Fit for Discharge?: A First-Cycle Audit Investigating the Documentation of Delirium in Medical Discharge Letters

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Aims: Delirium is an acute confusional state, characterised by impacting the affected individual's cognition and consciousness level to varying degrees over the course of an episode. Certain patient populations are more vulnerable to its development, of which the elderly are at particular risk. There are many factors that both predispose to and perpetuate a delirium, including having experienced it before. Not only does experiencing delirium once increase an individual's risk of experiencing it again, but it also increases the risk of developing progressive, terminal cognitive conditions such as dementia. Strong associations between delirium and increase in overall morbidity have also been confirmed in recent literature.

Despite this, recognition and documentation of inpatient delirium still has room to improve. There is ongoing investigation into the recognition, documentation and appropriate investigation/monitoring of delirium at my clinical base, Friarage Hospital (Northallerton), which is reflected both regionally and nationally. Even when delirium is diagnosed, monitored and investigated with the input of the psychiatry team, the documentation in the discharge letters from the ward often does not reflect this part of the patient experience: compromising vital opportunity for pattern recognition and early intervention.

Aims were: To determine the consistency in documentation of delirium in elderly patients who have had psychiatric involvement whilst admitted.

To advocate for awareness of inpatient delirium as a predictor for morbidity, specifically:

1. Further episodes of delirium on subsequent admissions.
2. Development of chronic cognitive conditions, such as dementia.

Methods: Retrospective analysis of all patients discharged from the medical wards at FHN in November 2024, with the following inclusion criteria:

Over the age of 65 years old.

Admitted for an organic illness to medical ward in Friarage Hospital, Northallerton.

Referred to psychiatric liaison services during inpatient stay.

Discharge letter completed by ward upon completion of inpatient stay.

The appropriate patient population was pulled from Liaison Team records of patient reviews. This was a total of 60 patients in the month of November 2024.

The documentation of the respective patients' inpatient stays was reviewed, using Miya and Patientrack for any mention of delirium or its varying presentations (confusion/agitation/aggression). Their discharge letters were then reviewed for any corresponding acknowledgement of this condition.

Results: 38 patients fit the inclusion criteria (above) in November 2024. When reviewing the Miya profiles of the selected patients, it was documented that 22 of these 38 (58%) experienced delirium during their inpatient stay.

Of those who experienced delirium, 13 (59%) had documentation of this in their final discharge letters. The remaining 9 patients (41%) had no mention of delirium OR its various presentations (confusion/agitation/aggression) in their final discharge letters.

The population was taken from all inpatient medical wards in the Friarage Hospital, Northallerton. This included the CDU (Clinical Decisions Unit) and the UTC (Urgent Treatment Centre), as well as the following wards: Romanby, Ainderby, Rutson.

In terms of patient location, the following was noted: 8 of the 22 patients with documentation of delirium were discharged from Romanby ward, 6 from Ainderby, 1 from Rutson, and 7 from CDU/UTC. The breakdown in documentation consistency was as follows:

Out of the 8 discharged from Romanby, 2 (25%) had appropriate documentation and 6 (75%) did not have documentation in their discharge letters.

Out of the 6 discharged from Ainderby, 5 (83%) had appropriate documentation and 1 (17%) did not have documentation in their discharge letters.

The single patient discharged from Rutson did not have documentation in their discharge letter.

Out of the 7 discharged from CDU and UTC, 6 (86%) had appropriate documentation and 1 (14%) did not have documentation in their discharge letters.

Conclusion: Understand that this is the patient population wherein the diagnosis of delirium is taken for granted, as it was recognised and investigated, with referrals made to psychiatry for management. There is likely a larger patient population who have experienced delirium as an inpatient: those who may not have been referred for psychiatric assessment or even been noted to have delirium.

Having aimed to assess the consistency of the existing documentation, there is hope that – by working backwards – can move to improve documentation of known cases initially and ultimately increase awareness and recognition of the condition in those who otherwise would not have been assessed. There is exciting potential in broadening the scope of this audit to cover all medical admissions.

Actions prior to re-audit (projected to be March 2025):

Education for ward staff in importance of including delirium/dementia in discharge summaries:

Teaching session for Foundation Year doctors in regards to documentation in discharges.

Informational posters on wards from 08/01/25.

Encourage documentation of previous episodes of delirium upon clerking (as other comorbidities are documented in 'Problems' section), even if patient doesn't immediately present as confused.

In the small population audited, results demonstrated that only a slim majority (59%) of patients who required psychiatric input for their delirium had this documented in their medical discharge letters.

We hope to re-audit in March 2025 (as a retrospective of discharges in February 2025), giving minimum of 1 month to assess for change to practice.

