FINAL

NHS

South East Delirium Webinar

5th November 2020 - Version 1.0

NHS England and NHS Improvement

Housekeeping

- Check that you can see the chat box and if not then leave meeting and accept invite and re-join
- Keep your mic off mute/camera off unless presenting
- Use Chat function to ask questions or make a comment
- Add organisation to any question (if possible)
- Meeting is being recorded and will be made available – please let us know if this is an issue
- All slides and recording will be shared on NHS Futures Platform

Aim of Delirium webinar

NHS

- It will cover the following topics on Delirium:
  1. The patient is medically fit for discharge – what next?
  2. Delirium – Models of Care
  3. Lesson learnt Developing Greater Manchester's Delirium Pathway
  4. Yorkshire & Humber Clinical Network – Delirium resources
- Lessons learnt and what can be done differently going forwards?
- Q & A session to allow opportunity for discussion and sharing of best practice

Presenters

- Dementia Clinical leads across South East
- Dr Bikram Raychaudhuri – GP
- Dr Sian Roberts – GP
- Dr Christopher Kipps – Consultant Neurologist
- Jo Gavins & Rachel Chappell - Quality Improvement Managers
- Presentors:
- **Dr Victoria Lukats** - Consultant Psychiatrist, Princess Royal Hospital & Sussex Partnership NHS Foundation Trust
- **Dr Josie Jenkinson** – Consultant Psychiatrist for Older People, ASPH Psychiatric Liaison Service & Vice-Chair, Faculty of Old Age Psychiatry, Royal College of Psychiatrists
- **Helen Pratt** – Clinician & Project Manager, Dementia United, Greater Manchester

Delirium: The patient is medically fit for discharge – what next?

Dr Victoria Lukats
Consultant Psychiatrist
Dementia Liaison Service, Princess Royal Hospital
Sussex Partnership NHS Foundation Trust

With thanks to Dr Scott Cherry

Delirium and Liaison Psychiatry

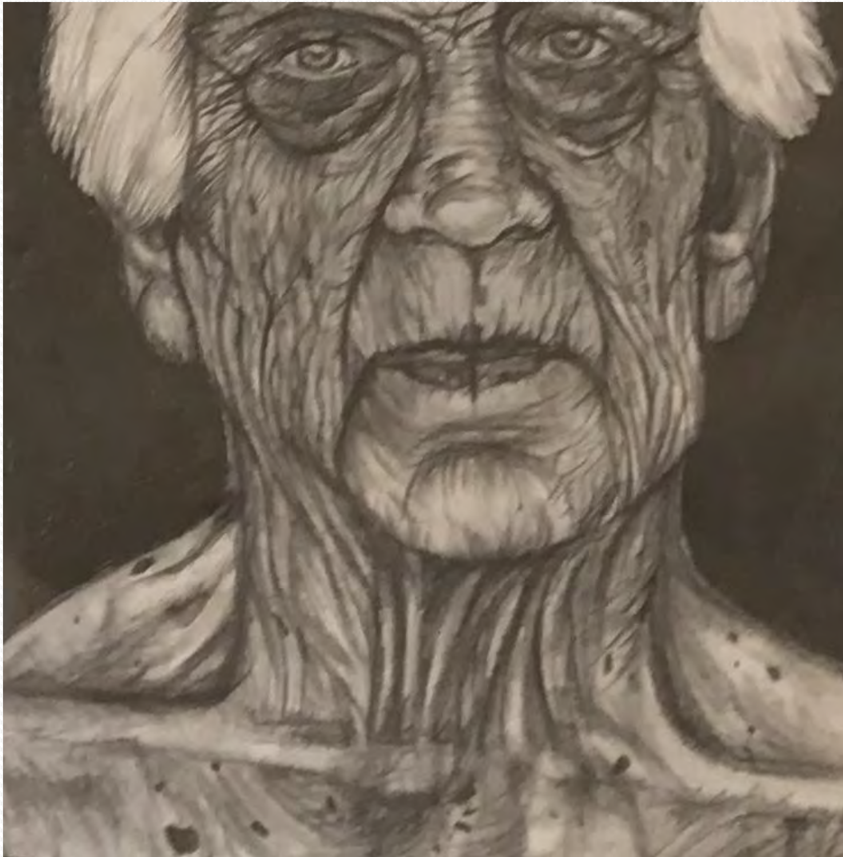
- Patients with delirium may present anywhere: primary care, nursing homes, A&E, hospital inpatients

- My own role: Dementia Liaison Service, Princess Royal Hospital, Haywards Heath. Delirium is frequent among inpatients with dementia. Often it is difficult to determine if the patient has underlying dementia without a good history.
- I see many patients with a delirium, sometimes undiagnosed at that point. General mental health liaison services frequently see patients with delirium.

