

Health of Older People Service Level Alliance Delirium Stocktake

A Report Prepared by

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SOUTH ISLAND ALLIANCE
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Delirium Stocktake 2017 for Health of Older People Service Level Alliance

Background

As part of its focus on improving the wellbeing of older people, Health of Older People Service Level Alliance (HOPSLA) is looking to better understand how delirium is prevented, recognised and managed in the South Island across all health service settings.

Internationally, literature advises that delirium is common but not well recognised. Left untreated, individuals have a higher risk of falls, a higher risk of deconditioning and developing pressure injuries, as well as resulting in higher morbidity and mortality. Further to this, it results in lengthier recovery times, longer lengths of stay, increased admissions to Aged Residential Care and significantly increased financial load.

Research suggests that up to one third of cases of delirium are preventable. One of the key ways that delirium can be avoided is by identifying potentially at risk individuals for early intervention and then managing them appropriately.

This stocktake is designed to establish what is happening across the continuum of health care in the South Island in relation to the prevention, recognition, assessment and management of delirium.

Summary

The survey results show there are areas for improvement in the monitoring, assessment and prevention of delirium across the South Island. The use of regular screening is low, and recognising and coding delirium is low which hampers reporting on delirium. This hinders a full understanding of the incidence and need for intervention.

Findings

145 overall responses (30 Respondents did not complete the survey after Q3 (no data))

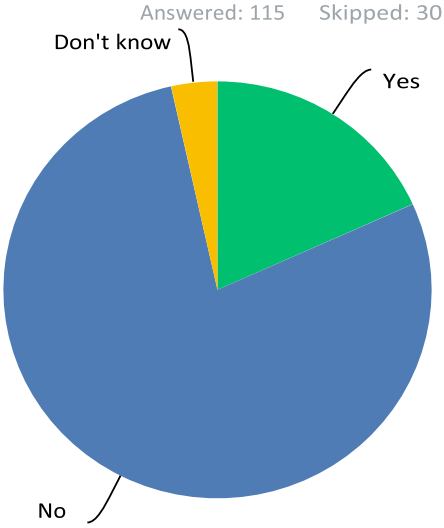
DHB
Canterbury – 47
Nelson Marlborough – 17
South Canterbury – 16
Southern – 50
West Coast – 13

Type of Service	
73 - ARC	4 – Palliative care services
22 - ATR	1 – NGO community team
16 - Acute medical	1 – Acute surgical
15 - DHB Community team	

Roles
50 - Senior nursing leader
43 – Manager
19 – Team member (health professional)
15 – Senior medical officer/clinical leader
12 – Other (GP, RN, clinical nurse manager, clinical manager, admin, senior experienced nurse, nurse specialist)
3 – Senior allied health leader
1 – Team member – non health professional

Q4 Does your service routinely screen people (50% or more of patients) who may be at risk of developing delirium, using a delirium screening tool?

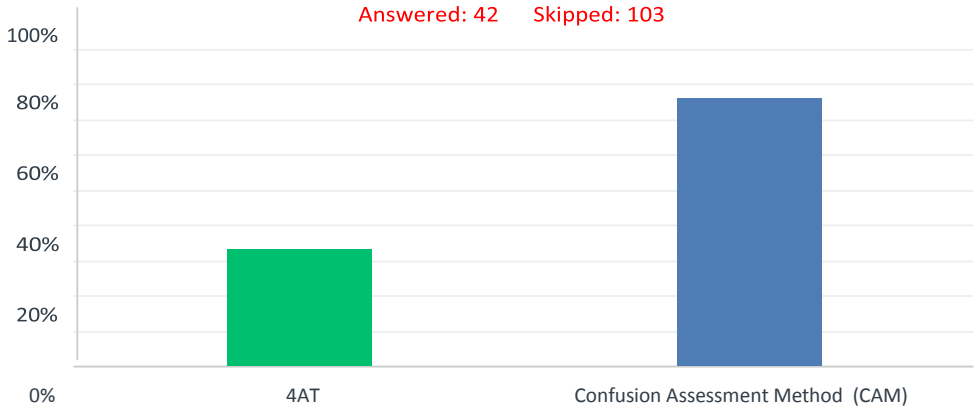
Answered: 115 Skipped: 30



Answer Choices	Responses	
Yes	18.26%	21
No	78.26%	90
Don't know	3.48%	4
Total		115

