Greater Manchester Health and Social Care Partnership

THE GREATER MANCHESTER COMMUNITY DELIRIUM TOOLKIT

PILOT REPORT
March 2021

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Contents

Executive summary

I will treat delirium as a medical emergency" (Care Home Unit Manager)

I will build stronger communication links with relatives and community services (Nurse Consultant)

Delirium is an acute deterioration in mental functioning arising over hours or days. It is one of the most common medical emergencies and can cause significant distress to patients and is independently linked to poor outcomes and increased mortality (Health Improvement Scotland 2019).

Across Greater Manchester, there is great variability in the assessment, management, and treatment of delirium in the community. Dementia United seized the opportunity to improve the current situation with the development of a standardised Greater Manchester community delirium toolkit; which was escalated and expedited as a working draft version for implementation, at the request of clinicians as a result of COVID-19. A patient delirium leaflet was also developed as part of the toolkit.

Dementia United supported five community teams to pilot the toolkit for six months, with fortnightly drop-in sessions offering the opportunity to access advice, using 'Plan Do Study Act' cycles, to review and amend the toolkit. The teams participating in the pilot were already established, for example: admission avoidance, urgent care, and a primary care network.

The goals of the pilot were to understand if the Greater Manchester community delirium toolkit could be implemented across Greater Manchester, what resources are required, and whether it would deliver intended benefits. The intended benefits were the early detection of delirium, improved outcomes, such as reduced hospital admission, and to provide information for patients and family members.

The community delirium toolkit was successfully implemented by several community teams, despite the barriers they faced due to the COVID-19 pandemic. 156 patients were screened using a standardised screening tool (4AT), of which 87 (56%) achieved the screening threshold for a probable diagnosis of delirium. Of the 87 diagnosed, 61 (70%) were able to avoid hospital admission and remain at home.

Onward referrals to mental health services sometimes caused delays, though there were no delays for referrals to other services.

Staff reported improvements in their ability to detect, diagnose and manage delirium. All teams reported increased competence and confidence. Feedback on the leaflet was very positive. Families reported that the leaflet was invaluable as it “made sense” of what their relative had experienced.

COVID-19 prevented the delivery of standardised training for teams implementing the toolkit, as well as impacting on staff engagement in the pilot and data reporting. Despite this, the pilot delivered on most of the intended goals and objectives. There were also positive ripple effects on wider engagement through the toolkit having been implemented by community teams across the localities and from regional and national interest in the work.

Dementia United will deliver finalised versions of the Greater Manchester community delirium toolkit and Greater Manchester delirium leaflet following this pilot and ensure wider cascading of these resources. Consideration should be given to wider implementation across Greater Manchester, including harnessing the locality engagement already achieved with the enthusiasm of community teams.

Background and context

What is delirium?

Delirium is an acute deterioration in mental functioning which arises over hours or days. It can be triggered by causes such as acute medical illness, surgery, and trauma. Delirium can cause significant distress to patients, families and is independently linked to poor outcomes such as increased likelihood of increased length of stay, of admission to long term care and increased mortality (Health Improvement Scotland 2019).

Delirium is one of the most common medical emergencies and can last for days and months. It is found to affect 1 in 8 hospital inpatients, though there is much less available data on the prevalence in community settings (Andrew et al 2006) and detection in care homes is known to be problematic (Siddiqi 2016). The prevalence in community settings can be as low as 2% but rises to 14% for older patients and can be as high as 60% for care home residents (British Geriatric Society 2020).

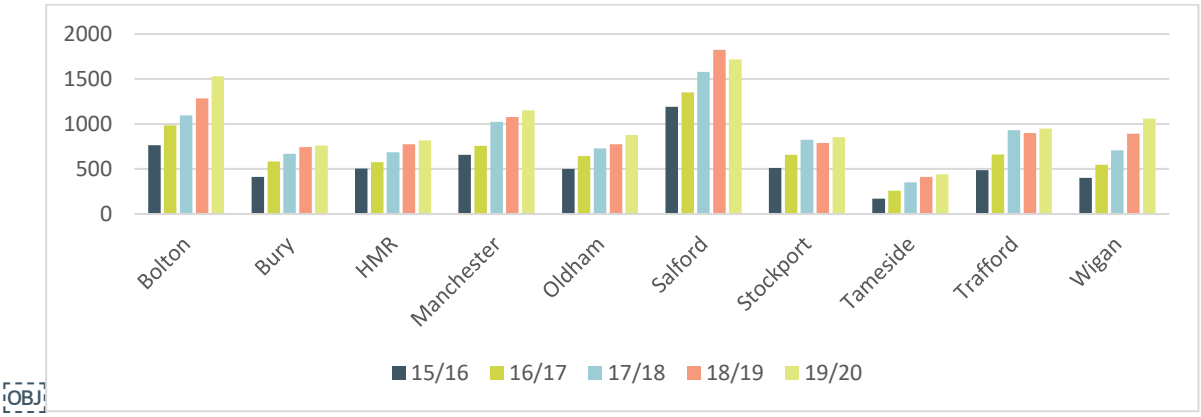
There have been further studies highlighting how the prevalence rises for people with dementia (Fick et al 2005), palliative care patients (Watt et al 2019) and more recently in patients with COVID-19 (Zazzarra et al 2020).

People who are older, or are living with dementia, or post-surgery are at higher risk of developing delirium. Additionally, there is a strong association between delirium and risk of future development of dementia. Delirium also hastens cognitive decline in those with existing dementia (Fong et al 2009).

Delirium is a treatable condition and is preventable in around a third of cases. The detection of delirium is therefore important to improve outcomes for patients as well as reducing distress for patients, carers, and families, and to realise economic and clinical improvements and savings.

Greater Manchester position

Across Greater Manchester, there is great variability in the assessment, management, and treatment of delirium. Between 2015 and 2020 hospital admissions increased in all ten Greater Manchester localities year on year, though numbers differed significantly (see graph). In 2018/2019, there were 9,119 admissions to acute hospitals in Greater Manchester which involved delirium. A significant percentage of these admissions (94.1%) came through the Emergency Department (Royal College of Psychiatrists 2019); please note the caveat that the numbers are not related to the size of the organisation.



Graph: Hospital admissions for delirium 2015 – 2020

The National Audit of Dementia round 3 and round 4 (Royal College of Psychiatrists 2017, 2019) showed that initial delirium screening rates in hospitals in Greater Manchester had improved between the two audit periods (see table). However, there was considerable variability in the percentage of patients who were screened, ranging from 26% (Fairfield General) and 28% (Tameside General) up to 84% (Stepping Hill). These compare with a national average of 58% for round 4.

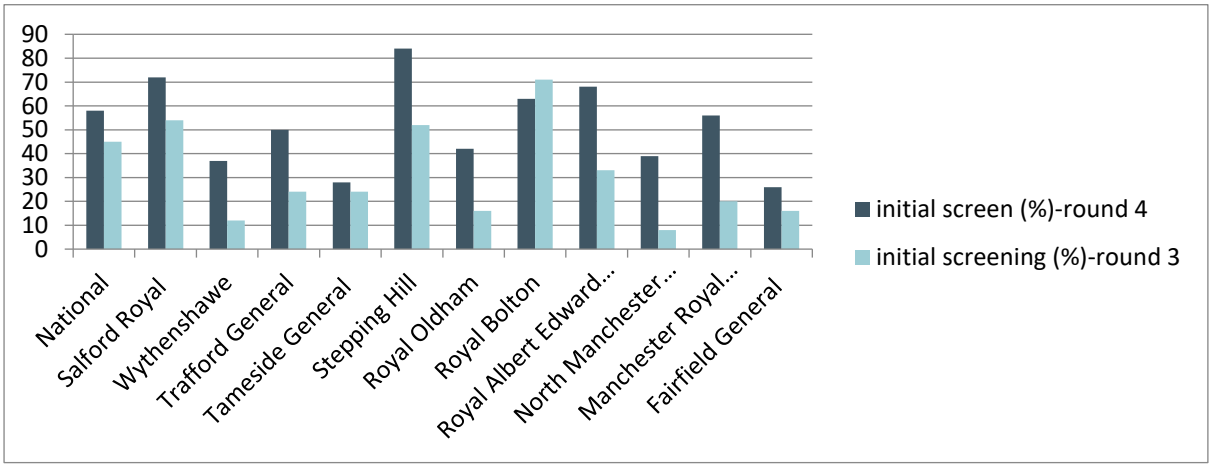


Table: Inpatients with dementia assessed for delirium (National Audit Dementia Round 3 and 4)

Greater Manchester Approach to Delirium

In 2017, Dementia United sent-out questionnaires to key delirium stakeholders, commissioners, mental health trusts, community care, and social care colleagues seeking information on any pathways or assessments. The results from these questionnaires completed by most localities, established that there were no pathways or standardised assessment tools for managing delirium in the community across Greater Manchester.

