Delirium in care homes
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Workshop

Aims

- How to detect delirium in care homes?

- What do commissioners want to know about delirium in care homes?
Workshop

Plan
• What do we mean by the term ‘care home’?
• Is delirium common in care homes?
• How do we detect delirium in care homes?
• Preventing delirium
• Commissioning for delirium
What is a care home?
What is a care home?

Statutory definition:
“the provision of residential accommodation, together with nursing or personal care.”
What is a care home?

- No relation between ageing status of a country and number of nursing home beds
- Institutionalisation rates differ
  - organisation and financing
  - responsibility for disabled older people by each sector
  - availability of beds
- Many countries are in the process of health and social care reforms.

_Nursing homes in 10 nations, Ribbe 1997_
What is a care home?

- 3/4 residents receiving nursing care, but distinction between nursing & residential?
- Declining length of stay: < 1 year by 2015
- Increasing people with dementia
- Increasing comorbidity- diabetes, obesity
- 90% high support needs
- “Care homes are moving away from being an alternative form of housing for frail older people towards a location of last resort for individuals with high support needs towards the end of life”

The changing role of care homes, Bupa and Centre for policy on ageing, 2011
How common is delirium?
How common is delirium?

- Reviews
  - 14% point prevalence (Siddiqi & Clegg 2010 Rev in Clin Geront)
  - Prevalence **1.4% to 70%**, depending on diagnostic criteria and on prevalence of dementia (De Lange et al 2013 Int J Ger Psych)

- Dutch nursing homes:
  - Prevalence **8.9%** (8.2% in residential homes). (NH-CAM) (Boorsma et al 2012 Int J Ger Psych)

- Swiss:
  - 39.7% had sub-syndromal and **6.5%** had full delirium on admission to nursing home (NH-CAM) (von Guntena & Mosimann 2010 Swiss Medical Weekly)

- Canada:
  - Prevalence **11.5%** (3.4% MMSE > 10 & 33.3% MMSE < than 10) (McCusker et al 2011 Int J Ger Psych)
How common is delirium?

- Canada:
  - Incidence **2.2 per 100 person-weeks** of follow-up (1.6 MMSE > 10) & 6.9 MMSE > 10) CAM (McCusker et al 2011 Int J Ger Psych)

- Dutch:
  - Incidence **20.7 per 100 person-years** (14.6 in residential homes) RAI (Boorsma et al 2012 Int J Ger Psych)

- US: nursing home patients in Emergency Room:
  - Nursing home residence independently associated with delirium in the ED **OR=4.2** (95% CI=1.8-9.7) (Han et al 2009 JAGS)
How common is delirium?

• PiTSTOP: Pilot Trial of Stop Delirium!
  – Prevalence
  – Incidence
  – per 100 person-months at risk*
  – per 100 person-weeks

• DOSS
  – No episodes of delirium at recruitment
  – per 100 person-months
  – per 100 person-weeks
Is delirium not as prevalent in care homes as we have thought?

OR

Is the seemingly low incidence due to problems with delirium detection?
How can we detect delirium in research studies in care homes?

- Many existing diagnostic tools for the detection of delirium require clinical expertise and training to administer (e.g. CAM, DRS-R-98)
- Research staff can be trained to deliver delirium assessment tools
- Some problems with administration of existing tools in the care home environment
- Requires training (including frequent top-up sessions), regular checks of inter-rater reliability
- Problems with detection delirium in the presence of co-morbidity – e.g. dementia, psychiatric illness, stroke etc.
Problems with delirium detection in care homes

• High prevalence of dementia
  – 2009 BUPA survey: 44% of care home residents have dementia

• Instruments which operationalise the DSM delirium diagnostic criteria (e.g. the CAM) make it difficult to distinguish delirium from dementia
  – Features such as fluctuation, disorganised thinking, incoherent speech are common

• Many care home residents have significant communication problems (e.g. post-stroke, severe dementia)

• This makes detection of delirium difficult in a subgroup particularly at risk of developing delirium

• Researchers may be reluctant to interview residents who are unwell / sleepy

• Time taken to perform assessments
How can we identify delirium on dementia in care homes?
• Detection of sudden onset of change (in behaviour or cognition) from baseline seems particularly key to diagnosis

• Detection relies on care home staff identifying (and recording) these changes – and researchers having a conversation with the care home staff
How do we detect delirium in routine care?

