Establishing the benefit of a multifactorial intervention on prevention, recognition and management of delirium in acute care

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Delirium

Most common complication for hospitalised older adults

Medical emergency with significant clinical burden

Poorly managed in acute care

Education reduces incidence, improves awareness and outcomes
What is Delirium?

A condition with rapid onset of symptoms, disturbances in attention, changes in cognition/perceptual disturbances, fluctuating during the day, not better explained by pre-existing disorders, with evidence of external causes.

(APA, 2013)
Who is most at risk?

- Severe illness
- Previous delirium
- Age > 65
- Surgery/trauma
- IV / IDC
- Hip #
- Frailty
- Cognitive impairment
Consequences to patient/family

• Adverse cognitive and functional decline
  – not always reversible
  – traumatic experience

• ↑ institutionalisation
  – more likely to enter residential care

• ↑ mortality

(Davis, 2012; Eeles, 2009; Ethamalingam, 201; Fick, 2013; Givens, 2009; Gonzalez, 2009; Inouye, 2006; MacLullich, 2009; Saxena, 2009; Tan, 2015; Travers, 2013; Tsai, 2012; Witlox, 2010)
Consequences to health system

• ↑ Length of stay (4 - 10 days longer)
  – deconditioning
  – iatrogenesis

• ↑ readmission rates

• ↑ health expenditure

(Davis, 2012; Eeles, 2009; Ethamalingam, 201; Fick, 2013; Givens, 2009; Gonzalez, 2009; Inouye, 2006; MacLullich, 2009; Saxena, 2009; Tan, 2015; Travers, 2013; Tsai, 2012; Witlox, 2010)
WDHB Delirium Stats

• Delirium prevalence 14.8%

• Increased mortality at 6 months - 39% (20%)

• Increased risk of institutionalisation - 66% (13%)

• LOS ~ 4 days more

(Tan, A. H & Scott, J. 2015)
**Waitemata demographics**

<table>
<thead>
<tr>
<th>Year</th>
<th>Older adults &gt;65</th>
<th>Older adults 85+</th>
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<tbody>
<tr>
<td>2006</td>
<td>55,100</td>
<td>5,979</td>
</tr>
<tr>
<td>2011</td>
<td>66,125</td>
<td>8,600</td>
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<tr>
<td>2026</td>
<td>115,000</td>
<td>15,530</td>
</tr>
</tbody>
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(WDHB, 2009; 2011)
Project rationale

• Research suggests poor prevention, recognition and management in acute care

• Educational programmes can improve outcomes.

(NICE, 2010; HIS, 2014; Inouye, 2006; Vidan et al., 2009)
Intervention

- Interdisciplinary
- Upskilling of educators/clinical coaches
- Roadshow, posters, quiz
- Workbook, teaching sessions, flowchart, lanyard cards
- Bedside support
- Pre/post blind audit - validated tool – statistically significant numbers
% of Patients Risk Assessed for Delirium

On presentation

- Pre n=163
- Post n=184

Within 24 hours

CAM

- Pre n=163
- Post n=184
More Questions than Answers

• What does this snapshot indicate?

• Are these issues bigger than delirium alone?

• Is this solely a nursing issue?

• As CNSs are we able to influence significant culture change?
“Care needs to be just as important as treatment. Older people should be properly valued and listened to, and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care”

(Dept. of Health, UK, 2012; UK Government response to Francis Report)
Recommendations

• Getting care right for older adults

• Embed best practice systematically

• Nurse led change process

• Workforce engagement
Recommendations

• Link with “First Do No Harm”? Northern region priority
• PiMS alert
• Organisational support/leadership/culture change
• Organisational quality and safety outcome
• Demonstration ward/resources
• Update local delirium policy
• Undergraduate education?
Recommendations

- Education – incentives/levers
- Sustained front door education programme
- Interdisciplinary case review process
- E learning tool – annual update
- Patient experience
- Nursing competencies
- Champions
- Delirium education for HCAs
Where we are at?

• Steering group DON, HOD, GNSs
  – Care pathway for older adults
  – Age-friendly hospital
  – Policy update
• Liaison with TrendCare
• Front door delirium drive
• Reaudit planned for 6 months
Questions?
References


References

References