Ontario's Delirium Quality Standard

Practical Implementation Guide

Support for organizations across the continuum of care in achieving quick wins when putting Ontario's Delirium Quality Standard into practice as part of a senior friendly approach to care.

Regardless of your type or size of organization, or where you're starting from (getting started or building on successes, or anything in between), this guide is intended to help you elevate your practice in delirium care.

This guide draws on: 1) The Senior Friendly Care (sfCare) Framework as an organization-wide approach that embeds evidence-based processes of care (like the quality statements in the Delirium Quality Standard), while considering the influences of the entire care environment, including organizational support, the emotional and behavioural environment, ethics and clinical care in research, and the physical environment; and 2) The Getting Started Guide: Putting Quality Standards Into Practice as an evidence-based approach to implementing changes to practice.

sfCare™ Senior Friendly Care

RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

Provincial Geriatrics Leadership Ontario

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Where is your organization starting from?

Use as much or as little of this implementation guide as you need.
For example:

	STEP 1 Assemble A Team	STEP 2 Prioritize A Change Idea	STEP 3 Create A Plan
Just Starting Your organization is getting started with delirium care and/or quality improvement	✓	✓	✓
Started but Stalled Your organization has implemented or partially implemented some of the quality statements, but sustainability and spread has been challenging	Review the entire section and refresh as needed	✓	Review the entire section and refresh as needed
On a Roll Your organization is already familiar with quality improvement and is building on successes with delirium care		✓	Review ready-to-use resources in "Table 3: Barriers and Strategies"

TIP

The best time to start is now! Even if there are system pressures or time challenges, get a team together, generate ideas and start planning for the implementation.

STEP 1

Assemble A Team

Just Starting

✓ You'll need 2 people to lead and be accountable for implementing the change: an Executive Sponsor and Team Lead. The team will also include the staff and leaders in the area where change is being implemented, and some or all may be designated as Front-Line Senior Friendly Champions (see Table 1).

Whichever role you currently occupy in your organization, find the other member(s). To do this:

- **Develop an elevator pitch** (a 10-15 second verbal snapshot of what the problem is, benefits of fixing it, where things are at now, and how the person can help). E.g. "Delirium is a preventable harm for our older patients which can lead to functional decline and death, yet we don't have reliable and consistent processes in place to prevent or manage it. We need to protect the well-being of our older patients by addressing the gaps in delirium care. Would you consider leading this change by joining the implementation team as a <role>? A senior leader / I will be supporting this work."
- **Provide a case for change** – use evidence to support why the change is needed, such as: The Delirium Quality Standard (pages 6-8) and the sfCare Hospital Policy Brief.

TIP

Engagement of stakeholders in your organization is important. Reflect on who these people are by using the sfCare 5Ws Worksheet. Consider engaging your local Regional Geriatric Programs (RGPs) / Specialized Geriatric Services (SGS) to support your work.

Started but Stalled

✓ **Review** the tips for just starting. ✓ **Reflect** on the team you have in place for implementing change – do you have an Executive Sponsor? Are they engaged and onboard with improving delirium care in your organization? ✓ **Refresh** your team – do you need to provide a case for change, or do you need to add or replace team members?

On a Roll

✓ **Go** to step 2.

Table 1: Team Composition And Roles

Role in the organization	Role on the implementation team	Description of implementation roles
1. Senior Leader	Executive Sponsor	**Paves the path for success** – meets with the team lead and front line champion(s) on a regular basis to establish goals, hold the team accountable to them, and remove barriers to achieving them
2. Front-line Healthcare Provider	Team Lead	**Coordinates and implements** – schedules meetings, creates and updates an action plan, and co-leads implementation activities with the front line cchampion(s)
3. Front-line Healthcare Provider	Front-Line Senior Friendly Champion(s)	**Implements** – creates the action plan with the team lead and co-leads implementation activities **Champions** – opinion leaders / change influencers

STEP 2

Prioritize A Change Idea

All Organizations

✔ Select a quality statement and change idea(s) (see Table 2) by considering:

- which statements are applicable to your organization
- what's most important to the people involved in the process
- what's easiest to implement (quick wins)

Just Starting

✔ Target areas in your organization where there are change champions. Active engagement of the people involved in the process is important for implementation success and sustainability. To do this:

- **Listen to the people involved in the process –**
  - **Approach staff, older adults, and caregivers** for their input. Use an elevator pitch (from step 1) to start the conversation, but change the ask - e.g. "we could really use your expertise to help us understand where to start".
  - **Share the quality statements** (pages 3-4 of the standard) that are applicable to your organization, and ask what care currently looks like compared to these statements.
  - **Ask why they think there's a gap** between the standard and current state (root causes)
  - **Ask what they think should change** first and why (prioritize solutions that are most important to them and address root causes).
  - **Ask for their change ideas** (what are some specific practices that would contribute to achieving the selected quality statement(s). Refer to the list of change ideas (Table 2), if needed.
- **Provide a way for people to share ongoing anonymous feedback** – consider things like surveys, comment books or boxes, or communication boards.

TIP

This step is not a comprehensive assessment of delirium care across the organization; it is a snapshot of current state and priorities from the frontline to support a rapid start and quick wins.

TIP

Consider starting first with change ideas that prevent delirium; this will have a direct and immediate impact on patient outcomes.

TIP

Do not underestimate the need for 2-way communication. If you are not getting any feedback you're not using the right feedback mechanism – try another one!

Started but Stalled

✔ **Review** the just starting section. ✔ **Reflect** on the strategy you have used in the past for engaging the organization in change. Did you ask for input from the front line before the implementation started? Did you have a mechanism for 2-way communication that worked well? Do you need to do a readiness assessment? ✔ **Refresh** your engagement strategy as needed.

On a Roll

✔ **Review** Table 2: Change Ideas

Table 2: Change Ideas

1. Identification of Risk Factors for Delirium

- **Delirium risk checklist** in the patient record to be used at initiation of care and at transitions in care, including (from page 14 of the standard):
  - Age 65 years or older
  - Cognitive impairment and/or dementia
  - Current hip fracture (broken hip)
  - Severe illness (a clinical condition that is deteriorating or is at risk for deterioration)
  - Previous delirium
  - Problematic alcohol or substance use
- **Tool to communicate delirium risk** to staff / patient / caregiver.

2. Interventions to Prevent Delirium

- Standardized order set
- Delirium Prevention Toolkit for patients
- 6 proven prevention strategies:

1. Stimulating the Mind:

- **Daily socializing**. Support virtual presence for family, caregivers, and volunteers by ensuring older adults have access to a phone or tablet wherever possible and assist with charging devices as needed (hospital and LTC). Use Virtual Visits Toolkit (LTC) and Social Rx (home and community and primary care).

Table 2: Change Ideas

2. Interventions to Prevent Delirium (continued)

- **Physical environment changes**: provide appropriate lighting, a 24-hour clock, and a calendar.
- **Cognitively stimulating activities** (e.g., reading, listening to music, doing crossword puzzles). Use A Guide to Virtual Creative Engagement for Older Adults (all sectors).

2. Moving
- **Physical activity** at least 3 times a day, such as the MOVE program (hospital, and adapt for LTC) or the RX for Physical Activity in Older Adults (home and community and primary care). sfCare mobility resources

3. Sleeping well
- **Sleep promotion**: close blinds / curtains and night (and open during daytime), minimize noise at night, limit caffeine to before 2 pm, relaxing activity close to bedtime (such as reading, meditating), and natural aids for sleep such as sleep masks and hot milk.
- **Assess and manage clinical issues which may be impairing sleep**, such as polypharmacy and pain.

4. Seeing and hearing
- **Ensure that older adults are using hearing aids and/or eyeglasses** before care is provided.

5. Staying hydrated
- **Hydration promotion**: encourage the older adult to drink regularly; ensuring a water jug is within reach, and use visual reminders such as a sign or a message on a cup.

6. Eating
- **Nutritious food throughout the day**, including: provision of food, respect for food preferences, assistance with eating if needed (and a way of identifying those who need assistance – such as red trays), eating with others where possible, and support for getting up for meals (not eating meals in bed). Sfcare nutrition resources

3. Early Screening for Delirium

Delirium screening tool. Use our brief comparison table of screening tools listed in the standard or standardized delirium assessment information cards.

