The Delirium and Dementia Outreach Team

Phillip Hall Senior Nurse Dementia

Ruby Guild Delirium Outreach Nurse

Heart of England Foundation NHS Trust

G1
G1

The team;

1 x Band 7 RMN

2.5 x Band 5 Nurses

5 x Band 2 Health Care Assistants

Remit; to improve the outcomes and experience and reduce length of stay for patients with dementia admitted to Solihull Hospital

Why delirium?

Problem 1 – Under recognition

- 10% - 20% of patients admitted to the acute hospital have delirium
- 10% - 30% of patients develop delirium during their admission

Outside of a handful of interested practitioners recognition was negligible. Some improvement but still low on the Solihull site

Acute confusional state

‘off legs’

Worsening dementia

Acute on chronic

Acopia

Poor food and fluid intake

4AT tool (circle score in each section on right and total score)		Circle
Alertness: this includes patients who are markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient if asleep, attempt to wake. Ask patient to state name and address to assist rating.	Normal (fully alert, but not agitated, throughout assessment) Mild sleepiness for <10 secs after waking then normal Clearly abnormal	0 0 4
AMT4 (age, D.O.B, place (hospital), current year)	No mistakes 1 mistake ≥2 mistakes/untestable	0 1 2
Attention: Ask the patient: "please tell me the months of the year in backwards order, starting at December."	Achieves 7 months or more correctly Starts but scores <7 months/refuses to start Untestable (cannot start because unwell, drowsy, inattentive)	0 1 2
Acute change or fluctuating course: Evidence of significant change or fluctuation in alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24 hours.	No Yes	0 4
	Total	

