Standard 2: Patients who have a clinical suspicion or confirmation of a hip fracture have the “Big Six” interventions/treatments before leaving the Emergency Department.

Identification of patients with delirium by means of a screening test within the ED is essential. Delirium screening is part of the ED hip fracture protocol. The 4AT is recommended for this purpose and can be conducted by both medical and nursing staff. Patients who score 4 or more should be identified as having delirium, requiring investigation of potential underlying causes and appropriate management. The presence of delirium has obvious implications with respect to the Informed Consent process and the patient’s capacity should be formally assessed and documented.

The details in this standard are supported by the work of Healthcare Improvement Scotland’s ‘Think Delirium Campaign’, for further information please visit the think delirium website [http://ihub.scot/delirium-toolkit/](http://ihub.scot/delirium-toolkit/)
Implementation

It’s widely recognised that the presence of delirium can negatively affect patient outcome as well as being incredibly distressing for both the person and friends and relatives, therefore early recognition and subsequent management of the condition is essential. Most ED units in Scotland have developed processes to ensure that frail and elderly people, including those with hip fractures, are screened for the presence of delirium prior to leaving the emergency department. In some areas where this has not been achieved there seems to be a lack of understanding regarding the pragmatic use of the 4AT tool, particularly when it is difficult to determine a patient’s prior mental state. Below is an account from senior nursing staff in two hospitals who manage to achieve 4AT screening in upwards of 80% of cases;

UNIVERSITY HOSPITAL CROSSHOUSE

The standard of care for patients who present to the emergency department at Crosshouse Hospital with Neck of Femur fractures has significantly improved since the Standards of Care were introduced in 2014. To provide the high quality of clinical care in Standard 2, we first recognised that we had to ensure the Big Six interventions were carried out prior to the patient being transferred to the orthopaedic ward. We set out to achieve this and identified that although we were good at completing some aspects of the Big Six we were not at others. We looked at why this was established and that lack of knowledge of the actual Standard was the problem. With a dedicated senior charge nurse and deputy charge nurse as leads, we set out to disseminate the required information at the daily handover for an 8 week period. We have steadily progressed to average 80% compliance however, improvements have still to be made and we therefore looked at how we could do this. The symphony computer system in the emergency department already generates paperwork as part of the local protocol – The Hip Proforma. This Proforma is primarily for the medical staff to complete however nursing documentation is also generated which includes the 4 AT delirium screening tool. This screening tool initially proved to be a challenge to complete and we believed this was due to other priorities of the Big Six requirements and the time restraints. A solution to this was to have a checklist including all of the Big Six requirements for nursing staff to complete which would be placed on the nursing documentation. This is in the form of a sticker which is simple and rapid to use.

Audrey Wallace, Deputy Charge Nurse, Emergency Department

FORTH VALLEY ROYAL HOSPITAL

Recording of 4AT felt like another task being asked of an already busy and time challenged work force. When asked to delirium screen all patients who attend over the age of 65 and all fractured neck of femur patients as this is a clinical standard we are required to meet. It was important to be able to tackle this sensibly and with as little delay to the patient’s journey.

To implement this we considered the best way to encourage staff to complete the bundle of care, we felt asking staff to add a Bundle sticker to the notes may not work, we already used a page for recording PVC insertion and bloods requested
and pressure area assessment. We were able to include the 4AT documentation on this, which meant the staff only had one page to complete.

By adopting this method staff have consistently been able to document this. All the information being in one place is both easy to complete and readily accessible for ward staff when patients move on. This is one of the last things to be checked prior to the patient being sent to the ward, if at this stage it has not been recorded it can be picked up.

It is now a habit and part of our routine to record it for all patients who are being admitted.

Our performance for the last 6 months has been around 80% which we are aiming to maintain and improve on.

Glynis Fotheringham, Senior Charge Nurse, Emergency Department.

Where can I find out more?

Tools and resources are available on the Scottish Hip Fracture Audit website www.shfa.scot.nhs.uk

Excellent short video on managing delirium from the Association of Elderly Medicine Education (AEME) is available here https://youtu.be/1iKe-6lc5b0