AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Consultation Report

Draft Delirium Clinical Care Standard

Clinical Care Standards

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Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) was created by Health Ministers in 2006 to lead and coordinate health care safety and quality improvements in Australia. *The National Health Reform Act 2011* established the Commission as an independent, statutory authority. It specifies that the Commission will formulate and monitor safety and quality standards and work with clinicians to identify best practice clinical care.

The *National Health Reform Agreement 2011* identifies that the Commission will work with clinicians to develop clinical standards for ensuring the appropriateness of care for people with specific clinical conditions, and that the Commission will recommend to Health Ministers the clinical standards suitable for implementation as national clinical standards.

The Commission has been working with consumers, clinicians, health managers and researchers to develop the Delirium Clinical Care Standard. It complements the Commission's Cognitive Impairment Program, *A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital (2014),* and builds on existing state and territory-based initiatives, such as the *Confused hospitalised older persons program* (NSW*), Best care for older people everywhere toolkit* (Victoria), and the *Delirium model of care* (WA).

This report provides a summary of consultation findings regarding the draft Delirium Clinical Care Standard.

About the consultation

The public consultation period ran from 25 May 2015 to 3 July 2015. A total of 203 responses were received by the Commission as part of this consultation process.

Consultation documents for this Clinical Care Standard are described below.

Draft Delirium Clinical Care Standard –This document outlines key components of care that a person with suspected delirium or at risk of developing delirium should receive from presentation to hospital through to transition to primary care. It covers screening for cognitive impairment, delirium assessment, putting in place preventive measures, identifying and treating underlying causes, preventing falls and pressure injuries, minimising use of antipsychotic medicines and transition from hospital care.

Summary of evidence sources – This document contains the evidence sources used to support the Clinical Care Standard, according to each quality statement.

Draft indicator specification – This document outlines a set of suggested indicators developed to assist with local implementation of this Clinical Care Standard. These indicators can be used by health services to monitor the implementation of the quality statements, and support improvement as needed.

Draft consumer and clinician fact sheets – These documents provide a summary of the quality statements for consumers and clinicians.

The purpose of the consultation process was to determine if the draft Clinical Care Standard covered key components of care, to assess the relevance of suggested indicators and fact sheets, and to identify potential enablers and barriers regarding the use of the Clinical Care Standard.

Stakeholders across Australia were contacted by post and requested to submit feedback on the draft Clinical Care Standard. The consultation was also promoted via the Commission's website, Twitter account, *On the Radar weekly* publication and email bulletin. Members of the Delirium Topic Working Group also promoted this consultation.

Those contacted included medical colleges, organisations, state health departments, local hospital networks/local health districts, Primary Health Networks, consumer groups and private sector organisations. Feedback was received by either written response or online survey from a cross-section of these stakeholders.

The following sections of the report provide a summary of the consultation process and responses.

Consultation process

Consultation questions

The Commission asked stakeholders to respond to the following consultation questions:

1. How well does each quality statement describe the key aspects of care?
2. What factors (barriers) currently prevent the care described in this Clinical Care Standard from being achieved?
3. What factors (enablers) will support the practical application of this Clinical Care Standard?
4. How relevant are the suggested indicators in supporting the local monitoring of the quality statements?
5. What improvements would support data collection for the suggested indicators?
6. Do you have any other comments about this Clinical Care Standard?

Submissions received

A total of 203 responses were received by the Commission during the consultation period. Disregarding those that provided demographic data only without any feedback on the Clinical Care Standard, a total of 141 assessable responses were received: 102 by online survey and 39 by email, letter or at meetings.

A breakdown of the 141 assessable responses is provided below:

Respondent type	Number of assessable responses
Individual	82
Health professional education providers (including Colleges)	12
Jurisdiction [a] (state or territory response)	10
Local hospital network/ Local health district [b]	25
Other organisation: - General - Primary health care - Private health care	 4 1 4
Committee	2
Unknown/not provided	1
Total responses	141

[a] State and territory health departments and/or agencies.
[b] Including public hospitals and other public health services

Assessment of submissions

Submissions were allocated an identification number and classified according to scope of the Clinical Care Standard, quality statement, indicator, consumer fact sheets, language/structure of the document, enablers/barriers, dissemination, and general comments.

Feedback was grouped under themes and then assigned into one of the following categories:

1. Consider now: Comments in this category were those relating to the scope of the Clinical Care Standard and the focus of each quality statement, terminology used, specificity, clarity of language particularly in the 'what it means' section, relevance of the proposed indicators, supporting evidence, and barriers and enablers relating to implementation.

2. Consider in the future: Comments in this category were those suggesting extending the current scope of the Clinical Care Standards (e.g. extending the Clinical Care Standard into the residential aged care settings)

3. No action: Comments in this category expressed agreement and/or support for the Clinical Care Standard. Comments in this category also related to personal experience or suggestions to include background information that was out of scope of a Clinical Care Standard.

