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Poster 26

St Ann's Hospice

Recognition, diagnosis and management of delirium in a palliative care setting

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Introduction

Delirium is a prevalent condition amongst hospitalised older people, of which palliative care patients are at increased risk (1)

Within palliative medicine reported incidence varies between 34-85% (2,3)

Potentially over two thirds of delirium cases in palliative care are missed(4)

Lack of understanding of diagnostic criteria and attribution of symptoms to other conditions such as depression or dementia are likely causes

Our audit aimed to assess current practice within a specialist inpatient palliative care setting (hospice inpatient unit), specifically looking at the risk of delirium on admission, diagnosis and management.

Methods

Retrospective collection of data from all inpatient admissions at a single centre adult hospice during January 2019. Patients were admitted for both end-of-life care and symptom management; this study followed them until the end of their stay.

Medical records were reviewed and confused and/or delirious patients were identified by the documentation of terms including delirium, confusion and agitation. NICE guidelines and quality standards were used to assess current practice for risk assessment, identification and management of delirium.

Results

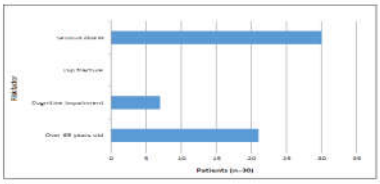
Demographics

30 patients (M 13:F 17)
Mean age 69 (range 32-87)
Mean length of stay 22 days (range 1-121 days)

Risk Assessment

Retrospective analysis revealed that all patients had at least one risk factor for delirium with a significant number having two or more. However, only two patients were identified by the admitting clinician to be at risk of delirium on admission.

Figure 1. Prevalence of delirium risk factors on admission to hospice



Presentation

The most common change was in physical behaviour, affecting 29 patients (97%), with reduced mobility being the most prevalent symptom, apparent in 24 patients (80%). Over half (53%) of patients were described as being confused.

Recognition

Figure 2. Prevalence of confusion, delirium diagnosis, management and outcomes

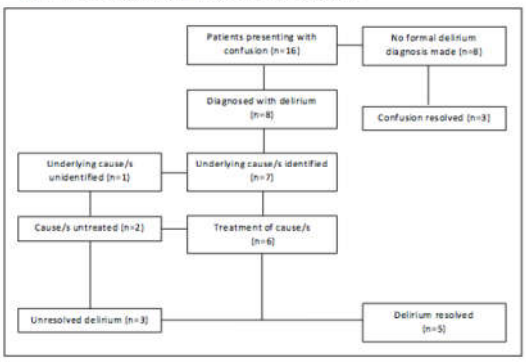


Figure 3. Underlying causes of delirium and subsequent treatment

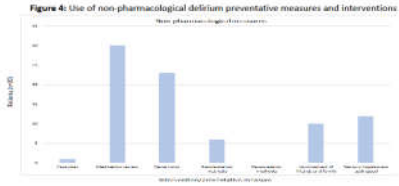
Underlying cause	Number of patients (n=8)	Treatment, if treated (number of patients n=8)
Disease progression	3	
Brain metastases	2	Steroids (1)
Medications	2	Medication review and alteration (1)
UTI	1	Antibiotics
Biliary sepsis	1	Hospital admission
Hospital acquired pneumonia	1	Antibiotics
Community acquired pneumonia	1	Antibiotics
Constipation	1	Bowel care
Jaundice	1	
Changed environment	1	

Management

1. Non-pharmacological

Most of the measures below were employed as part of general management. Only one patient had a care plan for the management of confusion.

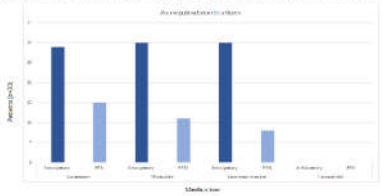
Figure 4: Use of non-pharmacological delirium preventative measures and interventions



2. Pharmacological

In current hospice practice, many of our patients are prescribed anticipatory and PRN benzodiazepines to manage agitation. No patients were prescribed haloperidol for PRN use in the management of agitated delirium.

Figure 5. Rate of anticipatory prescription and subsequent PRN administration of benzodiazepines and antipsychotic medications



Follow-up

Neither of the two patients who were discharged with delirium documented during the admission had this communicated in the discharge summary. Those with unresolved delirium died before their underlying cause was reassessed or being evaluated for a possible diagnosis of dementia.

Discussion

Identification of high risk patients was poor. Reasons for this might include a lack of awareness/confidence, time factors or not taking a collateral history. Although staff identified over half the patients as being "confused" at some point during admission, we failed to make a definitive diagnosis of delirium in half of these cases. Figure 2 would suggest that when a diagnosis of delirium was made, the patient had a better outcome. These patients were investigated for causes of their delirium and subsequently treated.

A proportion of patients had non-pharmacological measures for delirium during their admission, but this was not delivered as part of a management plan for delirium. NICE recommends haloperidol first line for management of delirium. We found many of our patients were receiving benzodiazepines for agitation. There was lack of consideration for delirium with an underlying cause. The delirium diagnosis was not communicated effectively to primary care in the two cases which were discharged.

Recommendations

- To improve delirium prevention and recognition we recommend all patients are screened formally at admission. This could be achieved by incorporating a standardized screening tool such as the 4AT or CAM score into the existing admission proforma.
- Aiming for more individualized prescribing by removing the pre-printed multi-drug prescription sections on the drug Kardexes.
- To improve communication with primary care, the discharge summary template could include a prompt on whether the patient experienced delirium or not, and our recommendation for follow up
- Formal education sessions in the form of presentations for clinical staff on delirium. This is currently being implemented at the hospice, with 2 of a proposed 3 sessions having taken place.

References

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