

# Wessex Spring Meeting 2021

27 May 2021, Online

[www.bgs.org.uk](http://www.bgs.org.uk)

Virtual  
**Book of Abstracts**

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**CQ - Clinical Quality - CQ - Clinical Effectiveness**

[Poster 582] Improving Discharge letters within a new OPAL (Older Person' Assessment and Liaison) unit at Heartlands Hospital, Birmingham

Dr Melanie Suseeharan; Dr Natalie Perez; Dr Esme O'Loughlin

Dr Melanie Suseeharan Heartlands Hospital Birmingham; Dr Natalie Perez Heartlands Hospital Birmingham; Dr Esme O'Loughlin Heartlands Hospital Birmingham

**Introduction**

Older persons assessment and liaison (OPAL) service is a geriatric specialist service that assesses elderly patients at admission to prevent unnecessary admissions and meet holistic care goals. There are 15 domains that are well documented in the literature that are key to a quality OPAL service and need to be documented on discharge.

**Methods**

Analysis of 70 randomly selected discharge letters produced by the service over a period of a month analysing whether the domains were addressed. Created a discharge pro-forma which was implemented to help ensure the domain were documented in OPAL discharge letters. Post implementation analysed 70 randomly selected discharge summaries again. 2 further cycles utilising the same methodology with the interventions being focused on educating doctors and improving the pro-forma.

**Results**

The percentage of discharge letters meeting each domain were analysed. The pro-forma resulted in better documentation of these domains on discharge with a total average increase in 17% across all domains. The next cycles involved educational sessions and implementation of an improved pro-forma with positive results and improved documentation identified in the subsequent cycles.

**Conclusion**

Quality of information available on discharge letters should ideally cover domains that are specific to the patient demographic. Covering these domains not only ensures patients receive adequate care on that admission but set the basis for future care. This audit has implemented as system for this to occur long-term.

# Improving the Quality of Discharge Letters on an Older Persons Assessment and Liaison Service.

Dr Melanie Suseeharan, Dr Natalie Perez, Dr Esme O'Loughlin

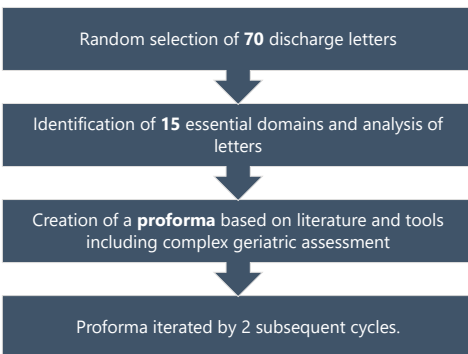
## AIMS

- Creation of a Standardised Proforma ensuring Clear Documentation and increasing Time Efficiency in writing discharge letters.

## BACKGROUND

- Discharge letters are essential in the **patient journey**.
- They are especially significant in the **geriatric setting**.
- They can be an essential tool for **holistic care**.

## METHODS



## INTERVENTIONS

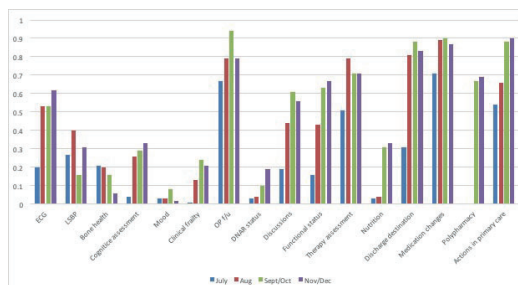
- Standardised proforma
- Education – focus groups, posters, increasing awareness, educating on importance of change
- Departmental presentation

## DISCUSSION

- Through the implementation of a proforma, there are safer discharges with clear letters meeting documented domains, as well as ease of access to salient information on further admissions.

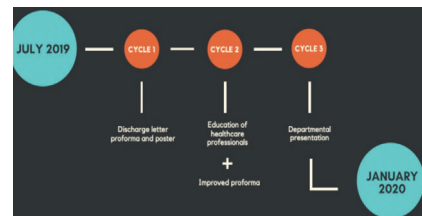
## RESULTS

- 1<sup>st</sup> cycle, overall 17% increase across all domains.
- 2<sup>nd</sup> cycle overall 6.5 % increase across all domains, with an overall positive change in 12 out of 16 domains.
- 3<sup>rd</sup> cycle identified stagnation in improvement since previous cycle with an average 1% reduction in documentation across all domains.
- Domains identifying most significant improvement overall included: ECG (+42%), Functional Status (+51%) and Discharge Destination (+52%)
- Domains poorly addressed throughout included: Bone Health (-15%), Mood (+1%), and DNAR status (+17%).



Graph depicting documentation of each domain per cycle

Standardised Proforma



3 cycles

## HAVE YOU CONSIDERED BONE PROTECTION?

Educational aids

## References

- <https://www.sheffield.ac.uk/FRAX/tool.aspx?country=9>
- [https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-02-08/BGS%20Toolkit%20-%20FINAL%20FOR%20WEB\\_0.pdf](https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-02-08/BGS%20Toolkit%20-%20FINAL%20FOR%20WEB_0.pdf)



**CQ - Clinical Quality - CQ - Patient Centredness**

[ Poster 585] South Somerset Complex Care Team (CCT);  
enabling urgent care by pre-emptive holistic patient centred care  
for frail older people

Dr Deb Gompertz

Complex Care GP Yeovil District Hospital

**Introduction**

CCTs consist of experienced GP, senior-nurse and support "key-worker", covering up to six local practices. Three CCTs, each aligned to a PCN, provide comprehensive assessments of complex patients, and coordination and information sharing with community, hospital and primary care. Shared knowledge between all community teams enables proactive management of patients social, health, mental health and general support needs. Resulting advanced care planning lowers risk of crisis requiring urgent care and ensures best chances of care at home when unavoidable deteriorations occur.

**Method**

The CCTs attend weekly "huddles" (multidisciplinary team meetings; MDTs) in GP surgeries including GPs and health coaches. These discuss hospital admissions and discharges for complex patients, those on the CCT caseload, and any of concern to the practices, community or hospital teams. CCT Team members advise on complex management and service coordination/ care planning and make contact with, and visit patients and carers. A weekly community MDT, involving community health, social, mental health teams, voluntary sector and hospital discharge teams, provides a forum to share knowledge, enabling visits/work-plans without duplication ; ensuring the most appropriate team engages with the patient, linking and supporting other services. The CCT has a liaison role communicating between primary care and the MDT.

**Results**

The combined complex care/ huddle/ health coach system has been linked to a 14% reduction in hospital admissions, and feedback from professionals and patients has been excellent.

**Conclusion**

The Complex Care Team coordinates the response from appropriate agencies to emergency needs, supporting the patient in the correct place for them, with prior knowledge of the patient's health, wishes and support. The urgent need may be identified by visiting professionals including community staff, GPs and members of the Complex Care Team themselves, or any other route. Our aspiration is to incorporate a paramedic practitioner available for appropriate urgent visits.

# South Somerset Complex Care Team; enabling appropriate urgent care by pre-emptive holistic patient centred approach for older/frail people.

Dr Deb Gompertz

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## Background

The current Complex Care Team (CCT) model, developed in 2016, pre-dated Primary Care Networks (PCNs).

