Doctor! The mafia is running this place!

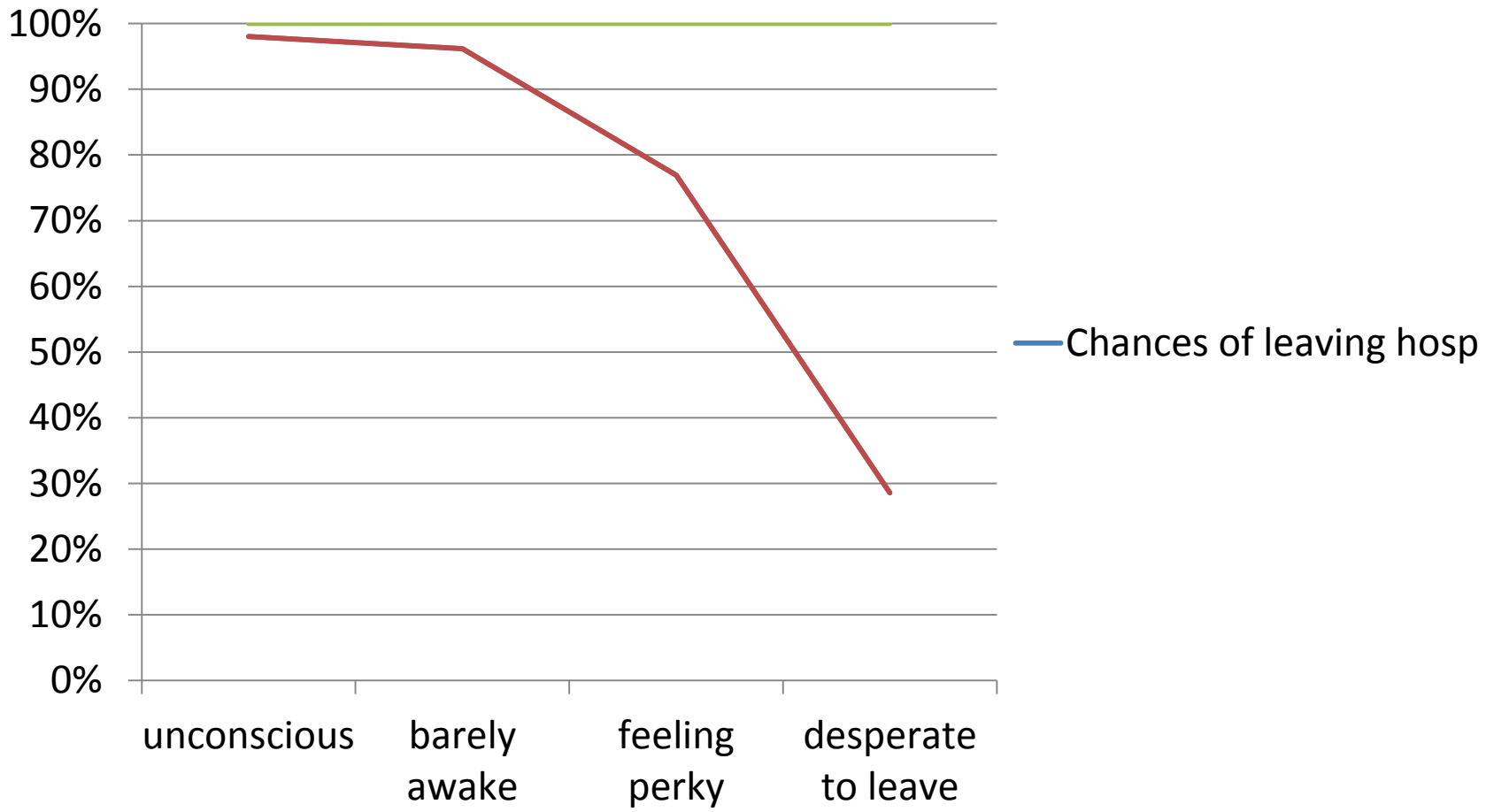
When does hospital become bad for your health?

Dr Sophie Edwards
Clinical Lead for Dementia
North Middlesex Hospital NHS Trust

The conveyor belt of healthcare

Time to go. Your meter has run out.

