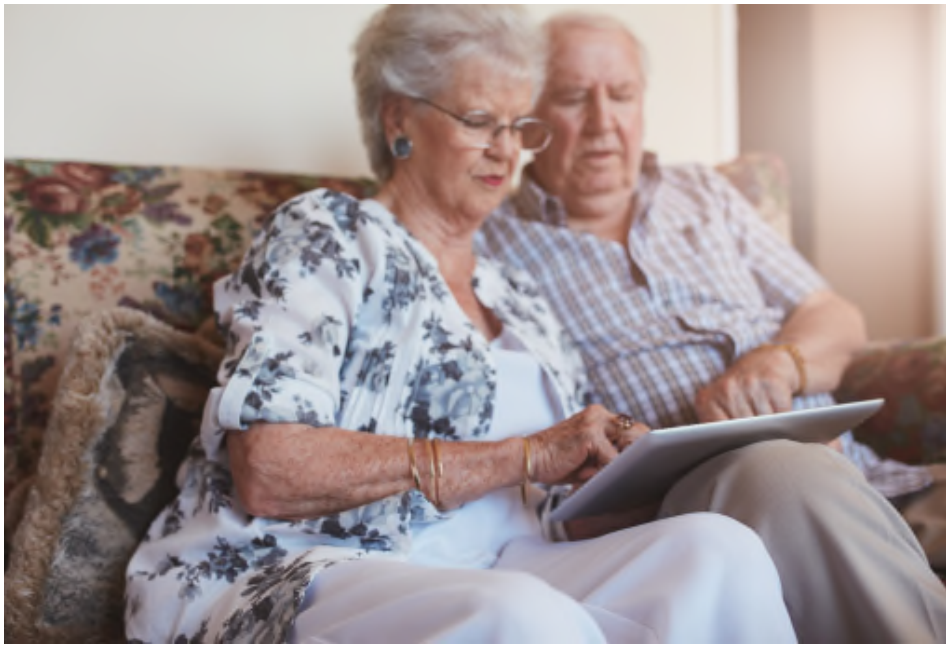
- Medication review for patients at high risk of delirium
- Recognition of potentially deliriogenic medications
- Education of staff about high risk medications
- Discharge education of patients/families about their medications

THE ROLE OF THE **DELIRIUM CHAMPION**

CLINICAL DELIRIUM CHAMPION:

A delirium champion is a health care provider (typically MD, RN, or SW) who has an interest in improving care for older adults who come to the emergency department. Delirium champions are supported by senior management and should be proactive clinician leaders with credibility among staff.

The delirium champion will spearhead education efforts and utilization of delirium assessment, recognition, and prevention tools in the emergency department.



Delirium Champions have:

- A commitment to quality care for older adults
- Leadership experience
- Excellent interpersonal skills
- The ability to influence and engage others in a course of action

Delirium Champions Tasks:

- Educational outreach to team members
- Remind staff to complete identified delirium protocols and ensure adherence
- Review charts and provide feedback regarding delirium in the ED
- Lead meetings or interdisciplinary rounds regarding delirium
- Offer tools for success including staff recognition and incentives

It is recommended that each ED has multiple delirium champions, ideally at least one on each shift in the ED in order to fully promote your delirium protocol.

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GAINING ADMINISTRATIVE SUPPORT:

The Delirium Champion should also gain administrative support from the ED and hospital leadership. Administrative leaders have a unique, behind-the-scenes role in establishing and supporting a delirium program in the ED. Administrators will lay the groundwork for staff empowerment and can ensure that the different clinical teams gel in this effort. We recommend approaching a senior member of the hospital management team with decision-making capacity. This individual can help support implementation efforts and provide resources to start and sustain your program.

You will need to convince your administrative leadership that a delirium protocol in the ED is an essential paradigm shift which may require providing additional education or hiring staff. Administrative leaders can help advocate for the change within the hospital decision-making hierarchy and help transmit the importance of the program to other administrative leaders.

Delirium in the Emergency Department (ED): Things for Caregivers to Know

Delirium is common and usually temporary

You can play an important role for your loved one

Immediately report any sudden changes in behavior or other symptoms of delirium to your healthcare provider

Reducing the risk of delirium in the ED

1. Try to bring all medications (or a list of all medications) with you to the ED.
2. If possible, bring a medical information sheet that lists all allergies, current physicians, medical conditions and usual pharmacy.
3. Try to bring eyeglasses, hearing aids, dentures and familiar objects to the ED.
4. Help orient your loved one throughout their stay by speaking calmly in a reassuring tone. Explain where they are and why.
5. If giving instructions, keep them simple and state only one task at a time.
6. As much as possible, stay with your loved one in the Emergency Department and/or hospital.
7. Inform the nurse or doctor immediately whenever you notice subtle changes in your loved one.

Adapted from: Delirium handout for family, Aging Brain Center, Harvard Institute for Aging Research and Delirium brochure by the Care of the Confused Hospitalized

Caring for your loved one with delirium

1. Seeing familiar people is reassuring for people with delirium. Encourage family and friends to visit.
2. When speaking to someone with delirium, use a slow, clear voice. It's helpful to identify yourself and the person (with delirium) by name.
3. Encourage and assist with adequate food and fluid intake.
4. Not knowing the time of day can increase confusion. Open the curtains and remind them where they are and what day and time it is.
5. Visual or hearing impairment can also worsen confusion. Help them put on their hearing aids and glasses if they are normally worn.
6. Do not try to restrain someone with delirium who is agitated or aggressive. Let them walk around but make sure they are safe from fall hazards.
7. When possible, bring personal items that remind your loved one of home (pictures, dressing gown, favorite music).
8. Talk with staff about any special personal information that may help orient your loved one (hobbies, significant events and people in their lives).

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Post-Discharge Family Education

SIGNS OF POTENTIAL DELIRIUM INVOLVE CHANGES IN:

ATTENTION:

- Difficulty focusing attention
- Easily distracted
- Trouble keeping track of what you are saying

SPEECH:

- Rambling or unrelated speech
- Difficult to follow thoughts
- Words that do not make sense
- Switching from subject to subject

SLEEP:

- Excessively sleepy or drowsy during the daytime
- Change from normal sleep behavior during the day

DISORIENTATION:

- Confused about times, places and people

VISUAL OR AUDITORY:

- Seeing or hearing things not actually there

DISTURBANCE:

- Mistaking one thing for something else

BEHAVIOR:

- Inappropriate behavior such as wandering, yelling out, being combative or agitated
- Fearful that others are trying to harm them

RECOGNIZING DELIRIUM:

Possible symptoms of delirium include a sudden change in your loved one's behavior and tend to come and go throughout the day. The earlier you can spot delirium the better, so any suspected change in thinking or behavior should be reported to a medical professional right away.

WHAT TO DO:

Call your loved one's physician right away if any changes noted above occur.

Be prepared to provide the following information:

- Your loved one's name, date of birth, and date of discharge from the ED or hospital
- When you first noticed the signs or changes
- The specific signs noted and if they come and go
- Patient's current temperature
- All current medications (including over the counter) and when last taken
- Diagnoses and details of recent ED visits, hospitalizations, or procedures
- Name and phone numbers of pharmacy and primary care physician

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