# Table 1. Search Strategy

<table>
<thead>
<tr>
<th>DATABASE SEARCHED &amp; TIME PERIOD COVERED:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The following databases have been searched for relevant information:</td>
<td></td>
</tr>
<tr>
<td>CINAHL (Cumulative Index to Nursing and Allied Health Literature)</td>
<td>Searched September 10, 2012</td>
</tr>
<tr>
<td>Cochrane Library</td>
<td>Searched September 10, 2012</td>
</tr>
<tr>
<td>EMBASE (Excerpta Medica)</td>
<td>1999 – September 7, 2012</td>
</tr>
<tr>
<td>MEDLINE</td>
<td>1999 – September 7, 2012</td>
</tr>
<tr>
<td>PreMEDLINE</td>
<td>1999 – September 7, 2012</td>
</tr>
<tr>
<td>PubMed</td>
<td>Searched September 7, 2012</td>
</tr>
</tbody>
</table>

**HAND SEARCHES OF JOURNAL & NONJOURNAL LITERATURE**

Journals and supplements maintained in ECRI Institute’s collections were routinely reviewed. Nonjournal publications and conference proceedings from professional organizations, private agencies, and government agencies were also screened. Other mechanisms used to retrieve additional relevant information included review of bibliographies/reference lists from peer-reviewed and gray literature. (Gray literature consists of reports, studies, articles, and monographs produced by federal and local government agencies, private organizations, educational facilities, consulting firms, and corporations. These documents do not appear in the peer-reviewed journal literature.)

**TOTAL NUMBER OF RESULTS: 673**
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Description of Patient Safety Strategy</th>
<th>Study Design and Patients</th>
<th>Theory or Logic Model</th>
<th>Contexts</th>
<th>Implementation Details</th>
<th>Outcomes: Benefits</th>
<th>Outcomes: Harms</th>
<th>Influence of Contexts on Outcomes</th>
<th>Overall Risk of Bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colombo et al. 2012 (19) Italy</td>
<td>Reorientation strategy where patients are 1) called by their first name, 2) given information on the ward, hospital, and illness progression; 3) mnemonically stimulated. Additional environmental, acoustic, and visual stimulation is provided.</td>
<td>Prospective controlled before-after (CBA) study 314 critically-ill patients admitted to a mixed medical-surgical ICU</td>
<td>Not reported, but the authors cite a recent review by key opinion leaders that proposed the strategy used in this study for critically-ill patients.</td>
<td>External: None mentioned Organizational Characteristics: Mixed medical-surgical ICU in a University hospital Teamwork: Four research nurses were trained to assess delirium, collect and input data into an electronic database, and to apply the Confusion Assessment Method for the ICU (CAM-ICU). Other team members not reported. Leadership: The lead author supervised proper application of the shared interventional reorientation algorithm. Culture: Not reported</td>
<td>Phase 1 involved implementing a sedation algorithm (used in Phase II as well). Mechanically-ventilated patients underwent daily interruption of sedation along with spontaneous breathing trial when clinically possible. Delirium assessment with CAM-ICU was performed twice daily (10 am and 10 pm) after sedation interruption. Pain was also assessed. Phase 1 lasted 5 months. Phase II was the intervention phase, where the reorientation strategy described under Description of Patient Safety Strategy was implemented. Phase II lasted 6 months.</td>
<td>Delirium incidence decreased from 35.5% during observational phase of study to 22% in the interventional phase (p&lt;0.020).</td>
<td>Not reported</td>
<td>Not reported</td>
<td>High</td>
</tr>
</tbody>
</table>
Deschot et al. 2012 (11) Belgium

Inpatient geriatric consultation team (IGCT)

Controlled clinical trial

171 patients aged ≥ 65 years admitted to an academic hospital emergency department with a hip fracture

IGCTs are intended to advise, sensitize and educate healthcare professionals on issues related to older adults and geriatric medicine, and to provide expertise for older adults on non-geriatric wards.