- Routine detection of delirium (e.g. by care home staff) is tricky
- Many care home staff have experience of residents with delirium
  - They are just unlikely to call it delirium (e.g. UTI)
- Behavioural changes in unwell residents are well recognised by care home staff
- Fluctuations in behaviour are often felt to be normal variation for individual residents
Preventing delirium in care homes

NICE 2010 delirium guideline:
• Assess for risk factors for delirium
• Implement multicomponent interventions to prevent delirium
• Includes long-term care setting
• Based on extrapolating cost-effectiveness from hospital settings
Stop Delirium!
Commissioning for delirium
Commissioning

- “is the process of specifying, securing and monitoring services to meet people’s needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the private and voluntary sectors.” (Audit Commission 2009,

- **Procurement**: “the process of acquiring goods, services and construction projects from providers/suppliers and managing these through to the end of the contract or disposal of assets. Plus the overarching activities that corporately maximise effectiveness, efficiency and value for money from this process.”
Commissioning

- Assumes a purchase / provision split, (not unique to UK).
- Invest to save and value for money principles, centered on the person
- **Statutory Health & Social Care** – legislatively different systems differently funded through a combination of national taxation (NHS) and local (council) taxes and budget setting. (UK)
- **Barker Commission (2014)** - Increasing moves to integration at all levels, (e.g. Health & Well Being Boards, Better Care Fund, Pooled Budgets, Section 75 agreements)
- **Plurality of providers** (independent, third sector, charities and not-for profit).
- Regulatory / operational influence but not primary regulatory mechanism (CQC)
- **Cyclical process** not a ‘one off’ – typically 3-5 years.
- **Single Integrated Commissioning** mechanism favoured going forward, (from 2017)
Kings Fund (2015)

Figure 1: Arrangements currently in place for jointly commissioning services between the local authority and CCG.
Figure 11: Who should carry out the role of a single local commissioner?
What Influences Commissioning?

Tends to be organised across larger population groups or function rather than clinical populations

- Demand
- Legislation and Statutory Duty
- Policy and guidance
- Regulation
- Population needs (Joint Strategic Needs Assessments)
- Market provision – availability, quality, cost
- Budgetary position / expectation
- Customer / public expectation / rights
- Benchmarking, PI’s, Service Specification & contract fulfilment
- Cost, Quality and performance against outcomes
Challenges

- Reorganisation & transition
- Competing priorities
- Finite budgets / need to realise savings
- Limited freedom to fund all but essential aspects of service
- Maturity / immaturity of commissioning arrangements
- Limited evidence of what works to inform process
- Variability in care home market (price, quality, availability, type)
- Provider behaviour
- Recruitment & retention of staff; minimum wages, sufficient quality provision within price
- Acuity and chronicity increasing within sector population
- Care Homes commissioned for different types of care:
  (Eg Respite, PoPs, Rehabilitation, Admission Avoidance, Services of Last Resort).
Making a Case

- Epidemiology, prevalence data & presentation of need.
- Economic arguments – invest to save, cost benefit / VFM studies.
- Business case – specificity of improved outcomes at micro level in addition to broader organisational and strategic objectives.
- Principles of Care Act (2014) “Prevent, delay, reduce”
- Promote innovation, quality & efficiency (CQUIN, QOF)
- Co-production and collaboration between providers / commissioners
- Service models which manage demand and improve clinical and financial outcomes: pilot studies; incremental changes
- Representation to decision-makers; evidence, policy – provider executive teams, local boards; fora and service user / carer groups.
Commissioning – a closing thought:

“In God we trust .......... everyone else has to supply data”