A delirium steering meeting was set up following the World Delirium Awareness Day event in 2018 to harness the interest and engagement of delegates.

Dementia United drafted an evidence-based 'Greater Manchester approach to delirium', which included a person-centred delirium pathway applied to all care settings, which was approved via Dementia United governance. The document can be accessed on the Dementia United website: Greater Manchester approach to delirium.

The impact of COVID-19

Although Dementia United had been developing the community delirium toolkit prior to the arrival of the COVID-19 pandemic, the pressures this caused within the healthcare system provided additional impetus to the work. Delirium is important in the context of COVID-19 because:

- Delirium may be a symptom at presentation or during management of COVID-19 (McLoughlin et al 2020)
- Behavioural changes commonly seen in delirium, particularly agitation, may make management of COVID-19 including delivery of care and reducing the risk of cross-infection more challenging (British Geriatric Society, 2020)

As evidence emerged nationally and internationally highlighting that delirium may be a symptom at presentation of COVID-19, Public Health England updated its guidance on 14 December 2020 suggesting that the presence of delirium should prompt clinicians to test for COVID-19 (COVID-19: investigation and initial clinical management of possible cases - GOV.UK (www.gov.uk)).

Clinical colleagues requested that work on the community delirium toolkit be escalated and expedited. This resulted from factors such as:

- People with delirium may need assessment for the presence of COVID-19
- Pressure on hospital beds meant that any resources that would assist in the prevention of a hospital admission would be of value plus
- Hospital admission meant visiting restrictions which would impact on patients and families

The toolkit was intended to provide colleagues working in community teams a systematic approach to assessing, treating, and managing delirium.

Development of the toolkit and pilot goals

In 2019, Dementia United established a community working group to focus on delivery of the standards from the Greater Manchester approach to delirium, applied to the community setting. These standards are:

- Every care organisation should have a standardised pathway for assessment and management of delirium
- Family carers are provided with information and support to help support relative with delirium
- Non-pharmacological measures/de-escalation techniques used before medication for agitation/distress
- Delirium diagnosis should be conveyed at all transitions of care and people with delirium should have multidisciplinary follow-up

Dementia United were aware of a community delirium pathway utilised by NHS Ayrshire and Arran Appendix 3) and this was used as an initial template for pathway development building on NICE (2019) and Health Improvement Scotland (2019) standards. The successful implementation of a digital delirium pathway as part of Salford Royal Hospital's Delirium Global Digital Exemplar (Vardy et al 2020) was also utilised to further develop the toolkit and the learning gained from implementation of this pathway.

At the World Delirium Awareness Day event in March 2020, Dementia United shared the draft versions of the toolkit and leaflet enabling 80 delegates, who were stakeholders from across health and social care, and carers of people with dementia, to review and develop these drafts. The working draft versions were approved by Dementia United governance and given support to be piloted. They were shared with the primary care cell in June 2020, who also supported them being piloted. The table below highlights the timeline of the development of the toolkit and pilot.

Timeline

March 2018	Hosted free **1st Greater Manchester World Delirium Awareness Day event**
Winter – Summer 2018	**Establish delirium steering group** • Develop evidence-based Greater Manchester approach to delirium and pathway
Spring – Autumn 2019	**Working groups established for different settings** • Involving carers, people living with dementia, doctors, nurses, mental health and social care professionals, North West Ambulance Service, primary care, and allied health professionals. • Hosted free 2nd World Delirium Awareness Day event, March 2019
Winter 2019 – Spring 2020	**toolkit and leaflet development** • Content reviewed and redrafted with 80 delegates at World Delirium Awareness Day event, March 2020. • Input and sign off from Dementia United governance of working version. • Shared with primary care cell, Dementia United stakeholders, and all delirium engaged stakeholders.
Summer – Winter 2020	**Testing** • Expressions of interest and launch meetings with piloting teams. • Fortnightly support for piloting teams. • Six-month Plan Do Study Act cycle of quality improvement, analysis, and feedback during the pilot.
Spring 2021	**End of pilot** • Analysis and report on findings, recommendations for rollout.

Pilot goals

The goals of the pilot were:

1. To understand if the community delirium toolkit could be implemented across Greater Manchester.
2. To identify what resources are needed to implement the community delirium toolkit.
3. To consider whether the toolkit is likely to deliver the intended benefits of:
    a. Early detection of delirium with standardised screening.
    b. Reduce hospital admissions whilst ensuring safe delivery of care at home.
    c. Improve outcomes for patients using standardised assessment and management.
    d. Education and information for patients and family members/carers.

The overall objectives of the pilot were to prepare the Greater Manchester community delirium toolkit for implementation, trial with community teams/primary care in localities, prepare practitioners, provide ongoing support during the pilot, test out and seek feedback on the delirium patient leaflet as well as determining if any changes need to be made to the toolkit. These can be broken down into the following key objectives:

- Provide the key documents in the community delirium toolkit along with associated suite of supporting documents via the Dementia United website
- Provide an expression of interest process for teams to apply to be part of the pilot
- Establishment of a launch meeting for interested teams, providing training resources and support for them to go live
- Support the teams in the pilot and utilising qualitative improvement methodology to review the toolkit
- Seek feedback across health and social care as well as with experts by lived experience on the leaflet
- Gather and collate data from pilot teams, using questionnaires to collect feedback and lessons learned from the teams
- Analyse data and report on the overall goals of the pilot, including recommendations for the wider implementation

The patient delirium leaflet included in the toolkit was intended to become the main public source for information about delirium in Greater Manchester. A system-wide engagement and feedback on the leaflet was undertaken to ensure that it met its goals. The Greater Manchester community delirium toolkit and delirium leaflet can be accessed on the Dementia United website: Greater Manchester community delirium toolkit

Engagement of the community teams in the pilot

Dementia United identified the following service prerequisites for teams to participate in piloting the Greater Manchester community delirium toolkit, although we were not prescriptive about how these could be accessed. For example, accessing venepuncture and treatment for medical causes could be through another service or general practitioner led. The prerequisites were:

- To use the 4AT screening tool - which does not require formal training and has diagnostic accuracy (Tieges et al 2020)
- Staff to be able to diagnose delirium
- To be able to determine the cause of delirium, which included access to venepuncture and other investigations as identified in the toolkit
- Acting on the results from the blood tests/investigations as part of treatment of underlying causes
- Management of delirium as identified in the toolkit
- To use the patient leaflet to provide education and support for the patient/family member/carer

From June 2020 onwards, Dementia United asked community teams to complete and return expressions of interest to participate in the pilot. Dementia United were hoping to receive expressions of interest from already established community teams, for example: reablement teams, urgent care, admission avoidance teams, community mental health teams and primary care networks. Community teams could return expressions of interest at any point during the six months of the pilot. This was in recognition of the impact COVID-19 was having on community teams, which may have affected their being able to train staff and engage with using the toolkit.
We received completed expressions of interests from five localities and five very different teams. Dementia United then followed these up and offered each team the following:

- A telephone call to discuss the team's expressions of interest, answer any initial questions, consider who they may want to invite for a virtual launch/feasibility meeting.
- A launch/feasibility meeting which covered:
    - Governance and accountability that they needed to consider for the go ahead locally for piloting the working/draft versions.
    - Staff preparation for going live and resources on the Dementia United website.

- Practicalities of what to consider for going live.
- Dementia United's offer of support:
  - Follow up telephone calls.
  - Fortnightly drop-in sessions throughout the period of the pilot.
- Plan Do Study Act cycle as part of the pilot quality improvement.
- Data collection form and ask of the teams, including qualitative feedback.

Make-up and focus of the teams in the pilot
The teams engaged in the pilot varied in terms of make-up, focus, geographical coverage and who they worked with. They were mostly already established teams. The table below provides a brief outline for each team.

Training

Staff in the pilot community teams had differing levels of expertise in screening, assessing, and diagnosing delirium. They had varied amounts of delirium training, prior to working with Dementia United in piloting the toolkit. Some had no training at all.

The COVID-19 pandemic prevented Dementia United from accessing in-person training as had been initially planned. We therefore offered alternatives, as outlined below, to build staff confidence and competence.