Table 2: Change Ideas

4. Education for People With Delirium, Family, and Caregivers

Written information such as:

- Delirium Prevention and Care with Older Adults for patients / caregivers / family
- Delirium – Know, Do, Tell, Ask for caregivers / family
- Changes in Thinking and Behaviour: Delirium for caregivers / family
- How to prevent and support delirium in an older adult in hospital or a care home, when you can't visit in person for caregivers / family

5. Management of Delirium

- **Comprehensive assessment** for patients with delirium to identify the cause(s): including a medical and social history, physical exam and relevant investigations. Consider using a standardized order set (which includes appropriate use of antipsychotic medication and appropriate dosing for older adults – pages 17-18 Introduction to Delirium – Clinician Learning Series).
- **Multi-component interprofessional management plan** which addresses underlying causes, uses interventions to prevent delirium and identifies and supports symptoms and safety concerns (for example, using non-confrontational redirection techniques for patients who appear agitated). Consider using a standardized order set (which includes interventions for the prevention and management of delirium – see page 3 of the order set example).

6. Antipsychotic Medication

- **Guide appropriate use of antipsychotic medication**, including the need to first use non-pharmacological interventions to manage delirium. Consider using a standardized order set (which includes appropriate use of antipsychotic medication and appropriate dosing for older adults – pages 17-18 Introduction to Delirium – Clinician Learning Series).

Table 2: Change Ideas

7. Transitions in Care

- **Mandatory field for the presence of delirium** in discharge summary / transfer of accountability / transition plan templates. Support standardized documentation by including (from page 35 of the standard):
  - Delirium status:
    - ☐ Current. Started on _____ (date)
      *Note that symptoms of delirium may persist at or beyond discharge from hospital
    - ☐ Resolved. Duration _____ (dates)
    - ☐ Delirium was not detected
  - Strategies for managing persistent delirium and for preventing recurrence of delirium
  - Description of ongoing treatments related to delirium and any follow-up care
  - If an antipsychotic medication has been prescribed, a plan for daily review and when to reduce and discontinue
  - Arrangements for follow-up care (e.g., primary care provider, medical specialist) or contact details of ongoing health and social support services available in the community, as appropriate
- **Support standardized coding of delirium** in the health record for example, ensuring that clinicians document delirium appropriately. Consider using a tool such as Quick Tips: Clinicians Documenting Dementia and Delirium.

STEP 3

Create An Action Plan

Just Starting

✔ Use the information from step 2 to inform an action plan. Consider what's most important to the people involved in the process and what's easiest to implement (quick wins).

Use the sfCare 5Ws Worksheet to explore the details, scope, and feasibility of the change ideas (what, when, where, why and who), to inform the action plan.

Use the sfCare Action Plan Template to capture:

- **Improvement aim** – what are you trying to accomplish? Be specific: use an indicator from the standard (pages 37-41), and add a timeframe for when this will be achieved.
- **Pilot area** – where will you pilot the change? Pick a unit or a population of patients that you think provide the right environment for achieving a quick win.
- **Team** – who will drive this work forward? (team identified in step 1)
- **Change ideas** – what do you want to implement at the point of care? Be specific about what actions need to be done differently, by who, and in what setting. When developing change ideas, there's no need to reinvent the wheel; use the resources provided in Step 2, search the internet, connect with others in your sector to ask if they have a tool they can share, or connect with your local Regional Geriatric Programs (RGPs) / Specialized Geriatric Services (SGS) for support in finding the resources you need.
- **Process Measures** – what will you measure to see if the changes are successful?

- **Testing your ideas** – what tasks needs to be done, by who and by when in order to plan for and test change ideas? (Plan Do Study Act – PDSA)

  Activities should support:

  - communication, data, tools for staff/patients/families, and general project tasks
  - collection of ongoing feedback on barriers and facilitators to implementation (using The Getting Started Guide: Putting Quality Standards Into Practice (pages 13-19)
  - continuing the pilot if the change needs to be adapted – do as many cycles of PDSA if needed. Despite having a date in mind for when a pilot should end, it is sometimes necessary to extend to ensure that the change is ready to adopt.

TIP

It's important not to get stuck or stop at this stage!

