Welcome to our Annual Public Meeting

16 JULY 2019
A warm welcome
Professor Sir Jonathan Montgomery, Chair
Review of the year and future plans

Dr Bruno Holthof, Chief Executive
Key facts 2018-19

- 1,185 beds
- 60 wards
- 48 operating theatres
- 11,836 staff
- 3,779 nurses and midwives
- 1,622 healthcare support workers
- 1,829 doctors
- 1,4 million patient contacts
- 7,500 babies delivered
- 1.2 million patient meals provided
- 105,000 planned admissions
- 80,500 emergency admissions
- 143,000 attendances at our Emergency Departments
- Turnover of over £1 billion
OUR YEAR – Highlights of 2018-19

WORKING TOGETHER for WINTER
OUR YEAR – *Highlights of 2018-19*

*Investing in HORTON GENERAL HOSPITAL*
OUR YEAR – Highlights of 2018-19

Improving EMERGENCY CARE
OUR YEAR – *Highlights of 2018-19*
The Year Ahead

Key Opportunities and Challenges for 2019-20
Dementia and Delirium

Implications for Hospital Management

Professor Sarah Pendlebury

Associate Professor in Medicine and Old Age Neuroscience
Consultant Physician
TALK OUTLINE

• What is dementia?
• What is delirium?
• How do stroke and acute illness affect thinking and memory?
• What are the implications for general hospitals?
• What do we do in OUH to look after confused patients?
What is Dementia?

- Dementia is a syndrome with many possible causes
- It is irreversible (‘chronic confusion’)
- The person has problems with thinking and memory severe enough to interfere with daily life
- People with dementia need support from others
Age and Incidence of Stroke and Dementia

Stroke and dementia share risk factors

Stroke and dementia increase the risks of each other
Dementia Subtypes

- Alzheimer dementia
- Vascular dementia
- Other dementia (eg Lewy body disease)
Clinical Characteristics

• Alzheimer disease
  – short term memory deficit

• Vascular dementia
  – problems with planning and sequencing
  – attentional deficit
  – apathy, depression

• Lewy body disease
  – fluctuation
  – Parkinsonism
  – visual hallucinations
Thinking and memory changes over time –
This may be rapid as well as gradual especially in acute illness.
What is Delirium

- Delirium is the medical term for **acute confusion**
- Fluctuation
- Poor attention
- Agitation or drowsiness
- Underlying medical problem
  *e.g. infection, constipation, pain*
Poor outcomes for dementia and delirium on hospitalised patients

- Mortality
- Institutionalisation
- Length of Stay
- Costs
- Dementia risk is increased after delirium
Confusion in OUH inpatients: rates

For patients aged 75+ years admitted as emergency:

• Over one fifth have known dementia
• Over one third are acutely confused (delirium)
• Over one half score low on thinking/memory tests
Most hospital patients with thinking and memory problems don’t have a dementia diagnosis

- Known dementia
- Delirium
- Low cognitive test score (AMTS)
- Recovery (TCI)
- New/accelerated cognitive decline
- Dementia diagnosis
Delirium
Acute confusion
Reversible
Thinking and memory problems

Dementia
Chronic confusion
Irreversible

Delirium
Acute confusion
Reversible

Transient thinking and memory problems

Ageing brain

Severe illness
Environment
Medication
Pain

Previous stroke damage

Memory
Executive
Language
Attention
Why should we assess patients for thinking and memory problems?

Recognition of confusion

- Quantify function
- Quantify frailty
- Capacity and consent
- Nursing care plans
- Coding Tariff
- Coding
- Mortality adjustment for case-mix
- Discharge planning
- Prognosis
- Sign-posting of care
- Environment
- Patient/carer information

Delirium
Dementia
Low cognitive score
Implementation of routine cognitive screening in OUH
OUH Cognitive Screen *(mandatory for older patients)*

### Clerking Proforma

<table>
<thead>
<tr>
<th>Space for Patient Information Sticker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment date/time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant/team</td>
</tr>
<tr>
<td>Assessing doctor</td>
</tr>
<tr>
<td>GP/ED/other referral</td>
</tr>
</tbody>
</table>

### Cognitive Screen

Complete on **ALL** patients ≥70 yrs and <70 yrs if confusion/altered behaviour, alcohol hx or brain disease e.g. stroke, PD, MS.

