Quality Improvement Clinic
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‘Infected, Undetected and Delirious!’

Delirium in those Living with Frailty - A serious condition deemed a medical emergency

NHS Health Education England
Working across Wessex

PROBLEM ARTICULATION

Delirium is a syndrome characterised by acute onset and fluctuating course of deterioration in mental functioning.
Is very commonly encountered in hospital medicine, complicating at least 10% of all medical admissions;
20-30% prevalence on medical wards, 15-53% of patients postoperatively and 70-87% of those in intensive care
Is a medical emergency independently associated with serious adverse outcomes;
- Increased mortality in older people - 35-40% at one year
- Increased risk of institutional placement
- Increased risk of in-hospital complications
It is preventable in up to 1/3 of cases.
It is treatable if identified, managed appropriately and urgently.

Hallucination•Agitated•Distracted
Disoriented•Rambling•Withdrawn
Restless Delirium sense of place
Bewildered •Confused•Incoherent
Hallucination•Agitated•Distracted
Disoriented•Rambling•Withdrawn

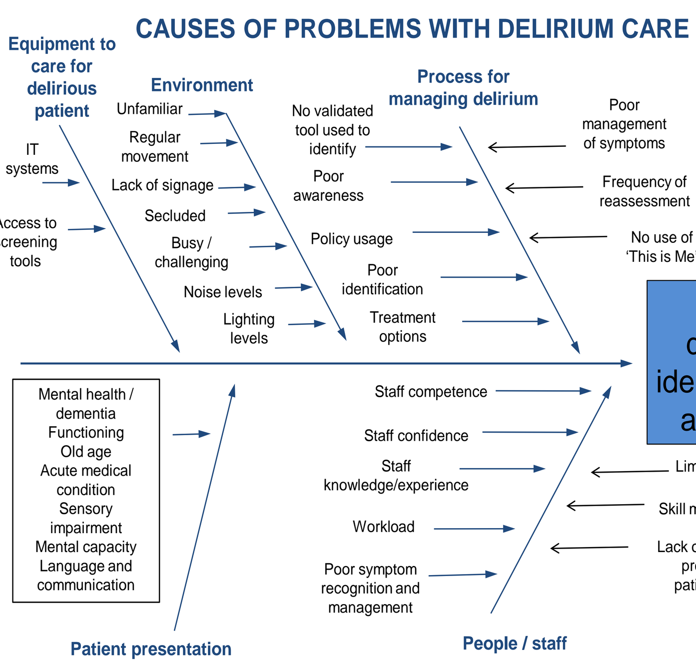
WITHIN THE FRAILTY INTERFACE TEAM AT QUEEN ALEXANDRA HOSPITAL, PATIENTS SCREENED POSITIVE FOR FRAILTY ON ADMISSION TO A&E REQUIRE A COMPREHENSIVE GERIATRIC ASSESSMENT – NO ROUTINE DELIRIUM SCREENING!

IMPROVEMENT AIMS – 6 MONTH PROJECT

By August 2017, all patients admitted to A&E screened positive for frailty will have an Abbreviated Mental Test Score (AMTS) assessment documented.

By August 2017, all patients with an AMTS score of 7/10 or less will have a delirium screen using the rapid assessment test 4AT.

DIAGNOSIS

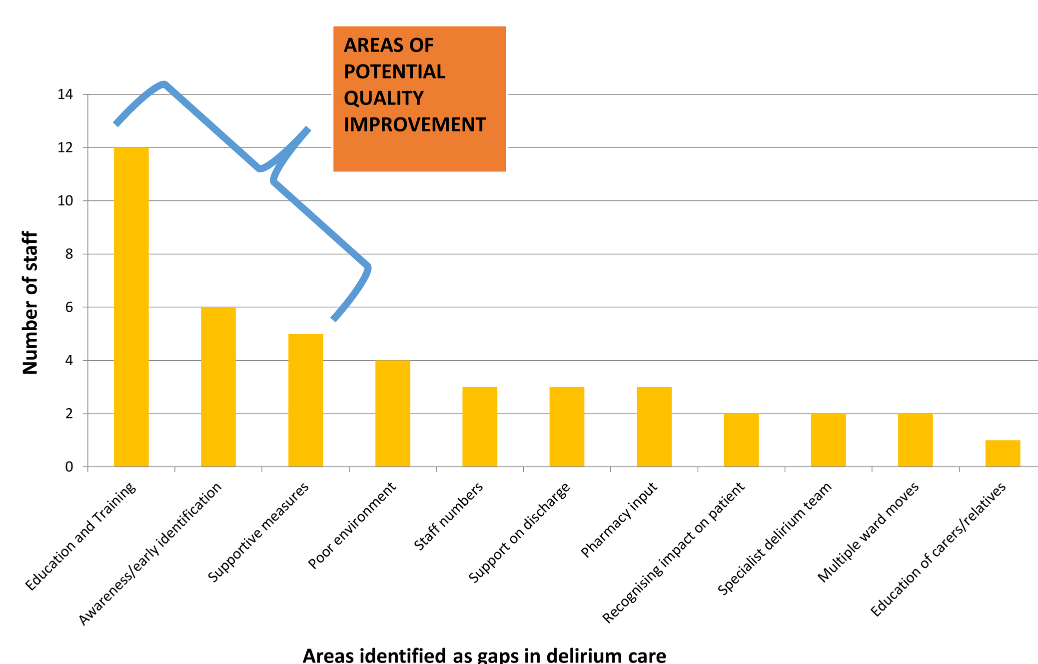


Patient views on delirium:

‘Didn’t know what I was or what I had done’

‘My mind does not work evenly, very frightening’

‘I don’t know what thing to do next – I still feel muddled and confused’



MEASURE DEFINITION

INCLUSIONS

POSITIVE FOR FRAILTY;
•>75 years of age
•Diagnosed with Dementia
•Diagnosed with Parkinson’s disease
• Fall or reduced mobility
•Three times daily package of care
•From a residential or nursing home

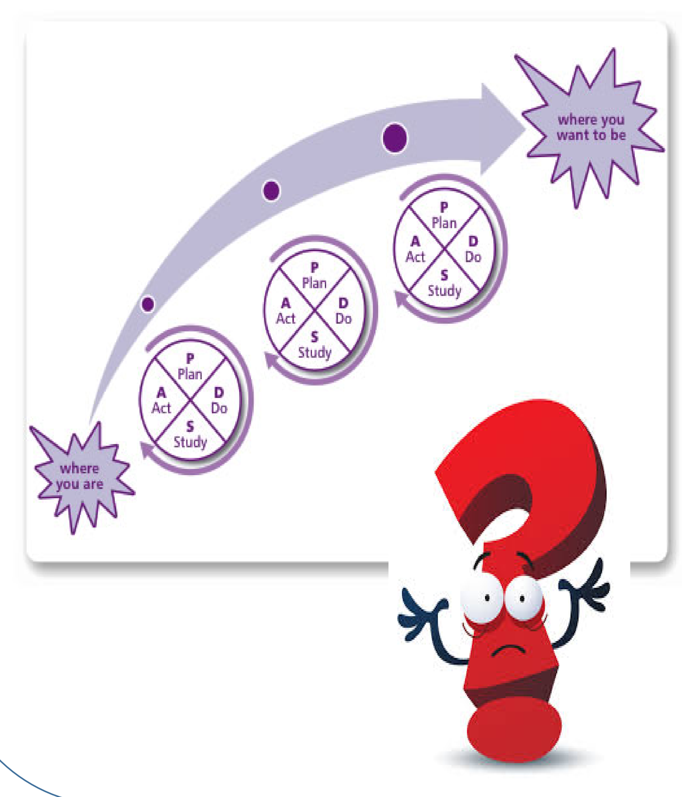
EXCLUSIONS

•Medically unstable
•< 75 years of age

SAMPLING

All patients screened positive for frailty requiring a Comprehensive Geriatric Assessment, with cognitive assessment using an AMTS – those with a score of <7/10 to have a delirium screen

PDSAs



PDSA TEST #	PLAN	DO	STUDY	ACT
No. 1 Establish staff confidence/ competence	To develop and implement staff questionnaire looking at confidence in identifying and competence managing delirium and gaps.	Implement questionnaire with 12 staff of different grades within A&E and AMU	Low identification levels and screening tool not used.	To establish aim Discuss in coaching To then look at further PDSAs/implementation of QI
No. 2 Identify patients who have a resolved delirium and document their experiences.	Develop interview schedule for asking patients regarding delirium.	Identify three patients recovering from delirium	Scary frightening experience, identified gaps in practice that need to be addressed	Feedback to team Address aspects in ideas!!!
No. 3a Practitioner within FIT to assess patient cognition using AMTS and document any associated information	Identify stakeholder Discuss task support. Develop data collection tool, print out and provide .	Give one week for data collection Meet after week and debrief	Took no time to complete data collection sheet, was easy to do and did not impact on her day to day clinical work. 4 patients needed assessment for delirium.	Further data needed New PDSA required with more staff, different grades and screen with AMTS and do 4AT for those with scores less than 7/10
No. 3b Establish use of AMTS across FIT, whether a delirium tool was used or if delirium signposted to medical team.	Obtain data for month of February 2017 Data collection paperwork to be developed. Time within my diary to facilitate..	264 patients included in review.	? Fishbone to understand reasons why AMTS not being done?	Teaching session for refresher of AMTS and education session for 4AT.

CHANGE IDEAS

* Mandatory 4AT delirium screening on admission to A&E.
* Prompts for staff to complete a 4AT.
* Reassessment of delirium with 4AT through patient journey.

