London: Virtual Ward Delirium Pathway for patients living with frailty.

Version 1.6

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This document will be reviewed and re-released to reflect new and emerging evidence as appropriate. Please email england.londoncagsupport@nhs.net to request the most recent version.

This London guide is designed to complement and not replace local guidance and professional judgement. It will be updated to align with other national and regional guidance once published.

NHS England London

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Catherina Nolan on Catherina.Nolan@nhs.net.

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Background

Across London, people being admitted to hospital with suspected delirium on average this currently reflects approximately 12,000 per year. There is a subset of people who have a short length of stay (less than 3 days) for management of delirium as an inpatient and this averages at approximately 200 patients per month across the capital per ICB (based on SUS data January 2020 to July 2022).

Older adults with a confirmed diagnosis of delirium often have poorer health outcome and protracted length of stay as an inpatient in hospital[1] . For some people this can have a detrimental impact on their ability to successfully return to their own home. An alien environment can hamper recovery of orientation to own geographical environment. There needs to be a suite of options for location and management of delirium. Care in a hospital setting whilst appropriate for some scenarios, is not always the best location that can deliver high quality care to treat and manage delirium.

Virtual ward care is the provision of intensive high acuity level care that would traditionally be provided in a hospital inpatient setting.
'*A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital, or supporting early discharge out of hospital*

NB: A virtual ward is not a mechanism intended for enhanced primary care programmes; chronic disease management; intermediate or day care; safety netting; proactive deterioration prevention; or social care for medically fit patients for discharge'[2]

Virtual ward has the ability to dovetail with existing services in Same day emergency care (SDEC) and urgent community response (UCR). Increasingly, in contrast to the above definition of Virtual Ward care, services in London are delivering virtual ward services in a setting other than the patient's own home e.g. step-down facility or care home etc.

How to Use this Document

This document is aimed to be used to support development of a clinical pathway for the management of delirium in the community through virtual ward service provision.

The pathway outlines clinical considerations within a working timescale framework of 7 days. We acknowledge that this may not cover all eventualities but rather should act as a guide to support when to step some up to virtual ward care under frailty management and when to consider step down to community services.

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[1] The association of delirium severity with patient and health system outcomes in hospitalised patients: a systematic review. Age and Ageing 2020; 49: 549–557 doi: 10.1093/ageing/afaa053

[2] National Virtual Wards Network. Definitions of virtual ward. [Virtual Ward Definitions and Reporting v1 - Virtual Wards Network - FutureNHS Collaboration Platform]

This is a clinical pathway document and therefore the type of remote monitoring to use , whilst important to virtual ward, was out of scope. This document should be used in collaboration with remote monitoring resource guides where available that can support delirium management.

This document should be considered alongside the Frailty virtual ward (Hospital at Home for those living with frailty)[3] We strongly recommend this document is read in conjunction with the NICE Guidance for Delirium (CG 103)

Workforce Requirements

We recognise that to run different pathways within a virtual ward, services will need to employ a core team of health and social professionals with skills and capabilities to work across different clinical pathways. When considering the skills and capabilities required to support the management of delirium in the community and the acuity level this may bring, we have detailed the workforce requirements to support this pathway. Access to these professionals is crucial to ensure swift timely decision making that is evidence based, safe, effective and person centred.

We recognise that within the virtual ward pathways utilisation of existing workforce will be optimised. All workforce should have completed the Tier 2b frailty e-learning education programme as a minimum.(Frailty - elearning for healthcare (e-lfh.org.uk)

For clinical management of Delirium, the following workforce need to be considered to achieve best outcomes.

Multidisciplinary team workforce	Core delivery workforce
Consultant geriatrician	Medical expertise in frailty and acute acuity (This could include SpR/ ACP/ Physician associate/ SHO)
Registered Nurse with experience and competency in rapid response high acuity level decision making.	Registered Nurse with skills and expertise in rapid assessment, high level acuity frailty related scenarios.
Qualified Occupational therapist and Physiotherapist with skills and expertise in rapid assessment, high level acuity frailty related scenarios	Qualified Occupational therapist and/ or Physiotherapist with skills and expertise in rapid assessment, high level acuity frailty related scenarios
Clinical Pharmacist (community)	Heath care support workers and rehabilitation support workers
Older Adults/ Frailty social worker	Formal care agency carers
Rapid Response teams	
Care navigators	

[3] NHS England (2021) Frailty virtual ward (Hospital at Home for those living with frailty). B1207-ii-guidance-note-frailty-virtual-ward.pdf (england.nhs.uk)

Access to: Safeguarding team, Community mental health services, Speech and Language therapy, Dietetics, Podiatry, Memory assessment services and any other speciality services as required.

Considerations for hospital admission/Triggers for escalation for patients within the service

Assuming no advance care plan against hospital transfer, patient agreeable to transfer or transfer believed to be in best interest:

- Physiological instability e.g. NEWS 2 greater than 4
- Underlying medical illness that can only be managed in acute hospital e.g. Acute MI, Stroke
- Require urgent access to diagnostics
- Safeguarding concerns
- Behavioural disturbance that cannot be safely managed at home
- Care needs cannot be safely managed at home
- Severe agitation or distress not responding to standard measures
- Doubt about diagnosis
- New concerns requiring considerations for hospital admission
- Severe agitation or distress not responding to standard measures
- Doubt about diagnosis
- New concerns requiring considerations for hospital admission

Access to Same Day Emergency Care (SDEC) diagnositics such as CT head may be required in certain circumstances and should be available.