The inverse relationship between readiness to leave and chances of getting out..



Where on earth am I?

- A&E
- AAU
- AEC
- OBU
- AMU
- SAU
- PCU
- ITU

Welcome to the ‘Toxic Hospital’

Please enjoy your stay and make the most of the many services we have to offer….

- Lack of exercise/movement
- Intermittent noise and light control
- Environmental manipulation
- Sleep deprivation/adjustment
- Controlled fear
- Disorientation
- Sensory deprivation (hearing and vision)

Otherwise known as ‘Hotel Torture’

- Lack of exercise/movement
- Intermittent noise and light control
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- Sensory deprivation (hearing and vision)

“you have two hours to create a ‘delirium showstopper’…….”

Dementia in hospitals is common

Common

In unselected medical admissions >70 years

- 50% cognitive impairment
- 42% dementia

High risk of adverse events

Under recognised

Only 50% with recognised diagnosis
Cannot offer best care without diagnosis
Cognitive assessment embedded in CGA

Sampson et al, BJP 2009 195(1):61-6
Goldberg SE et al, Age Ageing. 2012 ;41(1):80-6.

Screening for dementia in delirium

Problem

Delirium is common (15-25%)

Dementia main RF to develop delirium

- OR 6.6 (CI - 4.30-10.19)

DSD in 65% of people with delirium

Administration

By definition difficult to diagnose

Performance based tools not valid

Difficulty with persistent delirium

– when does it end?

Collins N et al, Age Ageing. 2010 Jan;39(1):131-5.
Ahmed S et al, Age Ageing. 2014 May;43(3):326-33.
Fick DM, J Am Geriatr Soc. 2002;50(10):1723-32.

What do we want?

- Good care needs recognition of problem
- Good care needs good understanding
- Good care needs on-going training and role modelling

Incentives for quality?

GOAL of CQUIN

To support the identification of patients with dementia and delirium, alone and in combination alongside other medical conditions. It aims to prompt appropriate referral, follow up, and effective communication between providers and general practice, through the introduction of a care plan on discharge; after the patient is discharged from hospital or community services following an episode of emergency unplanned care

Dementia CQUIN

Three part indicator:

3a:

The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services;

The proportion of those identified as potentially having dementia or delirium who are appropriately assessed;

The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP.

3b

To ensure that appropriate dementia training is available to staff through a locally determined training programme.

3c:

To ensure that carers of people with dementia and delirium feel adequately listened to and supported.

In summary

- FIND people with dementia and delirium
- Assess them appropriately
- Diagnose if appropriate OR signpost to community services
- Train all our staff appropriately
- Provide good carer experience

4AT

Assessment test for delirium & cognitive impairment

(label,

Patient name:

Date of birth:

Patient number:

Date: **Time:**

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

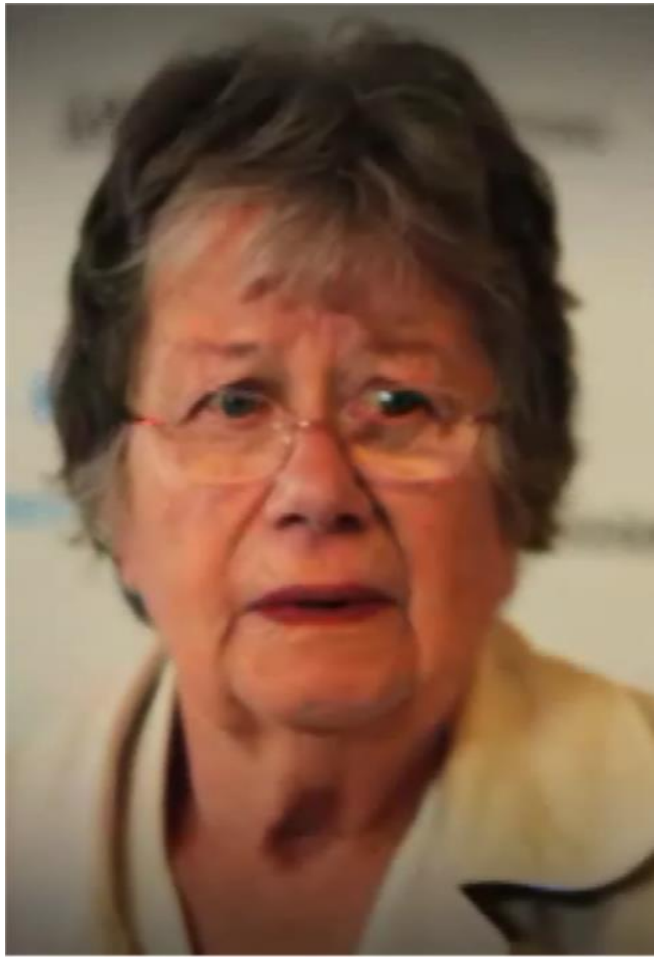
No	**0**
Yes	**4**

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE ☐

☐

Teaching and training



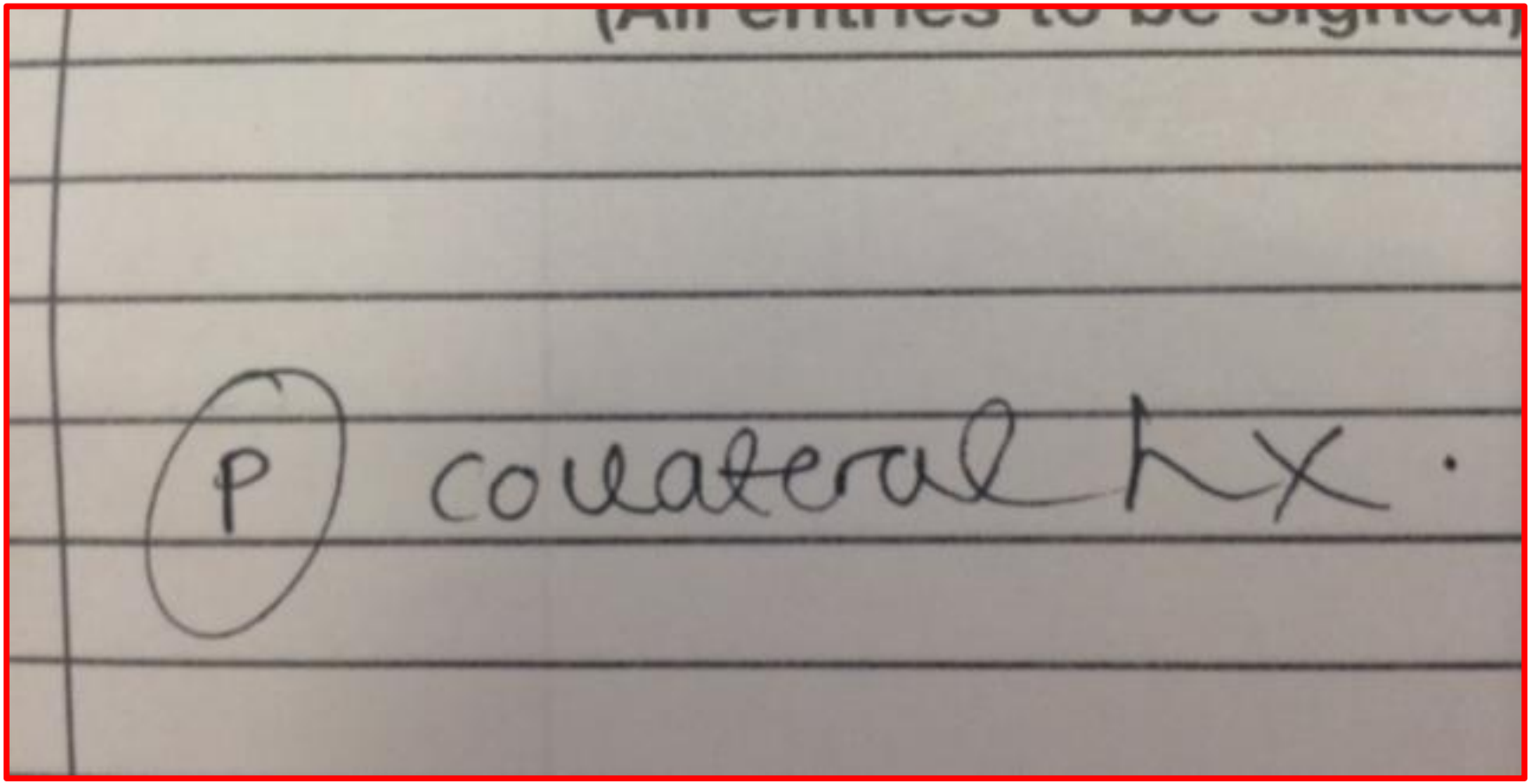
Carers survey

Father was being discharged without our knowledge!

I felt if I had not been there Mum would not have eaten

My husband's treatment was appalling! If he was an alcoholic he would have had better treatment. Being 80 with dementia you have no hope

Dementia is the forgotten illness and I have to watch her die slowly and awfully


(All entries to be signed)
P collateral Lx.

Methods

Population

Medical admissions aged >70 years
DSM-IV-TR delirium
Powered to recruit n=124

Index test

Informant interview

- IQCODE and AD8 completed

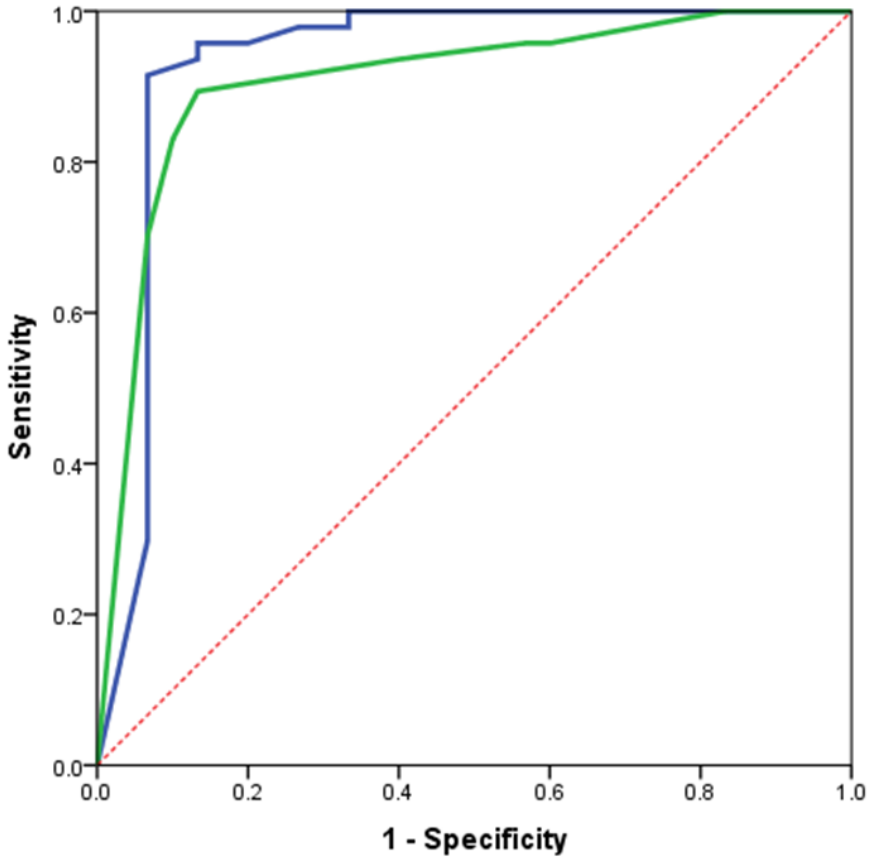
Reference Standard

3 month follow-up
Dementia diagnosis made (Blinded)
DSM-IV criteria using

- Interview and examination
- Addenbrooke's Cognitive Examination III (ACE III)