External:
None reported

Organizational Characteristics:
Academic hospital

Teamwork:
The team included a geriatrician, a nurse, a social worker, an occupational therapist and physiotherapist, all with geriatric care experience

Leadership:
Not reported

Culture:
Not reported

Implementation Tools:
An expert in geriatric assessment trained nurses to use the assessment tool during several sessions.

Standard care (including clinical assessment and pain medication) was administered to both groups. The intervention group received an IGCT consult managed as follows:

1. Team nurse administers preoperative comprehensive geriatric assessment
2. Geriatrician assesses medical status
3. Further evaluations are requested postoperatively based on team recommendations
4. “Multidimensional image” of the patient is developed
5. A detailed report is generated (inserted in electronic and paper files); discussed with primary nurse, head nurse and traumatologist
6. IGCT nurse responsible for feedback and follow through with recommendations or new issues

Delirium incidence*

Intervention: 21/74 (28.4%)  
Control: 25/57 (43.9%)  
Relative risk (RR): 0.65 (95% CI 0.41 to 1.03, p=0.067)

*Calculated by reviewers based on reported data

Martinez et al. 2012 (20)

Prophylactic environmental management of in-hospital

Single-blind randomized controlled trial (RCT)

Not reported

External:
None mentioned

Organizational

A non-pharmacological intervention included the following six

Delirium incidence

Intervention: 8 (5.6%)  
No harms reported for intervention. Four patients
Chile

*delirium (PEMID), a multicomponent management protocol*

287 patients > 70 years admitted to an internal medicine ward and considered to have at least one risk factor for delirium

**Characteristics:**
- Naval hospital
- Teamwork:
  - 3 independent observers assessed patients
- Leadership:
  - Not reported
- Culture:
  - Not reported

**Implementation Tools:** Educational pamphlet, interviews with family members, familiar items (e.g., photos) and items necessary for daily living (e.g., glasses)

1. **Education:** During a 10 minute interview, family members were educated on clinical features and prognostic implications of acute confusional syndrome. Educational pamphlet also distributed.
2. A clock and calendar was placed in the patients room
3. Patients glasses, dentures and hearing aids made available
4. Familiar objects such as photographs, cushions and radios placed in the room
5. Family members reorient patient with current date, time and events
6. Families allowed 5 hour visitations

Physicians provided delirium treatments.

**Control:** 19 (13.3%)

\[ RR = 0.41 \text{ (95% CI 0.19-0.92, } p=0.027) \]

in the control group experienced falls, one of which resulted in a fracture.

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**Allen et al. 2011(17) USA**

*System-wide quality improvement (QI) project to prevent delirium in hospitalized patients*

Prospective CBA study

199 patients

**External:** None mentioned

**Organizational Characteristics:** 6 community hospitals (part of Summa Health System), over 2,000 licensed beds. Acute Care for Elders (ACE) unit had prior experience using

First obtained stakeholder agreement, then multidisciplinary workgroup devised strategy and carried out the pilot project. It involved education of ACE unit staff on delirium screening, prevention and treatment protocols that were then

Delirium incidence decreased from 8.8% in pre-implementation group to 7.2% in implementation group (not statistically significant).

Mean length of stay decreased from 7.6 days to 4 days (difference 3.6)

No harms reported for intervention. Deaths, ICU transfers, and 30-day readmissions all decreased in intervention group.
delirium prevention guidelines.

**Teamwork:**
Multidisciplinary delirium workgroup with physicians and ACE nurses, director of hospital quality. Nurse quality management and leadership, clinical informatics nurses, geriatric pharmacy, and geriatric medicine fellows.