The assessment and intervention package developed incorporates a full comprehensive geriatric assessment and includes aspects outlined in the table below

Days/ Actions	Assessment	Intervention

0/ Immediate actions	• Confirm history of acute change in behaviour, function, and cognition. Take informant history if available.
	• Consider life-threatening illness e.g. sepsis, hypoxia
	• Perform 4AT/ NEWS2 and CFS and screen for other frailty syndromes
	• Clinical assessment and physical examination
	• Assessment of informal carers support needs
	• Medicines review
	    • Gather list of current medicines
	    • Review list of medicines potentially impacting delirium.
	Medical assessment may include the following:
		• Develop a multi component package for the treat of delirium.
		• Treat underlying causes and optimise management of co-existing co-morbidities
		    • **P**ain
		    • **I**nfection
		    • **N**utrition
		    • **C**onstipation
		    • **H**ydration
		    • **M**edication review
		    • **E**nvironmental factors
		• Identify type of Delirium as Hypo delirium, Hyper delirium, or Mixed Delirium.
		• Personalised care plan including
		    • Ensure glasses and hearing aids working

	• (Temperature, heart rate, blood pressure, respiratory rate)
	• Arousal level
	• Vision and hearing
	• Physical Examination
	• Constipation (PR)
	• Bladder and skin
	• MSU
	• ECG
	• Bloods – including FBC, U&E, glucose (LFT, bone profile)
	• Pressure care assessment
	• Functional assessment
	  • Sit to stand assessment
	  • Mobility inclusive of distance and use of existing mobility aid/ determine if mobility aid required
	
	• Capacity assessment for immediate interventions
	• Assessment of environment to support Virtual frailty ward care
	  • Fire safety
	  • Risks leaving the home
	  • Medicines
	  • Suitability to support 1:1 care if required overnight.
	  • Remote monitoring technology
		• Promote orientation
		• Signage for each area such as bedroom and bathroom, location of items such as tea, bread fridge etc.
		• **Access urgent step up social care as required** and refer to Rapid Response Team social worker
		• Explain diagnosis of delirium and plan to patient and carer. Provide information leaflet.

Days/ Actions	Assessment	Interventions

1-3/ Ongoing actions	• Repeat medical assessment as above, plus consider:
	  • Improvement in sleep pattern, behaviour and cognition can signal recovery from delirium
	  • New symptoms
	• Medicines assessment
	  • Medicines optimisation
	  • Review any old medicines in property
	  • Arrange for old or redundant medicines to be collected.
	  • Consider need for how medicines administered such as blister packs, Dossett boxes, suspension format etc.
	  • Consider these key questions: can they get it; can they take it and are they taking their medicines?
	• Cognitive assessment
	  • Understand if any prior levels of cognitive assessment completed, when and what was the results.
		• Continue to develop a multi component package for the treat of delirium and amend as necessary
		• Consider interventions related to the following:
		  • Promote activities and sleep hygiene
		  • Reduce Caffeine after 6pm, reduce Alcohol
		  • Reduce blue light from digital devices etc.
		  • Establish a bedtime routine/ sleep& wake cycle pattern
		  • Ensure adequate temperature not too hot or cold
		  • Reduce bright lights and create calming atmosphere.
		  • Explore breathing exercises and relaxation techniques (muscle and visualisation- where appropriate).
		  • Establish sleep diaries

	• Is the person known to memory services already and what were the outcomes? • Complete a Mini ACE assessment or a Linguistic sensitive assessment for their culture and language. *(MOCA is now licensed per prescriber not per organisation and use of would require administrator to detail pin number as part of pt. record)* • Functional assessment • Assessment of function that incorporates executive function such as multitask errand, preparing a hot drink and transporting this, grooming and oral hygiene. • Design graded activity level rehabilitation programme personalised to needs of individual and pre-existing care support • Establish a re-orientation programme based on changes in the O-Log if appropriate	• Increase physical activity in daylight hours • Minimise stress (e.g. adjust lighting, reduce background noise) • Commence O-Log • Check care needs are met and plan to step down extra care • Grade physical activities abilities to meet needs of individual with a 'win, win' approach supported by suitably trained health and social care workforce. • Continue with O-Log until no longer required or results demonstrate a change that requires escalation. Monitor levels of support needs and note when changed.

Days/ actions	Assessment	Intervention
4-7/ Discharge actions	Re-assess as clinically indicated for all of the above	**For all pts at discharge** • Document cognitive function Repeat cognitive batteries • Step down extra care +/- transfer care to social services as required • SMART Goals for handover to community teams (consider use of Goal Attainment Scaling Tool or another outcome measure) **Patients cognition improving but not returning to previous level (or has a history of repeated occurrence)** • Refer to memory services **Patient's with suspected underlying undiagnosed dementia** • Refer to memory services **Patient's cognition not improving (likely prolonged delirium)** • Discuss with Multidisciplinary team

Community Delirium Pathway

It is worth noting that the risk is elevated for older adults with delirium of acquiring dementia in the coming years and something that the GP will need to be mindful of for future action.

Memory Services will not accept a referral for an individual who are active delirium unless this is a reoccurrence or protracted delirium. Using screening tools such as IQCODE can assist in identifying those individuals with protracted delirium at high risk of development of dementia. It is worth considering including any screens such as these when referring to memory services for an assessment.

Appendix:

O-LOG