World Delirium Awareness Day (WDAD) 2023 Delirium Survey

A 1-day point-prevalence study about delirium across all settings on March 15th 2023

Welcome to the meeting of national collaborators!

Agenda

WDAD 2023

Contact: peter@nydahl.de

World Delirium Awareness Day (WDAD) 2023

https://www.europeandeliriumassociation.org/

WEBINAR: HALOPERIDOL IN ICU PRACTICE; DOES IT HELP?

WORLD DELIRIUM AWARENESS DAY, 15 MARCH 2023, 17:00 CENTRAL EUROPEAN TIME

The European Delirium Association would like to invite you to a webinar on World Delirium Awareness Day (WDAD).

15th March at 17:00 CET, for approximately 60 minutes.

Click the globe to watch the webinar!

Or log into Zoom using the following details:

Meeting ID: 893 5252 2706
Passcode: 476541

Webinar Program

- Welcome and introduction- **Dr. Elizabeth Sampson** (England)
- Haloperidol treatment in ICU patients with delirium- **Dr. Nina Andersen** (Denmark)
- Delphi study regarding experiences with antipsychotics practices in ICU patients- **Dr. Nathalia Jaworska** (Canada)
- Discussion- **Dr. Nina Andersen** and **Dr. Nathalia Jaworska**
- Closing- **Dr. Elizabeth Sampson**

For more information visit **EDA WEBINARS.**

World Delirium Awareness Day (WDAD) 2023

https://www.deliriumday.com/

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Munich Delirium Day

Wednesday, March 15, 2023

9:00 AM – 11:30 AM

Location: LMU University Hospital, Munich, Germany

March 15, 2023

2:00PM- 5:30PM (CEST)

World Delirium Awareness Day (WDAD) 2023

https://www.deliriumday.com/

iDelirium Presents: Delirium is Everybody's Business WDAD Webinar

Wednesday, March 15, 2023

10:00 AM – 11:00 AM

Join the iDelirium team to learn about how to engage everyone in reducing delirium.

From awareness and education to frontline strategies - everyone can play a role.

Zoom Webinar

Meeting ID: 818 2064 3377

PW: WDAD2023

Zoom Link; https://ed-ac-uk.zoom.us/j/81820643377

10:00 AM EST, 2:00PM GMT

World Delirium Awareness Day (WDAD) 2023

https://www.deliriumday.com/

Delirium in the critically ill patients: a review

Wednesday, March 15, 2023

2:00 PM – 3:00 PM

Webinar

Delirium and long -term cognitive dysfunction: Presentation of local evidence

- Delirium pharmacological treatment in ICU: Haloperidol and other options
- Delirium in Pediatrics: General Fundamentals
- Closure and questions

Wednesday March 15th, 2pm EST

Procedure & Link

Survey: the survey is opened now on March 14th, 1 p.m. UTC (due to the time shift it will be already March 15 somewhere on the world) and kept open till March 19th, 10 p.m. UTC.

The link is https://www.surveymonkey.de/r/WDAD2023

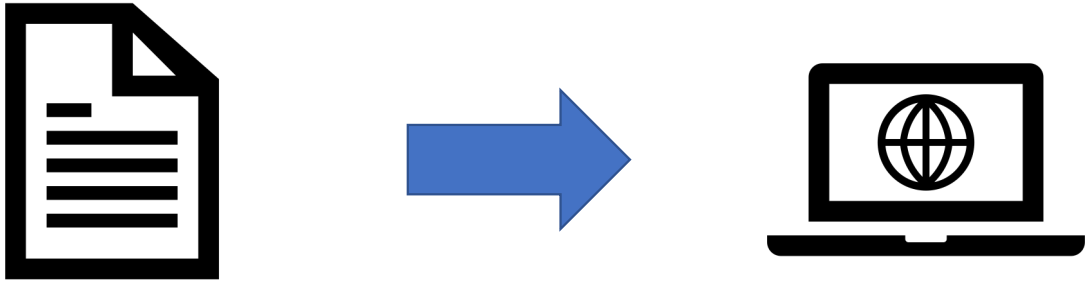
Distribution of the link:

- the link has been forwarded to you as national collaborators
- **National collaborators will forward the link to all of their national participants**
- The link is on the website

Please, do not post the link on social media, to reduce the risk of wrong data
We will not send reminders, due to the character of a 1-day point prevalence study

Afterwards, you have to transfer all data from the paper into the online survey

DO NOT INTERRUPT DATA TRANSFER OF A SINGLE UNIT!