## Complex Care Service

CCTs consist of experienced GP, senior nurse and band 4 support "key worker", covering up to six local practices. Three CCTs, each aligned to a PCN, provide comprehensive assessments of complex patients (often who are frail and elderly), coordination and information sharing with community, hospital and primary care.

Shared knowledge between all community teams enables proactive management of patients' social, health, mental health and general support needs. Resulting advanced care planning lowers risk of crises requiring urgent care, and ensures best chances of care at home when unavoidable deteriorations occur.

The CCTs attend weekly "huddles" (multidisciplinary team meetings; MDTs) in GP surgeries incorporating the whole GP team and health coaches. These discuss hospital admissions and discharges for complex patients, those on the CCT caseload, and any of concern to the practices, community or hospital teams. CCT Team members advise on complex management and service coordination/ care planning and make contact with, and visit patients and carers, when appropriate.

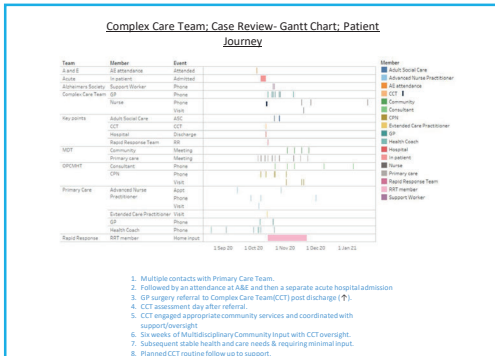
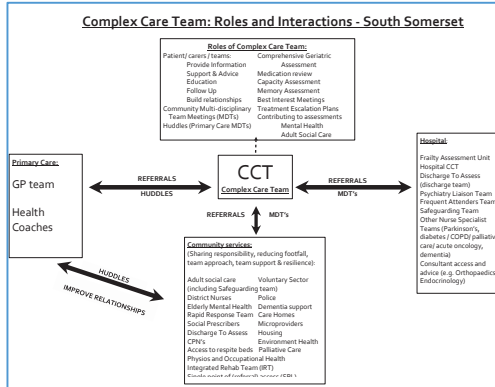
A separate weekly community MDT, involving community health, social, mental health teams, voluntary sector and hospital discharge teams, provides a forum to share knowledge, enabling visits/work-plans without duplication; ensuring the most appropriate team engages with the patient, linking and supporting other services. This has evolved organically to become a coherent neighbourhood team, encompassing all community based, and many hospital outreach teams.

The CCT has a liaison role communicating between primary care and the community MDT.

There are regular MDTs with Parkinson's team and hospital care of the Elderly Consultant, for advice and shared care of patients.

The CCT have active involvement with acute hospital attendances of complex patients, by providing detailed knowledge to enable safer care planning, particularly when there are safe-guarding and carer-strain concerns. This is through the dedicated hospital Complex Care Team, and through relationships built with in-patient teams.

**The Complex Care Team is an innovative clinical / coordinating service supporting complex patients; primarily aiming to improve outcomes with secondary benefit of reducing service usage (including admissions).**



## Driving Principles:

- Breaking down barriers to care
- Instilling the "What can we do to help?" mentality
- Remembering;

**"There is a patient (and family/carer) at the centre of every decision"**

## Relevance

During crises the Complex Care Team, with knowledge of the patients, and relationships with other services, coordinate enhanced care packages, community bed or interim care placement, when more appropriate than an acute admission. The flexibility of the CCT enables time-consuming negotiations to provide the right care-fit for the individual, which historically would not have been possible for the patient's usual GP due to time constraints, and may have resulted in an acute hospital admission.

Multi-disciplinary community team-working enables the right person to look after the patient at the right time.

CCT GP has used remote video consulting to provide urgent care advice to home-visiting healthcare team members; enabling immediate advice, guidance and intervention, and senior medical support for the staff. This successful pragmatic approach has led to a pilot using iPads allowing easier access of community team members to the CCT GP, and improved communication with the patient during these visits.

This more widespread use of any professional joining home visits remotely by video reduces risk by limiting footfall in patients' houses during the pandemic, and improves efficiency for staff by reduced duplication and travel.

Foundation Level 2 doctors are trained in a shared Complex Care and GP Surgery placement for 4 months, enabling better understanding of alternative options to acute hospital admission for the new generation of future primary and secondary care doctors.

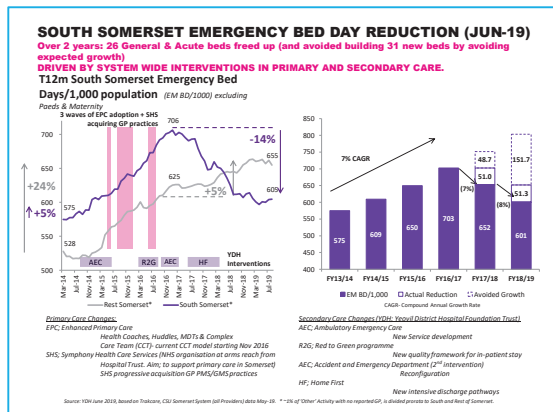
The existing CCT and multidisciplinary model aligns with integrated care systems proposed in the 2021 white paper "Integration and Innovation", and will gain from the benefits of formalised integrated Health and Social Care.

## Outcomes

The combined complex care/ huddle/ health coach system ("Enhanced Primary Care" model) has been linked with a 14% reduction in hospital admissions, as part of system wide intervention within primary and secondary care (see Figure).

Feedback from professionals and patients has been excellent:

"Being able to shed the usual organisational boundaries and access the skills and knowledge of the Complex Care GP so we truly work together to get the best outcomes for people for me has been one of the key benefits of the Role."; Adult Social Care Manager



The attached case demonstrates the journey for one patient, and provides a visual representation of how the balance of care needs changed in association with the involvement of the Complex Care Team. Although it is not possible to prove a change in outcome for an individual is linked to a specific intervention, the pattern of change is encouraging.

## Discussion

The Complex Care Team coordinates the response from appropriate agencies to emergency needs, supporting the patient in the correct place for them, with prior knowledge of the patient's health, wishes and support. The urgent need may be identified by visiting professionals including community staff, GPs and members of the Complex Care Team themselves, or any other route. Our aspiration is to incorporate a paramedic practitioner available for appropriate urgent visits.

The pivotal role of the CCT in relationship building, peer support and communication have been key to building the successful neighbourhood team, leading to mutual trust and respect and shared understanding of skills and roles.

A key motivator is when professionals realise that they have knowledge of the same patients, but were treating them in isolation.

**CQ - Clinical Quality - CQ - Patient Safety**

[ Poster 619] Cognitively impaired hip fracture patients are undergoing surgery without the knowledge of their loved ones – a QIP

Pardis Zalmay; Justin Collis; Helen Wilson

Royal Surrey Hospital; Epsom and St Helier's University Hospital; Royal Surrey Hospital

**Background**

Cognitively impaired patients with hip fractures are going into serious operations without attempts being made to notify their loved ones. The aim of this project was to improve early communication between clinicians and the next of kin (NoK) of these patients.

**Methods**

We used Plan-Do-Study-Act (PDSA) methodology to guide our quality improvement (QI) project. Cognitively impaired hip fracture patients were identified retrospectively by searching the 'Hip Fracture Database' of a medium-sized district general hospital (DGH). Their medical notes were reviewed for documented attempts at contacting their NoK prior to surgery. Secondary outcome measures were completion of the NoK section of the 'Consent Form Four', and orthopaedic surgeons being the contacting team.

