STORYBOARD ON IMPROVED HEALTHCARE JOURNEY

RPAH

8W1

What are we trying to accomplish?

Patients with delirium are not routinely screened using the CAM (Cognitive Assessment Method), thereby opportunities to reduce falls may be missed.

The CAM is a widely used tool for the detection of delirium worldwide.

What is the aim?

Within 3 months, all patients on 8W1 will have a CAM undertaken once a shift whilst attending vital observations during morning and afternoon shifts, new admissions to the ward will have a CAM completed within two hours and all patients with a positive CAM will have an escalation pathway initiated.

Inclusion criteria

All patient's on 8W1

Exclusion criteria

N/A

Falls Collaborative Driver Diagram

The Problem:

In 2016, 38 patients died in NSW public hospitals following a fall-related incident. In addition, there were 458 fall-related incidents resulting in serious patient harm
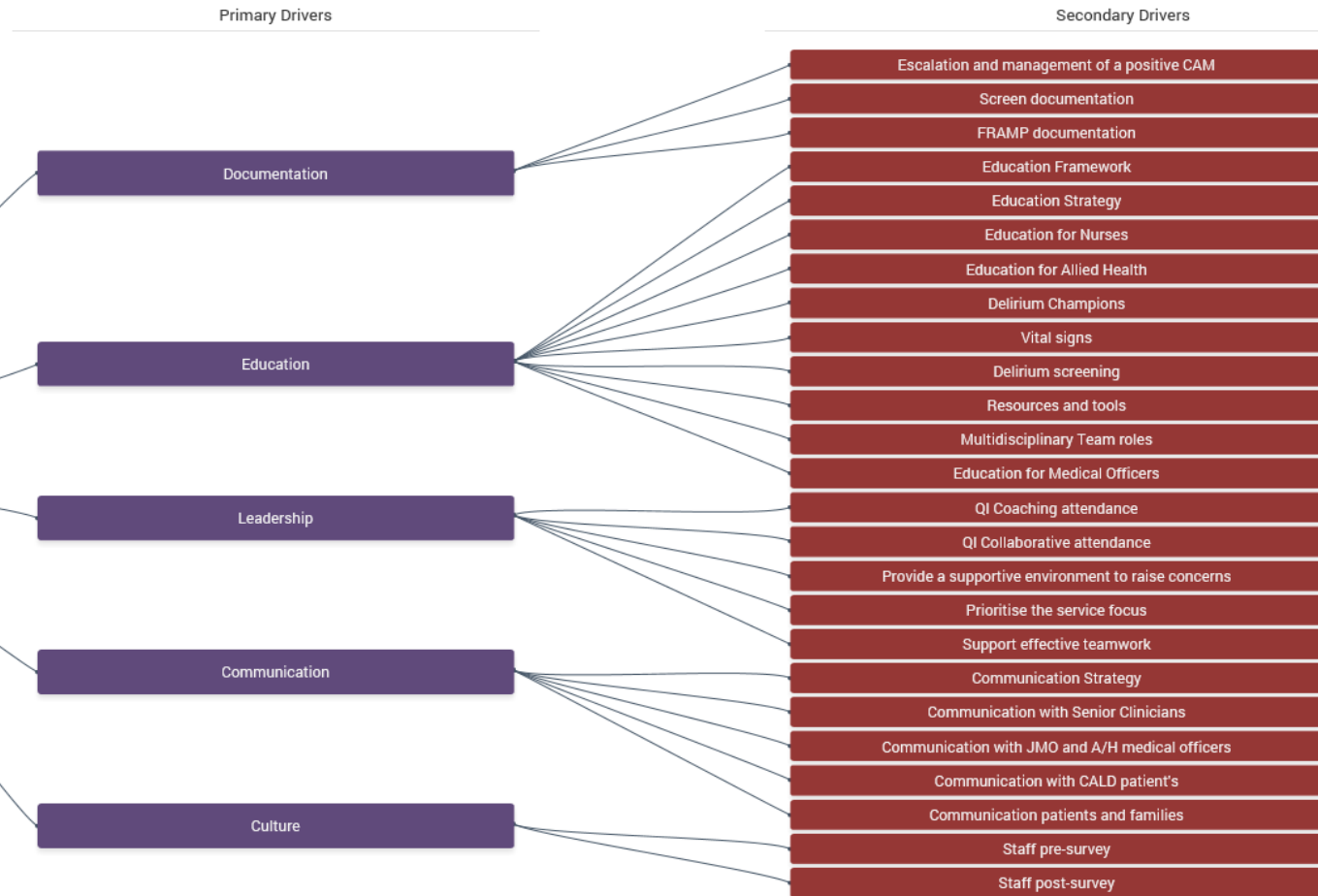
All patients on 8W1 to have a CAM undertaken once a shift with vital observations during morning and afternoon shifts. All patient's on 8W1 require a CAM on admission to the ward, to be taken within two hours.