Q5 What screening tools do you use when assessing someone with delirium? Please tick all that apply:

Answered: 42 Skipped: 103

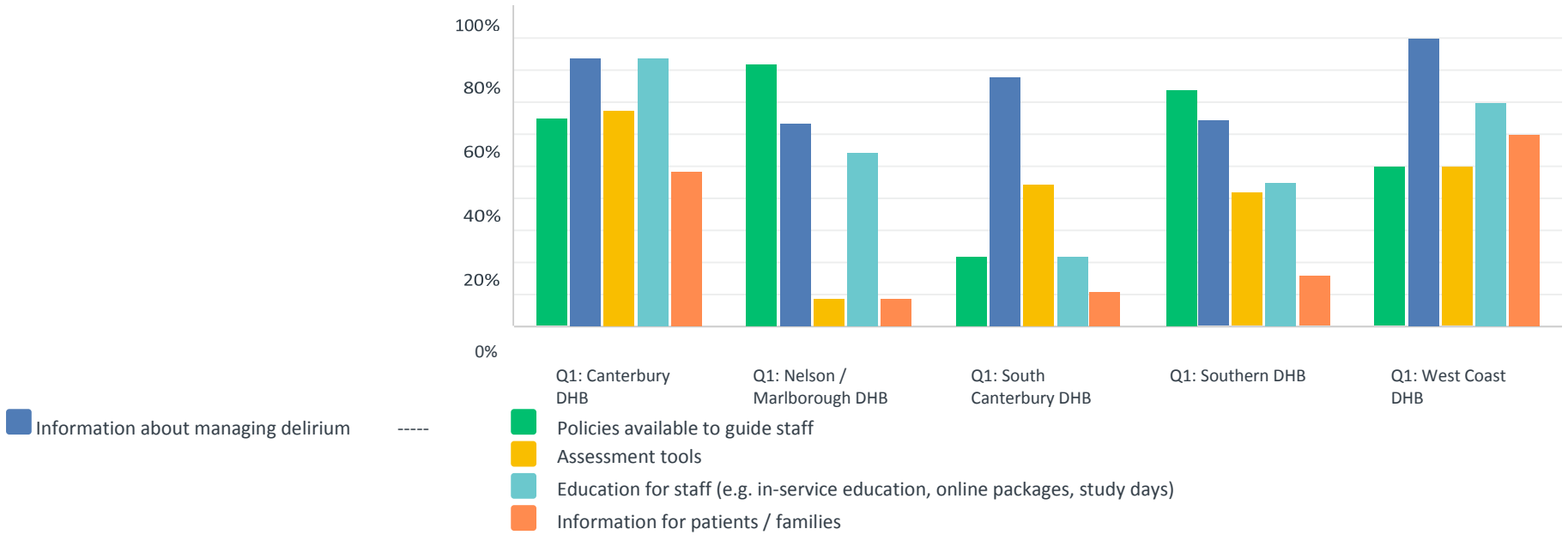


Answer Choices	Responses	
4AT	33.33%	14
Confusion Assessment Method (CAM)	76.19%	32

Total Respondents: 42	

Q6 Does your service have comprehensive resources with regard to delirium? Please tick all that apply:

Answered: 98 Skipped: 45

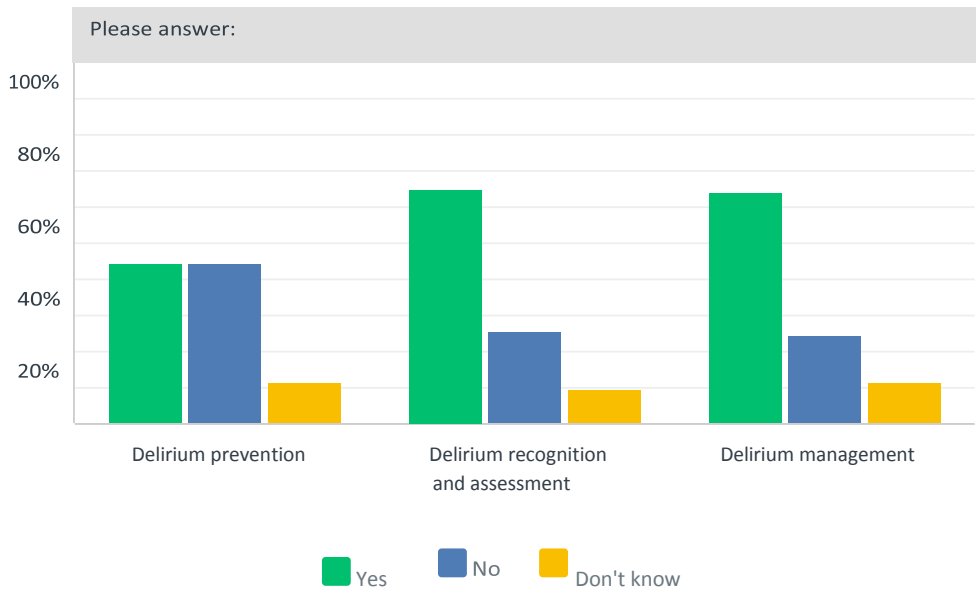


	POLICIES AVAILABLE TO GUIDE STAFF	INFORMATION ABOUT MANAGING DELIRIUM	ASSESSMENT TOOLS	EDUCATION FOR STAFF (E.G. IN-SERVICE EDUCATION, ONLINE PACKAGES, STUDY DAYS)	INFORMATION FOR PATIENTS / FAMILIES	TOTAL
Q1: Canterbury DHB	64.86% 24	83.78% 31	67.57% 25	83.78% 31	48.65% 18	131.63% 129
Q1: Nelson / Marlborough DHB	81.82% 9	63.64% 7	9.09% 1	54.55% 6	9.09% 1	24.49% 24
Q1: South Canterbury DHB	22.22% 2	77.78% 7	44.44% 4	22.22% 2	11.11% 1	16.33% 16
Q1: Southern DHB	74.19% 23	64.52% 20	41.94% 13	45.16% 14	16.13% 5	76.53% 75

Q1: West Coast DHB	50.00% 5	90.00% 9	50.00% 5	70.00% 7	60.00% 6	32.65% 32
Total Respondents	63	74	48	60	31	98

Q7 Does your service have resources, tools or education material that is currently being used to support:

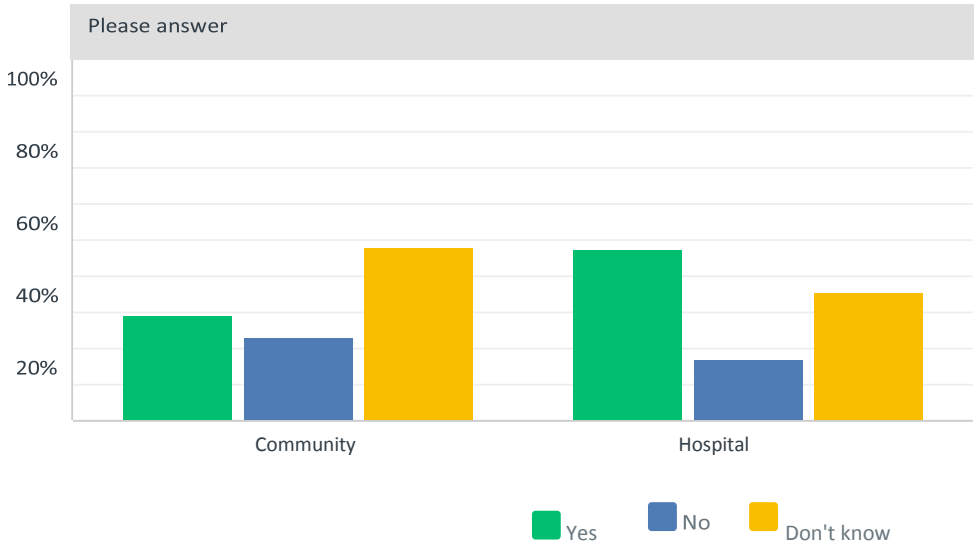
Answered: 108 Skipped: 37



Please answer:	Yes	No	Don't know	Total
Delirium prevention	44.34% 47	44.34% 47	11.32% 12	106
Delirium recognition and assessment	65.09% 69	25.47% 27	9.43% 10	106
Delirium management	64.15% 68	24.53% 26	11.32% 12	106

