with you, for you

QUALITY IMPROVEMENT PROJECT

INTRODUCTION OF A NATIONALLY RECOGNISED DELIRIUM SCREENING TOOL THE 4AT, IN ORDER TO INCREASE EARLY DELIRIUM IDENTIFICATION BY 75% WITHIN 6-MONTHS, THUS IMPROVING DELIRIUM MANAGEMENT, CARE AND EXPERIENCE FOR ELDERLY PATIENTS IN A COMMUNTY HOSPITAL SETTING.

NHS Gloucestershire Health and Care NHS Foundation Trust

NICE Guidance Updated 2023

'If indicators of delirium are identified, a health or social care practitioner who is competent to do so should carry out an assessment using the 4AT'

The 4AT is a short delirium assessment tool designed for routine use without specialist training. The 4AT comprises of four items: **Alertness. Abbreviated Mental Test, Attention** (months cited backward test) and **Acute change or fluctuating course**. It has a score range of 0-12, with a score of ≥4 or more highlighting possible delirium.

WHY DELIRIUM?

WHAT IS DELIRIUM?
Delirium is a common clinical syndrome involving disturbances in cognitive function, perception, attention and consciousness. Delirium may have fluctuating course and develop over hours or days.

COMMON TRIGGERS: PINCHMES
Pain, **I**nfection, **N**utrition, **C**onstipation, **H**ydration, **M**edications, **E**nvironment, **S**urgery / **S**leep (or a combination of causes).

PREVALENCE:
The prevalence of delirium for patients on medical wards varies between 15% and 30%.

RISKS FROM DELIRIUM:
Increased length of stay
Increased incidence of dementia
Increased hospital-acquired complications (such as falls, dehydration and pressure sores).
Increased incidence of being admitted to long-term care,
Increased risk of dying
Distress for patient and family /carers

BENEFITS OF EARLY DETECTION:
Generating investigations into potential causes of delirium.
Initiating treatment.
Reducing associated risks.
Recognising and addressing distress.
Informing patients and carers of the diagnosis.

EASY WINS

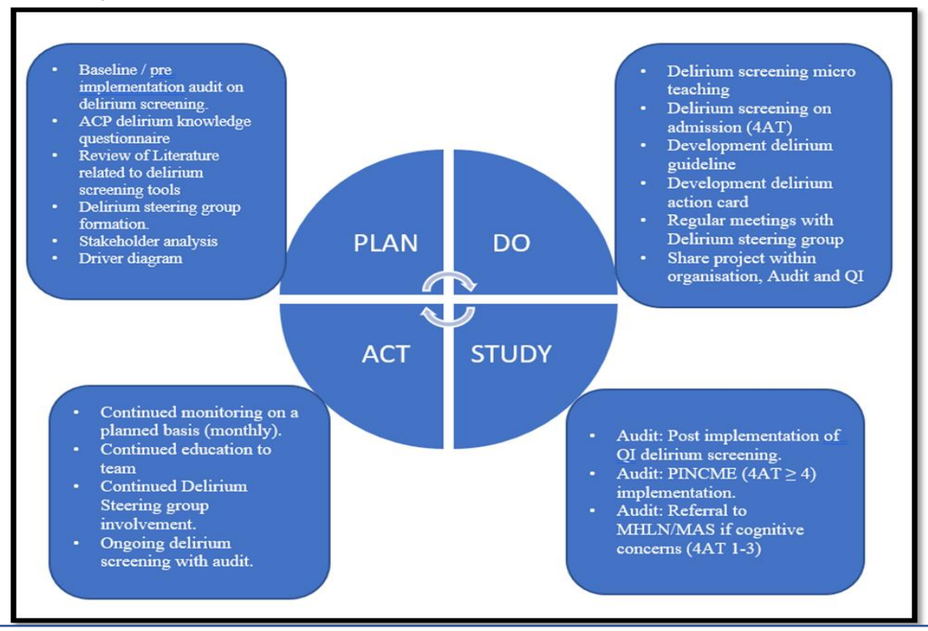
* Undertake 4AT on all admissions (End of Life patients exempt) and record in electronic notes
* If score ≥4 or more suggests possible delirium, please implement PINCHME care plan and discuss with MHLN.
* If score 1-3 and NOT known dementia = possible cognitive decline, consider discussion / referral to MHLN or MAS on discharge.

