AMENDing the Care of the Critically Ill Older Adult: a Quality Improvement Project

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In 2014, older adults accounted for about 15% of the total United States population, and this total is projected to increase to 21% by the year 2030 (Federal Interagency Forum on Aging-Related Statistics, 2016). As this population continues to grow, there is a rising prevalence of older patients within the United States’ healthcare system. Currently, older adults make up more than half of patients and account for 48% to 58% of Intensive Care Unit (ICU) admissions (Casey, 2013). It has been shown that the severity of illness in older adults in the ICU has increased, mortality has risen slightly from 11.3% to 12%, and more patients are being discharged to places other home (Sjoding, Prescott, Wunsch, Iwashyna, & Cooke, 2016; Chang, Chen, & Su, 2012). The increase in amount of older adult patients in the ICU and their severity of illness has necessitated that providers be knowledgeable about the complex physiologic changes of aging when combined with critical illness or injury.

A variety of checklist style tools have been developed for use by ICU providers to assist clinicians in identifying patients at high risk of complications, and to assist them in recalling specific interventions to reduce these risks. These tools have often been compared to those used in an aviation cockpit to improve safety and have been shown to be helpful in caring for patients within the ICU (Vincent, 2005). Current ICU clinical tools, such as FastHug and the ABCDEF Bundle, have been shown to improve awareness of specific clinical risks and improve overall clinical care within the ICU. These tools have been created to serve most patients within the ICU, but not specific populations of concern such as the critically ill older adult population. The older adult ICU population has specific clinical needs and risks that vary from the younger ICU patient population. Many articles focus on individual geriatric syndromes that need to be improved in the care of the older adult, but few articles tie them all together in the overall care of
the older adult patient in the ICU. Providers who care for these patients in the ICU could benefit from the development of a tool designed to identify and treat common geriatric syndromes in the ICU, including pain, mobility, elimination, nutrition, delirium, and medication selection/dosing. These areas, if not managed appropriately, can increase morbidity, mortality, hospital length of stay and healthcare costs. The available literature supports the development of an ICU tool specific to geriatric related syndromes that complicate care in the ICU.

The purpose of this project was to create a checklist that could be used in the ICU to give providers evidence-based, age-appropriate suggestions to help guide the care of the critically ill older adult. The checklist was then tested in one ICU to determine if providers found it to be useful and if it could help them give better care to this specific population.

**Approach to the Project**

**Setting**

The setting for this quality improvement project took place within Oregon Health & Science University Hospital's Cardiovascular Intensive Care Units (CVICU) which is a 26-bed unit within the tertiary academic medical center in Portland, Oregon. This ICU does not routinely have access to a geriatrics consult service, and the providers regularly care for patients aged 65 and older with a multitude of various critical illnesses and injuries. As OHSU is an academic medical center, the CVICU has a variety of providers with various levels of knowledge and experience caring for the patients.

**Population**

There were two target populations being looked at within this project: the providers and the patients. Patient inclusion criteria included: patients aged 65 or older who are cared for
within the CVICU, with any diagnosis, for at least 24 hours. Patient exclusion criteria: any
patient transferred out of the ICU within 24 hours and therefore did not have time to have the
tool applied to them, and patients younger than 65 years old. Provider inclusion criteria included:
any CVICU faculty member (physicians, nurse practitioners, physician assistants) and resident
physician. Provider exclusion criteria: students (MD, NP, and PA) and any provider who were
not available to receive the education on the checklist tool. The study did not have a size limit
and included any patient that met the inclusion criteria within the dates the project ran. This was
designed to allow for a large enough sample to allow providers time to create opinions on the use
of the tool.

Provider Demographics

On a typical day, the CVICU has five to six providers managing the care of the patients,
which are split into two teams that are each led by an attending physician. The CVICU employs
15 Advanced Practice Providers (APPs), including eight Physician Assistants (PAs) and seven
Nurse Practitioners (NPs). Four providers are male (three PAs, one NP), and the remaining are
female (five PAs, six NPs). Eighty-seven percent of the APPs work in the ICU full time, and the
other 13% are part time. The rest of the unit’s providers are made up of medical residents
(fellows, residents, interns) that rotate through the unit every four weeks. Only the residents who
would be there during the project’s timeframe were educated about the checklist and the
suggested interventions. The residents were encouraged to participate, but the APPs were the
main focus of the project as they do the majority of direct patient care.

