Improving Delirium Risk Screening and Risk Assessment in the Aged Care Units

Liverpool Hospital

Vicki Deane and Kelli Flowers

December 2015
Liverpool Hospital Delirium Working Party

- Sharon Shunker, ICU Clinical Nurse Consultant
- Kelli Flowers, Aged Care Clinical Nurse Consultant
- Lynette McEvoy, Orthopaedic Clinical Nurse Consultant
- Charmaine O’Connor, Palliative Care Consultative Service Clinical Nurse Consultant
- Margaret Moseley, ASET Clinical Nurse Consultant
- Vicki Deane, ASET Acting Clinical Nurse Consultant
- Silvana Techera, Nursing Executive Officer to the Director of Nursing and Midwifery Services
- Anna Thornton, Former Director of Nursing and Midwifery Services
Identifying the need for a pathway

A 93 year old lady was admitted to ED with increased confusion and hypothermia.

– CALD background
– Increased confusion and hypothermia
– Past medical history of dementia, HTN, DM, CCF, AF and falls.

Admitted with delirium on background of dementia, sepsis and hypoglycaemia
The patient was initially hypoactive during her admission, however began climbing out of bed and wandering around the ward at night.

Several days after admission, the patient was found on the floor next to her bed after a presumed fall.

MET call attended, not suitable for ICU – comfort care provided

Passed away that night
The RCA team found that prior to the fall, the patient was documented to have delirium by medical staff, however no clear plan was put in place to manage the patient's delirium.

The RCA team also found that nursing staff outside of the Aged Care speciality had not received formal education on recognition and management of delirium.
With the view of preventing similar incidents from occurring in the future, a recommendation of the RCA team was for staff across the hospital to receive education and training in the recognition and management of delirium.
Falls and delirium

● In 2013 there were ten SAC 2 incidents where patients fell and sustained a serious injury.

● Of these, seven patients were documented as exhibiting signs of acute confusion.
Roll out of Delirium Awareness, identification, prevention and management

- Education sessions – included YouTube clips on delirium and the CAM
- Resource folders
- Delirium champions
- Delirium stickers
- Screening tools
- Prevention strategies
- Management strategies
DELIRIUM PREVENTION PATHWAY

Patient admitted to the ward

Delirium Screen (CAM) attended

-VE

+VE

Delirium Risk Screen attended

Low

Usual Care

Medium

High

Refer to JMO
Consider Referral to CNC

Implement Delirium and Falls Prevention Strategies

Attend Delirium Screen/ CAM every 24 hours
If patient has a positive Delirium Screen this not applicable

DOCUMENT STRATEGIES AND CARE
<table>
<thead>
<tr>
<th>Delirium Screening Tool</th>
<th>No</th>
<th>Yes</th>
<th>Uncertain. Specify</th>
<th>Question</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute onset and fluctuating course</td>
<td>No</td>
<td>Yes</td>
<td>Uncertain. Specify</td>
<td>Is there evidence of an acute change in mental status from the patient's baseline?</td>
<td>e.g. tend to come and go, or increase and decrease in severity?</td>
</tr>
<tr>
<td>Inattention</td>
<td>No</td>
<td>Yes</td>
<td>Uncertain. Specify</td>
<td>Did the patient have difficulty focusing attention during the interview?</td>
<td>e.g. being easily distractable, or having difficulty keeping track of what was being said?</td>
</tr>
<tr>
<td>Disorganised thinking</td>
<td>No</td>
<td>Yes</td>
<td>Uncertain. Specify</td>
<td>Was the patient's thinking disorganised or incoherent?</td>
<td>e.g. rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from one subject to another?</td>
</tr>
<tr>
<td>Altered level of conscious</td>
<td>No</td>
<td>Yes</td>
<td>Uncertain. Specify</td>
<td>Overall, how would you rate the patient's level of consciousness?</td>
<td>Altered e.g. Vigilant (hyperalert), Lethargic (drowsy), Stupor (difficult to arouse), Coma (unrousable), Uncertain.</td>
</tr>
</tbody>
</table>

Delirium is present if features 1 and 2 AND either 3 or 4 are present.

Delirium symptoms: not present / present

Medical Officer Notified: Yes / No

Name: [ ] Designation: [ ] Signature: [ ] Date: [ ]
## Delirium Risk Screen for Patients

### Aged 70 yrs. and over with Sensory Impairment – any history of visual or hearing impairment, need for glasses or hearing aids

<table>
<thead>
<tr>
<th>Yes / No</th>
</tr>
</thead>
</table>

### Cognitive Impairment – any history of dementia, memory problems, previous history of delirium

<table>
<thead>
<tr>
<th>Yes / No</th>
</tr>
</thead>
</table>

### Dehydration – any history of fluid losses, poor oral intake, signs of dehydration

<table>
<thead>
<tr>
<th>Yes / No</th>
</tr>
</thead>
</table>

### In bed or chair > 50% of the day over the last 1 week (excludes wheelchair)

<table>
<thead>
<tr>
<th>Yes = 1 point</th>
</tr>
</thead>
</table>

#### Delirium Risk

- □ Low risk
- □ Medium risk
- □ High risk

#### Medium and High Risk

- □ Attend CAM (Delirium Screen) if the CAM is positive refer to MO
- □ Commence Delirium and Falls Prevention Strategies
- □ Referral to CNC (specify name)

### Score:

- 1 = low risk
- 2 = medium risk
- ≥3 = high risk of delirium

### Name: ____________________________

### Designation: ____________________________

### Signature: ____________________________

### Date: ____________________________

ID 6080953 Sep 14
Delirium Awareness Video Presentations

- Delirium In Elderly Patient
  
  https://www.youtube.com/watch?v=mKcbeXVdygg

- S&S Neuro Status Delirium CAM
  
  http://www.youtube.com/watch?v=u9B0UVd4jFA&feature=player_detailpage
DELIRIUM PREVENTION

Sensory: ensure hearing aids and glasses are clean and available and fitted correctly, ensure the temperature is comfortable, minimise noise.

Mobility: mobilise as soon as possible, consider planned walks, mobilise > 4 times per day, sit out of bed ensure mobility aid if required.

Cognitive impairment: establish a baseline, use orientation techniques and reassess when change identified, arrange familiar people to visit, talk about current events.

Nutrition and hydration: commence fluid balance chart, food chart and encourage/adviser oral intake, regular weight, well fitting dentures.

Sleep: maintain sleep/wake cycles, encourage no more than 90mins sleep during the day - unless medical advise, open curtains during the day, provide a dark room at night (use night lights), reduce noise and distractions at night.

Avoid restraints.

Delirium can affect any age group.
Current Results

Delirium Screen

- 81% of patients have a delirium screen attended on admission to the aged care unit

Delirium risk assessment

- 85% of patients had a risk screen attended on admission with 80% scoring medium or high risk

Falls rates reduced by 60% since the introduction
Key Points To Remember
Why do we need to screen for delirium?

- Anyone can have delirium
- Delirium can be prevented and treated
- It is different from dementia and depression
- Delirium is a medical emergency
- Delirium is not a normal part of ageing
- The patient may remember their delirium
- Reducing the duration of delirium is known to improve the clinical outcome for the patient
Question Time

Thank You