Quality Improvement Programme

Wythenshawe Hospital

Delirium Screening

Round 3 National Audit of Dementia

- Problem – low percentage of delirium screening conducted on admission
- No actual formal screening process

What were we trying to achieve

- Introduce a delirium screening tool
- Increase numbers of patients assessed for delirium admitted to our hospital

What needed to happen

- Which assessment to use ? SQID, CAM, 4AT
- Identify patient parameters. ? All patients ? All patients over a specified age?
- Where to place assessment. ? Paper based ? Electronic based?
- Where to place assessment? Nursing led ? Medical led
- When ? On admission ? First clinical contact ? Admission to treating ward?

Which assessment to use?

- Decided to use SQID. This was as a result of presentations at National Workshops following Round 3 of the NAD. Decided on 'modified' SQID as this ensures assessment considers HYPO as well as HYPER delirium.
- SQID – Is the patient more confused than before?
- 'Modified SQID' – Is the person more confused or more drowsy than usual?

Identify patient parameters

- Decision taken to screen all patients over 18 on an understanding that Delirium doesn't just affect those people with dementia
- NICE guidelines recommend increase risk of delirium in
  - +65
  - Cognitive Impairment and/or dementia
  - Current Hip Fracture
  - Severe Illness

Where to place assessment

- Electronic Patient Records – introduction of EPR in trust coincided with QIP delirium work post round 3. SQID added to EPR with plans to add 4AT supported by Delirium pathway and guidelines in the future.
- Placed on Nursing Risk Admission Assessment as this allowed immediate electronic based assessment. Medical records to remain paper based and not to be transferred to EPR until future date.
- Delirium screening also placed on On-going nursing assessment to acknowledge the potential for developing a delirium during hospital admission

Issues and future considerations

- Work soon to be finalised to introduce 4AT on EPR
- Guidelines and pathway with delirium information leaflet due to be launched once ratified
- Currently a nursing led assessment – ideally should be all staff at initial contact and as part of going assessment, care and treatment
- Teaching and education required to ensure use of delirium screening is meaningful and across all staff groups

Use of Symbols

- Staff identified usefulness of separate Icon to identify delirium
- White Forget Me Not now used both on EPR and as magnet for use by bedside to identify delirium diagnosis.

Contact Details

Email:

Eleanor.Ford@mft.nhs.uk

Twitter:

https://twitter.com/DementiaWtwa

Phone:

0161 291 5223