Patient Demographics
The patients in the CVICU have a variety of diagnoses that are co-managed by multiple different specialty services: cardiac surgery, heart failure (including advanced mechanical support), cardiology, thoracic surgery, vascular surgery, head and neck surgery (ENT/OMFS), orthopedic surgery, urology, and OB/GYN. Between January 16 and March 16, the CVICU providers cared for 316 total patients [118 female (37%), 198 male (63%)]. Of those 316 patients, 155 (49%) were 65 or older [57 female (37%), 98 male 63%]). The average hospital length of stay for the total 316 patients was 8.3 days, with an average ICU length of stay of 4 days. For those that were 65 and older, the average hospital length of stay was 6.97 days, with an average ICU length of stay of 3.2 days.

Project Details

The project’s intervention was a checklist-style tool called AMEND-Med. It included evidence based suggested interventions involving analgesia, mobility, elimination, nutrition, delirium, and medication prescribing for the older adult. The initial format of the tool was designed to be applied within an electronic medical record (Figure 1). The tool was then adjusted and created in paper format (Figure 2), which was the format ultimately used for the project. Prior to implementing the checklist, an email was sent to all potential users (residents and APPs) and other CVICU staff (MDs and RNs) so that they were aware of the checklists usage. This email also included a PowerPoint presentation giving a description of the project, the checklist, and the evidence behind the multiple suggestions (Appendix 1).

**Analgesia.** The analgesia section prompted providers to: consider scheduling acetaminophen to help limit the need for higher doses of opioids (Schofield, 2014; Pharmacological management of persistent pain in older persons, 2009); consider alternative treatments like non-opioid pain medications, ice, heat, massage, and acupuncture/pressure as
appropriate (Schofield, 2014); lower the dose of as-needed opioids (Herr, 2010; McLachlan et al, 2011; Coldrey, Upton, & Macintyre, 2011); and avoidance of opioids that are not metabolized well in the older adult (Coldrey, Upton, & Macintyre, 2011). Education included information about pain treatment in the older adult, including the "start low and go slow" approach with dosing analgesics (Herr, 2010; McLachlan et al, 2011).

**Mobility.** The mobility section prompted providers to: find out what the patient’s baseline functional status is and to document if this has been altered; to change activity orders and allow for early mobilization if appropriate (Casey, 2013; Richmond & Jacoby, 2007); and it encouraged the use of physical and occupational therapy referrals if needed. Education included interventions and ways to prevent functional decline. Some specific interventions that can help prevent decline include a routine walking schedule, activities to prevent sensory deprivation, and timely hospital discharge (Graf, 2006). Lach, Lorenz, & L'Ecuyer (2014) feel that there are four factors that are essential in early mobilization for an older adult in the ICU: inclusion of a mobility plan for every ICU patient, individualized patient assessment, provider's judgment, and interprofessional consultation.

**Elimination.** The elimination section focused on assessing for and preventing constipation, incontinence, and urinary retention. It suggested prevention and treatment strategies for each of the items selected that apply to the specific patient. Education also included similar details. If constipation was selected, it suggested addressing risk factors and ordering a bowel regimen for prevention and treatment (McKay, Fravel, & Scanlon, 2012; Woodward, 2012; Gandell et al, 2013). The selection of incontinence prompted providers to focus on prevention of skin breakdown and suggested the use of a toileting schedule. Selecting urinary retention prompted providers to consider multiple causes of the retention (including anesthesia, chronic
BPH, and medications), suggested utilizing a toileting schedule and as-needed bladder scanning and straight catheterization, and only using medications if the cause was felt to be chronic and not likely to improve in the next 48 hours (due to the risks associated with alpha blockers) (Foster, Mohorn, & Luis, 2015; Darrah, Griebling, & Silverstein, 2009).

**Nutrition.** Preventing malnutrition was the focus of this section. It prompted providers to consider screening the patient if unsure of nutrition status; adjust the diet order and encourage PO intake as appropriate; and consider supplementation if needed (Finocchiaro & Hook, 2015; Harrington, 2004; Dimaria-Ghalili & Nicolo, 2014; Nestle Nutrition Institute, n.d.; Reid & Allard-Gould, 2004; Hegerova, Dedkova, & Sobotka, 2015). It also encouraged an early dietician consult if the patient was felt to be malnourished or had new dietary restrictions ordered due to their disease processes (Reid & Allard-Gould, 2004; Ferrucci & Studenski, 2015). Education included ways to assess for malnutrition, and suggestions to prevent and treat it in the hospitalized patient.