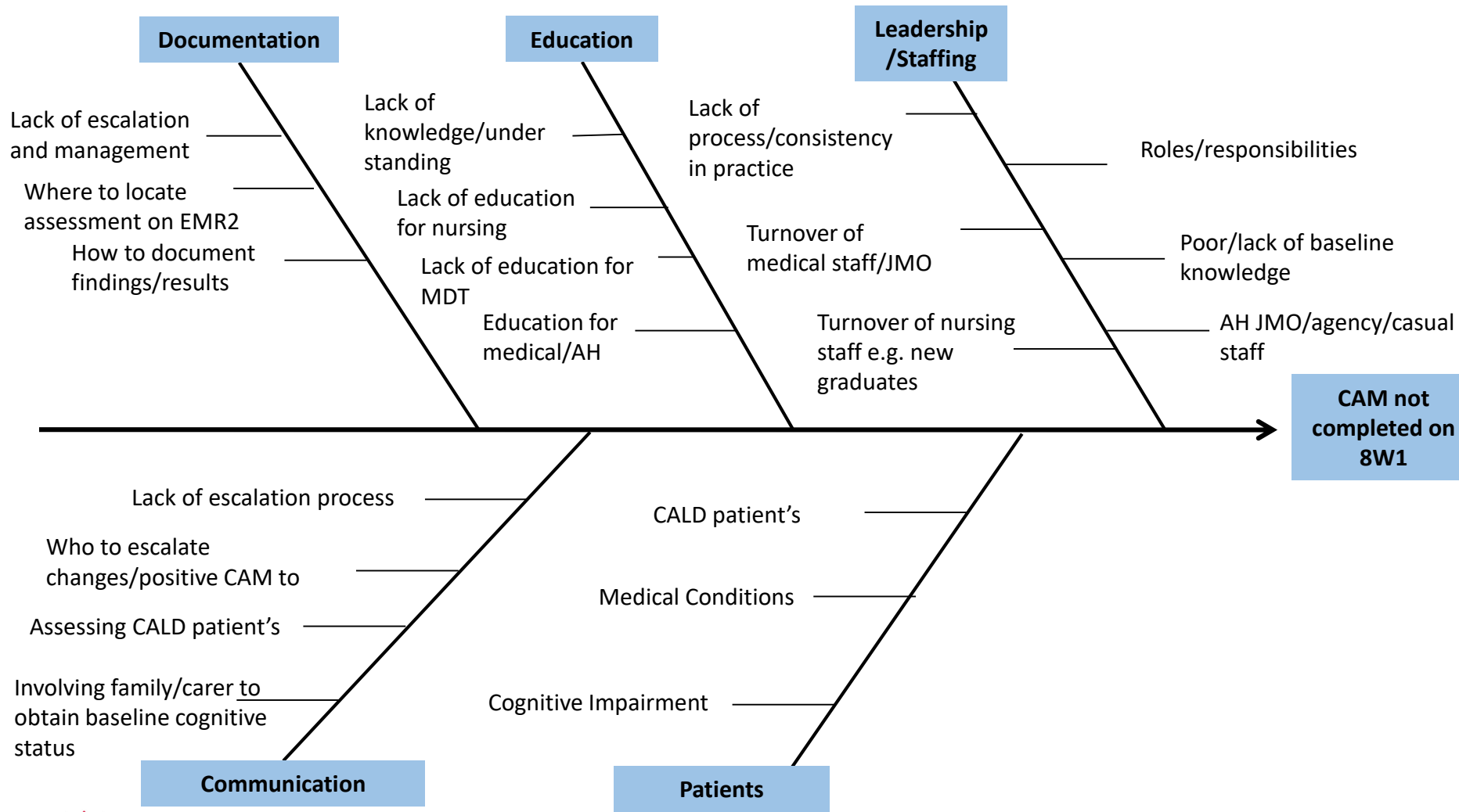**All patient's on 8W1 who have a positive CAM have an escalation pathway initiated*.**

Outcome Measure:
How much: Decrease rate of falls with harm by 5% by 30 June 2018.

