North Derbyshire Delirium Pathway:
Early Supported Discharge and Recovery Programme

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Introduction

- Delirium is used to describe an acute confusional state with features of fluctuating cognition and inattention. Patients most at risk of developing a delirium are those with a known diagnosis of dementia or chronic impairment (NICE Guidance CG103, 2010).

- Delirium can be caused by any inter-current medical illness such as infection, heart attack, stroke or pulmonary embolus (NICE Guidance CG103, 2010).

- This condition can develop whilst a patient is in hospital secondary due to a change in that person's environment and disruption to routine with no other medical cause identified (Fong TG, Tulebaev SR, Inouye SK, 2009)

- **We have developed a comprehensive delirium pathway for use in all health and social care settings within North Derbyshire in order to promote better management and outcomes for this serious and under-recognised condition.**

- It includes a delirium guideline and education programme as well as a Delirium Early Supported Discharge and Recovery Programme similar to the West Hertfordshire model.

Aims of the Delirium ESDR Programme

- Current literature describes an average length of hospital stay of around 19 days for patients with delirium (McCusker J, Cole M, Abrahamowicz M, Primeau F, Belzile E, 2002).

- The programme identifies patients in the acute setting that have potentially reversible components of confusion and treats them appropriately. The programme enables the patient to be discharged safely back to their own property sooner than they might otherwise have been.

The aims are to:

To provide cost effective, holistic person centred care across organisational boundaries;

To allow early supportive discharge back home to support active physical and cognitive recovery in a familiar environment;

To reduce the risk of hospital acquired harm and deconditioning from the increased length of hospital stay associated with delirium.

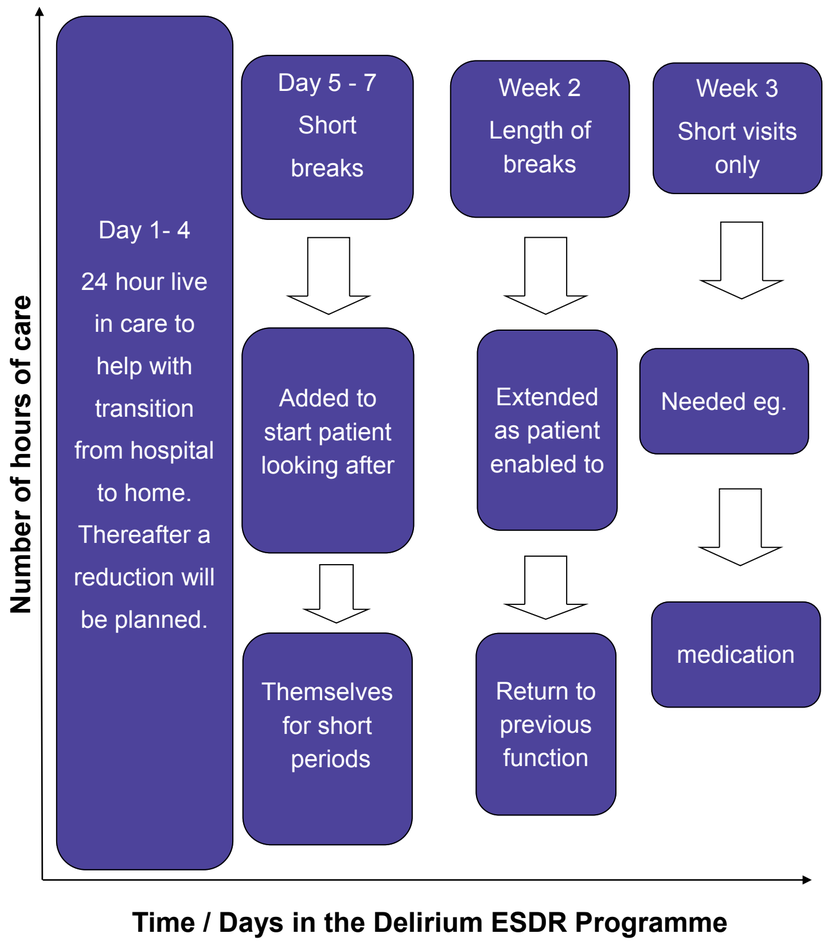
To reduce the risk of early hospital readmission post discharge as delirium settles;

To promote parity of esteem for a vulnerable group of patients.

What does the Programme involve?

1) The patient is identified by a therapist, consultant physician and psychiatrist as suitable (i.e. has a reversible component to their confusion.
2) The Occupational therapist writes a tailored care plan based on the patient's normal daily routine.
3) Family Discharge Planning Meeting with Multidisciplinary Team.
4) On discharge, the 24 hour live in carer or 12 hour day care at home will be provided on discharge for up to a maximum of 2 weeks.
5) The live in carer is legally required to have 3 hours per day covered either by family or care agency.
6) During the 2 weeks the OT and social worker will review the patients progress and start to reduce the level of support provided by the carer.
7) The aim is by the end of the 2 weeks, the care support will look like a package of care that social service with provide.

Example of the care support over the 3 weeks on the Delirium Recovery Programme



The Role of the Family

- The key contact times for families to discuss care with the professionals will be at the review meeting.

- It is not anticipated that the family should provide any more support than they would normally provide the person and should visit as they normally would.

The Role of the Carer

- The carer in the home is there to **enable** the person to get back to their previous activities and level of function - **not to do it for them.**

- The carer is the 'eyes and ears' of the hospital medical/ therapy and social work team and will report back daily on progress.

- The carer is **not** the decision maker about ongoing care needs.

- The carers document all events over the time period that they are with the person.

- For repeat prescriptions the carer should contact the person's GP. We will send the person home with two week's worth of medication.

- Medical issues will be resolved at the medical review.

- If the person becomes acutely unwell the live in carer should call an ambulance.

Acknowledgements

Our work builds on that already done by Drs Angel and Mandell and OT Gemma Holland with their Delirium Recovery Programme in West Hertfordshire -http://www.rcpsych.ac.uk/pdf/RAID%20Delirium%20Recovery%20programme2.pdf

References

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