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

Liverpool Hospital

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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.

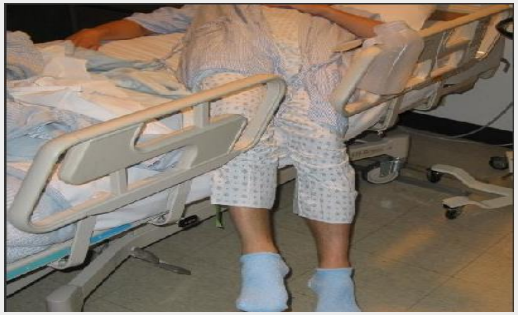
Admitted with delirium on background of dementia, sepsis and hypoglycaemia

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.

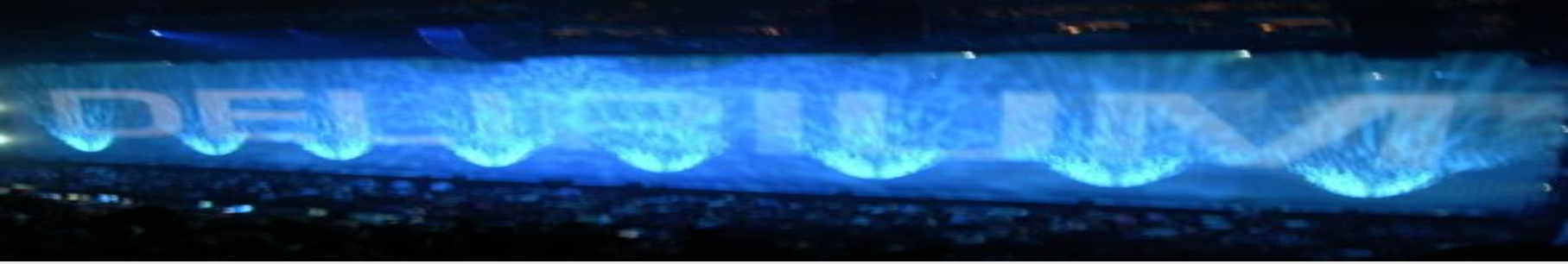
MET call attended, not suitable for ICU – comfort care provided

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 patients 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.

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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.

