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We're doing a short podcast to help students with recognizing delirium

Tania: Hello. My name is Tanya Murray. I am a nursing student at Queen's University Belfast. Today, I'm joined by three colleagues from nursing, medicine, and pharmacy. And today we're just doing a short podcast to help students with recognizing delirium.

Louise: Hello, everyone. I'm Louise. I am an adult nurse at Queen's University Belfast.

Will: Hi, my name is Will, and I am a medical student at, Queen's University Belfast.

Adiola: Hello, everyone. My name is Adiola, and I'm a pharmacy student at, Queens University Belfast.

Tania: Okay, so I'm going to ask the first question.

How do different healthcare professions collaborate in assessment of delirium

how do different healthcare professions collaborate in the assessment of delirium?

Louise: Coming from a nursing perspective here, I think what we just see is, like,

behavioral observations on the floor, so it can be kind of, maybe like a hyperactive delirium or a hypo, which is a little bit harder to see. But, I think that's kind of where from nurses, kind of. That's the first things that we notice. What do you guys think?

Will: I know. From a medicine perspective, anyway. the role of the doctor is really to sort of establish potential causes and look at the medical history in particular for any potential causes there, or whether that's to do with the presenting complaint. And that really comes into its own when it comes to reversing that potential cause, because that has an impact on the treatment and the overall prognosis of that patient.

Adiola: And I think in pharmacy, it'd be more. So looking at medication, and just looking at the pharmacical landscape and, in terms of pharmacodynamics and pharmacokinetics, just interactions, drug interactions that could potentially cause delirium.

Louise: Would you agree that it's kind of like a multidisciplinary, like that it's kind of, everybody comes together and has to kind of diagnose it together, or would you think it's more specific to one area?

Adiola: No, I definitely think it's multidisciplinary, disciplinary. Yeah, sorry. just because there's so many different aspects of it that it's kind of hard for just one profession to say, yeah, this is it.

Louise: Yeah, definitely, isn't it? And it's even like, I see the occupational therapists come into it, physiotherapists and dietitians as well, kind of. They all come into how to properly collaborate on the assessment.

What are the key signs and symptoms that each profession looks for in identifying delirium

Tania: so the second question is, what are the key signs and symptoms that each profession looks for in identifying delirium?

Will: I think, in terms of the role of the doctor as I mentioned before, it's about sort of looking at medical history and the presenting complaints and investigating whether any of these could be precipitating factors, in the delirium. But then, I suppose when it comes to assessment, we would look at both the cognitive aspect of things. M looking at patients cognitive function, how their memory is, et cetera, but also the physical manifestations of delirium, such as changes in the vital signs or any sort of changes in the neurological signs.

Adiola: I think in pharmacy, like, as a pharmacist, it would definitely, once again, just be looking at medication that the patient is on, because polypharmacy. So taking multiple drugs, especially, like, in the likes of older patients, could be a very big contributing factor. and it would also really be important to identify side effects of drugs that the patient is on, just to see if the side effects could mimic delirium symptoms.

Tania: Yeah.

Louise: And then I think, coming from nursing perspective, I think, tanya, you'll agree with me, is kind of like the sudden changes, usually from my own personal experience, would be like the family would usually be the people that would notice first. Kind of like maybe just completely being really not themselves, as I said, like behavioral changes. and then, like, restlessness and agitation. From personal experience. I remember

having a woman who thought there was rats crawling on the ceiling, which is completely not like herself, and then, like, sleep disturbances. So be like, being asleep during the day and being wide awake at night and just not knowing the difference from day and night. that's kind of what I have came to see, the signs and symptoms. And then, yeah, I think family is just really important. I think we'll all agree they are usually the people that kind of first people to see this.

Tania: Yeah. I also feel like, in my placement recently, I noticed that one of our patients was, trying to jump out of his bed, and, he was experiencing what seemed really real to him. Obviously, we can see them lying down in their bed, and he thinks he's on the edge of a cliff and he's shouting for help. So, it's looking out for signs like that as well. Really unusual behaviors.

What does it feel like to encounter someone living with delirium

Tania: Okay, I'll move on to the next question. what does it feel like to encounter someone living with delirium?

