Screening for delirium in acute care oncology patients: an evidenced based project to impact patient outcomes

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Purpose

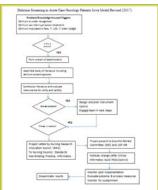
This evidenced based practice project implemented routine screening for delirium in all inpatient units in a major cancer center with a consistent instrument and the adoption of an interprofessional plan of care for delirium based on national guidelines.

Background

- Delirium is a serious iatrogenic potential complication of inpatient cancer care.
- Within the last 2 years 17-38% of discharges from Moffitt Cancer Center experienced at least one episode of delirium during their hospitalization.
- Adequate identification can lead to improved long term patient outcomes.
- Routine screening by nurses with a valid and reliable instrument allows early targeted interventions.
- Strong evidence supports regular screening and a comprehensive plan of care to restore baseline cognitive status.
- Utilizing the same screening tool across all nursing units promotes communication and enhances the handoff process.

Conceptual Framework

The Iowa Model of Evidenced Based Practice-Revised (2017) provides a pathway to determine and implement evidence based practice initiatives in the Moffitt Cancer Center nursing department.



Measurement and Evaluation

Outcome Measures:

- ☐ Reduce the number of falls with injury by 5%
- ☐ Reduce the LOS of patients with delirium by 0.5 day

Data source: Weekly reports

Process Measures:

- ☐ Screen 95% patients for delirium Q shift
- Institute Delirium Interprofessional Plan of Care in 100% of patients screened + for delirium

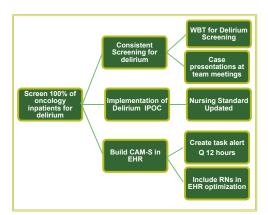
Data source: EHR review

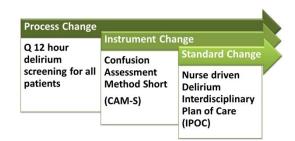
Balancing Measure:

 Increase the utilization the of decision tree for remote visual monitoring and one to one observation

Data source: Daily Bed Summary reports

Driver Diagram

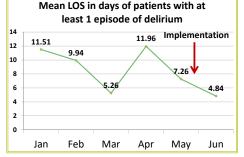




Results

- Identification of delirium with routine screening
- Nursing screening provider diagnosis
 Implementation of Delirium IPOC may have contributed to modest initial in LOS in patients screening positive for delirium
- □ 31% to 49% of delirium patients ≥ 65 years
 of age
- No change in # falls with injury

| Identification of Delirium | Jan | Feb | Mar | Apr | May | Jun |
|------------------------------|-----|-----|-----|-----|-----|-----|
| Delirium identified by ICD10 | 36 | 33 | 36 | 73 | 66 | 65 |
| Delirium + by DOS | 71 | 74 | 71 | 86 | 83 | |
| Delirium + w/CAM-S | | | | | | 67 |



Delirium IPOC

| Collaborate with tean | n for underlying cause of delirium | | |
|--|--|--|--|
| Orient in context of c | are | | |
| Address pain and disc | omfort | | |
| mplement non-phari | nacological sleep strategies | | |
| Organize treatments | with consideration of sleep requirements | | |
| stablish normal slee | p/wake patterns | | |
| Regulate sensory stim | ulation and Maximize sensory perception | | |
| mplement High Fall s | afety modalities Initiate Remote Visual Monitoring | | |
| mplement injury pre | vention strategies if indicated; Avoid restraints | | |
| ncrease frequency of | purposeful rounding | | |
| nstitute 1:1 Observat | ion in a healing environment if indicated | | |
| Jtilize Teach-Back Me | thod w family: Treatment plan fall/injury prevention | | |
| OOB for meals unless | contraindicated | | |
| mplement early prog | ressive mobilization protocol Engage PT/OT in consultation | | |
| dentify include author | orized substituted decision-maker mutual problem solving | | |
| ncourage family/car | egiver to participate in care | | |
| ducate family about | signs, symptoms, causes of delirium | | |
| Monitor nutrition star | tus | | |
| Monitor bowel and b | adder function | | |
| Avoid use of indwelling | ng urinary catheters | | |
| Monitor closely for de | hydration/fluid & electrolyte imbalance | | |
| Collaborate and enga | ge in mutual problem solving with Behavioral Medicine | | |
| Collaborate with clinical pharmacist for medication review | | | |
| Suggest baseline EKG; Monitor QTc in QT prolongation meds (requires order) | | | |
| Discourage the use of zolpidem, consider melantonin receptor agonist (rozerem) | | | |
| Suggest avoidance of | anticholinergics if possible | | |
| Discuss the use of Ha | operidol smallest dose within the shortest time frame | | |
| Suggest avoidance of | benzodiazepines if possible | | |

Limitations

At the time of publication, only one data point post implementation was available for review. Ongoing evaluation will include monthly reporting of incidence of delirium (single patient cases of + delirium screening/patient days), LOS of patients with delirium, monitoring of implementation of the delirium IPOC, and fall with injury.

Discussions

Older adults with cancer were found to be a significant proportion of the delirious patients. The unit based geriatric resource nurse can function as delirium experts. Implementing routine screening identifies the oncology patient with delirium allowing early interventions during hospitalization. Next steps include identifying the potential oncology inpatient at risk for the development of delirium and implementing best practice interventions to **prevent** delirium.

References

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