

Prevention and Management of Behavioral Disturbances in Older Adults

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QUALITY IMPROVEMENT

The other day on Med A

A tale of two patients

A patient who was admitted for confusion became aggressive overnight with staff.

When the resident tried to redirect the patient, the patient attempted to choke him.

Physical restraints and antipsychotics were used to deescalate the situation and a plan put in place to prevent any recurrence.

A patient admitted for behavioral symptoms of dementia including aggression that had escalated to the point that family was unable to care for him.

Staff got to know him, let him wear his own clothes, walked laps around the unit, and conversed with him at the nursing station.

He never received a physical restraint.



Importance

Why does this project matter?

We want to provide gold standard care for older adults.



This population is at risk of behavioral symptoms from delirium and/or dementia.



Behavioral symptoms can make it difficult to provide needed care.



Chemical and physical restraints are sometimes necessary but can cause harm and non-pharm methods are preferred.

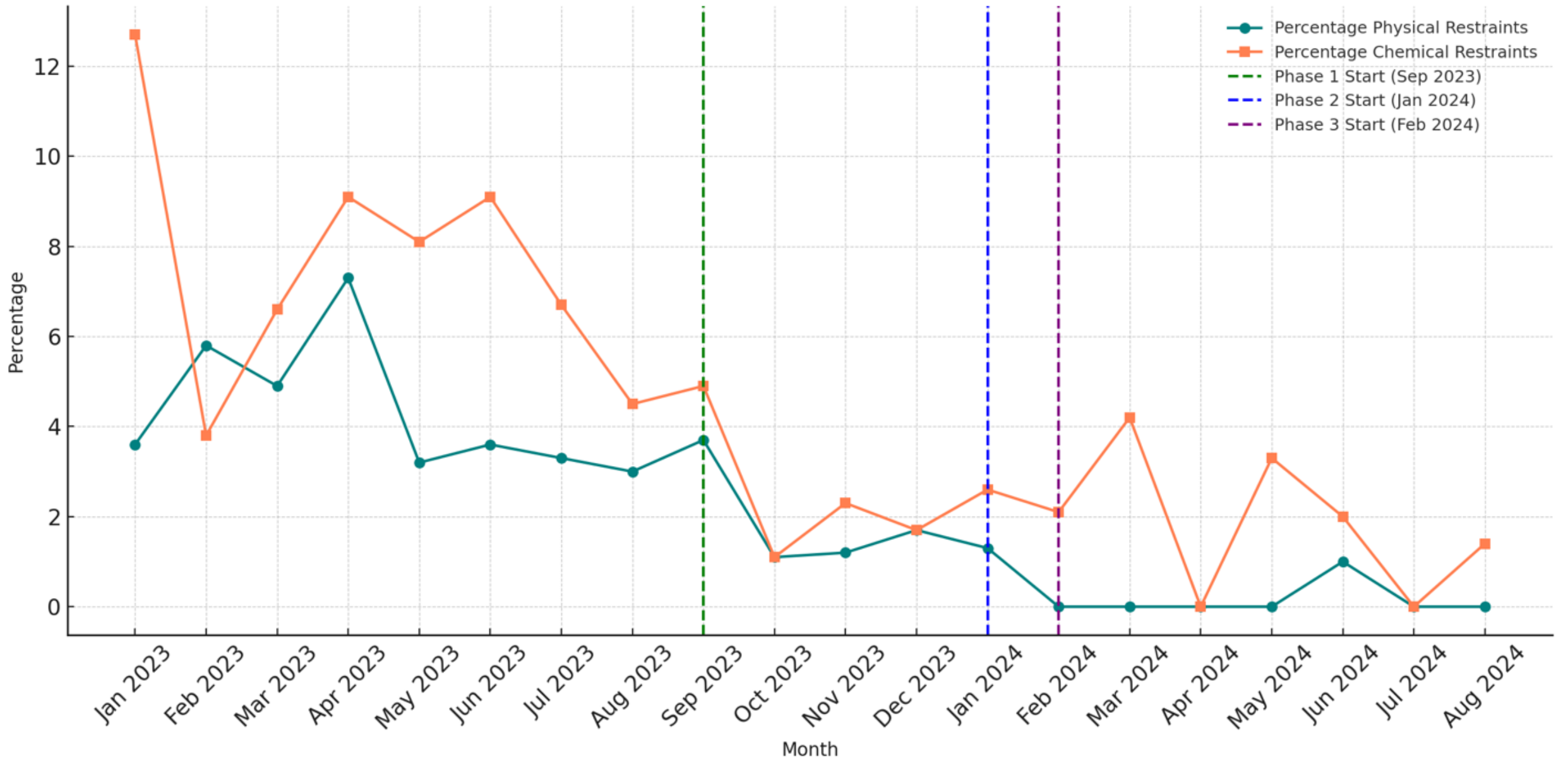
Our project is part of a multifaceted approach to standardize care and management of behavioral issues for cognitively impaired older adult patients through team empowerment and multidisciplinary collaboration.