**Leadership:**
3 of the authors led the pilot in the ACE unit.

**Culture:**
Statement that Summa Health System “maintains a strong commitment to patient safety and quality”

**Implementation tools:**
Staff education and training, use of audit and feedback implemented.

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**Incident delirium:**

- **Intervention:** 25/87 (29%)
- **Control:** 64/83 (77%)
- **OR:** 0.12 (95% CI: 0.06-0.24)
- **P:** <0.0001

Authors also state “there were no significant differences in mean scores between groups.”
<table>
<thead>
<tr>
<th>Chen et al.</th>
<th>Modified Hospital Elder Life Program (HELP)</th>
<th>Taiwan</th>
<th>( \text{CBA study (historical control)} )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>189 patients admitted to a gastrointestinal ward for elective surgery, with expected length of stay &gt;6 days</td>
<td>189 patients aged ≥65 years admitted to a gastrointestinal ward for elective surgery, with expected length of stay &gt;6 days</td>
<td>Prior evidence suggests the HELP model can prevent and reduce older patients’ post-surgical functional decline. The authors’ earlier work suggests that 3 key elements are the most relevant for surgical patients and those were used in this study.</td>
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<tr>
<td><strong>Culture</strong></td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
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<tr>
<td><strong>Implementation tools</strong></td>
<td>A full-time trained HELP nurse, blinded to the study hypothesis and not an outcomes assessor, implemented the program. The trained HELP nurse helped (sometimes with family members) mobilize patients and simultaneously engaged them in cognitive activities (such as discussing things that interested the patient); the nurse also provided nutritional assistance (oral care, assisted feeding if necessary).</td>
<td>Modified HELP protocols (early mobilization, nutritional assistance)</td>
<td>Delirium at discharge: HELP 0/102 (0%); Control 12/77 (15.6%); OR = 0.03 (95% CI: 0.001-0.44); ( P &lt; 0.001 )</td>
</tr>
<tr>
<td><strong>External factors</strong></td>
<td>None mentioned</td>
<td>None mentioned</td>
<td>None mentioned</td>
</tr>
<tr>
<td><strong>Organizational Characteristics</strong></td>
<td>Urban medical hospital (2,200 beds, 36-bed gastrointestinal ward)</td>
<td>Urban medical hospital (2,200 beds, 36-bed gastrointestinal ward)</td>
<td>Urban medical hospital (2,200 beds, 36-bed gastrointestinal ward)</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Researchers designed program and led the study</td>
<td>Researchers designed program and led the study</td>
<td>Researchers designed program and led the study</td>
</tr>
<tr>
<td><strong>Teamwork</strong></td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
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</tbody>
</table>

**Implementation**

The researchers provided an information booklet describing how to prevent delirium; they also provided verbal and printed introduction to the study and booklet.
HELP was first implemented in one 40-bed medical unit in 2002; by 2008 it had spread to 6 units with a total of 184 beds. The project director initially worked with hospital leadership to determine metrics for measuring success; initial success in the proposed metrics was demonstrated, so the hospital agreed to continue funding and allowed expansion to additional units; before starting in a new unit, the project director solicited input from each nursing unit director; the project director worked with the Chief Nursing Director to identify subsequent units to target; as patient volume increased, paid HELP staff and volunteers were added; one Elder Life Specialist became the lead volunteer coordinator; weekly meetings of staff were held to maintain quality and document modifications to the original HELP protocols.

### Delirium rate:

<table>
<thead>
<tr>
<th>Year</th>
<th>Delirium Rate</th>
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<tbody>
<tr>
<td>Pre-HELP (2001)</td>
<td>41%</td>
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<tr>
<td>HELP (2002)</td>
<td>26%</td>
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<tr>
<td>HELP (2005)</td>
<td>16%</td>
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<tr>
<td>HELP (2008)</td>
<td>18%</td>
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</tbody>
</table>

### Nurse satisfaction:

Nurses and nurses aides reported benefit and satisfaction with HELP and agreed with a questionnaire item that their job was “more satisfying due to HELP.”
Inouye et al. 2003(7), 1999(10) USA

**HELP for prevention of delirium in elderly patients**

**Prospective matched CBA study**

- 852 patients at least 70 years old admitted to general medicine floor (later study included 422 patients from the HELP arm of the study)

Delirium has been associated with several risk factors; the HELP targets 6 of these risk factors (cognitive impairment, sleep deprivation, immobility, visual impairment, hearing impairment, and dehydration)

**External:**
- None mentioned

**Organizational Characteristics:**
- Urban teaching hospital (900 beds)

**Teamwork:**
- Interdisciplinary team including a geriatric nurse-specialist, two Elder Life specialists, a certified therapeutic-recreation specialist, a physical therapy consultant, a geriatrician, and trained volunteers.

