Think Delirium

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Delirium Management Pathway

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Outline

- Patrick's story- Colette McFarlane
- Why bother about delirium?
- **What are the challenges in your place of work?**
- SDA Pathway
- Examples of improvement work
- **What are the benefits/ challenges of implementing pathway in your work area?**
- Feedback

Patrick’s Story

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Why bother about delirium?

Why delirium?

- Medical Emergency
- Common
- Adverse Outcomes

In a typical district general hospital with 500 beds, older people will occupy 330 of these beds, and 220 of these will have a mental disorder. Three disorders; delirium, dementia and depression, will account for 80% of these mental disorders.

- 66 patients will have delirium

- 102 will have dementia

- 96 will have depression

- *Who Cares Wins*, Royal College of Psychiatrists & British Geriatrics Society, 2005

How common is delirium?

- 15% of adult acute general hospital patients
- 25% of acute geriatrics patients
- Post hip-fracture surgery: 40-60%
- 7% of all persons > 65 will develop delirium annually

Adverse Outcome of delirium

- Mortality *3 at 90 days, controlling for other illness
- *2 length of stay
- *5 risk of institutionalisation
- Higher rates of dementia in those without baseline dementia
- Poorer long-term quality

Why a delirium pathway?

“If it resolves, delirium may be followed by loss of memory and reasoning power”

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Barrough, The Method of Physik, 1583

“Terminological chaos”

- “acute confusional state”
- “acute confusion”
- “confusion”
- “agitation”
- “toxic psychosis”
- “ICU psychosis”
- “a bit knocked off”
- “vague”
- “poor historian”
- “a bit muddled”
- “not themselves today”
- “post-operative psychosis”
- “metabolic encephalopathy”
- “acute brain failure”
- “organic brain syndrome”
- “cerebral insufficiency”
- “acute befuddlement”
- “non-compliance with examination”

ill-defined, confusing and therefore unhelpful descriptions

> best to use the term delirium

Why a delirium pathway?

- Lack of understanding on severity delirium
- Variability in approach to clinical management
- Low rates of detection
- Adverse outcomes

- Pathway improves all of above

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SDA
Delirium Management Pathway

Think Delirium!

- Consider AWI early
- Informant history
- Urgent clinical assessment
- Early treatment of causes
- Document DELIRIUM diagnosis
- Monitor response
- May persist for months
- Ongoing assessment
- Review for possible dementia

SDA
Delirium Management Pathway

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- 30% cases no cause found
- Continue delirium management
- Explain and inform
- Encourage family support
- Environmental measures
- Good basic nursing care
- Good basic medical care