1. **Does the patient have a known diagnosis of dementia?**
   - [ ] Y
   - [ ] N
   - [ ] uncertain

   - **Age**
   - **Recognise 2 people**
   - **Time (nearest hr)**
   - **DOB**
   - **Recall (42 West Street)**
   - **WW2 (start or end year)**
   - **Year**
   - **Monarch**
   - **Location**
   - **20 to 1 backwards**

2. **AMTS Total = 10.**
   - **AMTS not done [ ] Reason:**

3. **Does the patient have delirium?**
   - [ ] Y
   - [ ] N
   - [ ] uncertain

   - **1. Acute onset &/or fluctuating confusion/altered behaviour**
   - **2. Inattention e.g. unable to do 20 - 1 or distractable**
   - **3. Altered conscious level e.g. agitated or sleepy**
   - **4. Disordered thinking (e.g. rambling)**
   - CAM: Delirium = 1+2+(3 or 4) OR clinical diagnosis

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*Age and Ageing 2015*
## Cognitive Screen

### Is AMTS feasible?  
- **Yes**  
- **No**  

### Reason AMTS not done  
- Too unwell  
- Uncooperative  
- Euphoric  
- Language barrier  
- Other.

### Age  
- **Yes**  
- **No**

### Year  
- **Yes**  
- **No**

### Time (nearest hour)  
- **Yes**  
- **No**

### Date of birth  
- **Yes**  
- **No**

### Year of 2nd WW (start or end)  
- **Yes**  
- **No**

### Now ask patient to remember this address: 42 West Street

### Location  
- **Yes**  
- **No**

### Monarch  
- **Yes**  
- **No**

### Count backwards (from 20 to 1)  
- **Yes**  
- **No**

### Recall 42 west street  
- **Yes**  
- **No**

### AMTS score  
- **10**

### Does the patient have a known diagnosis of dementia?  
- **Yes**  
- **No**  
- **Uncertain**

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### Aid to identify delirium (CAM)

1. Acute onset and/or fluctuating confusion/altered behaviour  
2. Inattention (unable to do 20-1 or distractable)  
3. Altered conscious level (agitated or sleepy)  
4. Disordered thinking (rambling)

**Delirium exists if patient satisfies conditions: 1 + 2 + (3 or 4) but note that CAM sensitivity is not 100% particularly for hypoactive (SLEEPY) delirium, so if patient has clinical diagnosis of delirium, even if CAM negative, select "yes".**

### Does the patient have delirium?  
- **Yes**  
- **No**  
- **Uncertain**

### Forgetfulness in the last 12 months  
- **Yes**  
- **No**  
- **Not assessable**

### Have you/had the patient been more forgetful in the past 12 months to the extent that it has significantly affected you/their daily life?  
- **Yes**  
- **No**  
- **Uncertain**
Improving rates of routine cognitive screening

% aged >75 years screened

Screening proforma introduced

2011 2012 2014 2019
Impact on Process of Care in OUH

2010: Introduced clerking proforma with cognitive screen, frailty domains, and co-morbidity
- EPR version planned for 2019

2015: Cognitive screen (AMTS,CAM) built in EPR 2015, mandatory for all \( \geq 70 \) years or at risk
- Screening rates now \( \sim 85\% \) in general surgery, \( >80\% \) in acute medicine
- 25,000 patient episodes with screening per year

2015: At-risk of dementia status (from the cognitive screen) transferred automatically to electronic discharge documentation

2015: Cognitive screening data used for the National Dementia CQUIN/NHS Digital

2015: Delirium score introduced into OUHFT clerking proforma
EPR automatic algorithm calculation planned for 2019.
Cited in evidence-based point of care database (www.dynamed.com), 2018

2018: Cognitive screen used to trigger specific nursing care plans

2018: Extended cognitive tests (MoCA, MMSE, ACE-III, IQCODE etc) introduced into EPR