Q8 Are there pathways available with regard to delirium in the community and hospital:

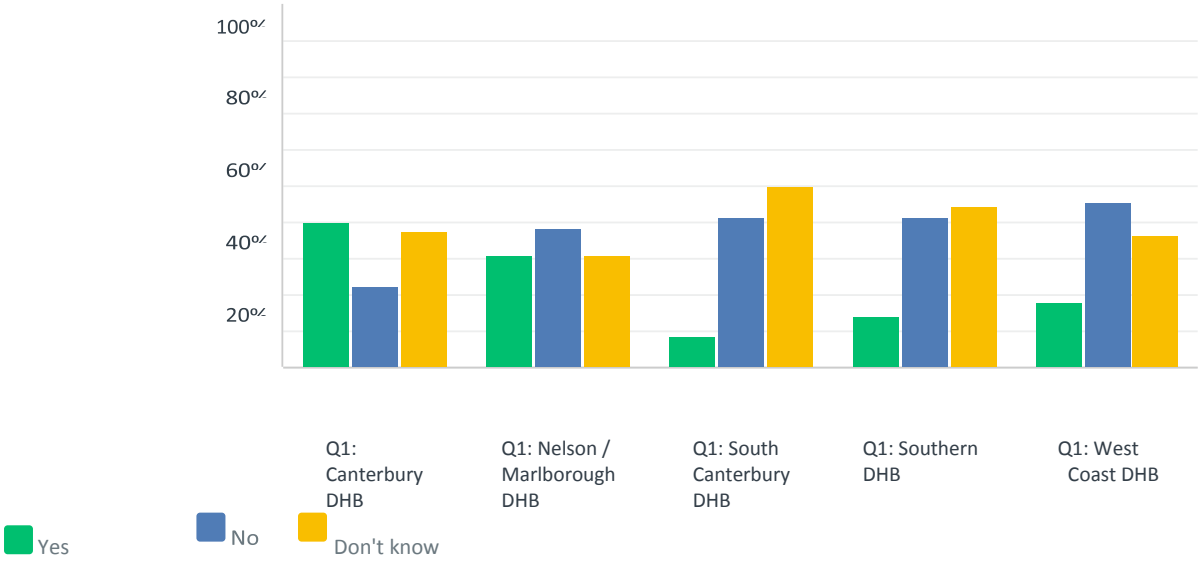
Answered: 107 Skipped: 38



Please answer				
	Yeses	No	Don't know	Total
Community	29.17% 28	22.92% 22	47.92% 46	96
Hospital	47.47% 47	17.17% 17	35.35% 35	99

Q9 Is there anyone in your DHB who has dedicated time (full time equivalent hours) to advise and support services for delirium management (hospital or community) that you know of and can access?

