

recognising and management of delirium and agitation after the educational intervention

P-96 **DIAGNOSIS AND ASSESSMENT OF DELIRIUM IN HOSPICE INPATIENTS**

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Background Delirium may be reversible in up to 50% of patients with advanced cancer and the majority of patients who recover from delirium recall it as highly distressing.

Aims To retrospectively identify episodes of delirium in hospice inpatients and explore practice around consideration and management of potentially reversible causes.

Methods A retrospective review of all patients who were inpatients in the hospice during a two-week period was performed by searching electronic records for use of descriptors agreed by a group of healthcare professionals to be reasonable proxy terms for delirium. For each delirium episode the following were considered:

- Whether a diagnosis of delirium was made
- Whether the most likely cause was identified and addressed where appropriate.

Results 28 patients were included in the project with 38 episodes of delirium identified in total. A diagnosis of ‘delirium’ was made in 13 of these 38 episodes. In 23 of the 38 episodes a most likely cause was identified. An attempt was made to address the documented most likely cause in 16/23 cases. In seven this was either not possible or thought to be inappropriate due to the patient’s condition.

Discussion Proxy descriptors were used to identify delirium episodes. The use of proxy descriptors is likely to underestimate hypoactive delirium which is thought to represent the majority of delirium seen in hospice populations. It was more difficult to assess from descriptors of hypoactive delirium e.g., drowsy or sleepy if symptoms are related to delirium or to disease progression. A quality improvement project has been established to improve recognition and assessment of delirium. A validated screening tool has been introduced. Education has focused on prompt identification and active consideration of possible causes of delirium, and whether it is possible and appropriate to reverse these.

P-97 **AN AUDIT OF THE ASSESSMENT OF DELIRIUM IN HOSPICE ADMISSIONS THROUGH THE INTRODUCTION OF THE 4AT**

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Background Delirium is a significant problem in the palliative care setting, with incidence of delirium ranging from 5%–45% of inpatients (Hosie et al., 2013). In Scotland there has been development of a new management pathway for delirium by Healthcare Improvement Scotland and the Scottish Delirium Association (2016). This recommends the use of the 4AT to help diagnose delirium.

Aims This is an audit to review the practice of screening for delirium in the hospice setting. The aim of the audit is to

ensure delirium assessment in the hospice is in line with current guideline. The standard is that 100% of patients over the age of 65 should have a documented cognitive screen on admission.

Methods Notes from patients admitted from 19 June to 19 November 2015 were retrospectively reviewed to assess for formal documentation of delirium screening and also the incidence of delirium in this population. Patients over the age of 65 were included and patients that were admitted for care in the last days of life were excluded from the data. Stage two involved the introduction of the 4AT in the above inpatient population. The use of the 4AT was then re-audited in patients who were admitted to the hospice in the following six months.

Results Prior to the intervention only three out of 38 patients had formal assessment of delirium on admission. Post intervention 26/29 patients had formal assessment with the use of the 4AT. 58% patients who were admitted over this year period and fitted the inclusion criteria developed a delirium during their stay.

Conclusion This audit has shown that education and introduction of simple routine assessment can increase the recognition of delirium in a palliative care setting, potentially improving levels of care for patients.

P-98 **PALLIATIVE CARE AND DEMENTIA COLLABORATION PROJECT**

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Background There are unmet palliative care needs in dementia (Van der Steen et al., 2013; Dempsey et al., 2015). The number of people dying with dementia is rapidly increasing (Etkind et al., 2017). Choice in end of life care is a national priority (National Palliative & End of Life Care Partnership, 2015; Department of Health, 2015). NICE Guidance recommends a palliative care approach from point of diagnosis and equitable access to services based on need (NICE clinical guideline reviewed, 2016; Dixon et al., 2015). Electronic care registers (My Care Choices Register in North East Essex) enables recording and sharing of care preferences (Wee, 2015; Department of Health, 2015). Hospices have a pivotal role in sharing palliative care expertise and enabling other teams to incorporate palliative care principles and practices into their work (Calanzani et al., 2013; Hospice UK., 2015). Palliative care teams also need to develop skills in dementia (Van der Steen et al., 2013; Hospice UK., 2015). We therefore developed the Palliative Care and Dementia Project in September 2016.

Aims 1) Develop collaborative working between Palliative Care and Mental Health.

2) Identify unmet palliative care needs in advanced dementia.

3) Increase number of referrals for Dementia patients.

4) Establish use of My Care Choices Register.

Methods Senior Palliative Doctor providing weekly direct support to two Acute Dementia wards over six months. Baseline and subsequent audit of My Care Choices Register registration and hospice referrals. Use of SPICT (10) – Supportive and