Dementia United collated national awareness-raising and training resources and made them available on the Dementia United website: delirium toolkit training resources. We offered fortnightly drop-in sessions, throughout the duration of the pilot. At these sessions, staff had access to a consultant geriatrician, a mental health nurse who formed the Dementia United project management team, and peer support from other teams engaged in the pilot.

Each community team adopted their own approach to preparing staff for using the toolkit. Trafford community enhanced care service and Manchester intermediate care spent time training all staff before going live with the toolkit. Whereas Bolton admission avoidance team opted to train some staff and then went live with a plan to train more staff once the senior staff had been using the toolkit for some time. Each team went live at different times, as indicated in the table below. These decisions were taken at a local level depending on the training and preparation that they wanted to implement before going live.

Community Team make up, coverage and scope

Team	Staffing	Coverage	Staff skills in relation to the pilot	Referrals received from	Service on offer	Support offered in relation to the pilot	Pilot live date
Trafford Community Enhanced Care Service	Nurses (Band 5, 6, 7, 8), Health Care Assistants (HCA), medicine manager Access to Allied Health Professionals and Social Services **Trained as part of the pilot and using the toolkit**: All nurses, HCAs (trained and had the delirium leaflet)	All Trafford GPs. Patients at home and in care homes.	Venepuncture ECGs non-medical prescribing	GPs, ED and inpatient wards, NWAS, social workers, District Nurses, MacMillan nurses, crisis response, AHPs	Urgent - hospital admission avoidance. Routine - Chronic condition management, proactive engagement with frequent hospital attenders	Nursing review, HCA support, access to social services, aids and adaptations, Step up beds	03/08/20
Salford Urgent Care Team	Advanced Practitioners, nurses, OTs, Physio	All Salford GPs	Venepuncture ECGs non-medical prescribing	GPs, ED and inpatient wards, crisis response	Hospital admission avoidance Discharge home pathway	Nursing reviews, aids and adaptations, Step up beds	01/09/20
Bolton Admission Avoidance Team	Advanced clinical practitioners (ACP), nurses, OT, Physio **Trained as part of the pilot and using the toolkit**: ACPs	All Bolton GPs At home and in care homes	Venepuncture non-medical prescribing	GPs, ED and inpatient wards, urgent care teams, crisis response	Hospital admission avoidance 72 hours after which time the reablement services or other appropriate care will take over alongside therapy/rehab input	Nursing reviews, aids and adaptations, Step up beds	14/09/20

Stockport Proactive Victoria Primary Care Network	25 District Nurses; Neighbourhood ACP, Matron; 20 Crisis response; 2 CPNs. Adult Social Care (ASC) neighbourhood LCO, 5 GP practices **Trained as part of the pilot & using the toolkit**: All DNs, ACP, Matron, CPNs, Crisis response team	5 GP practices, 1 PCN. Patients at home only as part of the pilot.	Venepuncture ECG non-medical prescribing	GPs, ED and inpatient wards, urgent care teams, crisis response, ASC	Hospital admission avoidance		05/10/20
Manchester Intermediate Care, Gorton South	All staff trained as part of the pilot - ANP, nurses, OTs, Physio, HCAs Access to GP	In reach nursing and residential beds and home pathway beds (community patients). Central Manchester	Venepuncture Prescribing	GPs, Hospital	Intermediate care Work closely with discharge to assess, home pathways		01/12/20

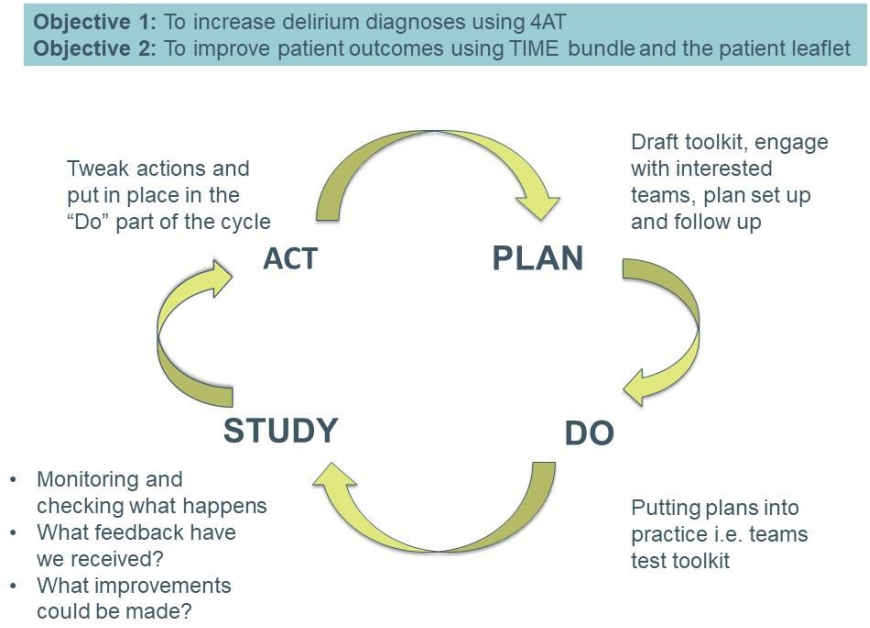
Methodology

Quality Improvement (QI) is a useful methodology that can be used to make timely improvements in clinical practice. It enables clinical improvements to be made in real time and allows learning that can be shared and spread to others (HQIP 2020). HQIP (2020) recommend using a combination of tools for successful completion of quality improvement projects.

One of these tools is the use of a Plan Do Study Act (PDSA) cycle, which enables changes to be tested on a small scale, in a live setting. These stages are planning the change, testing it out, evaluating and acting upon results. After testing, learning, and refining through several PDSA cycles, the change is implemented on a wider scale (HQIP 2020).

The figure below, outlines the PDSA cycle applied to the pilot. Dementia United utilised the fortnightly drop-in sessions, with the community teams, as opportunities to repeat PDSA cycles in developing the toolkit and leaflet.

PDSA cycle applied to the pilot



Measuring outcomes

The community teams were asked to collect data, however we did not want to make this onerous on them, as we recognised the impact of undertaking a pilot during the COVID-19 pandemic.

Teams engaged in the pilot collected data on:

- numbers screened using a 4AT following a positive Single Question In Delirium (SQID)
- numbers where the TIME Bundle was used

- numbers where delirium bloods were completed
- on average number of days patient with the team (looking to capture any delays)
- onward referrals required
- numbers given the delirium patient leaflet
- number of patients admitted to hospital
- causes of delirium

We intended to use a triangulated approach to obtain feedback from the staff engaged in the pilot. This included:

- detailed questionnaires with the team managers about pilot engagement and lessons learnt ((see appendix 4)
- staff questionnaires (see appendix 4)
- in-depth case study with one of the teams looking at their experience with the toolkit allowing insight in to how its adoption has affected their work

We also collated and mapped out all interest locally, regionally, nationally, and internationally which emerged during the pilot. This included any developments that were led by the community teams themselves, as well as by Dementia United.

Results

Data from the trial of the community delirium toolkit was collected from a total of four teams over a period of eight months, from August 2020 to March 2021. The data was submitted in fornightly reporting periods, starting on Monday and ending on the Sunday of the following week. Not all teams submitted data throughout the whole period. Manchester intermediate care, submtited no data despite initiating the pilot of the toolkit in their team.

