Iatrogenic Delirium

Overview

Julie Apold
Sr. Director, Patient Safety
Minnesota Hospital Association
Polling Question

What is the current status of your delirium program?

• Have an established program
• Making good progress on getting practices in place
• Just getting started
• Have not really addressed delirium
Polling Question

- Do you have fairly established delirium identification, prevention and management practices in *The ICU*?
  - Yes
  - No
Polling Question

- Do you have fairly established delirium identification, prevention and management practices in Med/Surg Units?
  - Yes
  - No
Polling Question

- Do you have fairly established delirium identification practices in *The Emergency Department*
  - Yes
  - No
Center for Medicare and Medicaid Innovation (CMMI) allocated $1 billion in funding for the Partnerships for Patients Initiatives

- Phase 1: Decrease preventable hospital-acquired conditions by 40% across 10 topics
- Phase 2: Leading Edge Advanced Practice Topics (LEAPT)
  - Tests of innovation in 5 new topics, including:
    - Iatrogenic Delirium (Minnesota one of 3 states to address this topic)
LEAPT: Iatrogenic Delirium

Phases:

1. Development of a delirium “change package” with a small group of pilot hospitals.
   - Innovation encouraged
   - Small tests of change

2. Development and broad dissemination of a Delirium “Road map” of best practices with supporting tools and resources.
Outcome:

- 10% reduction in the rate of iatrogenic delirium (patients with initially negative delirium screen that move to a positive diagnosis of delirium during their hospital stay) by December 2014.
  
  • Expect initial increase with improvement in delirium detection
Process:

- 20% decrease in the number of patients in the target population that are administered benzodiazepines or antihistamines by December 2014.
- 40% increase in the % of best practices implemented from the Delirium Roadmap by December 2014.
Pilot Hospitals

- HealthEast Care System
  - St. John’s Hospital
  - St. Joseph’s Hospital
  - Woodwinds Health Campus
- New Ulm Medical Center
- Park Nicollet Methodist Hospital
- Rice Memorial Hospital
Goals of Today

- Provide information to staff from pilot hospitals on delirium screening, prevention and management as they begin or continue their implementation journey.
- Provide information for other hospitals interested in beginning or continuing this important work prior to the fall “kick-off”
- Delirium kick-off scheduled for September 24th
Presenters

Sue Bikkie

Dr. William Orr
Management and Prevention of Delirium in Hospitalized Elders

Sue Bikkie DNP, GNP, GCNS, APRN, BC
William B. Orr, PhD, MD
Objectives:

✓ Explain the incidence of delirium in hospitalized patients.
✓ Describe common causes of delirium.
✓ Identify risks and contributing factors for the development of delirium.
✓ Identify non-pharmacological and pharmacological interventions to help manage the patient with delirium.
Delirium: Pathophysiology

- Alterations in cholinergic and dopaminergic transmission in cortical and subcorital brain structures responsible for attention
- In patients with delirium who lack exposure to anticholinergic medications, evidence of a possible presence of endogenous anticholinergic substances
- Growing body of data indicates delirium may result from the direct and indirect effects of cytokines on the brain
Delirium: Synonyms

- Acute brain failure
- Acute confusional state
- Encephalopathy
- ICU psychosis
- ICU Syndrome
- Postoperative delirium
## Delirium: Distinguishing from Dementia

<table>
<thead>
<tr>
<th></th>
<th>Delirium</th>
<th>Dementia</th>
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</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Acute</td>
<td>Insidious</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Variable</td>
<td>Lifetime</td>
</tr>
<tr>
<td><strong>Course</strong></td>
<td>Fluctuating</td>
<td>Steadily progressive</td>
</tr>
<tr>
<td><strong>Consciousness and orientation</strong></td>
<td>Clouded, disoriented</td>
<td>Clear until late stages</td>
</tr>
<tr>
<td><strong>Attention and memory</strong></td>
<td>Poor short term memory, inattention</td>
<td>Poor short term memory without marked inattention</td>
</tr>
</tbody>
</table>
# Delirium: Distinguishing from Dementia