**Leadership:**
- Not reported

**Culture:**
- Not reported

**Implementation tools:**
- All staff and volunteers underwent quarterly standardization to ensure consistent application of all intervention protocols

With oversight by a geriatric nurse specialist and geriatrician, the Elder Life specialists implemented 6 interventions: orientation, therapeutic activities, mobility, sleep, hearing or vision, and volume repletion (for dehydration); they were assisted by trained volunteers; all patients were assigned orientation, therapeutic activities, and mobility; other protocols were targeted to a subgroup of patients with the identified risk factor.

In the earlier publication, incident delirium was significantly lower in the intervention group vs. the usual care group (9.9% vs. 15%, OR: 0.60 (95% CI: 0.39–0.92); P = 0.02

**Adherence**
- Not reported

**High patient adherence to individual interventions significantly reduced incident delirium rates.**

- **Adherence (each 1 point increase):**
  - OR: 0.69 (95% CI: 0.56-0.87)
  - P = 0.001
Björkelund et al.
2010(3)
Sweden

Multifactorial intervention including pre-hospital and perioperative treatment and care of patients with hip fracture. Components include supplemental oxygen 3-4l/min, IV fluid supplementation and extra nutrition, increased monitoring of vital physiological parameters, adequate pain relief, avoid delay in transfer logistics, daily delirium screening using Organic Brain Syndrome (OBS) scale, avoid polypharmacy, and perioperative/anesthetic period protocol.

Authors cite prior multifactorial intervention studies; they added pre-hospital component because prior studies have identified preop risk factors for delirium.

Prospective CBA study
263 patients aged ≥65 years with hip fracture

Post-op delirium:
Intervention: 28/131 (21.4%)
Control: 44/132 (33.3%)
OR = 0.54 (0.31-0.95)
P = 0.03

Any complications:
Intervention: 66/131 (50.4%)
Control: 70/132 (53.0%)
P = 0.67

Patients underwent pre-hospital care, nurse assessment immediately after admission, orthopedic surgeon assessment 30 min before referral to X-ray department, then transfer to orthopedic ward, then surgery for hip fracture with general or spinal anesthesia. Delirium was assessed by researchers within 4 hrs of admission and 8 hr after the end of anesthesia.

Leadership:
Researchers were in charge

Teamwork:
Nurses and orthopedic surgeons were part of the team

Culture:
Not reported

Implementation tools:
Two of the authors were in charge of implementation

External: None mentioned
Organizational Characteristics:
Academic hospital, also pre-hospital ambulance care

Internal:
Not reported

High
Needham et al. 2010(12) USA

Structured quality improvement (QI) model with components including: understanding the problem within the larger healthcare system, creating a multidisciplinary improvement team, enlisting all stakeholders to identify barriers to change and appropriate solutions, and creating a change in practice through engagement, education, execution, and evaluation

CBA study (historical control)

57 patients with acute respiratory failure

The QI model was based on a “4 Es” model (engage, educate, execute, and evaluate). Previous studies have shown that early physical medicine and rehabilitation (PM&R) in the ICU provides benefits for critically ill patients, and the QI model applied this evidence to patients in the medical ICU (MICU).

External: None mentioned

Organizational Characteristics: Academic hospital with 16-bed MICU

Leadership: The lead author was the project leader.

Researchers were in charge

Teamwork: A multidisciplinary QI team with representatives from each relevant clinician group in the MICU and PM&R

Culture: Not reported

Implementation tools:

Education and training of nurses, physical therapists, occupational therapists, and respiratory therapists to obtain specific skills related to rehab of mechanically ventilated patients.

Standardized MICU admission modified to change default activity from “bed rest” to “as tolerated,” change in sedation practice from continuous intravenous infusions to “as needed” bolus doses; establishing guidelines for PT and OT consultation; developing safety-related guidelines for PM&R-related consultation; including a full-time PT and OT and a part-time rehab assistant; consulting a physiatrist; and increasing consultations to neurologists for MICU patients with severe or prolonged muscle weakness.