Inclusions: Age ≥ 70 years Inpatients in a health service Partial and assisted falls Exclusions: Staff, visitors.
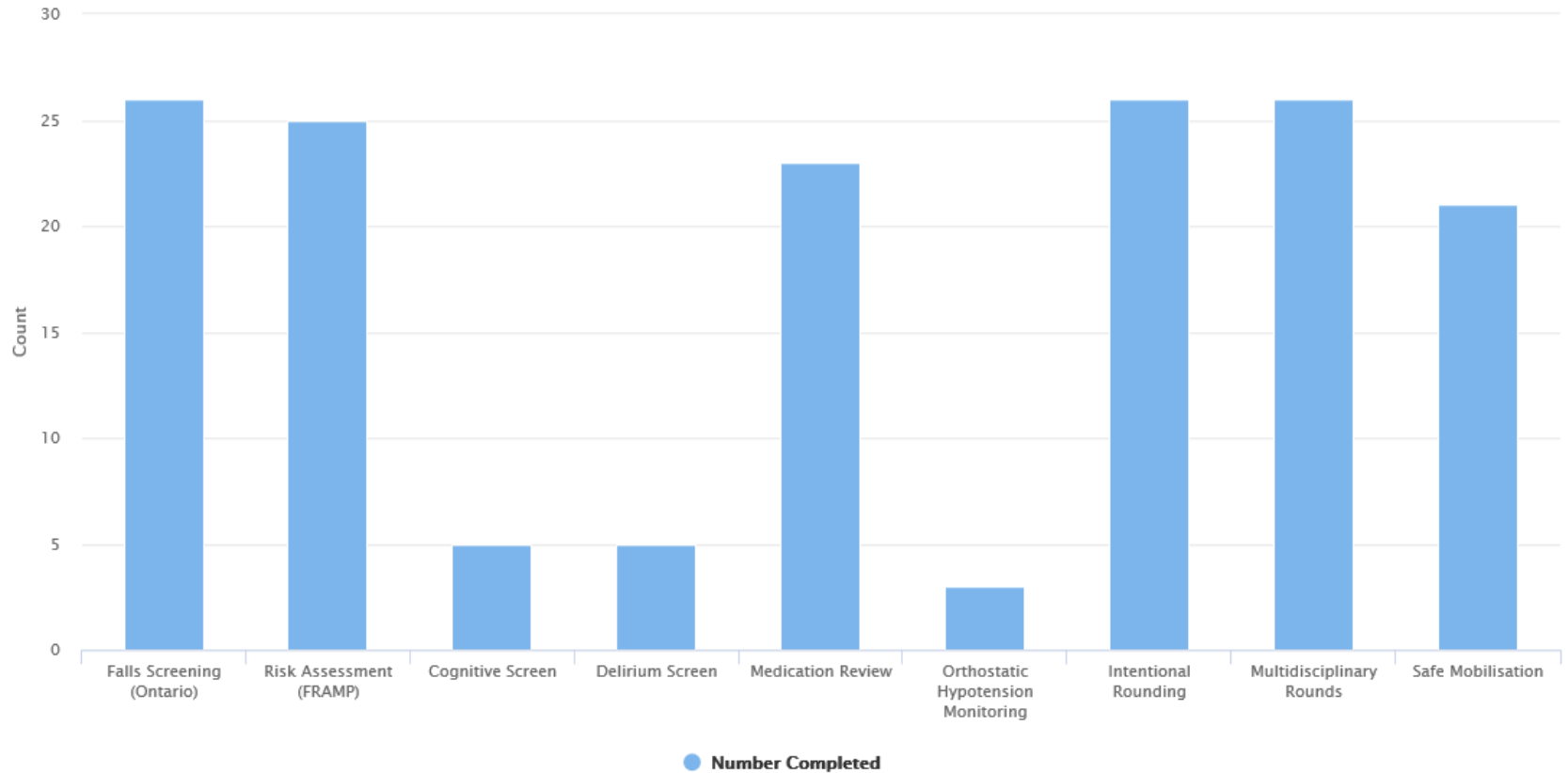
Primary Drivers

- Documentation
- Education
- Leadership
- Communication
- Culture

Secondary Drivers

- Escalation and management of a positive CAM
- Screen documentation
- FRAMP documentation
- Education Framework
- Education Strategy
- Education for Nurses
- Education for Allied Health
- Delirium Champions
- Vital signs
- Delirium screening
- Resources and tools
- Multidisciplinary Team roles
- Education for Medical Officers
- QI Coaching attendance
- QI Collaborative attendance
- Provide a supportive environment to raise concerns
- Prioritise the service focus
- Support effective teamwork
- Communication Strategy
- Communication with Senior Clinicians
- Communication with JMO and A/H medical officers
- Communication with CALD patient's
- Communication patients and families
- Staff pre-survey
- Staff post-survey

