Delirium recognition at the end of life

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Background

A practice/knowledge gap exists that prevents the recognition of delirium in patients at the end of life (EoL). Up to **88%** of palliative patients die with delirium present (Hosie et al 2014). Most of these patients will have at least four causal factors for delirium and many will have reversable causes. A symptom of hyperactive delirium is agitation and restlessness. Terminal agitation/restlessness is a symptom commonly seen at the end of life and is term and concept integral to nursing practice in palliative care, but it may well be this cultural and ambiguous language that is restricting the recognition of delirium (Bush et al 2014). After pain, full bladder/bowels or soiling have been excluded if a patient is agitated or restless in the last weeks/days of life it is regarded as terminal agitation and part of the dying process. The medication prescribed for terminal agitation is contraindicatory to that recommended for delirium. The medication given for agitation can in fact worsen delirium, it is a sedative and if three or more doses are given in 24hours a syringe driver will be commenced.

Aims and objectives

To see if the introduction of the delirium recognition tool 4AT with some education would increase the recognition and awareness of delirium in the patients seen by an Out of Hours Palliative Care Team.

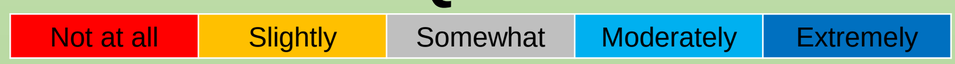
Method

Participants: The Out of Hours Palliative Care Team, comprising of 12 nurses.

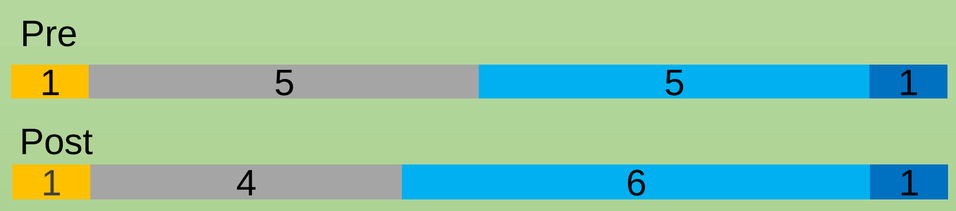
Design: A mixed methods approach.

This involved: **1)** A literature search which confirmed that delirium is under-recognised by nurses in palliative care. **2)** A pre and post 5 scale Likert questionnaire to measure the team's understanding and confidence in recognising delirium following an education session. **3)** The trial of the 4AT tool for 8 weeks. **4)** Two focus groups with semi-structured interviews to explore the team's perceptions, knowledge and discussions of patients seen with terminal agitation/delirium. The themes of the focus groups where then interpreted and compared against the questionnaires and the completed 4ATs.

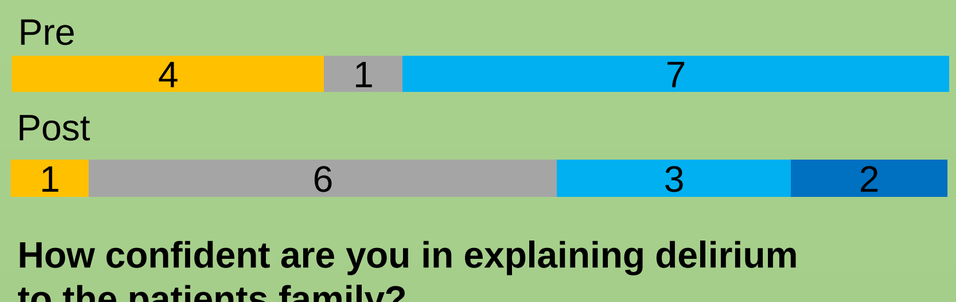
Pre and Post Questionnaire



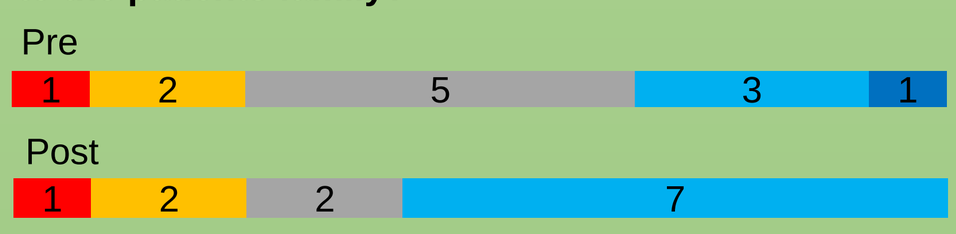
How confident are you in recognising delirium in patients?



How confident are you in managing patients with delirium?



How confident are you in explaining delirium to the patients family?



PRE: Do you think a rapid clinical test for delirium would be helpful in identifying patients with delirium?

POST: Do you think the 4AT tool has been helpful in identifying patients with delirium?

Results

16 4AT tools were completed on agitated patients.

13 had a score of over **4**, which was a delirium positive indicator. Only 1 4AT did the nurse feel it was a definite delirium, the other comments put on the sheet where that the nurses felt the agitation was due to other factors.

The focus groups: Two main themes emerged throughout both sets of interviews: barriers and enablers to recognising delirium.

Discussion

4AT: Comparing the completed 4AT results against the nurses' comments and on closer examination it was found to give a false positive score on semi-conscious patients. It was also found to be difficult, intrusive and inappropriate to use on actively dying patients. This perception highlights the paradigm described by (Bush et al, 2014) of the integral concept of terminal agitation being a stage of dying rather than a symptom of delirium. This paradigm was recognised in the focus groups.

Barriers: There is an overall decrease in the confidence of managing patients with delirium. This becomes evident from the barriers that are prevalent in practice to not only recognising delirium but having the knowledge, policies and procedures of how to treat.

Enablers: The team implicitly use their tacit knowledge to try to ensure a calm environment, helping to orientate the patient to the time of day. Prior knowledge is applied from past experience of patients with delirium. A need for a checklist/tool relevant to EoL patients was identified and the requirement for anticipatory prescribing for delirium was acknowledged.

Conclusion

The 4AT has been unsuccessful at helping nurses to identify patients with delirium. There was insufficient evidence to prove whether education by itself raised the team's awareness of delirium. There was sufficient evidence from the questionnaires and focus groups to say that the team's awareness and questioning of delirium was evolving. What was apparent from the focus groups was the lack of policy, leadership, guidance, support and strategy needed to be in place when delirium is identified. Without this the purpose of recognising delirium at the end of life seems questionable.

References: Bush, S., Leonard, M., Spiller, J., Wright, D., Meagher, D.& Bruera, E. (2014) 'End-of-Life Delirium: Issues Regarding Recognition, Optimal Management, and the Role of Sedation in the Dying Phase' Journal of Pain and Symptom Management 48(2) pp215-230

Hosie, A., Agar, M., Lobb, E., Davidson, P. & Phillips, J. (2014) 'Palliative care nurses' recognition and assessment of patients with delirium symptoms: A qualitative study using critical incident technique' International Journal of Nursing Studies 51 pp 1353-1365