Incident delirium:

QI period: 125/482 (28%) MICU patient days

Pre-QI period: 107/312 (36%) MICU patient days

P = 0.003

Unexpected events:

QI period: 4 cases of rectal or feeding tube removal, without any significant complications

Pre-QI period: No unexpected events

P > 0.99

Vidán et al. 2009(14) Spain

Education measures and specific actions in 7 risk areas (orientation, sensory impairment, sleep, mobilization, hydration, nutrition, drug use), with daily monitoring of

Controlled clinical trial

542 patients aged ≥70 years admitted to a geriatric acute care unit and two internal medicine wards

Authors discuss the HELP program as inspiration, but the new protocol was designed to be implemented in daily practice without extra staff (unlike

External: None mentioned

Organizational Characteristics: Academic hospital

Leadership: A specialist geriatric nurse coordinated the intervention and monitored adherence.

Teamwork:

Intervention implemented within first 24 hours of admission to geriatric ward by geriatricians, residents, and nurses. A specialist geriatric nurse coordinated the intervention and monitored adherence.

New delirium episodes:

Intervention: 20/170 (11.7%)

Usual care: 69/372 (18.5%)

OR = 0.59 (95% CI: 0.34-1.00)

P = 0.05

Unexpected events:

Not reported

High

Not reported

High
| Study | Setting | Proactive care of older people undergoing surgery (POPS); multidisciplinary preoperative comprehensive geriatric assessment (CGA) service with post-operative follow-through | CBA study (historical control) | The authors hypothesized that preoperative CGA “incorporating prediction of adverse outcomes combined with targeted interventions, would reduce post-operative complications and hence length of stay (LOS) in older people undergoing elective surgery.” This strategy did not target delirium alone, but any factor that might contribute to complications or longer LOS. | The multidisciplinary QI team implemented POPS. Most patients received pre-op home visits from occupational therapist and physiotherapy. Social worker provided inputs if needed. Patients were educated in optimizing post-op recovery. The geriatrician and nurse reviewed patients in surgical wards and provided staff education in post-op early detection and treatment of medical complications, early mobilization, pain management, bowel-bladder function, nutrition and discharge planning. Follow-up therapy home visits were provided to those with functional difficulties, and outpatient clinical review in those with post-op delirium: POPS: 3/54 (5.6%) Pre-POPS: 10/54 (18.5%) OR = 0.26 (0.07-1.00) P = 0.036 | Only reported complications were related to surgery, not POPS | Not reported | High |

<p>| Harari et al. 2007(15) U.K. | Proactive care of older people undergoing surgery (POPS); multidisciplinary preoperative comprehensive geriatric assessment (CGA) service with post-operative follow-through | CBA study (historical control) | The authors hypothesized that preoperative CGA “incorporating prediction of adverse outcomes combined with targeted interventions, would reduce post-operative complications and hence length of stay (LOS) in older people undergoing elective surgery.” This strategy did not target delirium alone, but any factor that might contribute to complications or longer LOS. | The multidisciplinary QI team implemented POPS. Most patients received pre-op home visits from occupational therapist and physiotherapy. Social worker provided inputs if needed. Patients were educated in optimizing post-op recovery. The geriatrician and nurse reviewed patients in surgical wards and provided staff education in post-op early detection and treatment of medical complications, early mobilization, pain management, bowel-bladder function, nutrition and discharge planning. Follow-up therapy home visits were provided to those with functional difficulties, and outpatient clinical review in those with post-op delirium: POPS: 3/54 (5.6%) Pre-POPS: 10/54 (18.5%) OR = 0.26 (0.07-1.00) P = 0.036 | Only reported complications were related to surgery, not POPS | Not reported | High |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample Size</th>
<th>Intervention Details</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lundström et al. 2007(4) Sweden</td>
<td>RCT</td>
<td>199 patients aged ≥70 years with femoral neck fractures</td>
<td>Early mobilization, pain management, bowel-bladder function, nutrition and discharge planning.</td>
<td>Post-op delirium: Intervention: 56/102 (54.9%) Control: 73/97 (75.3%) OR = 0.40 (0.22-0.73) p = 0.003 Days with post-op delirium: Intervention: 5.0 ±7.1 days Control: 10.2±13.3 days, p = 0.009</td>
</tr>
<tr>
<td>Lundström et al. 2005(16) Sweden</td>
<td>Quasi-RCT</td>
<td>400 patients aged ≥70 years admitted to two wards (intervention and usual)</td>
<td>Education program and reorganization of nursing and medical care</td>
<td>Prevalent delirium within 24 hrs of admission: Intervention: 63/200 (31.5%) Control: 62/200 (31%)</td>
</tr>
</tbody>
</table>

