Care of Confused Hospitalised Older Persons Program

How to Guide for Data Collection and Auditing

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Introduction

The Care of Confused Hospitalised Older Person Program aims to improve the identification and management of older people with confusion in hospital. This *How to Guide for Data Collection and Auditing* provides a summary of the audit tools and quality measures to evaluate the CHOPs Program. The Guide covers the following tools:

1. Pre- implementation Systems Audit
2. Staff Questionnaire (project team)
3. Medical Record Audit
4. Collection of Measures
5. Environmental Audit
6. Staff Knowledge and Attitude Audit
7. Staff Focus Groups
8. Patient Experience Trackers (PETs) Carers Questionnaire
9. Carers Focus Groups

Local measures

The ACI can assist local teams to develop measures for specific issues identified as local priorities.

Ethics approval

Please note that Site Specific Approval (SSA) is necessary before data is collected.

SSA Ethics form will be transferred to you to complete, to do this you will need a log in and password, which can be obtained from the online forms site https://ethicsform.org/Au/Signin.aspx

It is a good idea to contact your local research governance officer, each LHD has slightly different ways of obtaining an approval for a site specific application.

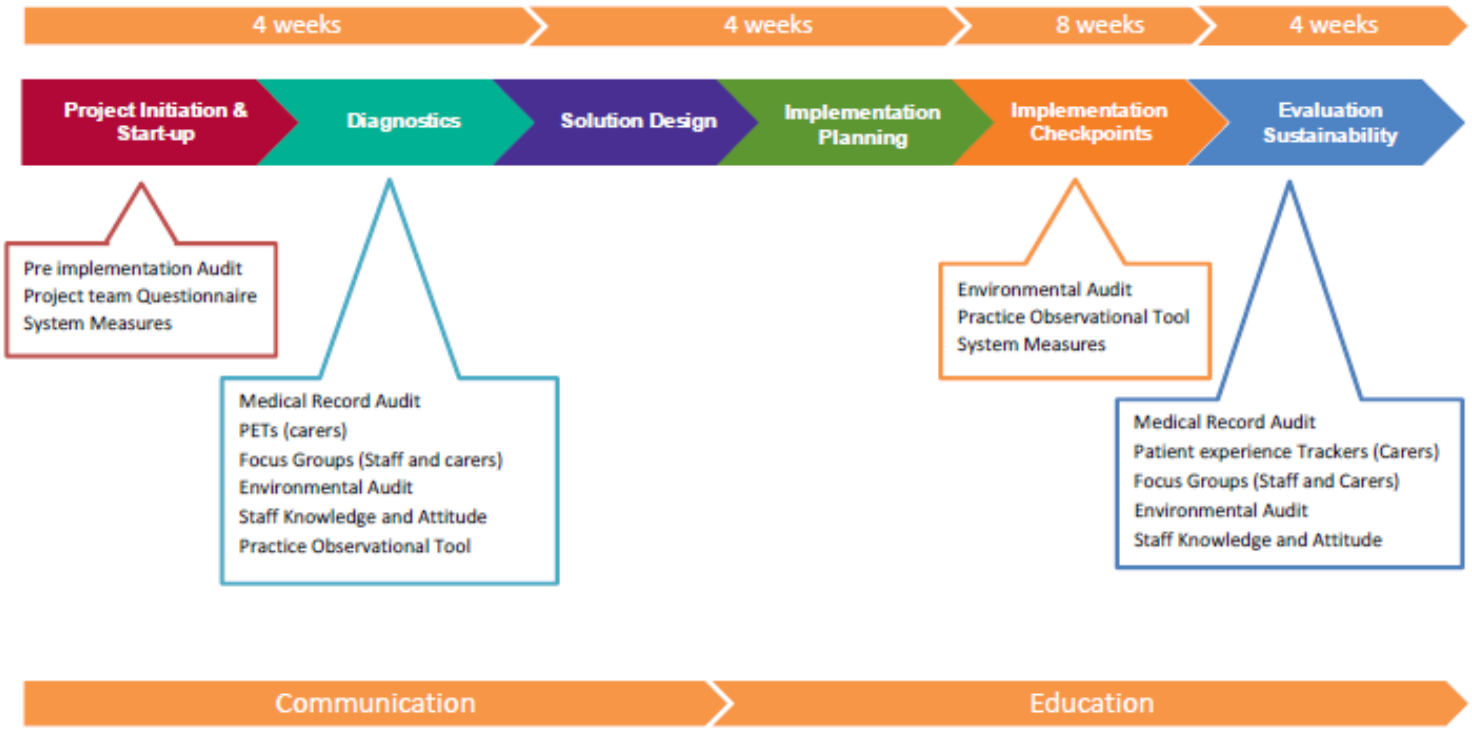
Keeping track

It is important that the information collected in routine manner. The following checklist will assist you to keep track of your data collection.