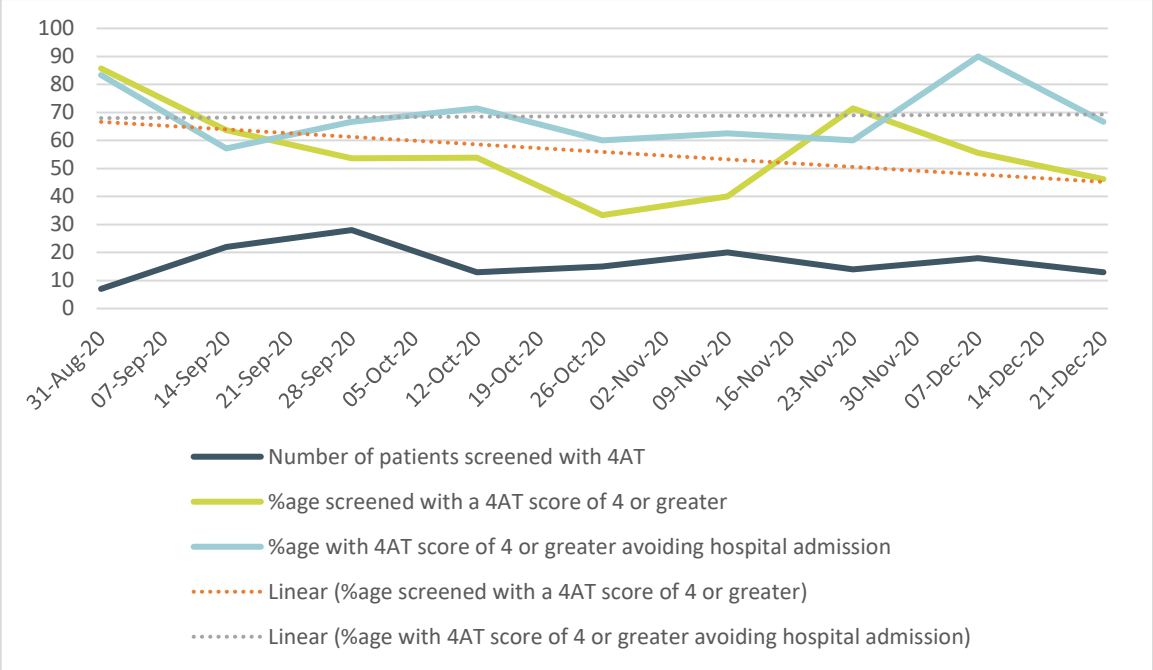
Teams only submitted data relating to patients who presented with new confusion, omitting counts of total patients seen and preventing calculation of what proportion of their patients present with new confusion. All patients with new confusion were screened using 4AT. Thus the data submitted for patients effectively begins at the point on the pathway where they were screened using the 4AT.

A total of 156 patients were screened using 4AT. These were spread unevenly between the four teams due to differences in team size and data submission. Of those screened, 87 (56%) had a score equal to or greater 4, achieving the screening threshold for a possible diagnosis of delirium.

One team submitted data on test scores, showing that scores ranged from 0 to 8. The highest possible 4AT is 12, suggesting that the final question, relating to fluctuating course, was not used. There were also some screening results of 4 or greater which were marked as unlikely to be delirium. These are still included in the count as they met the screening theshold and the decision not to treat as delirium was subsequent clinical judgement outside the 4AT screening tool.

The use of the TIME bundle and Greater Manchester Delirium leaflet was almost wholly split between different teams. Teams either completed the TIME bundle and provided the leaflet for every patient in their care or for none.

Of the 87 patients who had a 4AT screening score of 4 or greater, 61 (70%) were able to avoid hospital admission and remain at home. The rest of the patients were mostly admitted to hospital, though a few had other outcomes, including admission to a hospice or death.
Due to differing levels of engagement and data submission from teams involved in piloting the delirium community toolkit the data between 31 August 2020 and 3 January 2021 is most complete and amenable to breakdown. The chart below shows the collated figures for three measures: number of patients screened, percentage of patients screened with a 4AT of 4 or greater, and the percentage of those with a 4AT score of 4 or greater who avoided hospital admission.



A wide range of causes of delirium were found in those patients managed by community teams piloting the toolkit. Identified causes include dehydration, chest infection, urinary tract infection, pain, hypernatremia, hyponatremia, high calcium, CRP, head injury, respiratory tract infection, COVID-19, cholecystitis, and cellulitis. Not every patient had a cause listed, and some cases of delirium were attributed to unknown causes, but for most patients the teams had managed to discern a cause for the delirium. The community teams did not complete delirium bloods on all patients who they assessed as presenting with delirium. 40 of the 87 patients had their bloods taken. There were some patients with causes identified where bloods had not been taken.

Some of the community teams reported on services they referred patients with delirium to. They indicated if this onward referral delayed the patient being discharged from the team's care. Most teams reported that there were no delays in accessing services and onward referrals for therapy, podiatry, adult social care, and bladder and bowel services.

There were some delays for some of the teams, when referring for mental health services for the patients. Access to mental health services differed by team, with each having their own pathway for engaging with or referring into such services. These differences impacted their access to advice and support required. For example:

- Stockport's community team includes access to community psychiatric nurses and they were therefore able to access advice and support easily. There were no delays in accessing mental health services for patients that they referred with delirium. They reported that three patients with delirium were already known to mental health services
- Trafford's community team refer through the patient's GP for access to mental health services. They reported delays in accessing memory assessment. They can, however, directly refer into Psychological Therapies, which did not result in any delay.

Staff engagement

Throughout the pilot, the drop-in sessions had variable engagement from the community teams. One team attended all sessions, whilst other community teams attended one or two. Where a team did not attend several sessions in a row, Dementia United offered an individual catch up meeting with that team. This enabled all teams to feel that they could discuss issues, successes, barriers, and any questions they may have within the pilot.

Using a PDSA cycle, Dementia United adapted and changed the focus of these sessions to reflect the feedback received and emerging issues. An example of this, was a need to engage with mental health services for people presenting with delirium. We established a small working group with two key colleagues from Pennine Care and Greater Manchester Mental Health NHS Trust, to explore how we could build links to locality based mental health services to support community teams.

Clinicians from across Greater Manchester, who wanted to find out more about the community delirium toolkit, were also invited to attend these drop-in sessions. This was to enable these interested colleagues, to hear from teams who were themselves implementing the toolkit. We had a wide range of colleagues attending from a director from urgent care and Salford intermediate care unit.

Impact on the staff teams and services

We used a triangulated approach to obtain feedback from the staff engaged in the pilot. This included information from anonymous staff questionnaires (4 completed), detailed interviews with the team managers about their engagement and lessons learnt.

100% of the staff who responded stated that they agreed or strongly agreed:

- That they understood the difference between delirium and dementia
- Felt confident in using key documents in the toolkit, such as the 4AT screening tool and the TIME bundle to identify and manage cases of delirium
- Had gained confidence and competence through participating in the pilot

In more detailed discussions, staff teams reported several changes from their involvement with the pilot and connections with other services through local rollouts.

In Stockport, staff reported that they were more likely to recognise delirium and seek help in its management. The crisis response team have asked that the toolkit be adopted throughout Stockport as a result. There is also a plan to work with extra care housing, to train staff to recognise and seek help for a resident with delirium.

Staff in Stockport reported:
"that the toolkit certainly helped staff increase knowledge in delirium and understand what action to take. It kept patients out of hospital. Bloods and other investigations were taken and acted on quickly."

In Salford, the intermediate care (IMC) bed-based unit, became involved in implementing the toolkit following links with the Salford urgent care team. Staff members from Salford IMC designed a lanyard card which prompts for symptoms of delirium and causes using the established acronym PINCH ME (see appendix 5).

The diagram below outlines the connections and developments that the community teams have made through their involvement with the pilot.

Developments by the community teams in the pilots

Trafford provided a highly detailed response in terms of the impact of the adoption of the toolkit allowing for the creation of the case study below, based on their experiences.

The community teams reported very positive feedback from people with delirium and from family members and carers in relation to the Greater Manchester delirium leaflet. Families reported that the leaflet was invaluable as it "made sense" of what their relative had experienced. They considered the information in the leaflet to be valuable in helping their understanding of what delirium is, how to spot it and prevent it.

Quotes from family members and staff:

> **I think it is excellent and I wished I'd had this when both my mum and mum-in-law had delirium.**

> **it has helped one family recognise delirium in their relative and seek medical help.**

Trafford community enhanced care service case study

The Trafford community enhanced care service was the first team to begin piloting the community delirium toolkit, in August 2020. The team has submitted data throughout the pilot and provided qualitative feedback on the use of the toolkit. A more detailed look at their experience with the toolkit allows insight to how its adoption has affected their work.

Context
The service is staffed by 25 nurses and 15 healthcare assistants, split across four geographical teams. The service is also supported by a medication manager and a pharmacy technician is shared with the intermediate care team at Ascot House. Their team previously included occupational therapists and physiotherapists, who have since been moved from the team but are still accessible for direct referral. The service has daily communication with social services about their patients.

The service covers 32 GP areas, all in Trafford, and care homes in the same area. The service provides a routine service for patients who have chronic health conditions (typically patients with chronic obstructive pulmonary disease, and heart failure), as well as those who are frequent attendees at hospital; as well as 15 urgent beds.

Routine referrals come from; district nurses, North West Ambulance Service community paramedics, Macmillan nurses, secondary care if the patient is a frequent attendee, GPs, and therapists. Urgent referrals come from similar sources, but also include hospital wards such as the Acute Medical Unit and OPAL discharge to assess unit mostly from Wythenshawe and Trafford Hospitals, with a few from Salford Royal and Manchester Royal Infirmary. A few referrals coming from care home residents.