Louise: I think coming from a nursing perspective, it's really distressing. It's actually kind of scary in a way, because from what I have experienced, it's quite a sudden thing. So for 1 minute, they're a lovely lady sitting there, and then the next minute, they're like, oh, my God, I'm going to die. It's quite sudden and it can be really distressing, especially for family members. Also personally as well, being on that side, you just don't know what it is and it's really frightening. And then just found like, it kind of slows down maybe the healing process and other things as well, because obviously delirium is the first treatment. It is the first thing you want to treat. Yeah, I just think the altered behaviors is

just really kind of frightening. What do you guys think?

Will: Yeah, it can be quite concerning as well from the medical perspective, in terms of you're trying to find out what has potentially precipitated this, and these things can take time. And as you mentioned there, you've got family who you need to explain things to as well. And you don't always have the full picture that you would need to give a good explanation to family members. because it takes time to find out the diagnosis, the precipitating factors and the treatment. So, yeah, it can be quite an uncertain time and quite a concerning one as well.

Patient describes vividly imagining hospital being bombed during delirium

Tania: Okay. so basically, I have a patient story below here, and I hope that you don't mind me sharing. I'm going to read it out for you quickly. so this patient has said that during the delirium, it was like my brain hit the panic button. I vividly imagined the hospital being bombed, alarms blaring, chaos everywhere. It sounds absurd now, but in the moment it felt so real. The fear for my safety and, the sheer absurdity of imagining a hospital under attack. It's like my mind was playing a wild movie. Even after it passed, the memory of that surreal danger stayed with me for a long time. So I chose that one to read because it highlights that the patient remembers what happened during that time and remembers how dangerous, it felt for him in that moment. So I just thought that was something that I would like to point out.

Louise: Yeah, I think from the lady that I encountered with the next morning, I remember she was saying, did we call the guards last night? Did we ring the guards?

Adiola: And I was just like, about what?

Louise: And she's just like, well, we got broken into last night and she was fully lucid at this time. And I was just like, I'm sorry. Everything's fine. We're okay now. This lady did also have dementia, so it was kind of a little bit confusing. But she was fully convinced, fully convinced that there was somebody after breaking in, there was rats coming from the ceiling. And the fact that she m remembered all of it was really distressing for her, like, even the day afterwards or the two days afterwards. And the thing was, for her, it was like her sleep was her main thing. She wasn't getting any sleep. And I personally remember there was a student nurse in there at the time. I was working catering, so I didn't really have much to do with her. But there was a student nurse in with her and gave her earplugs and gave her a face mask or an eye mask and things like that, and it just made her delirium a lot less. These are little interventions, I think, that can help sometimes. like the non pharmaceutical things.

Patients do remember delirious episodes vividly, even after recovery

Will: I think it's such a good point to bring up as well, that I think there's a misconception that people think these delirious episodes are almost like a void in the memory. And when you recover, they disappear. And it's not like that. Patients do remember these periods vividly. And even after they become lucid and they recover from their delirium, the actual memory, the vivid memory of it still haunts them, in effect.

Adiola: Think the thing with memories is that they also come with emotions and feelings, and it's just to really be aware that, yeah, last night your patient was absolutely frightened for their lives, and that fear is still with them because, along with confusion

as well, and all those other types, maybe anxiety, just to be aware that just the fact that they remember.

Tania: Yeah, no, perfect.

Any health professional can use the 480s to diagnose delirium

Okay, so, moving on, how do you diagnose delirium?

Louise: Yeah, so there's a thing called the four at. it's kind of the standardized delirium diagnosis. So I think anybody who is a health professional can diagnose somebody with delirium. They just have to be quite competent in their diagnosis. So they starts off with alertness. So it's just kind of gauging the patient's alertness and their level of consciousness. And then it goes on to the abbreviated mental test of, you have a better kind of understanding of, Wouldn't be very, well diversed with 480s. Unfortunately, as a student nurse.

Will: I know that we conduct abbreviated mental tests in quite a lot of context in medicine. I have not, from my personal experience, conducted one in the context of delirium. But it's a really good, it's a really quick way, really succinct way of assessing somebody's memory by asking them a couple of short questions, and then asking them to. Before you ask those questions, you ask them to remember a piece of information, and then you ask them to recall it slightly later on. And that's just a really good way of gauging someone's memory.