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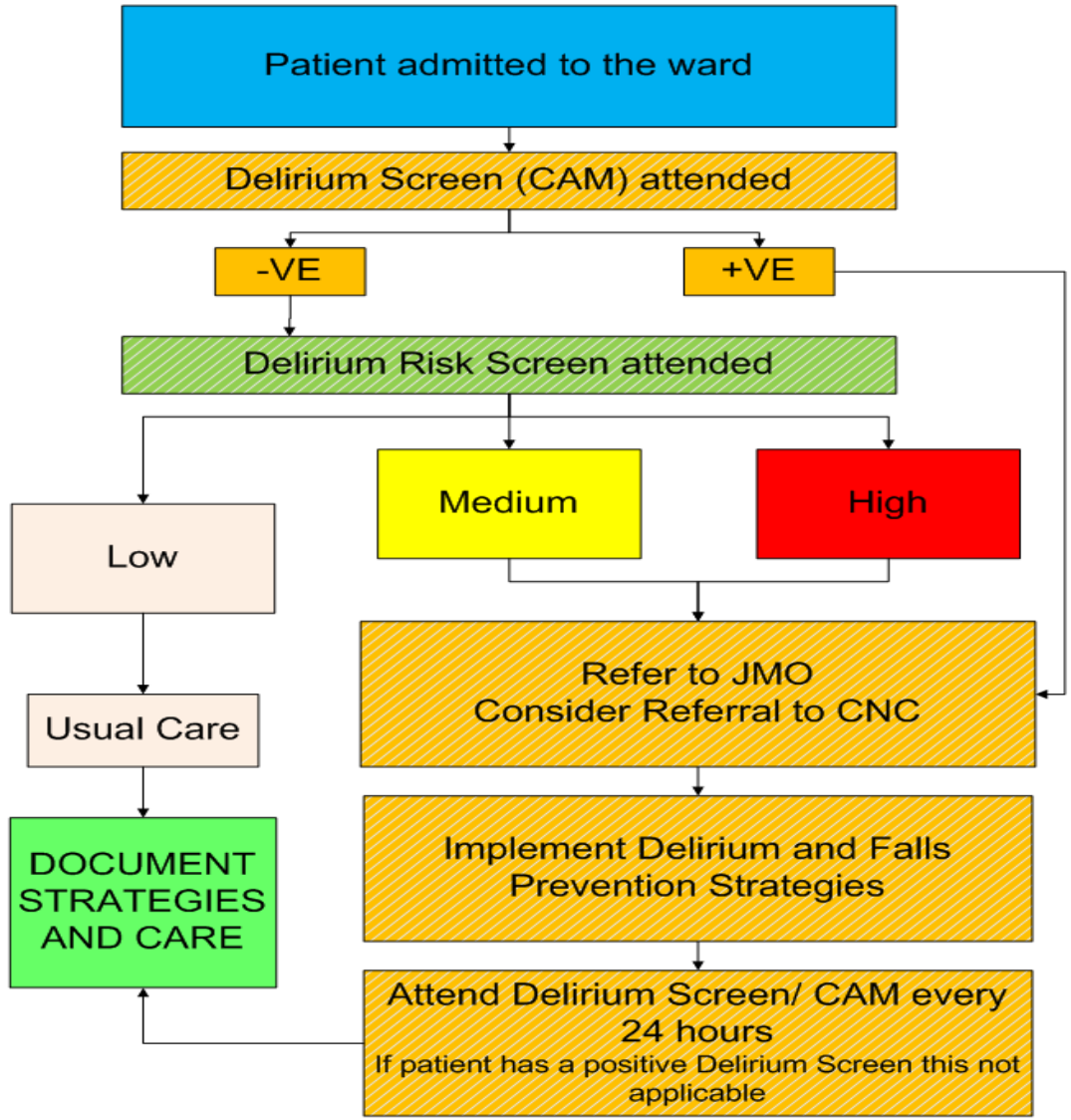
Roll out of Delirium Awareness, identification, prevention and management

- 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



Delirium Screening Tool

MRN:				Patient Name:		
CONFUSION ASSESSMENT METHOD (CAM)						
1	**Acute onset and fluctuating course**	No	Yes	Uncertain. *Specify*_____ _____	Is there evidence of an acute change in mental status from the patients baseline? If so, did the abnormal behaviour fluctuate during the day.	e.g. tend to come and go, or increase and decrease in severity?
2	**Inattention**	No	Yes	Uncertain. *Specify*_____ _____	Did the patient have difficulty focusing attention during the interview?	e.g. being easily distractable, or having difficulty keeping track of what was being said?
3	**Disorganised thinking**	No	Yes	Uncertain. *Specify*_____ _____	Was the patient's thinking disorganised or incoherent?	e.g. rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from one subject to another?
4	**Altered level of conscious**	No	Yes	Uncertain. *Specify*_____ _____	Overall, how would you rate the patient's level of consciousness?	Altered e.g. Vigilant (hyperalert), Lethargic (drowsy), Stupor (difficult to arouse), Coma (unrousable), Uncertain.
Delirium is present if features 1 and 2 AND either 3 or 4 are present						
Delirium symptoms: not present / present					Date: / /	
Medical Officer Notified: Yes / No						
Name:		Designation:		Signature:		Date: / /

Inouye et al (1990)

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MRN:	Patient Name:

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	Yes / No
Cognitive Impairment – any history of dementia, memory problems, previous history of delirium	Yes / No
Dehydration – any history of fluid losses, poor oral intake, signs of dehydration	Yes / No
In bed or chair > 50% of the day over the last 1 week (excludes wheelchair)	Yes / No
Yes = 1 point *1 = low risk 2 = medium risk ≥3 = high risk of delirium*	Score:

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) _____

Name:	Designation:
Signature:	Date:

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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

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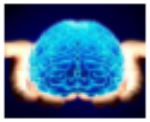

DELIRIUM PREVENTION

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
AVOID Restraints

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/ assist oral intake, regular weigh
Sheet.1
well fitting dentures

Delirium can effect any age group

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 Sleeping medications

November 2013

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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