Problem 2 – Poor understanding of risk factors and causes

Dementia

Old age

Sensory difficulties

Immobility

Inactivity

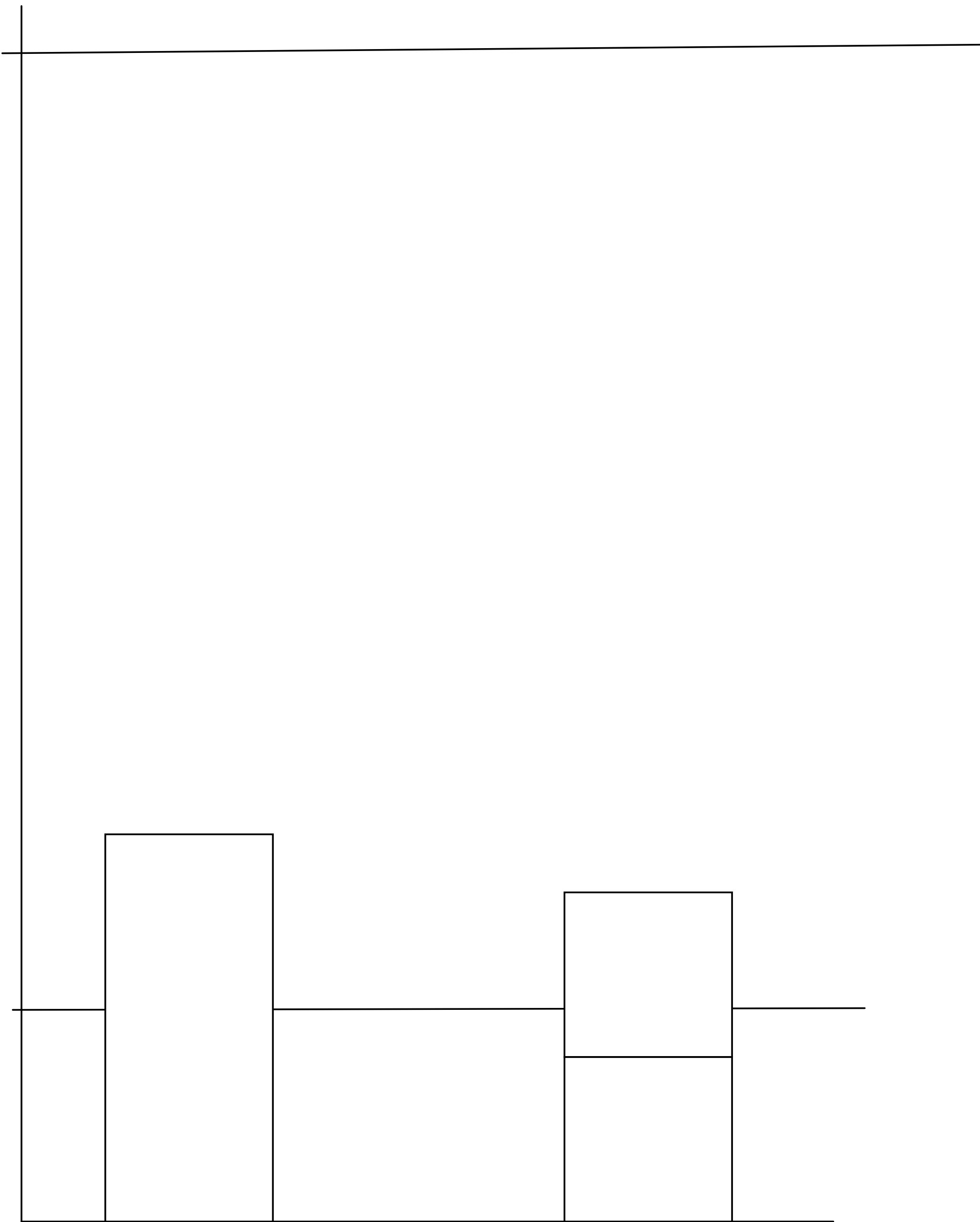
Poor sleep

Emotional disturbance

Dehydration

Malnutrition

Pain Infection Constipation Hypoxia Medication Electrolytes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Constipation
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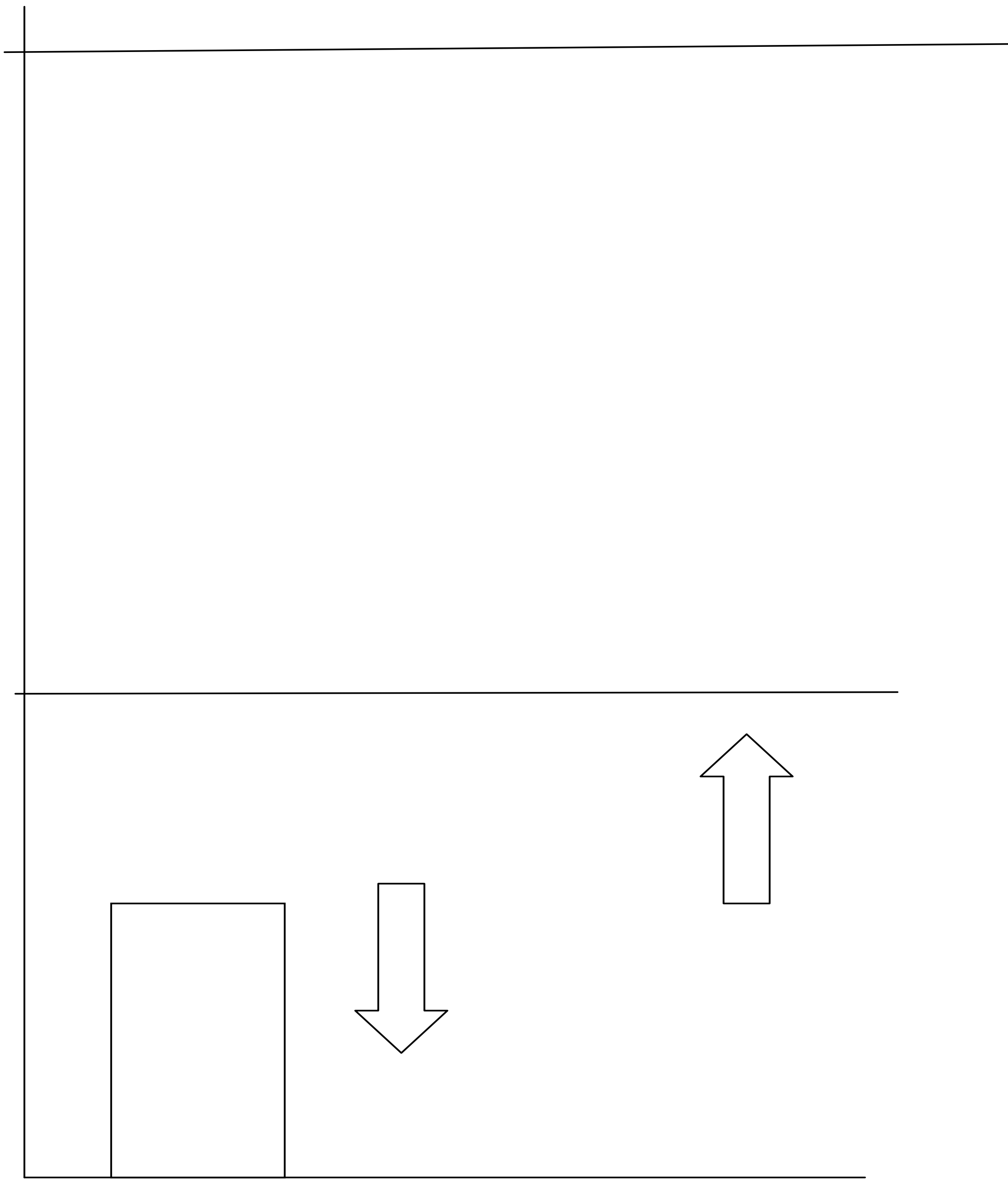
Medication
Electrolytes

Problem 3 – Failure to prevent delirium

Between 30% and 50% of new cases in the acute hospital are preventable if optimal care is provided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DON'T
WALK
PAST
CLEAN
HANDS
ONLY
TAKE A
MINUTE
NHS
National Patient
Safety Agency
Purell
Automatic
fire door
keep clear
Automatic
fire door
keep clear

Problem 4 – Discharge

‘Not safe to go home’

vs

Not safe to stay here

Case study - Delirium

Mrs Smith

- Diagnosis of AD, lives with husband, no POC
- Goes to GP with increased confusion, new agitation and disturbed sleep
- In AMU nothing concerning on vital signs, bloods or CT head so 'MSFD' and 'social admission'
- On ward very distressed, RMN 'special' booked, has stat dose IM Lorazepam at night

- Next morning seen by DDOT nurse, 4AT of 12
- PInCH ME assessment completed
- History gathered and baseline established
- Treated for constipation
- LOS 17 days, 6 requiring 1:1 care

Mr Jones

- End stages VD, lives in NH, puree diet, syrup fluids, hoist transfer, all care, no verbal communication
- GP referral for suspected aspirational pneumonia
- In AMU CAP is diagnosed, prescribed IVI and IVABX

- Admitted to respiratory ward, NG tube inserted but not tolerated, IV therapy continues
- Seen by DDOT, family contacted and baseline established. No LPA or advance care planning in place
- Ceiling of care established
- LOS 11 days, died before discharge date confirmed

What we are doing;

- Dementia Outreach Nurse virtual ward
- PREVENTS volunteers
- Early supported discharge
- Program of education

THINK DELIRIUM

Any questions?

Any advice??