**Intervention**

Drawing on concepts from established theories of behaviour change, a feedback intervention was delivered in the form of a mixed oral and visual presentation as well as a written email. The target of the intervention was the current cohort of orthopaedic registrars responsible for consenting hip fracture patients.

**Results**

Post-intervention, all the patients had documented attempts at contacting their NoK before surgery, a significant improvement from only 80% pre-intervention. There was a significant increase in completion of the NoK section of the consent form from 30% to 64.3% and a non-significant improvement in orthopaedic surgeons being the contacting team, from 41.7% to 57.1%.

**Conclusions**

Simple audit and feedback interventions can produce modest but significant positive changes in communication between clinicians and NoK of cognitively impaired hip fracture patients. Further interventions have been implemented to sustain these improvements.

# Do people with cognitive impairment undergo hip fracture surgery without the knowledge of their loved ones? A QIP.



P. Zalmay, J. Collis & H. Wilson  
Royal Surrey NHS Foundation Trust

## Introduction

The 'Consent Form Four' is used by a professional when it is deemed that a patient lacks capacity to consent to an investigation or treatment.

The Mental Capacity Act 2005 states that clinicians should discuss the treatment proposed with those close to the patient, when appropriate.<sup>1</sup>

Our aims were to investigate whether this communication was taking place in cognitively impaired hip fracture patients, and if not, to improve on this.

## Results & Intervention

Of 30 patients, **six** went into surgery with **no documented attempts** to contact their NoK. There was inadequate completion of the NoK section of the consent form and most communication was being left to the orthogeriatricians.

The orthopaedic registrars responsible for consenting these patients were selected, and a **targeted feedback intervention** was delivered drawing on established theories of behaviour change.<sup>2</sup>

Post-intervention **improvements** were seen in all **three outcome measures**.

## Method

Patient with AMTS <8 were filtered from the hip fracture database from June – October 2019 (pre-intervention) and May – September 2020 (post-intervention).

Exclusion criteria:

- No next of kin (NoK).
- Use of different consent form.

| Audit measures                   | Pre     | Post    |
|----------------------------------|---------|---------|
| Attempts to discuss with NoK     | 24 / 30 | 28 / 28 |
| Orthopaedics team making attempt | 10 / 24 | 16 / 28 |
| Completion of NoK section        | 10 / 30 | 18 / 28 |



## Conclusion & Next Steps

Although discussion with next of kin is not necessary for valid consent, it is good practice and so should be sought. Surgeons are best placed to have these conversations as orthogeriatrics is not an out-of-hours service and discussions revolve around perceived benefits and drawbacks of surgery. This project has identified shortcomings and demonstrated that audit and feedback can lead to positive outcomes.

Going ahead: repeat iterations of audit and feedback, re-design of the consent form, and consent form training modules for incoming registrars are proposed to build on these improvements.

1. Mental Capacity Act (2005), [online] available at: <https://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf> (accessed on 25th April 2020)
2. Michie, S, Johnston, M, Abraham, C, et al. Making psychological theory useful for implementing evidence based practice: a consensus approach. Qual Saf Health Care 2005; 14(1): 26-33.



**CQ - Clinical Quality - CQ - Clinical Effectiveness**

[ Poster 621] Current management of inpatients with Parkinson's disease: re-audit

Mehreen Saleem

Airedale General Hospital, West Yorkshire

**Introduction**

This is an audit undertaken to analyze the quality of Parkinson Medication prescriptions in a small district general hospital.

**Methods**

The following standards were used to measure compliance to PD medication regimes: 100% of patients received time-critical medication within 30 minutes. 100% of patients were prescribed the correct medication on admission. 100% of patients that missed a dose had a reason accounted for: clinical omission, patient refusal, drug unavailable etc. 100% of patients that had a delayed dose had a valid reason for this. 100% of patients converted to the correct strength and dose of Rotigotine. 100% of patients have received a level 2 review by a pharmacist, after Rotigotine was started. 100% of medications given to PD patients were not contraindicated with PD itself. 100% of patients would have a pharmacy review of their PD medicines by pharmacist within 24 hours of admission. Data was taken from our electronic patient records. It was retrospectively collected between 6/11/20 & 13/11/20. In addition another 20 patients were selected across the year to look at broader compliance with expected Parkinson Medicine regimes.

**Results**

The results were sadly disappointing and demonstrated that in 7 out of 8 of the standards measured, the expected outcomes were not met. The only standard that had 100% of compliance was patients receiving the correct dose of rotigotine. Other standard results were as low as 53%.

**Conclusions**

The authors concluded that more education needed to be undertaken with regards of timing of medication to help improve compliance to acceptable drug regimes.

# Current management of inpatients with Parkinson's disease: re-audit

## S Mercer Geriatrics Spr AGH, M Saleem- Pharmacist AGH

### Introduction

Parkinsons disease (PD) is a progressive neuro degenerative disease, characterised by bradykinesia, tremor & hypertonia. There are several medicines available to help & they are deemed to be time critical. This to prevent "off time" meaning reduced mobility. This audit aimed to examine how well our local hospital (Airedale General Hospital) was performing with medicine deliverance. The foundation of our audit points were the NICE guidelines. These highlight the need for prompt medicine delivery.

### Standards:

- The following standards were used to measure compliance to PD medication regimes: 100% of patients received time-critical medication within 30 minutes.
- 100% of patients were prescribed the correct medication on admission.
- 100% of patients that missed a dose had a reason accounted for: clinical omission, patient refusal, drug unavailable etc.
- 100% of patients that had a delayed dose had a valid reason for this.
- 100% of patients converted to the correct strength and dose of Rotigotine.
- 100% of patients have received a level 2 review by a pharmacist, after Rotigotine was started.
- 100% of medications given to PD patients were not contraindicated with PD itself.
- 100% of patients would have a pharmacy review of their PD medicines by pharmacist within 24 hours of admission

### Methodology

The data was collected as follows:

- Retrospective audit of 49 hospital electronic records ( using SystemOne). Data was collected between 6/11/20 & 13/11/20, during the first 72 hours of admission for 10 patients prescribed PD medications, correlating to 30 separate medications for PD.
- 2 of these 10 patients were prescribed rotigotine patches, so a further 19 inpatients prescribed rotigotine patches in the last 6 months were also reviewed.
- 20 more inpatients admitted in the last year were included to assess the broader trust compliance of PD medications.

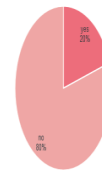
### Results

Below are charts documenting the results that are our reaudit showed. A summary of the standards reached is included here:

|   |      |
|---|------|
| 1. 100% of medications prescribed for PD were prescribed the correct medication and times for the patient on admission. | 79%  |
| 2. 100% of patients received time-critical medication within 30 minutes.  | 53%  |
| 3. 100% of patients that missed a dose had a reason accounted for.  | 73%  |
| 4. 100% of patients that had a delayed dose, it was not more than an hour.  | 23%  |
| 5. 100% of patients converted to the correct strength and dose of Rotigotine.   | 100% |
| 6. 100% of patients have received a level 2 review by a pharmacist, after Rotigotine was started.                       | 69%  |
| 7. 100% of medications prescribed to PD patients were not contraindicated with the disease.                             | 70%  |
| 8. 100% of patients would have a pharmacy review of their PD medicines by pharmacist within 24 hours of admission       | 80%  |



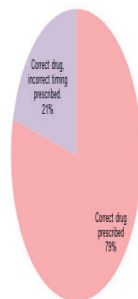
STANDARD 7- PERCENTAGE OF PATIENTS PRESCRIBED MEDICATION CONTRAINDICATED IN PARKINSON'S DISEASE.



