Delirium: the great imposter

A re-audit of the clinical assessment and management of patients with delirium referred to a Psychiatry of Later Life liaison service.

João Costa[1], Leonard Douglas [2], Lisa Uruejoma[3], Sinead Murphy[4], Colm Cooney[5]

[1, 2, 3, 4, 5] St. Vincent's University Hospital, Elm Park, Dublin, Co. Dublin

What is Delirium?

Delirium is a clinical diagnosis characterised by an acute impairment of consciousness producing a generalised cognitive impairment.

It is often confused as mental illness due to associated neuropsychiatric symptoms.

Clinical features include reduced attention span, changes in thinking and increased confusion.

Based on the patient's psychomotor activity, it can be classified as hyperactive, hypoactive or mixed.

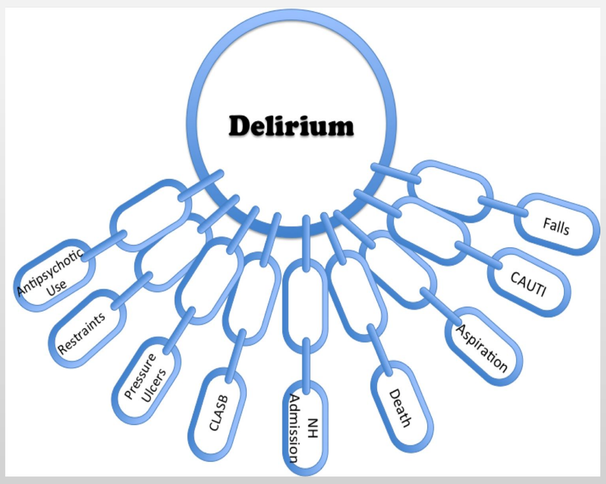
Symptoms can develop quickly and often fluctuate during the day.

Risk

Delirium has a prevalence of 20% to 40% in general hospital inpatients. [1]

It is associated with increased morbidity, mortality and reduced socio-adaptive functioning.

Despite its widespread occurrence, reports indicate that delirium is overlooked in up to two thirds of cases inspite of multiple international guidelines and initiatives.[2,3] Therefore it is often misdiagnosed or simply untreated.[1]



Key findings of this audit

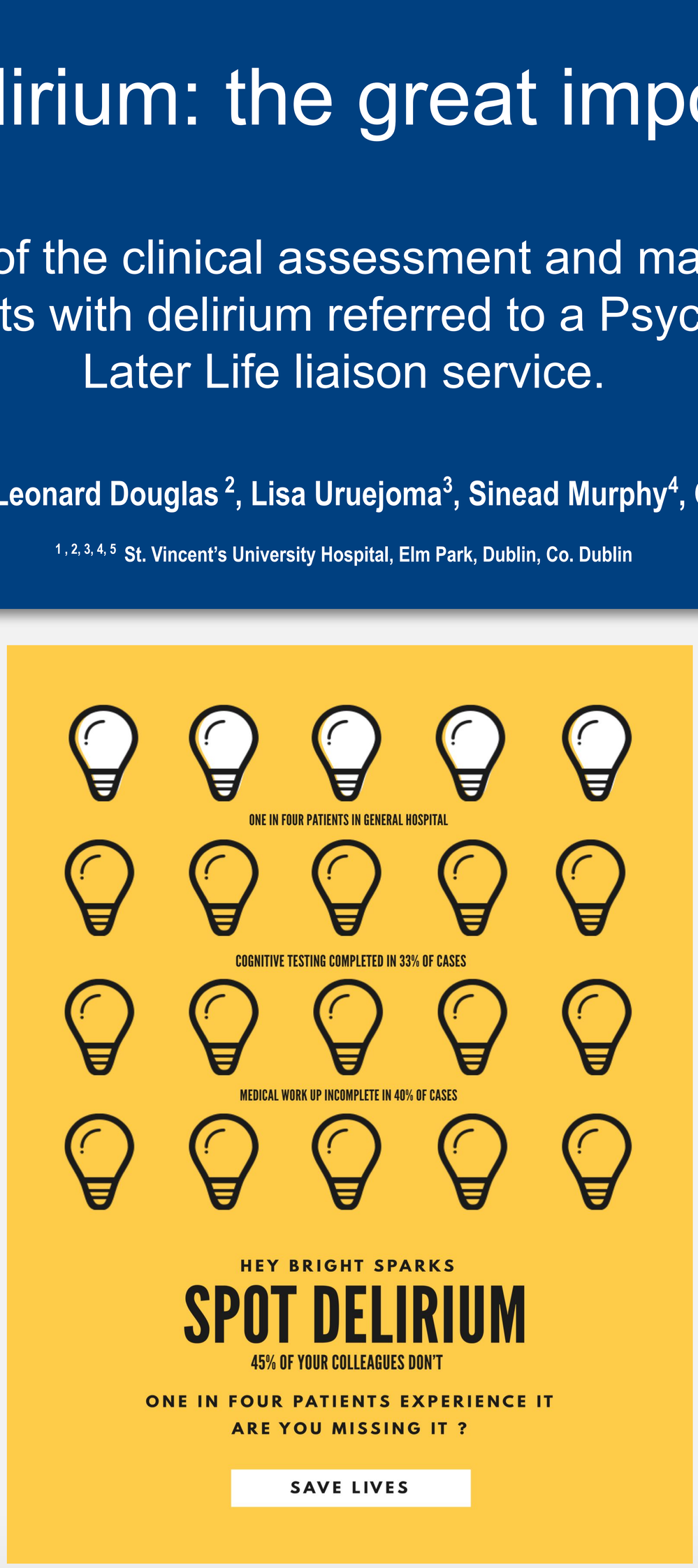
Cognitive testing (MMSE) was performed in 33% of cases.