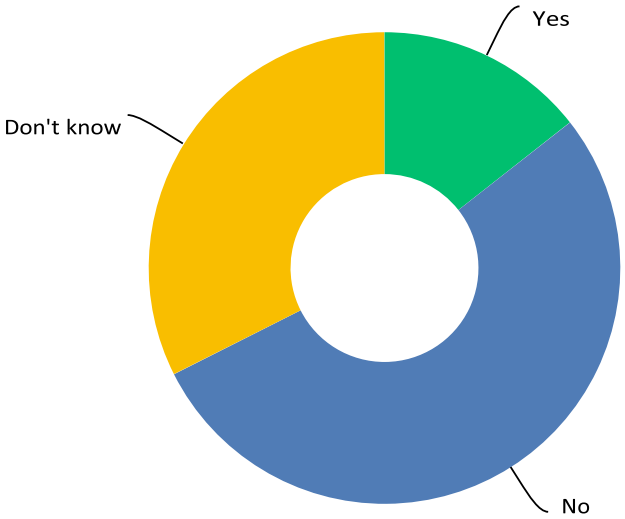
Answered: 112 Skipped: 31



DHB	Yes	No	Don't know	Total
Canterbury	40.00% (16)	22.5% (9)	37.5% (15)	40
Nelson/Marlborough	30.77% (4)	38.46% (5)	30.77% (4)	13
South Canterbury	8.33% (1)	41.67% (5)	50% (6)	12
Southern	13.89% (5)	41.67% (15)	44.44% (16)	36
West Coast	18.18% (2)	45.45% (4)	36.36% (4)	11
				112

Q10 Do you know how delirium as a disorder is coded in your service?

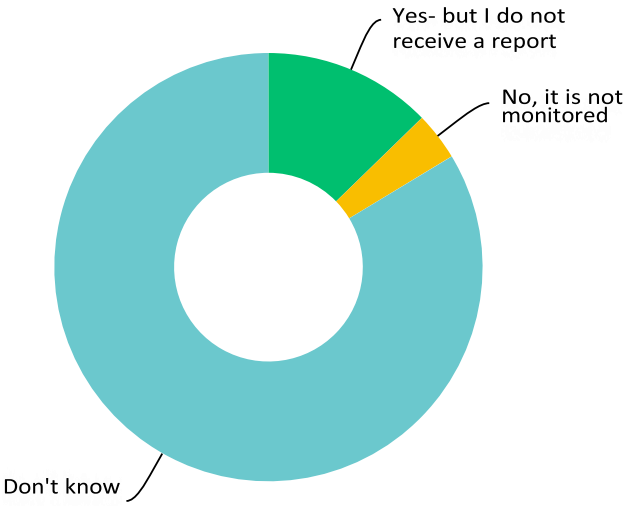
Answered: 111 Skipped: 34



Answer Choices	Responses	
Yes	14.41%	16
No	53.15%	59
Don't know	32.43%	36
Total		111

