Diagnosing Delirium on the Care of the Elderly Ward

A Quality Improvement Project

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Background:

Delirium is a severe neuro-psychiatric syndrome that has the triple threat of **high incidence**, being significantly **under-recognised,** and having a **substantial impact** on both **morbidity** and **mortality**.

Delirium is associated with **increased length of stay** and **institutionalisation** at discharge. Inpatient mortality rates for patients with delirium have approached up to 40% in some studies. Moreover, following discharge from hospital, delirium is associated with increased mortality (20% increased mortality at 3/12, 50% increased mortality at 1 year) and both **increased rates of dementia** and **accelerated decline in cognitive function.**

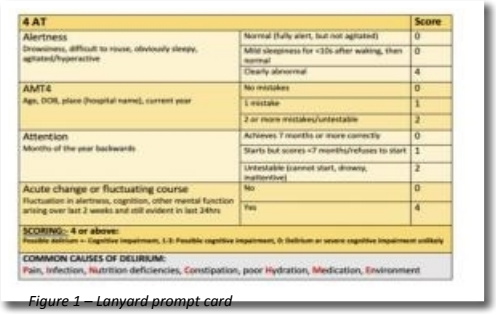
Nice Guidance (Jan 2023) advises **assessment of all inpatients for delirium at presentation** with assessment of risk factors and observation for evidence of delirium with particular attention to be paid to high risk patients.

Aim:

The aim of this project was to ensure **100%** of patients on Geriatric wards have a diagnosis of delirium considered via the 4AT as per NICE guidelines.

Methodology:

A Plan-Do-Study-Act methodology was utilised with an initial audit exploring identification and documentation of delirium diagnosis.
A Lanyard Prompt Card was then distributed to all physicians with the 4AT score illustrated. A departmental teaching session about Delirium was delivered to all juniors.



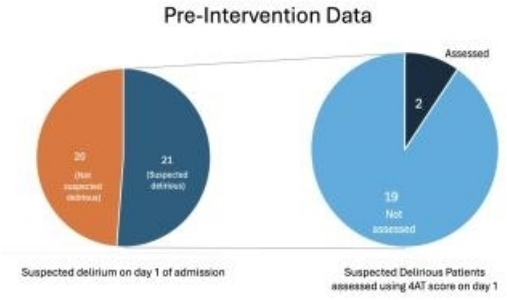
4 AT		Score
Alertness Drowsiness, difficult to rouse, obviously sleepy, agitated/hyperactive	Normal (fully alert, but not agitated)	0
	Mild sleepiness for <10s after waking, then normal	0
	Clearly abnormal	4
AMT4 Age, DOB, place (hospital name), current year	No mistakes	0
	1 mistake	1
	2 or more mistakes/untestable	2
Attention Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores <7 months/refuses to start	1
	Untestable (cannot start, drowsy, inattentive)	2
Acute change or fluctuating course Fluctuation in alertness, cognition, other mental function arising over last 2 weeks and still evident in last 24hrs	No	0
	Yes	4
SCORING: 4 or above: Possible delirium + cognitive impairment, 1-3: Possible cognitive impairment, 0: Delirium or severe cognitive impairment unlikely		
COMMON CAUSES OF DELIRIUM: Pain, Infection, Nutrition deficiencies, Constipation, poor Hydration, Medication, Environment		

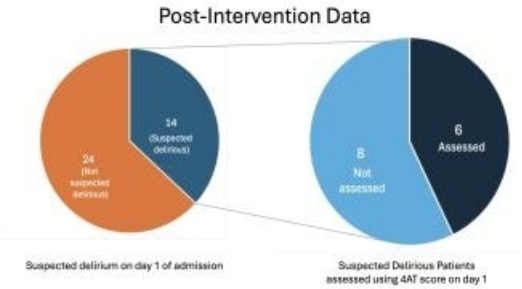
Figure 1 – Lanyard prompt card

Results:

Of the **41 patients** evaluated initially, **50.7% (21)** were suspected to be delirious. Of these, **9.5% (2)** had been assessed for delirium on the same day delirium was suspected.

Post-intervention audit revealed out of **38 patients**, **36% (14)** were suspected to be delirious and of these patients, **43% (6)** had a 4AT score on the same day.





Conclusion:

This project revealed 4AT assessments were **approximately tripled** in patients suspected to be delirious post-interventions.

There **remains scope for improvement** in confidence and skill of documenting assessments to meet the NICE recommendations and **potential to explore barriers.**

Ultimately, we aim to **expand across all medical and surgical wards** to upskill all MDT members on identification and management of delirium.