**Delirium.** The delirium section: prompted providers to ensure it was being assessed for; suggested prevention by reorientation, removing restraints, promoting sleep hygiene, implementing early mobilization, and thorough medication review (Brummel & Girard 2015; Garpestad & Devlin, 2017); and suggested treatment if needed by discontinuing medications that can lead to delirium (i.e. benzodiazepines, anticholinergics), giving supportive care, and using haldol if felt to be a harm to self or others (Ferrucci & Studenski, 2015; Brummel & Girard, 2015; Balas et al., 2012; VUMC, 2013; Garpestad & Devlin, 2017). Education included rationale behind the areas focused on, along with more detail than was included within the tool.

**Medication prescribing.** The section on medication prescribing in the older adult included prompts to go through the home medication list and continue needed medications,
encouraged providers to go through the hospital medication list and de-prescribe as able to help prevent polypharmacy, and suggested ordering a pharmacist consult for assistance if needed. Education included a review of the definition of polypharmacy, the risks associated with it, and a review of the STOPP/START and Beer's list criteria.

**Methods**

Project data included quantitative data from the checklists and qualitative data derived from the surveys. Measures of the quality improvement project included gauging providers' feelings and opinions on the use of the tool, specifically if they felt it helped them improve management of the critically ill older adult. It also looked at the usage of the tool and the barriers that kept providers from using the it. Provider opinions were obtained by the use of a survey that included yes and no questions, Likert-type scale questions, select-all-that-apply questions, and space to provide comments (Figure 3). Accuracy of the data collected was ensured by encouraging only those providers who used the tool to complete the survey. Patient outcomes were not assessed during this specific project.

**Implementation**

The checklists were implemented from January 16\textsuperscript{th} to March 16\textsuperscript{th} 2018 within the CVICU. After the initial introductory email, two additional emails were sent, spaced a few weeks apart, to encourage continued use of the checklist. Boxes were placed in the provider workroom; one contained blank checklists and the other was for the completed forms. They were allowed to complete the checklist at any time during their shift; it was not specifically used during ICU rounds and was not included in the electronic progress notes. If they had the same older adult patient for multiple days, they were told that only one checklist was needed unless
more changes were made that would require another form to be filled out. The paper forms were collected every two weeks and the data was entered into an Excel spreadsheet. At the end of the two months, the checklists were removed and the surveys were supplied. Another email was sent to all the providers encouraging them to complete the anonymous paper survey and return it to the box in the provider workroom. The surveys were made available for two weeks (March 26, 2018 – April 8, 2018).

Results

The project ran for 60 total days; of those, 30 days had checklists filled out. There were 103 checklists completed which represented 76 unique older adult patients. The checklist was filled out on 49% (76/155) of eligible patients.

Once the timeframe of completing the checklist was done, the surveys were distributed. There was a potential of having 14 APPs and four medical residents fill out the survey; seven surveys (39%) were returned, analyzed, and compared with the checklist data.

The survey asked the providers about the potential barriers for completing the checklist in a select-all-that-apply format. All of the responses indicated that remembering to do it was the biggest barrier (100%), with using the paper form (42%), time (29%), and the applicability to the patient (29%) as other responses. When asked what would cause them to be more willing to use the checklist (in a select-all-that-apply format), using it during rounds (43%) and having it within the Electronic Medical Record (43%) were the most common responses. One provider indicated that the paper format worked well, and one provider indicated that there would be no format that would cause them to be willing to use it. Seventy-one percent (5/7) of providers somewhat agreed that the checklist helped them provide more age-appropriate care to their older adult
patients (two somewhat disagreed, and none strongly agreed or disagreed), and 57% (4/7) felt that they changed their plans based on suggestions from the checklist.