Following this assessment, this information was provided to the Delirium Clinical Care Standard Topic Working Group for further refinement of the Clinical Care Standard.

Summary of consultation feedback

Overall, there was strong support for the development of a Clinical Care Standard for delirium. Many respondents expressed appreciation that delirium was being addressed, with concern about the current care of patients with delirium and the growing burden of the condition on the health system.

The Clinical Care Standard appeared to address the main elements of care effectively, with over 80% of respondents to the online survey answering that each quality statement described the key aspects of care well or very well. In general, the quality of the Clinical Care Standard was commended, with positive feedback about the content and structure.

There was support for the composition of the Topic Working Group, although one respondent was critical of the lack of pain management representation.

Below is a summary, although not exhaustive, of the responses received.

Structure and language

Feedback was generally positive about the presentation, layout and structure of the information. Overall, the Clinical Care Standard was commended as being clear and well-written. However, there was mixed opinion about the level of detail in the Clinical Care Standard, with comments ranging from ‘clear and concise’ and ‘quite brief’ through to ‘comprehensive’ and ‘wordy’. The main concerns about language were: consistency of meaning, particularly between the clinician and consumer sections; unclear terminology in parts, such as lack of definition for a ‘change in cognitive function or behaviour’; and the complexity of some terms in the consumer fact sheet.

Both the patient-centred approach and the emphasis on the role of carers were commended. Several improvements to the consumer fact sheet were suggested, which included simplifying the language, improving readability and making the icons more intuitive.

Scope and context

Several suggestions were received to extend the scope to other patient groups and settings. Of these, a strong case was put forward to extend the scope to patients receiving palliative care, who are currently excluded from the scope. The separation of this group of patients was seen as being unnecessary, as their treatment needs are similar to other patients presenting to hospital with delirium or risk factors for delirium.

Other key comments related to scope were: to include screening for post-operative delirium, which is not specifically addressed in any of the quality statements; to include children; and to extend the setting to residential aged care facilities.

There were also suggestions to extend the setting for screening (quality statement 1) to include primary health centres in remote areas, day surgeries, ambulances and pre-admission clinics.

Support for carers, and the communication of delirium risk at clinical handover were highlighted as practice gaps that were missing from the Clinical Care Standard.

Quality statements

Draft quality statement 1: Screening for cognitive impairment

A patient presenting to hospital with one or more risk factors for delirium is screened for cognitive impairment using a validated test

This quality statement generated the most amount of feedback from consultation, which highlighted a number of key themes.

A chief concern was that the role of carers in providing a patient history at the time of patient presentation was missing, and that the quality statement overemphasised the role of screening tools. It was argued that presentation is a critical time for history taking, and that asking about previous delirium or confusion is an important part of assessing a patient's risk of delirium during their hospital stay. Related to these themes, were conflicting views on whether screening for cognitive impairment should be the first step in identifying patients with delirium. Some considered an initial clinical assessment to be more appropriate.

A number of respondents commented on the appropriateness of the four delirium risk factors listed for screening and why others are not included. Related to this theme was criticism that the risk factor, 'severe medical illness' was not defined and may not be feasible to screen for.

Several requests were received for additional examples of cognitive impairment tests to be included in the footnote. Also, despite being labelled as examples only, the tests were seen by some as being those recommended by the Commission, suggesting that further clarification on the suitability of tests was needed.

Feedback was also received on whether screening for cognitive impairment should be 'on admission' rather than 'on presentation', as there was concern that screening for all patients may not be feasible or appropriate in the Emergency Department.

Draft quality statement 2: Assessing for delirium

A patient with cognitive impairment on presentation to hospital, or who has a change in cognitive function or behaviour during a hospital stay is promptly assessed for delirium by a clinician trained and competent in the use of a validated diagnostic tool. The patient and their carer are asked about any changes (within hours or days) they have observed, and the patient's diagnosis is discussed with them and documented.

The main comments included a suggestion to clarify who requires assessment for delirium. There was concern that the statement did not address patients with dementia who have an acute change in cognition or behaviour.

There was also concern that the place of diagnostic tools was overemphasised and that the need for clinical assessment needed to be highlighted.

Draft quality statement 3: Interventions to prevent delirium

A patient at risk of delirium is offered a set of interventions to prevent delirium.

Concern was highlighted about the absence of any information on monitoring patients at risk of delirium once preventative strategies are put in place. In particular, it was suggested that patients are monitored for changes in cognition or behaviour, as well as for clinical deterioration. There were also queries about how frequently patients should be monitored and whether this could be specified.

Several respondents were concerned with the brevity of the statement and suggested specifying the preventative interventions in the statement rather than under the clinician's section. There were also suggestions to include more details about specific interventions, such as medication review and visual and hearing aids.