Q11 Do you know whether delirium is monitored in your DHB? *

Answered: 113 Skipped: 32

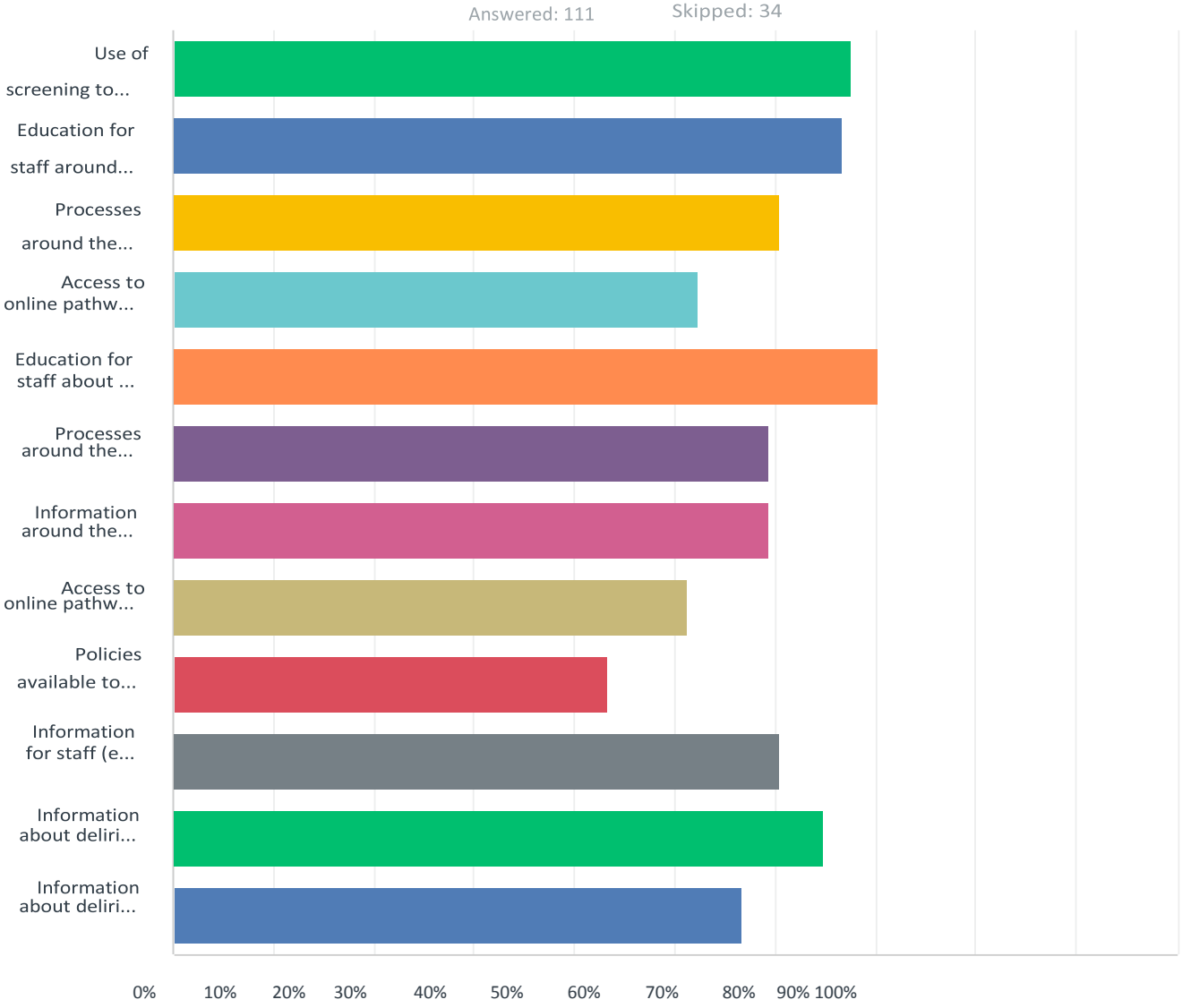


Answer Choices	Responses	
Yes- but I do not receive a report	12.73%	7
Yes- I receive a report	0.00%	0
No, it is not monitored	3.64%	2
Don't know	83.64%	46
TOTAL		55

***This graph is without any of the ARC services included**

Q12 Which areas do you think require further development for your service in relation to the prevention, assessment or management of delirium? Tick all which apply:

Answered: 111 Skipped: 34



Answer Choices	Responses	
Use of screening to better identify delirium	67.57%	75
Education for staff around the prevention of delirium	66.67%	74
Processes around the assessment of delirium	60.36%	67
Access to online pathway information for guidance on assessing for delirium	52.25%	58
Education for staff about the assessment of delirium	70.27%	78
Processes around the management of delirium	59.46%	66
Information around the non-pharmacological and pharmacological ways of managing delirium	59.46%	66
Access to online pathway information for guidance for delirium or management of delirium	51.35%	57
Policies available to guide staff	43.24%	48
Information for staff (e.g. in-service education, online package)	60.36%	67

Discussion

The overall response rate (n=145) was a good size however it is not an even representation of each DHB. 30 people only completed page one of the survey which covers location, role and service. This leaves 115 completed surveys. Of these 60% of respondents did not answer what screening tool they use, though this may have been due to survey design as the question prompted the responder to choose either the 4AT or the CAM. It could therefore be assumed that if person skipped this question it was because they used neither the 4AT nor the CAM in their clinical setting.

There was one response from hospital surgical services which therefore is also a limitation to the survey. Historically, the incidence of delirium can be higher in surgical settings and so not having this sector of care reflected in the results means that there are potential developments and practices which are not included in these findings.

ARC have the highest number of respondents (n=73) with ATR the next highest (n=22). Most respondents were senior health professional staff or management. Most services (78%) do not regularly screen for delirium with a tool. There is no standardised approach to delirium assessment.

The most common resource for staff is information about management of delirium at (75%), followed by policies (64%) then education for staff (61%). There are fewer resources for Delirium prevention (44%).

