Delirium: Opportunity for Comfort in Palliative Care

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Delirium

- Common, serious and potentially preventable neuropsychiatric disorder seen in
  - Very ill
  - End of life as part of the dying process
  - Patients labeled confused/agitated
  - No further assessment or evaluation is done
  - Most common complication experienced by patients with advanced illness
  - Occurring in up to 85% of patients in the last weeks of life
What Does Delirium Do? (Why do I care?)

- Frightens patients and families
- Robs patients of valuable time to spend with loved ones
- Patients remember episode as very distressing
- Negative experience for family members, caregivers, and professional nurses
- Leads to functional decline
- Impedes quality of life for the patient and family

(Hosie, Davidson, Agar, Sanderson, & Phillips, 2012; Close, 2012; Harrison et al., 2016)
Delirium Outcomes

- Emotional distress – patients are anxious, angry, or depressed
- Poor pain management: pain is very difficult to treat in patients with delirium
- Hyperactive: risk for falls and other injuries
- Interferes with patient’s ability to make choices about their care
- Prolonged hospitalization
- Increased mortality
- More likely to discharge to long term care

(LeGrand, 2012; Harrison et al., 2016; Breitbart & Alici, 2012)
Delirium in Palliative Care

- Very common in hospitalized patients
- Incidence in patients with advanced cancer ranges from 6%-68%
- 26%-44% of people with advanced cancer in the
- Frequency increases up to 90% in cancer patients near end of life 88% of people with terminal illness in the last days of life

(Kang, Shin, & Bruera, 2013; Keeley, 2009; Gonçalves, Almeida, & Pereira, 2016)
Screening for Delirium in Palliative Care

- Providers have difficulty recognizing delirium
  - Varying presentations
  - Lack of knowledge of delirium
  - Lack of routine utilization of a standardized assessment tool
- Supports the need for a standardized assessment tool
- Confusion Assessment Method: widely used; reliability and validity established in numerous patient settings
  - Acute change in mental status, inattention, and either disorganized thinking or altered level of consciousness

(Harrison et al., 2016; Ryan, 2009)
Frequency, Characteristics, and Outcomes Among Cancer Patients with Delirium Admitted to an Acute Palliative Care Unit

- 556 patients admitted to APCU, 323 (58%) had a diagnosis of delirium
- Of those, 229 (71%) had a delirium diagnosis on admission and 94 (29%) developed delirium after admission
- Delirium reversed in 85 of the 323 episodes
- Half of the patients with delirium (n=162) died
- Patients with a delirium had a lower overall survival than those without
- Patients who developed delirium after admission had poorer survival and lower rate of delirium reversal
- Diagnosis of delirium was associated with poorer survival
More Evidence Needed?

- Systematic review by Hosie et al., 2012, Australia. (8 studies 1079 participants)
- Eight different screening and assessment tools were used
  - Hypoactive delirium most prevalent in palliative care populations
  - May appear less severe than the other subtypes, **and** cause less difficulties in ward management, but associated with increased mortality
  - Clinicians involved in patient screening and assessment
  - Delirium screening by nurses is feasible and effective

**Should routine screening be implemented in palliative care settings?**
Questions?

- Is screening acceptable to patients and family and does screening cause minimal harm?
- Is it cost-effective?
- Does early recognition and treatment of delirium improve mortality and morbidity?
- What are the adverse effects of delirium treatment?
- What is the best screening tool?

(Hosie, Davidson, Agar, Sanderson, & Phillips, 2012)
Ethical Consideration of Delirium Research

- Paramount to protect participants from any harm or risk, conduct ethical and lawful research, and produce ethical and meaningful results.

- **Inclusion in Research**

- **Informed Consent and Capacity**
  - Information must be provided about the reason for the proposed matter, risks and benefits, and alternative options
  - The individual in question must understand, retain, and believe the information provided
  - They must deliberate, make a decision, and be able to communicate this decision

(Sweet, et al., 2014)
Protocol for the Control of Agitation in Palliative Care

- Haloperidol - 5 mg IM + midazolam - 5 mg IM
- 30 minutes later, if situation is not controlled
  - Haloperidol-2mg SC = midazolam-5 mg SC, up to 2 doses (30 min. apart)
- 30 minutes later, if the situation is not controlled
  - Midazolam 5 mg SC every hour until control of the situation
- If agitation recurs
  - Less than 2 hours after control: resume the protocol from the interruption point
  - More than 2 hours later: restart the protocol from the beginning.

(Gonçalves, Almeida, & Pereira, 2016)
References


References


References


Ethical challenges and solutions regarding delirium studies in palliative care.
http://dx.doi.org/10.1016/j.painsymman.2013.07.017.