<table>
<thead>
<tr>
<th></th>
<th>Delirium</th>
<th>Dementia</th>
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</thead>
<tbody>
<tr>
<td><strong>Hallucinations</strong></td>
<td>Common, especially visual</td>
<td>Often absent</td>
</tr>
<tr>
<td><strong>Delusions</strong></td>
<td>Fleeting</td>
<td>Often absent</td>
</tr>
<tr>
<td><strong>Psychomotor activity</strong></td>
<td>Increased, reduced, or unpredictable</td>
<td>Can be normal</td>
</tr>
</tbody>
</table>
Characterized by a disturbance of consciousness (*reduced ability to focus, sustain, or shift attention*), a change in cognitive status, or a perceptual disturbance that *develops over a short period of time* and tends to fluctuate during the course of the day.
Delirium: Prevalence and Incidence
Delirium present upon admission to the hospital (prevalence) in medical inpatients ranges from 10-30%.

New onset of delirium that develops during hospitalization ranges from 4-53.2%.

Some studies show up to 80% of elderly experience delirium while in the hospital.
Postoperative delirium occurs in 10-61% of elders.

Occurs in 20-55% of hip fracture patients.

Develops in 25-40% of all elders with a cancer diagnosis.

20% of patients with advanced cancer are admitted to hospice due to delirium.
Delirium – Prevalence and Incidence

- Delirium present upon hospital admission (prevalence) in medical inpatients ranges from 10 to 30% and 31% of patients admitted to ICU.

- Occurrence of delirium range from 19% to 22% to 62% to 81.7% to 83.3% of patients in critical care.

- Incidence of delirium after cardiac surgery is approximately 32%.
Mechanically Ventilated Patients

Delirium occurs in as many as 8/10 mechanically ventilated medical ICU patients
Delirium- Who’s More Vulnerable?

- Older patients (chronological age, by itself, doesn’t place the individual at risk of becoming acutely confused, but many factors associated with aging do)
- Sicker
- Those who have a preexisting cognitive or functional impairment
- Dementia is the most commonly cited risk factor and has the strongest and most consistent relationship with delirium
Delirium: Caregivers

- Most healthcare professionals consider delirium a serious problem but few monitor for it.

- Delirium goes unrecognized by both physicians and nurses.
Delirium: Presentations

Hyperactive
- Agitation, restlessness, attempting to remove catheters or tubes, hitting, biting and emotional labiality; may be delusional and/or experience hallucinations

Hypoactive
- Much easier to overlook
- Characterized by withdrawal, flat affect, apathy, lethargy, and even decreased responsiveness; subdued, apathetic

Mixed
- Concurrent or sequential appearance of some features of both hyperactive and hypoactive delirium
Delirium: Behavioral Manifestations

Behavioral manifestations may include:

- Attempts to escape one’s environment
- Removal of medical equipment
- Disturbances in vocalizations
- A predilection to attack others
Patient Outcomes

- Adverse reactions to therapeutic doses of medications
- Fall more frequently
- More prone to develop pressure ulcers
- Develop more infections
Delirium: Patient Outcomes

- Predictive of prolonged length of stays in the hospital and ICU
- Higher risk for postoperative complications, longer postoperative recuperation periods and long-term disability
Delirium: Patient Outcomes

- Complicates hospital stays for more than 2.3 million older people
- Involves more than 17.5 million inpatient days (up to 49% of inpt. days)
- Accounts for more than 6.9 billion of Medicare expenditures
Delirium outcomes....

- Hospitals lose an average of $30,000 per acutely confused patient

- Mortality rate 3 months after a patient is diagnosed with delirium, ranges between 23% ad 33%

- In a 1 year follow-up, there was a 50% mortality rate for patients diagnosed with confusion
Early Signs of Delirium

* Forgetfulness
* Disorientation
* Inattentiveness/easy distractibility
* Misperceptions
* Daytime sleepiness
* Fear
* Verbal complaints of feeling mixed-up or thinking fuzzy
* Insomnia
Delirium Timeline

- Usually occurs shortly after admission to the hospital, between the 2\textsuperscript{nd} and 3\textsuperscript{rd} day

- Usually lasts less than five days
  - If you can find cause(s)
Delirium: Duration

- Typically the symptoms of delirium resolve within 10-12 days; however, up to 15% of patients with delirium have symptoms that persist for up to 30 days and beyond
Delirium rarely has one cause; rather, it represents an intrinsically multifactor syndrome.
ROUND UP THE USUAL SUSPECTS
America the Overmedicated?