Data from the checklists showed that 55% of the older adult patients had acute/chronic pain. Many comments written onto the individual checklists involved the analgesia section. Providers often wanted to explain why they were not doing the suggested interventions, or they included additional options that were not listed (i.e. patient had an epidural). Only 26% of checklists had the box checked indicating that they lowered the dose of oxycodone. Due to the higher number of surgical patients seen in the CVICU, providers may not have felt that a lower dose of oxycodone was appropriate. As a result of the incidence of physiological age- and disease-related changes in an older adult, an individualized pain regimen may need to be considered for each patient (Falzone, Hoffmann, & Keita, 2013). However, the “start low and go slow” philosophy should be considered in the older adult due to the pharmacokinetic and pharmacodynamic changes and the higher incidence of polypharmacy and comorbidities (Falzone et al., 2013).

In regards to mobility, 57% of providers felt that they knew their patients’ baseline pre-hospital level of mobility. The checklist had providers indicate if their patient had an altered level of mobility, of which 52% responded “yes.” It is a possibility that the patients could have had more alteration from baseline than providers were able to assess and then appropriate interventions may not have been applied (only 13% adjusted the activity order to minimize bedrest, and 27% encouraged mobilization). Due to the high surgical population in the CVICU many patients automatically have a physical therapy consult placed, so it was not surprising to see that the box for the PT consult was not often checked (35%).
Sixty-one percent had no suspected problems with elimination, and of those with problems, the most commonly reported was constipation at 17%. Due to multiple risk factors such as limited physical activity, inadequate diet, polypharmacy, and comorbid diseases, prevalence rates of constipation can be up to 75% in institutionalized older adults (McKay, Fravel & Scanlon, 2012; Woodward, 2012). Constipation in CVICU patients is either being underestimated or providers are doing a better job at preventing it than the average. Many of the comments written on the checklist in the elimination section seemed to be related to keeping the foley catheter in place postoperatively or due to aggressive diuresis in a critically ill patient. The “remove foley” intervention was only checked 9% of the time, though this could also indicate that not many patients had one in to be removed in the first place.

Providers were asked to rate how they agreed or disagreed with the statement “I felt like malnutrition was an issue with a lot of my patients.” Seventy-one percent of providers reported that they somewhat agreed with this statement (29% somewhat disagreed). The checklist asked if patients had evidence of malnutrition and 19% of the forms had the box checked “yes.” The prevalence of malnutrition in older adults admitted to an ICU has been reported at being 50% or more (Finocchiaro & Hook, 2015). Patients in the CVICU may have been less malnourished compared to what studies have shown due to the fact that many were there following elective surgical procedures and not due to debilitating chronic illness. There is also the possibility that providers were unsure if their patients were malnourished at the time of filling out the checklist, as the criteria for malnutrition can be vague and not easily assessed for. Taking the time and learning how to assess for malnutrition could allow for more appropriate application of the suggested nutrition checklist interventions.
Providers felt that the delirium interventions were already being applied to their patients. Many of those interventions were nursing focused, and not always clearly documented, so it would be difficult to determine if they were truly being applied. Only 14% of patients were documented as being delirious when the checklist was filled out. Eighty-six percent of those that were delirious had at least one intervention selected that was being applied. Some of the interventions were helpful with preventing delirium, and many providers checked those boxes appropriately (when indicating that the patient did not have delirium).

Results of the checklist indicated that 89% of patients were taking more than four medications. One of the suggestions on the checklist was to evaluate the home and hospital medication lists for potentially inappropriate medications; 84% of the checklists indicated that this was done. Eighteen percent of checklists had the box checked to indicate that a pharmacist consult was obtained to help with the medication lists. The survey asked if providers were familiar with medications on the Beer’s List; 42% of providers responded “somewhat agree,” 29% responded that they “somewhat disagree,” and another 29% responded that they “strongly disagree.” More than half of the survey responses suggested that providers were unfamiliar with the medications that may be inappropriate for their patients and may have benefited more from a greater involvement of the ICU pharmacist. The prevalence of potentially inappropriate medications (PIMs) in older adults has been shown to occur in up to one-third of hospitalized patients (Hubbard, O'Mahony, & Woodhouse, 2013). The number of PIMs has also been found to directly correlate with the duration of the ICU stay (Garpestad & Devlin, 2017). Critically ill older adults in the ICU are often on at least 12 different medications at the time of admission, with more added on during the duration of the hospitalization (Garpestad & Devlin, 2017). Older adults taking multiple medications are more at risk for adverse drug reactions, delirium,
falls, and malnutrition (Hubbard, O'Mahony, & Woodhouse, 2013; Dimaria-Ghalili & Nicolo, 2014; Le Couteur et al., 2004). Involving the ICU pharmacist more frequently than was indicated as being done on the checklists (18%) may benefit these critically ill older adult patients.

