

# Microteaching to improve delirium screening and recognition in older surgical patients

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## Background:

Delirium is a common but serious complication in older surgical patients, associated with increased morbidity and mortality, prolonged length of stay and poorer long-term outcomes. The diagnosis and documentation of delirium is important for coding, handover of care and for helping patients and families understand their symptoms. Anecdotally, patients at risk of delirium do not always have risk factors identified and documented on admission and those with delirium do not always have the diagnoses documented in their medical notes or discharge summary.

**Aims:** to improve care of older patients admitted under general surgery by

1. Raising awareness and understanding of delirium through education of the surgical MDT.
2. Improving identification and management of delirium and its risk factors.
3. Improving documentation and communication of delirium diagnosis.

**Objectives:**

1. All delirium **risk factors** identified and documented in first 24 hours.
2. All suspected or confirmed delirium **diagnoses** documented in notes.
3. All delirium diagnoses documented on **discharge summary**.

**Methods:**

Clinical notes of patients aged  $\geq 65$  discharged from general surgery in January 2025 (n = 38) were audited for screening, identification and documentation of delirium and its risk factors. A teaching session on delirium was delivered by a Geriatrics registrar to resident doctors in general surgery, and posters summarising features of delirium were displayed on the ward at notes stations and in the doctors' office. Patient notes from July 2025 (n = 46) were then audited.

**Results & Impact:** Simple interventions such as microteaching and posters improved delirium identification (from 6.7% to 34.6%), diagnosis documentation (from 10% to 19.2%) and inclusion on discharge summary (from 33.3% to 40%) between January and July 2025.

We also observed that the use of formal delirium screening tools (such as the 4AT) and the practice of consenting for delirium as a postoperative complication are areas for improvement.

**Limitations:** We have no way of knowing the true incidence of delirium in each patient group, so we assume that it remained stable from one cycle to another.

**Next steps:**

1. 3rd PDSA cycle currently underway, involving delivering teaching to wider MDT including nurses, OT, physio and HCAs.
2. We could expand data collection to evaluate consenting for delirium as a perioperative complication.

## Delirium



NICE Guidelines

### PDSA Cycle 1

Developed **15 min** teaching session on delirium for resident doctors in general surgery.

Teaching delivered as part of **weekly departmental teaching** programme, mid-rotation.

### PDSA Cycle 2

Teaching session repeated but delivered **earlier in rotation**.

**Poster\*** created and displayed in doctors' office and on wards (aimed at whole MDT).

### PDSA Cycle 3

Teaching session incorporated into **surgical induction programme** for foundation doctors.

Posters remain in place currently.

Plan for ward based MDT teaching

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Is your patient drowsy or confused?

**Think Delirium!**

Delirium affects up to **50% of all hospital inpatients** over 65  
Emergency surgery carries a 20-45% risk of delirium

**Associated with...**  
Longer hospital stay  
10 x increased mortality  
Higher healthcare costs  
Worse long-term recovery

It is also **distressing**  
for patients and  
their loved ones

**Delirium is treatable and reversible!**  
**The earlier it's spotted, the better the outcome.**

People at higher risk of delirium include those with dementia, hearing or visual impairment, and frailty

**Signs of delirium appear over hours to days:**  
• Impaired concentration/ slowed thinking  
• Communication difficulties  
• Fluctuating alertness  
• Change in mood, sleep or appetite  
• Altered perception e.g. hallucinations

Are they...  
HypERactive (restless)  
or  
HypOactive (drowsy)?

**Ask the question:**

Are they behaving differently or more confused than usual?

**Delirium: spot it, name it, treat it early**

For more info about delirium and our quality improvement work on surgical wards, contact  
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