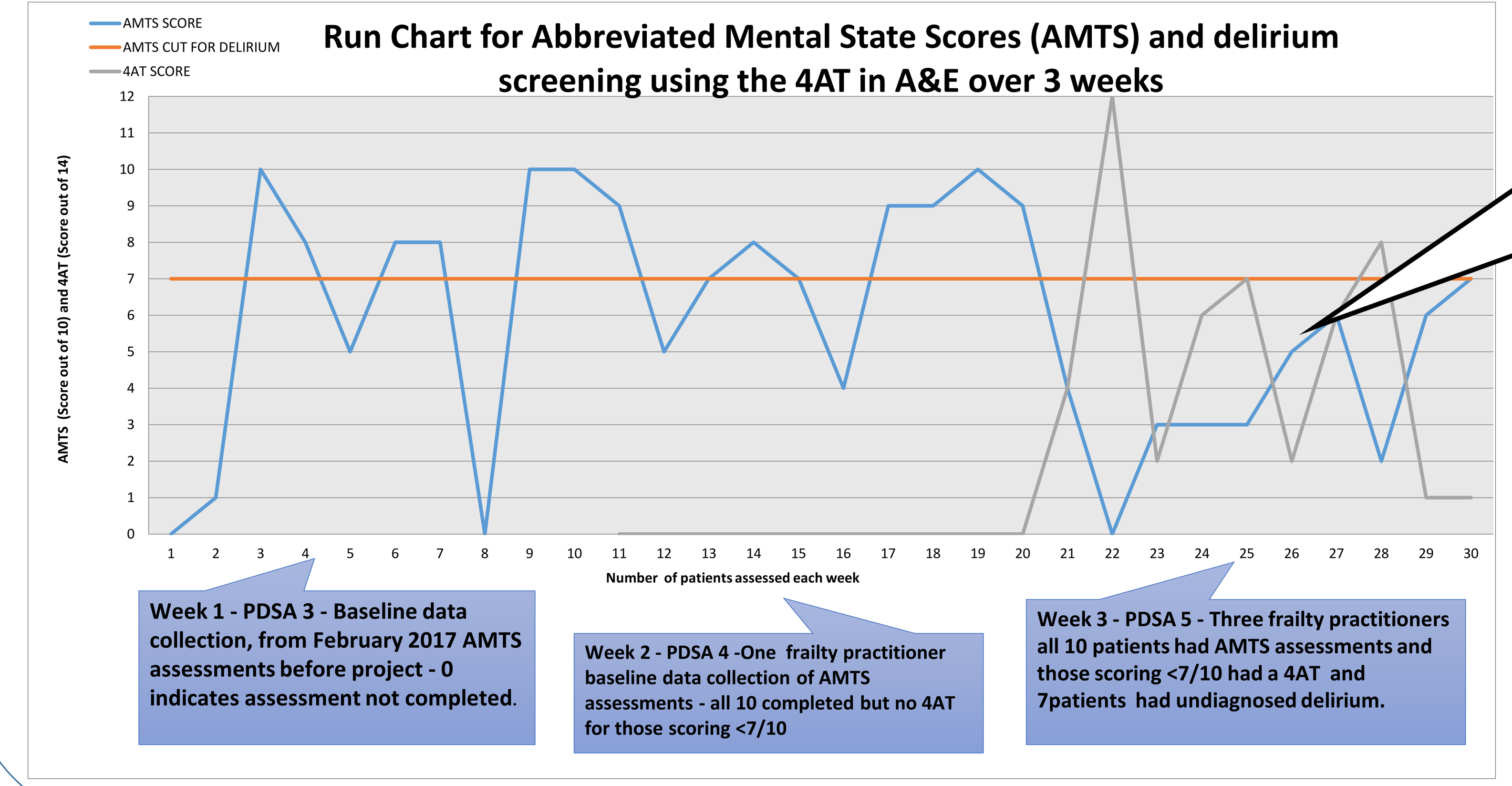
Delirium Champions

Education and Training for all staff

Environmental changes within A&E / MAU

Physical health needs to address delirium symptoms AND psychological support for cognitive recovery.

RUN CHART



Case Study Example –
81 year old gent conveyed to A&E with a fall and probable chest infection.
No diagnosis of cognitive impairment.
Collateral history identified high level of functioning, living independently and no complex physical co-morbidities.
Presenting with hypoactive delirium (lethargy, withdrawn difficult to rouse and fluctuating alertness). Delirium identified = early treatment.

Observation on learning and impact of PDSAs

1. Positive engagement with stakeholders.
2. PDSAs have obtained data needed.
3. More work to be done!

4AT RAPID ASSESSMENT TEST FOR DELIRIUM

LEARNING AND REFLECTION

Influencing without authority.
Improver habits – facilitative, generating ideas and team player.
Motivation and drive to improve patient mental health outcomes within the acute hospital.
Vital importance of stakeholder involvement - patients and relatives .

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NEXT STEPS

1. Continue project and achieve aims
2. Share learning outcomes and project outcomes with the Frailty Interface Team
3. Ensure positive engagement and sustainability
4. Disseminate learning at the Acute Frailty Conference on 27th June 2017.