- **Making your ideas stick** – what strategies and resources will help you target some of the implementation barriers you are experiencing?
  - Reflect on the underlying barriers by analyzing the feedback you have received. Use the tool provided on pages 14-15 in The Getting Started Guide: Putting Quality Standards Into Practice.
  - Use implementation strategies to target common barriers in practice change for delirium care such as in Table 3, which were adapted from The Getting Started Guide: Putting Quality Standards Into Practice.
  - Celebrate successes along the way, and announce what comes next (continue with PDSAs, sustain, or spread). The Executive Sponsor should take an active role in acknowledging the change efforts and outcomes and support next steps.
  - Plan for how changes will be hardwired. How will you make it easy to do the right thing and hard not to? Consider embedding changes in electronic medical records, and in policies and procedures. It's also important to ensure that there is an ongoing plan for measurement and accountability.
  - Plan for spread – decide if these changes should be spread to other areas in your organization or if you should start work on another quality statement in the same pilot area or in another area. Don't stop now; build on the momentum achieved from your successes!

TIP

Designating a person who is responsible for ensuring the practice change continues is not hardwiring!

✔ Review the action plan with the Executive Sponsor.

Started but Stalled

✔ **Review** the just starting section. ✔ **Reflect** on what's worked well, and what hasn't in past implementations. Try to pinpoint (find the root cause) for when and why previous implementations have stalled. Look at the tools and templates you have in place for implementing change – are they easy to use / is your team experienced with them? Do you have strategies in place to target common barriers? ✔ **Refresh** your plan – consider trying new tools and strategies for this implementation.

On a Roll

✔ **Review** Table 3: Barriers and Strategies

Table 3: Barriers And Strategies

Healthcare professionals do not have the knowledge or skills to complete the practice as intended

Strategies: Educational outreach/training – This may include interactive educational meetings/workshops that include role play and discussion or one-on-one visits with health care professionals to discuss practice change.

Resources:

- sfCare Learning Series – Delirium, provides ready-to-use education and tools for healthcare providers, patients and families
- Communication tips for clinicians caring for older adults experiencing delirium during the COVID-19 pandemic

Healthcare professionals are busy and may forget to perform the practice

Strategies:

- Reminders – Prompts to encourage change in practice may include automated reminders, posters, pocket cards, data collection systems, order sets, etc.
- Audit and provide feedback – see barrier 4

Resources:

- Poster – 6 ways to prevent delirium in older adults
- Clinician's Pocket Card – Delirium Assessment and Treatment for Older Adults
- PSW Pocket Guide

Table 3: Barriers And Strategies

Healthcare professionals are busy and feel they don't have time to perform the practice

Strategies:

- Engage patients /caregivers as partners in care. Provide them with information on delirium care so they understand what to expect and can ask for it, and can also actively participate in care.
- Promote delirium care as everyone's responsibility – all staff should have a role to play and should support each other.

Resources:

- Senior Friendly 7 Delirium Toolkit
- Delirium Prevention and Care with Older Adults for patients / caregivers / family
- Changes in Thinking and Behaviour: Delirium for caregivers / family

Healthcare professionals are not aware of what's expected, how they will be held accountable, or their current performance

Strategies: Evaluate what staff, older adults, and caregivers need in "Organizational Support" (sfCare Framework domain) to support the change. For example:

- Audit and provide feedback. Regularly report back on process measures to engage the front-line in progress against the goals – use data to generate light, not heat. Use a communication board to post results, conduct a 5 min. daily or 15 min weekly huddle to share results / successes / challenges, and have the Executive Sponsor engage staff and patients by asking them how the changes are going.
- Incorporate into individual performance reviews.
- Ensure that the change has been hard-wired by creating protocols, policies or procedures documents.

Healthcare professionals feel that there are competing organizational priorities, or that these changes may not be a priority for the organization

Strategies: Evaluate what staff, older adults, and caregivers need in "Organizational Support" (sfCare Framework domain) to support the change. For example:

- Ensure a senior friendly team is in place (see Step 1).
- Ensure that there are explicit goals related to sfCare within the strategic plan, operational plan and/or QIP.
- Align with other priorities that your organization is committed to (for example ALC, workplace violence, and health equity).
- Ensure that the change has been hard-wired by creating protocols, policies or procedures documents.