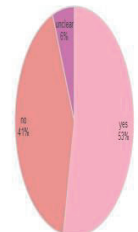
STANDARD 8- ARE PATIENTS HAVING THEIR PD MEDS VERIFIED BY A PHARMACIST WITHIN 24 HOURS?



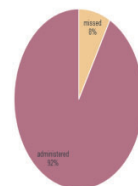
STANDARD 1- PERCENTAGE OF CORRECT DRUG AND TIME PRESCRIBED ON ADMISSION



STANDARD 2- AVERAGE DOSES ADMINISTERED TO PATIENTS WITHIN 30 MINUTES.



STANDARD 3 AVERAGE PERCENTAGE OF MISSED DOSES FOR CORRECTLY PRESCRIBED MEDICATIONS



### Discussion

The following points can be made about each standard:

Standard 1: The standard was not met, without having access to the medical notes it is hard to know the reasoning why this didn't occur. It appears that prescribing was better on a weekend than a weekday.

Standard 2: only 53% of patients met our standard, Again surprisingly compliance was better at a weekend than a weekday

Standard 3: It was noted that some wards didn't have the medicines in stock- this is something that will need investigating

Standard 4- a common reason for delays in doses was going to theatre or being in theatre. This suggest we need to plan better perioperatively.

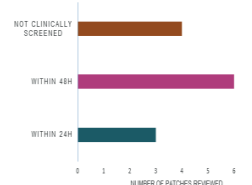
Standard 5- this shows excellent work

Standard 6- Measures should be taken to ensure that people with Parkinson's always get the correct medication at the correct time to minimise the consequences of missed or late doses.

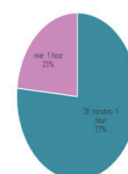
Standard 7- we need to be more careful in not prescribing medicines that are contraindicated in PD

Standard 8- likely COVID restrictions have meant that pharmacists have not been able to get to the wards to check medicines. However we must look at ways to improve medicine verification methods.

STANDARD 6- TIME TAKEN FOR PHARMACIST TO LEVEL 2 PATIENTS UPON STARTING NEW PATCHES



STANDARD 4- AVERAGE PERCENTAGE OF DELAY IN ADMINISTERING MEDICATION



### Conclusion

Though many positive work has been we sadly still have a way to go to optimize PD medicine use. It appears that previous improvements from the audit in 2018 were not sustained. We should where possible enact policies & training to try and enhance understanding of PD meds so that prescribing and rationalizing of medicines can be optimized. For example at board rounds it may be useful to highlight those who are on time critical meds, so the drug rounds can be prioritized. One thing we really need to work on is giving medicines within 30 minutes to reduce on/off times. A future QIP could be enacted to promote the timely giving of time critical medicines.

**CQ - Clinical Quality - CQ - Clinical Effectiveness**

[ Poster 625] The Implementation of a Neck of Femur Fracture Clerking Checklist on an Electronic Patient Record

William Watkinson; Jack Corkerry; James Chowdhury; Alison McMurtry; Graham Radcliffe

Bradford Royal Infirmary

**Introduction**

As medicine adjusts to the advances in technology, one aspect is the transfer from paper notes to an electronic system. Electronic notes allow physicians to document their clerking as they would write it on a blank piece of paper, often nullifying the benefits of previously commonly used paper proformas. The aim of this audit was to evaluate and optimise the standard of electronic admission clerkings of neck of femur (NOF) fracture patients against the current NICE guidelines.

**Methods**

A closed loop audit was performed, focusing on the percentage completion of pre-operative tasks in NOF clerkings between November 2019-January 2020 (n=56) and August 2020-January 2021 (n=40). 27 pre-operative tasks were evaluated, aiming for 100% completion in each. After the first loop we implemented a NOF clerking checklist that can be recorded on the electronic system with the aim of increasing completion of pre-operative tasks and ultimately streamlining pre-operative care.

**Results**

In the first loop 10/27 pre-operative tasks achieved >70% completion. In the second loop 21/27 of the pre-operative tasks were >70%. Most notably, a large improvement in IV fluid prescription was found (from 56% to 98%), VTE prophylaxis prescription (from 69% to 98%).

**Conclusion**

The NOF checklist allows a physician to tick the tasks completed once they have clerked the patient, highlighting tasks that have not been completed and ensures they are acted upon. The checklist is visible to all healthcare staff, providing consistency, continuity and allowing reflection and review. We have shown a simple checklist improves the recording and performance of preoperative tasks by physicians. We hypothesise this checklist will help reduce morbidity, mortality, reduce error risk, and improve patient optimisation preoperatively.

# Creation & implementation of a neck of femur fracture clerking checklist on an electronic patient record

Jack Corkerry\*, William Watkinson\*, James Chowdhury\*, Alison McMurtry, Graham Radcliffe  
Orthopaedics, Bradford Royal Infirmary

## Introduction:

As medicine adjusts to advances in technology, one aspect is the transfer from paper notes to electronic systems. Electronic notes allow physicians to document their clerking as they would write it on a blank piece of paper, often nullifying the benefits of previously commonly used paper proformas. The aim of this audit was to evaluate and optimise the standard of electronic admission clerkings of neck of femur (NOF) fracture patients against the current NICE guidelines.<sup>1</sup>

## Methods:

- A closed loop audit was performed, focusing on the percentage completion of pre-operative tasks in NOF clerkings between November 2019-January 2020 (n=56) and August 2020-January 2021 (n=40).
- 22 pre-operative tasks were evaluated, aiming for 100% completion in each.
- After the first loop we implemented a NOF clerking checklist that can be recorded on the electronic system with the aim of increasing completion of pre-operative tasks and ultimately streamlining pre-operative care.

| Orthopaedic Surgery Checklist<br>Fracture Neck of Femur Pathway |  | Doctor |
|---|--|--------|
| VTE assessment & Prescription                                   |  |        |
| Analgesia, Antiemetic, Laxative Prescribed                      |  |        |
| IV Fluid Prescribed   |  |        |
| PMH documented  |  |        |
| AMTS Documented   |  |        |
| NBM from: (Date + Time)   |  |        |
| Consent, Marked, Banded   |  |        |
| CXR   |  |        |
| ECG   |  |        |
| Blood Results:  | Hb:<br>Platelets<br>WCC:<br>INR:<br>eGFR:<br>Urea, Creatinine:<br>Na, K: |        |
| G+S (X2)  |  |        |
| Drug History, Medicines Reconciled                              |  |        |
| Anticoagulation: Drug, Dose, Time last taken                    |  |        |
| Doctors Name:   | Bleep: #465  |        |

Figure 1: Neck of Femur Fracture Surgical Checklist<sup>2</sup>

## Results



## Discussion:

This audit has shown improvement in the completion of perioperative tasks for NOF fracture patients after the implementation of the checklist, 21 aspects achieved >70%. Notably, we demonstrated the checklist increased the correctable abnormalities identified and acted upon, as failure to correct reversible abnormalities leads to increased mortality.<sup>3</sup> Secondly, we have shown an improvement of IV fluid therapy prescription and administration. IV Fluid therapy is a key aspect of best anaesthetic care in NOF fracture patients and reduces the risk of AKI.<sup>4,5</sup> We hypothesise this improvement in completion of tasks improves perioperative care and reduces morbidity and mortality. However, no evaluation or analysis into actual morbidity or mortality was performed, as patient outcomes were not formally assessed in this study.