Development

Implementation starting in late 2023

- 1** Introduced and increased usage of cognitive impairment assessment tools into nursing workflow. Had these integrated into Epic flowsheets.
- 2** Introduced the “4M’s” to internal medicine residents and incorporated a 4M’s checklist into new patient presentations and progress notes.
- 3** Tracking chemical and physical restraint usage and review cases when used to assess for areas of improvement.
- 4** Developed a CARES note template to guide residents when behavioral disturbances arise.

Monthly percentage of patients who received a physical and chemical restraint.



Can we sustain efforts in our unit?

Nursing training around identification of delirium and dementia, coupled with training in delirium precautions

Tip sheet for Managing Confused Patients on 4BT

We do our best on 4BT to manage confusion/behavioral disturbances with non pharmacological management. This leads to decreased length of stay, and less harmful lasting effects for the patients.

- Try to be proactive, assess basic needs before they become frustrations



- Food: Make sure to help the patient with ordering meals, set them up for meals, feed them if need be

- Water: Make sure the patient has water at the bedside at all times (unless they are on a fluid restriction)



- Toileting: Proactive toileting, utilize bedside commodes



- Ambulation: Encourage the patient to get out of bed, up to the chair for meals, walk in the hallway if possible

- Comfort: Is the room temperature comfortable? Do they need a blanket? Do they need an extra pillow? Do they need pain medication? Are they clean and dry?

- Offer distraction - give them washcloths to fold, turn on music, give them magazines to read, or busy apron to play with
- Provide them with tools to orient them to their surroundings: hearing aids, glasses, telephone and call bell within reach, write name on the whiteboard, have pictures of their loved ones nearby

10 Absolutes of Communication

1. Never argue, Instead AGREE
2. Never reason, Instead DIVERT
3. Never shame, Instead DISTRACT
4. Never lecture, Instead REASSURE
5. Never say remember, Instead REMINISCE
6. Never say "I told you", Instead REPEAT
7. Never say "you can't", Instead "DO WHAT YOU CAN"
8. Never command or demand, Instead ASK/MODEL
9. Never condescend, Instead ENCOURAGE/PRAISE
10. Never force, Instead REINFORCE

Could it be Delirium?

Delirium is a reversible, medical condition, caused by an underlying condition such as:

- Urinary retention
- Fecal impaction
- Dehydration/sodium imbalance
- Uncontrolled pain
- Infection
- Reduced sensory input (hearing or vision difficulty)
- Withdrawal of medication
- New medication
- Intracranial, myocardial or pulmonary disorders

Ongoing Data

Mentation



Domain	Goal	12-month	Last month
Mentation			
Delirium			
CAM Documentation	90%	91.12%	94.08%
Delirium incidence	<10%	6.67%	4.05%
Delirium prevalence	NA	31.27%	42.86%
Cognitive Function			
6CIT Documentation	90%	86.48%	84.61%
Prevalence of established diagnosis of Dementia	NA	32.56%	38.46%
Suspected Cognitive Impairment	NA	41.68%	53.84%
Formal cognitive assessment	NA	---	---