The IQCODE and AD8 are ‘very good’ at diagnosing dementia in delirium

Receiver operating characteristic curve to diagnose dementia



IQCODE

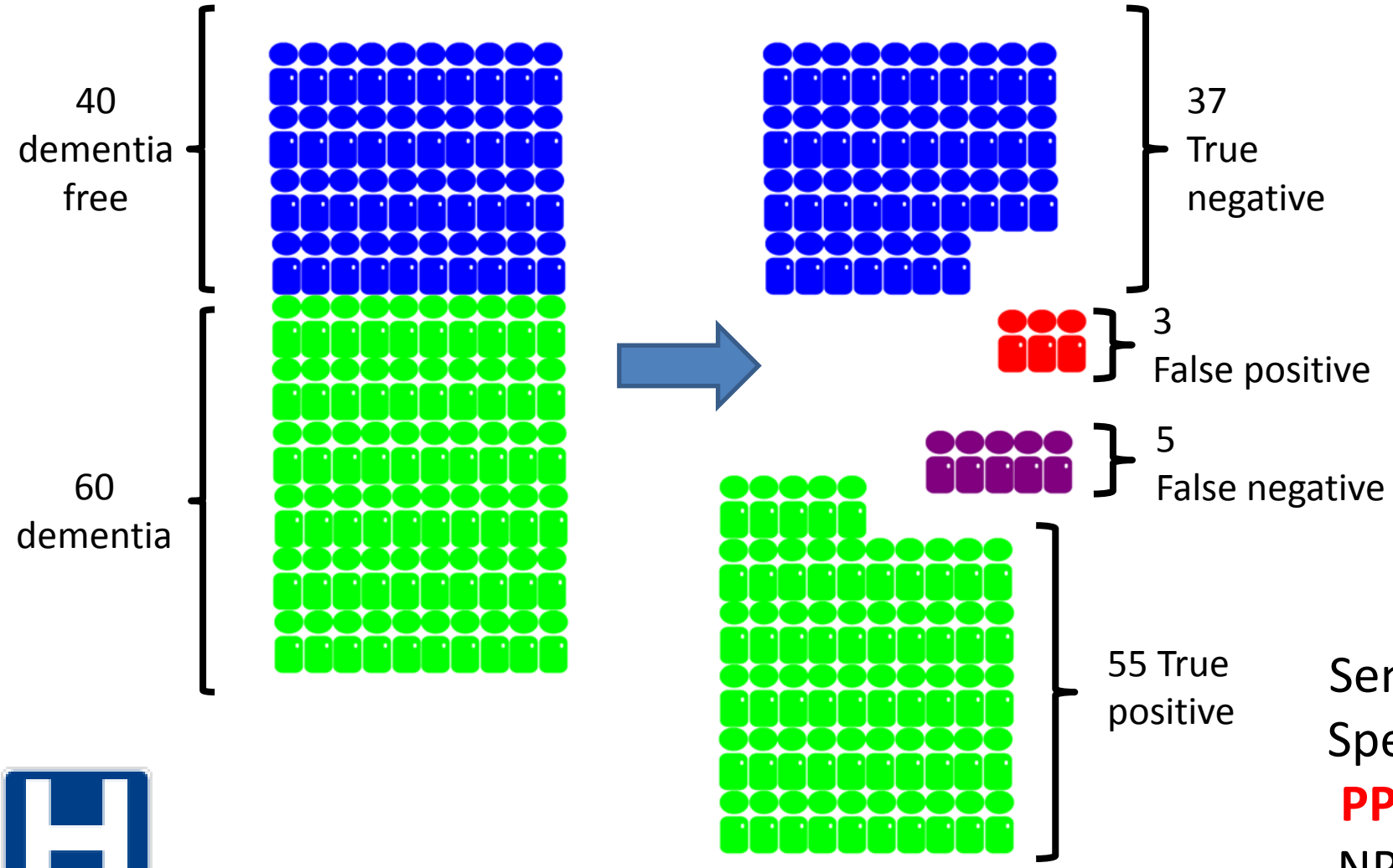
AUROC 0.93
95% CI 0.86-1.00
p<0.0005

AD8

AUROC 0.91
95% CI 0.83-0.98
p<0.0005

Reference line

The impact of implementing the IQCODE in older people with delirium



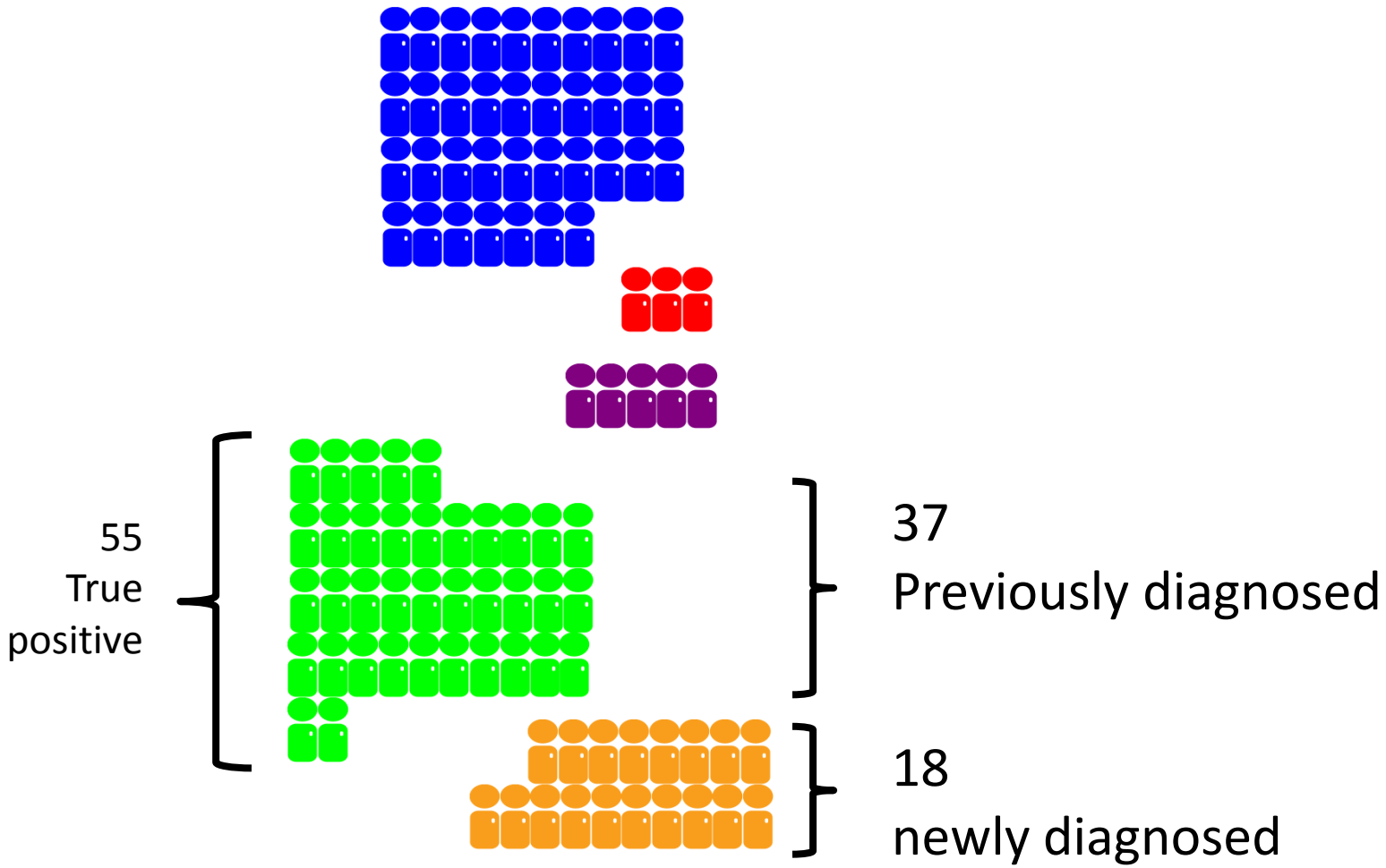
Sens 91%

Spec 93%

PPV 95%

NPV 88%

The impact of implementing the IQCODE in older people with delirium



Conclusions

Useful

The IQCODE at >3.82 and AD8 at >6 are both a sensitive and specific indicator of dementia in those with delirium

Impact

Significant impact to research community

Routine use of either tool in clinical practice will have significant impact on patient care

Summary/thoughts

- We look after a lot of dementia and delirium
- It is under recognised
- The CQUIN has helped this a bit but few many trusts not using money to drive improvements
- Other options for diagnosing should be considered
- ?impact on memory clinics