AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for health service organisations

Delirium

Clinical Care Standard

The *Delirium Clinical Care Standard* aims to improve the prevention of delirium in patients at risk and the early diagnosis and treatment of patients with delirium, so that the incidence, severity and duration of delirium are reduced.

The *Delirium Clinical Care Standard* contains eight quality statements describing the care that adult patients (18 years and older) with suspected delirium – or are at risk of developing delirium – should receive.

It includes a set of indicators to support health service organisations to monitor how well they are implementing the care recommended in this clinical care standard and to support local quality improvement activities.

Monitoring the implementation of this clinical care standard will help organisations to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).

Relevant standards and actions include:

- Clinical Governance Standard: Actions 1.27b and 1.28
- Comprehensive Care Standard: Action 5.29
- Recognising and Responding to Acute Deterioration Standard: Actions 8.05 (a)(b)(c)(d)(e), 8.06 and 8.07.

1 Early identification of risk

A patient with any key risk factor for delirium is identified on presentation and a validated tool is used to screen for cognitive impairment, or obtain a current score if they have known cognitive impairment. Before any planned admission, the risk of delirium is assessed and discussed with the patient, to enable an informed decision about the benefits and risks.

Ensure systems, policies and procedures are in place to identify risk of delirium within 24 hours of presentation, and to support routine screening of cognitive function for patients at risk of delirium who present to a health service and are admitted for care. A structured approach can improve detection rates. Identify and use a local delirium screening and assessment pathway. This includes ensuring the availability of locally agreed, validated delirium screening and cognitive screening tools that are appropriate to the cultural backgrounds of relevant communities and protocols for when they will be used. Ensure that the staff who use these tools are trained and competent in their use, and that workforce proficiency is maintained.

Ensure policies and procedures are in place to inform at-risk patients and their family or carer about the risk of delirium and to encourage participation in care.

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Ensure pre-admission protocols and consent processes incorporate an assessment of the risk of delirium and discussion with the patient before surgery or another procedure, as part of their informed consent. The Commission's ***Informed Consent in Health Care – Fact sheet for clinicians*** can direct clinicians in obtaining valid informed consent.

Indicator 1a: Evidence of a locally approved policy that defines the process for delirium risk identification, screening, and assessment. The policy should specify the:

- Process to identify patients who have risk factors for delirium
- Process to inform at-risk patients and their family or carer about the risk of delirium and to encourage participation in care
- Local delirium screening and assessment pathway
- Endorsed validated tools for screening and assessment, and the process for documenting the results
- Process to ensure staff are trained and competent in the use of the policy and the endorsed screening and assessment tools
- Process to assess adherence to the policy.

Indicator 1b: Proportion of patients aged 65 years or older or 45 years or older for Aboriginal and Torres Strait Islander people who were screened for cognitive impairment using a validated tool within 24 hours of presentation to hospital.

2 Interventions to prevent delirium

A patient at risk of delirium is offered a set of interventions to prevent delirium and is regularly monitored for changes in behaviour, cognition and physical condition. Appropriate interventions are determined before a planned admission or on admission to hospital, in discussion with the patient and their family or carer.

Ensure that policies, procedures and protocols are in place to enable clinicians to provide patients at risk of delirium with a multicomponent set of preventive strategies and to conduct regular monitoring. Ensure processes are in place for clinicians to partner with patients and their family or carers when determining and implementing interventions. Ensure that staff are trained and competent in providing care to prevent and manage delirium. Identify and implement a format for prevention plans for high-risk patients.

Ensure that systems are in place for medication reconciliation to occur whenever patients are transferred between locations of care, especially when transferring out of ICU or before discharge. This is to reduce the inappropriate continuation of short-term medicines.

Ensure that policies and procedures support environmental care strategies, such as reducing noise and avoiding ward moves wherever possible for patients at risk of delirium or with delirium.

Ensure that equipment and devices, such as call bells, signs, calendars and clocks, are available to help orientate patients to decrease the risk of, or effectively manage, delirium.