Monthly referrals (routine/urgent) range from 10 to 40. The total caseload for all four geographical teams is about 100 routine cases. The number of referrals in 2020 was similar to previous years despite COVID-19, although there may have been a reduction in the number of flu cases and referrals from secondary care. A new scheme which started in October 2020, where community paramedics in the North West Ambulance Service diverted patients to the Trafford team, which meant an increase in referrals via this pathway.

Adoption

In preparation for adopting the Greater Manchester community delirium toolkit, all nurses in the team were provided with training on using the toolkit. This was over a two-week period and involved a detailed look at the key resources and focusing on signs and symptoms of delirium. The healthcare assistants were also provided with training using the Greater Manchester delirium leaflet, to help them spot the signs of delirium in patients. All training was delivered before going live with the toolkit. Each of the four geographical areas, then had a link nurse who took the lead on delirium, including collating all data as part of the pilot.

As a result of the pilot, all nurses used the toolkit to identify and manage patients with delirium. They all administered the 4AT screening tool. They also all used the TIME bundle provided to ensure they followed a standardised and structured approach to identify the causes of delirium and followed the management plan. All the staff reported that the toolkit provided consistency of care for all patients. As a result, they have found that the nurses have become more confident dealing with known or suspected cases of delirium. Cases of delirium have been diagnosed earlier and there has been a greater emphasis on prevention.

Blood tests and ECGs taken on patients with suspected delirium were regarded as urgent. Blood results are returned the same or following day, and ECG results interpreted immediately by telemetry. Bladder scanning was needed on one or two patients, which required a referral to a dedicated team outside the service; however, this had not resulted in any delays in accessing this when needed.

The staff reported that it has become more normal to adopt a watch and wait approach rather than to prescribe antibiotics; where there is no clear cause of delirium found. They had started to note that for some patients the change of environment may have been a contributory cause to their delirium. Previously this might have been attributed to a urine infection by the family. Increased education and awareness about delirium has helped identify or consider other causes, including environmental changes when people have come out of hospital.

Previously the teams work included more routine and long-term management of patients with chronic conditions. They have noted that more of these patients now have family members living with them due to the COVID-19 pandemic. This may have improved the ability of patients to manage better, due to family members ensuring wraparound care. For example, they had noted improvement in eating and drinking habits, which may have prevented some cases of delirium. This has been reflected to patients and families, where patients are at risk of developing delirium and is being taken forward as a prevention strategy.

They shared the leaflet with family members and patients where the team diagnosed with delirium, as well as where patients had been diagnosed with delirium in the past (or on a recent hospital admission). Reports from the recipients suggest that it has been useful to know and understand what delirium is and how to prevent it.

Trafford have engaged with colleagues from other services, as part of the pilot and implementation of the toolkit. For example:

- A community paramedic with the North West Ambulance Service, as part of their academic studies has devised a QI project focusing on the training of North West Ambulance Service staff in delirium and promoting the use of the 4AT screening tool, as well as socialising colleagues to the toolkit.
- Rolling out the Greater Manchester delirium leaflet with staff from Ascot House (Trafford Intermediate Care Service).

Feedback on the Greater Manchester delirium leaflet

We sought health and social care system wide 'expert by experience' feedback on the leaflet (See Appendix 1 for a list of questions sent out the with the leaflet and Appendix 2 for the list of stakeholders that reviewed and commented on the leaflet).

Stakeholders suggested several useful changes to the style and phrasing of the leaflet's content. Particularly around how the leaflet addresses the reader as a carer for somebody with delirium and ensuring that the terms used are appropriate for the general public. Further changes included ensuring that the leaflet was easy to read even when printed in black and white. The feedback has been used to create updated drafts of the leaflet.

Discussion

Successes

The community delirium toolkit was successfully implemented by several community teams in Greater Manchester, despite the barriers they faced. These teams used the 4AT to screen for possible cases of delirium, the TIME bundle including the management guidance was used to support the management of patients with delirium, and the delirium leaflet was provided to patients and family members to inform them about the condition. Overall, piloting teams did not report problems with implementation, and so the first goal of the pilot, to understand if the toolkit could be implemented across Greater Manchester, can be considered as having been met. Bed-based intermediate care services also engaged with the toolkit, raising awareness of delirium with their staff team.

The second goal, of identifying what resources are needed to implement the community delirium toolkit, was only partly met. The teams were able to utilise the toolkit and any additional resources that were provided via the Dementia United website. Standardised training for staff members was not delivered due to COVID-19 restrictions (see below), and we are not able to assess or compare the training which was delivered by individual teams. It is possible to say that training should be delivered in preparation for implementing the toolkit, as several teams reported finding this useful.

The teams reported that not all the patients had delirium bloods undertaken. Some of teams reported that causes of delirium had been identified that did not require these bloods.

There were ongoing discussions throughout the pilot over the importance of obtaining standard delirium bloods, or not for every patient. Some teams reported that they completed these on all patients and in so doing, picked up other potential multiple causes of delirium that may have been missed. One team adopted a watch and wait approach and then would consider obtaining bloods as needed. The option of having standard delirium bloods for all patients would need to be considered, with any wider roll out of the toolkit, including who would act on any results.

The importance of having access to a bladder scanner for all patients with a probable delirium, was considered and discussed on a regular basis within the drop-in fortnightly sessions. One team highlighted the need for access to bladder scanner for a small number of patients, and they were able to access this via onward referral. The wider need for access to this may well be something to consider for wider roll out, or at least pathways to these services being agreed when this is required.

Teams had differing levels of access to other services, such as mental health services and therefore this required onward referral. Inadequate access to these services did reportedly delay some patients accessing subsequent assessments. Implementing teams need to consider these as necessary resources and have agreed pathways when preparing to adopt the toolkit.

The third goal, showing whether the toolkit it likely to deliver the intended benefits, can be considered as met, as most patients were managed safely at home. Teams implemented the 4AT screening tool and applied it to all relevant patients who entered their care. This standardised approach meant that cases of delirium were identified at the earliest possible time during the patient's interaction with the community team. In fact, we heard that Teams were able to focus on the prevention of delirium, in patients who were at higher risk, which was a whole new focus for them, a further indirect benefit from the toolkit implementation.

The TIME bundle provided a standardised way to manage patients with delirium, though not all teams applied it to all patients in their care. Teams which trained all staff members with a detailed review of the key documents in the toolkit were most likely to use all documents in the toolkit.

There were several other successes as below.

- The provision of education and information for patients and family members. Staff shared the Greater Manchester delirium leaflet and completed the person-centred care plan where appropriate, which is part of the leaflet.
- Dementia United project team and the community teams were able to meet up virtually on a fortnightly basis and share best practice as part of the PDSA cycle.
- Increases in staff confidence and competence meant that the community teams socialised the toolkit with colleagues in their wider teams or other services. All of the teams engaged in the pilot have continued to raise awareness of delirium in their locality.

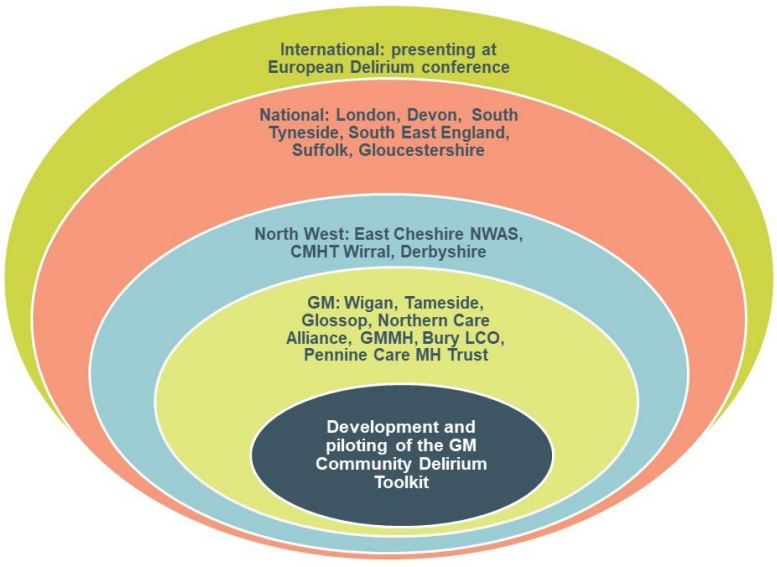
The toolkit ensured that the key standards outlined below, that were agreed by Dementia United governance in 2019 for a community setting, have been mostly met:

- Every care organisation should have a standardised pathway for assessment and management of delirium
- Family carers are provided with information and support to help support relative with delirium
- Non-pharmacological measures/de-escalation techniques used before medication for agitation/distress
- Delirium diagnosis should be conveyed at all transitions of care and people with delirium should have multidisciplinary follow up

The development of the toolkit has led to Dementia United making connections with teams and services in Greater Manchester, across the North West, nationally, and internationally. These connections are highlighted in the figure below as positive ripple effects from the pilot project. Dementia United's goal was to ensure that there was wider awareness of the delirium programme of work in Greater Manchester. At a Greater Manchester level, Dementia United engaged with the GP Excellence team, Health Innovation Manchester Safe Steps programme in Care homes, and presented at the Infection Prevention Control Care Homes webinar series as well as linking in with colleagues within GM Adult Social Care and Independent Provider Network.

