2015/2016 Summer Studentship Project Application Form

Send to: Research Office, University of Otago Christchurch, PO Box 4345, Christchurch, by 5pm on **3 July 2015**

Supervisor Information (First named supervisor will be the contact):	
Supervisor's Name and Title(s): Susan Gee, Tracey Hawkes, Matthew Croucher	
Department: Psychiatric Service for the elderly	Institution: CDHB
Phone: 337 8894	E-mail: susan.gee@cdhb.health.nz
Mailing Address: Level 2 Heathcote Building The Princess Margaret Hospital PO Box 800 Christchurch 8022	

Research Category (Choose one category only – to be used for judging the students' presentations):		
Clinical X	**Laboratory**	**Community**

Project Title (20 words MAXIMUM):
Raising awareness of factors that can help prevent delirium: A pilot of an appreciative inquiry approach

Project Description:

INTRODUCTION

Delirium is common amongst older people in hospital: 10-15% of older people admitted to acute care are delirious at the time of admission and 10-40% of older patients in acute care develop new episodes of delirium (Senior friendly hospitals, Britton& Russell, 2005, Fann, 2000). People who have dementia are up to five times more likely to have delirium while they are in hospital (Cole, 2005; Fick, Agostini, & Inouye, 2002). Delirium is associated with serious negative outcomes. Older people in hospital who develop delirium

- Stay in hospital longer

- Have more complications while they are in hospital

- Are more likely to be admitted to long-term care or be re-admitted to hospital once they are discharged

- Are more likely to die

(Fick, et al., 2002; Royal College of Psychiatrists, 2005; Sheehan, Stinton, & Mitchell, 2010; Waitemata District Health Board, 2007)

There is considerable evidence and consensus about the risk factors and causes of delirium, and these in turn point to the priorities for preventative protocols. Research suggests that delirium can be substantially reduced by multi-disciplinary multi-component interventions to reduce risk factors, generally involving extra resources such as a designated position or a team of volunteer helpers to ensure that a protocol is followed (Inouye, et al., 1999; Lundström, et al., 2005; Marcantonio, Flacker, Wright, & Resnick, 2001; Milisen, et al., 2001; Naughton, et al., 2005; Wong Tin Niam, Bruce, & Bruce, 2005, Hsheih et al., 2015). Many guidelines around the world encourage a proactive multicomponent approach to help prevent delirium (American Psychiatric Association, 1999; Australian Health Ministers' Advisory Council, 2006; Royal College of Physicians, 2006).

> *Given the higher prevalence, costs, and preventability of delirium compared with readmission, one would think that it would be of higher importance in the current policy landscape. Yet, despite 15 to 20 years of evidence for protocols to reduce inpatient complications for older adults …policies to speed the dissemination of such programs are nowhere on the horizon. Increasingly, efforts to prevent adverse events for older adults in the hospital seem stymied in a pernicious "know-do" gap: as the evidence grows, the state of implementation is not keeping up.…there may be an assumption held by many physicians and hospital leaders along the lines of "aren't we doing all this stuff already?"* (Greyson, 2015)

In this project we seek an effective yet low cost change intervention to increase awareness of preventable risk factors for delirium by taking an appreciative inquiry approach to encourage staff to reflect and identify changes themselves.

AIM

This demonstration project will trial an appreciative inquiry approach to raise awareness of preventable risk factors for delirium. We will assess whether a brief intervention with self-motivated health professionals is able to produce a measureable change in self-awareness of the current status of delirium risk factors in patients in clinical practice.

METHOD

An appreciative inquiry process will be used with CDHB health professionals, recruited through Psychiatric Service for the Elderly education days on delirium. Appreciative inquiry (AI) is a model for to create and analyse change that encourages change by asking positive questions. The dual defining characteristics of the approach are a focus on the positive, and a conceptualisation of change as a process of participatory inquiry (Whitney & Trosten-Bloom, 2010).

1. The first phase is a one-to-one structured interview with staff about a specific (non-identified) case to understand what is happening currently, to identify strategies that people are using that are working well, and to start to identify what they would most like to change. This will be coded to provide a pre-intervention baseline measure of awareness of patient status for risk factors. The appreciative inquiry questions will gather information about what is working well to share at the brainstorming sessions.

2. The second phase is to gather together staff for a brainstorming session with an experienced appreciative inquiry facilitator. The aim is to identify small and manageable changes that the staff themselves actually want to action. The participants will receive feedback on the interviews, and be asked to 'brainstorm' the risk factor/s to identify facilitators and barriers, to come up with ideas about strategies for these, and then to identify and plan the changes that they want to implement.

3. The third phase is a follow-up interview to gauge how much has changed since the first interview. Awareness of the patients' status for each of the risk factors will be categorised as unknown, cursory, or thorough. This score will then be used to compare risk awareness pre and post intervention. There will also be qualitative analysis of changes that staff have made or intend to implement at an individual and team level after the intial summer studentship time period.

STUDENT ROLE

A self-contained pilot study will be conducted within the studentship time frame to investigate changes in individuals' awareness and assessment of risk factors. This will be part of a wider appreciative inquiry process that will involve changes at a team level that will extend beyond the studentship.

The student will have the opportunity to gain supported experience in an appreciative inquiry process, structured interview data collection, data entry and management, analysis, and interpretation. The student will also gain practical experience in conducting research in a health care setting including issues such as understanding privacy and maintaining confidentiality. The student's role will include:

1. Familiarisation with key work in the area
2. Structured interviewing pre and post intervention
3. Data input and management
4. Participation in the analysis and interpretation of results
5. Literature review
6. Contributing to the dissemination of results.

SIGNIFICANCE

Changing practice in acute care settings is never easy, however we now have the evidence to know what to do to prevent delirium (Greyson, 2015). The challenge is to find ways to bridge the "know-do" gap. As an established method of change appreciative inquiry may offer one way to help health professionals 'just do it'. If the results of the pilot are positive, the next step will be to offer and evaluate a full appreciative inquiry cycle intervention for whole teams within.

Student Prerequisites (eg. Medical Student) if applicable:
None