A small number (24%) knew they could access dedicated staff for advice and support for delirium management and many (40%) did not know if there was dedicated staff for advice and support. About half of respondents did not know if there was a community pathway available with regard to delirium and a third did not know if there was a hospital pathway available.

Coding of delirium is low, reports are mostly not available with 16% are aware of the reporting. Three people reported receiving a report. There is significant recognition that further development of the services in relation to prevention, assessment and management is needed and education for staff around prevention was the highest area identified with along with the actual use of a screening to identify delirium.

InterRAI &Delirium

Within the comments section for Question 5, regarding which screening tool respondents utilised in their clinical setting, several respondents indicated they used interRAI. The following guidance around interRAI has been received from DHBSS with regards to delirium assessment:

InterRAi contains a screen for risk of Delirium.
Delirium CAP definition: Problems with Delirium suggested the person exhibits any of the following symptoms
[C3a] Easily Distracted =2
[C3b] Disorganised Speech=2
[C3c] Mental function varies over day =2
[C4] Acute change in Mental Status =1
The purpose of the delirium CAP is to identify persons with active symptoms of delirium – acute change in mental status and behaviour appears different from usual functioning. The goal is to intervene to return the person to his or her baseline status.

If a person has the delirium CAP triggered it is a message to the assessor that seeking formal diagnosis is appropriate, and that there are useful actions that they can take to help **and** because in the interRAI one aspect of the assessment influences another it is a signal to the assessor that the overall assessment results may be influenced by the delirium.

Conclusion

These survey findings support the need to improve delirium assessment, prevention and treatment around the South Island. Responses suggest that where there are available resources, staff are not necessarily aware of them or do not know how to access them, and that there is an opportunity to improve the recognition, prevention,

management and monitoring of delirium across the South Island. Resources including health pathways and delirium prevention, which are already available, could be further communicated and shared with health professionals across settings and across the South Island, to ensure that people who are at risk of delirium can benefit from an equitable approach regardless of where they may live across the region.

Comments

Question 4

Does your service routinely screen people (50% or more of patients) who may be at risk of developing delirium, using a delirium screening tool?

- Routine interRAI screening x 3
- When unwell or an alteration in health – SOAP assessment is completed
- One Medical Ward is screening 70%. We have yet to achieve this across the organisation
- Not aware of a specific screening tool for those at risk. However, may use CAM if patient appears to present differently from their usual (cognitive status). Promote PINCHES ME kindly to assist staff/colleagues on prevention/awareness of delirium
- The team does recommend completing a delirium screen to both primary and secondary services.

Question 5

What screening tools do you use when assessing someone with delirium? Please tick all that apply:

- interRAI x 6
- visual and knowing the resident
- The CAM is a tool that is given to every house officer in their orientation packet when they train on AT&R
- These are the two tools that we have available, however they are not routinely used
- we assume that it is delirium from symptoms & behaviour

Question 6

Does your services have comprehensive resources with regard to delirium? Please tick all that apply:

- Education ad hoc based on interactions with staff about individual cases.
- Lippincott
- If Delirium suspected GP contacted and Older Persons Mental Health
- Challenging behaviour policy and procedure
- Rely on OPMH which can be slow to give input, & own team also has input. Mainly medically driven and patient supported with a 'watch'.
- We have brochures for families around the prevention of delirium while in hospital. I have run study days in the past around dementia and delirium. Assessment tools are available but not widely utilised. I'm not aware of any policies except that through community and hospital Healthpathways.

Question 7

Does your service have resources, tools or education material with is currently being used to support: (delirium prevention, delirium recognition and assessment, delirium management)

- Community and Hospital HealthPathways and Healthinfo
- From WDHB Residential Aged Care Integration Programme, Local GP service
- Acute Delirium Decision making guide