You have got three days for it till March 19

Yes, in **case of multiple units/wards from one single hospital**,
You have to put in the data of country, city, hospital size again and again.
We are sorry for it, but cannot change it

Ethic approval

Ethic: in case, ethic approval is not ready: do not participate, at least do not collect patient data

First is ethic approval,

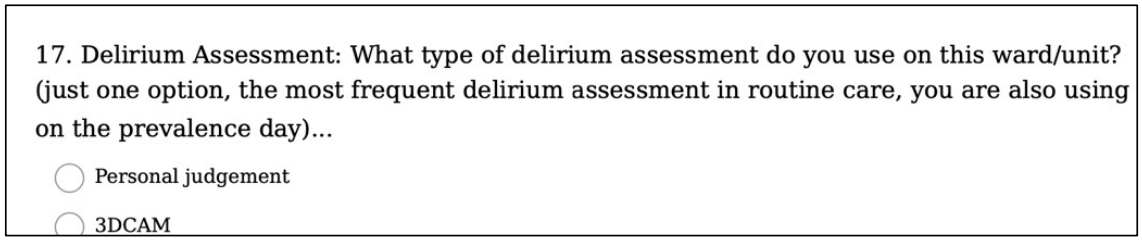
Second is patient inclusion.

It cannot be the other way round. It counts the date on the paper of the IRB.

We already organized a table for clinicians who will join in 2024, including 10 clinicians so far (who are still waiting for their ethic approval)

Questionnaire

- First page, we added the sentence: “NEW INFORMATION: The questionnaire has been translated into different languages, see pdf’s on http://www.wdad-study.center/Documents/ “
- We revised question 17: “**type of delirium assessment**” from
  - multiple answers to a **single answer**, deleted “multiple options”,
  - and added “(**just one option, the most frequent delirium assessment in routine care, you are also using on the prevalence day**)”.
  - This will make the analysis much easier.
  - Note: **wards/units which use “none” or “personal judgement” can participate in this study, too**, because we will not include them in the prevalence rate, but will perform sub-analysis with them, especially for present protocols, barriers, and others


17. Delirium Assessment: What type of delirium assessment do you use on this ward/unit? (just one option, the most frequent delirium assessment in routine care, you are also using on the prevalence day)...

◯ Personal judgement

◯ 3DCAM

Questionnaire

20. **Total patients**: How many patients were present on the ward/unit in the morning at 8 a.m.?

21. **Assessed patients**: How many patients were assessed for delirium by using the above reported assessment?

22. **Delirious patients**: How many patients were assessed positive for delirium by using the above reported assessment?

23. **Non-delirious patients**: How many patients were assessed free of delirium by using the above reported assessment?

24. **Not assessable/unclear patients**: How many patients **were not assessable** for delirium (e.g. comatose, sedated, disturbed consciousness, too sleepy, away for procedures, aphasic, different language, or else) **and/or had unclear results** by using the above reported assessment (e.g. unclear presence of delirium superimposed on dementia/depression, or else)?

Not assessable/unclear patients do count to the total number of assessed patients:
well, they were present on the unit and at least you considered their assessability

Group co-authorship

Group-co-authorship means that you are not reported with your name on the title of the publication but tagged to the WDAD-Study-Group. This is Pubmed indexed and recognized as a co-authorship with other indexing search engines.

- National collaborators of the very beginning will be co-authors
- **National collaborators**: will receive group-co-authorship if in their countries > 100 patients are collected, We identify national collaborators by their country and compare them with our lists.
- **Local participants** have to collect >100 patients in their hospitals for receiving group-co-authorship. If your unit has 10 or 30 patients, you have to collect more patients on other units, too.
- Local groups/teams:
  - clinicians will get one (1) group-co-authorship per >100 patients. If team =3 clinicians, they need > 300 patients
  - For this they have to enter their names in acknowledgement
- We identify them when we will have the complete data, we will sort the data by clinicians' names, and count the number of collected patients per clinician. Everyone > 100 patients will be on the list of group-co-authorship.

Codes

We can identify data of clinicians by their country, city, type of hospital, number of hospital‘s bed, or achknowledged name

You need a code if

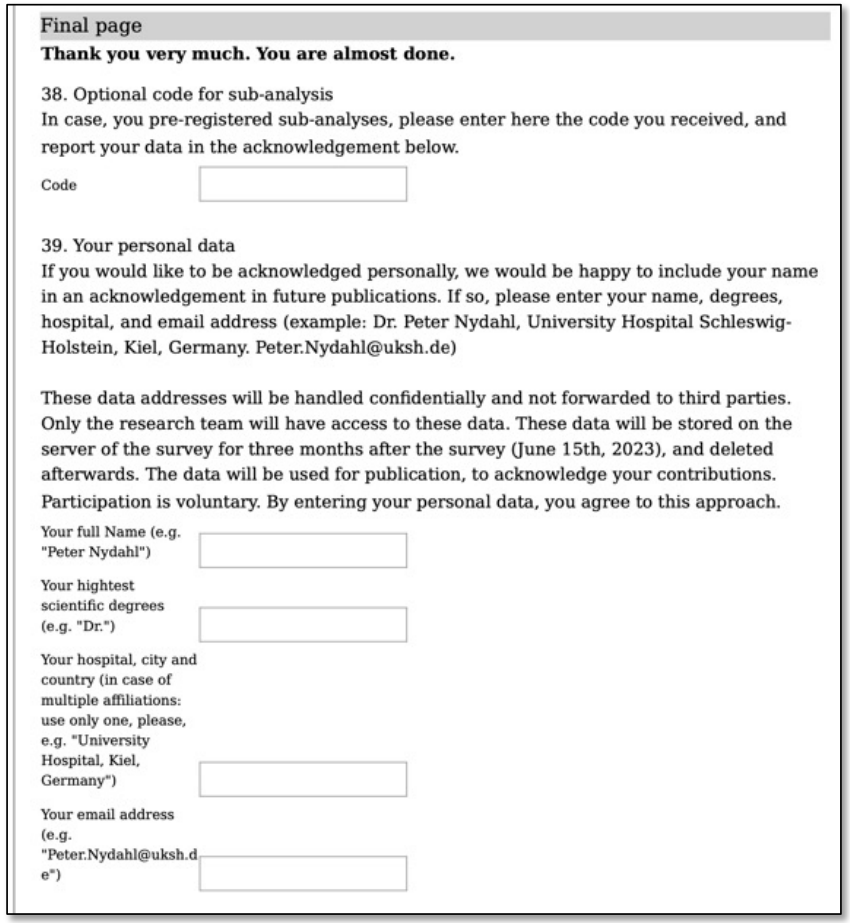
- **You have multiple similar hospitals in one city**
- **You have multiple units/wards across multiple hospitals**

Fulfillment inclusion criteria
Security: city and name of ward
Sociodemographic data
- Profession
- Leading position
- Years of clinical experience

Hospital data
- Country
- Number of beds
- Type of hospital

Unit/ward data
- Age groups
- Discipline
- Type of ward or Unit (ED, ICU, …)
- Number of beds

Acknowledgement



Final page

Thank you very much. You are almost done.

38. Optional code for sub-analysis
In case, you pre-registered sub-analyses, please enter here the code you received, and report your data in the acknowledgement below.

Code

39. Your personal data
If you would like to be acknowledged personally, we would be happy to include your name in an acknowledgement in future publications. If so, please enter your name, degrees, hospital, and email address (example: Dr. Peter Nydahl, University Hospital Schleswig-Holstein, Kiel, Germany. Peter.Nydahl@uksh.de)

These data addresses will be handled confidentially and not forwarded to third parties. Only the research team will have access to these data. These data will be stored on the server of the survey for three months after the survey (June 15th, 2023), and deleted afterwards. The data will be used for publication, to acknowledge your contributions. Participation is voluntary. By entering your personal data, you agree to this approach.

Your full Name (e.g. "Peter Nydahl")

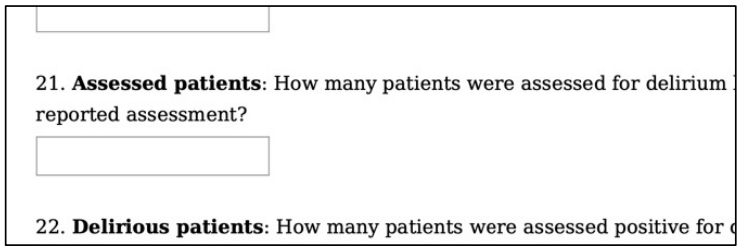
Your hightest scientific degrees (e.g. "Dr.")

