

# Delirium



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# Acknowledgement

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## Background

- Increasing number of “confused” elderly patients in acute care settings led to questions being asked about how to provide quality care
- High impact (acuity), high cost



## Background

- Implementation of dedicated room with permanent specialising and facilities such as:
  - Music
  - Fiddle blankets
  - Clock
  - Non-slip mats etc.



## So What?

- 10% of all hospitalised patients will suffer from delirium
- Up to 80% in high risk groups



## Financial Cost

The economic impact of delirium is substantial and equates to the health care costs of diabetes mellitus

Cost of specialising/medical care

Cost of falls and other complications

Increased length of stay

Higher level of care on discharge



## Emotional cost

- Patient / family/ carer stress
- Decreased quality of life for patient
- Impact on nursing staff



## Health Cost

- Increased mortality
- Increased morbidity

## Why this project?

International research:

- Medical and nursing staff are not good at recognising delirium
- Treatment can be prolonged and difficult
- **PREVENTION is paramount**



## Difficulty separating diagnoses



- Dementia
- Delirium
- Dementia with superimposed delirium
- Depression and dementia

Made worse by inconsistent or missing baseline information available when patient admitted

## Focus of program of research

Keeping elderly people healthy in the acute care setting- major focus on confusion and particularly delirium



## Prevalence of confusion

In 2006 four point prevalence audits were conducted over four weeks to identify how many confused patients were in the hospital. To be counted as “confused” patients had to be:

- Identified by nurse in charge staff as being confused, having a delirium, “being a bit off” or appearing depressed; and,
- These or other descriptors had to be documented in the patient’s notes.



Fremantle Hospital - Nursing Research & Evaluation

<b>Delirium Prevalence Survey</b> <b>Patient Information</b> <small>Use addressograph label if available →</small>	SURNAME: _____	DOB: _____	SEX: _____
	FORENAME: _____	BIRTH DATE: _____	
	ADDRESS: _____		

Ward: \_\_\_\_\_ Room: \_\_\_\_\_ Admit Date: \_\_\_\_\_

Admit Diagnosis: \_\_\_\_\_

**Behaviour Descriptors:**

Confused

<input type="checkbox"/> Agitated	<input type="checkbox"/> Wandering	<input type="checkbox"/> Plucking/pulling	<input type="checkbox"/> Noisy
<input type="checkbox"/> Angry	<input type="checkbox"/> Threatening	<input type="checkbox"/> Verbally abusive	<input type="checkbox"/> Physically aggressive
<input type="checkbox"/> Disorientated	<input type="checkbox"/> Insomnia (night)	<input type="checkbox"/> Hallucinating	<input type="checkbox"/> Fearful
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Vague	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Drowsy

Other \_\_\_\_\_

**Behaviour Frequency:**

Fluctuating     Constant     Unknown

**Questions**

1 Known Dementia?  Yes State type, eg *Alzheimer's* \_\_\_\_\_ **STOP**  
     Confirm from notes     No go to 2

2 Confused on admission?  Yes go to 3  
      No Date of onset \_\_\_\_\_

3 Evidence of identified contributing factors? (verbal from staff, recorded in notes)

\_\_\_\_\_

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Speed, G., McGowan, S., Wynaden, D., Hare, M., & Landsborough, I. (2006).

## Prevalence of confusion

A total of 1209 patients were covered on 15 medical and surgical wards at two hospitals.

Of these 183 patients (15%) were identified as confused:

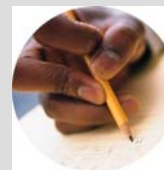
- 107 females and 76 males.
- Mean age of 80.5 years.



## Possible causes of confusion

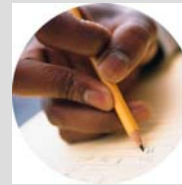
Of the 183 patients 132 (72%) displayed features consistent with delirium:

- 58 patients (44%) = **Possible** delirium superimposed on a confirmed dementia.
- 48 patients (36%) = Diagnosed delirium that may or may not be hospital acquired.
- 26 (20%) = **Possible** delirium



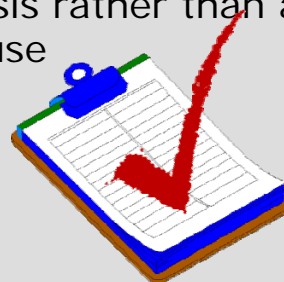
## The remaining 51 (28%) of the 183 patients:

- 29 (57%) = Behaviour related to **confirmed** dementia.
- 15 (29%) = Behaviour related to **confirmed** organic brain disorder that may or may not resolve.
- 7 (14%) = Behaviour related to **possible** unconfirmed dementia.