Vignette1

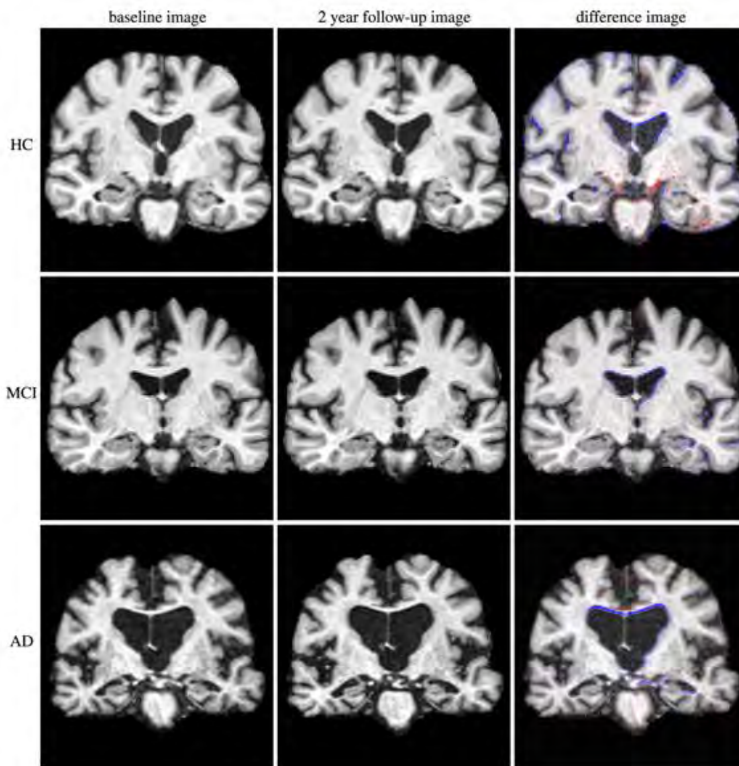
- Mrs C
- 83 year old woman
- MFFD
- Treated for UTI (Required IV antibiotics due to antibiotic sensitivity)
- Paranoid delusions and visual hallucinations: fears she is to be killed
- Lives alone, daughter visits
- Probable underlying MCI
- Previous episodes of delirium take 1-2 months to settle
- Unable to live independently when floridly psychotic

Vignette 2



- 94 year old woman
- Known mixed dementia
- Fractured NOF after fall on medical ward
- Previous falls and fractures
- Previous episodes of delirium
- Severe hyperactive delirium post-op
- Advice needed on underlying cause (multifactorial), management of behaviour, discharge planning

Vignette 3



- Mrs E, 92 year old woman, on medical ward, MFFD
- Married, husband carer
- Known Alzheimer's dementia, discharged from mental health
- UTI, delirium, treated by GP
- Behavioural disturbance at home: fluctuations

Clinical Context: Delirium Definition

- Transient
- Fluctuating
- Acute confusional state
- Multifactorial aetiology
- Complex neuropsychiatric disorder

ICD-10 FO5 DELIRIUM,

- NOT INDUCED BY ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES
- A. Clouding of consciousness, i.e. reduced clarity of awareness of the environment, with reduced ability to focus, sustain, or shift attention.
- B. Disturbance of cognition, manifest by both:
- (1) impairment of immediate recall and recent memory, with relatively intact remote memory; (2) disorientation in time, place or person.
- C. At least one of the following psychomotor disturbances:
- (1) rapid, unpredictable shifts from hypo-activity to hyper-activity;
- (2) increased reaction time
- (3) increased or decreased flow of speech;
- (4) enhanced startle reaction.

ICD-10 FO5 DELIRIUM,

- D. Disturbance of sleep or the sleep-wake cycle, manifest by at least one of the following:
- (1) insomnia, which in severe cases may involve total sleep loss, with or without daytime drowsiness, or reversal of the sleep-wake cycle;
- (2) nocturnal worsening of symptoms;
- (3) disturbing dreams and nightmares which may continue as hallucinations or illusions after awakening.
- E. Rapid onset and fluctuations of the symptoms over the course of the day.
- F. Objective evidence from history, physical and neurological examination or laboratory tests of an underlying cerebral or systemic disease (other than psychoactive substance-related) that can be presumed to be responsible for the clinical manifestations in A-D.

Subtypes

- Hyperactive > Hypoactive
- Agitation & restlessness good prognostic factors
- Better outcome in hyperactive pts
- ↓ hospitalisation in hyperactive pts
- Hypoactive pts more cognitively impaired

Subtypes

Table V. Definition of motor subtypes (Meagher et al., 2008).

Hyperactive subtype if definite evidence in the previous 24 hours of (and this should be a deviation from pre-delirious baseline) of at least two of:

1. Increased quantity of motor activity: Is there evidence of excessive level of activity, e.g. pacing, fidgeting, general overactivity?
2. Loss of control of activity: Is the patient unable to maintain levels of activity that are appropriate for the circumstances, e.g. remain still when required?
3. Restlessness: Does the patient complain of mental restlessness or appear agitated?
4. Wandering: Is the patient moving around without clear direction or purpose?