**External:** None reported

**Organizational Characteristics:**
- Academic hospital with 24-bed geriatric unit (used only for intervention group)
- Leadership: Not reported
- Teamwork: A multidisciplinary team including RNs, LPNs, registered physiotherapists, registered occupational therapists, a dietician and geriatricians
- Culture: Not reported
- Implementation tools: All nursing and medical staff members attended a 4-day course in caring, rehabilitation, teamwork, and medical knowledge.

**Post-op delirium:**
- Post-op: Intervention: 56/102 (54.9%) Control: 73/97 (75.3%)
- OR = 0.40 (0.22-0.73) p = 0.003
- Days with post-op delirium:
  - Intervention: 5.0 ±7.1 days
  - Control: 10.2±13.3 days, p = 0.009

**Prevalent delirium within 24 hrs of admission:**
- Intervention: 63/200 (31.5%)
- Control: 62/200 (31%)
were the leaders of the program.

Teamwork:
A multidisciplinary team including all staff in the intervention ward.

Culture:
Not reported.

Implementation tools:
All nursing and medical staff members attended a 2-day course focusing on dementia and delirium in geriatric patients. Staff was also trained in the caregiver-patient interaction.

Nursing care was reorganized to support individualized care, and nursing staff received guidance once a month by a supervisor observing a nursing action.

P = 0.91

Delirium on Day 7:

Intervention: 19/63 (30.2%)
Control: 37/62 (59.7%)
OR = 0.29 (0.14-0.61)
P = 0.001

Tabet et al. 2005(13); 2006(23)
U.K.

Educational package for medical and nursing staff to reduce incidence of delirium in hospitalized elderly patients; a control ward did not receive the educational package and performed usual practice.

CBA study (concurrent control)
250 patients aged ≥70 years admitted to two acute admission wards

The authors cite prior studies of educational programs directed at staff that have influenced nursing practice in relation to mental health issues in elderly people.

External:
None mentioned.

Organizational Characteristics:
Two acute admission wards in an inner-city teaching hospital.

Teamwork:
Geriatric psychiatrist educated staff, who altered their practice based on the education.

Leadership:
The lead investigator (a geriatric psychiatrist) supervised the project.

Culture:
Not reported.

Implementation tools:
Education program

The educational package, which highlighted delirium risk factors, was delivered on site and at various times to ensure all staff were involved. There was an initial 1 hr formal presentation, written information on guidelines for delirium prevention and management, and regular follow-up meetings to reinforce learning; researchers did not intervene in day-to-day management or provide specific advice pertaining to specific patients.

Point prevalence of delirium:

Intervention ward: 12/122 (9.8%)
Usual care ward: 25/128 (19.5%)
OR: 0.45 (95% CI: 0.21-0.94, P<0.05)

Not reported

The educational package was found to more effectively prevent delirium in men (OR: 0.17, 95% CI: 0.05-0.65) than in women (OR: 1.04, 95% CI: 0.38-2.81).
Delirium education for hospital staff plus recommendations by geriatric registrar for up to 10 possible targeted intervention strategies to prevent delirium after hip fracture

CBA study (historical control)
99 patients aged >50 years with hip fracture admitted to a general orthopedic unit

This strategy had been successfully used at a U.S. hospital in a previously published study; targeted recommendations include regulation of bladder and bowel function, early detection/treatment of major complications, correction of fluid and electrolyte imbalance, discontinuation of unnecessary medications, provision of oxygen, severe pain treatment, agitated delirium treatment, use of appropriate environmental stimuli, adequate nutritional intake, and early mobilization and rehabilitation.

