Delirium occurs in 10-20% of medical patients on admission and a further 10-30% develop delirium as an inpatient. Delirium is associated with increased length of stay, morbidity, mortality, and risk of institutional placement. There is poor knowledge of delirium recognition and management, and a need to raise awareness and training of all staff. NICE have produced guidelines for diagnosis, prevention and management of delirium.

A retrospective departmental audit demonstrated that delirium was under-recognised i.e. only 5.7% of discharges in one year. A staff questionnaire revealed poor knowledge of types of delirium and a significant underestimation of prevalence, with poor identification of risk factors. A multi-professional group was formed to raise staff awareness and develop a care pathway for delirium. A 19 bed acute elderly care ward was identified for the project.

Ward based and departmental educational meetings were held. A Trust based awareness programme was also provided. Information leaflets on delirium were produced for patients, carers and families and posters at ward level. Environmental changes (signage) at ward level were introduced to improve the environment for patients. A delirium care pathway was created to encourage documentation of mental score, assessment of delirium, review of reversible medical causes and a nursing care plan. This pathway was reviewed regularly on ward rounds and feedback given to staff present.

Following these interventions the notes of 106 consecutive discharges were reviewed over an 11-week period. 99% of at risk patients were screened for delirium. 35% of patients were diagnosed with delirium increasing the recognition rate from 5.7%. There was significant improvement among the staff in recognizing and managing patients with delirium through the use of a delirium care pathway. Education improves understanding and awareness of delirium and a care pathway focuses attention on this area, improving patient safety and quality of care.

Problem

Delirium (sometimes called ‘acute confusional state’) is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually develops over 1–2 days (1). It is a serious condition that is associated with poor outcomes. However, it can be prevented and treated if dealt with urgently (1). The Ulster Hospital, South Eastern Health and Social Care Trust (SEHSCT), Northern Ireland, is a district general teaching hospital with approximately 440 beds providing care in a range of medical and surgical specialties. There are four wards dedicated to Care of the Elderly. Older people and people with dementia, severe illness or a hip fracture are more at risk of delirium (1).

Background

Delirium occurs in 10-20% of medical patients on admission and a further 10-30% develop delirium as an inpatient (2). Delirium is associated with increased length of stay, morbidity, mortality and risk of institutional placement (3,4,5). There is poor knowledge of delirium recognition and management and a need to raise awareness among staff. NICE have produced guidelines for diagnosis, prevention and management of delirium and a delirium awareness workshop session guide designed to raise staff awareness (1).

Major difficulties arise when introducing evidence and clinical guidelines into routine daily practice (6). Substantial evidence suggests that to change behaviour is possible, but this change generally requires comprehensive approaches at different levels (doctor, team practice, hospital, wider environment), tailored to specific settings and target groups (6).

Baseline Measurement

The Ulster Hospital, South Eastern Health and Social Care Trust (SEHSCT), Northern Ireland, is a district general teaching hospital with approximately 440 beds providing care in a range of medical and surgical specialties. There are four wards (78 beds) dedicated to acute Elderly Care which includes a 20 bedded all age stroke unit.

A previous retrospective audit of discharges from the Dept. of Elderly Care demonstrated that delirium was under-recognised i.e.
only 5.7% of discharges April 2011 - March 2012 recorded a
diagnosis of delirium. A staff questionnaire was subsequently
performed to assess the understanding and educational needs of
staff about delirium. This revealed poor knowledge of types of
delirium and a significant underestimation of prevalence with poor
identification of risk factors. It was noted that the majority of staff,
particularly allied health professionals and nursing colleagues, had
received no previous teaching on delirium.

Design

We aimed to prevent delirium in patients identified at risk and when
delirium develops improve our recognition and management
through use of a delirium care pathway. A delirium project group
medical, nursing and pharmacy) was formed. A 19 bedded acute
elderly care ward identified for the project. The results and
proposed plans for change were presented at the safety, quality
and experience (SQE) programme within the Trust and
disseminated to different staff groups through ward and
departmental based educational meetings. Ward managers were
engaged in providing information leaflets to the patients, carers and
families. The medical team were involved in monitoring compliance
with risk assessment and delirium care pathways.

Results

The notes of 106 consecutive discharges were reviewed over an
11-week period at the end of the study period. 99% of at risk
patients were screened for delirium. There was limitation in using
mental score for patients who were agitated or had language and
hearing difficulties. Confusion assessment method (CAM) was used
in 82% of patients. Medical and nursing management checklist was
completed in 94% of CAM positive patients. 35% of patients were
diagnosed with delirium increasing the recognition rate from the
previous audit of 5.7%.

Lessons and Limitations

A process of staff education and introduction of a delirium care
pathway has increased delirium awareness within the elderly care
staff. Our view is that both components of the intervention programme were required to improve delirium
awareness. A limitation of this data is that we cannot determine if
one strategy alone was responsible for the improvement. Education
of staff was undertaken at multiple levels within the Trust and we
believe this is important as delirium is relevant to most acute
medical and surgical specialties. A limitation of the ward based
sessions is that only small numbers of staff were able to attend any
one session making them labour intensive. The care pathway
provided evidence of improved assessment and
management of risk factors for delirium. The pathway was regularly
reviewed on ward rounds and we believe this improved compliance.
Our improvements have been demonstrated in one ward area and
we are in role out across the unit. We anticipate that a
champion will be required in each ward area to continue to
promote education at ward level and challenge compliance with the
care pathway. We would suggest that this should be either a
member of the permanent medical or nursing staff complement of
the ward to provide continuity of education and learning.

Conclusion

Education improves understanding and awareness of delirium and
a care pathway focuses attention on this area, improving patient
safety and quality of care.

References

1. NICE guideline 103. Delirium: diagnosis, prevention and
management 2010
412-415.

Declaration of interests

None

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