In 3% of the cases, was a 4AT easily retrievable from the patient's chart.

Essential medical work-up was incomplete in 40% of the cases.

Only FBC and U+E were consistency completed in most patients.

The was no difference between work- up rates in medical or surgical specialties.



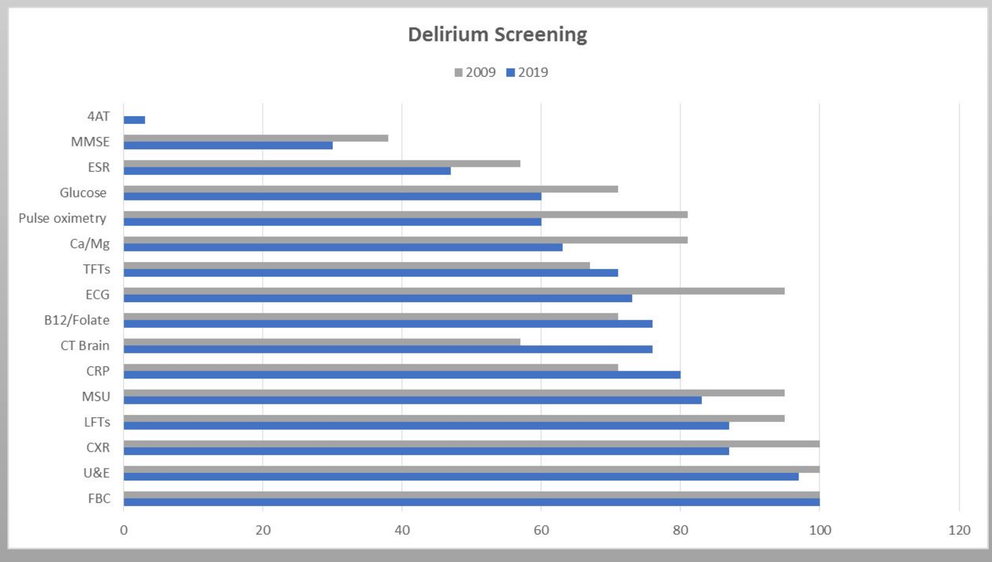
Comparison to 2009 Audit

Despite interventions in the hospital over the past ten years, progress seems somewhat resistant to improvement.

Prior to referral to POA team, delirium was recognised by treating team in 62% of the cases vs 50% in 2009.

The rate of use of neuroimaging has increased from 57% to 75%.

Cognitive assessment (MMSE) was carried in 33% of the cases vs 38% in 2009.



Conclusions

Delirium is often misidentified as mental illness . It is important to identify, understand the causes and manage delirium correctly.

It is clear that over a ten year period this remains a problem that clearly needs further educational and systemic improvements.

The most effective and cost neutral way to diagnose and monitor delirium is through obtaining a detailed history and cognitive testing. A 4AT is completed on most patients being admitted but was difficult to retrieve in patient charts and seldom referred to in the clinical work up or referral to our team. The use of cognitive testing has reduced over the comparison period. Conversely costly neuroimaging has increased in this time.

Interventions.

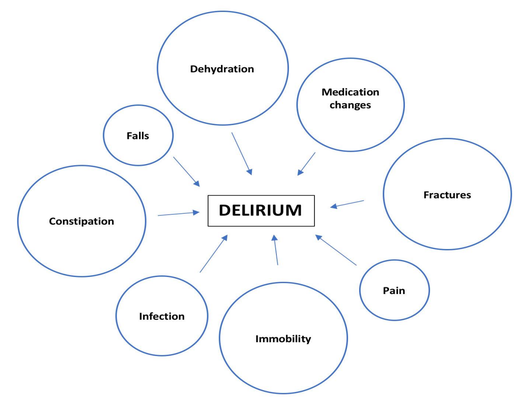
- Optimise the referral process to our team. An online referral tool is currently being developed by our team to support our colleagues identify, consider the causes of and manage delirium effectively.
- In addition we propose a poster campaign to highlight the issue of delirium in the hospital.

Targets for Education

Identify

- Becoming restless, agitated, aggressive
- Being withdrawn, quiet or more sleepy
- Hear or see things that aren't there
- Struggle to think clearly
- Have vivid dreams
- Be more confused certain times of the day, especially evenings and night time
- Feel an urge to wander around
- Be less aware of what is going on around them or where they are

Understand Causes



Manage

- Treat the underlying cause
- Reassure and reorientate the patient
- Ensure hydration is adequate
- Normalise sleep patterns
- Ensure pain relief is adequate
- Avoid unnecessary medication
- Educate the patient, family and carers
- Treat violent or distressed behaviour with carefully monitored antipsychotic medication

References

[1] Fitzgerald, J., 2019. Delirium and the acute hospital system of the Republic of Ireland: Challenges, solutions and opportunities.. *Irish Medical Journal*, [Online]. 1, 596.

[2] British Geriatric Society . Guidelines for the prevention, diagnosis and management of delirium in older people in hospital. 2006

[3] Nice guidelines : www.nice.org.uk/guidance/CG103

Ethical considerations

The above audit was approved by the Clinical Audit Committee – St.Vincent's University Hospital

✉ joaopaulocostasilva@svhg.ie