**Survey Comments**

The survey left space for comments and suggestions. Three providers left the following comments:

1. “Many of the things were already applied to my patients with the exception of home medication eval by pharmacist.”
2. “I liked the checklist but it was difficult to remember. But it made me reassess the need for certain meds and doses that I am prescribing for my geriatric patients.”
3. “Often we were doing the opposite your checklist interventions. Patient with postop pain requiring more pain meds. Foley having to be replaced.”

The same three providers left the following suggestions:

1. “In the EMR would be more helpful.”
2. “I think adding a section for blood pressure. A lot of times we medicate elderly patients for a BP goal of 120/80, but that is not necessary and could cause issues when a patient discharges home. Do I really need to give/increase this antihypertensive med considering the patient is 85 and her blood pressure is 135/80?”
3. “Maybe this would be beneficial in medical patients; not so much cardiac patients.”

**Thematic Assessment**
Observations of overarching themes were recorded after each checklist data entry period and again after surveys were reviewed. It was quickly noted that many checklists were filled out on days that the primary investigator was also working on the unit, likely due to reminders that were given during the shifts. There would be groups of days at a time where no checklists were completed, that also fell on the PI’s days off. There was less delirium and malnutrition in the patient population than expected. Most providers checked the box that they evaluated the patients’ medication lists, but there wasn’t any way to verify that occurred. There were many comments written on the paper checklist forms which suggested that the available interventions may not always be adequate for the patients seen in the CVICU. There was also some need for clarity about whether the providers should only check the box if they implemented the intervention or if the box should be checked even if it had already been applied.

**Discussion**

It was difficult to determine the significance of the results when the surveys and checklists were compared due to the poor response rate (50% of checklists done, and less than half of providers completing the survey). The results of the survey could suggest that there were significant barriers preventing providers from completing the checklists, though a majority still felt that it was at least somewhat helpful in providing more age-appropriate care.

There were multiple factors that seemed to limit full compliance of providers completing the checklist. In the survey, all of the providers indicated that remembering to complete the checklist was the most common reason it was not done, with it being on a paper form as the second most common reason. This leads to suspicion that adding a paper form goes against the usual norms of an ICU that is accustomed to doing all documentation within the electronic medical record. The burden of completing a paper checklist may have been an unrealistic
expectation to ask of these ICU providers that have their time already filled with managing a
diversity of critically ill patients and documenting all that was done.

The timing of the project may have been a confounding factor in the success of utilizing
the checklist. The CVICU was going through some change in management, providers were
experiencing burnout due to having to rotate day and night shifts, and having a few providers
give notice of leaving the practice, with others out on FMLA, requiring an increase in overtime
needs. These changes have led to some decreased morale among the APP team. Adding more
work to providers who are experiencing burnout could cause more burnout and a decreased
willingness to complete a task that was strictly voluntary.

As described in the results, many providers felt that the interventions were often already
being done for their patients. Due to the way many of these interventions are documented, it
would be difficult to track if the interventions were always being completed as the providers
indicated in the survey. Providers naturally want to do what is best for their patients, but it is
often difficult to ensure this is happening when there are so many different, complex patients to
care for within each shift. Utilizing a checklist can help ensure that certain aspects of evidence-
based care are acknowledged and managed for specific patient populations. Within the CVICU
progress notes there is the FASTHUG mnemonic that helps remind providers to address feeding,
analgesia, sedation, thromboprophylaxis, head of bed, ulcer prophylaxis, and glucose control.
Each of these areas have been shown to be important in the care of the critically ill patient,
regardless of age. Adding a specific checklist, such as the AMEND-Med checklist, to electronic
progress notes could be beneficial in helping to address specific areas that are important in
managing the care of the critically ill older adult and may be more successful than doing this in
paper format as shown in the results of this project.
Limitations

Many of the limitations of the project have been discussed within each topic, though the biggest limitation was felt to be due to the limited number of survey responses. Due to it not being reported how often the providers filled out the checklist, there is a possibility that the providers who used the checklist the most did not fill out the survey. One provider indicated on the survey that they did not use the checklist, however they still filled out the remaining questions (and these responses were still counted). Lastly, some of the results from the checklist did not match the results of the survey as would have been expected (as described above).

