CLiP

15 minute Worksheet

Helping patients with symptoms other than pain

9: Delirium

Intermediate level

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Aim of this worksheet

To review the features and causes of confusional states, and to consider how to help

How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, and then turn to the Work page overleaf.
- Work any way you want. You can start with the exercises on the Work page using your own knowledge. The answers are on the Information page - this is not cheating since you learn as you find the information. Alternatively you may prefer to start by reading the Information page before moving to the exercises on the Work page.
- This CLiP worksheet should take about 15 minutes to complete, but will take longer if you are working with colleagues or in a group. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know.
- Take this learning into your workplace using the activity on the back page.

Case study

John is a 54 year old man who had surgery for a carcinoma of the colon. Two weeks ago his wife noticed he seemed vague on occasions. Over the past week he has become increasingly disorientated. At times he has been agitated and suspicious of anyone visiting.

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INFORMATION PAGE: Delirium

A*cute confusional states* or delirium are the commonest form of confusion in advanced disease. It is present if there are four or more typical features. Six are highly specific: acute onset, fluctuating course, disorganised thinking, inattention, memory impairment and disorientation. Five are less specific: altered sleep-awake cycle, abnormal psychomotor activity, altered level of consciousness and perceptual disturbance.

Chronic confusional states are seen in the dementias. They can have similar features to acute states, but the history is longer, the symptoms fluctuate less, and the patient's alertness is unlikely to have changed.

Features of a delirium

CAM Confusion Assessment Method =

Acute onset and fluctuating course + inattention + Disorganised thinking or altered consciousness

Acute onset: this can be seconds or minutes (eg. hypoglycaemia), hours or a few days. It does not develop over many weeks or months.

Inattention: this can be misinterpreted as memory loss but is due to inattention, not a failure to remember.

Disorganised thinking: this can be mild (unsure of time or place) or severe (eg. paranoia).

*Alteration in the level of alertness***:** in acute confusional states this can be either increased (hyperactive delirium) or decreased (hypoactive delirium). Around 80% of delirium is hypoactive, so it is often missed.
In chronic confusional states such as dementia, alertness is usually unchanged.

First things first

- **Are you sure this is a delirium?** Consider dementia, intellectual disability, severe depression, severe anxiety, Parkinson's or psychosis.
- **Have you looked for the cause?**
  Immediately: check BP, respiratory rate, pulse, oxygen saturation, evidence of trauma, hydration status, focal neurological deficit. Exclude urinary infection and faecal loading.
  Within the first hour: exclude infection, check for drugs or chemicals started or stopped, check blood biochemistry, exclude cerebral or cardiac causes.

Simple approaches

Check the cause: sometimes these are obvious, eg. recently started drugs, a chest infection.

Explanation: delirium can be frightening for all involved as the patients fear they are 'losing their mind' while carers feel uneasy at the unpredictability of the patient's words and actions. Confused patients can understand explanations, although if their concentration is impaired this explanation may have to be repeated several times.

Stable environment: it helps to keep the environment quiet and light, while keeping staff changes to a minimum.

Re-orientation: repeated, gentle reminders of place, time and people provide 'hooks on which to hang their reality'.

Managing severe agitation

- **If there is an *immediate* risk to health or safety of staff or patient:** Ensure that a) you do not challenge the patient directly; b) one-to-one supervision of the patient is available; c) you seek an urgent review by a senior member of the clinical team; d) you take advice from the liaison psychiatry teams.
- **Verbal de-escalation techniques**: these are not usually helpful in a severely agitated patient with delirium.
- **If the patient has alcohol withdrawal, Parkinsons or Lewey-Body dementia:** start a benzodiazepine, e.g. lorazepam 0.5–1 mg 8-hourly (follow local protocol).
- **For other patiens with severe agitation:**
  Haloperidol can be given orally (the injection solution is odourless, colourless and tasteless) *If the distress is mild* haloperidol 0.5–2 mg PO 6-hourly PRN (peak effect 2–6 hours). The goal is a reduction in distress without sedation. Parenteral routes are best avoided for most patients as the injections risk increasing the distress.
- **Senior clinical review is essential within 24 hours especially if:**
  – 3 doses of haloperidol have been given without benefit.
- **Will the patient's liberty have to be restricted?** See CLiP worksheet *Deprivation of Liberty Safeguards.*

Persisting delirium

Ensure that the senior clinician responsible has reviewed the patient, and the partner and relatives have received an explanation and support.

Consider persisting dehydration, organic causes (e.g. hypothyroidism, subdural haematoma, limbic encephalitis), psychiatric causes (dementia, psychosis, agitated depression), unknown or hidden chemical abuse (alcohol or drugs).

If there is still no clear solution: ask for help from the liaison psychiatry team.

And afterwards?

Explore if the patient has unpleasant memories of the delirium episode.

Explain what happened.

Ensure that all the patient's key carers are informed of the delirium episode so that they can be aware of the increased risk of delirium in similar circumstances in the future.

WORK PAGE: Delirium

Choose **Ring** **the features which are typical of these two types of confusional state**

Acute confusional state eg. infection	**Chronic confusional state** eg. dementia
acute onset	acute onset
long history	long history
slow deterioration	slow deterioration
poor concentration	poor concentration
memory failure	memory failure
disorientation	disorientation
altered sleep-awake cycle	altered sleep-awake cycle
changes in alertness	changes in alertness
alertness unchanged	alertness unchanged

Reflect **Think about possible causes of John's confusion**

- Most likely:

- Less likely:

Choose simple **From this list ring the simplest approaches to help John**

Identifying the cause	Starting diazepam
Taking bloods	Explaining the cause to John
Restricting visitors	Asking several specialists to review John
Speaking loudly	Repeated reminders of place and time

Reflect **Think about what would make you feel that urgent control of the confusion with drugs was needed**

FURTHER ACTIVITY: Delirium

Think back to the last confused patient you met.