Hypoactive subtype if definite evidence in the previous 24 hours of (and this should be a deviation from pre-delirious baseline) two or more of* (:*Where at least one of either decreased amount of activity or speed of actions is present)

1. Decreased amount of activity: Does the patient engage in less activity than is usual or appropriate for the circumstances, e.g. sits still with few spontaneous movements?
2. Decreased speed of actions: Is the patient slow in initiation and performance of movements e.g. walking?
3. Reduced awareness of surroundings: Does the patient show a relative absence of emotional reactivity to the environment, i.e. show a passive attitude to his/her surroundings?
4. Decreased amount of speech: Does the patient have a reduced quantity of speech in relation to the environment, e.g. answers are unforthcoming or restricted to a minimum?
5. Decreased speed of speech: Does the patient speak more slowly than usual, e.g. long pauses and slowing of actual verbal output?
6. Listlessness: Is the patient less reactive to his/her environment, e.g. are responses to activity in surroundings slow or reduced in amount?
7. Reduced alertness/withdrawal: Does the patient appear detached or lacking in awareness of his/her surroundings or their significance?

Mixed motor subtype if evidence of both hyperactive and hypoactive subtype in the previous 24 hours.

No motor subtype if evidence of neither hyperactive or hypoactive subtype in the previous 24 hours.

What causes delirium?

- **Potentially modifiable risk factors**
- Sensory impairment (hearing or vision)
- Immobilization (catheters or restraints)
- Medications (for example, sedative hypnotics, narcotics, anticholinergic drugs, corticosteroids, polypharmacy, withdrawal of alcohol or other drugs)
- Acute neurological diseases (for example, acute stroke [usually right parietal], intracranial hemorrhage, meningitis, enkephalitis)
- Intercurrent illness (for example, infections, iatrogenic complications, severe acute illness, anemia, dehydration, poor nutritional status, fracture or trauma, HIV infection)
- Metabolic derangement
- Surgery
- Environment (for example, admission to an intensive care unit)
- Pain
- Emotional distress
- Sustained sleep deprivation
- **Nonmodifiable risk factors**
- **<u>Dementia or cognitive impairment</u>**
- Advancing age (>65 years)
- History of delirium, stroke, neurological disease, falls or gait disorder
- Multiple comorbidities
- Male sex
- Chronic renal or hepatic disease

Fong et al, 2009

Drugs and delirium

- Many drugs induce delirium
- 3rd commonest cause: Significant potentially PREVENTABLE cause.
- Highest risk for anticholinergic drugs crossing BBB
    - Karlsson 1999
    - Tune & Egeli 1999
    - Francis et al 1990
- Various rating scales to assess/quantify use of anticholinergic drugs Anticholinergic Drug Burden (ADB)
    - Anticholinergic Risk Scale (ARS)
    - Anticholinergic Cognitive Burden Scale (ACB)
    - The list of Chew
    - Anticholinergic Drug Scale (ADB)

Delirium and anticholinergic drugs

J Am Med Dir Assoc
. 2020 Jul 20;S1525-8610(20)30349-2.
doi: 10.1016/j.jamda.2020.04.019. Online ahead of print.

Anticholinergic Drug Burden and Delirium: A Systematic Review

Angelique Egberts[1], Rafael Moreno-Gonzalez[2], Hava Alan[3], Gijsbertus Ziere[3], Francesco U S Mattace-Raso[3]

ADB assessed with the ARS is consistently associated with delirium.

ARS might be a useful tool to identify patients at increased risk for delirium

Delirium and anticholinergic drugs

- Pharmacol Res Perspect. 2017 Jun; 5(3): e00310.
- Published online 2017 May 11. doi: 10.1002/prp2.310
- PMCID: PMC5464339
- PMID: 28603629

- **Anticholinergic drug exposure is associated with delirium and postdischarge institutionalization in acutely ill hospitalized older patients**

- Angelique Egberts,[1] Saskia T. van der Craats,[1] Melissa D. van Wijk,[1] Shams Alkilabe,[1] Patricia M. L. A. van den Bemt,[2] and Francesco U. S. Mattace-Raso[1]

Delirium: scale of problem

- 10% of admissions
- 10-30% develop it in hospital
- Post-op 15-53%
- ICU 70-87%

Beh emerg eld hosp nurs 05

- Common
- Costly
- Associated mortality, loss of function, falls
- Preventable (? 30-40%)
- Possible precursor of dementia
- Pharmacologic treatments may lead to harm

Inouye, Lancet 2014

What effect does delirium have on outcomes?
Or Why is delirium important?

- LOS, and the subsequent impact on outcomes and costs
- Falls
- Institutionalization post-discharge
- Mortality
- Prognosis in dementia

The solution?

- Not every case of delirium can be prevented.
- Estimated 30% may be preventable
- A systematic approach is needed to
- Prevent delirium
- Identify those at risk
- Optimise care and improve outcomes of those with delirium

Delirium models of care

NHS
Surrey and Borders
Partnership
NHS Foundation Trust

The bigger picture

Dr Josie Jenkinson
Consultant Psychiatrist for Older People
ASPH Psychiatric Liaison Service

Vice-Chair, Faculty of Old Age Psychiatry
Royal College of Psychiatrists

Mental Health
Services

For a better life

Introduction

- Why me?
- Drivers for change
- Delirium and the need for integrated care
- Evidence base
- MH services and delirium care – the political landscape
- Obstacles and how we can overcome them
- Practical tips

Why me?

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- Since starting as a liaison consultant, it has been obvious to me that we MUST do better for people with delirium
- I see previous lack of attention and progress with delirium care as an example of ageism
- There is nothing pleasant about being confused
- We can improve things in the hospital but this is just part of care
- We need system wide change to support people and their carers to get better care
- Improving and developing models of care for delirium is an exciting opportunity to make a huge positive difference to people's care

Drivers for change

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- Greater focus on healthy ageing and older people's health needs with an ageing population
- Increasing body of research → greater recognition of the problem in terms of outcomes and costs
- Development of screening tools - easier identification
- Development of national guidelines – first NICE and now the more comprehensive SIGN guideline (2019)
- Progression nationally in terms of integrated care following the FYFV – evolving integrated care systems (e.g. Surrey Heartlands Health and Care Partnership)
- Development of specific services with growing understanding and recognition of the issues (dementia support, psychiatric liaison, frailty services)
- COVID-19 - an increasingly pressurised system, and delirium a common feature of COVID-19

The need for better models of care

- Missed opportunities to reduce impact of this horrible condition in terms of morbidity and costs
- Carer stress
- Missed diagnoses of dementia
- Increased admission and readmission rates to hospital
- Missed opportunities to reduce impact of this horrible condition in terms of morbidity and costs
- Health professional stress

Evidence base

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NHS Foundation Trust

- Growing evidence base for screening and diagnostic tools and interventions
- Lack of research available on effectiveness on different care models – gap in the research
- Community based pathways are increasingly being described, dementia/delirium wards – but little evaluation data
- Difficult area to research, possibly due to overlap with other conditions

The importance of integrated care

- Delirium is seemingly a perfect example of the need for integrated care models
- Does not fall neatly into one specialty
- Requires a true MDT approach -different professionals all add something to care
- Needs different specialties to work together across traditional organisational boundaries and physical settings
- Overlap with other conditions – dementia, end of life care, frailty

Mental health services and delirium care - political landscape

Surrey and Borders Partnership NHS Foundation Trust

- Increasing emphasis on holistic care and parity of esteem between physical and mental health
- Growing specialty of old age liaison psychiatry who increasingly see it as core business
- Increasing recognition of importance of mental health input into delirium care BUT community mental health services for older people are chronically underinvested
- FYFV for MH - crisis care for older people's mental health is a priority and this includes provision for dementia
- Many dementia crises are related to delirium - how can this this all fit together?

Obstacles…

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- Traditional roles, siloed working and organisational boundaries
- IG and data sharing
- Lack of resources and underfunding of MH services
- Lack of confidence amongst professionals
- Lack of time
- Complexity - interface with other conditions
- Lack of evidence into best models of care

How to overcome them…

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- Develop relationships across organisations and engage clinicians
- Awareness campaigns and a community of engagement
- Digital overhaul - e.g. Surrey Shared Care records
- Have tough discussions re: responsibilities and funding - investment in MH services needed
- Allocate people and resources to this issue – eg Champions
- Development of educational resources and training
- PPI and evaluation emergent pathways - importance of co-production, and data is king!

Practical tips from experience…

Surrey and Borders Partnership NHS Foundation Trust

- Start simple - work out what is happening in your area – map it out – where are the gaps?
- Identify key leads in your local ICS if you have one, or your trust, and get in on the discussion
- Networking is key
- Raise the issues continuously at whatever fora you can
- Build a network of interested clinicians
- Be patient, change is slow

Thank you

NHS
Surrey and Borders Partnership
NHS Foundation Trust

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Greater Manchester Health and Social Care Partnership

Dementia United

LESSONS LEARNT - DEVELOPING GREATER MANCHESTER'S DELIRIUM PATHWAYS

Helen Pratt, Dementia United

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Tweet: @Dementiaunited

NHS in Greater Manchester

CONTEXT

Devolved health and social care

Vision - To deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people of Greater Manchester