Quality statement 4: Identifying and treating underlying causes

A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment.

The main feedback was that there should be more detailed information and recommendations on investigations and management. Among these were more information about medication review, nutritional assessment and when to notify a Clinical Nurse Consultant.

There were somewhat conflicting views on whether the assessment should be comprehensive or focused. One respondent suggested seeking a patient summary from the patient's general practitioner to help focus the investigation. However, another respondent argued that delirium can have many causes and suggested highlighting that the investigation should continue even after a potential cause has been identified.

Quality statement 5: Preventing falls and pressure injuries

A patient with delirium is provided with care based on their risk of falls and pressure injuries.

Of key concern was the rationale for limiting this quality statement to falls and pressure injuries rather than other important complications of delirium. Some suggested broadening the quality statement to include functional decline. There was also concern raised about duplication of this quality statement with the Nationals Safety and Quality Health Service Standards. Overall, the feedback suggested that more explanation was required for the focus and intent of this quality statement.

Quality statement 6: Minimising use of antipsychotic medicines

Treatment with an antipsychotic medicine is only considered if a patient with delirium is distressed and the cause of their distress cannot be addressed and non-drug strategies have failed to ease their symptoms.

It was highlighted that antipsychotic medicines may be required for some patients who remain distressed even though causes have been identified and treated.

There were conflicting views about the place of antipsychotics and benzodiazepines in managing distress. Several respondents suggested that benzodiazepines could be used in certain circumstances to reduce agitation.

Another issue of concern was the appropriateness of antipsychotics (in general) or certain antipsychotics for patients with Parkinson's Disease and Lewy Body dementia.

Other themes highlighted from feedback on this quality statement were:

- concern about the lack of specific advice about informed consent and ensuring patients and carers are informed about risks and benefits of antipsychotic medicines
- request for more information on physical restraints and the need to avoid them

- suggestion to include medication review as part of investigating causes for disturbed behaviour
- suggestion to define distress
- suggestion to incorporate need for strategy or protocols on de-escalation and behaviour management.

Quality statement 7: Transition from hospital care

Before a patient with current or resolved delirium leaves hospital; the patient and their carer are involved in the development of an individualised care plan and are provided with information about delirium. The plan describes the ongoing care that the patient will require after they leave hospital, including a summary of any changes in medicines, strategies to help reduce the risk of delirium and prevent complications from it, and any other ongoing treatments. This plan is provided to the patient and their carer before discharge, and to their general practitioner or ongoing clinical provider within 48 hours of discharge

Engagement and involvement of the patient's general practitioner (GP) in developing the ongoing care plan was highlighted. A few comments were received suggesting that the plan should be provided to the GP within 24 hours or within 24 to 48 hours.

Several respondents suggested providing a template of the ongoing care plan or a link to an example of a plan.

There were several suggestions for additional items for the care plan, such as the need for nutritional follow up, cognitive assessment follow up, Advanced Care planning, need to advise of this episode of delirium in future admissions, and referral to a falls risk program.

Feedback on Indicators

The Commission received 56 comments on the indicators from a number of organisations and individuals. Respondents were asked to comment on the following two questions:

- How relevant are the suggested indicators in supporting the local monitoring of the quality statements?
- What improvements would support data collection for the suggested indicators?

Relevance of indicators

Feedback on the indicator specification was generally supportive. More than 60% of survey respondents considered all the indicators relevant, and more than 90% considered all the indicators either relevant or somewhat relevant.

The main suggested changes were for the following indicators:

- **Indicator 1a: evidence of local arrangements for screening for cognitive impairment of patients presenting to hospital with one or more risk factors for delirium.**

One respondent suggested the inclusion of a new indicator that measures daily or regular cognitive impairment or delirium screening during a patient's admission.

- **Indicator 1b: proportion of older patients screened for cognitive impairment using a validated test within 24 hours of admission to hospital.**

One respondent suggested expanding indicator 1b to include all admitted patients, not just those in the specified age groups. Another suggested, removing the exclusion of patients who die on presentation to ED or on the day of admission. Another suggested incorporating screening for delirium into indicator 1b.

- **Indicator 5a: evidence of local arrangements for patients with delirium to be assessed for risk of falls and pressure injuries.**

Two respondents suggested that indicator 5a be changed to focus on implementing appropriate strategies for patients and/or the environment in general rather than being about having systems in place to assess risk.

- **Indicator 5c: proportion of patients with delirium who have had a fall or a pressure injury during their hospital stay.**

One respondent suggested that ICD-10 codes be used to measure both falls and pressure injuries rather than sourcing data from an incident reporting system, which may be too subjective and under-reported.