Table 3: Barriers And Strategies

Healthcare professionals feel that they don't have the required tools / resources in the physical environment to support the practice

Strategies: Evaluate what staff, older adults, and caregivers need in the "Physical Environment" (sfCare Framework domain) to support the change. For example:

- To provide clear cues for day / date / time, resources like clocks, calendars or whiteboards may need to be purchased, and changes or fixes made to facilitate having the lights on / blinds up during the day only.
- To facilitate mobility, ensure the required mobility devices are available.

Healthcare professionals feel that there are barriers to implementing the practice in a way that is respectful, compassionate, sensitive, and free of ageism

Strategies: Evaluate what staff, older adults, and caregivers need in the "Emotional and Behavioural Environment" (sfCare Framework domain) to support the change. For example:

- Communicate effectively through PPE with someone who is experiencing delirium. Make yourself recognizable, smile when you speak, and ask for permission before approaching or touching. To overcome the challenge of being unrecognizable in PPE, ensure that with each interaction you introduce yourself, call the person by name, and explain your role/what you are going to do, and consider adding a laminated photo of yourself with your name and role to your gown.
- Align with and leverage the organization's person-centred approach.

Resources:

- 1-page tip sheet: Communication Tips for Clinicians Caring for Older Adults Experiencing Delirium during the Covid-19 Pandemic.
- Example of a laminated photo of yourself with your name and role

Healthcare professionals feel that there are ethical issues that need to be considered

Strategies: Evaluate what staff, older adults, and caregivers need in "Ethics in Clinical Care & Research" (sfCare Framework domain) to support the change. For example:

- When there are visitor restrictions in place in your organization or if the older adult's caregiver or family are unable to visit due to other reasons, create a communication plan and provide support for virtual visits. Support for an older adult's identified care partner should include a clear communication plan between the care team and the care partner; guidance on how the care partner can provide support virtually; and the facilitation of virtual visits.
- Ensure that a substitute decision maker has been identified for the older adult.

Resources:

- 1-page tip sheet: How To Prevent And Support Delirium In An Older Adult In Hospital Or A Care Home, When You Can't Visit In Person

Resources in this Document

Getting Started

- Delirium Quality Standard
- The Senior Friendly Care (sfCare) Framework
- The Getting Started Guide: Putting Quality Standards Into Practice

STEP 1 Assembling a Team

- sfCare Hospital Policy Brief
- sfCare 5Ws Worksheet
- Your local Regional Geriatric Programs (RGPs) / Specialized Geriatric Services (SGS)

STEP 2 Change Ideas

- Standardized order set
- Delirium Prevention Toolkit
- Virtual Visits Toolkit
- Social Rx
- A Guide to Virtual Creative Engagement for Older Adults
- The MOVE program
- RX for Physical Activity in Older Adults
- sfCare mobility resources
- sfCare nutrition resources
- Comparison table of screening tools listed in the standard
- Standardized delirium assessment information cards
- Delirium Prevention and Care with Older Adults
- Delirium – Know, Do, Tell, Ask
- Changes in Thinking and Behaviour: Delirium
- How to prevent and support delirium in an older adult in hospital or a care home, when you can't visit in person
- Introduction to Delirium – Clinician Learning Series
- Quick Tips: Clinicians Documenting Dementia and Delirium

STEP 3 Action Planning, Barriers and Strategies

- sfCare 5Ws Worksheet
- sfCare Action Plan Template
- Your local Regional Geriatric Programs (RGPs) / Specialized Geriatric Services (SGS)
- The Getting Started Guide: Putting Quality Standards Into Practice
- sfCare Learning Series – Delirium
- Communication tips for clinicians caring for older adults experiencing delirium during the COVID-19 pandemic
- Poster – 6 ways to prevent delirium in older adults
- Clinician's Pocket Card – Delirium Assessment and Treatment for Older Adults
- PSW Pocket Guide
- Senior Friendly 7 Delirium Toolkit
- Delirium Prevention and Care with Older Adults
- Changes in Thinking and Behaviour: Delirium
- Example of a laminated photo of yourself with your name and role
- How To Prevent And Support Delirium In An Older Adult In Hospital Or A Care Home, When You Can't Visit In Person