- We have delirium educational sessions for incoming house officers and regularly encourage delirium assessments in new admissions from surgical and medical wards
- InterRAI, Challenging behaviour policy and procedure and training in this
- We educate our staff the differences between Delirium, dementia and depression symptom, we teach our HCAs need to be aware and report to RNs if residents showing any unusual behaviour. For RNs, we check for the infection, then report to GP. X3
- We have Bridge education available online.
- Reduce risk factors e.g. provide calm environment, assess and review medications, ensure good hydration and nutrition
- Flower chart, good communication with relatives etc. use of watches
- RN knowledge of delirium
- Booklet regarding Delirium
- Use our GP for prevention re: medications/UTI screening and preventing multi pharmaceuticals
- We utilise the 'Think delirium' resources for delirium prevention, we have developed some education which covers all three of these- but it is not accessed by all staff, and is offered only on a sporadic basis. We do utilise some in-hospital strategies such as sunflower charts to aid communication, and we include it as a prompt on the releasing time to care patient status at a glance boards. Currently we are undertaking a trial around the implementation of activity trolleys in the wards which can assist in management.

Question 8

Are there pathways available with regard to delirium in the: (community, hospital)

- 5 x Healthpathways
- Residents checked by their GP then sent to local Hospital Clutha Health First or Dunedin Public Hospital if unable to be treated in the facility.
- GP is first contact although RN delirium concerns not appreciated by GPs
- Yes but difficult to achieve timely results OPMHS/MCT would make sense but we have had to use police and geriatrician via emergency department when aggression became an acute problem
- Via EPS, nurse practitioner and A&E

Question 9

Is there anyone in your DHB who has dedicated times (full time equivalent hours) to advise and support services for delirium management (hospital or community) that you know of and can access?

- WCDHB not big enough to support dedicated resource IMHO. This should be part of geriatrician, psychogeriatrician, gerontology nurse specialist and clinical assessor w interest in dementia roles (previously dementia nurse specialist). These roles are generalist in nature and must cover many disease states.
- Psychiatric liaison service
- Our facility refer to our consulting GP.
- Older Persons Mental Health.
- OPH and general medicine have both done education and resource development for delirium
- We used to have a nurse practitioner for delirium however she no longer works in this role. There also used to be a delirium management service, though I'm not sure if this is still active.

Question 10

Do you know how delirium as a disorder is coded in your service?

- InterRAI codes for delirium x 2
- ? not coded specifically in LTCF, just a potential or actual problem care planned for if needed to be or not.
- Challenging Behaviour
- HONOS x 2

- Coded if mentions delirium. Now we have the CAM tool, more likely to be picked up
- We recently started getting this data on this through the 'seeing our system' portal available through the CDHB intranet. Quite low figures suggesting it's under reported.

Question 12

Which areas do you think require further development for your service in relation to the prevention, assessment or management of delirium? Tick all which apply:

- We need to increase awareness and skills about delirium in general workforce. Resources are there, not sure how much they are being used. X4
- Many of our residents live with dementia and it is often extremely difficult to differentiate between dementia and delirium. However, the staff know the residents very well and will very quickly identify when a resident is acutely unwell. We are not always well supported by ambulance and hospital staff who will question our observations and second guess our decision to send a person to hospital after hours for investigations and intervention
- With the new evidence that drug management with antipsychotics is not only unhelpful but also prolongs episode of delirium and mortality, it is imperative that the wider health care team are more vigilant in prevention, screening and assessment and non-drug management
- More consistency around the peri-op management of patients predisposed to post-op delirium
- Patients are frequently moved from room to room and ward to ward and then nursed in 4 bedded rooms with other delirious patients so that their sleep is interrupted!
- ARC prevention and management of Delirium
- I think there could be a lot of emphasis placed on risk assessment/ identification of vulnerable adults at risk of developing delirium. There could also be a greater emphasis on the types of delirium, and how these can be missed- e.g. hypoactive delirium.

Question 13

Any other comments?

- Also need better awareness and education in aged residential care.
- There is no quantifiable measure employed to measure knowledge and application of the tools yet in the facility.
- As a stand-alone resthome without 24/7 RN cover, we cannot manage people when they are develop delirium. We neither have the staff or skills to cope.
- In this area it is difficult to access the support required
- Regularly delirium in spotlight towards staff as reminder
- We have a delirium and dementia resource group for staff as well as a dementia and delirium working/ operational group consisting of senior clinicians and managers. Currently we are looking at the development of online learning as well as our management strategies, particularly around hospital aide specialling.