METHODOLOGY

What are we trying to Acomplish?
- The implementation of a nationally recognised delirium screening tool the 4AT, in order to increase early delirium identification by 75% within a 6-month time period'.

How will we knonw that a change is an improvement ?
- Monitor Measures through audit cycles including:
- Percentage of patients screened for delirium using the 4AT.
- If 4AT score ≥4 was a PINCHME care plan commenced
- Increased staff confidence and awareness identifying delirium using 4AT screening tool.

what changes can we make that will result in an improvement?
- Introduction of 4AT delirium screening tool.
- Education / micro teach sessions for staff.
- Produce a delirium Clinical Guideline.
- Develop a community hospital specific delirium action card / flow chart.
- Embed screening tool in local computer system

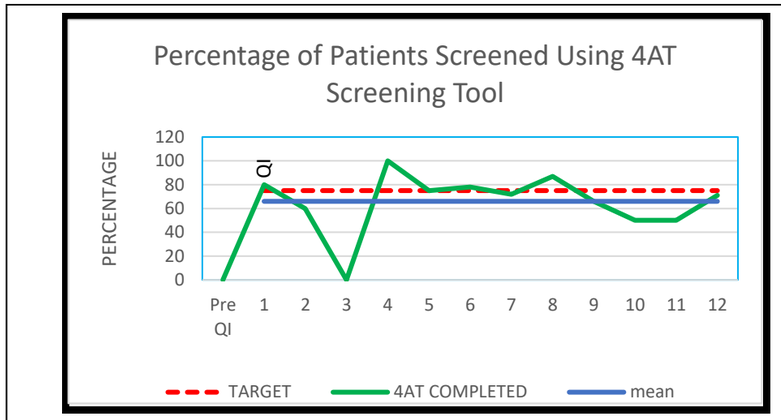


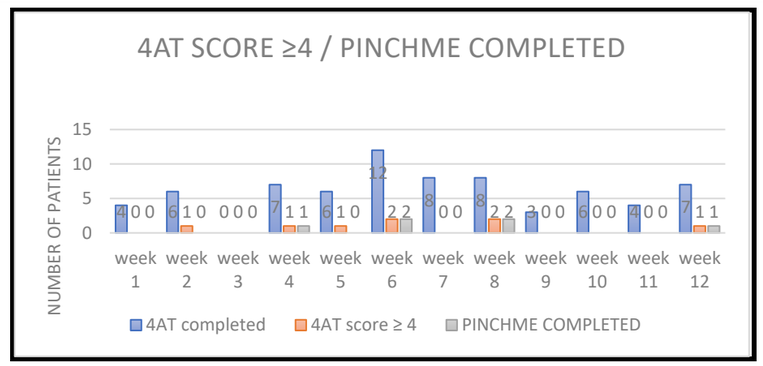
RESULTS AT TWELVE WEEKS

A positive increase in 4AT screening from 0% to a mean of 66% in 12 weeks.

A 4AT score ≥4 identifying incidence of delirium = 13% (n=61), in line with national average.

A positive improvement with PINCHME care plan introduced if 4AT score ≥4 = 75%





WHAT NEXT?

- Continue data collection / analysis
- Explore feasibility of embedding 4AT as a mandatory assessment within electronic clerking notes proforma.
- Continued development of Delirium Guideline.
- Continued development of delirium Action Cards.
- Share QI / Data with wider organisation
- Consider feasibility of extending 4AT assessment to other community hospitals within organisation.

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