- **Indicator 6a: evidence of local arrangements to ensure that patients with delirium are not routinely prescribed antipsychotic medicines; and indicator 6b: proportion of patients with delirium prescribed antipsychotic medicines in hospital.**

One respondent suggested including information that antipsychotics and benzodiazepines may be required in certain instances. Another suggested that 6b focus on a specific aspect of antipsychotic prescription, such as the dose of antipsychotic, the rate of side effects, or the dose stopped prior to discharge. For both these indicators, one respondent noted that

antipsychotics should not be prescribed to patients with delirium superimposed on Parkinson's disease or Lewy Body dementia.

In addition to the above feedback, there were also a number of suggestions for additional indicators, including a new indicator on the 'number of patients who deviate from a medication protocol' and 'proportion of patients with delirium who are monitored for deterioration.'

Other feedback about the content of the indicators was similar to that received on the quality statements, e.g. including carer perspectives in discussions with patients, suggestions to include other examples of screening or diagnostic tools.

Improvements to support data collection

Respondents had a range of suggestions for supporting data collection of the indicators, as summarised below:

Improvements to data capture

- coding or identifying all at-risk admissions (e.g. sticker)
- consistency in delirium screening and assessment tools to remove subjectivity of assessments, which would allow better comparison of data over time
- inclusion of delirium on all falls assessment tools
- training of clinical staff (see below)

Data collection tools/databases

- a data collection tool or template, preferably electronic
- electronic bar codes for each intervention that can be scanned with patient ID
- a centralised database for collection and assessment of data
- patient chart review
- use of checklists

Use of electronic medical record systems

- inclusion of cognitive and delirium assessment in electronic medical record management systems (e.g. eMR) for patients aged 65 years and over or with other risk factors for delirium.

Staff training and education

- education and training of staff in data collection, coding and auditing
- training of clinical staff in documentation and coding of delirium
- support, not pressure, for staff to undertake data collection
- a dedicated data collector with relevant clinical knowledge and experience

Feedback of data

- Monthly feedback of data to clinicians

Barriers and enablers to care identified in the Clinical Care Standard

The barriers identified can be summarised as follows:

- **Systems/operational**: poor patient flow and too many transfers of patients with delirium; lack of hospital protocols on screening, managing patients who are distressed, appropriate use of antipsychotics; lack of consistency in policies across hospitals about bedrails and restraints; lack of clarity about best screening tool.

- **Staffing**: inadequate staff to patient ratios to provide supportive care and supervision when needed (i.e. 'specialling', one-to-one nursing).

- **Resources/Environment**: inadequate or unsafe ward environment for patients with delirium and/or dementia.

- **Communication**: inadequate communication between teams and poor documentation, poor communication with carers and families, lack of communication with general practitioners.

- **Staff education and training**: lack of knowledge about delirium detection and management, lack of training in managing behavioural disturbances and in de-escalation techniques, lack of training in use of delirium assessment tools.

- **Patient and carer engagement and education**: lack of involvement of carers in providing patient history, lack of engagement of carers and family throughout the patient's admission, lack of patient and carer education about delirium.

Enablers identified can be summarised as follows:

- **Protocols and policies**: accelerated admission pathways, cognitive impairment screening protocols, screening for nutritional risk in protocols, use of alert stickers, use of cognitive impairment identifiers for patients. Policies on benzodiazepine prescribing, management of confused patients, patients with behavioural psychological symptoms of dementia.

- **Staffing**: specialist cognition nurses, clinical nurse consultants, multidisciplinary teams, minimum staff to patient ratios, pod nursing, ward champions for delirium.

- **Resources/Environment:** wards designed for patients with delirium, delirium tool kit web site, agreed assessment tools, low burden tools, clinical guidelines.

- **Transition of care and general practitioner involvement**: a shared care approach, ongoing care plan to general practitioners within 24 hours.

- **Staff education and training**: continuing professional development activities, online learning, delirium assessment tool training, training in managing people with cognitive impairment.

- **Engagement and education of patients, carers and families**: engaging families in decision-making, decision aids, written resources.

- **Geriatrician access and involvement**: access to geriatricians; geriatrician review if patient not normalised by day 4.

- **Audits.**

Next steps

Feedback from the consultation process was collated and analysed, and a summary of key findings was presented to the Delirium Clinical Care Standard Topic Working Group. Following this, the Clinical Care Standard was revised and finalised for submission to the Commission's various committees.

The endorsement process for Clinical Care Standards involves passage through the Commission's governance committees, and then endorsement from the Australian Health Ministers' Advisory Council and the Council of Australian Governments Health Council; two national committees that lead coordination of health services across Australia.

It is envisaged that the Commission will provide high-level implementation support for this Clinical Care Standard, with activities and resources to be identified in the coming months.

Further information about this Clinical Care Standard can be found at www.safetyandquality.gov.au/ccs.

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