Service Priorities and Programmes

Electronic Presentations

Convention ID: 970
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The Preliminary report of Delirium Care Model in Management of Delirium in Acute Geriatric Setting

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Keywords:
delirium
care model
geriatric
confusion

Introduction

Background: A delirium care model (DCM) has been implemented in United Christian Hospital acute geriatric ward for 1.5 year, which provided a comprehensive approach to prevention and management of delirium. The model involved preventing delirium in high risk older people and identifying and defining appropriate health service provision and management options in order to achieve best possible health outcomes.

Objectives

1. To describe the preliminary results of DCM in management of delirious patients in acute geriatric setting. 2. To illustrate a patient journey with incorporation of DCM

Methodology

Prospective recruitment of suitable cases in two geriatric wards with adoption of DCM

Result

Results: Totally 47 patients (22 males and 25 females) were recruited from mid 2011 to 2013. 40 and 7 patients were diagnosed hyperactive and hypoactive delirium respectively. The average length of stay in acute bed was 7 days. Totally 44 reversible risk factors such as faecal impaction(31%), urinary retention (31%) and electrolyte imbalance (36%) were identified at the early onset of confusion. Non-pharmacological interventions were provided promptly, including reality orientation, early mobilization, providing visual/ hearing device, promoting sleep and limiting use of physical restraint. Staff compliance was 100% to reality orientation, 89% to early mobilization and 45% to limitation to use of physical restraint. Prototype as illustration: A 79 years old lady was admitted to geriatric ward for fever and hyponatremia. She was orientated upon admission but she was found to be confused (kept standing at the corridor and refused to move over-night after toileting) on the third night of admission (Day3). She was diagnosed hyperactive delirium after doctor's assessment by Confusion Assessment Method (CAM). The delirium care model was activated. A comprehensive assessment to identify the causes and address the precipitating

factors was performed by using a screening checklist. An appropriate care plan was developed and implemented promptly, which included frequent reality orientation, environmental modification, maintaining hydration, early mobilization and early family participation. Education to her family was also provided. The care plan was reviewed regularly with her family members. Low dose haloperidol was used in this case. The lady regained orientation on day 6. However she was marked deconditioned and in-patient rehabilitation was provided. She was fully out of delirium on day 9 and was discharged to geriatric day hospital for rehabilitation on day 12. Conclusion: The delirium care model provided a clear clinical pathway for healthcare providers to manage delirium in acute geriatric setting.