The lead investigator educated staff, supervised data collection and assessed patients; the project team met fortnightly to supervise the program; the intervention was implemented over a 3-month period; the major barrier was a high turnover of nursing staff that was partly overcome by the nurse manager of the orthopedic unit ensuring that all nursing staff attended the tutorials and received education about the use of the CAM.

**Incident delirium:**

<table>
<thead>
<tr>
<th>Intervention:</th>
<th>None reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-intervention:</td>
<td>10/28 (37.5%)</td>
</tr>
<tr>
<td>OR = 0.26</td>
<td>(95% CI: 0.09-0.74)</td>
</tr>
<tr>
<td>P = 0.012</td>
<td></td>
</tr>
</tbody>
</table>

Organizational Characteristics:

- Urban teaching hospital (460 beds)
- Multidisciplinary committee with medical, nursing, and allied health members of the orthopedic, geriatric, and anesthetic depts.

Leadership:
The lead investigator supervised the project.

Culture:
Not reported

Implementation tools:
The leader educated frontline staff (interns, ward nurses, and allied health staff) on delirium every 10 weeks.

**External:**
None mentioned

**Organizational Characteristics:**

- Urban teaching hospital (460 beds)
- Multidisciplinary committee with medical, nursing, and allied health members of the orthopedic, geriatric, and anesthetic depts.

**Leadership:**
The lead investigator supervised the project.

**Culture:**
Not reported

**Implementation tools:**
The leader educated frontline staff (interns, ward nurses, and allied health staff) on delirium every 10 weeks.

**Incident delirium:**

<p>| None reported | Not reported | High |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Setting</th>
<th>Teamwork</th>
<th>Leadership</th>
<th>Culture</th>
<th>Implementation Tools</th>
<th>External</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcantonio et al. 2001(8) USA</td>
<td>Single-blind RCT</td>
<td>126 patients aged ≥65 years admitted emergently for surgical repair of hip fracture</td>
<td>Academic tertiary medical center</td>
<td>Geriatrician and orthopedics team worked together</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>None mentioned</td>
<td>Not clearly stated, other than that geriatrics consultation is easily implementable and that a targeted, proactive strategy with intervention on defined outcomes has shown effectiveness, although it is not clear whether it has shown prior effectiveness in delirium prevention.</td>
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<td></td>
<td>A geriatrician evaluated patients preoperatively or within 24 hours postop, performed daily visits for duration of hospitalization and made targeted recommendations. The orthopedics team (surgeons and nurses) implemented the recommendations (adherence rate: 77%). The usual care group received management by the orthopedics team, including internal medicine or geriatric consults on a reactive rather than proactive basis.</td>
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<td></td>
<td></td>
<td>Post-op delirium: Consult: 20/62 (32%) Usual care: 32/64 (50%) P = 0.04 However, when adjusted for baseline imbalances the effect size was no longer statistically significant: OR: 0.6 (95% CI: 0.3-1.3) No significant between-group difference in days of delirium per episode</td>
<td></td>
</tr>
</tbody>
</table>

