4AT Delirium and Cognition Screening Tool Education Project – Session Plan

4AT Delirium and Cognition Screening Tool Education Session				
Time 40 mins				
Learning Outcomes: By the end of this session participants will be able to: • Recognise the importance of an interdisciplinary approach to the recognition of delirium/reduced cognition, including engaging with family and carers. • Identify Patients' that are at high risk of a developing delirium. • Identify when to screen for delirium /reduced cognition and how to accurately complete the 4AT Delirium and Cognition Screening tool. • Actioning the 4 AT score			**Resource List** • Laptop /projector • 4AT Delirium and Cognition Screening Tool PPT Presentation • Copy of Procedure (SWSLHD_PROC_2020: Delirium) • In-service /education sign on sheet	
Time	**Topic**	**Content**	**Program activities**	**Resources**
6 mins	Welcome & Sign on	Welcome participants Introduce yourself (name and title) Introduction – brief explanation as to why you are conducting this education session.	Presenter to welcome participants Ensure all participants sign on	Laptop Projector Sign on sheet PPT Slide 1
	What is Delirium?	Explanation of 'What is Delirium'? Characteristics of Delirium Difference between hyperactive, hypoactive & mixed delirium. Highlight that Delirium is a MEDICAL EMERGENCY.	**Key Questions:** *Before showing slide 2 ask participants:* Does anyone know the different types of Delirium? Does anyone know the difference between hyperactive, hypoactive & mixed delirium?	PPT slide 2
	Why are we screening for delirium?	Delirium is a serious medical condition Discuss potential adverse outcomes Discuss delirium related statistics		PPT slide 3

4 mins	Common causes of Delirium Two useful mnemonics	To help identify potential causes of delirium, explain the two mnemonics that can be used: 1) *PINCH ME* (Pain, Infection, Nutrition, Constipation, Hydration, Medication, Environment) 2) *The 5 P's* (Pee, Poo, Pain, Pills & Pus)	**Key Question:** *Before showing slide 4 ask participants:* Can anyone name some of the common causes of delirium?	PPT slide 4
2 mins	Screening for Delirium	Explain the two tools used for the screening of delirium and the difference between the two tools: 1) *DRAT* - identifies people at risk of developing delirium 2) *4AT Assessment* - screens for cognitive impairment and presence of delirium.		PPT slide 5
5 mins	How to access DRAT Assessment on Powerchart and FirstNet	Overview of computer screenshots on *slides 6 -7*: • Explain how to access online DRAT Assessment on Powerchart. • *For ED staff* – explain how to access online DRAT Assessment on FirstNet *Slide 8* – Explain how to complete the DRAT Assessment, including the DRAT scoring system: **Score 0** = Low risk **Score 1 - 2** = Medium risk **Score > 3** = High risk of delirium	**Activity:** If time permits, log onto Powerchart / FirstNet and demonstrate how to access DRAT Assessment.	PPT slides 6 - 8
5 mins	Where to access 4AT Assessment on Powerchart	Overview of computer screenshots on *slides 9 -10*: • Explain how to access online 4AT Assessment on Powerchart. • Via Document launcher / via Ad Hoc Folder	**Activity:** If time permits, log onto Powerchart and demonstrate how to access 4AT Assessment.	PPT slides 9 - 10

6 mins	The 4AT Assessment	Overview of computer screenshot of 4AT Assessment on *slide 11*. Explain the *four categories* that are screened on the 4AT Assessment: 1) Alertness 2) AMT 4 (Orientation) 3) Attention 4) Acute Change or Fluctuating Course. Discuss the 4AT Assessment scoring system: **Score 0** - delirium or severe cognitive impairment unlikely **Score 1 - 3** - possible cognitive impairment **Score = / > 4** - possible delirium +/- cognitive impairment	**Key Question:** Does anyone have any questions /concerns regarding the 4AT Assessment? How & who would you escalate the result to?	PPT slide 11
5 mins	Case Study One (1) (54 year old gentleman)	**Case Study 1** *Slide 12*: Discussion of patient's medical history and overview of patient's presentation to ED. *Slide 13*: Concerns for Patient 1: Discuss the current concerns for the patient. *Slide 14*: Impact of delirium for patient: Discuss the impact of delirium on this patient and the consequences (ie: palliation & death).	**Key Questions:** *Slide 13:* From the patient's medical history and condition on arrival to ED, what concerns do you have for this patient? What makes this patient at risk of delirium? *Slide 14:* What was the impact of delirium on this patient?	PPT slides 12 -14

5 min	Case Study Two (2) (68 year old gentleman)	*Slide 15*: Discussion of patient's medical history and overview of patient's presentation to ED. *Slide 16*: Concerns for Patient 2: Discuss the current concerns for the patient. *Slide 17*: Impact of delirium for patient: Discuss the impact of delirium on this patient and the consequences (ie: cognitive/functional decline, loss of independence and institutionalization).	**Key Questions:** *Slide 16:* From the patient's medical history and condition on arrival to ED, what concerns do you have for this patient? What makes this patient at risk of delirium? *Slide 17:* What was the impact of delirium on this patient?	PPT slides 15 -17
2 min	Take home message and Reference List	Reiterate the following key points, *slide 18:* Early screening and identification is paramount. The importance of implementing person centred delirium prevention & management strategies to minimize patient harm.	**Key Question:** Does anyone have any questions? Reference List Provided.	PPT slides 18 -19