Delirium Observation Screening Scale (DOS Scale)

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NICHE Nurses Improving Care for Healthsystem Elders

Problem:

Delirium is common in hospitalized older adults. Tools utilized in the past to identify delirium were inconsistently completed and adoption by nursing was not successful. Assessment tools must identify a problem without providing additional workload to the nurse on busy inpatient units.

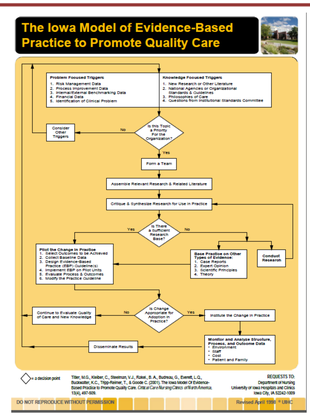
Purpose:

This poster describes the use of the Delirium Observation Screening Scale (DOS Scale) in identification, and early treatment using the electronic medical record to support the staff nurse at the bedside.

Synthesis of the Evidence:

- Unrecognized delirium may result in poor outcomes, falls associated with fractures, pneumonia from inactivity, under treatment of pain, use of restraints, increased length of stay, nursing home placement and even death. (Van Rompaey, et al., 2009)
- Delirium is common in elderly patients and those at the end of life. Delirium develops in a short period of time and symptoms fluctuate during the day. (Inouye, 1999)
- The average length of stay, total hospital costs, risk for in-hospital mortality, and post hospital institutionalization increase significantly if delirium occurs while the older adult is hospitalized. (Rizzo et al 2001)

Process



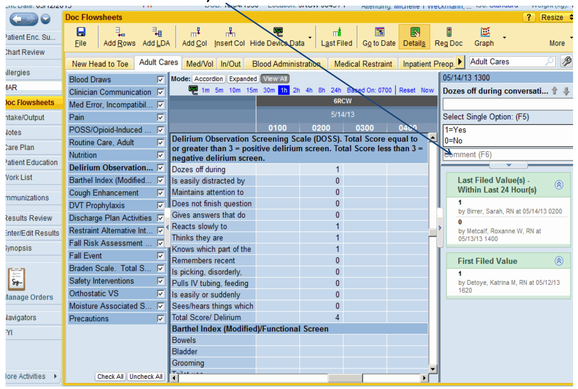
Titler, M.G., Kleiber, C., Steelman, V., Rakel, B.A., Budreau, G., Everett, L.Q., et al. (2001). The Iowa model of evidence-based practice to promote qualitycare. Critical Care Nursing Clinics of North America, 13, 497-509.

Materials & Methods

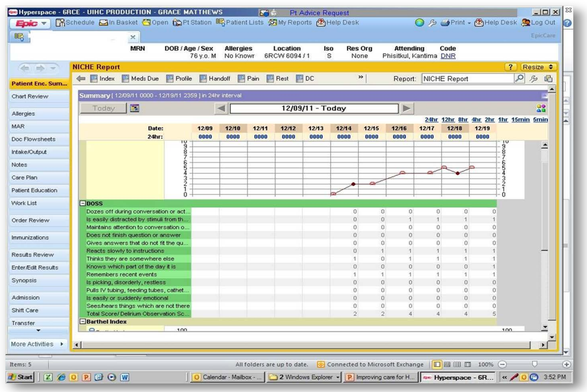
The DOS Scale is based on specific observed criteria for each delirium behavior, which were included within the scale, and could be viewed during documentation.

Staff nurses documented DOS Scale evaluations at 02:00 and 14:00 each day which provided sufficient time within their given shift to observe the patient for signs of delirium.

(*Hovering* over the row provides a description of the observed behavior)

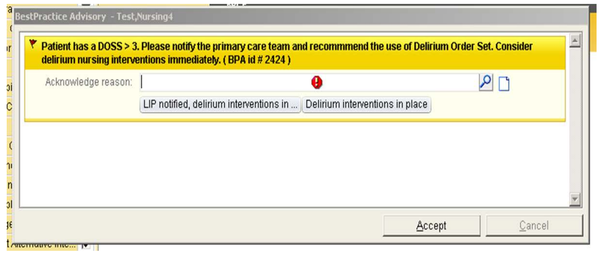


A NICHE report was developed to trend delirium status over the length of the admission

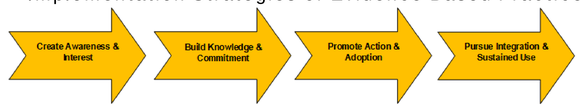


Implementation

A Best Practice Alert is used if the DOS Scale is >3 to remind the nurse to implement delirium strategies and notify the LIP to use the Delirium Order set



Implementation Strategies of Evidence Based Practice

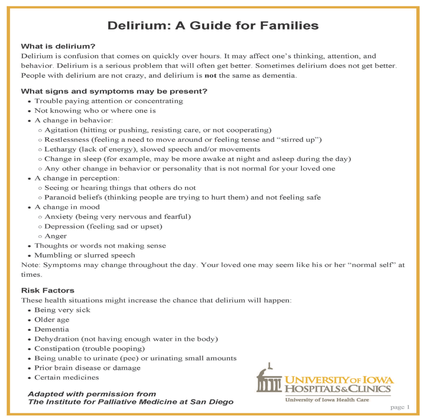


Cullen, L. & Adams, S. (2012). Planning Implementation of Evidence-Based Practice. JONA,42(4), 222-230

Nurses were educated about the DOS Scale using:

Orientation	Inservice	Staff Meetings	Chart Audits
Coaching and support from Unit GRN	Monthly email	Newsletters	Posters

Family Handout was developed in English and Spanish to educate families abut delirium



Delirium: A Guide for Families

What is delirium?
Delirium is confusion that comes on quickly over hours. It may affect one's thinking, attention, and behavior. Delirium is a serious problem that will often get better. Sometimes delirium does not get better. People with delirium are not crazy, and delirium is **not** the same as dementia.