Furthermore, only 47.5% completed and documented the checklist in the notes. This could be explained by physicians becoming accustomed to using the checklist initially and incorporating the elements into their clerking, more senior physicians being less likely to use the checklist, and locums being unfamiliar with the process. However, when the checklist was used a higher proportion of items were completed when compared to when not. In addition, the data analysis was subjective: when analysing the documentation of the clerking physician, not every thought process & decision of the physician is documented in their clerking and the data was collected retrospectively. Further analysis is warranted using prospective data to evaluate the improvement of outcomes of patient after the implementation of the checklist.

## Conclusion:

The NOF checklist allows a physician to tick the tasks completed once they have clerked the patient, highlighting tasks that have not been completed and ensures they are acted upon. The checklist is visible to all healthcare staff, providing consistency, continuity and allowing reflection and review. We have shown a simple checklist improves the recording and performance of preoperative tasks by physicians. We hypothesise this checklist will help reduce morbidity, mortality, reduce error risk, and improve patient optimisation preoperatively. The next step will be to analyse outcomes to test this hypothesis.

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**CQ - Clinical Quality - CQ - Patient Centredness**

[ Poster 626] Improving Communication with relatives during COVID-19

Danial Robertson; Ben Booker; Stuart Ruff; Ahmed Khalifa

University Hospitals Dorset

**Introduction**

During the pandemic, effective communication between relatives and the health care team has become paramount, especially on elderly care wards with restricted visiting rules. Communication has taken an almost entirely verbal telephone-reliant form and this project was set up to look at how relatives felt about updates from the hospital and how best we could improve the way we communicate with next of kin's (NOKs).

**Method**

We undertook a telephone survey with NOKs who had relatives admitted to one of our elderly care wards during November 2020. The survey focused on how many times relatives were contacted during the patient's hospital stay, the quality of these telephone updates and whether they felt they were adequately kept updated regards to diagnosis, progress and discharge planning. We then implanted various communication tools outlined in the poster and re-surveyed relatives to show improvement.

**Results**

From the initial survey, 60% of NOKs felt communication could be improved with only 48% feeling informed of the current medical plan whilst an in-patient. We then implemented a 'Communication log' – a central space on a patient's Electronic Personal Record (EPR) to record all communication encounters and conversations with relatives across the MDT. After installing the communication log we found that 100% of people had been contacted after admission with 71% feeling informed of the medical plan for their relatives.

**Conclusion**

Effective communication with relatives is a key area for improvement, especially within the current Covid-19 climate. The use of a communication log provides a better documentation platform to allow family updates to occur within the medical team and we hope to enroll this across both the MDT and other hospital specialties.

# Improving Communication with next of kin during COVID-19 pandemic

Dr Benjamin Booker <sup>1</sup> Dr Daniel Robertson <sup>1</sup> Dr Ahmed Khalifa <sup>1</sup> Dr Stuart Ruff <sup>1</sup>

## ABSTRACT

1

During the pandemic, effective communication between relatives and the health care team has become paramount, especially on elderly care wards with restricted visiting rules. Communication has taken an almost entirely verbal telephone-reliant form and this project was set up to look at how relatives felt about updates from the hospital and how best we could improve the way we communicate with next of kin's (NOKs).

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Effective communication with relatives is a key area for improvement, especially within the current Covid-19 climate. The use of a communication log provides a better documentation platform to allow family updates to occur within the medical team and we hope to enroll this across both the MDT and other

## BACKGROUND

2

Effective communication underpins all patient care and is a cornerstone of good medical practice.

Driving factors behind this project:

- An increase in complaints regarding communication.
- COVID-19 restrictions causing limitations in communication.
- Older patients with sensory and cognitive impairment may struggle to communicate with their NOK.
- Communication deficiency leads to misunderstandings regarding patient care.

## AIM & METHOD

3

The overall aim of this project was to improve the way in which we keep NOK updated during an inpatient admission.

Method:

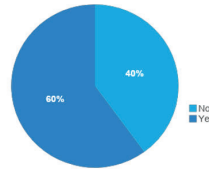
- Initial phone call interviews with NOK of patients recently discharged from Kimmeridge Ward
- Create a central document for all communications with relatives
- Create an area on the ward handover sheet outlining when relatives updated
- Review communication as part of the daily MDT
- Re-interview relatives after these measures were put in place

## FEEDBACK FROM NOK

4

- Collected feedback from NOK recently discharged from the ward, consent gained from both parties.
- Contacted 25 NOKs and undertook a qualitative survey which included the following questions:

NOK feedback: could communication to relatives for patients on kimmeridge be improved?



- Patients time on ward.
- Last documented NOK discussion.
- Initial call to NOK once arriving on ward.
- Last contact with healthcare services.
- Whether they feel informed.
- Whether they tried to contact the ward but not got a response
- Whether it is difficult to contact the ward.
- Whether we could improve.
- Comments made by the NOK with regards to communication.

## RESULTS

5

- 40% had not been contacted since initial update
- 48% felt informed of current plan
- 44% had tried contacting the ward and had no response
- 32% had difficult contacting a doctor/nurse/therapist if needed
- 60% of patients NOK felt we could improve our communicating, but feedback echoed was "doing the best with what we have"

- Patient average time on ward was 12 days
- 28% of NOK received a phone call on admission to Kimmeridge.
- 100% who received an initial call felt it was useful.
- 65% were contact within one day of admission to Kimmeridge
- 8% had no contact at all.

## IMPLEMENTATION

6

- Following this survey, we then implemented a "Communication log" in every patient's electronic record. This allowed any ward staff to update electronically the time and content of any communication.
- We also incorporated a "Communication" column into the handover sheet and included it within the MDT discussion each day.

We then re-surveyed 7 relatives of patient with a communication log:

- 100% had been contacted since initial update
- 71% felt informed of current plan
- 43% had tried contacting the ward and had no response
- 29% had difficulty contacting a doctor/nurse/therapist if needed
- 43% felt that we could improve our communication

## NEXT STEPS?

7

- Creation and implantation of a unique document on every patient's electronic record called "COMMUNICATION LOG"
- Raise awareness of the benefits of using this tool amongst colleagues around the hospital.
- Adopt use of the communication log across all OPM wards, especially use within the admission wards.
- Encouraging other AHPs to make use of the log.
- Ensuring patients have clearly documented NOK and contact numbers on their electronic record.

## Communication Log

[Show Patient Details](#)

Patient Name TESTCATHY TEST STROKE Author Benjamin Booker  
 Patient Number 4279735 Bleep No  
 Note Date 02/03/2021 15:37

Communication log for admission 01/03/21:

01/03 @ 14:00: Phoned NOK (01547\*\*\*\*\*) to update that patient has been admitted to hospital with a severe chest infection and is currently being treated with IV ABs. Explained that he is currently confused likely secondary to the infection but in safe hands. Daughter explained that patient has been unwell for some time but not normally confused, but feels that he is struggling to manage at home on his own. Dr B F1

02/03 @ 11:00: Phoned daughter to update on progress. Explained that patient is responding well to antibiotics and we are still supporting his fluids with IVs. His blood tests are improving and we are hoping the delirium will settle with time. I have asked our therapy teams to review patient with regards to help upon discharge. Dr R F2

02/03 @ 15:00: Phoned daughter to explain my role as an occupational therapist. Reviewed patient on ward this afternoon and feel that patient would benefit from additional POC on discharge, especially with regards to personal hygiene. Daughter happy to support with shopping and cooking but feels some extra support would be hugely beneficial as she has no support from other family members. We shall await the physio assessment and plan for BD POC on discharge. Miss A OT

## LIMITATIONS

8

- Preliminary results of this audit and intervention were based on a small sample size of 25.

## CONCLUSIONS

9

The COVID-19 pandemic has caused a dynamic change in the way we communicate. With this qualitative data we have preliminary evidence to show a focus on communication and the use of a central electronic document can improve communication with NOK.

The log has become a strong reminder of the last contact with NOK and clinicians have found it clear and concise. Going forward we look to create a unique "Communications Log" tab in every patient's electronic record and expand the use trust-wide.

**CQ - Clinical Quality - CQ - Clinical Effectiveness**

[ Poster 629] Pre-tibial Lacerations and Frailty: A Plastic Surgery Perspective

David Peberdy

Royal Devon and Exeter Hospital

**OBJECTIVES:**

Frailty is increasingly recognised as an important factor for patients under the care of surgical departments. Pre-tibial laceration is a common presenting problem to plastic surgery units across the UK. We set out to assess the mortality outcome of this cohort presenting to our unit. We also breakdown our management of these patients.

**DESIGN**

Retrospective cohort analysis of prospectively maintained clinical database from May 2018 to December 2019 and systematic review of existing literature. SETTING: A UK Regional Plastic Surgery Centre

**PARTICIPANTS**

Patients referred to the Royal Devon and Exeter Hospital with pre-tibial injury.

**MEASUREMENTS**

Patients were given frailty scores according to the Clinical Frailty Scale system (CFS) and recorded as either Non-frail (CFS <5) or Frail (CFS ≥5). Patient demographics, management approach, and outcomes following injury were assessed. We specifically wanted to know whether frailty was a significant predictor of 1 year mortality in this patient cohort.

**RESULTS**

A total of 85 patients were included in the study. Mean age was 76.4 (± 18 years, 1 st.dev), with a 2.5 : 1 female to male preponderance, with a third of these patients having a CFS of ≥5 . Across all patients presenting to the plastic surgery department with pre-tibial injury there was a 20% (17/85) mortality at one year. In frail patients (CFS ≥ 5) 1 year mortality was 47.6% (10/21). Frail patients had longer inpatient stays and higher rates of changes to level of care following referral.

**CONCLUSION:** Frailty is present in a significant minority of patients referred with pre-tibial injury to Plastic Surgery. This is a significant predictor of 1 year mortality in this cohort. Standardised evidence based pathways of care for these patients would help reduced morbidity and mortality and this would require a cooperative approach between clinical teams.





**CQ - Clinical Quality - CQ - Patient Centredness****[ Poster 641] How has COVID19 infection affected stroke care?**M Varadarajan<sup>1</sup>; S Ran<sup>1</sup>, K Muthana<sup>1</sup>, A Sen<sup>1</sup>**1. Hyperacute stroke unit, Princess Royal University Hospital****Introduction**

COVID19 infection has affected both acute stroke care and stroke rehab. Patients who tested positive at admission were outlied to COVID19 positive wards. Patients who tested positive on the stroke rehab ward were outlied. The Royal College of Physicians National Clinical Guidance for Stroke summaries how stroke care should be provided. The aim of this project was to assess and compare the quality of care of outliers and inliers admitted to the hyperacute stroke unit (HASU) and stroke unit (SU).

**Methods**

80 patients (20 from each group) with suspected or confirmed strokes admitted to the PRUH between 25/12/2020 and 05/02/2021 were randomly selected from the ward or outliers list. The medical notes including clinical entries, flowsheets, orders, results, drug charts were reviewed using Sunrise EPR. Data was collected and analysed using Microsoft Excel.

**Results**

The table below compares the quality of care for inliers and outliers admitted to HASU: Criteria Percentage of inlier patients (%) Percentage of outlier patients (%)  
 Hourly neuro observations 100 25 Swallow screen within 4hours 65 75 SLT assessment within 24hours if deemed necessary 90 80 IPCs placed appropriately 95 50 VTE correctly completed 100 75 Daily consultant ward round 100 90 Documented medical update to the next of kin 40 20 Board round entry 55 10 Adverse events 20 45 SU patients who were outlied had fewer multidisciplinary team meetings and had less frequent therapy and neuropsychology reviews.

**Conclusion**

Due to COVID19 infection, more patients on both HASU and SU were outlied. Overall, the patients who were outlied had poorer care particularly reduced therapy input and greater number of adverse events leading to prolonged admissions. These findings are in keeping with the literature which suggest outlied patients have longer hospital admissions but no increase in mortality or readmissions.

# How has COVID19 infection affected stroke care?

M Varadarajan<sup>1</sup>, S Ran<sup>1</sup>, K Muthana<sup>1</sup>, A Sen<sup>1</sup>  
 1) Hyperacute stroke unit, Princess Royal University Hospital

Contact details:  
 Maithili.Varadarajan@nhs.net



## Introduction

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## Methods

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## Results

SU patients who were outlied had fewer multidisciplinary team meetings and had less frequent therapy and neuropsychology reviews.

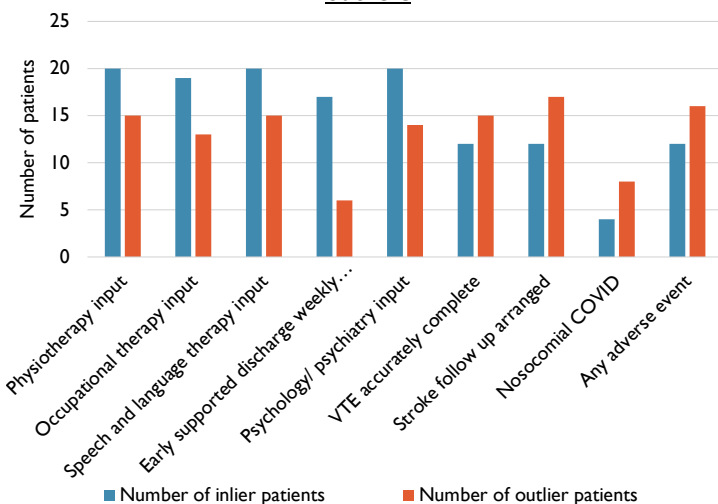
The table below compares the quality of care for inliers and outliers admitted to HASU:

| Criteria  | Percentage of inlier patients (%) | Percentage of outlier patients (%) |
|---|-----------------------------------|------------------------------------|
| Hourly neuro observations                         | 100                               | 25                                 |
| Swallow screen within 4hours                      | 65                                | 75                                 |
| SLT assessment within 24hours if deemed necessary | 90                                | 80                                 |
| IPCs placed appropriately                         | 95                                | 50                                 |
| VTE correctly completed                           | 100                               | 75                                 |
| Daily consultant ward round                       | 100                               | 90                                 |
| Documented medical update to the next of kin      | 40                                | 20                                 |
| Board round entry                                 | 55                                | 10                                 |
| Adverse events                                    | 20                                | 45                                 |

## Conclusion

Due to COVID19 infection, more patients on both HASU and SU were outlied. Overall, the patients who were outlied had poorer care particularly reduced therapy input and greater number of adverse events leading to prolonged admissions. These findings are in keeping with the literature which suggest outlied patients have longer hospital admissions but no increase in mortality or readmissions.