NSW GOVERNMENT | CLINICAL EXCELLENCE COMMISSION

Fishbone (Cause & Effect) Diagram

Documentation
- Lack of escalation and management
- Where to locate assessment on EMR2
- How to document findings/results

Education
- Lack of knowledge/understanding
- Lack of education for nursing
- Lack of education for MDT
- Education for medical/AH

Leadership /Staffing
- Lack of process/consistency in practice
- Turnover of medical staff/JMO
- Turnover of nursing staff e.g. new graduates
- Roles/responsibilities
- Poor/lack of baseline knowledge
- AH JMO/agency/casual staff

Communication
- Lack of escalation process
- Who to escalate changes/positive CAM to
- Assessing CALD patient's
- Involving family/carer to obtain baseline cognitive status

Patients
- CALD patient's
- Medical Conditions
- Cognitive Impairment

CAM not completed on 8W1

Pareto Chart
What is the size of the problem?

What changes can we make that will result in an improvement?

- Perform risk assessments
- Increase awareness of delirium
- Education for nursing/medical/allied health
- Introduce a pathway to escalate new delirium
- Reduce adverse events/outcomes such as falls, pressure injuries, length of stay, institutionalisation, mortality

Ideal Process Map
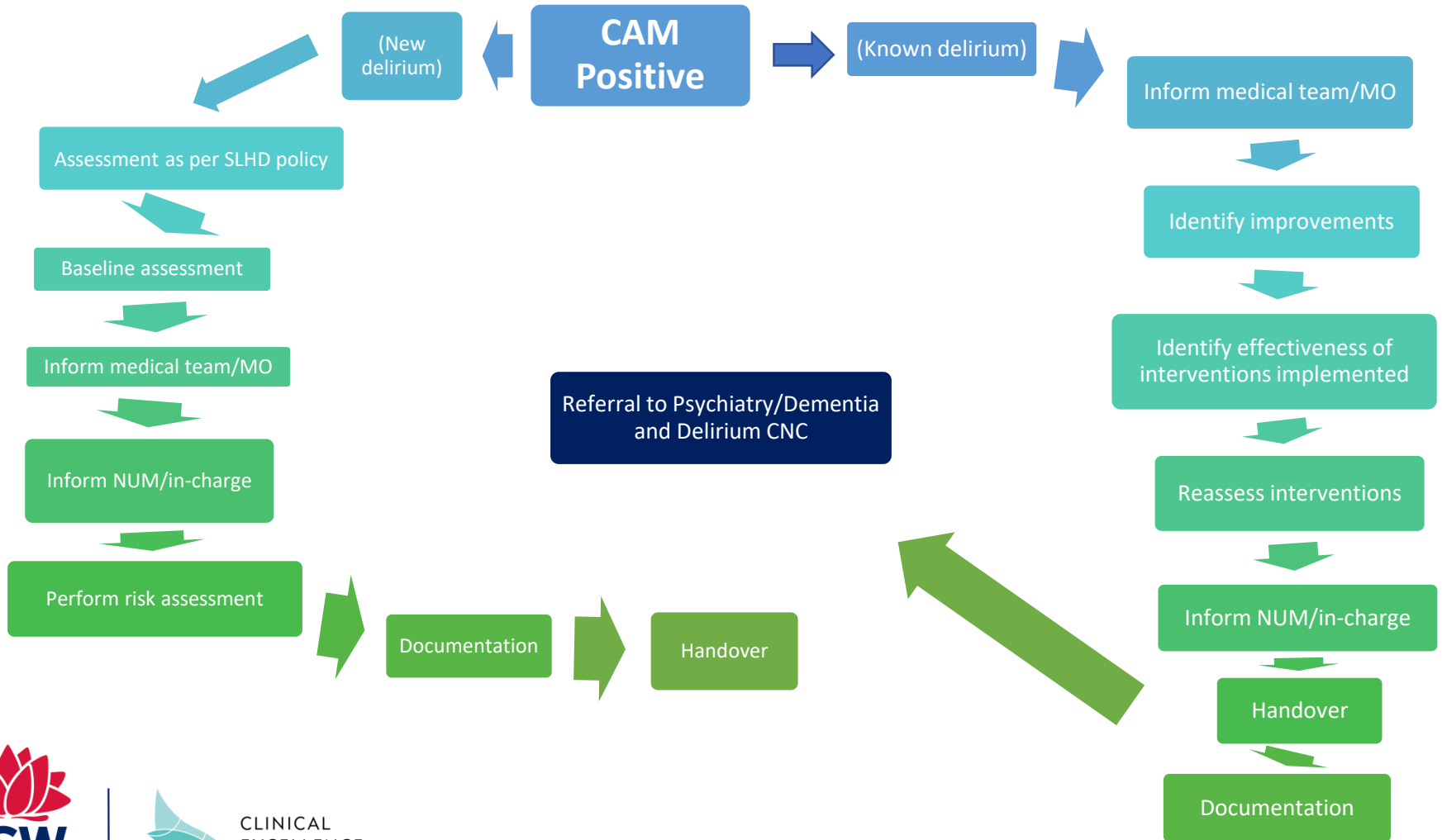
PDSA Summary

PDSAs – Education strategy

1. Baseline knowledge of delirium and CAM was obtained from nursing staff on 8W1
2. An educational needs analysis survey was distributed to assist in identifying how staff would prefer to receive information about delirium, also confirming that the staff were aware of the knowledge gaps associated with delirium
3. Ward in-services were conducted with the district Dementia & Delirium CNC on delirium and CAM
4. An online education portal was created and commenced in July 2018

Online Education Portal

PDSAs – Communication strategy

1. Discussion at meetings/committees within the hospital and district
2. 8W1 celebrated 'World Delirium Awareness Day on the 14th March 2018 to increase awareness and get the ward staff to talk and ask about delirium
3. Ward staff are updated on a fortnightly basis with statistics via email and displayed on the Quality Improvement Board
4. Fortnight LBVC team meeting which occurs on the ward
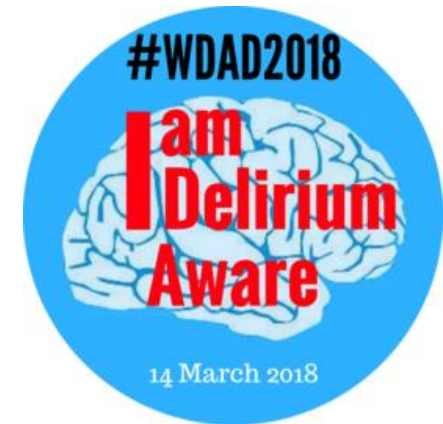
PDSAs – Delirium screening

