



Poster 41

Patients' experiences with delirium assessments

Bring ideas to life
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Introduction

The number of delirium assessment tools has increased significantly over the past few decades and their use is recommended worldwide. Unfortunately, nurses do not often conduct delirium assessments. Patients' reservations towards delirium assessments seem to affect nursing practices with regard to screening. Addressing barriers to routine screening is important to effective implementation. A better understanding of patients' attitudes could be key to implementing routine screenings.

"I think the questions are strange. The one with months is hard. It's also difficult for people who are not confused, I guess. I do not understand... [why screening is necessary]." (i8)

"Funny questions, but now [hindsight], I think they are really good and important questions" (i8).

Conclusions

Patients appreciate that professionals are interested in their mental and physical well-being. Despite their initial scepticism, patients find delirium assessments valuable when they had better understand the assessments' purpose. This indicates that barriers related to patients' scepticism towards delirium assessments should be overcome by healthcare professionals.

"I find it important that the staff also pay attention to my mental health" (i1)

"Well, that's really silly [laughing]" (i5).

Methods

We used a qualitative method to summarise, in everyday terms, specific events observed by researchers and experienced by patients. We performed participant observations on eight patients and nurses and conducted seven individual semi-structured face-to-face interviews at a nursing home with patients who had experienced delirium assessment using the bCAM. We carried out content analysis using an inductive approach.

"If you have a good psyche, you will heal more easily" (i5)

Results

Our findings indicate that patients approached delirium assessment with **initial scepticism** due to a lack of knowledge. Their scepticism changed to **complete acceptance** after the assessment's purpose was explained. However, some patients **gave up** on the assessment due to cognitive challenges, lack of energy, fatigue, or language barriers. Patients appreciated that professionals were interested in their mental and physical well-being. Despite initial scepticism, the patients found the delirium assessment valuable when they better understood its purpose. Thus, healthcare professionals should provide patients' with relevant information about delirium assessments.

"I thought I was going to be psychoanalyzed" (i4).

"She wanted me to recite the months backwards, which I can't, and then there was a sum to do, which you can easily make a mess of..." (i2).

Brief Confusion Assessment Method (bCAM), which consists of four features:
1. Mental state is assessed for attention or fluctuations throughout the day. This is primarily determined through surrogate interviews or by staff with knowledge of the patient.
2. Inattention is assessed by asking the patient to recite months backwards from December to July. If the patient makes an error or is unable or refuses to perform the task, inattention is present.
3. Altered consciousness level is determined using the Richmond Agitation-Sedation Scale.
4. Disorganized thinking is assessed by asking the patient to answer yes or no to four questions and respond to a command:
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?
5. "Hold up this many fingers" (staff holds up two fingers). "Now, do the same thing with the other hand" (staff does not demonstrate).
Patients are considered delirious if features 1 and 2 are present and either feature 3 or feature 4 is present.
Ref: Lee J, et al. Validation of an 11-item delirium identification instrument: improved reliability and validity of the Confusion Assessment Method. *Am J Geriatr Psychiatry* 2003;11:1025-32.