Bar graph to compare SU care for inliers and outliers



## References

1. Stroke Working Group, 2016. National Guidance for stroke [Online]. London: Royal College of Physicians
2. Alameda C, Suárez C. Clinical outcomes in medical outliers admitted to hospital with heart failure. Eur J Intern Med. 2009 Dec;20(8):764-7.
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**CQ - Clinical Quality - CQ - Patient Safety**

[ Poster 644] SupPOSE Audit: Screening for Potentially-inappropriate medications (PIMs) in Older patients undergoing Surgery Electively

M Waterstone\*; T Elsherif\*, A Murphy, J O'Byrne

Cappagh National Orthopaedic Hospital, Dublin 11; Professorial Unit, RCSI

**Introduction**

International statistics suggest that >50% of elderly patients are prescribed potentially inappropriate medications (PIMs). Such PIMs increase the risk of adverse drug reactions including falls, delirium and cognitive impairment, thereby increasing length of hospital stay, re-admission rates and mortality. In the setting of elective surgery, this translates to increased perioperative complication rates, lengthened recovery periods and significant financial burden, both for the patient and the treating institution.

**Objectives**

Our aims were to examine the practicality of screening for PIMs in patients >65 years in the context of admission to a busy Irish orthopaedic hospital, and to ascertain the burden and type of such PIMs in our chosen population.

**Methods**

Over a 6-week period, the medications of all patients aged >65 were screened on the morning of surgery using two separate, validated screening tools; the Beers' and STOPP-START criteria. This rapid screening was performed with the help of proformas and was serially timed to enable analysis of the time investment required.

**Results**

Here, we demonstrate prospectively that opportunistic medication screening is both possible and practical at the time of surgical admission, taking an average of 3 minutes to complete. Of 117 patients >65 years admitted to our hospital over a 6 week period, 34.2% and 39.3% were prescribed a PIM as defined by the Beer's and STOPP-START criteria, respectively. The pattern of these PIMs was similar to that previously reported in other patient cohorts and included a significant proportion of PIMs of high clinical significance.

**Conclusion**

To our knowledge this is the first audit of its kind in the elective surgical population, and introduces a new paradigm for fast, targeted screening for PIMs in the surgical setting. This interdisciplinary approach may aid service improvement and KPI attainment in centres that cater for elective admissions, while safeguarding the older patient population.

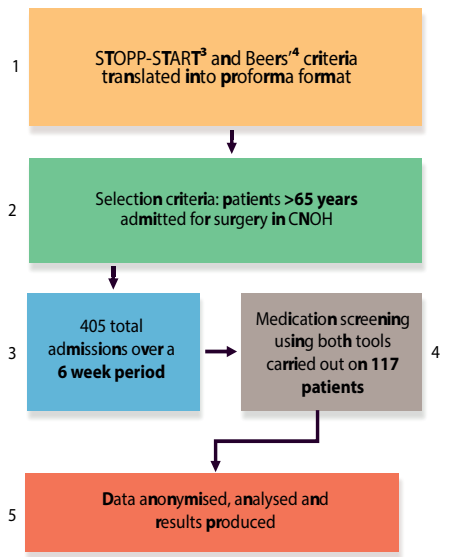
# SupPOSE: Screening for Potentially inappropriate medications (PIMs) in Older patients undergoing Surgery Electively

M Waterstone\*<sup>1</sup>, T Elsherif\*<sup>1</sup>, A Murphy<sup>1</sup>, J O'Byrne<sup>1,2</sup>  
 \* = Co-authors  
<sup>1</sup> = Cappagh National Orthopaedic Hospital, Dublin 11  
<sup>2</sup> = Professorial Unit, RCSI

## INTRODUCTION:

- International statistics suggest that **>50% of older patients** are prescribed potentially inappropriate medications (PIMs)<sup>1</sup>.
- These PIMs increase the risk of **falls, delirium and cognitive impairment**, thereby increasing length of hospital stay, re-admission rates and mortality<sup>2</sup>.
- In the setting of elective surgery, this translates to **increased perioperative complication rates, lengthened recovery periods and significant financial burden**, both for the patient and the treating institution.

## METHODS:



# Screening older patients' medications on admission for elective surgery is **fast** and **effective**.

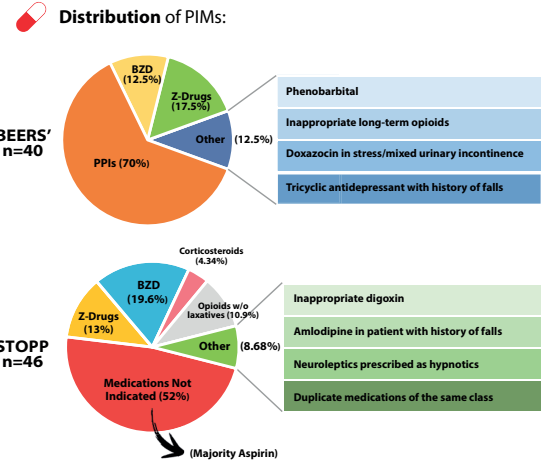
# The **STOPP-START** criteria were the **best** validated screening tool of those tested.



Patient safety  
 Potentially Inappropriate Medications  
 Interdisciplinary Co-operation

## RESULTS:

- Mean no. medications prescribed per patient = **4.99**
- Instrument yield (% of all patients in whom a PIM was detected):  
 Beers' criteria: **34.2%**  
 STOPP-START criteria: **39.3%**
- Time required to screen:  
 Beers' criteria: **3.5 min**  
 STOPP-START criteria: **2.5 min**



## HIGHLIGHTS:

- Our approach is fast, effective, low-cost and can be carried out by any member of the MDT
- The STOPP-START criteria performed better than the Beers' criteria; producing a **higher sensitivity for less time investment**
- The STOPP-START criteria also identified PIMs of greater clinical relevance, specifically:
  - Inappropriate aspirin prescribing, increasing bleeding risk
  - More PIMs contributing to falls
  - PIMs causing constipation, incl. inadequate co-prescribing
- Over a 6 week period, it is likely that we prevented at least one adverse drug event, making it probable that this intervention was **cost-effective**
- Overall, our results highlight the need for increased cooperation between surgical and medical specialities

## REFERENCES:

1: Rossi ML, Young A, Maher R, et al. Polypharmacy and health beliefs in older outpatients. *Am J Geriatr Pharmacother.* 2007;5:317-323  
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 4: O'Mahony et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age and Ageing.* Volume 44, Issue 2, March 2015, Pages 213-218.



**CQ - Clinical Quality - CQ - Clinical Effectiveness**

[ Poster 652] DELIRIUM : THE MISSING PIECE

Wah P Phyu ; Wint W Soe

Ealing Hospital ; Dorset County Hospital

**Introduction**

Delirium is a medical emergency and failure to recognize the delirium can increase the risk of morbidity, mortality and increase the loss of independence. Delirium is often poorly recognised by healthcare professionals.