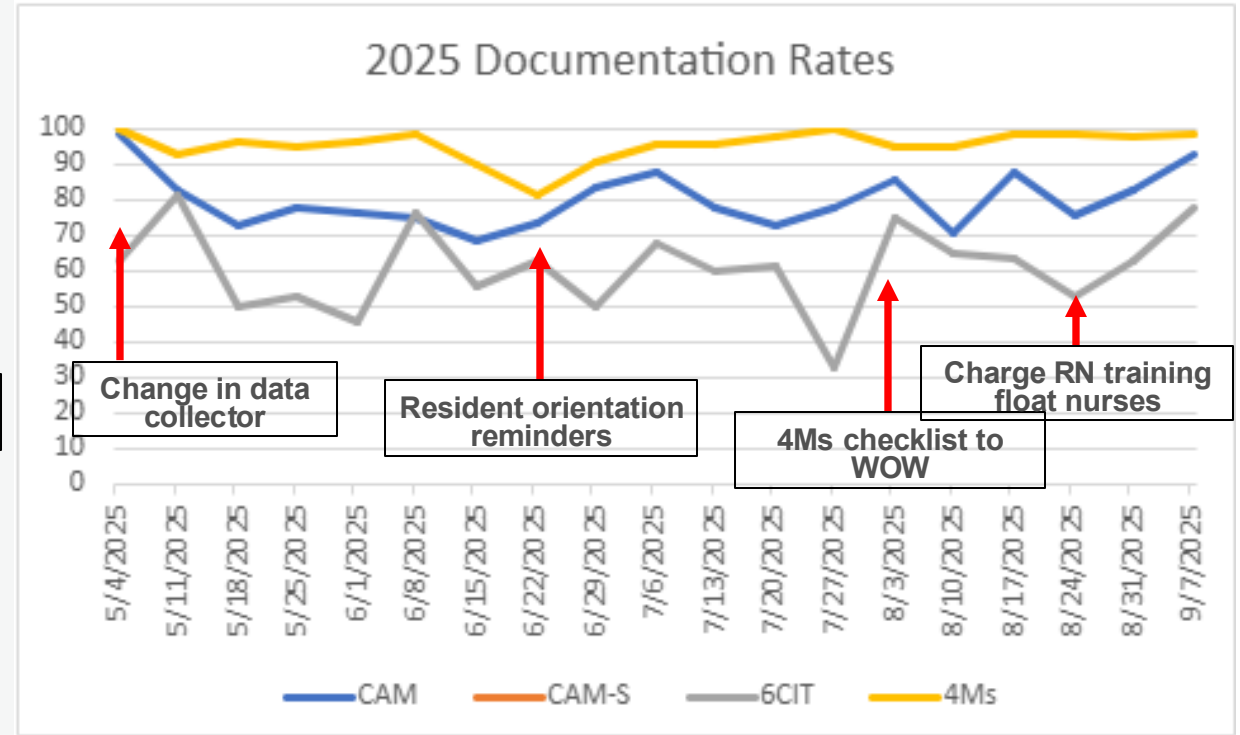
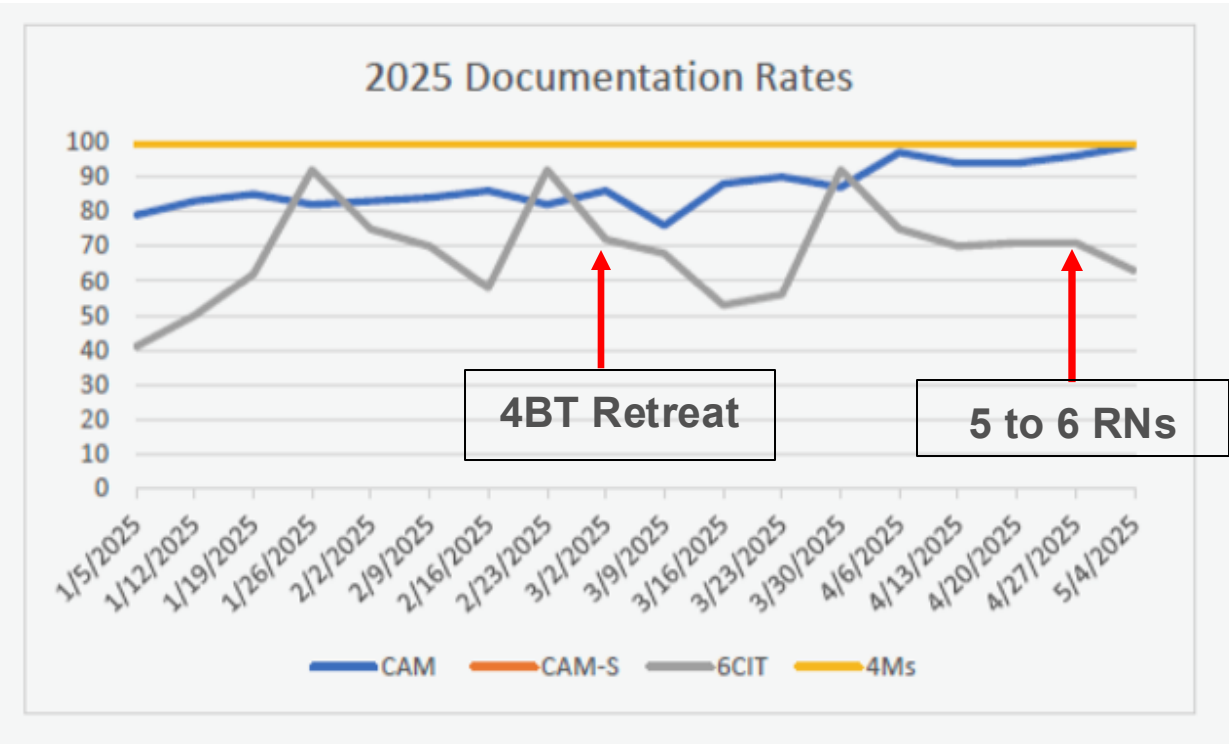
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Ongoing Data



