

**DELIRIUM RECOGNITION AND ASSESSMENT
PRACTICE IN
PALLIATIVE CARE INPATIENT SETTINGS:
A MIXED METHODS KNOWLEDGE
TRANSLATION
PROJECT**

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Acknowledgements

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Background

- Delirium is an acute neurocognitive disorder acute frequently experienced by hospitalised patients
- Distressing and increases the risk of poorer outcomes
- Under-recognised by nurses

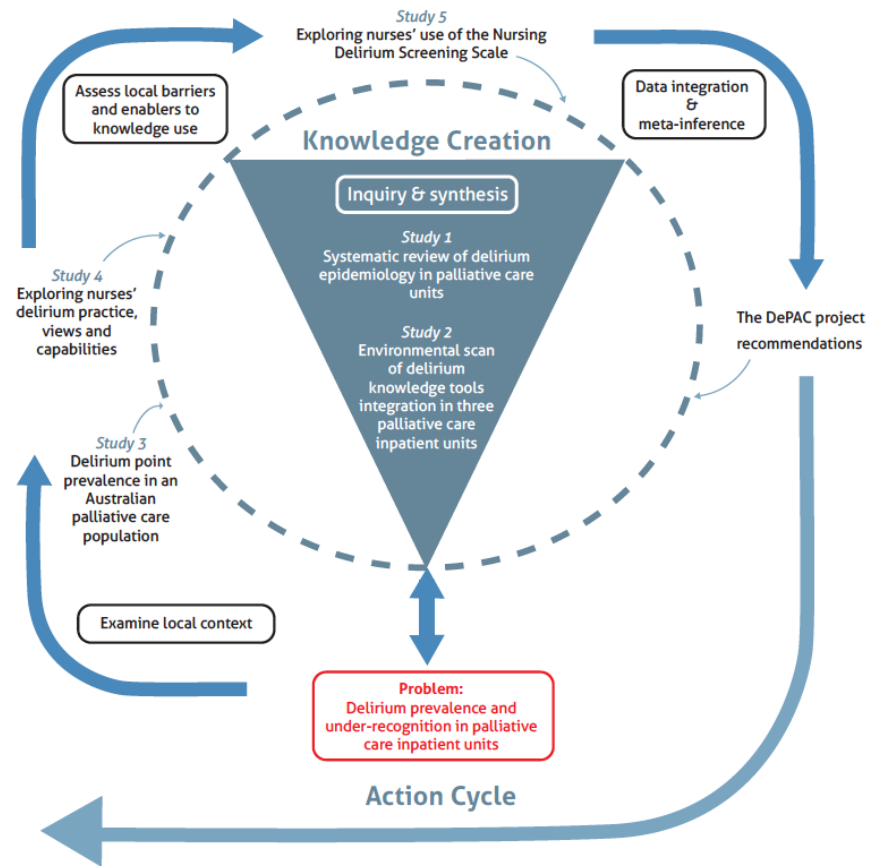
Aim

- To identify the actions required to improve the capabilities of specialist inpatient palliative care nurses to recognise and assess delirium

Design

- Two phase sequential transformative mixed methods design examined delirium in palliative care inpatient settings from epidemiological, systems and nursing practice perspectives
 1. Phase one: systematic review on delirium prevalence and incidence, cross sectional study and environmental scan.
 2. Phase two: the Critical Incident Technique and focus groups explored palliative nurses' delirium experiences, perceptions and capabilities
 3. Data were integrated at the conclusion of the project

Knowledge translation



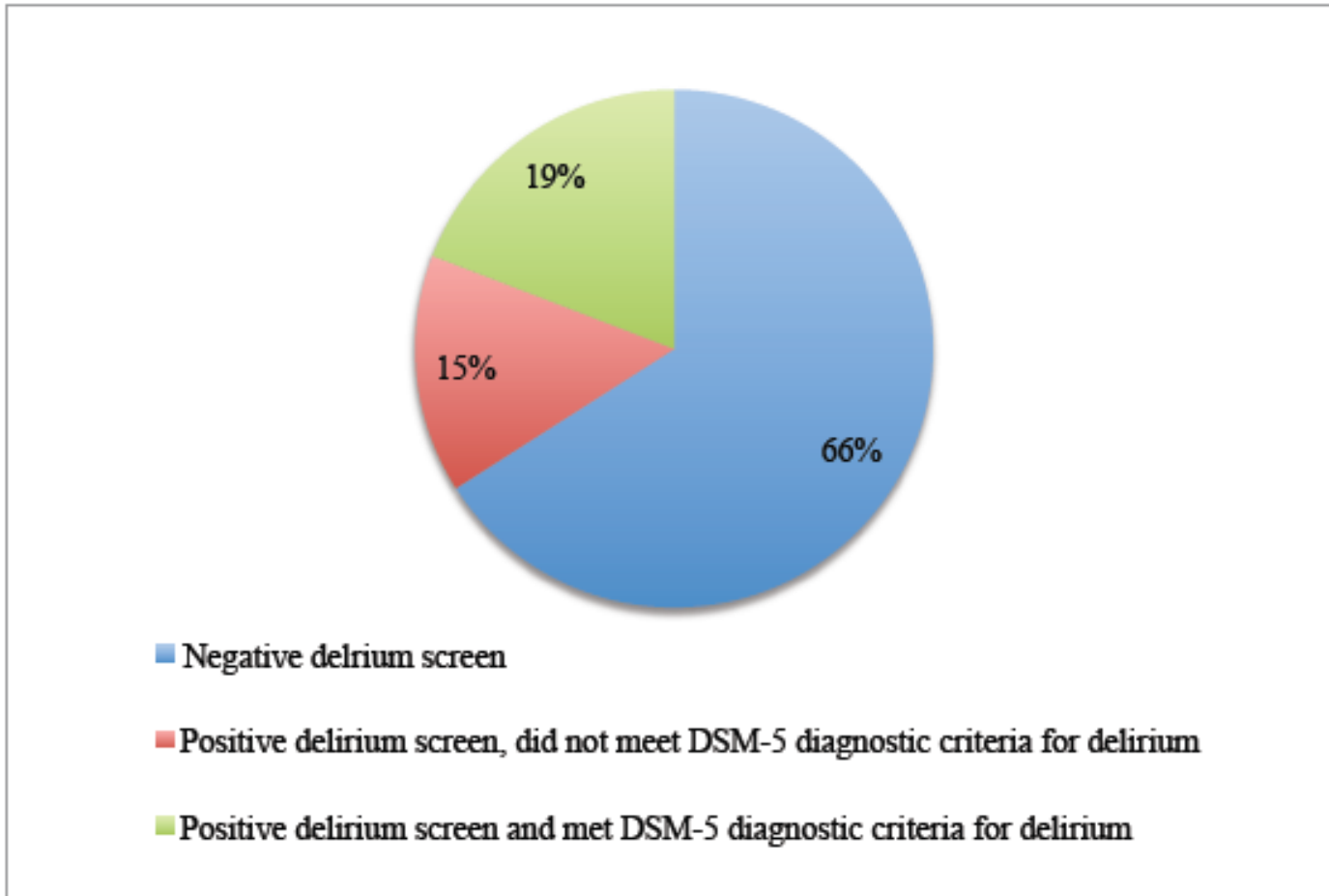
Epidemiology

- Systematic review
 - Eight studies (1980-2012)
 - All in Northern hemisphere
 - Majority of participants (n=1079) had advanced cancer (98.9%)
 - Mean age 66.24 years
 - Eight different screening and assessment tools used
- Incidence 3-45%
 - Incidence rates higher in studies screening at least daily (32.8-45%)
- Prevalence
 - 13.3-42.3% at admission
 - 26-62% during admission
 - 58.8-88% in weeks or hours preceding death
- Hypoactive subtype most prevalent
 - 68-86% of cases

Epidemiology

- 24-hour delirium point prevalence in two palliative care inpatient units in Sydney, Australia
 - Participants (n=47) with advanced cancer (96%)
 - Mean age 74 years (± 10)
 - Five with a diagnosis of an existing chronic cognitive impairment
 - Nu-DESC, MDAS, DSM-5
- 34% (n=16) screened positive for delirium at least one shift during the 24-hours
- 19% (n=9) met the DSM-5 delirium criteria

Proportion of patients with a positive Nu-DESC and diagnosed as delirious



Systems

Practice	Degree of integration	Recommendation/resource
<ul style="list-style-type: none"> Awareness of delirium as a problem for palliative care patients No delirium risk assessment undertaken 	≈	<ul style="list-style-type: none"> Clinicians to be aware of the risk of delirium Assess patients' delirium risk on admission to the health care setting
<ul style="list-style-type: none"> Unstructured, non-specific or sporadic assessment of patients' delirium status on admission Sporadic or non-existent use of tools during admission, despite availability (n=5) Training in use of some tools, separately for different disciplines 	≈	<ul style="list-style-type: none"> Routinely at and during admission Structured, use brief, low-burden validated tools (variously recommended: n= 16) Clinician training in use of validated tools Confirm with family or others who know the patient
<ul style="list-style-type: none"> Validated tools for delirium diagnosis or confirmation not used No readily accessible information about the diagnostic criteria for delirium 	≠	<ul style="list-style-type: none"> Use delirium diagnostic criteria or validated tools
<ul style="list-style-type: none"> No point-of-care guidance for comprehensive assessment 	≠	<ul style="list-style-type: none"> Multifaceted: history, physical, social, psychological, cultural, spiritual, illness phase, goals of care, patient wishes, level of patient and family distress, safety, assessment results in a plan of care
<ul style="list-style-type: none"> Multidisciplinary Specialist referral for psychiatric conditions other than delirium 	≠	<ul style="list-style-type: none"> Interdisciplinary Specialist referral as required
<ul style="list-style-type: none"> No family of patient information resources used 	≠	<ul style="list-style-type: none"> Two brochures, two fact sheets, one information booklet

Delirium clinical practice guidelines identified in search (n=10)

- Adults (n=4)
 - Hospital (n=2)
 - Hospital and long term care
 - ICU
- Adults with life limiting illness across care settings (n=2)
- Older adults (n=3)
 - Hospital (n=2)
 - Hospital, residential aged care and community
- Older adults with life limiting illness across care settings (n=1)

- Exclude patients receiving palliative or end of life care (n=3):**
- Older adults in hospital
 - Older adults in hospital, residential aged care and community
 - Adults in hospital and long term care

- Omit reference to palliative care (n=3):**
- Adults in hospital
 - Adults in ICU
 - Older adults in hospital

- Ambiguous about inclusion of palliative care patients (n=1):**
- Adults (with a cognitive impairment) in hospital

Adults (n=2) and older adult (n=1) with life limiting illness, across care settings

Recommendations not based on evidence (n=2)

One evidence based guideline for delirium care of older adults with life limiting illness, across care settings: **Canadian Coalition for Seniors' Mental Health (2010) Guideline on the Assessment and Treatment of Delirium in Older Adults at the End of Life**

Nursing practice

- Ambiguous terminology and nurses' poor conceptual understanding of delirium contributes to under-recognition and inadequate assessment
- Nurses too rapidly move from recognition of patient distress related to delirium symptoms to 'cloak' their distress
- Poor delirium communication between team members

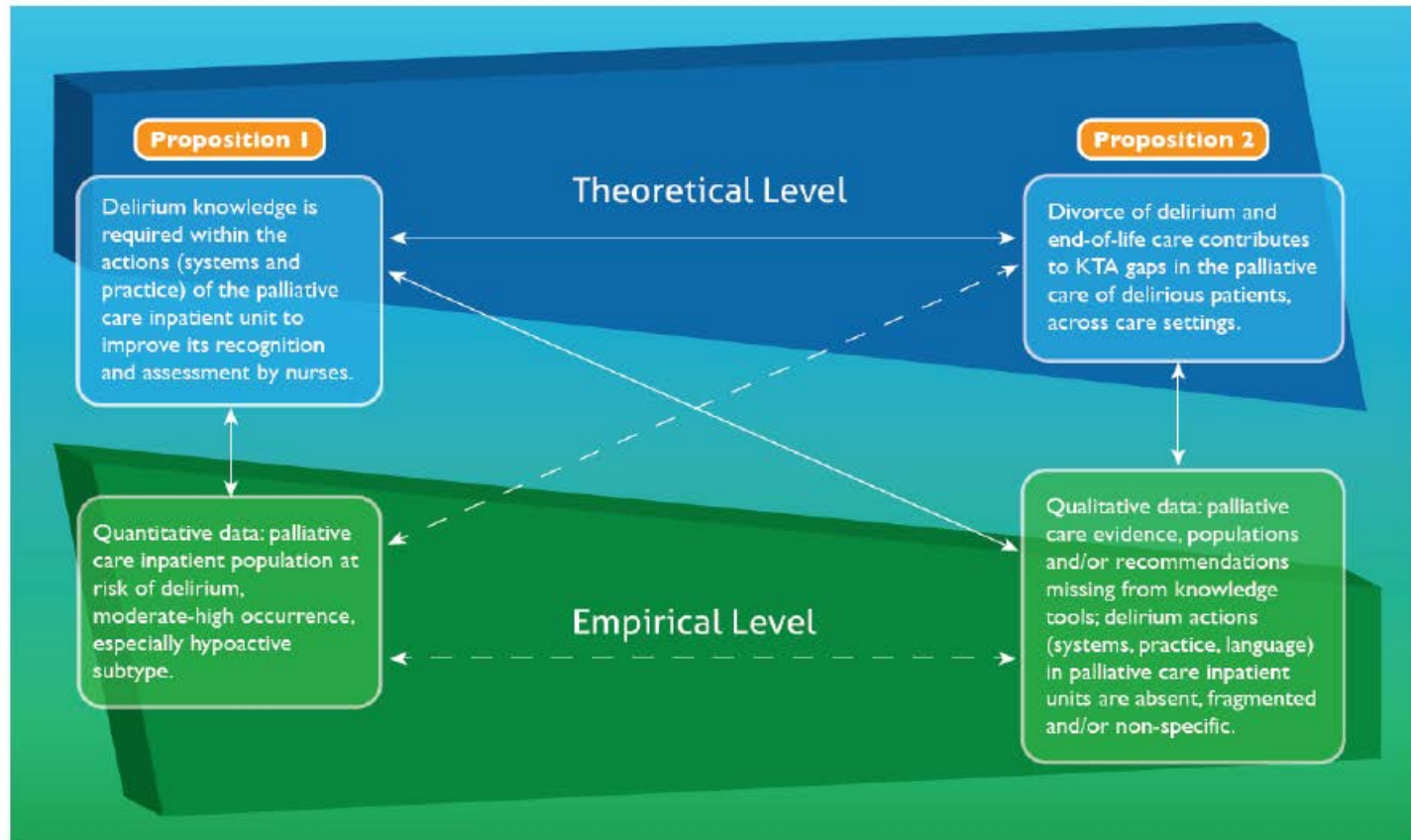
Use of a screening tool

- The Nursing Delirium Screening Scale is brief, simple and feasible for use...

Interdisciplinary practice

- Optimal delirium recognition and assessment by nurses also requires:
 - Rapport with patients
 - Engagement of family
 - Validation of delirium tools in this setting
 - Point-of-care guidance
 - Education relevant to palliative care contexts
 - Interdisciplinary teamwork

Meta-inference



Conclusion

- More careful navigation of palliative care patients away from an incipient or existing episode of delirium is entirely possible
- Better recognition, assessment and responses to delirium must become core business within specialist palliative care inpatient units

Recommendations

1. That specialist inpatient palliative care units promote optimal cognitive and physical function for all patients.
2. That patients and their family be routinely informed about delirium and supported during and after an episode.
3. That all Australian inpatient palliative care teams use delirium diagnostic criteria and validated delirium tools to confirm and communicate patients' neurocognitive changes.
4. That the PCOC tools be expanded to include validated delirium measures.
5. That the assessment of delirious palliative care patients is routine, comprehensive, structured and person-centred.

Recommendations

6. That palliative care inpatient services adopt systems to ensure the informed consent is obtained prior to nurse administration of psychoactive medication.
7. That the Nu-DESC, 4AT, SQiD, RADAR, and brief and/or family versions of the CAM be validated for use in inpatient palliative care populations.
8. That interdisciplinary delirium education resources be developed.
9. That interdisciplinary clinical interventions be developed and tested.
10. That future delirium clinical practice guidelines and standards address the needs of palliative care populations in accordance with the best evidence.



Thank you

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