**METHOD**

( Part A )All patients older than 70 years admitted to the Acute Medical Unit (AMU) at Charing Cross Hospital were objectively assessed for likely presence of delirium by using 4AT score. The case notes were screened for evidence of a diagnosis of delirium by reviewing daily ward round and documentations in the Cerner for a patient who had 4AT four or above. (Part B) Doctors' views regarding the awareness of Delirium were explored using the questionnaires.

**RESULTS**

(Part A )Total 34 patients included in the audit. 50% (n=8)of the patients had known diagnosis of dementia or cognitive impairment.56%(n=9) had no documented 4AT score and 44% of patients were document (6 patients during OPAL assessment and 1 patient during the clerking) .During the audit 47% of patients were found to have 4AT  $\geq 4$  .Among them, 56% has no document for the diagnosis of delirium or possible delirium. The delirium diagnosis were documented in only 19% (n=3) and no documentation in 81% (n=13). (Part B) Poor awareness about delirium was noted among the doctors including delirium symptoms and signs, risk factors for delirium, medications which can cause delirium.

**CONCLUSION**

Although advances in practice guidelines promoting delirium assessment, the delirium recognition remained poor. The audit highlighted that the documentation of delirium diagnosis and documentation of 4AT score are need to be improved. It is important to give the education sessions to doctors and nurses to raise the awareness about delirium, complications and consequences of delirium and importance of identifying who are at risk of delirium.

# DELIRIUM : WHAT ARE WE MISSING ? / THE UNDER-RECOGNIZED SYNDROME

• DR. W PHYU<sup>1</sup> , DR. WINT SOE<sup>2</sup>

1. GERIATRIC REGISTRAR , EALING HOSPITAL 2.RESPIRATORY REGISTRAR , DORSETT HOSPITAL

## INTRODUCTION

- Delirium is a medical emergency and failure to recognize the delirium can increase the risk of morbidity, mortality and increase the loss of independence.
- Delirium is often poorly recognised by healthcare professionals.

## AIMS AND OBJECTIVES

- To increase awareness of Delirium and early recognition among Doctors and Healthcare Professionals
- To determine the prevalence of Delirium in acute medical unit (AMU)
- To improve the documentation of Delirium diagnosis

## METHODS

- ( Part A ) All patients older than 70 years admitted to the Acute Medical Unit (AMU) at Charing Cross Hospital were objectively assessed for likely presence of delirium by using 4AT score. The case notes were screened for evidence of a diagnosis of delirium by reviewing daily ward round and documentations in the Corner for a patient who had 4AT four or above.

- Demographic  
Total 34 patients ( Male =18 , Female = 16)  
Age ( 70 yrs – 98 yrs )

- Clinical standard/guideline – Delirium Policy according to the Trust Guideline

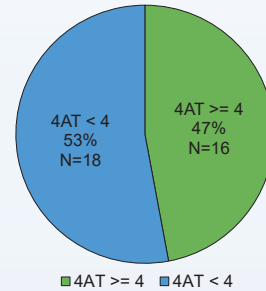
- (Part B) Doctors' views regarding the awareness of Delirium were explored using the questionnaires.

## IDENTIFIED PROBLEMS

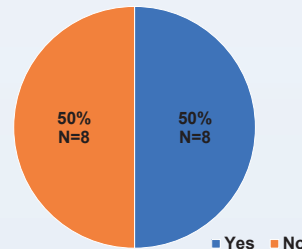
- Poor documentation of 4AT score
- Poor recognition of delirium

## RESULTS (PART A)

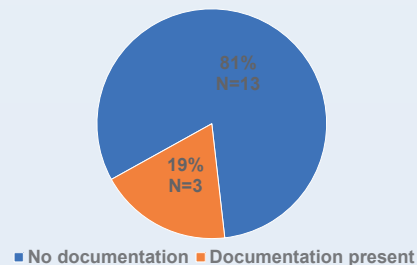
4AT screening at the time of audit



Documented Dementia/Cognitive impairment

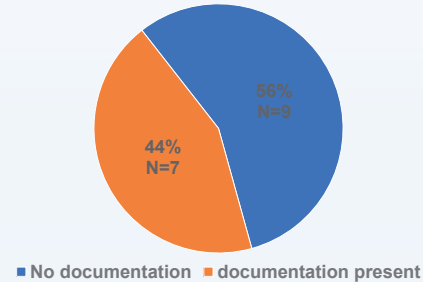


Delirium Diagnosis documented in case notes

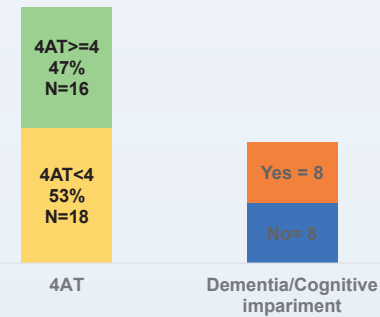


## RESULTS (PART A)

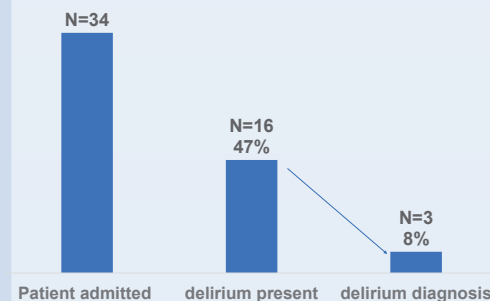
Compliance to 4AT scoring records



Delirium in relation to Dementia



Recognition of delirium



## RESULTS (PART B)

| TRUTH ABOUT DELIRIUM                                       | AGREE | NOT SURE | NOT AGREE |
|--|-------|----------|-----------|
| Delirium is a medical emergency                            | 59%   | 18%      | 24%       |
| Normal for older people in hospital to be confused         | 21%   | 9%       | 71%       |
| Preventable and treatable                                  | 91%   | 9%       | 0%        |
| Patients who recovered from delirium can recall the events | 3%    | 21%      | 76%       |

| FACTORS FAVOUR DELIRIUM RATHER THAN DEMENTIA | AGREE | NOT SURE | NOT AGREE |
|--|-------|----------|-----------|
| Inattention                                  | 82%   | 9%       | 9%        |
| Fluctuating course                           | 97%   | 3%       | 0%        |
| Aphasia, Apraxia, Anoxia                     | 9%    | 26%      | 65%       |
| Abrupt onset                                 | 91%   | 6%       | 3%        |

| DELIRIANTS                       | AGREE | NOT SURE | NOT AGREE |
|----------------------------------|-------|----------|-----------|
| NSAIDS                           | 21%   | 21%      | 59%       |
| Benzodiazepines                  | 94%   | 3%       | 3%        |
| Levofloxacin                     | 29%   | 21%      | 50%       |
| Digoxin                          | 33%   | 32%      | 35%       |
| Amitriptyline                    | 82%   | 15%      | 3%        |
| Chlorpheniramine (antihistamine) | 15%   | 24%      | 62%       |
| Polypharmacy                     | 0%    | 3%       | 97%       |

## CONCLUSION

- Although advances in practice guidelines promoting delirium assessment, the delirium recognition and documentation was still poor.

## ACTION PLANS

- Education sessions to doctors and nurses to raise the awareness about delirium
- Educating complications and consequences of delirium and importance of identifying who are at risk of delirium
- Repeat cycle