2018: OUHFT consent forms changed to prompt consideration of capacity
Consent Form 1

Patient Agreement to Investigation or Treatment

Patient details (or pre-printed label)

NHS Organisation
Patient’s surname/family name
Date of Birth
NHS number (or other identifier)

Male □ Female □

Name of proposed procedure or course of treatment
(include brief explanation if medical term not clear)

Statement of health professional
(to be filled in by health professional who is capable of performing the procedure unsupervised, OR who has received specific training to obtain consent for the procedure, in accordance with OUHFT’s Consent Policy, which staff may access on the OUH Intranet).

☐ In my opinion there are no reasons to doubt the patient’s capacity to consent to/refuse this treatment;
☐ The patient’s mental capacity to consent to/refuse this treatment has been assessed and the patient has the mental capacity to make this decision.

I have explained the procedure to the patient. In particular, I have explained:

1) The intended benefits.

2) Serious, unavoidable or frequently occurring risks.
Recommended actions:

- Consider the need for a chaperone, if distressed. If considering one-to-one nursing, you must complete the Enhance Care risk assessment and discuss with Nurse in charge.
- Consider ward/bed space moves only in the best interest of the patient. If requested to relocate patient ensure that you inform family.
- Family informed of transfer.
- Try to encourage dressing in own clothes.
- Own clothes available?
- Anxiety, Agitation, Distress
  - Remember that behaviour is a way of communicating.
  - If distressed, observe for triggers to minimise symptoms.
  - Signs of distress?
  - Ensure that the Multi-Disciplinary Team is aware of distress, to rule out organic causes.
  - MDT informed of distress.
  - Encourage participation in activities to reassure and minimise distress.
  - Participated in activities for cognitive impairment.
- Promotion of Independence
  - Consider personal needs and management to include continence, mobility, eating and drinking and person centred care choices. If issues identified ensure relevant Care Plans are initiated.
- Carers
  - Ensure lead carer is identified and involved in care planning, as appropriate. Ask if they have any specific information needs. Provide information about Carers Liaison Service and refer, if required.
  - Lead carer identified.
ORCHARD: data included

- demographics (age, sex)
- postcode
- residence
- cognitive function (cognitive tests, delirium, and dementia diagnoses)
- diagnoses (from ICD-10 coding)
- illness severity (SIRS)
- falls risk
- in-patient fall*
- pressure sore risk
- in-patient pressure sore*
- functional status (from pressure sore and falls risk)
- length of stay
- delayed transfers of care (DTOC)
- reason for delay
- increased care needs at discharge*
- behavioural disturbance*
- sleep disturbance*
- constipation*
- catheterisation*
- discharge destination
- mortality
- readmission

ORCHARD: planned studies

- Prevalence of cognitive co-morbidity
- Delirium outcomes and predictors of future dementia risk
- Survival impact of physical, cognitive frailty vs comorbidities and illness severity
- Overlap between cognitive and physical frailty
- Factors associated with in-patient complications including falls
- Predictors of DTOC and care needs at discharge
ORCHARD: where do the data come from?

On admission, patient is assessed by doctor, nurse. All OUHFT patients >70 years get the cognitive screen.

Patient data entered by staff into the electronic patient record (EPR) using the OUHFT computers.

Later assessments on the ward also entered into EPR.

Data from earlier OUHFT-approved audits done prior to introduction of the Electronic Patient Record (EPR) would also be transferred to the database.

Data warehouse EPR, SEND

Specific data extracted by the OUHFT Information Analysts at request of STP.

HAVEN
Illness severity
Dynamic physiol. changes

Oxford Health CRIS database
Dementia MCI Cognitive test scores Depression
ORCHARD: Future studies to inform process of care

- Prediction of increased care needs
  – *could be used to target MDT assessment*

- Rates of dementia, delirium and cognitive impairment across the OUHFT

- Rates of physical frailty

- Impact on death and complications (falls, pressure sores)
Sensitivity, percent

Year of study cycle

Delirium coding

Dementia coding
Thank you for coming.
Have a safe journey.