Tool	Date collected	Data Coordinator	Location of data	No collected/no requested
Project Initiation and Setup				
Pre implementation Systems Audit				
Project Team Questionnaire				
System Measures				
Diagnostic				
Medical Record Audit				
PETs (Carers)		ACI	ACI	
Focus Groups (Staff)		ACI	ACI	
Focus Groups (Carers)		ACI	ACI	
Environmental Audit				
Staff Knowledge and Attitude				
Practice Observational Tool				
Implementation Checkpoints				
Environmental Audit				
Practice Observational Tool				
System Measures				
Evaluation Sustainability				
Medical Record Audit				
PETs (Carers)		ACI	ACI	
Focus groups (Staff)		ACI	ACI	
Focus groups (Carers)		ACI	ACI	
Environmental audit				
Staff Knowledge and Attitude				

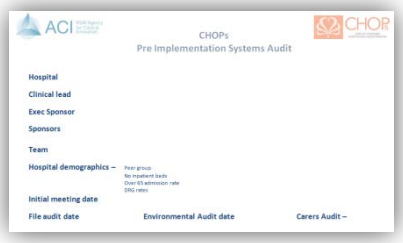
Care of Confused Hospitalised Older Persons Program

Evaluation Plan Summary



1. Pre-implementation Systems Audit

1.1 Purpose


CHOPs
Pre Implementation Systems Audit
Hospital
Clinical lead
Exec Sponsor
Sponsors
Team
Hospital demographics –
Initial meeting date
File audit date
Environmental Audit date
Carers Audit –

The pre-implementation systems audit aims to gather high-level information of systems currently in place for caring for confused hospitalised older people at your site. This audit provides baseline information before the commencement of the project.

This audit will provide the project team with information to consider any system gaps in aligning their services to the key principles for CHOPs

1.2 Time point

This audit can be conducted as part of the initial meeting with the project lead, the site project team and the ACI team.

1.3 Method

The ACI Project Team will administer the pre-implementation audit in discussion with the project team and feedback results to the project team and site.

2. Project Team Questionnaire

2.1 Purpose

The project team questionnaire will evaluate the impact of CHOPs on the project and ward teams.

2.2 Time point

The staff questionnaire is given to the project team on the initial meeting with the ACI team and to the ward staff where the project is being implemented. It will also be repeated at the evaluation phase of the project

2.3 Method

The ACI Team and project leads will distribute the staff questionnaire and feedback results to the project team and site.

3. System Measures

3.1 Purpose:

A number of measures that may be currently collected at a hospital level can assist teams to understand their current practice in relation to the principles of care so that specific or targeted areas for improvement can be identified and the impact of these improvements can be measured.

This list includes

- Hospital Delirium DRG's
- Falls rates (hospital and Ward)
- Antipsychotic usage
- Individual patient special (IPS) rates

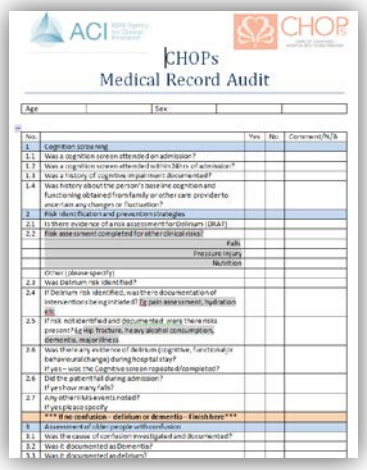
3.2 Time point

Specific measures can be identified and collated during the initiation phase (week 1-2) and may continue to be monitored throughout the implementation (week 8 – 16) as well as during the evaluation (week 20).