Palliative care centers (dedicated hospital units and/or stand-alone hospices) Consultation showed a trend toward being more effective among patients without prefracture dementia or ADL impairment, but the differences were not statistically significant.
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design</th>
<th>Participants</th>
<th>Setting</th>
<th>Intervention Details</th>
<th>Comparison Group</th>
<th>Comparison of Delirium Incidence</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gagnon et al. 2012 (21)</td>
<td>Controlled clinical trial</td>
<td>1516 patients admitted to seven palliative care centers for terminally-ill patients</td>
<td>Canada</td>
<td>Multi-component intervention to prevent delirium in terminal cancer patients; intervention included a patient/physician component</td>
<td>Not reported</td>
<td>Delirium incidence: Intervention: 49.1% Usual care: 43.9%</td>
<td>When adjusted for confounding variables, no between-group difference was found for delirium incidence (OR 0.94, p=0.66).</td>
</tr>
<tr>
<td>Lapane et al. 2011 (22)</td>
<td>Quasi-RCT</td>
<td>3,202 patients (2003) 3,321 patients (2004) 25 nursing homes were</td>
<td>USA</td>
<td>Pharmacist-led Geriatric Risk Assessment MedGuide (GRAM) reports and automated monitoring plans focusing on medication</td>
<td>Not reported</td>
<td>No significant difference between groups for potential adverse-event related hospitalization, falls, or death</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

**Long-term care**

- **External:** None mentioned
- **Organizational Characteristics:** Palliative care centers
- **Teamwork:** Physicians, nurses, and family members worked together to implement the intervention
- **Leadership:** Principal investigators led the project; a research staff nurse oversaw study procedures in every participating center
- **Culture:** Not reported
- **Implementation Tools:** Bedside nurses attended training sessions on screening and monitoring for delirium symptoms using the Confusion Rating Scale.
- **Delirium incidence:** Not reported

The multicomponent intervention was implemented at 2 of the 7 palliative care centers; the others provided usual care. At all centers, bedside nurses assessed the presence and intensity of symptoms at the end of each 8-hour shift. For the intervention, the research nurse recorded patient risk factors for delirium on a form that was sent to the physician so they could determine what further steps to take. Nurses also oriented the patient as early as possible in the nurse shift. Bedside nurses educated the closest family member about delirium and provided them with the American College of Physicians recommendations for avoiding symptoms of confusion in patients with advanced cancer.

**Potential delirium indicator:**

- **In home 2003/04:** Adjusted hazard ratio: 0.93 (0.80-1.09)
- **New admits 2004:** Adjusted hazard
monitoring phase to prevent potential adverse drug events (falls and delirium) in nursing homes randomized to receive intervention or control identification when evaluating complex medication regimens of older adults to identify, resolve, and prevent medication-related problems, aid in evaluation of medications as a cause or aggravating factor contributing to an older adult’s physical, cognitive, or functional decline, and facilitate incorporation of medication monitoring information into the older adult’s plan of care. Omnicare and had few short stay residents Teamwork: Pharmacists shared reports with facility nurses. Leadership: Consultant pharmacists Culture: Not reported Implementation tools: The ASCP Foundation developed and delivered in-service programs for nursing staff and consultant pharmacists. Two of the authors were instructors. generated on medications that contribute to falls and delirium, as well as medication monitoring care plans and flow records. Facility nurses received reports within 24 h of admission for new admissions; consultant pharmacists did on-site reviews of drug regimens for each resident once every 30 days.

ACE – Acute care for elders
ADL – Activities of daily living
CAM – Confusion assessment method
CBA – Controlled before-after
CGA – Comprehensive geriatric assessment
GRAM – Geriatric risk assessment medguide
HELP – Hospital elder life program
ICU – Intensive care unit
IGCT – Inpatient geriatric consultation team
LOS – Length of stay
LPN – Licensed practical nurse
MICU – Medical ICU
OR – Odds ratio
OT – Occupational therapist

ratio: 0.42 (0.35-0.52)
Figure. Study flow diagram.

Titles (n = 673)

- Clearly irrelevant (n = 364)

Reviewed articles (n = 309)

Rejected studies (n = 219)
- Commentaries, reviews, systematic reviews, protocols, letters, meeting abstracts, or studies that did not address a key question: 186
- <20 patients per group: 6
- No data on efficacy/effectiveness: 5
- Other: 22

- Prognostic studies (reviewed in full PSP report) (n = 55)
- Comparative studies (multicomponent interventions) (n = 19)
- Comparative studies (single-component interventions; reviewed in full PSP report) (n = 16)

PSP = patient safety practice.