Improving the recognition of delirium in acute care at QA Hospital, Portsmouth

Russell Thomas, Older Persons Mental Health Liason Practitioner

Background: Nationally delirium is under recognised (local and national data) and appropriate assessment and management of patients with delirium is not consistently achieved. Delirium has consequences for patients with risk of longer hospital stay, worse clinical outcomes, higher rates of mortality and a greater risk of future cognitive decline. Delay to identification may increase this risk. NICE Clinical Guideline 103 (210) advises that patients at risk for clinical features contributing to delirium should be assessed within 24 hours of admission. The project began in January 2019 and has been funded by HEE Wessex.

Aim: Initially the project aim was to improve the recognition and management of delirium in two clinical areas , the Acute Medical Unit (AMU) and a Medicines for older Persons ward (G3) at Queen Alexandra Hospital, Portsmouth. As the initial scoping work was undertaken it became apparent that the project aim was too ambitious for the available timeframes. The aim was changed to reflect this and focus on improving the recognition of delirium in the Blue area of the AMU by the 30th September 2019. There was additional aim of development of QI skills in two members of staff through attendance at QI training days (QSIR programme) and developing the project.

PDSA cycle summary

1. Staff questionnaires for medical/nursing staff utilised to gauge current staff awareness regarding delirium. This information to be used to focus on a specific/achievable goal.

2. The next stage was to ascertain staff awareness of the Single Question In Delirium (SQID), a method used to improve identification of delirium. Staff awareness was assessed, the next stage in to seek to implant it into practice on the two highlighted clinical areas to begin our trial for change.

3. Meeting arranged, with relevant professionals, to explore potential changes to IT systems at QAH so that SQID could be integrated into practice.

4. Review of progress made and project goal. Project goal needed redefining, having two clinical areas was simply too much to manage/co-ordinate, and therefore the clinical area for the project was reduced to one ward. Sadly it was not possible for potential IT solutions to be implemented at this time.

5. As well as making potential changes to assessment process/templates it was also found that staff training I the area of delirium could be improved, hence work began on devising a suitable training programme.

6. Implement two templates in the AMU area, one for the frailty interface team and one for band 3 clinical staff. The purpose would be to see how many positive (Yes) answers the SQID receives, we can then see how many times this leads to recognition and therefore treatment of delirium.

Fig 1. Driver Diagram

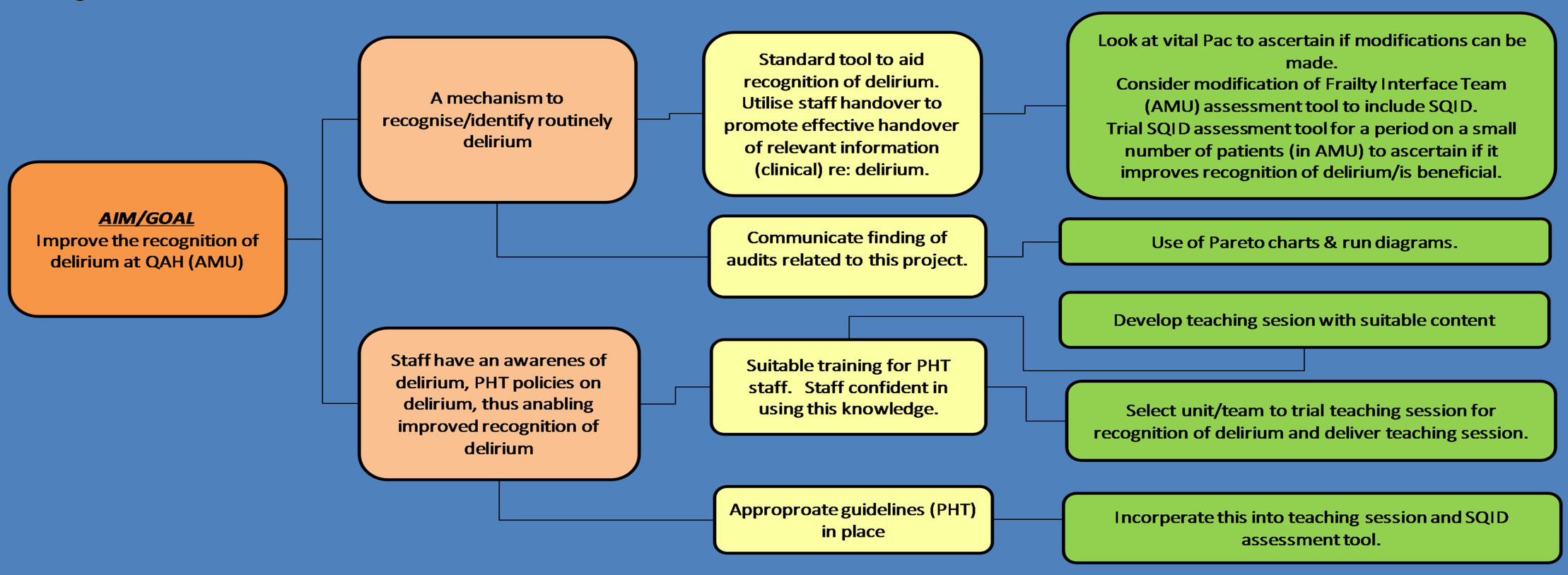

Fig 2. What changes doctors felt would improve recognition of delirium

Fig 3. Review of medical records/clinical assessment relating to delirium recognition

Learning and next steps

Given the timeframe and the ambition to develop new QI skills it was too ambitious and complex to work in several areas on several different steps in the process (identification and management). Focusing on identification in a smaller area allowed better exploration of the potential changes. Spread to other areas will be done if the change is successful. Education and training development for delirium will be informed by this improvement work. The QI approach will be carried forward by the project nurse.