10 geographical localities make up Greater Manchester

The GM Health and Care System

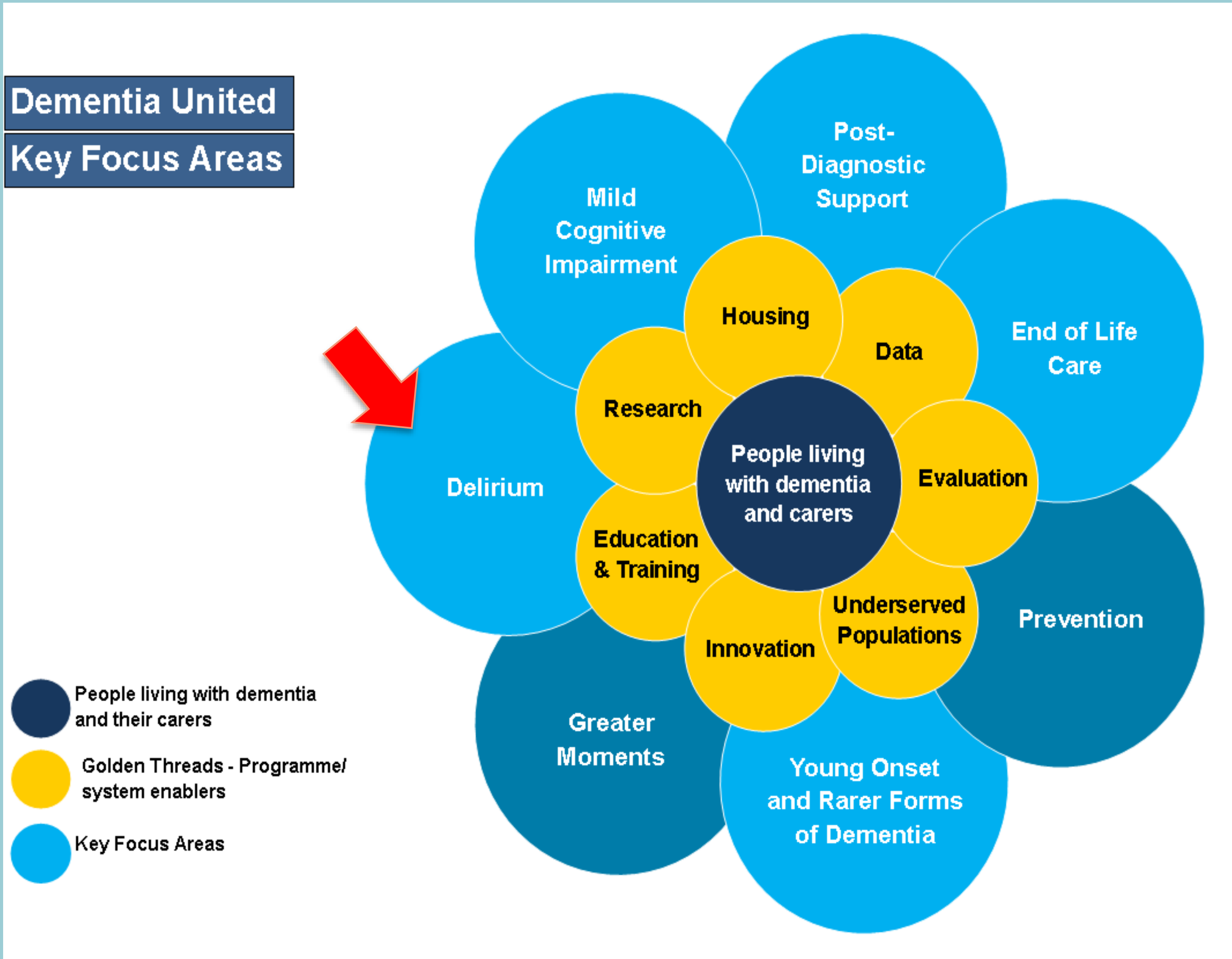
- 12 Clinical Commissioning Groups (CCGs)
- 14 acute, community and MH Trusts & 1 ambulance Trust
- 500 GP Practices
- 450 General Dental Services
- 700 community pharmacies
- 300 community optometry services
- At least 300,000 carers
- 10 local Authorities
- 27 social housing providers
- 14,500 voluntary and community organisations
- GM Police
- GM Fire & Rescue Service
- And 2.8m residents

CONTEXT

Dementia United is Greater Manchester's improvement programme for dementia

Dementia United's vision

- Improve the lived experience
- Reduce variation
- Increase access to quality services
- Co-production and redesign



CONTEXT

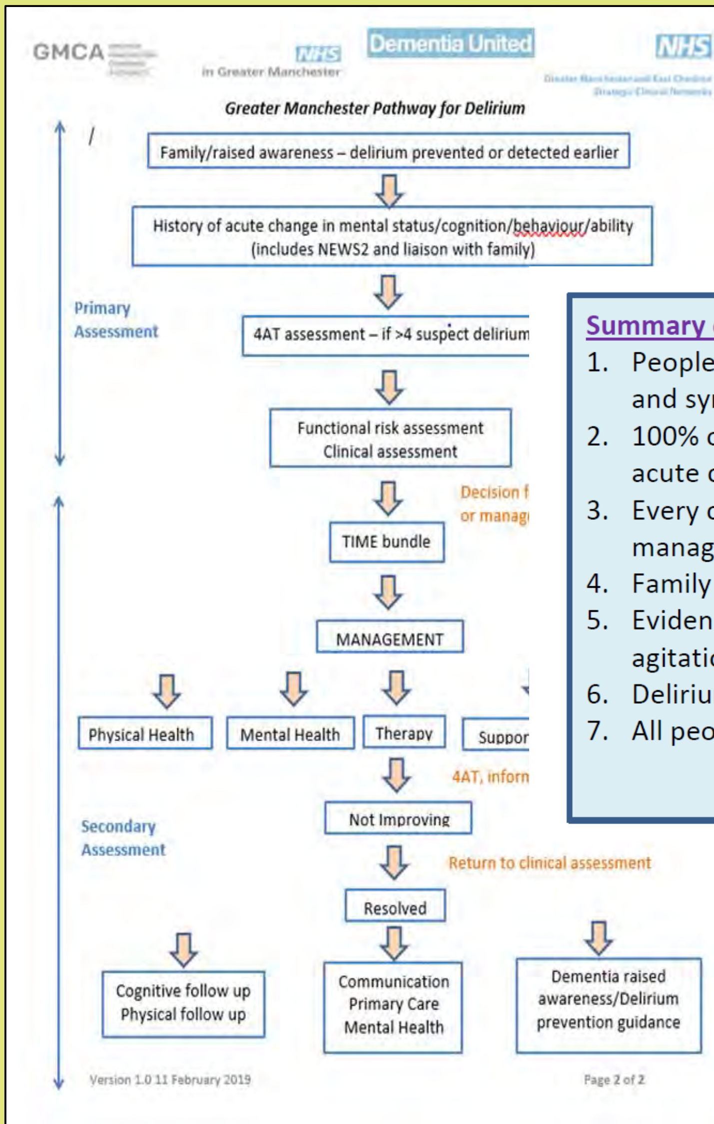
Problem to address

- No formal delirium pathways
- Range of screening tools/assessments
- Delirium diagnosis not routinely shared
- Delirium data not captured routinely
- Limited awareness

Addressing the problem

- Clinical leadership
- Establish a community of engagement
- Delirium champions
- Co-production
- Harnessed expertise and momentum
- Make the case for change

GREATER MANCHESTER'S VISION



Summary of Key GM Delirium Standards

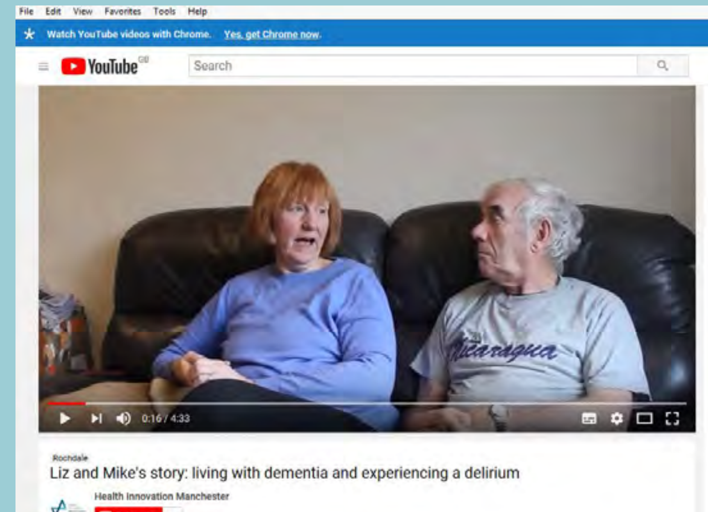
1. People >65yo or who have a dementia diagnosis are provided with information on signs and symptoms of delirium and prevention measures
2. 100% of patients >65yo or who have a dementia diagnosis that are admitted to the acute care setting/mental health are assessed for delirium using 4AT on admission
3. Every care organisation should have a standardised pathway for assessment and management of delirium
4. Family carers are provided with information to help support relative with delirium
5. Evidence that non-pharmacological de-escalation techniques used before medication for agitation/distress
6. Delirium diagnosis should be conveyed at all transitions of care
7. All people with delirium should have multidisciplinary follow up

HOSPITAL PATHWAY

Salford Royal Hospital Delirium Global Digital Exemplar benefits

- People over 65yrs screened for delirium risen from 800 to 5600 in Emergency Department
- Cases identified risen by 650 (34% increase)
- Length of stay of patients with delirium reduced by 11% saving estimated £1,700,000 in the first year

Health Innovation Manchester supporting digital tool roll out in to two further hospitals in GM



'DRAFT' GM COMMUNITY DELIRIUM TOOLKIT

GREATER MANCHESTER COMMUNITY DELIRIUM TOOLKIT

FOR THOSE OVER THE AGE OF 18 AND NOT UNDER THE INFLUENCE OF DRUGS AND/OR ALCOHOL

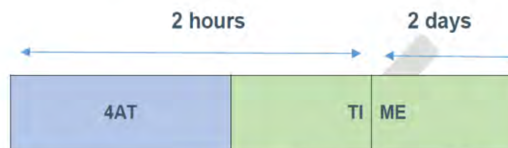
KEY DOCUMENT 1:

OVERVIEW: How to identify and manage delirium in the community

The 4A Test: screening instrument for cognitive impairment and delirium

TIME FRAMES

Delirium is a medical emergency. As part of the NHS Long Term Plan for out of hospital care, urgent community response should aim to be given within two hours in a crisis with a two-day referral for reablement care.



KEY DOCUMENT 3:
Greater Manchester Community Delirium TIME Bundle

KEY DOCUMENT 4:
Greater Manchester Delirium Management and Engagement Guide

GREATER MANCHESTER DELIRIUM LEAFLET

DRAFT V0.7
MAY 2020

GM COMMUNITY DELIRIUM TOOLKIT

KEY DOCUMENT 3: Greater Manchester Community Delirium TIME Bundle

TIME = **T**riggers, **I**nvestigations (2hours) **M**anagement, **E**ngage (2 days)

T = TRIGGERS – think "**PINCH ME**"	**Summarise suspected trigger(s):**
PAIN e.g. Abbey pain scale score (7)	
INTRACEREBRAL e.g. haemorrhage **INFECTION** Any clinical signs to warrant investigations?	
(mal) NUTRITION e.g. use Age UK paper weight arm band tool (8a), mouth care assessment (9)	
CONSTIPATION e.g. bowels last moved/stool chart (10)	
HYPOXIA – Pulse oximeter reading **HYPOGLYCAEMIC** – Glucometer reading **(de)HYDRATION** e.g. urine colour chart, drink taken (8b), urinary retention	
METABOLIC e.g. hyponatraemia, hypercalcaemia **MEDICATION** – Structured medication review, anticholinergic burden e.g. West Essex CCG Anticholinergic side-effects and prescribing guidance (11)	
ENVIRONMENTAL e.g. disturbed sleep, sensory deficits, recent major surgery, falls, over or under stimulation etc.	
I = INVESTIGATIONS	
Standard Delirium Bloods: FBC, UE, LFT, Calcium, Magnesium, CRP, glucose, phosphate	
Urinalysis if applicable e.g. Bury UTI Assessment Tool (12) (sterile urine culture, not dipstick)	
Other tests required if applicable e.g. scans, ECG **Please state:**	

Some *Optional Resources* are included in this toolkit, but you may have appropriate tools that you already use in your organisation.

TRIGGERS

- *Optional Resource 7: Abbey Pain Scale*
- **Blood pressure monitor**
- **Thermometer**
- *Optional Resource 8A: Paper Weight Arm band can be used to indicate malnutrition*
- *Optional Resource 8B: Monitoring fluid, food intake and oral hygiene*
- *Optional Resource 9: Health Education England Mouth Care Assessment Guide*
- *Optional Resource 10: Bristol Stool Chart*
- **Pulse oximeter**
- **Glucometer**
- **Bladder Scanner** (may be useful for urinary retention)
- *Optional Resource 11: West Essex CCG Anticholinergic side-effects and prescribing guidance*

DRAFT

GM COMMUNITY DELIRIUM TOOLKIT

KEY DOCUMENT 4: Greater Manchester Delirium Management and Engagement Guide

- **GM Delirium Management and Engagement Guide (Key Document 4)**

Engagement with family members and informal and formal carers, to assist with supporting and monitoring for signs of improvement or not for person with delirium and in undertaking to:

- Meet the needs of reassurance, orientation and occupation
- Meet the needs of physical comfort and well-being
- Meet the needs to feel safe, secure and receive comfort and reassurance when distressed

- *Optional Resource 13A: Greater Manchester Nutrition and Hydration: Eat, Drink, Live Well*
- *Optional Resource 13B: Eating and drinking well – supporting people living with dementia*
- *Optional Resource 13C: Keep GM Moving: Moving More at Home*
- *Optional Resource 13D: GM COVID-19 specific guide for living well at home*
- *Optional Resource 14:* Alzheimer's Society "This is Me" document

DRAFT

GM COMMUNITY DELIRIUM TOOLKIT

GREATER MANCHESTER DELIRIUM LEAFLET

DRAFT V0.7
MAY 2020

Person-centred delirium plan for (enter name): ....

If you have been diagnosed with delirium, **your health and care team can complete the below**.

Completed by (staff name, role and/or name of health and care team):

....

Date diagnosis of delirium made (dd/mm/yyyy): ....