3.3 Method

The information will primarily be local data and site specific, it is recommended that the project lead works with their data managers and teams to identify and monitor the agreed appropriate measures. ACI may have access to some sources of centralised information and will assist the site lead to collate the data.

4. Medical Record Audit


ACI CHOP
CHOPs
Medical Record Audit
Age Sex

No.		Yes	No	Comment/N/A
1	Cognition screening			
1.1	Was a cognition screen attended on admission?			
1.2	Was a cognition screen attended within 24hrs of admission?			
1.3	Was a history of cognitive impairment documented?			
1.4	Was history about the person's baseline cognition and functioning obtained from family or other care provider to ascertain any changes or fluctuation?			
2	Risk identification and prevention strategies			
2.1	Is there evidence of a risk assessment for Delirium (DRAT)			
2.2	Risk assessment completed for other clinical risks?			
	Falls			
	Pressure Injury			
	Nutrition			
	Other (please specify)			
2.3	Was Delirium risk identified?			
2.4	If Delirium risk identified, was there documentation of interventions being initiated? Eg pain assessment, hydration etc			
2.5	If risk not identified and documented, were there risks present? Eg Hip fracture, heavy alcohol consumption, dementia, major illness			
2.6	Was there any evidence of delirium (cognitive, functional or behavioural change) during hospital stay? If yes – was the Cognitive screen repeated/completed?			
2.6	Did the patient fall during admission? If yes how many falls?			
2.7	Any other risk events noted? If yes please specify			
	*** If no confusion – delirium or dementia – Finish here ***			
3	Assessment of older people with confusion			
3.1	Was the cause of confusion investigated and documented?			
3.2	Was it documented as Dementia?			
3.3	Was it documented as delirium?			

4.1 Purpose

The Medical record audit gathers information from the medical files as well as from eMR. The audit tool has been based on the NICE Delirium audit(1) and refined so that it investigates the individual patient journey, their assessment and outcomes. It seeks to audit the care provided to older people in hospital as well as to identify a baseline and monitor change.

4.2 Time point

The medical record audit will be conducted during the diagnostic phase (week 2-4) of the project and again during the evaluation phase (week 16).

4.3 Method

The medical record audit will need to be conducted by a team of people. The ACI team and Site will work together to develop this group. The group may be made up of clinicians, quality/redesign staff, ACI team, site project team members.

Site lead should liaise with the medical records department and the audit team to organise an appropriate time, date and place to conduct the audit.

Sites will need to identify number of beds in the wards implementing CHOPs. ACI will use this information to determine the sample size of medical records to be audited.

Specifications for requesting medical records for CHOPs audit:

- Request 115 medical records for patients 70 years or over (75 years and older depending on your scope)
- Records will be from the wards which are implementing CHOPs
- Records will be for patients admitted to those wards in the preceding 3-6 months
- Exclude patients with day only admission
- Exclude patients with Emergency department only admissions

Each record is reviewed by an auditor and the questions are answered on the electronic tablet or on the paper version.

5. Patient Experience Trackers (PETs) for Carers

5.1 Purpose

It is important to include the needs and experiences of carers and consumers. The PET System is an electronic, mobile patient/staff feedback device offering a simple and fast solution to measure patient/staff experience at the point of care. The questions have been carefully crafted and tested to ensure validity and to provide health leaders with actionable data.

5.2 Time point

It is suggested that the PETs be used during the diagnostic phase of the project (week 2-4)

5.3 Method

The PETs are organised by ACI Patient and Carer experience team. The ACI currently leases the PET System from Customer Feedback Systems (CFS) and provides devices to NSW Health facilities free of charge.

The PET System is an electronic, mobile patient/staff feedback device offering a simple and fast solution to measure carer experience at the point of care. The carers read each of the five selected questions and make a response by pressing the touchpad. The de-identified responses are collated within the touchpad and sent via the mobile telephone network to a data server three times per day. The reports are automatically generated and e-mailed to nominated staff.

The sampling of Carers does not need to be random but we do want to ensure that the various ‘voices’ are heard. Potential Carer participants will be identified (ie all carers on ward x during am or pm shift on y number of days). Carers will be approached and provided with information and a demonstration of the PET by the expert Project Team during the specific timeframe in collaboration with local leaders from pilot sites.

Participation in surveys (and the focus group) is completely voluntary and can be withdrawn at any time. Obvious biases in the sample will be declared. The sample will be dependent on the Carers that are currently at each of the pilot hospitals during the specified time the surveys are conducted.

All carers will informed of the CHOPs Program by the staff in the participating wards and provided with a program brochure. They will be asked to complete five questions on the electronic mobile patient feedback device.

6. Staff Focus Groups

6.1 Purpose

Focus groups are an effective way to gather further qualitative information about staff knowledge and attitudes in identifying and managing confusion.

6.2 Time point

These measures can be gathered during the initiation phase or diagnostic phase (week 1-4) as well as during the evaluation (week 20).

6.3 Method

The ACI will facilitate the focus groups with the site leads.

The site project team will invite a random sample of staff members to attend a pre and post focus group/interviews. Staff will not be under obligation to participate. An Information sheet for staff participating in the program and evaluation will be provided. Staff will be asked to complete a consent form.

These focus groups will be facilitated as independently as possible from the ACI and local site project teams.

7. Carers Focus Groups

7.1 Purpose

It is important to include the needs and experiences of carers and consumers. Focus groups are an effective way to gather further qualitative information about carer experiences and the needs of older people with confusion in hospital.

7.2 Time point

These measures can be gathered during the initiation phase (week 1-2) as well as during the evaluation (week 20).

7.3 Method

ACI will facilitate the focus groups with the site leads.

The site project team will also invite a random sample of carers to attend a pre and post focus group/interviews. Carers will not be under obligation to participate. An Information sheet for carers participating in the program will be provided to them, with information about the evaluation and they will be asked to complete a written consent form.

These focus groups will be facilitated as independently as possible from the ACI and local site project teams.

8. Environmental Audit

8.1 Purpose

The environmental audit will identify areas that may be able to be adapted to better meet the needs of confused people in hospital e.g signage. It can also audits the immediate area surrounding confused patients on the ward e.g patient access to personal belongings. This also provides baseline information from which to focus education, training and prioritisation of strategies.

8.2 Time point

The medical record audit will be conducted during the diagnostic phase (week 2-4) of the project and again during the evaluation phase (week 16).

8.3 Method

The environmental audit will need to be conducted by a small team of people as determined by the site lead. The group may be made up of clinicians, quality/redesign staff, ACI team, site project team members.

The team will visit each CHOPs ward and complete the audit. The team will discuss with the team leader/NUM to identify people with confusion on the ward.

9. Staff Knowledge and Attitude Audit

9.1 Purpose

The Staff Knowledge and attitude audit provides a baseline of pre-education knowledge and attitude. This will assist in the development of education strategies and education plan. This audit tool was based on a questionnaire developed in Western Australia to determine nurses knowledge of delirium.(2)

9.2 Time point

The Staff knowledge and attitude audit will be conducted during the diagnostic phase (week 2-4) of the project and again during the evaluation phase (week 16).

9.3 Method

The staff knowledge and attitude survey can be given to all multidisciplinary clinical staff on the targeted wards. It is recommended for larger facilities to survey up to 100 staff. For smaller facilities, please discuss with ACI team.

References

1. National Institute for Health and clinical Excellence (NICE). Delirium: diagnosis, prevention and management. 2010.
2. Hare M, Wynaden D, McGowan S, Landsborough I, Speed G. A questionnaire to determine nurses' knowledge of delirium and its risk factors. Contemporary nurse. 2008;29(1):23-31.