Balance Measures - Falls

UNC HOSPITALS

Filter Options

Fiscal Year: FY 2025

Month and Year: (All)

Level of Care: HBH

NDNQI Unit Type: Acute Inpatient

Nursing Service Line: HILLSBOROUGH

MD Service: (All)

Unit: 4 BT1 HBR

Age Range: (All)

Additional Filters for Comparison Charts

Fiscal Year: (Multiple values)

Exclude Recent Month

Inpatient NDNQI Reporting Group

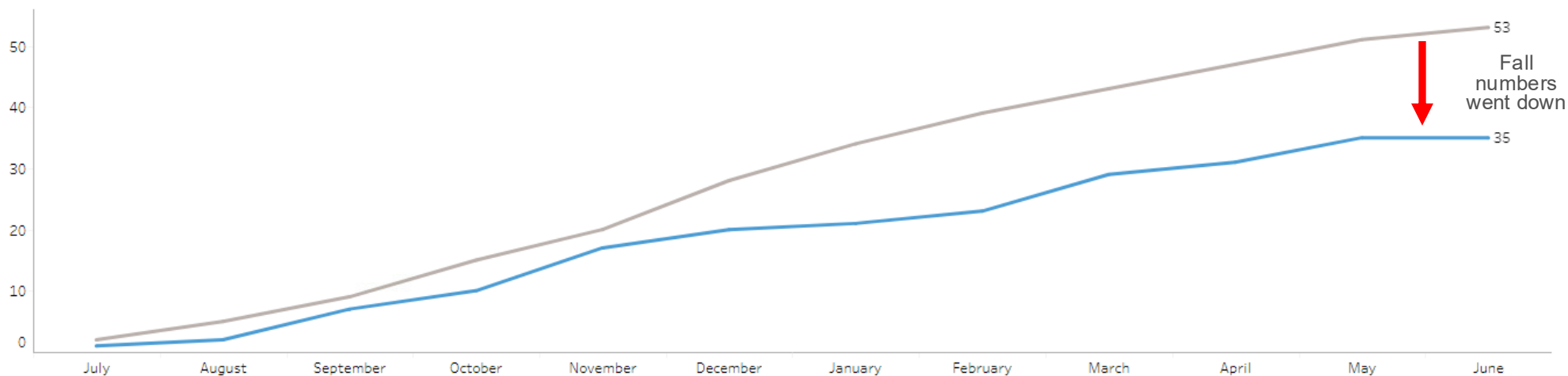
Reporting Group	16	35	8	8	4.59	1.11	0
	Days Since Last Fall	Falls	Falls with Injury	Reported Falls with Injury	NDNQI Falls Rate	NDNQI Falls with Injury Rate	Falls with Missing Fall Type
	% with Injury	% Physiological Falls	% Assisted Falls	% Post Fall Reassessed w/in 24h	% Repeat Falls	% Deep Dives	
	23%	40%	17%	94%	11%	86%	

Fiscal Year Comparison: Inpatient NDNQI Reporting Group

Select to change comparison view: Falls

Fiscal Year: FY 2025 (blue), FY 2024 (grey)

Fiscal Year to Date Falls Running Total

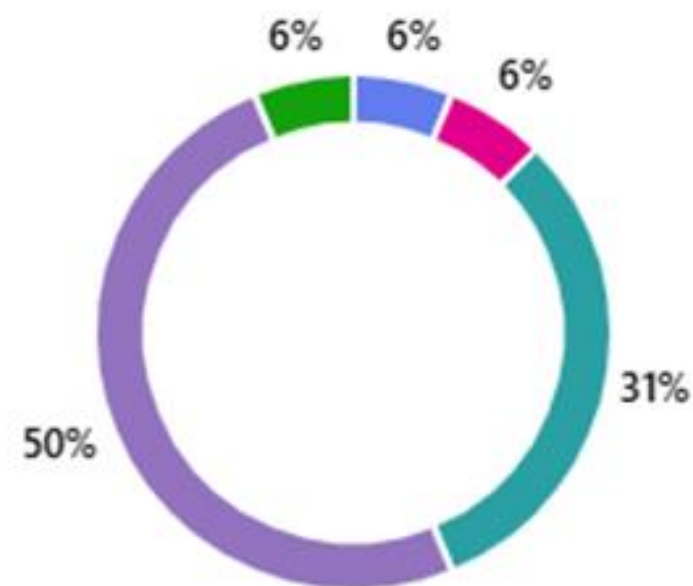


Balance Measures - Burnout

On a scale of 1-10 (1 not at all, 10 very engaged), how engaged do you feel in the IHQI work on 4BT (0 point)

● 1-3	1
● 3-5	1
● 5-7	5
● 7-9	8
● 10	1

← Majority felt engaged



Patient and Family Partnership

How do you plan to partner with patient and families and/or include their voices into your changes for improvement?

Family concerns:

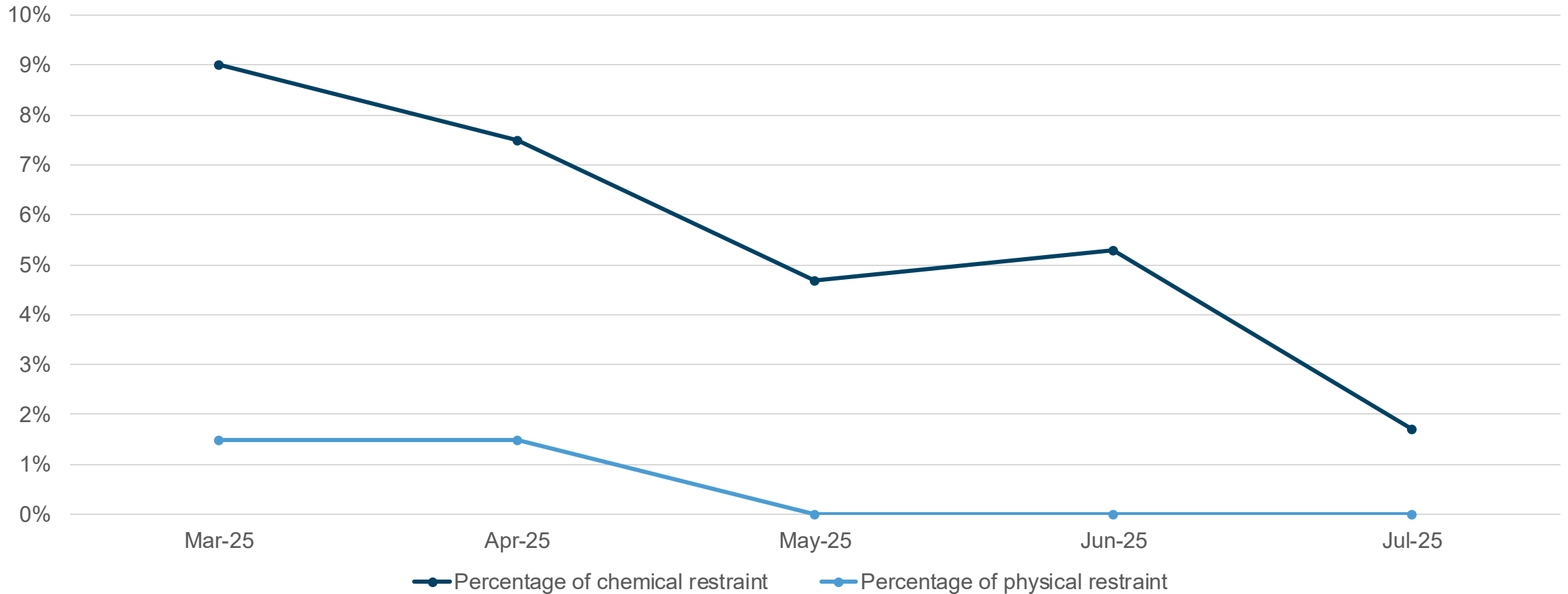
- Why is there not an alert in the medical record, stating that my loved one has dementia?
- My loved one transported to the ED via EMS. by the time I got there, they were asking her questions, that she was attempting to answer.
- The ED staff asked for changes at recent medication
- What is the protocol? It feels to the family that nothing is happening.
- It is frustrating to see my loved one being cared for by a geriatric-trained nurse when she made eye contact with my mom, and provided a gentle touch on the arm or hand”
- The analog clock is not helpful for orientation

Family praises:

- 4BT is the only place my loved one has been hospitalized at, that has talked about delirium
- The staff on 4BT made eye contact, spoke close so my loved one could hear, and listened to her concern

Sustainment

Monthly percentage of patients who received a physical and chemical restraint.



Can we take what we've learned and develop a protocol that can be shared to other areas of the hospital?

Differences to consider

Components unique to our unit

- Majority older adult patients
- Specialized training for nursing staff in care for older adults
- Consistent efforts to identify patients at risk for delirium and behavioral disturbances
- Geriatric Nurse Practitioner
- Attending Geriatricians

Differences to consider

- Processes/learning that is sustained despite wider variability of patient ages
- No geriatric-trained MDs/NPs in other units
- No specialized training in older adults for nursing staff
- Variable services present (hospitalist, fam med, surgery)

Collaboration with CMS Age-Friendly Measures

Considering changes across the hospital system

- Including CAM assessment into general workflow
- Standardizing delirium precautions
- Advisory alerts to avoid medications that can provoke delirium
- Development of a dashboard to track data

Acknowledgements

We owe so much gratitude to all the nursing staff who have helped provide their stakeholder feedback through this process. Their feedback and perspective has been invaluable to this process and inspires new ideas everyday.

Thanks to Drs. David Lynch and Reaves Houston who were instrumental in the development of this project, and Willow Butler, Tejal Vanukuru, and Samantha Kodikara who helped collect all of our data.

Lastly, many thanks to the IHQI and our project coaching and mentorship from Matt Huemmer and Dr. Casey Olm-Shipman!!