There has also been wide interest regionally and nationally in the toolkit, from organisations in Gloucestershire, Essex, Suffolk, Tyneside, and South East England. Members of Greater Manchester's Dementia United project team have also delivered presentations across the UK and internationally on the toolkit and the wider programme of work. For example, at the South East England Strategic Clinical Network on the 5 November 2020, the NHS/I national dementia clinical network delirium webinar on 19 June 2020.

Ripple effect of the Greater Manchester community delirium toolkit



Barriers

Impact of COVID-19

Undoubtedly the single greatest barrier to the success of the community delirium toolkit pilot was the onset of the COVID-19 pandemic in early 2020. The pandemic affected the pilot in two distinct ways: inability to engage the piloting teams in person, especially with training, and changes to the workload and priorities for community teams.

Plans for Dementia United to provide a common standard of training to staff had to be abandoned. Instead, teams provided their own training drawing on the information in the toolkit and the resources provided by Dementia United via the webpages.
This meant that the knowledge of staff within teams could vary significantly depending both on previous experience and the level of training provided. There is no guarantee that the relative success or failure of implementing the toolkit is not dependent on differing levels of training. Nor has the pilot provided any firm evidence for the provision of training as part of a future rollout.

More significant to the pilot were the changes in workload and priorities for participating teams. Every team experienced alteration to working practices due to infection control and the need to identify cases of COVID-19 among their patients. Some staff were moved into other work areas focused on COVID-19. All teams had staff who needed to self-isolate, shield, or were on sick leave at some point during the pilot. Manchester's intermediate care service had to quarantine the whole unit and stop admissions due to infection.

Not all teams were equally affected, with some still managing to participate throughout the pilot, but many had their participation curtailed. Some teams submitted very little data or feedback to the pilot. It is testament to the community teams who were able to continue piloting the toolkit during the COVID-19 pandemic and to make it the success it has been.

Limitations

The total number of patients who were screened as part of the pilot were low, which may well reflect the low prevalence of delirium in community settings, which we know from the evidence can be as low as 2% but rises to 14% for older patients (British Geriatric Society 2020).

As the toolkit was not piloted by community teams who used it to support residents in care homes, this is an area where there would need to be further exploration of the potential effects and what would need to be in place to support this. We have the Enhanced Care in Care Homes framework the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)highlighting the importance of assessing and managing delirium and therefore the role out of this in Greater Manchester, would be a great opportunity.

It is not possible to provide comparative data from the teams in relation to their detection of delirium prior to the pilot, as this was not within the scope of this project. Limitations in the data provided by the community teams mean that causal links between delirium and individual outcomes could not be made.

Not all the staff in the piloting teams engaged in the implementation of the toolkit. Some teams limited the pilot to senior practitioners, which we know will have impacted on the total numbers of patients screened. These teams are considering wider socialisation with all their staff, including the provision of training. We are continuing to engage with these teams monthly and therefore there may be opportunity to review and update the data if this is considered to be of value.

Next steps and recommendations

The next step is to seek approval via Dementia United governance for the pilot report. This will include consideration as to the wider implementation of the community delirium toolkit across Greater Manchester, as well as the sharing of the Greater Manchester delirium leaflet with public/patients/families.

There has been real interest in the work, with many services across the UK asking for access to the toolkit and lessons learned from the pilot. There is an opportunity for Greater Manchester to showcase the work that we have developed and tested as a proof of concept.

Dementia United recommends that these two tested resources are rolled out across Greater Manchester. With a further recommendation to engage teams that were not engaged in the pilot in order to understand the applicability of the toolkit to their work, such as mental health teams and teams that support care homes.

We have champions in the teams from the pilots, who remain very passionate about the toolkit and localised roll out. It will be of value to continue to harness their expertise and form a ‘community of practice’ to support their roll out of delirium toolkit in their localities. It would also be worth considering how to support these teams (what resources would be needed) to provide peer support to further services, outside their localities, who may want to implement the toolkit. Consideration needs to be given to perhaps having one or two localities taking a lead and trailblazing the implementation across all health and care stakeholders in their locality and beyond too.

Dementia United will undertake the following next steps:

- Review and update the Greater Manchester delirium leaflet and engage a graphic designer to produce final versions (long and short version) - completed
- Review and update the Greater Manchester community delirium toolkit - completed
- Ensure all updated resources are available on the Dementia United website - completed
- Cascade these resources to colleagues who had contributed to their development and piloting - completed

- Greater Manchester wide cascading of the resources to coincide with the World Delirium Awareness Day on 17 March 2021
- Checking cultural appropriateness and making audio translations of the Greater Manchester delirium leaflet, as requested in feedback on the leaflet – in progress
- Consider the provision of other resources to support the toolkit, such as podcast recordings from the community teams and lead clinicians who supported the pilot
- The British Geriatric Society and European Delirium Association have expressed interest in promoting the pilot and the toolkit
- To take this draft pilot report through Dementia United governance, for approval and to ask for a steer in terms of any further scoping, next steps that Dementia United may be required to undertake, including support for wider implementation. This includes consideration of wider national interest in the toolkit.

Note of thanks

Dementia United would like to thank all those people who worked with us over the last four years in supporting the development of the delirium programme of work, which included:

- Delirium task and finish group members including people with lived experience and carers.
- Delegates who attended the annual World Delirium Awareness Day events in 2018, 2019 and 2020; thank you to Michelle Davies Strategic Clinical Networks for her support with these events.
- Dementia Carers Expert Reference Group who very kindly provided initial feedback on the delirium leaflet and the wider engagement of carers in the programme of work.
- With special thanks to NHS Ayrshire and Arran for their community pathway, Healthcare Improvement/Scottish Delirium Association for delirium toolkit and TIME bundle.
- The community teams who engaged with the pilot; Trafford community enhanced care service, Bolton admission avoidance team, Salford urgent care team, Manchester intermediate care service (Gorton South), Stockport proactive victoria primary care network and wider engaging colleagues such as Salford intermediate care service, North West Ambulance Service.
- Dr Emma Vardy – Consultant Geriatrician, Greater Manchester and East Cheshire Strategic Clinical Network Clinical Dementia Lead, Clinical lead for delirium programme; as well as the wider Dementia United delirium team Emma May Smith, Lyndsey Kavanagh, and Helen Pratt.