Practice-related Implications

The aim of this quality improvement project was to determine if a checklist was felt to help ICU providers give more age-appropriate care to their critically ill older adult patients. As shown in the previous sections, the suggested interventions have evidence behind them in showing the importance of application for older adult patients. However, as suggested by one of the provider’s comments, the interventions may not always be appropriate for every type of patient population. Each checklist should be filled out with consideration for the individual patient’s circumstances and needs. It may be beneficial to apply this checklist to an even more narrow patient population (i.e. medical patients as one provider suggested) to see if it would be more useful.

The survey indicated that another format or utilization of the checklist may be beneficial when compared to the paper form; it could be implemented within the EMR and/or during ICU rounds to see if that would improve its use and helpfulness. If giving providers more work to do in an already complex, stressful environment, it should be formatted in a way that does not
become overly burdensome to complete. More work needs to be done to determine if this checklist, when applied more frequently in a format that is easy to complete, can improve the outcomes in the critically ill older adult.

**Conclusion**

Providers seemed to find the checklist helpful for managing the care of the critically ill older adult, but overall compliance of the checklist was poor, likely due to having it in a paper format. Despite evidence that checklists can improve patient outcomes and healthcare delivery, many checklists remain underutilized due to time, practicality, concern about the patients’ individual needs, and sustaining the discipline needed to fill them out (Newkirk et al, 2012). The AMEND-Med checklist quality improvement project showed that the checklist was only completed about half of the time and remembering to fill out the paper form seemed to be the biggest barrier, which aligns with the previous statement. While 71% felt that the checklist somewhat helped them provide more age-appropriate care, that result was only based on a 39% survey response rate. Utilizing the checklist in daily ICU rounds or implementing it in the EMR (i.e. imbedded in a progress note template) may be helpful in increasing compliance. Once utilization of the checklist is improved, future studies could be done to determine if the AMEND-Med checklist and its suggested interventions could improve outcomes for this critically ill older adult population.
Figure 1.

AMEND-Med EMR Design

[Diagram showing flowchart for AMEND-Med EMR Design]
Figure 2.

AMEND-Med Checklist Paper Format

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<th>Improving the Care of the Critically Ill Older Adult: AMEND-Med</th>
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<tr>
<td>Please fill out for each patient who is 65 years or older. Check the boxes if they have been applied to the patient. Place in basket in workroom when finished.</td>
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<td>Contact Karleena Twitchell if you have questions: p16392, 702-343-2966, <a href="mailto:twitchel@ohsu.edu">twitchel@ohsu.edu</a></td>
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AMEND-Med (Older Adult in ICU) Checklist Survey

Please answer the questions and provide feedback about using the AMEND-Med Checklist for patients (65 or older) in the CVICU. Please return survey to the checklist box in the workroom or by emailing it to twitchel@ohsu.edu

1. Did you utilize the checklist on your older adult patients? (circle one)
   Yes          No

2. I felt that the checklist helped me to provide more age-appropriate care to my older adult patients. (Circle response that correlates to your level of agreement with this statement)
   Strongly agree   Somewhat agree   Somewhat disagree   Strongly disagree

3. Did you ever change your plan based on suggestions from the checklist? (circle one)
   Yes          No

4. What do you feel were the biggest barriers that kept you from using the checklist for every older adult patient you cared for? (check any that apply and/or provide your own answer)
   [ ] Time
   [ ] Remembering to do it
   [ ] Applicability to the patient
   [ ] Filling out the paper form
   [ ] Other __________________________

5. In regards to Analgesia, the suggested interventions... (check the one that applies most closely to your experience)
   [ ] Often prompted me to change orders
   [ ] Were often already applied to my patients
   [ ] Were not often applicable

6. Did you know what your patient’s pre-hospital level of mobility was? (circle one)
   Yes          No

7. In regards to Elimination (constipation, urinary retention, incontinence), the suggested interventions... (check the one that applies most closely to your experience)
   [ ] Often prompted me to change orders
   [ ] Were often already applied to my patients
   [ ] Were not often applicable
8. I felt like malnutrition was an issue with a lot of my patients. (Circle the response that correlates with your level of agreement with this statement)
   - Strongly agree
   - Somewhat agree
   - Somewhat disagree
   - Strongly disagree

