



Service Priorities and Programmes
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Development of Delirium Care Model in Acute Geriatric Ward

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Introduction

Delirium is a common and severe neuropsychiatric syndrome, affecting hospitalized elder patients. It is associated with significant morbidity and mortality, increased workload of healthcare providers and length of hospital stay. However, it is often under-recognized and poorly managed. Hence, we developed a Delirium Care Model (DCM) for delirious patients in the acute geriatric setting for effective management.

Objectives

1. To enhance knowledge and awareness of healthcare providers regards to the management of delirious patient. 2. To prevent, detect and manage delirium through DCM effectively.

Methodology

In the past 1.5 years, we had systematically reviewed and categorized our practices for management of delirium among hospitalized elders according to assessment and diagnostic tools, precipitating and predisposing factors, preventive measures and interventions. An IT system (i.e. K drive) was set up to facilitate data recording and communication. DCM was developed to reflect a comprehensive approach to prevention and management of delirium. It consisted of three main areas: 1. Prevention: Preventive strategies were developed with concept of structured core interventions in Hospital Elder Life Program (HELP). 2. Detection: All patients were assessed the cognitive function as baseline on admission and prevalence screening. During hospitalization, healthcare providers repeated the cognitive assessment to detect incident cases. All screened positive cases would be seen by doctors for diagnosis with Confusion Assessment Method (CAM). 3. Management: The main approach to management of delirious patients was nurse-led, non-pharmacological and multicomponent interventions. Evidence-based drug treatment was commenced.

A continuing educational program was provided to healthcare providers in order to improve their awareness and increase the applicability of DCM.

Result

From mid-2011 to 2013, we have recruited 47 cases. 40 patients have been

diagnosed as hyperactive delirium whereas 7 cases were hypoactive type. DCM has improved the management of delirium and brought about a positive change to our workplace and culture. With the creation of checklist and care plan, staffs have become more competent in handling delirium cases. We have also received positive feedbacks from the caretakers involved in DCM. Delirious patients who have participated in the DCM had better clinical outcomes. There was lesser need for physical restraints as compared to those under the normal care. Involvement of relatives/ caregivers in the caring process for delirious patients was noted to be one of important successful factors in delirium management. Conclusion DCM is found to be practicable through systemic review and revision of strategies. We believed that this model not only contributes to better clinical outcomes for delirious elders, but also increased staff knowledge and awareness.