Tania: Okay. so we do have the alertness. then we have the abbreviated mental test

four, which is amt four. this assesses the memory by asking the patient to recall a name and address after a short interval, and it helps identify potential memory impairment. the next a is for attention and involves tasks like counting backwards or subtraction of seven from 100. and that, helps just evaluate a patient's ability to sustain their attention and their focus. And, the final a is acute change. And that is just, ah, the overall, immediate or acute change in their mental status and determining if there's been a recent alteration in cognitive function or anything like that. it's very quick to do. it takes around two or three, minutes. And it's practical. You can use it just in your routine wardround. And if you happen to notice anything and just want to double check them quickly. do you have anything, Hela?

Adiola: just think the 480 is easy enough to even be used by family members and non healthcare professionals. because as you said, the family is more than likely the first person who will notice the change. so it's not limited to just healthcare professionals, just as I know.

Tania: Okay. So yeah, it is pretty easy to use. You do get a score at the end, and that will tell you the likelihood that they have the delirium. yeah. Is there anything else anyone would like to add?

Louise: They also, I think they have different, kind of different versions of the four eightyes, I think, for the likes of ICU and stuff like that. So it makes this test, it's quite good for all different areas. I think they have it in maybe like post surgery or different post surgery recovery, critical care. So it's quite a universal, universal test.

Tania: Yeah. And who can actually diagnose this delirium in people?

Louise: I think any health professional can use this 480s. So it's like anyone can screen and then, any healthcare professional I think can diagnose. Now, correct me if I'm wrong, but I think that's right.

Tania: Okay.

The causes of delirium include infection, nutrition, hydration medication

is there any other way, you can kind of diagnose or look at delirium? Any other, there is a pinch me one that you were talking about earlier.

Louise: Oh, yeah. So pinch me is the causes, isn't it? Yeah. The causes of delirium. So P-I-N-C-H-M-E. So you have like pain. then infection. So infection, nutrition, constipation hydration medication and environment. So these are, like, the causes. So people can have delirium due to excessive pain or due to, serious infection, due to lack of nutrition, malnutrition, also due to constipation. Personally, I've seen constipation being a big issue with people with learning disabilities. And then later on, developing delirium. That's just from my own personal background. Then hydration medication and medication come under, like, the polypharmacy, I think, adiol, isn't it? And then the environment, as well. Sometimes a change in environment can bring on delirium as well.

Tania: Yeah. Ah, I have had an experience where, it was actually a family member, experienced delirium, and they actually lost their husband. And what had happened was they stopped taking care of themselves. They stopped eating properly, they stopped drinking properly. So, obviously, the loss of nutrition in that instance caused her

delirium. And it was very hard. At the time, I didn't really know very much about delirium, so I was getting confused, like, maybe she has dementia, because she was obviously, an older person. Ah, so you do start to think, oh, dementia. But no, it was. It was actually delirium because of what she was experiencing and the things that she was expressing, that she was seeing. So, yeah, that was.

Louise: Yeah. I think the first thing you think about, though, is when an older person gets confused, you're like, oh, my God, they have dementia. It's the first thing we all think about. I know I have a personal experience as well, where they were convinced this lady in my family had dementia. And it turns out, no, she needed good nutrition, like you were saying, good nutrition, hydration and sleep, and she was back to being lucid, these little things.

Will: But that really underlines the fact that one of the key points about delirium is that it's an acute change. And, that really underlines point. There can be background confusion, there can be background cognitive impairment going on. But when there's an acute change in that, or when there's an acute sort of degeneration in that, that would really trigger you to think about delirium.

Louise: Absolutely. Yeah.

How do you treat delirium? First line treatment is non pharmacological

Tania: Okay, so, moving on, the next question would be, how do you treat delirium? Who would like to go first?

Louise: So, treat delirium, then? I think kind of the non pharmaceutical kind of intervention is probably the best way to go. I know that puts poor adiola out of a job, but I think, things like what I've found is the sleep and nutrition, identifying the causes, obviously. So, like, if it's pain or infection. Treating them first. utis was major thing that we all see that infection just seems to drive people wild. Yes. So I think it's just like managing and identifying the underlying issues first, if you guys agree.