9. In regards to Delirium, the suggested interventions... (check the one that applies most closely to your experience)
   - Often prompted me to change my practice
   - Were often already applied to my patients
   - Were not often applicable

10. I am familiar with medications used in the ICU that are also on the Beer’s List. (Circle the response that correlates with your level of agreement with this statement)
    - Strongly agree
    - Somewhat agree
    - Somewhat disagree
    - Strongly disagree

11. I might be more willing to use this checklist and implement its suggestions if... (check any that apply)
    - It was in the EMR as a part of the progress note (similar to FASTHUG)
    - It was used during rounds
    - N/A: The paper checklist worked well
    - N/A: I would not be more willing to use it in any form

12. Comments about your experience using the checklist:

    

13. Suggestions for improving the checklist:

    

Appendix 1.
Powerpoint (3 pages)
EVIDENCE BEHIND THE AMPED-MED SUGGESTIONS

ANALGESIA

- 26.6% of older adults experience pain compared to only 17% of young adults (18-35 years old). This can be explained by:
- Consider availability, cost, and physical ability to help limit the need for higher doses of opioids.
- Consider alternatives: analgesics like non-opioid pain medications, ice, heat, massage, and exercise.
- Recognize pain that is not medication-related to the older adult.
- Avoidance of opioids that are not medication-related to the older adult.
- Use the “start low and go slow” approach with opioids.

ELIMINATION: CONSTIPATION

- Constipation can be a problem in older adults who have many risks factors: limited physical activity, changes in diet, reduced fiber intake, underlying disease (diabetes, CVD, liver failure), and medications (oxygen therapy, bowel irritants).
- Avoid the use of laxatives and cathartics for long-term management.
- Bulking agents are considered first-line in the treatment of constipation in the older adult with other forms of treatment being considered as needed.

ELIMINATION: URINARY RETENTION AND INCONTINENCE

- At least 15% of community-dwelling older adults and up to 30% of institutionalized older adults have significant urinary incontinence (National Institute on Aging, 2005).
- Focus on prevention of bladder and urethral angle of normal patients.
- Factors known to be related to urinary incontinence include: constipation, general anesthesia, anticholinergic medications, immobility, medications, high fluid intake, and limited access to water.
- TAUCEUR and the elderly are not being treated due to false alarm of other patients.
- Treadmill and the elderly are not being treated due to false alarm of other patients.
- Urinary incontinence is a common complication in older adults.
- Maintenance of regular emptying of the bladder is important in maintaining continence.

MOBILITY

- Functional mobility is crucial in elderly patients often due to arthritis in combination with being elderly (Crum, 2015).
- Focus on improving mobility and allowing for early mobilization.
- Use physical and occupational therapy referrals if needed.
- Use a walking aid to help prevent falls.

NUTRITION

- The prevalence of nutrition in older adults admitted to an ICU has been reported as being between 23% to 34% documented in times of the past 10 years (Crum, 2015).
- Consider removing the peripheral of venous access (catheters, tubing, etc.)
- Adjust the diet and encourage RN to assess appetite.
- Consider early discharge if the patient is not to be rehospitalized or has no dietary restrictions on intake. Due to dietary maintenance, Katz, Alzheimer’s disease.

AVERAGE DAILY RATION

- High protein, low fiber diet
- Include lean protein sources such as chicken, fish, and tofu.
- Limit the intake of red meat and processed meats.
- Include whole grains, such as brown rice, quinoa, and barley, as they are high in fiber.
- Limit the intake of added sugars and sweetened beverages.
- Include a variety of vegetables and fruits, such as berries, citrus fruits, and leafy greens, for their fiber and antioxidant content.
- Include a variety of dairy products, such as low-fat milk and yogurt, for their calcium content and vitamin D.
DEPRESSION

- ICU Depression can include emotional distress, increased anxiety, and sadness.
  - Possible interventions include counseling, antidepressant medications, and exercise programs.
  - Early recognition and intervention are key to managing depression.

REFERENCES


MEDICATION PRESCRIBING

- Polypharmacy is defined as the use of 4 or more medications, especially in older adults, and is associated with negative outcomes.
  - Medication review is crucial to prevent adverse drug interactions and optimize therapy.
  - Consideration of patient preferences and goals of care is important.

REFERENCES

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