Your hospital, city and country (in case of multiple affiliations: use only one, please, e.g. "University Hospital, Kiel, Germany")

Your email address (e.g. "Peter.Nydahl@uksh.de")

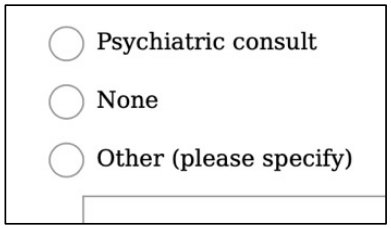
Q: Survey will be open from March 14th noon (Central Europe Time) till March 19th?

A: Yes



Q: group co-authorship?

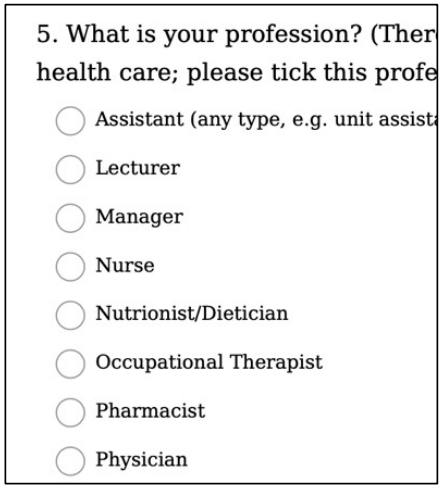
A: more than >100 patients in total = sum of assessed patients at 8.a.m.



Q: some units units are not able to use a valid assessment and cannot collect patients' delirium data?

A: yes, they can still collect data of structures and processes

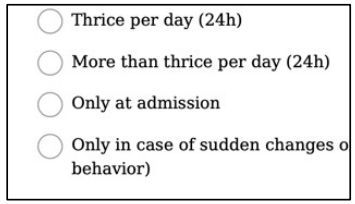
Q: Question 5,6,7 (profession, leadership, experience): **is this relating to the person completing the survey** (which for us will often be a geriatrician or a designee); **or is it about the person who reports the data on prevalence and ward practice** - which is usually a nurse manager for the ward



A: In case, the data-collecting-person and the data-reporting-person are different, the information about **the person who reports the data** should be answered (question 6 & 7 refer to „on your unit/ward").
Example: a study nurse (not working on the ward) is asking a nurse leader of a geriatric ward about delirium management, the information of the nurse leader should be assessed and reported in the questionnaire

Q: Question 13 (type of ward)- if they tick 'other' is there an option to enter the details of the ward- we want to identify geriatric wards and to separate out medical and surgical wards

A: Yes, you can do this, but we try to avoid this to reduce the number of categories. Here we are just asking for the type of ward or Unit. When you combine the type (Q13) with the discipline (Q12) and the age group (Q11), you can identify a geriatric ward: Q11: >75 y, Q12: mixed/general, Q13: general ward = geriatric ward. A pediatric ward would be Q11 0-17y, Q12 mixed/general, Q13: general ward.



Q: Question 18 (time of assessment) - is "on admission" the admission to the ward (not to the hospital)?

A: yes. All information belongs to this specific ward/unit, and hence, also to the admission on the ward.

Q: Question 31 (Delirium prevention/therapy) : what is a bed boarder- it is a guard or rail to stop a patient falling out?

A: Answer: my apologies, in Germany we call this „boarder“, and it is a rail to stop patients from falling out of the bed

Q: if we collect 10 patients in the morning, and 10 patients in the evening. Do they count as 20 patients (for group-co-authorship)?

A: no. We count the number of patients in the morning, for counting group-co-authorship

Q: our nurses will be on strike, and patients might be transferred to other units. How do we count in the morning vs evening?

A: we just count raw numbers. We do not consider discharged, transferred, or new admitted patients. 10 at 8 a.m.; 0 at 8 p.m.

Any more questions?

All the best for a successful WDAD 2023

Projects on www.deliriumday.com

Next Meeting: April 11th

Heidi, Rebecca, Keibun, and Peter