Indicator 2: Evidence of a locally approved policy to ensure interventions are implemented to prevent delirium for at-risk patients. The policy should specify the:

- Interventions available, and the patient groups and settings where they are appropriate
- Process to partner with patients and their family or carers to select and implement interventions
- Process to monitor changes in behaviour, cognition and physical condition
- Process to ensure clinicians are trained and competent in providing the interventions
- Process to assess adherence to the policy.

3 Patient-centred information and support

A patient at risk of delirium and their family or carer are encouraged to be active participants in care. If a patient is at significant risk or has, delirium, they and their family or carer are provided with information about delirium and its prevention in a way that they can understand. When delirium occurs, they receive support to cope with the experience and its effects.

Ensure that systems are in place to support clinicians in providing person-centred care for those with, or at risk of, delirium. Consider flexible visiting arrangements to support family or carer involvement in delirium prevention and management.

Identify appropriate interpreting services and educate the workforce on the appropriate use of interpreters.

Ensure that systems are in place to recognise when a patient has cognitive impairment and to work with the person, families and carers in a safe, calm and respectful environment. The Commission has developed resources to support health service organisations to provide safe care for people with cognitive impairment during COVID-19, which can be found at **Cognitive impairment and COVID-19**.

Ensure that processes are in place for patients, carers or families to directly escalate care. Examples of good practice include the following:

- **Ryan's Rule** is a three-step process in place in Queensland public hospitals to support patients, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected.
- **Call and Respond Early (CARE)** (**WA** and **ACT**) is another example of allowing patients, or their families and carers to call for rapid assistance when they feel that the healthcare team has not fully recognised the patient's changing health condition.
- **REACH (Recognise, Engage, Act, Call, Help is on its way)** (**NSW**) is a patient and family escalation system developed by the NSW Clinical Excellence Commission for New South Wales hospitals.

4 Assessing and diagnosing delirium

A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed using a validated tool by a clinician trained to assess delirium. The patient and their family or carer are asked about any recent changes in the patient's behaviour or thinking.

A diagnosis of delirium is determined and documented by a clinician working within their scope of practice.

Ensure that systems, policies and processes are in place to support clinicians who are assessing patients with suspected delirium. The policy should ensure that a locally agreed, validated diagnostic tool for delirium is available and that clinicians are competent in its use. Educate clinicians on the use of the tool, including specified training where required and according to the tool chosen.

Develop and implement protocols for escalating care when acute deterioration occurs.

Ensure that protocols are in place to support accurate documentation and coding of delirium. Monitor rates of delirium to enable quality improvement. Awareness of delirium prevalence can assist in the effective planning of services, such as the capacity for adequate resourcing, which may include specialist nurses.

Indicator 4a: Proportion of admitted patients who screened positive for cognitive impairment on presentation to hospital who were then assessed for delirium using a validated tool.

Indicator 4b: Evidence of a locally approved policy that defines the process for monitoring rates of delirium and improving documentation of delirium. The policy should specify the:

- Process to monitor rates of delirium
- The information that must be documented in the patient's medical record if delirium is diagnosed
- Process to monitor and improve the documentation of delirium.

5 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 that includes relevant multidisciplinary consultation.

Ensure that systems and processes are in place to support clinicians in identifying and treating the causes of delirium. Ensure that arrangements support multidisciplinary assessment, including telehealth consultation with clinicians, such as dietitian, nurse practitioner, geriatric medicine or psychiatry consultants when required.

Within a local health region, consider the hub-and-spoke organisation design model to support the provision of multidisciplinary assessment to rural and remote health services. The relationship between the larger hospital (hub) and the rural facility (spoke) could be structured to suit local arrangements, using information and communication technologies.

Provide regular training for staff on strategies to prevent and treat delirium.

Indicator 5a: Proportion of patients with delirium who had a comprehensive assessment that includes relevant multidisciplinary consultation to investigate the cause(s) of delirium.

Indicator 5b: Proportion of patients with delirium who received multicomponent interventions to treat delirium.

6 Preventing complications of care

A patient with delirium receives care to prevent functional decline, dehydration, malnutrition, falls and pressure injuries, based on their risk.