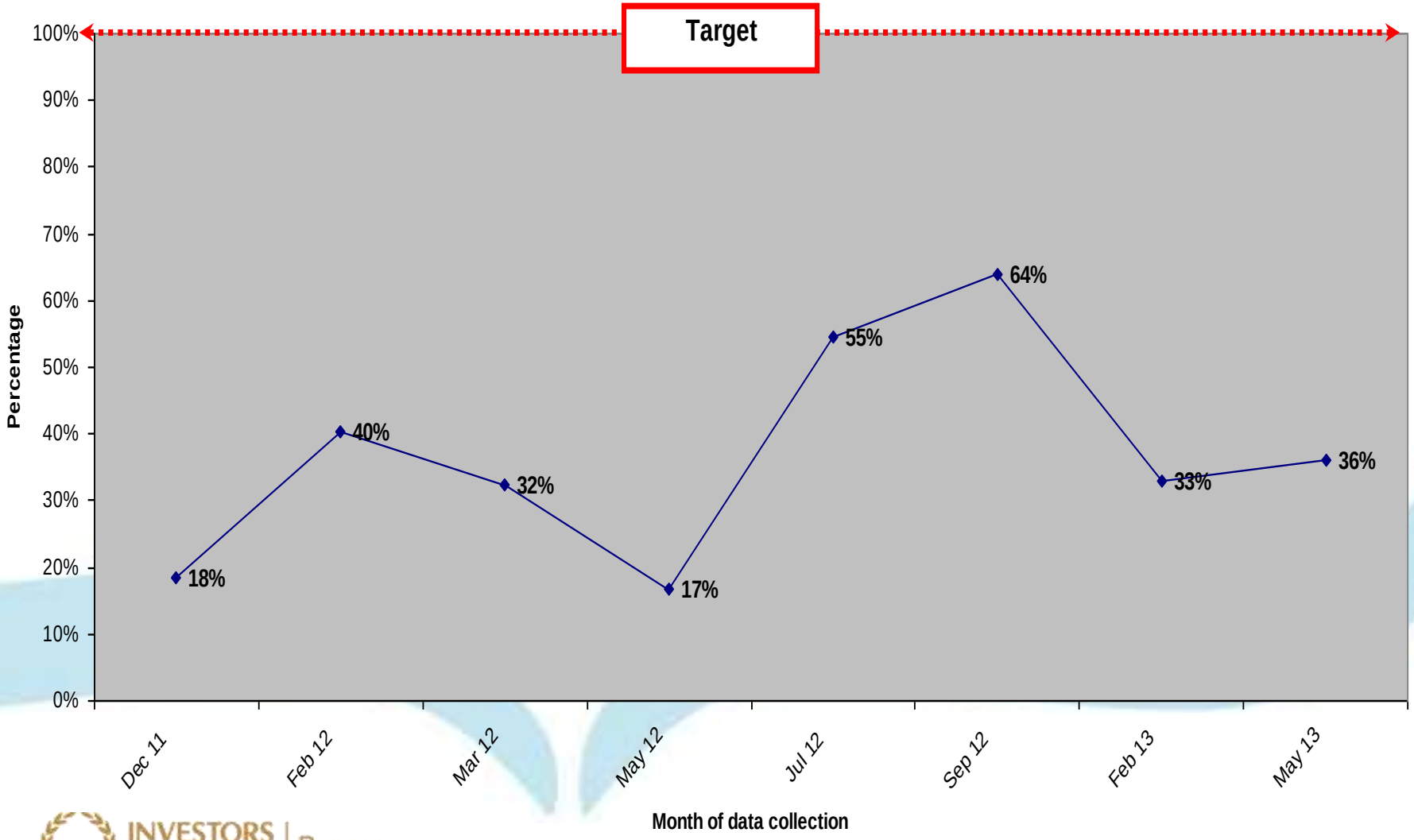
SDA
Delirium Management Pathway

- May persist for months
- Continue delirium screening
- Stop antipsychotics
- Repeat cognitive assessment
- Inform GP
- Refer for formal assessment if dementia suspected

Improving Delirium Management in Hip# September 2011

- Patient story
- Training for all nursing staff
- Cognitive assessment pathway for >65yrs
- Guidance on delirium management
- Pain management pathway
- Carers leaflet
- Care bundle development
- Ward screensaver
- Signage for toilets/bathrooms

AMT10 Completion (65 and over, within 24 hours of admission to ward)



INVESTORS IN PEOPLE | Bronze

- Daily CAM for 7 days or until 2 consecutive negative CAMs

- Daily fluid intake of >1l for first 72 hours post surgery

- Regular analgesia prescribed as per pathway and given

- Up to sit within 24 hours of surgery

- Delirium diagnosis documented in discharge letter to GP

Measures Jan 2013

- 24 patients over 64 years with #NOF
- (66%) had AMT10 done
- (62%) had an AMT<9
- (90%) had a CAM performed
- (33%) were CAM positive ie 3 patients
- 0f these, 50% had reliable care

Other reported improvements

- “It’s opened my eyes…better understanding it’s the illness-it’s not them”
- “I’m more aware of relatives”
- “ we recognise delirium and act on it more quickly”
- “ I’m more comfortable with treating delirium”
- “If we treat early they get better quicker and we can discharge home rather than to a community ward”
- “ fewer severe delirium cases
- “Complaints are much fewer”
- Letter to CE re excellent care

Think Delirium!