References

- Andrew M. K et al (2006). Prevalence and outcomes of delirium in community and non-acute care settings in people without dementia: a report from the Canadian Study of Health and Aging | BMC Medicine | Full Text (biomedcentral.com) accessed 30/01/21.
- British Geriatric Society (2020). Coronavirus: Managing delirium in confirmed and suspected cases.
- Fick DM et al (2005). Delirium superimposed on dementia in a community-dwelling managed care population: a 3-year retrospective study of occurrence, costs, and utilization. J Gerontol A Biol Sci Med Sci. 2005; 60:748–753.
- Fong et al (2009). Delirium accelerates cognitive decline in Alzheimer Disease. Neurology 2009 (May), 72(18), 1570 – 1575.
- Healthcare Quality Improvement Partnership (2020). A guide to quality improvement tools.
- Health Improvement Scotland (2019). Scottish Intercollegiate Guidelines Network. Risk reduction and management of delirium. A national clinical guideline.
- McLoughlin et al (2020). Functional and cognitive outcomes after COVID-19 delirium. *European Geriatric Medicine*. Available at: https://link.springer.com/article/10.1007/s41999-020-00353-8
- National Institute for Health and Care Excellence (2019). Delirium: prevention, diagnosis and management
- Royal College of Psychiatrists, (2019). National Audit of Dementia care in general hospitals 2018–19: Round four audit report. London: Royal College of Psychiatrists.
- Royal College of Psychiatrists (2017). National Audit of Dementia care in general hospitals 2016-2017: Round three audit report. London: Royal College of Psychiatrists.
- Siddiqi N. et al (2016). The PiTSTOP study: a feasibility cluster randomized trial of delirium prevention in care homes for older people. Age and Ageing 2016; 45: 651–661.
- Tieges Z. et al (2020). Diagnostic Accuracy of the 4AT for delirium detection in older adults: systematic review and meta analysis. Diagnostic accuracy of the 4AT for delirium detection in older adults: systematic review and meta-analysis - PubMed (nih.gov) accessed 08/03/21.
- Vardy et al (2020). Use of a digital delirium pathway and quality improvement to improve delirium detection in the emergency department and outcomes in an acute hospital Age and Ageing 49: 672–678
- Watt et al (2019) The incidence and prevalence of delirium across palliative care settings: A systematic review - Christine L Watt, Franco Momoli, Mohammed T Ansari, Lindsey Sikora, Shirley H Bush, Annmarie Hosie, Monisha Kabir, Erin Rosenberg, Salmaan Kanji, Peter G Lawlor, 2019 (sagepub.com) accessed 30/01/21
- Zazzara et al (2020). Probable delirium is a presenting symptom of COVID-19 in frail, older adults: a cohort study of 322 hospitalised and 535 community-based older adults. Age and Ageing 2020; 1–9 doi: 10.1093/ageing/afaa223

Appendices

Appendix 1

Questions sent out with the Greater Manchester delirium leaflet – Seeking feedback

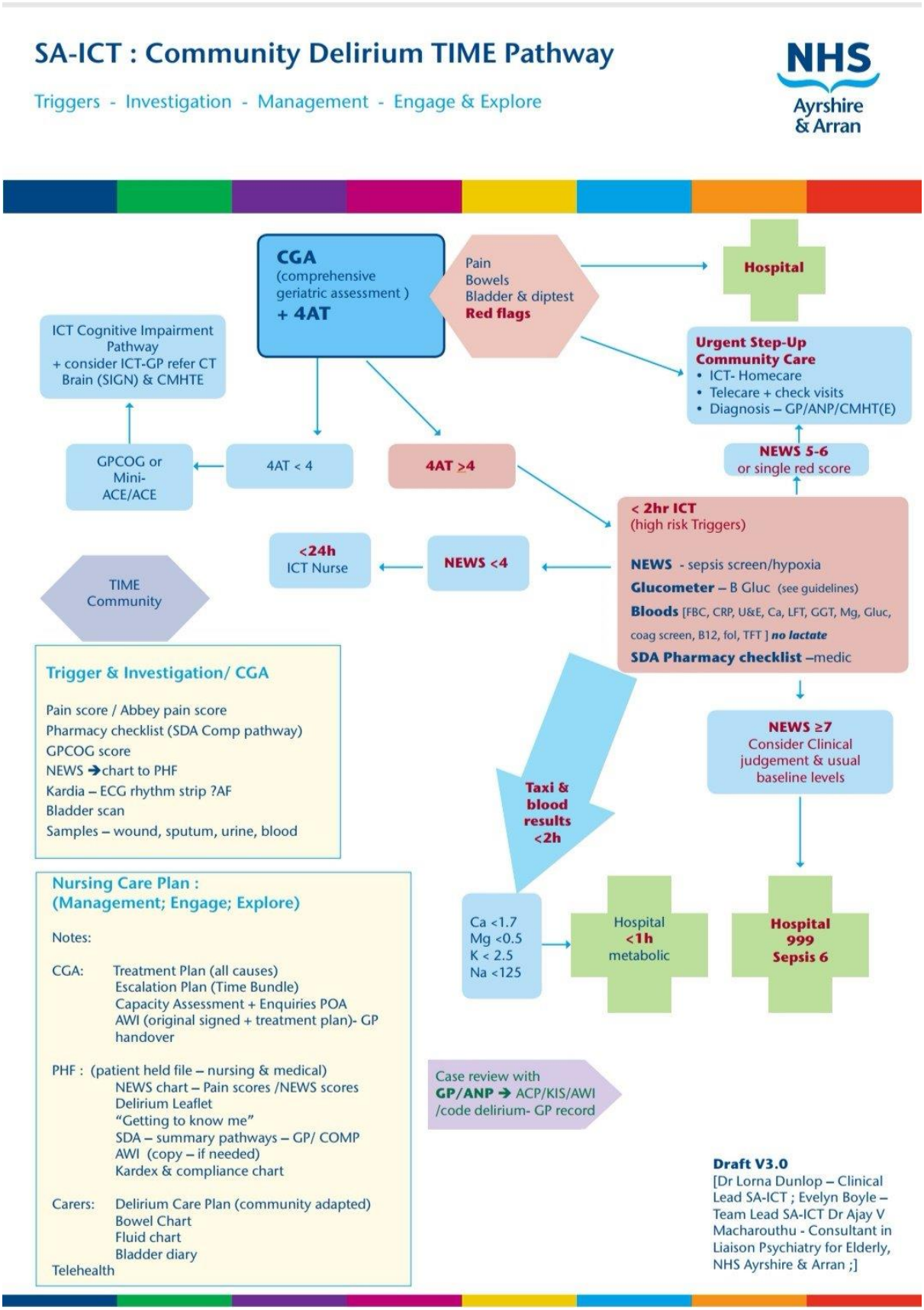
Question number	Question in relation to the Greater Manchester delirium leaflet
1.	How easy was it to read?
2.	Anything you really like?
3.	Anything you are not sure about?
4.	Anything that you think we need to change?
5.	Anything you would want us to add in?
6.	Does it inform you more about how to prevent delirium if you are at risk?
7.	Do you think the last section, which is more of person-centred care plan, is helpful?

Appendix 2

System wide engagement and feedback in the development of the Greater Manchester delirium leaflet

	Agency/organisation	Date	Feedback received
1	Dementia United delirium working group/steering group	March 2020	Yes
2	Dementia United governance board meeting members, including clinical leads	April 2020	Yes
3	Dementia United Dementia Carers Expert Reference group	April 2020	Yes
4	South Asian Carers group via Shahid Mohammed DCERG/tide	May 2020	Yes
5	Alzheimer's Society; to share with Dementia Voices network	May July 2020	Yes
6	Dementia locality leads via Dementia United Friday locality briefings, locality leads meetings eg Stockport , locality leads shared with dementia champions	May - Nov 2020	Yes
7	Dementia United bulletin to all Dementia United stakeholders	June, Sept, Nov 2020	Yes
8	Greater Manchester Older Peoples Network – Health working group; along with attendance at a virtual meeting 30th Nov, further detailed proof reading	Nov – Jan 2021	Yes
9	Healthwatch	Nov 2020	Yes
10	Greater Manchester mental health programme colleagues and mental health trusts e.g. Pennine Care - Stockport Memory Assessment Service/Tameside Liaison Services, Greater Manchester Mental Health Trust	Oct 2020	Yes
11	Community teams engaged in piloting the toolkit; feedback directly from patients/family/carers	Sept – Dec 2020	Yes
12	Independent provider network via Carol Mitchell (Skills for Care) and Susie Wright (Adult Social Care); e.g. Age UK Stockport, Oldham Registered Managers Network	Nov 2020	Yes
13	Via Janine Dyson, Lead Nurse – Independent Care Sector eg care homes	Dec 2020	Yes