Karsten Ivey, Florida Times Union, Jacksonville, Florida December 31, 2000
Medications are part of the cause of delirium in 20-40% of cases.

Most prescribed drugs can cause delirium.

Decrease delirium risk by:

- assessing the need for medications
- minimizing exposure to high risk drugs
- considering alternative medications
Drugs as Culprits

- **Drugs with anticholinergic activity**
  - diphenhydramine (Benadryl)
  - prochlorperazine (Compazine)
  - Famotidine (Pepcid)
  - Hydroxyzine (Vistaril)

- **Benzodiazepines**
  - lorazepam (Ativan)
  - Valium (long half life)
  - Xanax

- **Opioids**
  - morphine

- **Antidysrhythmic Agents**
  - Procainamide
  - lidocaine
Delirium Causes

- Polypharmacy (particularly drugs with anti-cholinergic properties or those that have potent CNS effects).
- Metabolic disturbances.
- Immobility.
- Infection (particularly UTI’s, and URI’s).
- Dehydration and electrolyte imbalance (especially hypo-or hypernatremia and hypo-and hyperkalemia).
- Sensory impairment.
- Environmental changes.
- Bladder catheters.
The greater the number of predisposing factors, indicating higher patient vulnerability at baseline, the fewer precipitating and facilitating factors are needed to cause an episode of delirium.

The fewer predisposing factors, indicating less patient vulnerability at baseline, the greater number of precipitating and facilitating factors that are needed to cause an episode of delirium.
What are the Contributing Factors for Delirium?

- Predisposing factors: Advanced age, dementia, depression, substance abuse, history of delirium, and use of restraints
- Precipitating factors: hypoxia, pain, cold, malnutrition, sleep deprivation, sensory overload or deprivation, lack of normal routine, hunger, and thirst
Delirium: Prevention

- Patients at intermediate or high risk
- Standardized protocols – Orientation, Sleep enhancement, Early mobilization, Vision & Hearing and Dehydration protocol
- Delirium 9.9% (intervention) vs. 15.0 (usual care)
Delirium: Prevention

- “An ounce of prevention beats a pound of cure.”
- Prevention is the best approach
“The difficulties of providing the critically ill patient with 4 to 6 hours of uninterrupted sleep are well known.”
Assessment Tools

- NEECHAM
- CAM-ICU
- CAM
- Delirium Rating Scale
- BEERS Criteria
Delirium: Treatment and Management

Treatment should be aimed at the specific symptoms of delirium, and efforts should be made to identify and treat the underlying causes.
Delirium: Prevention and Treatment

Physiologic factors
- Pain management
- Elimination
- Hydration
- Nutrition
- Oxygenation
- Anxiety reduction interventions
Nonpharmacological Intervention Goals

- Maintain a familiar environment and maximize the safety of the environment
- Increase the patient's ability to interpret the surroundings appropriately
- Provide psychosocial support to patient/family during an extremely stressful time
- Use consistency in evidence-based intervention to lead positive patient outcomes/prevent deterioration
Use Communication Strategies

- Call patient by name, use significant others’ names and keep apprise of treatment.

- Speak clearly, slowly, and use repetition.

- Patient-nurse interaction of at least 10 minutes (when time allows).

- Reassurance about transient nature of confusion to patient and family.
Get patients out of bed daily.
- If ambulatory, walk in hallway TID
- If bed restricted do ROM, TID

Take patients out of room.

Consult PT & OT for patients with more than 3 deficits in ADL’s.

Consider thrombosis prophylaxis.

Avoid restraints and protect from harm.
Manipulate the Environment

- **Orient patient to surroundings**
  - Remind and inform them about the day, time, place, day of week, and current events.

- **Use orienting devices**
  - Use watch, clock, calendar and place within patient’s view and within reach.
  - Use personal possessions, bedclothes, blankets from home.
  - Use reading material, favorite TV and radio programs used at least part of shift.

- **Visual and hearing deficits**
  - glasses, contacts, hearing aids.
Manipulate the Environment - cont.

- Control Sensory Input.
  - Quiet. (alarms)
  - Uncluttered environment.
  - Room temperature regulated between 70-75 degrees.
  - Assign same caregiver over time.
  - One task at a time

- Promote sleep
  - Simulate day-night cycles
  - Adequate light when awake, over-bed light on, night light.
Delirium: Prevention and Treatment
Supportive - Environmental

- Provide psychosocial support to patient/family at an extremely stressful time
- Encourage frequent visits & calls; ask them to bring in photos and mementos
- Family members taught to use eye contact, frequent touch, verbal orientation to person, place & time
Pharmacological Intervention

- Start with lower doses.
- Aggressive initial titration.
- Use combination therapy if needed.
- Optimize pain management
- Consider nicotine replacement (if smoker)
- Multivitamin replacement for possibility of vitamin B deficiencies.
- Consult pharmacist (polypharmacy)
Haloperidol (Haldol)

Drug of choice
-0.5-5mg IV/IM/PO BID to every 6 hr.
- Elderly patients 0.25-0.5 mg MR X1 after 30 minutes to titrate to usual dose 1-10 mg/day

*Advantages
- favorable respiratory profile
- less anticholinergic activity

*Disadvantages
- Occasional hypotension (IV)
- EPS and tardive dyskinesia
- QT changes
Atypical Antipsychotics

- Used in adults and adolescents
- Diminished incidence of tardive dyskinesia
- Small, uncontrolled trials
- Olanzapine, Risperidones, Quetiapine, Ziprasidone
Drug: Olanzapine (Zyprexa®)

Dose: 2.5 – 5 mg/day (Dose at bedtime)
  Maximum of 20 mg/24 hours

Route: PO/NG or IM
  Disintegrating tablets (Zydis) for patients with dysphagia

Disadvantages: May cause significant hypotension
Drug: Risperidone (Resperidol®)

Dose: 0.25-0.5 mg daily - BID
   May use prn orders of 0.25-0.5 mg
   every 4 hours prn to aid in titration

Route: PO/NG
   Available as liquid, and disintegrating tab
   for patients with difficulty with
   swallowing
Drug: Quetiapine (Seroquel®)

Dose: 12.5-50 mg every 4 hours prn for agitation or increased symptoms
Maximum of 600 mg/day

Route: PO/NG
Tablet may be crushed
Delirium: Pharmacological Intervention

**Drug:** Ziprasidone (Geodon®)

**Dose:** 10-20 mg every 4 hours, prn, to a maximum dose of 40 mg/day

**Route:** PO/NG/IM

- Capsule may be opened

**Disadvantage:**
- Contraindicated in patients with QTc>500 msec, recent myocardial infarction, or uncompensated heart failure
Benzodiazepines

- Drugs of choice for ETOH or sedative withdrawal
  - lorazepam (Ativan)
  - 0.5-2mg IV/PO every 6 hr.

*Advantages*
- no anticholinergic activity
- no effect on QT interval

*Disadvantages*
- respiratory depression
- CNS depression
- paradoxical reactions with the elderly being more sensitive
Delirium Assessment Conclusions

- Acute confusion is common and *preventable!*
- Early identification of at-risk patients & prevention of acute confusion are key
- Identify contributing factors: predisposing, precipitating, and facilitating.
- Assess risk in all patients upon admission and as change in condition warrants
- Consistent use of non-pharmacological interventions is the most powerful intervention for acute confusion
  - Eliminate medications or reduce the dose of medications that increase the risk of delirium.
Questions?
MHA LEAPT project

Implementing HELP at Park Nicollet Methodist Hospital

Paula J. Duncan, RN, BS, Coordinator HELP
Susan Schumacher, RN, MS, Geriatric CNS
April 22, 2014
Park Nicollet Methodist Hospital
At the conclusion the learner will be able to:

1. Understand how Park Nicollet Methodist Hospital positioned itself to be ready for a delirium prevention strategy
2. Develop an understanding of how we measure
   - Outcome success
   - Program success
3. Explain successes and opportunities for implementation and sustainability of a delirium prevention program
“a little delirium” Why should we care?