This is what we think is causing your delirium:

PILOTING THE GM COMMUNITY TOOLKIT

Testing teams

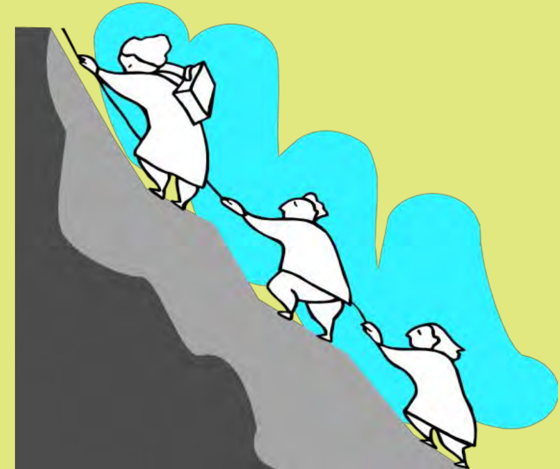
- E.g. Urgent care, Admission avoidance, Primary Care Network, Intermediate Care Service, GP Residential Care Homes
- All teams offered project management support – Microsoft Teams channel, bi-weekly meeting
- Quality improvement - PDSA

Innovation

- Training resources shared
- North West Ambulance Service
- Lanyard prompt cards
- Linking in with Mental Health teams

CHALLENGES

- COVID-19
  - prep for teams
  - competing priorities
  - swabbing
- Governance and wider locality engagement
  - ownership and team structures
  - bloods
  - timescales
- What do they currently use vs what is recommended
- Data collection



RECIPE FOR SUCCESS

- Early engagement and involvement
- Co-production and endorsement from experts by experience
- Clinical leadership
- Project management support
- Align to existing strategies
- COVID-19 - opportunities

NEXT STEPS

Outputs

- GM Community Toolkit
  - Report/analysis of pilot
- GM Delirium Leaflet
  - Collate feedback/translation
- Hospital offer
  - Digital roll out/Resources
- Delirium training

Process

- Wider engagement and socialisation
- Business case - GM wide roll out
- Digital options
- Sustainability and legacy

LINKS TO GM RESOURCES

GM Community Delirium Toolkit and **GM Delirium leaflet** can be accessed via the Dementia United website:
https://dementia-united.org.uk/delirium-community-toolkit/
Further Delirium resources are available here https://dementia-united.org.uk/resources/ you will need to scroll down to the Delirium section.

Salford **Global Digital Exemplar** can be accessed here:
https://future.nhs.uk/connect.ti/system/login?nextURL=%2Fconnect%2Eti%2FGDEcommunity%2FgroupHome
Health Innovation Manchester for digital hospital roll out
https://healthinnovationmanchester.com/our-work/early-detection-for-delirium/
Publication in **Age and Ageing -** Hospital Digital pathway
https://academic.oup.com/ageing/article-abstract/49/4/672/5837832

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ACKNOWLEDGEMENTS

- **Dr Emma Vardy** – Consultant Geriatrician, Greater Manchester & East Cheshire Strategic Clinical Network Clinical Dementia Lead, Clinical lead for Delirium programme – Dementia United
- **Health Innovation Manchester** support with phased roll out of Global Digital Exemplar
- **Delirium task and finish group members** including people with lived experience and carers
- Delegates who have attended the annual **World Delirium Awareness events** held in 2018, 2019 and 2020
- **Dementia Carers Expert Reference Group** – part of governance for Dementia United who very kindly provided initial feedback on the Delirium Leaflet

- With special thanks to **NHS Ayrshire and Arran** for their Community Pathway, Healthcare Improvement/Scottish Delirium Association for Delirium Toolkit and TIME bundle

Contact us
If you have any queries about these guidelines, contact the GMHSC communications team: gm.hsccomms@nhs.net

www.gmhsc.org.uk
@GM_HSC

NHS

Yorkshire & Humber Clinical Network - Delirium resources

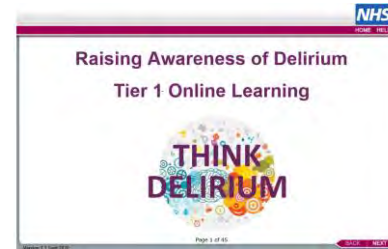
NHS England and NHS Improvement

NHS
Yorkshire and the Humber
Clinical Networks

West Yorkshire and Harrogate
Health and Care Partnership

Yorkshire and the Humber Dementia and Older Peoples Clinical Network
West Yorkshire and Harrogate Health and Care Partnership
Raising Awareness and Training of Delirium

E-LEARNING
Raising Awareness of Delirium
This e-learning provides the baseline knowledge and skills required by all staff working in health and social care settings and also for those working in an individual's own home. It is also aimed at carers of people who may be more at risk of developing delirium



THINK DELIRIUM resources

- THINK DELIRIUM Poster
- THINK DELIRIUM Charter Poster
- THINK DELIRIUM Leaflet
- THINK DELIRIUM Prompt Card
- THINK DELIRIUM Business Card

Delirium Dramas
We have produced a series of Delirium Dramas
The films are acted out scenarios of people experiencing delirium in different setting, in the acute hospital, in a care home and in a domiciliary care setting.

Contacts

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