What signs and symptoms may be present?
- Trouble paying attention or concentrating
- Not knowing who or where one is
- A change in behavior
  - Agitation (hitting or pushing, resisting care, or not cooperating)
  - Restlessness (feeling a need to move around or feeling tense and "stirred up")
  - Lethargy (lack of energy), slowed speech and/or movements
  - Change in sleep (For example, may be more awake at night and asleep during the day)
  - Any other change in behavior or personality that is not normal for your loved one
- A change in perception:
  - Seeing or hearing things that others do not
  - Paranoid beliefs (thinking people are trying to hurt them) and not feeling safe
- A change in mood
  - Anxiety (being very nervous and fearful)
  - Depression (feeling sad or upset)
  - Anger
- Thoughts or words not making sense
- Mumbling or slurred speech

Note: Symptoms may change throughout the day. Your loved one may seem like his or her "normal self" at times.

Risk Factors
These health situations might increase the chance that delirium will happen:
- Being very sick
- Older age
- Dementia
- Dehydration (not having enough water in the body)
- Constipation (trouble pooping)
- Being unable to urinate (pee) or urinating small amounts
- Prior brain disease or damage
- Certain medicines

Adapted with permission from The Institute for Palliative Medicine at San Diego

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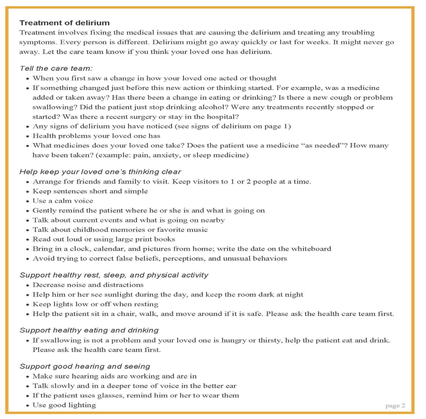

Treatment of delirium
Treatment involves fixing the medical issues that are causing the delirium and treating any troubling symptoms. Every person is different. Delirium might go away quickly or last for weeks. It might never go away. Let the care team know if you think your loved one has delirium.

Tell the care team:
- When you first saw a change in how your loved one acted or thought
- If something changed just before this new action or thinking started. For example, was a medicine added or taken away? Has there been a change in eating or drinking? Is there a new cough or problem swallowing? Did the patient just stop drinking alcohol? Were any treatments recently stopped or started? Was there a recent surgery or stay in the hospital?
- Any signs of delirium you have noticed (see signs of delirium on page 1)
- Health problems your loved one has
- What medicines does your loved one take? Does the patient use a medicine "as needed"? How many have been taken? (example: pain, anxiety, or sleep medicine)

Help keep your loved one's thinking clear
- Arrange for friends and family to visit. Keep visitors to 1 or 2 people at a time.
- Keep sentences short and simple
- Use a calm voice
- Gently remind the patient where he or she is and what is going on
- Talk about current events and what is going on nearby
- Talk about childhood memories or favorite music
- Read out loud or using large print books
- Bring in a clock, calendar, and pictures from home; write the date on the whiteboard
- Avoid trying to correct false beliefs, perceptions, and unusual behaviors

Support healthy rest, sleep, and physical activity
- Decrease noise and distractions
- Help him or her see sunlight during the day, and keep the room dark at night
- Keep lights low or off when resting
- Help the patient sit in a chair, walk, and move around if it is safe. Please ask the health care team first.

Support healthy eating and drinking
- If swallowing is not a problem and your loved one is hungry or thirsty, help the patient eat and drink. Please ask the health care team first.

Support good hearing and seeing
- Make sure hearing aids are working and are in
- Talk slowly and in a deeper tone of voice in the better ear
- If the patient uses glasses, remind him or her to wear them
- Use good lighting

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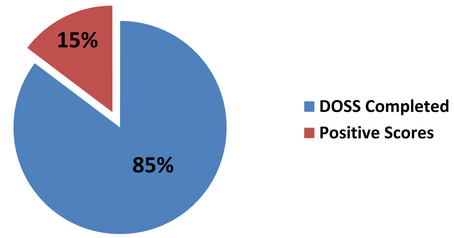
Results

In a unit survey, nurses reported:

- 87% confidence in administration of the DOS Scale
- 91% agreeing it could be completed in less than 3 minutes
- 79% agree it was easy to perform

Documentation:

19,632 admissions
13, 262 patients



Conclusion

Busy inpatient nurses need tools to help them obtain the assessment needed. Delirium assessments should be uncomplicated and easily accessible, to improve delirium identification.