Appendix 1: Pre-implementation Systems Audit

CHOPs
Pre Implementation Systems Audit

Hospital

Clinical lead

Exec Sponsor

Team

Hospital demographics – Peer group

- **No inpatient beds**
- **Over 65 admission rate**
- **DRG rates**

Initial meeting date

File audit date

Environmental Audit date

CHOPs

Pre Implementation Systems Audit

Element	Level	Measure	Yes -all of hospital	Some of hospital	None of hospital	Comment
COGNITIVE SCREENING	System	Cognitive screening tool is available for staff Name of tool(s) _____				
	Patient	Policy that Older people aged 65 years and over who have received cognitive screening on admission or within 24 hours				
	Staff	Staff identified by hospital as responsible for screening are trained in administering and interpretation of cognitive screening				
DELIRIUM RISK	System	Delirium Risk Assessment Tool (DRAT) tool in place				
		Evidence of Standardised process for identification and management of risk				
	Patient	Delirium risk assessed, documented and prevention strategies in place	N/A	N/A	N/A	Medical record audit
	Staff	Staff aware of delirium risk and prevention strategies	N/A	N/A	N/A	
ASSESSMENT	System	Cognitive assessment Method (CAM) tool available				
		Comprehensive assessment process in place including referral for dementia assessment if necessary				
	Patient	Dementia and delirium documented and appropriately coded	N/A	N/A	N/A	
	Carer	Process in place for carer consultation regarding patient prior history				
		Process in place for carers needs to be assessed				

CHOPs

Pre Implementation Systems Audit

Element	Level	Measure	Yes -all of	Some of hospital	None of hospital	Comment
MANAGEMENT	System	Policies, procedures, guidelines referral pathways and /or protocols in place				
	Patient	Process in place to measure number of ward moves for patients				
		Process in place to measure use of antipsychotics				
		Process in place to measure complication rates - falls, pressure injury				
		Process in place to measure Length of stay, mortality				
	Carer	Process in place to measure that carer informed of their role in management				
		Process in place to measure that carer involved in the development of a management plan				
	Staff	Appropriate referrals to specialist services for confusion and underlying causes Staff knowledge increase				
COMMUNICATION	System	"Get to know you" system developed and promoted				
		Process to communicate information with patients, carers and staff				
		Clinical handover includes cognitive status and any recent changes in cognition				
	Carer	Process in place to measure carer satisfaction with consultation about person care				
		Process in place to measure that staff listen to carers				
		Process in place to measure that carers receive education				

CHOPs

Pre Implementation Systems Audit

Element	Level	Measure	Yes -all of	Some of hospital	None of hospital	Comment
EDUCATION	System	Staff knowledge and attitude surveys utilised				
		Organisational education plan developed and implemented				
		Access to HETI and other training modules				
		Dementia e learning facilitators in place				
	Staff	Process to measure training sessions held (total)				
		Process to measure staff attending training sessions (total and percentage)				
		Process to measure staff satisfaction				
		Process to measure staff confidence				
		Process to measure staff knowledge				
ENVIRONMENT	System	Environmental Audit available				
		Dementia friendly design principles are considered in any capital works/refurbishment				
	Patient	Ways available to address identified environmental issues at individual level				
		Ways available to address identified environmental issues at individual level				

Appendix 2: Project Team Questionnaire

Confused Hospitalised Older Persons Program – CHOPS
Staff questionnaire

The Agency for Clinical Innovation (ACI) is embarking on an evaluation of CHOPS at selected sites across NSW.

The expected benefits of CHOPS include improved identification and management, more knowledgeable staff, leading to improved treatment and prevention of delirium, reduced adverse events such as falls, and improved carer satisfaction with the hospital experience.

The primary aim of the evaluation is to identify factors that impede or facilitate the implementation of the program to enable ongoing improvement as the program evolves, to assist staff with knowledge about the program and to assess changes in clinical outcomes for patients.

To assist in the evaluation, please complete the following questions with regards to CHOPS at your facility.

Position.....Facilty.....

To what extent do you agree or disagree with the following statements?	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I have a good understanding of the issues that face older people experiencing delirium and/or confusion while in hospital	○	○	○	○	○
2. The unit where I work supports older people with, or at risk of, delirium and/or confusion	○	○	○	○	○
3. I am supported by my unit to work effectively with older people with, or at risk of, delirium and/or confusion	○	○	○	○	○
4. It is important to assess all older people presenting to Emergency Departments for, or at risk of, delirium and/or confusion	○	○	○	○	○
5. It is important to assess all older people admitted to hospital for, or at risk of, delirium and/or confusion	○	○	○	○	○
6. I have a sound knowledge of the Confused Hospitalised Older Persons (CHOPS) program	○	○	○	○	○
7. I believe CHOPS has the potential to improve the care for older people in hospital	○	○	○	○	○
8. I use the tools provided through CHOPS to work with patients	○	○	○	○	○
9. Other staff in the unit where I work are aware of CHOPS	○	○	○	○	○
10. Other staff in the unit where I work are committed to CHOPS to improve the care of older people in our unit	○	○	○	○	○

Do you think CHOPS can be improved? Please provide details.....