## Discussion Points

- Prevalence rates probably under estimated.
- Acceptance of managing confused patients.
- Confusion is seen as a diagnosis rather than a symptom of an underlying cause



## Discussion Points

- Improved documentation on patient's cognitive state is required. Again, confusion is a poor descriptor to use as it is difficult to measure change over a period of time. As a result, staff may not identify the cause and continue to just manage the resulting behaviours.

## Discussion Points

Management is often compounded by a lack of baseline data on the patient's level of cognitive functioning --- approximately 60% of patients in the audit came from home with no accompanying cognitive assessment.



## Discussion Points

Health professionals' level of knowledge of the causes of confusion is also questionable. A study of nurses' knowledge of delirium and associated risk factors demonstrated this (Hare, Wynaden, McGowan & Speed, 2006).

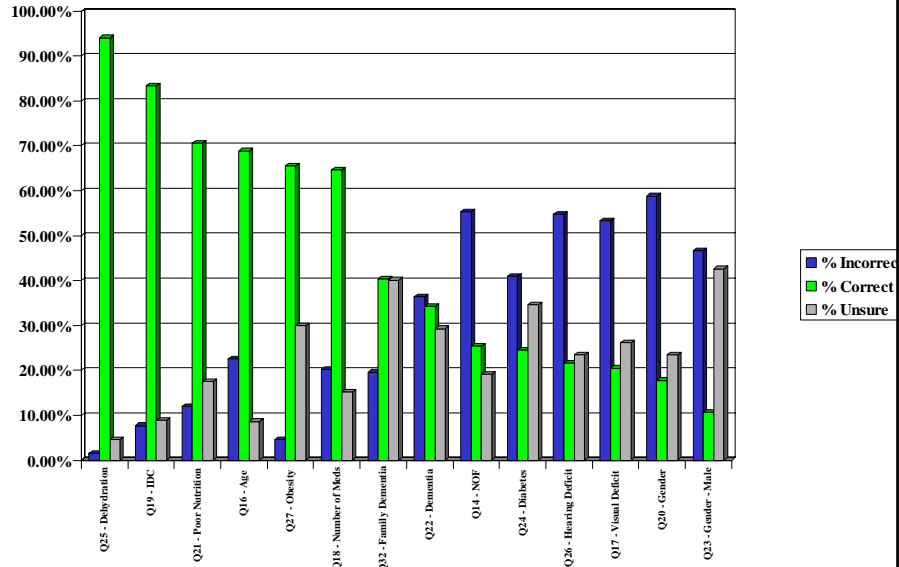


## Nurses' level of knowledge of delirium and associated risk factors

- Questionnaire sent to 1100 non-casual nursing staff 338 returns (30.7%).
- Poor level of recognition of risk factors particularly things like dementia, gender, hypoactive form of delirium.
- Level of knowledge of management of delirium was also low.



## Risk Factors



## Qualitative study on nurses caring for patients with delirium

1. Qualitative study conducted at two hospitals
2. Two main themes emerged
  - Inability to differentiate confusion
  - Managing confused patients



## Inability to differentiate confusion

### Three subthemes:

- Caring for so many confused patients
- Feeling helpless and
- Lack of education and training to assess confused and delirious patients



## Managing confused patients

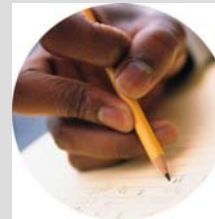
### Three subthemes:

- Safety issues
- Attitudes of staff
- The environment



## Where to from here?

Assessment of cognition in the elderly should have the same importance as physical assessment in all health professional undergraduate curricula and clinical practice areas.



## Where to from here?

- Develop a screening tool for delirium – ED study currently underway- pilot study now basis of a much larger study
- Elderly friendly hospitals
- Educate elderly people “how to survive” hospitalisation.



## Where to from here?

- Improved discharge planning to ensure family and carers understand the experience of hospitalisation particularly when the patient has experienced a delirium.
- Educational program in area of confusion/delirium

<http://cra.curtin.edu.au/wadtsc/wadtsc-mentiatrainingresources.html>



## Thank you

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