- What simple measures were used to help?

FURTHER READING: Delirium

Journal articles

Adamis D, Reich S, Treloar A, Macdonald AJ, Martin FC. Dysgraphia in elderly delirious medical inpatients. *Aging Clinical & Experimental Research.* 2006; **18**(4): 334–9.

Agar M, *et al.* Differing management of people with advanced cancer and delirium by four sub-specialties. *Palliative Medicine*. 2008; **22**(5): 633-40.

Bruera E, *et al.*Impact of delirium and recall on the level of distress in patients with advanced cancer and their family caregivers. *Cancer.* 2009; **115**(9): 2004-12.

Caraceni A, *et al*. Impact of delirium on the short term prognosis of advanced cancer patients. Italian Multicenter Study Group on Palliative Care. *Cancer.* 2000; **89**(5): 1145-9.

Dasgupta M, Hillier LM. Factors associated with prolonged delirium: a systematic review. *International Psychogeriatrics.* 2010; **22**(3): 373-94.

Fang CK, Chen HW, Liu SI, Lin CJ, *et al*. Prevalence, detection and treatment of delirium in terminal cancer inpatients: a prospective survey. *Japanese Journal of Clinical Oncology*. 2008; **38**(1): 56–63.

Gagnon PR. Treatment of delirium in supportive and palliative care. *Current Opinion in Supportive & Palliative Care*. 2008; **2**(1): 60–6.

Lawlor PG, *et al*. Occurrence, causes, and outcome of delirium in patients with advanced cancer: a prospective study. *Archives of Internal Medicine.* 2000: **160**(6): 786-94.

Lawlor PG, Bruera ED. Delirium in patients with advanced cancer. *Hematology - Oncology Clinics of North America.* 2002; **16**(3): 701-14.

Lawlor PG. The panorama of opioid-related cognitive dysfunction in patients with cancer: a critical literature appraisal. *Cancer.* 2002; **94**(6): 1836-53.

Leonard M, Raju B, Conroy M, Donnelly S, *et al.* Reversibility of delirium in terminally ill patients and predictors of mortality. *Palliative Medicine.* 2008; **22**(7): 848–54.

Leonard M, *et al*. Symptoms of depression and delirium assessed serially in palliative-care inpatients. *Psychosomatics*. 2009; **50**(5): 506-14.

Lonergan E, Luxenberg J, Colford J. Haloperidol for agitation in dementia (Cochrane Review). *The Cochrane Library, 2002; Issue 2.* Oxford: Update Software Ltd. (www.cochrane.org)

Meagher D, Leonard M. The active management of delirium: improving detection and treatment. *Advances in Psychiatric Treatment.* 2008; **14**: 292–301

Michaud L, Bula C, Berney A, Camus V, *et al.* Delirium Guidelines Development Group. Delirium: guidelines for general hospitals. *Journal of Psychosomatic Research.* 2007; **62**(3): 371–83.

Ryan K, *et al.* Validation of the confusion assessment method in the palliative care setting. *Palliative Medicine.* 2009; **23**(1): 40-5.

Spiller JA, Keen JC. Hypoactive delirium: assessing the extent of the problem for inpatient specialist palliative care. *Palliative Medicine*. 2006; **20**(1): 17–23.

Wada T, Wada M, Wada M, Onishi H. Characteristics, interventions, and outcomes of misdiagnosed delirium in cancer patients. *Palliative & Supportive Care*. 2010; **8**(2): 125-31.

Zama IN, Maynard WK, Davis MP. Clocking delirium: the value of the Clock Drawing Test with case illustrations.
American Journal of Hospice & Palliative Medicine. 2008; **25**(5): 385-8.

Further resources

A Guide to Symptom Relief in Palliative Care, 6th ed. Regnard C, Dean M. Oxford: Radcliffe Medical Press, 2010

e-lfh: e-Learning for Healthcare contains a range of online self-learning programmes, including several relating to end-of-life care (e-ecla). Registration is required but is free. http://www.e-lfh.org.uk/projects/e-elca/index.html

Oxford Textbook of Palliative Medicine 4th ed. Hanks G, Cherny NI, Christakis NA, Fallon M, Kaasa S, Portenoy RK. eds. Oxford : Oxford University Press, 2010.

PCF4- Palliative Care Formulary, 4th ed. Twycross RG, Wilcock A. www.palliativebooks.com

Stedeford A. Confusion. In, *Facing Death: patients, families and professionals, 2nd edition*. Oxford: Sobell Publications, 1994

Symptom Management in Advanced Cancer, 4th edition.. Twycross RG, Wilcock A, Stark Toller C. Oxford: Radcliffe Press, 2009

CLiP 15 minute Worksheet

Current Learning in Palliative care

An accessible learning programme for health care professionals

15 minute worksheets are available on:

- An introduction to palliative care
- Helping the patient with pain
- Helping the patient with symptoms other than pain
- Moving the ill patient
- Psychological and spiritual needs
- Helping patients with reduced hydration and nutrition
- Procedures in palliative care
- Planning care in advance
- Understanding and helping the person with learning disabilities
- The last hours and days
- Bereavement

Available online on www.clip.org.uk