Ensure that systems and policies are in place to support clinicians to identify and manage the risk of functional decline, falls, pressure injuries, malnutrition, dehydration and other complications for patients with delirium. This includes implementation of the National Safety and Quality Health Service Standards (second edition).

Ensure that appropriate resources and equipment are available to decrease the risk of complications (such as low-rise beds for falls prevention).

Indicator 6a: Proportion of patients with delirium who were assessed for risk of functional decline, dehydration, malnutrition, falls and pressure injuries.

Indicator 6b: Proportion of patients with delirium who experienced dehydration, malnutrition, a fall resulting in fracture or other intracranial injury or a pressure injury during their hospital stay.

7 Avoiding use of antipsychotic medicines

Antipsychotic medicines are not recommended to treat delirium. Behavioural and psychological symptoms in a patient with delirium are managed using non-drug strategies.

Ensure that policies and systems are in place to treat delirium and to support using non-drug strategies as first-line therapy. The policies should include guidance about the non-drug strategies to be tried, evaluated and documented. These may include patient specialling (cohort care or one-on-one nursing), using specialist delirium/dementia care nurses with expertise in behaviour interventions, and involving family or carers. Provide regular training for clinicians on de-escalation techniques and other non-drug strategies.

Ensure that clinicians have access to guidance about:

- The potential harms of antipsychotic medicines and current recommendations for their use in delirium
- Appropriate prescribing when there is an imminent risk of self-harm or harm to others, including the appropriate choice of antipsychotic, and dose and duration (such as described in *Therapeutic Guidelines: Psychotropic*).

Policies should describe the process followed for when an antipsychotic is being considered for a patient at risk of harming themselves or others. The process should include documenting:

- The non-drug strategies tried
- How the patient and family will be advised and provide informed consent
- The process for review, monitoring and cessation of the medicine, including review before discharge.

If antipsychotic use occurs in an emergency context, the policy should ensure that the patient and family or carer are advised.

Ensure that discharge communication to primary care clinicians and care providers, the patient and their family or carer is accurate, to prevent inadvertent continuation of antipsychotics used acutely.

Ensure that systems are in place to minimise the use of physical restraints, and that clinicians are educated in the appropriate use of restraints.

Indicator 7: Proportion of patients with delirium who were prescribed antipsychotic medicines in hospital.

8 Transition from hospital care

Before a patient with persistent or resolved delirium leaves hospital, an individualised comprehensive care plan is developed collaboratively with the patient and their family or carer. The plan describes the patient's post-discharge care needs and includes strategies to help reduce the risk of delirium and related complications, a summary of changes in medicines and any other ongoing treatment. This plan is provided to the patient and their family or carer before discharge, and to their general practitioner and other regular clinicians within 48 hours of discharge.

Ensure that systems, policies and procedures are in place for clinicians to provide information about delirium to patients and their family or carer, and to develop an individualised comprehensive care plan with the patient and family or carer before discharge. The care plan should include the details of cognitive screening tests or assessments that were conducted and arrangements for follow-up care post-discharge.

Ensure that systems enable the plan to be provided to the patient's general practitioner and other regular clinicians and care providers within 48 hours of discharge. Where systems allow, enable uploading of the discharge care plan to the patient's My Health Record. This enables other clinicians to access the details of the patient's hospital care, which can be vital for informing ongoing care in the community. Sharing information on the care provided in hospital is particularly important if the patient is discharged to interim care (rehabilitation hospital or respite aged care) before returning home or consulting their usual general practitioner.

Indicator 8a: Proportion of patients with current or resolved delirium who had an individualised comprehensive care plan on discharge.

Indicator 8b: Proportion of patients aged 65 years or older or 45 years or older for Aboriginal and Torres Strait Islander people who experienced delirium in hospital and were readmitted for delirium within 10 days.

The definitions required to collect and calculate indicator data are specified online: **meteor.aihw.gov.au/content/index.phtml/itemId/745804**

Questions?

For more information about the clinical care standard, please visit: **safetyandquality.gov.au/delirium-ccs**.

You can also contact the Clinical Care Standards project team at: **ccs@safetyandquality.gov.au**.