Improving Patient Outcomes through Assessing for Delirium
A Pilot of a Nursing Driven Guideline
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Background

Delirium is often unrecognized by nurses and has been associated with mortality rates up to 33%, increased risk of patient falls, reduced functional status, prolonged length of stay and increased costs. Experts suggest that the majority of medical-surgical patients who are restrained are suffering from hyper or mixed type of delirium. Restraints not only increase the incidence and severity of delirium but also contribute to falls and functional decline.

Aim

To Reduce Restraint and Fall rates by implementing a delirium assessment and develop a nurse driven guideline in the management and prevention of delirium

Actions

A review of contributing factors in relation to patient falls and restraint use exposed a correlation of cognitive impairment, acute confusional state, and/or altered mental status. An Interdisciplinary team was formed; consisting of Safe Patient Handling & Mobility Program manager, MDs, Volunteer services, Nursing, Education Department, Psychiatric Nurse Liaison, etc.; to discuss fall rates, restraint rate and its connection to delirium. The team

• Collaborated with Intensive Care Unit (ICU) RNs and Med-Surg RNs
• Chose an assessment tool feasible for both ICU and Med-Surg RNs to use
• Developed a Nurse Driven guideline in prevention and management of Delirium
• Engaged Volunteers to assist in management of the delirious patient

Results

Using the Confusion Assessment Method (CAM) empowered the RNs to improve the work environment by distributing the assignment of delirious patients, moving delirious patients to safer locations on the unit, and discussing possible changes to plan of care for delirium patients. The pilot demonstrated more delirium presented at night, the patient’s were mostly calm (Figure B), and decrease in overall restraint utilization and falls rates by 54% and 28% respectively on the Med-Surg unit, as compared to the same time period the previous year (Figure A). However, the ICU did not show a marked decrease in either restraint or fall rates (Figure A) which was a result from lack of understanding how to assess using the CAM-ICU which was implemented years prior.

Conclusion

As our patient population ages the incidence of delirium with its associated costs and worsening outcomes will also increase. Using CAM to recognize delirium, in not only the ICU but also medical-surgical patients, allowing for the use of a nurse driven guideline to manage patients in collaboration with the interprofessional team improves overall patient safety.

During the PDSA cycle we did discover unreliable assessment practices among the ICUs and re-education efforts are currently underway

References