Developing a structured approach to early recognition and management of delirium

Highland Quality Approach

NHS Highland

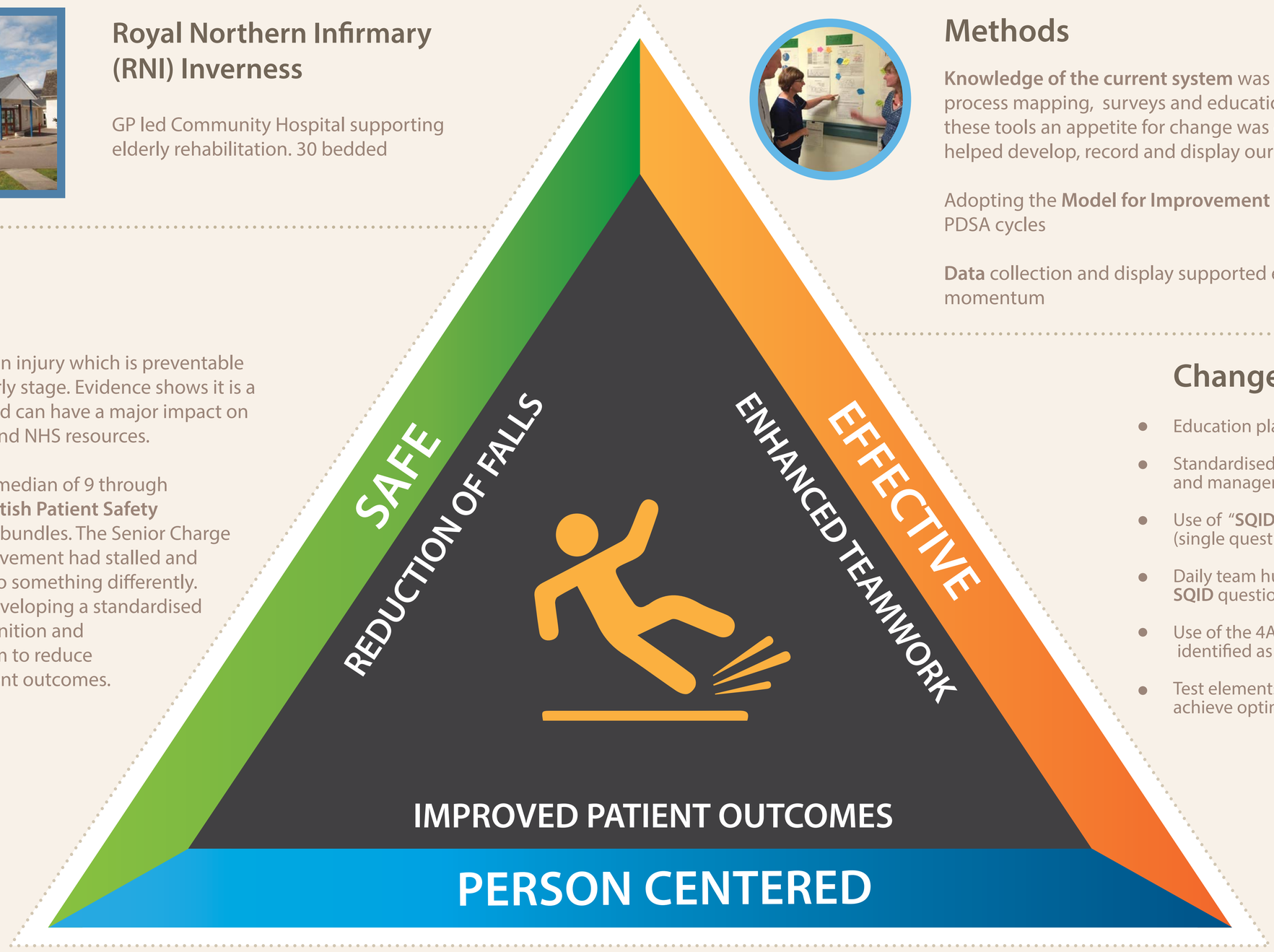
Royal Northern Infirmary (RNI) Inverness

GP led Community Hospital supporting elderly rehabilitation. 30 bedded

Aim

Delirium is an acute brain injury which is preventable and detectable at an early stage. Evidence shows it is a high indicator of falls and can have a major impact on patients, their families and NHS resources.

Falls were reduced to a median of 9 through introduction of the **Scottish Patient Safety Programme** (SPSP) falls bundles. The Senior Charge Nurse recognised improvement had stalled and identified the need to do something differently. The team focused on developing a standardised approach to early recognition and management of delirium to reduce harm and improve patient outcomes.



Methods

Knowledge of the current system was generated through use of process mapping, surveys and education discussions. Through use of these tools an appetite for change was created. A driver diagram helped develop, record and display our vision.

Adopting the **Model for Improvement** changes were tested through PDSA cycles

Data collection and display supported engagement and sustained momentum

Changes

- Education plan.
- Standardised approach to recognition and management of delirium.
- Use of "**SQID**" (single question to identify delirium).
- Daily team huddle - a forum to ask the **SQID** question.
- Use of the 4AT assessment tool on patients identified as **SQID** +ve.
- Test elements of a delirium bundle to achieve optimum management and reliability.

> The daily huddle SQID conversation is key. We share our experiences and learning which facilitates person centred assessment and care.

Staff feelings about recognising and managing delirium

Before

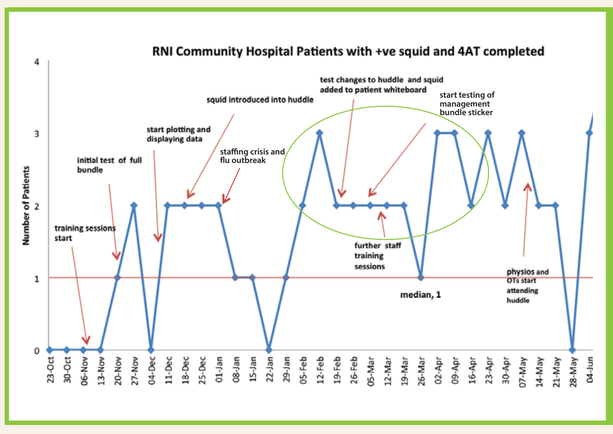
Now

> Because we are recognising and preventing delirium we are not seeing patients with the same levels of confusion and agitation that we used to. The ward is a different place

Results

Data enabled us to understand the problem and be clear about what was making a difference

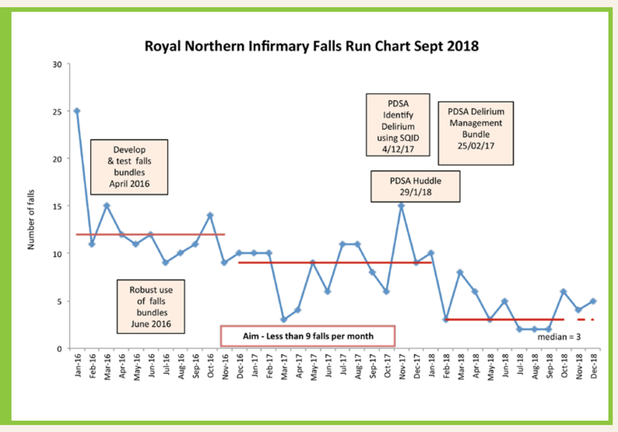
Process Measure



Number of falls reduced from median of 12 to 3 falls per month

58 people identified with potential delirium in the first 6 months of the project

Outcome Measure



Conclusions

Our approach has resulted in a transformational change which supports the journey towards NHS Scotland 2030 Vision

- A standardised process is in place which promotes timely and effective multidiscplinary response
- A culture for ongoing improvement has been generated through staff empowerment and education
- An effective and sustainable model of care has been achieved through use of QI methodology
- Improved patient outcomes have been demonstrated by reduction in falls

By getting delirium care right we can have major impacts on patient and family experience, length of stay in hospital and potential mortality

References

Delirium Toolkit. Health Improvement Scotland. The Improvement Hub. 2019.
Langley et al. The Improvement Guide. 2nd ed. San Francisco: Jossey-Boss Publishers; 2009

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Highland Quality Approach (HQA) Award to RNI Team for Improvements in Reduction of Falls