• Once this sudden brain dysfunction occurs, it multiplies the chances of dying. Not only do patients have a 25 percent to 70 percent higher chance of dying during their hospital stay, but they are also at a 62 percent higher risk of mortality in the following year. Dr. Sharon K. Inouye

• The odds are worse for patients who experience delirium in the intensive care unit. It can triple the chances of dying in the next year. Dr. E. Wesley Ely

• Delirium also is one of the most costly complications of a trip to the hospital. It leads to longer stays — up to 10 days longer. That can cost each elderly patient an extra $60,000 to $64,000 per hospital stay. And post-hospital treatment for delirium costs $143 billion to $152 billion per year, according to a study this year in The Journal of American Geriatric Society. That includes additional rehabilitation services, home health and caregiver care, and nursing home care.

• That’s why prevention is crucial. “We could solve the Medicare problem just by preventing hospital delirium, and 30 to 40 percent of it could be prevented,” said Dr. Inouye.
Characteristics of delirium:

• Common problem, 25-60% older hospitalized persons
• Serious complications, including increased rates of morbidity, institutionalization, and mortality
• Often unrecognized
• At least 40% of cases may be preventable
• 35% of the U.S. population aged ≥ 65 years is hospitalized each year accounting for > 50% of all inpatient days
• Assuming a delirium rate of 20%:
  – 7% of all persons ≥ 65 years will develop delirium annually
  – Delirium will complicate hospital stay for > 2.2 million persons/year, involving > 17.5 million in-patient days/year
• Estimated costs: > $8 billion/year
UNIQUE ASPECTS OF HELP: a delirium prevention program

• Hospital-wide focus; geriatric unit is not required
• Provision of skilled staff and trained volunteers to carry out interventions; contrasts with geriatric consultation program
• Use of practical interventions directed at 6 known risk factors for cognitive and functional decline
• Targeting program for appropriate patients
• Standard procedures which leads to quality assurance
Goal 1. Understand what Park Nicollet Methodist Hospital did to be ready to implement a delirium prevention strategy

• Park Nicollet Methodist Hospital Delirium Initiative

Four basic principles:

– **Recognize** it promptly if it occurs
– **Treat** it promptly if it occurs
– **Document** it accurately
– **Prevent** it before it occurs
Recognize & Treat delirium

• **Nursing**
  • CAM assessment within 4 hours of admission on all patients 70+ better
  • CAM assessment every shift after initial assessment
  • CAM + notify MD within 15 minutes of CAM +
  • Ongoing audit of RN CAM accuracy

• **Clinicians**
  • Agreement from hospitalists on 6 delirium codes
  • Agreement from hospitalists on medications for treatment of delirium on order set
  • Agreement from hospitalists to respond within 15 minutes of a CAM + finding to utilize the order set
Document delirium accurately

• Coders
  • Education for knowing HOW to code appropriately for appropriate, maximum reimbursement utilizing clinician dictation
  • Understand the 6 approved delirium codes for accurate coding using clinician dictation

• Clinicians
  • Agreement from hospitalists on 6 delirium codes
  • Standardization of delirium dictation for appropriate, maximum reimbursement
  • Standardization allowed for capturing severity of illness via dictation/coding
Prevention via Hospital Elder Life Program®
HELP Model: Best Practices

• Dedicated HELP Staffing
• Elder Life Specialist; Elder Life Nurse Specialist; Geriatrician; Trained Volunteers
• Volunteer Recruitment and Training
• Dedicated, well-trained volunteer staff to cover all shifts, 7 days a week
• Patient Enrollment
• Screening process for all admitted older persons; individualized plan of interventions
• HELP Intervention Protocols
• All protocols implemented; regular interdisciplinary rounds
• Quality Assurance
• Intervention adherence monitored; HELP working group; performance reviews of staff and volunteers; patient/family surveys
• Outcome Tracking and Reporting
  Documentation of key outcomes; annual reports to hospital leadership
Overall HELP® Goals

• Maintain physical and cognitive functioning during hospitalization (through daily interventions)
• Maximize independence at discharge
• Assist with the appropriate transition from hospital to home or step-down setting
• Improve geriatric skills of staff throughout the hospital.
INTERVENTION PROCESS