IMMEDIATE MANAGEMENT OF DELIRIUM

There's no **TIME** like the present

For patients aged 75 and over when clinical history suggests delirium, or assessment tool (eg the 4AT or CAM) positive

Initiate all elements of this CARE BUNDLE within 2 hours

Delirium Care Bundle		
Care Bundle Elements		
T	**THINK** about possible triggers	Acute illness, pain, trauma
I	**INVESTIGATE**	Carry out early warning score Start fluid balance chart Send routine bloods and appropriate cultures, imaging, consider drug withdrawal/intoxication, alcohol
M	**MANAGEMENT PLAN**	Medication, infection, hypoxia Use Scottish Delirium Association Pathway
E	**ENGAGE**	Document 'DELIRIUM' diagnosis Engage with patient, family/carer Use delirium leaflet

Delirium Bundle in Checklist Format

CHI

Date: / /
Zero Time: :
Patient over 75? Y/N
Do you think the patient is more confused than normal?: Y/N

Practitioner Name: _____ Practitioner Signature: _____

	TIME Initiate all elements within 2 hours (initial and write time of completion)	*Assessed/sent*	*Results seen*	*Abnormality found*
T	Think exclude and treat possible triggers			
	NEWS (think sepsis six)			
	Blood glucose			
	Medication history (identify new medications/change of dose/medication recently stopped)			
	Alcohol history (withdrawal/intoxication)			
	Assess for urinary retention			
	Assess for constipation			
I	Investigate and intervene to correct underlying causes			
	Assess Hydration and start fluid balance chart			
	Bloods (FBC, U&E, LFT, CRP, Mg)			
	Look for symptoms/signs of infection (skin, chest, urine, CNS) and perform appropriate cultures/imaging depending on clinical assessment (see sepsis six)			
	ECG (MI/ACS)			
M	Management Plan			*Completed*
	Initiate treatment of *ALL* underlying causes found above			
E	Engage and Explore			
	Engage with patient/family/carer – explore if this is normal behaviour. How would you like to be involved?			
	Explain diagnosis of delirium to patient and family/carers (use delirium leaflet)			
	Document diagnosis of delirium			

Exploring the patient, family and staff experience

- Used emotional touchpoints to explore what it is like to care and be cared for when a person experiences delirium
- Purposive and pragmatic sample – 1 patient, 2 family carers, 7 staff
- I hour interview, transcribed and themed

Vulnerable

Frustrated

Caring for a person with a delirium

Let down

Rewarding

Question we need to ask

- *What is your relative like normally?*
- *What interests them (eg, occupation, hobbies, grandchildren - helping you to connect with the patient)*
- *What normally makes them feel reassured?*
- *How do you want to be involved/how can you help us to care for your relative?*

Other things that helped

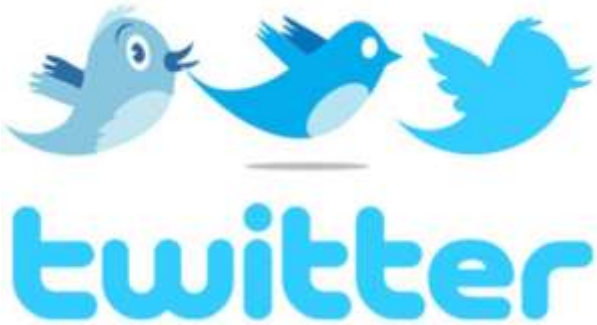
- Flexible visiting time
- Expert knowledge of the family
- Getting a break
- Talking about the challenges
- Being asked about dreams
- Reassurance that is was not permanent
- Sharing with others that this was not normal behaviour
- Knowing something about the person to help to connect

Other things that helped

- Information about delirium
- Valuing the time it takes to support person with delirium
- Humour and sensitivity
- Value of experiential learning rather than online (staff)

Evidence | Improvement | Scrutiny

Healthcare Improvement Scotland



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www.knowledge.scot.nhs.uk/improvingcareforolderpeople