1. Interviewing and process map of nursing, allied health and medical in regards to current practice/process of delirium screening on patient's admitted to 8W1 was performed
2. The CAM (Cognitive Assessment Method) was then introduced to nursing staff, initially trialled on a few patients
3. Nursing staff were then advised to complete the CAM as part of vital observations and within 2 hours of an admission, transfer to the ward or commencement of a nursing shift
4. Prompt cards were created and placed within the ward and on WOW/POW, to increase awareness to agency and casual staff that worked within 8W1

Think Delirium!
Confusion Assessment Method (CAM)
with each set of vital observations

Find me on EMR or ask the in-charge, thank you!

13

PDSAs – Escalation and management of delirium

1. Positive outcomes and discussion surround the escalation and management of delirium within the ward and across the hospital following the introduction of the CAM as a delirium screening tool
2. Advocated that staff utilise the Clinical Emergency Response System (CERS) if concerned following a positive CAM or if there has been a significant change in the patients behaviour
3. Prompt review of patients exhibiting a new or worsening delirium has occurred
4. Interventions to reduce their risk of adverse events within the hospital environment have been implemented and examinations to distinguish source of infection have commenced earlier

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

Escalation pathway for Nursing Staff!

Example

1
- **CAM Positive**

2
- **Call** Medical Officer

3
- **Consider source of infection** such as urinalysis, urinary retention, environmental factors

4
- **Interventions implemented to reduce risk/adverse events** such as specialling, high risk room

5
- **Document** actions taken, describe changes/behaviour in EMR, ongoing plan

# How do we know change is an improvement?

At the beginning of the Falls Collaborative and following review of falls on 8W1 it was identified that 53 per cent of patients had cognitive impairment, and there was no process in place for CAM screening.

Following data collection, it was evident that there was a significant gap in delirium screening within the ward. In February 2018, the CAM was introduced to the ward and staff began to use the assessment tool.