.....

.....

Are there any barriers to implementing CHOPS at your site.....

.....

.....

Thank you for taking the time to complete this questionnaire

Appendix 3: System Measures

Collection of Measures Hospital -

DRG delirium rate

Graph – 5 year rate

Anthea can do this

Falls rate

2019	2010	2011	2012	2013

Total numbers of falls in ward 1 – *These could be graphed*

3 months prior	2 months prior	1 month prior	Intervention Month 1	Intervention Month 2	Post Month 1

Total numbers of falls in ward 2

3 months prior	2 months prior	1 month prior	Intervention Month 1	Intervention Month 2	Post Month 1

Total numbers of falls in ward 3

3 months prior	2 months prior	1 month prior	Intervention Month 1	Intervention Month 2	Post Month 1

Specials – IPS

Total numbers of patients requiring IPS (special) in ward 1

3 months prior	2 months prior	1 month prior	Intervention Month 1	Intervention Month 2	Post Month 1

Total numbers of patients requiring IPS (special) in ward 2

3 months prior	2 months prior	1 month prior	Intervention Month 1	Intervention Month 2	Post Month 1

Total numbers of patients requiring IPS (special) in ward 1

3 months prior	2 months prior	1 month prior	Intervention Month 1	Intervention Month 2	Post Month 1

Anti-psychotic use

Ward or hospital? Some of these will be collected in medical file audit

Could be broken down by specific anti-psychotic medication

3 months prior	2 months prior	1 month prior	Intervention Month 1	Intervention Month 2	Post Month 1

Could be graphed

Appendix 4: Medical Record Audit

CHOPs
Medical Record Audit

Age		Sex		

No.		Yes	No	Comment/N/A
1	Cognition screening			
1.1	Was a cognition screen attended on admission?			
1.2	Was a cognition screen attended within 24hrs of admission?			
1.3	Was a history of cognitive impairment documented?			
1.4	Was history about the person's baseline cognition and functioning obtained from family or other care provider to ascertain any changes or fluctuation?			
2	Risk Identification and prevention strategies			
2.1	Is there evidence of a risk assessment for Delirium (DRAT)			
2.2	Risk assessment completed for other clinical risks?			
	Falls			
	Pressure Injury			
	Nutrition			
	Other (please specify)			
2.3	Was Delirium risk identified?			
2.4	If Delirium risk identified, was there documentation of interventions being initiated? Eg pain assessment, hydration etc			
2.5	If risk not identified and documented were there risks present? Eg Hip fracture, heavy alcohol consumption, dementia, major illness			
2.6	Was there any evidence of delirium (cognitive, functional or behavioural change) during hospital stay? If yes – was the Cognitive screen repeated/completed?			
2.6	Did the patient fall during admission? If yes how many falls?			
2.7	Any other IIMS events noted? If yes please specify			
	***** If no confusion – delirium or dementia – Finish here*****			
3	Assessment of older people with confusion			
3.1	Was the cause of confusion investigated and documented?			
3.2	Was it documented as Dementia?			
3.3	Was it documented as delirium?			
3.4	If not documented – does the clinical information suggest delirium?			
	Dementia?			
	Delirium superimposed on dementia?			
4	Management			
4.1	Were delirium Dementia policy/procedures followed or was the Delirium Pathway used?			

4.2	Were recommended delirium screening investigations conducted?			
4.3	Were anti-psychotics or sedatives initiated on or during admission? *If so please specify*_____			
	If so were the anti-psychotics PRN?			
4.4	Were any physical /Mechanical restraint used?			
4.5	Was specialist assessment/input sort? If yes whom – CNC/NP, Snr nursing, allied Health Geriatrician, Psychiatry			
4.6	Was the patient nursed 1:1?			
5	Communication / Education			
	Was there documentation describing interaction with carer/family?			
6	Discharge			
	Was Delirium / dementia noted in discharge summary?			
	Was delirium / dementia coded in DRG/case mix data?			
	Was discharge destination a change from admission?			
	Did patient die?			
	Other comments.....			