• Screening: all patients ≥ 70 years are screened
• Inclusion: as inclusive as possible, must have at least one risk factor for cognitive/functional decline
• Exclusion: minimized, mainly inability to participate in interventions
• Assignment: after screening, patients assigned to interventions based on their risk factors by Elder Life Specialists. Individualized menu of interventions
• Adherence: completion of all interventions tracked daily by Elder Life Specialists
HELP specific protocols

- Focus on 6 delirium risk factors
  - Cognitive Impairment
  - Sleep disturbances
  - Dehydration
  - Mobility issues
  - Sensory impairment; hearing & vision
# ELDER LIFE PROGRAM VOLUNTEER ACTIVITIES

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Cognitive Impairment</td>
<td>Reality orientation</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Activities Program</td>
</tr>
<tr>
<td>Vision/Hearing Impairment</td>
<td>Vision/Hearing Aids</td>
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<tr>
<td></td>
<td>Adaptive Equipment</td>
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<tr>
<td>Immobilization</td>
<td>Early Mobilization</td>
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<tr>
<td></td>
<td>Minimizing immobilizing equipment</td>
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<tr>
<td>Psychoactive Medication Use</td>
<td>Non-pharmacologic approaches to sleep/anxiety</td>
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<tr>
<td></td>
<td>Restricted use of sleeping medications</td>
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<tr>
<td>Dehydration</td>
<td>Early recognition</td>
</tr>
<tr>
<td></td>
<td>Volume repletion</td>
</tr>
<tr>
<td>Sleep Deprivation</td>
<td>Noise reduction strategies</td>
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<tr>
<td></td>
<td>Sleep enhancement program</td>
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</table>
"The cake"...the volunteers

- **Unique role:** Hands-on, ELS & daily staff are volunteers
- **Selection criteria:** Responsibility, caring, and respect for older persons.
- **Commitment:** Minimum of one 4 hour shift/week for 6 months
- **Training:** Intensive, 6 hours didactic group, followed by 8 hours one-on-one training with patients
- **Quality checks:** Quarterly competency-based checklists
- **Volunteer retention:** Daily staff communication, quarterly educational/support session, monthly newsletter, and incentive awards
- Role can be covered by paid staff, but lose many benefits of cost-effectiveness and spirit
ELS; the role of the Elder Life Specialist

- Most program this is a paid position
- Consult are received electronically from nursing following CAM assessment of a negative status
- Complete electronic & face to face assessment of patient observing for 6 risk factors
- Give recommendations to the volunteers with regards to activities for specific risk factors
- Assist in data collection
- Train new ELS’s from St. Mary’s U of MN
- Participate in daily HELP huddles
ELNS; the role of the Elder Life Nurse Specialist

- Participate in daily huddles
- Consults for patients who become delirious or are at high risk for delirium
- Develop and implement education for nursing staff on CAM, delirium prevention, and dementia.
- System improvements and outcome measurement.
The Geriatrician role

- Hospitalist that dedicated 0.1 fte to the support of the HELP program
- Attends huddles as possible
- Provides guidance for the team for learning of special patient needs
- Assists in deepening our understanding of the geriatric patient to assist in the prevention of delirium
What did HELP at Methodist look like when we started?

- 0.5 fte (volunteer) coordinator
- 0.5 fte (volunteer) ELS/HELP coordinator
- 0.1 fte Geriatrician; Hospitalist
- Volunteer supply and demand; the perfect fill 21/7
- Started on 1 unit in April 2010
- Protocols we started with:
  - Orientation
  - Therapeutic
How did we do it?

• $10,000 grant funds from the Service League
• A paid staff volunteered to work as ELS/HELP coordinator in addition to current job role
• A paid staff volunteered to work as the Volunteer coordinator in addition to current job role
• 3P/RPIW utilized to plan implementation from the toolkit purchased from HELP corporate
• Application process used to determine on which unit we would start to offer delirium prevention
• Guidance from Delirium steering team throughout process
Goal 2. Measuring outcomes

Patient outcomes
Program outcomes

• Data collection is the name of the game and essential to demonstrate success to your organization.
## Program outcomes “how are we doing?”

<table>
<thead>
<tr>
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<th>2010 (9/10-12/10)</th>
<th>2011</th>
<th>2012</th>
</tr>
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<tbody>
<tr>
<td>Total HELP Orders</td>
<td>865</td>
<td>2911</td>
<td>3123</td>
</tr>
<tr>
<td>Total patient’s seen (enrolled)</td>
<td>449</td>
<td>1968</td>
<td>2578</td>
</tr>
<tr>
<td>% of patients with an order who are seen by a HELP volunteer</td>
<td>52%</td>
<td>64.4%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Average number of patients with HELP order per month</td>
<td>216</td>
<td>243</td>
<td>390</td>
</tr>
<tr>
<td>Number of HELP visits per patient stay/hospitalization</td>
<td>NA</td>
<td>1.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Hospital acquired delirium (delirium/1000 patient days)</td>
<td>2.49%</td>
<td>2.49%</td>
<td>2.27%</td>
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</table>
Patient outcomes ‘staying delirium free’

PNMH Cam Negative Maintenance Rate
Patient's enrolled in HELP Program

CAM Neg Maintenance Rate
Goal
What does the patient experience?

- Lots of attention: encouragement and support to participate in getting better
- Predictable cycle each day with access to “someone who can listen”
- Volunteers can help identify patient needs and communicate with staff: Volunteers do not discuss clinical issues with patients
- Consistent support for orientation and therapeutic activities
What does the nursing staff experience?

- Non-clinical needs of patient are effectively met by volunteers, reducing interruptions and demands on floor staff
- In-services on geriatric topics and regular interdisciplinary rounds
- Oversight by HELP® coordinator
- Reduce rate of delirium
Let’s face it, it’s all about the stories what our patients are saying

- I saw her yesterday afternoon and she said that a nice man came to visit her and also gave her some playing cards. In addition she has told everyone, while sporting a huge smile, about the 3 dogs that came to see her. She LOVES DOGS!!!! THANKS!!!!

- Knowing HELP is alive and well at Methodist I would never think of her going to any other hospital but Methodist. The great care, friendly staff and HELP program gives me and my family the peace of mind.

- The patient stated to her physician that after talking to the HELP volunteer, she felt like she truly was seen as a “whole person” and not like just parts of her were under review.
Being "present" saves lives
by  Abelson, David (MD)  “The blog”

• The simple act of one human being “present” for another saves lives. According to a fascinating New York Times column, simple listening could contribute to solving the Medicare cost problem. In this time of spiraling health care technology costs, we overlook simple but profoundly effective activities.

• The highlight of the HELP event was hearing the responses to the request to “tell me about a special moment you have had as a volunteer.” One volunteer after another talked about what it meant to simply be present and listen.

• As I listened, I glimpsed how important the experiences were to them. Could it be that the volunteers were enhancing their own longevity by being present at the bedside of patients and listening?

• We learn from HELP about the power of healing relationships. Everyday miracles occur when one human being is fully present and connects with another. Delirium is averted, lives are saved, healthcare costs are reduced and the connection enhances the wellbeing and perhaps even the longevity of the volunteers.
Being Present
The skill of being present has a profoundly positive effect on how patients feel about their health. It validates their concerns by allowing them to "feel heard". It also gives them the confidence to move forward in their relationship with those who are caring for them. It creates trust. The HELP program is an amazing effort by many individuals. Its focus is all about being present and can be used as the measuring stick for all of us who strive to be present.

   Jeff Mendeloff, MD

Meeting our Mission
Thank you for this beautifully written blog. I feel truly blessed to be able to be a part of such a great team. The Volunteer Services Department mission is to enhance patient care by the development of volunteer opportunities that mutually benefit patients, staff and volunteers. In HELP, we are able to accomplish our mission. It’s a joy to be able to place volunteers in a role where they are able to truly impact patient care, and also grow not only their clinical knowledge but their skills in compassion, caring and listening.

   Amy Lobitz, Volunteer manager
we’re moving our culture

Connections
This program is truly an example of how our "connections" as caring people are an integral part of healing and prevention of complications in our acute care population. A huge thank you to all of the volunteers and to Paula for making this program a reality for our patients and families. Truly, an example of how doing the right thing leads to the best results in a very profound and sacred way.

Roxanna Gapstur, VP, CNO  Park Nicollet Methodist Hospital

Reciprocal Benefits
The HELP program is very important and beneficial to patients, as can be seen by the testimonies of patients and their family members. But in my job, I appreciate the ability to offer such a rewarding, engaging volunteer opportunity to our very skilled volunteers who are looking to truly contribute in a substantial way to the wellbeing of Park Nicollet patients.

Katie Elden, Volunteer services

HELP program helps
I am touched by this blog. As a member of the sandwich generation I am learning to listen, slow down and just be there for my 89 year old father. The elderly need respect, time and patience to process as well as the reassurance of another human being who cares at their side. In this day and age, the force of learning to care for and respect your elders can be healing. To our loss we too often do not respect our elders' perspectives, their knowledge and, yes, their fears. They go bravely before us. I wish there was no need for the HELP program...that families would all see fully the need to 'be' there quietly and to comfort. But, since that is not always the case, hurray for the HELP program! As I grow older I learn that I am the lucky one when I help!

Leslie Baken, MD
Understand successes and the opportunities that must exist for implementation/sustainability of a delirium prevention program

- Senior Leadership support
- Funding
  - Start up
  - Day to day operations
  - Growth/additions to Staff
- Identifying resources
  - Volunteer department partners
  - Inpatient unit leader partners
  - Finding & sustaining qualified volunteers
- Sharing the story; networking
  - Internal customers
  - External customers
Culture changes at Methodist

- Deepening the program to ‘get to the real high risk patients’ by creating a delirium risk assessment tool
- Addition of the ELS role via a collaborative with St. Mary’s U of MN
- Addition of ELNS role
- Updating patient & family education materials to help patients & families understand what we do, and why we care so much, and resources available
- Improving volunteer documentation into the electronic medical record
- Developing the new HELP roles to offer to potential volunteer candidates.
- Increasing awareness by continuously sharing the story for others! Internal and External marketing strategy
- The possibility of touching the patient and improving care along the continuum of care by partnering with a long term care facility
- Analyzing the data to drive continuous improvement
Lessons learned

- Plan; current state and future state. DREAM BIG!
- Collect baseline data. IMPORTANT STARTING PLACE!
- Create standards, No improvement can happen without standards, training staff on standard work.
- PDCA; Observe activity & improve it, CONTINUOUSLY
- SEVEN DESIGNS, SEVEN WHYS unstick thinking!
- Grow & expand as the volunteer pool grows!
- COLLABORATE!!! PCU’s, Rehab services, Spiritual Care, Integrative therapies, Nursing, Nursing leadership, Informatics, Quality Improvement to name a few
- Develop rich relationships with internal and external customers; Students, ICSI, MHA, Physicians, Therapists, Pharmacy, as examples
- You MUST have strong support from senior leadership to plan, implement and sustain this program.
- Celebrate every success along the way!
How do you get started?
HELP WEBSITE
http://hospitalelderlifeprogram.org

• Sign up, it’s FREE! All the tools are at your fingertips.

• Site contains:
  – General information on delirium and hospitalization for consumers, families & clinicians
  – Key articles about delirium and searchable bibliography of over 700 indexed articles
  – Information for sites interested starting HELP
If the letters are too small for you to easily read, click here to enlarge the typeface.

The Hospital Elder Life Program (HELP)
Developed by Dr. Sharon K. Inouye and colleagues at the Yale University School of Medicine

Welcome!

When older adults are ill and hospitalized, their daily routines are disrupted and they can lose their bearings and become mentally confused and disoriented.

This confusion is alarming to those who know them, but those who work with hospitalized older adults know it is a common problem and they know how to help.

The medical term for this situation is delirium.

This website provides information about recognizing delirium (new mental confusion). It also describes a program that prevents delirium in hospitalized older people, the Hospital Elder Life Program, or HELP.

What is delirium?

- Delirium is an under-recognized, but surprisingly common problem, particularly among older adults who are hospitalized.
- People who are delirious have trouble thinking clearly, focusing their thoughts, and paying attention.
Continuous improvement
Thank you!

Paula J Duncan, RN, BS, Coordinator HELP
Paula.Duncan@parknicollet.com
952-993-5604
Delirium Video

- The Minnesota Hospital Association has been fortunate to work with HealthEast Care System St. John's Hospital in Maplewood to prevent patients from developing delirium while hospitalized.

- To view this video please follow the link below:
  - http://youtu.be/EOmGUEiJJrs