Appendix 3


SA-ICT : Community Delirium TIME Pathway
Triggers - Investigation - Management - Engage & Explore
NHS Ayrshire & Arran
CGA (comprehensive geriatric assessment) + 4AT
Pain
Bowels
Bladder & diptest
Red flags
Hospital
Urgent Step-Up Community Care
• ICT- Homecare
• Telecare + check visits
• Diagnosis – GP/ANP/CMHT(E)
ICT Cognitive Impairment Pathway + consider ICT-GP refer CT Brain (SIGN) & CMHTE
GPCOG or Mini-ACE/ACE
4AT < 4
4AT ≥4
NEWS 5-6 or single red score
< 2hr ICT (high risk Triggers)
NEWS - sepsis screen/hypoxia
Glucometer – B Gluc (see guidelines)
Bloods [FBC, CRP, U&E, Ca, LFT, GGT, Mg, Gluc, coag screen, B12, fol, TFT] no lactate
SDA Pharmacy checklist –medic
<24h ICT Nurse
NEWS <4
TIME Community
Trigger & Investigation/ CGA
Pain score / Abbey pain score
Pharmacy checklist (SDA Comp pathway)
GPCOG score
NEWS →chart to PHF
Kardia – ECG rhythm strip ?AF
Bladder scan
Samples – wound, sputum, urine, blood
NEWS ≥7 Consider Clinical judgement & usual baseline levels
Taxi & blood results <2h
Nursing Care Plan : (Management; Engage; Explore)
Notes:
CGA: Treatment Plan (all causes)
Escalation Plan (Time Bundle)
Capacity Assessment + Enquiries POA
AWI (original signed + treatment plan)- GP handover
PHF : (patient held file – nursing & medical)
NEWS chart – Pain scores /NEWS scores
Delirium Leaflet
"Getting to know me"
SDA – summary pathways – GP/ COMP
AWI (copy – if needed)
Kardex & compliance chart
Carers: Delirium Care Plan (community adapted)
Bowel Chart
Fluid chart
Bladder diary
Telehealth
Ca <1.7
Mg <0.5
K < 2.5
Na <125
Hospital <1h metabolic
Hospital 999 Sepsis 6
Case review with GP/ANP → ACP/KIS/AWI /code delirium- GP record
Draft V3.0
[Dr Lorna Dunlop – Clinical Lead SA-ICT ; Evelyn Boyle – Team Lead SA-ICT Dr Ajay V Macharouthu - Consultant in Liaison Psychiatry for Elderly, NHS Ayrshire & Arran ;]

Appendix 4

Delirium questions for teams in the pilot inclusive of a staff questionnaire

Delirium questions for teams/services piloting the delirium toolkit version 0.2

Team/Service name:
Locality in Greater Manchester:
Contact details (email/telephone):
Date completed:

1. **Team Composition:**
   a) Who is in your team?
      - Including number of these, provide details of health and social care staff

   b) Of these staff listed above; who has been involved in testing out the toolkit?

   c) Do you have staff that are trained in the following:
      - ☐ Dual qualifications e.g. RGN & RMN
      - Other dual qualifications - please list

   d) Do you have access within your team/service to any of the following? Please indicate with a tick in the list below. If there are additional roles within your team, then please provide details under Others.
      - ☐ Undertake blood tests and act on results
      - ☐ Undertake ECGs
      - ☐ Undertake bladder scanning
      - ☐ Non-medical prescribing
      - Others – please provide details.

   e) Did you have staff using the toolkit that were able to complete any of the above?

2. **Referrals into your teams/service:**
   a) Are you **community based only?** Yes – please refer to questions below. If no – move to the next section 2b.
      - What geographical area do you cover?
        - Number of GP practices
        - Population size of your catchment for patients

      - Does this include care homes and similar facilities? Provide details

      - Criteria of referrals to your team/service – provide details
      - Who do you take referrals from? Please indicate with a tick from the list below. If there are additional places that refer to your team/service, then please provide details.

- ☐ GPs
- ☐ NWAS
- ☐ Acute Hospital - Emergency Department
- ☐ Acute Hospital - inpatient wards
- ☐ Urgent Care teams
- ☐ Crisis response teams
- Other - please list

- Number of referrals you would normally receive for example in a 6 months period prior to COVID-19. Please provide the date and the numbers.

b) Are you **bed based and community service**? Yes – please refer to the questions below. If no - then move to the next section 2c.

- How many beds do you have?
  - What geographical area do you cover?
- What is the coverage for your community service? GP practices, population catchment.
- Criteria of referrals to your service – provide some detail – for bed based and community service
- Who do you take referrals from? Please indicate with a tick from the list below. If there are additional places that refer to your team/service, then please provide details.
  - ☐ GPs
  - ☐ NWAS
  - ☐ Acute Hospital - Emergency Department
  - ☐ Acute Hospital - inpatient wards
  - ☐ Urgent Care teams
  - ☐ Crisis response teams
  - Other - please list

- Number of referrals in to the community service and number of admissions you would normally receive for example in a 6 months period prior to COVID-19. Please provide the date and the numbers.

c) Do you provide a **bed based only**? Yes – please refer to the questions below.

- How many beds do you have?
  - What geographical area do you cover?
- Criteria of referrals to your service – provide some detail
- Who do you take referrals from? Please indicate with a tick from the list below. If there are additional places that refer to your team/service, then please provide details.
  - ☐ GPs

- ☐ NWAS
- ☐ Acute Hospital - Emergency Department
- ☐ Acute Hospital - inpatient wards
- ☐ Urgent Care teams
- ☐ Crisis response teams
- ☐ Other - please list

- Number of admissions you would normally receive for example in a six month period prior to COVID-19. Please provide the date and the numbers.

3. **Services to refer on to**
   a) Do you link in closely with any other services, that mean that you do not make a referral? Give examples of these.

   b)What services are available by onward referral? Give examples of these.

   c)Is there a delay in the time that these services you refer on to respond? What is the impact of this delay?

4. **Delirium leaflet**
   a) How has the Greater Manchester delirium leaflet been useful if at all? Please provide examples

5. **Outcomes**
   a) What are your experiences of how delirium identification and management has changed?
      - Had using the toolkit made a clear difference to people's care and lives? Please provide details eg if hospital avoidance has meant longer time spent with the team while being managed, or whether identification of delirium has made it possible to discharge patients to self/family care.

   b) Did you have patients that you required mental health advice and or referral onwards to memory assessment services? If yes. Please could you provide details of the numbers and the types of problems eg presence of behaviour that challenges, ongoing cognitive impairment once the delirium subsided requiring memory assessment

6. **Lessons learnt**
   a) Any lessons learnt from being part of the pilot and using the toolkit.
      - Have you actioned training of staff as a result in delirium? A phased roll out of the toolkit with some colleagues only initially? Provide details and any rationale for choice of roll out.
      - Have staff knowledge and skills developed as a result? If so, please provide details.

- Are you linking in with more services to consider delirium eg Are you promoting the toolkit and leaflet it with other sectors and services. Please provide details
- Anything that needs to change in the toolkit documents?

- Any recommendations for rolling this out widely across Greater Manchester? Things that we could consider? Things you would want to consider and do? Who do we or yourselves need to link in to? How might this be best undertaken?

We have provided a **Staff Questionnaire**. This can be shared with your wider staff team, as we would welcome hearing from anyone who has being using the toolkit.

If staff would like to complete the questionnaire, then please can these be sent back to us via email. Our contact details are at the bottom of the questionnaire. The cut-off date for these to come back to us is **31/01/21.**

Delirium staff questionnaire version 0.1 – page 1 of 2

Team/service name:
Locality in Greater Manchester:
Date completed:

Question 1. How confident are you at identifying delirium? 1 = not at all confident, 10 = extremely confident.

Score 1-10 ☐

Question 2. I have previously had training on delirium. Please indicate yes or no in the box.

☐

Question 3. I understand the difference between delirium and dementia. Please indicate with a tick in the box.

☐ Strongly agree:
☐ Agree:
☐ Neither agree not disagree:
☐ Disagree:
☐ Strongly disagree:

Question 4. I feel confident using the 4AT. Please indicate with a tick in the box.

☐ agree:
☐ Agree:
☐ Neither agree not disagree:
☐ Disagree:

☐Strongly disagree:

Delirium staff questionnaire version 0.1 – page 2 of 2.

Question 5. I am familiar with using the TIME bundle for patients with suspected delirium. Please indicate with a tick in the box.

☐Strongly agree:
☐Agree:
☐Neither agree not disagree:
☐Disagree:
☐Strongly disagree:

Question 6. I have further training needs in relation to delirium. Please indicate yes or no in the box.

☐

If you indicated yes. Please provide more details on these:

Thank you for completing this questionnaire.

Please send all completed forms back to us by 31/01/21 via email to Emma.Smith96@nhs.net

Dementia United would also like to thank you all for being part of the pilot over the last few months. We really do appreciate all the time and work that you and your team/service have put in to using the toolkit and feeding back to us. We plan to report on the pilot and have a finalised version of the toolkit in Spring 2021.

Contact details if you have any questions: Helen.pratt5@nhs.net

Appendix 5

Salford intermediate care service - Lanyard prompt for delirium

So how do I remember it? **PINCH ME**

- Think Pain
- Infection
- Nutrition
- Constipation
- Hydration
- Medication
- Environment

How does it present?

Hyperactive	**Hypoactive**
Agitation	Withdrawn
Aggression	Quiet
Disorientated	Apathetic
Wander	Depressed
Fidget	Falls
Fall	
Hallucinations	
Disturbed sleep	

GET IN TOUCH

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