Could be added to drop box if online

Appendix 5: Environmental Audit

CHOPS – Environmental Audit

Hospital -

Ward _____

	Yes/number	No/ Number	Comments
Number of single rooms potentially available for cognitively impaired patient			
Number of beds visible from nurses station			
Number of beds where toilet can be seen from bed			
Toilet signs			
Shower signs			
Toilet pictures			
Shower pictures			
Height of signs appropriate			
Signs Contrast/easily read			
Toilet seats contrast to tiles			
White board visible from bed			
Clock visible from bed			
Corridor free from clutter			
Lounge or visitor room available for patients			
Lounge chairs suitable height and arms			
Natural light available in all pt rooms			
Night light available in all pt rooms			
Ability for family to stay with patient overnight and out of visiting hours			
Number of low low beds			
Number of alarm mats			

Confused patients in ward (per bed)										
Per bed										
Noise – minimised (buzzers, alarms, staff)										
Personal items at bed side										
Clear access from bed to toilet										
Rooms free from clutter										
Chair with arms										
Mechanical restraint used?										
"Get to know you" system in place eg Sunflower /Top 5										

Appendix 6: Staff Knowledge and attitude audit

Care of Confused Older People Staff Survey please circle Pre/post

We would like you to take some time to think about your experiences in caring for people with confusion in the hospital setting, and then answer the below questions.

1. Designation (*eg RN, CNC, Allied Health, Intern*) _____
2. Years of service _____
3. Have you received training on managing confused older patients? YES /NO
4. Do you feel the training has been sufficient? YES /NO
5. Thinking over the last month, what is the behaviour you find most difficult when caring for a patient with dementia and/or delirium?

☐ Confusion	☐ Disorientation	☐ Drowsiness or lethargy
☐ Agitation	☐ Aggression	☐ Resistance to care
☐ Pulling out tubing	☐ Lack of co-operation	☐ Crying or calling out
☐ Withdrawal	☐ Trying to climb out of bed or abscond	
☐ Hallucinations	☐ Suspiciousness or paranoia	
☐ Other: _____		

6. Have you been exposed to any episodes of aggressive behaviour? YES /NO
7. How confident do you feel in the management of a patient with confusion?

0	1	2	3	4	5	6	7	8	9	10
Not confident at all										*Very confident*

8. How much stress does managing a patient with confusion cause you?

0	1	2	3	4	5	6	7	8	9	10
No stress										*Extreme stress*

9. How confident are you in recognising the risk factors for Delirium?

0	1	2	3	4	5	6	7	8	9	10
Not confident at all										Very confident

10. How confident do you feel in recognising when a patient has delirium?

0	1	2	3	4	5	6	7	8	9	10
Not confident at all										Very confident

11. How confident are you in using the Confusion Assessment Method (CAM) to assess for delirium?

0	1	2	3	4	5	6	7	8	9	10
Not confident at all										Very confident

Care of Confused Older People Staff Survey please circle Pre/post

Please turn over

Questions	True	False
1. Fluctuating between orientation and disorientation is not typical of delirium		
2. Acute alteration in cognition is normal for old people		
3. Treatment for delirium always includes sedation		
4. Patients never remember episodes of delirium		
5. It is best practice to restrain confused patients		
6. Delirium never lasts for more than a few hours		
7. The care needs of a person with dementia need to be focused holistically and include their carer		
8. A patient who is lethargic and difficult to rouse does not have a delirium		
9. Patients with delirium are always physically and/or verbally aggressive		
10. Delirium is generally caused by alcohol withdrawal		
11. Patients with delirium have poorer outcomes such as increase mortality rate and institutionalisation		
12. Behavioural changes in the course of the day are typical of delirium		
13. Dementia is the greatest risk factor for delirium		
14. Patients with delirium will often experience hallucinations		
15. A urinary catheter in situ reduces the risk of delirium		
16. The Confusion Assessment method (CAM) is the tool used to diagnose delirium		
17. An episode of delirium increases an individuals risk of developing dementia		
18. Dementia is the third leading cause of death after heart disease and stroke		
19. A cognition screen is not helpful in obtaining a baseline assessment of an older person		
20. The care environment can influence the behaviour of someone with dementia		

Please answer true or false to the following statements