All patients within 8W1 have a CAM completed with vital observations to date, weekly data collection shows the compliance of CAM's completed.
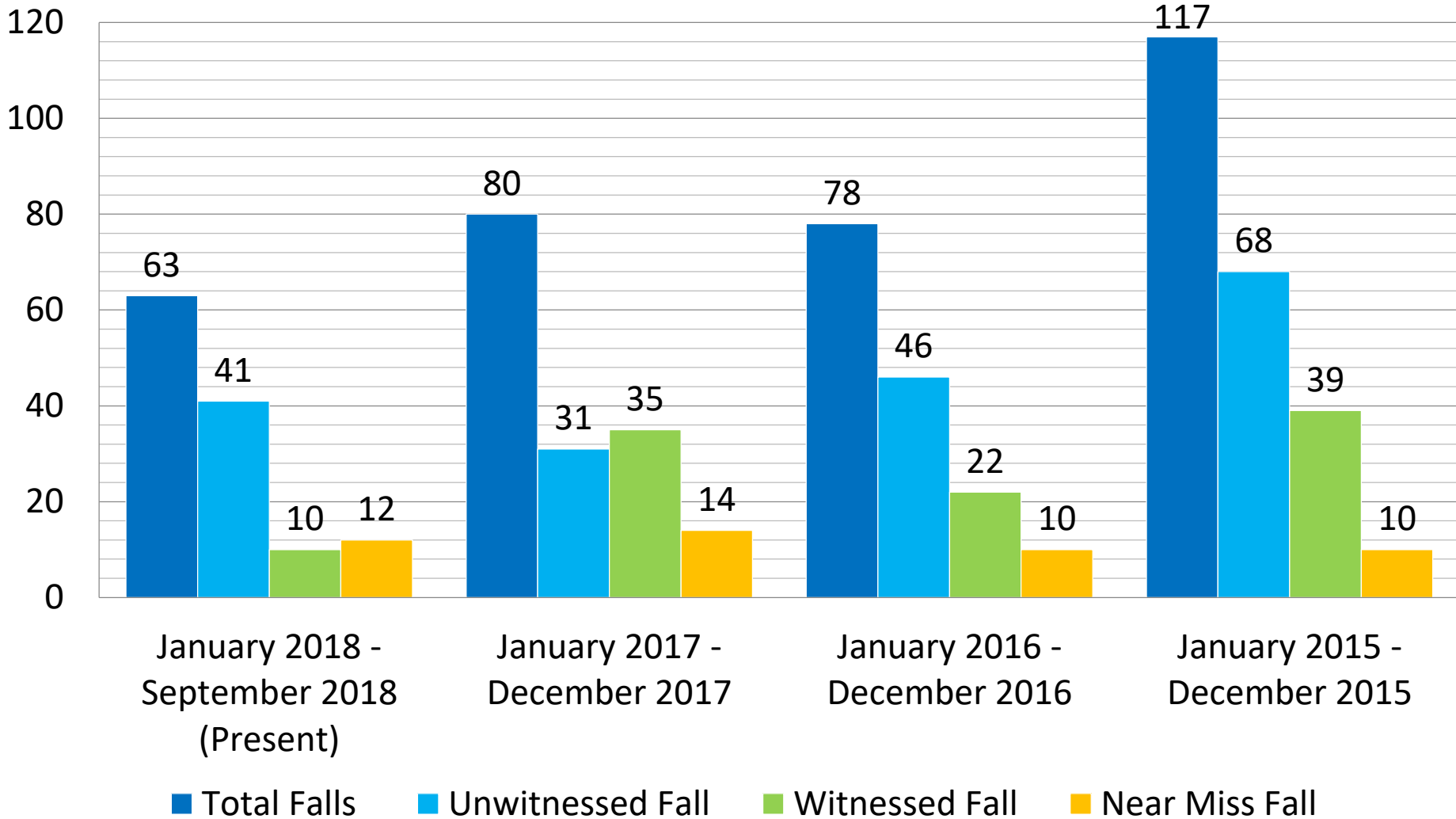
Measures

CAM completed within a nursing shift

CAM completed within a two hours of a nursing shift
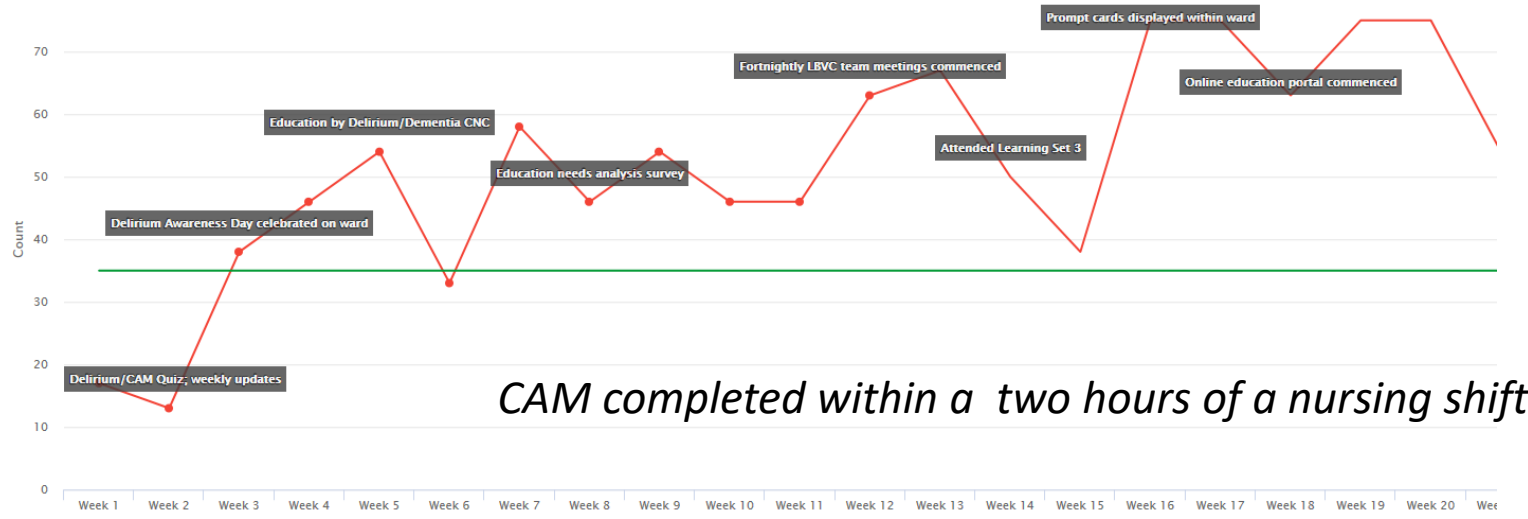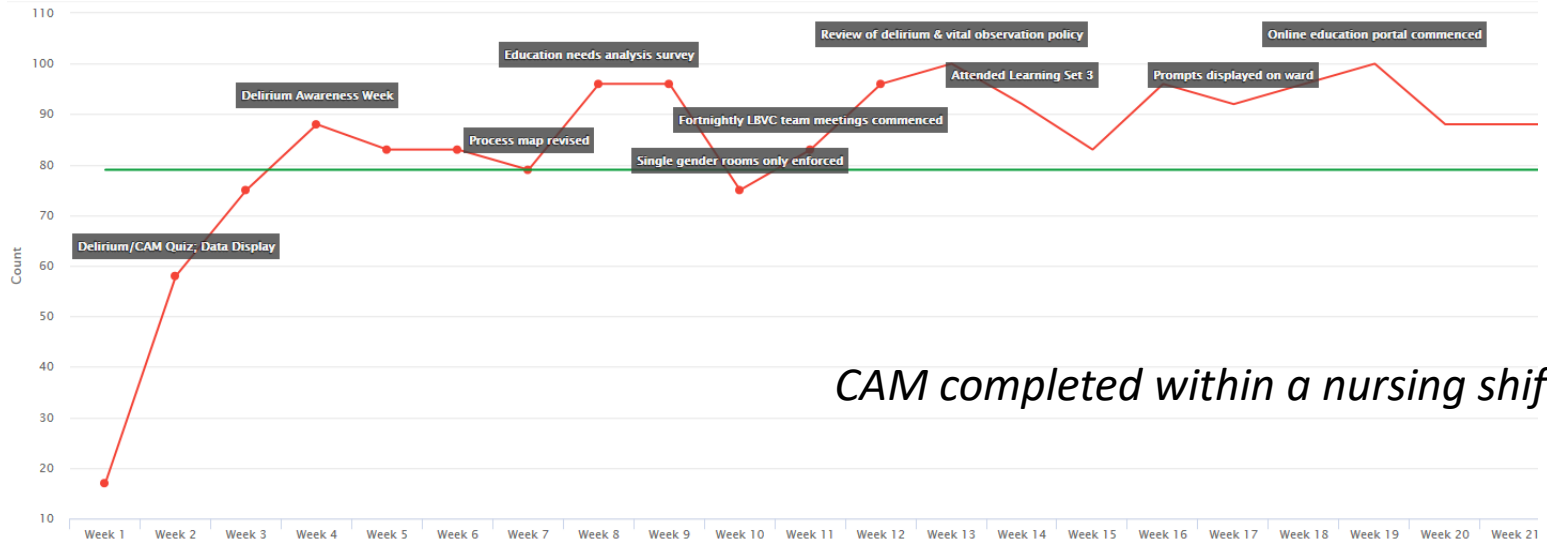
Positive Outcomes

- Comprehensive assessment of patients for delirium and sustained application in clinical practice

- Engagement across the ward, with opportunities to disseminate this across the hospital through committees and meetings

- Education module on HETI created with interest from both hospital and district

- Process of nursing escalation has been established within the ward

- MDT collaboration including district and executive involvement

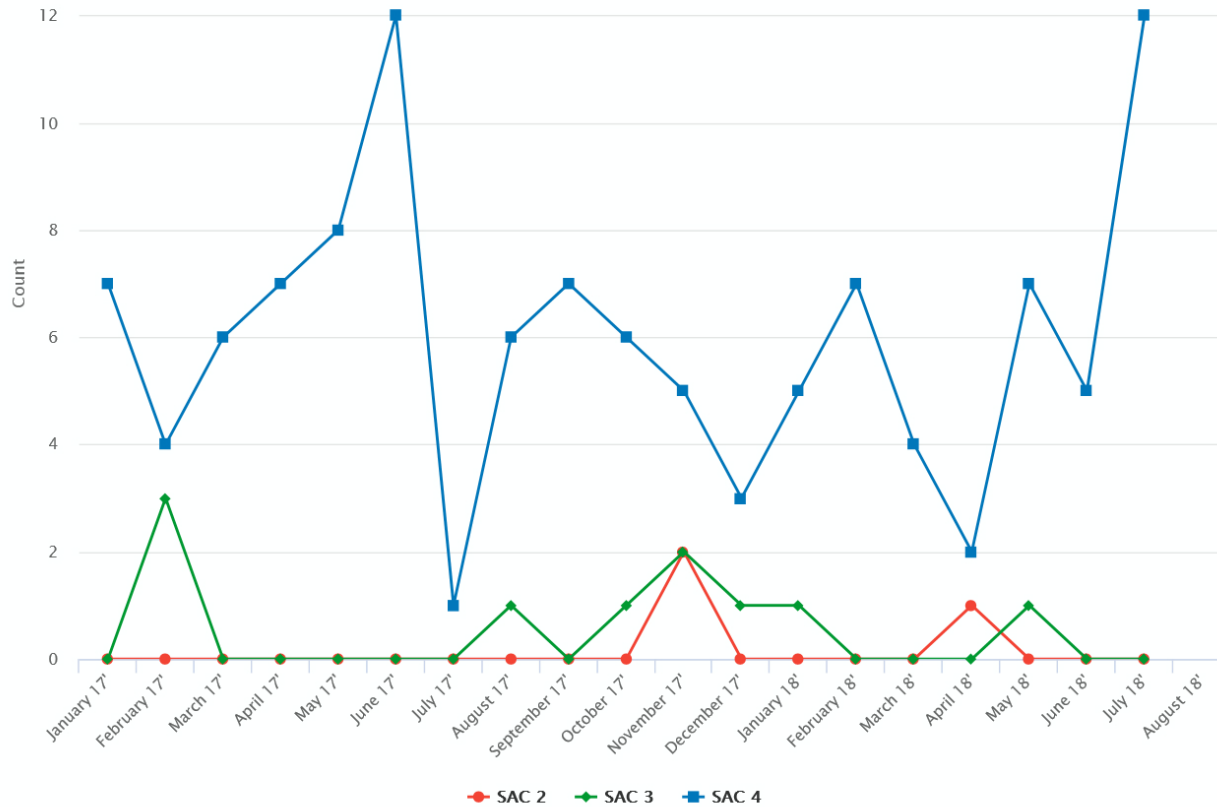Comparative data
January 2015 to Present

Year to date
January – May 2019 vs January – May 2019

Incidences of Falls

	January - May 2018	January - May 2019
■ Incidences of Falls	26	22

Outcome Measures

IIMS recorded falls incidences on 8W1 (SAC 2, 3 and 4) there were no SAC 1 incidences during this period

CAMs completed to date!

8W1 nursing staff have assessed their patients on

22,316

Between 12th February 2018
to 12th February 2019

Future planning

- Formalise escalation pathway for delirium

- Medical education across the hospital, including after hours medical officers

- Increase awareness and screening of delirium across the facility

- Prevention of delirium
  - completion of environmental improvements within the ward
  - fast tracking patients from the emergency department for patients at risk of delirium
  - introduction of 'My Story' individual patient care plans