To Determine if Patients on Birkdale Ward Are Assessed for Risk of Venous Thromboembolism in Compliance With the Trust's Standard Operating Procedure

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Aims: In August 2023 the Trust-wide standard operating procedure (SOP) titled 'Prevention and Management of Venous

Thromboembolism (VTE) for inpatients within Mersey care foundation trust (MCFT)' was developed. The purpose for this was to explain the procedure to be followed for assessing and managing VTE in inpatient (IP) services as it is a common and potentially preventable problem. NICE Guidance recommends that all service users admitted to any hospital should receive a VTE risk assessment and prophylaxis where appropriate.

In secure settings, catatonia, use of supportive holds and sedation can be associated with reduced mobility and increased risk of VTE. Therefore the policy was updated to allow for use in Secure Divisions within MCFT as well.

The aims of this audit was to: critique the audit to ensure it is fit for purpose for trust-wide use and identify any shortfalls in the practice and if required to rectify these.

Methods: A VTE audit tool was initially designed on Trust AMAT software for Mental Health IP wards to complete, this was later adapted to reflect Secure IP. The tool assessed whether VTE was assessed appropriately during the total time of their admission as well as during the trigger points set out in the SOP.

All patients in one team on Birkdale ward were included: this was 8 in total.

Results: The overall compliance level was 0% which is extremely poor. 68% of patients were appropriately assessed during all trigger points in their admission however 38% were not and required an up-to-date VTE assessment.

Conclusion: As part of critiquing the audit tool, as mentioned before changes were made to questions in order to reflect the long-term admissions that patients can experience in secure settings. Due to this a time frame for data collection needed to be defined as using the total admission length was not viable.

In order to improve practice, all patients who required an up to date VTE assessment received one and the SOP was disseminated to the ward staff to increase awareness of what current practice is meant to be.

However many concerns were raised about applicability and effe ctiveness of the current SOP, both in acute and secure IP settings. Therefore following a discussion with the trust-wide team involved, a decision was made to amend the SOP. Following this, IP services will need to be re-audited to see if they are complaint with the new version.

Vitamin D Deficiency: Monitoring and Assessment of Rehabilitation Inpatients

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Aims: Vitamin D deficiency mainly occurs due to inadequate sun exposure and a diet insufficient in vitamin D sources. Patients undergoing rehabilitation as an inpatient have long admissions that could last years. The evidence has suggested that vitamin D deficiency is commonly observed in psychiatric inpatients and is linked to a variety of psychiatric disorders.

Aims were to evaluate the prevalence of vitamin D deficiency in a psychiatry rehabilitation unit.

To establish the treatment compliance with the current available guidance – Local Trusts and Public Health.

Methods: This is a re-audit of the original done in 2023 to close the loop. Data was collected for patients admitted to the psychiatric rehabilitation unit over a 3-month period in 2024. Blood tests were reviewed using the I-Lab, and treatment records were reviewed through WellSky. The data was then compared with regional standards set by the LPT (Leicestershire Partnership Trust).

Results: An audit conducted in 2023 involving 38 patients revealed that 5 patients (13%) had vitamin D deficiency, none of whom received replacement. Additionally, 23 patients (60.5%) out of the total 38 were administered vitamin D maintenance therapy.

A re-audit conducted in 2024, which included 35 patients, found that 3 patients (8.5%) had vitamin D deficiency, defined as a serum level below 25 nmol/L. Of those with deficiency, only 1 patient received a vitamin D replacement. Overall, 14 patients (40%) of the 35 were prescribed vitamin D supplements.

Guidelines: LPT guidance:

All mental health and learning disability inpatients to have vitamin D levels checked on admission and then annually.

Patients should be treated with standardised vitamin D replacement as needed.

All long-term (more than 3 months) inpatients should be prescribed 400 units (10 mcg) daily.

Public Health England (PHE) is advising that 10 micrograms of vitamin D are needed daily to help keep healthy bones, and muscles particularly in in autumn and winter (21 July 2016).

Conclusion: The earlier mentioned guidelines advise that everyone should take vitamin D supplements. However, only 40% of the patients in the re-audit were receiving the recommended supplementation.

Vitamin D deficiency is commonly observed in psychiatric patients, particularly in rehabilitation settings, due to l imited sun exposure. Timely identification and treatment of vitamin D deficiency have the potential to improve patients' mental health and prevent further deterioration of psychiatric symptoms.

Prevalence of Valproate Prescription in Males 18– 55 Years

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Aims: To understand the number of men of childbearing age that are prescribed valproate on the inpatient wards in GMMH.

The number of men who are advised about the reproductive safety of valproate.

The number of men who have consented to valproate following discussion around the reproductive issues and have a risk assessment completed.

Methods: Attaining patients' details was initially done by communicating with lead pharmacists in every ward, to help with the data collection, in line with collecting data available also on PARIS system, EPMA the electronic prescribing system, having the information about patients' prescriptions, doses, ward, ward capacity, consent, and start date of the prescription, has been done through patient notes on PARIS system, going through the notes for the last 20 years to ensure having all the information needed, and searching for every needed information with more than keyword, for example: