Delirium Assessment and the assessment of people at risk

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Delirium

• **What is delirium?**
• Historically seen as a person who is confused/may have dementia or in an acute confusional state
• Delirium is characterised by recent onset of fluctuating awareness.
• Sudden onset of behaviours different to normal- sudden onset of confusion, or increased levels of confusion, marked disorientation, some people also develop strange ideas, or paranoia, and hallucinations.
Delirium

- Delirium is a common presentation of acute illness, with a higher incidence in older people.
- The development of delirium is associated with adverse outcomes, including death.
- Delirium can occur at any age, and can affect around 1 in 8 of all hospital patients.
- Higher incidence of delirium is found in older people.
Delirium

- **Local Context:**
  - Rotherham has a population of 253,900, with most people living in urban areas and about 50% living in the central area of the town.
  - Rotherham has an ageing population with 36% aged 50 or above, a 66% increase in the 75+ population and a 163% increase in the 85+ population since 1981.
  - There is evidence of a decline in some of the young age groups; 10 to 14 (-29%) and 20 to 29 (-17%).
  - The Rotherham NHS FT combines a 460 bedded general hospital with a wide range of community services ranging from District nurses and Community Matrons, through to Community Dental practices and specialist respiratory hospital.
  - Historically an area of heavy industry which through the 1980’s has been in decline.
Delirium

• Impact locally -
• Approximately 25% of all elderly patients admitted to hospital will experience delirium either on admission or during their hospital stay.
• Sometimes it is the only presenting symptom of illness in the elderly.
• Increase ALOS by average of 8 days
• Risk of adverse events while in hospital are increased; Pressure Ulcers, Falls risk, compromised dignity.
• Residual mental health and cognitive risks at 6 and 12 months post discharge
• 1 in 5 dead in one month.
• Increased risk of new institutionalisation
Delirium

• Three different presentations

1. Hyperactive presentation - this dominant construction of a confused physically active person, with heightened arousal, restless appearance, sometime inappropriate behaviours including destructive and/or aggressive behaviours towards healthcare staff and other patients.

• Many guidelines and policies refer mainly to this type of presentation
Delirium

2. **Hypoactive presentation**
   - A higher proportion of people – older people –
   - Up to 85% of the delirium presentations in acute settings.
   - Lethargy, reduced motor activity, lack of interest, will comply with simple requests, possibly smiling as staff ask questions.
   - Not seen as showing the traditional signs of risk of a Hyperactive delirium presentation, not initiating requests or participating in their own care, can be frequently overlooked in care delivery.

3. **Mixed presentation:** combination/ fluctuating presentations diurnal patterns evident.
Delirium

- **Risk Factors:**
  - Age 65 and over
  - Have a current Fracture
  - Evidence of cognitive impairment- (past or present) and /or dementia
  - Have a severe illness- chronic condition that has potential for deterioration ( e.g. Kidney failure, diabetes)
  - The above increase ones risk factors , especially when combined with some seemingly simple issues:

- **Complications of delirium:**
  - Infections, dehydration, constipation, strokes, heart attacks, recent surgery, excess alcohol, some progress to stupor/ coma with eventual death. 1 in 5 dead in one month. Increased risk of new institutionalisation.
  - This list is not exhaustive
Delirium

Frequency:

• Within the general community only 1-2% of people have delirium, rising to an increase of 14% for those people aged over 85.
• Within acute settings the risk of developing delirium rises, with estimates of
  • A&E departments 14-24% of people attending.
  • Post operative patients <50%
  • Acute Elder care pathway <50%
  • And ICU with <50% people experiencing some level of delirium

• This might be understandable if delirium was unavoidable or untreatable, but the existing evidence base for delirium is sufficiently robust for prevention or attenuation of the condition to be a realistic proposition.
Delirium

• What could improve the situation?
• A Consistent robust system of routine cognitive assessment in unwell older people would improve detection rates.

• Effective Risk assessments
  1. PINCHME – Pain, Infection, Nutrition, Constipation, Hydration/ Hypoxia, Sleep, Medication, Environment
  2. TIME bundle management tool – Triggers, Investigate, Manage, Engage
Delirium

• **Effective Risk assessments cont.**

3. SQID - (Single Question to Identify Delirium)

4. 4AT . 5. CAM. 6. Delirium Observational score,( DOS) J. Schuurmans, UMC Utrecht, 2001

7. Cquin Dementia and Delirium Screening, 2014.

• It is important to involve families or carers in identifying delirium.

• Good research evidence exists that, with better systems of routine care, delirium could be prevented in at least a third of patients.
Outcomes of the different assessments.

• Requirement for professional judgement
• Part of holistic review of the patient
• All aiming to provide clear information as to present status of the individual, but all measuring a fluctuating presentation.
• All require input and intervention not assessment from a distance.
• For best practice in improved wellbeing, the contribution of family/friends should be sought.
Delirium

- **Practical measures:**
- Young, found that “healthcare systems and services often unintentionally stimulate or substantially aggravate the development of delirium in older people.

- **AVOID:**
- Bed and ward moves
- Unnecessary interventions
- Assumption
- Dehydration- support encourage and monitor/record
Delirium

- Pain, Constipation, Sleep disturbance, look for and treat infractions,
- Ensure any sensory impairments are reduced to a minimum- remove ear wax, offer the persons spectacles/visual aids
- A person not being mobile (for example after surgery)
- Catheterisation
- Disorientation- no landmarks / clocks/ awareness of location/ isolation from family members/ familiar people
Delirium

• Some local actions taken at TRFT
• Addition of SQID to Dementia Screening process- so now information re numbers of people affected locally
• TRFT’s Forget Me Not scheme
• MDT Staff education programme, to improve recognition in identifying those highly vulnerable “hypo” patients as well as supporting management skills of those than heightened emotions, “hyper”
• New joint strategy for Delirium and Dementia, offering guidelines - in line with the new NICE Quality Standards
• Collaborative work with NHS England Acute Dementia Champions group –spreading best practice.
• Trauma and Orthopaedics pathway
Delirium

• How do you feel after having delirium?
• Some people may not remember what it was like to have delirium, especially if they already have problems with their memory.
• Others can be left with unpleasant or frightening memories.
• Some people worry that they are developing a type of dementia
Delirium

• **Conclusions:**
• Delirium is a common and serious disorder that is preventable and treatable, yet all too often the common risk factors are not identified systematically and many delirium cases remain undetected and undiagnosed.
• This places those who are the most vulnerable at higher risk.
• Staff development and training is required to reduce assumption, and increase the rate of recognition within acute hospitals.
Delirium

- Delirium can persist for weeks or months after the cause is treated
- The Hypoactive form and mixed type are more common than the hyperactive type of delirium
- With little or no public recognition of delirium, the bedside nurse is in a key position to make an episode of delirium less distressful for the both the patient and the family.
- Following a period of delirium people can have mixed responses, and may need extra support.
- With robust, better systems of routine care, delirium could be prevented in at least a third of patients.
Delirium

• Case studies:
  • Mr Joe Bloggs
  • Mrs Freda Bloggs
Delirium

- References:
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- Thank you for your time,

- Any Questions.