Will: Yeah, definitely. I mean, you can support somebody through delirium, you can provide supportive care, but at the end of the day, that's why it's so important to sort of identify the cause or that precipitating factor. Because reversing that and correcting that really is the definitive kind of management in treating it.

Louise: Yeah, absolutely. In a comfortable environment as well.

Adiola: Yeah.

Louise: I think I've seen on a delirium video or something before was that they brought in things from home into the hospital room and it really helped as well. So things like that, making the person feel comfortable and safe, I think is a really, big way to treat it as well.

Adiola: And just on that note, with home, I think it's really important to get the family involved as well, and just to keep them informed on what is delirium and the fact that it's reversible and that, as a healthcare professional, you're going to need their help in sort of getting the patient back to baseline.

Will: It's worth mentioning as well. You can provide that supportive care and you can

provide that comforting environment, but unfortunately, there will be a small cohort of patients who just don't respond to that. And in those situations, you can consider medically managing m. Delirium. And that would be in the form of m. Haloperidol. And the risks and benefits of that using that need to be, considered. But that is an option for those unresponsive patients.

Louise: Would you advise halperidol in just like a really severe situation, or would you start that off, would you start off with medicating the person?

Adiola: It's a really severe situation. As you said, first line treatment is non pharmacological most of the time. So it's just if there's a risk of them hurting themselves, and obviously if it's not contraindicated with their other medication, then it could be an option.

What can we do to comfort and support a patient with delirium

Tania: Okay. So on that note, we did touch on, family support, in the hospital ward. What could we do to comfort and support a patient?

Louise: comfort and support a patient, I think it's just kind of like being there, really, and just kind of like obviously making sure that they're safe.

Tania: Yeah. Reassuring them, reassuring them where they are, I guess.

Louise: And then there are things like there's support groups and things like that for family members as well, which can be very useful. And then just reminding that it is

such a massive toll on the family, and the person as well, to just try and reach out and self care and things like that, I think is very important.

Adiola: Yeah.

Tania: Leaflets and things as well.

Adiola: could I, add just about the patient? I think it's also really important to listen because although for hyperactive delirium, it could present in different ways in terms of what they're actually saying. And if you're going to reassure a patient, you need to kind of understand where they're coming from. For example, you mentioned rats crawling on the ceiling. You can't just say it's going to be okay because that's not what they said. Said there's rats calling on the ceiling. So it's just really important to listen as well.

Tania: Yeah. Okay, thank you.

How do you prevent delirium then? How are we going to prevent it

So how do you prevent delirium then? How are we going to prevent it?

Louise: I think preventing it is just kind of obviously, awareness and education would be, a huge thing, especially being we're all students, and now we are a lot more aware of it, so we're spotting it out. I think you were saying earlier that now that we're on placement and things, that we're actually really seeing these. We're seeing these patients, but a lot more. So that kind of proves that education works, I think.

Adiola: Definitely, yeah.

Will: It can be really difficult to prevent delirium because, as we were discussing before, one of the major precipitating factors is an unfamiliar environment or an unfamiliar routine. And it's extremely difficult, in hospitals and in the health service to provide a sort of homely environment, a homely routine. It's just an inevitable consequence of being in a hospital that patients are going to be in an environment that they don't feel comfortable in. They're going to have routines that they don't feel comfortable in. But, I was reading, a couple of weeks ago about certain new hospitals which are being built, and they were actually designed to prevent delirium on wards, such as things like big open windows, so that they allow a day and night cycle to allow the light to come in. Now, I'm not suggesting that people should rebuild hospitals to prevent delirium, but even if you consider, what is that actually getting at? What is the big windows getting out? It's getting at allowing natural lighting. So even simple things such as opening curtains, allowing natural light in, that's something that you can apply into all hospital settings. Really?

Tania: Yeah. okay, so what about the nursing sort of rule? So, like, making sure they're getting nutrition, making sure they're getting enough oxygen.

Louise: I think just staying on track, like staying on the person, making sure that, yes, they are drinking the fort sip and they're not hiding it under the bed, which is a common thing, and just kind of staying on top of it. It takes a lot of observation to make sure that people, sometimes elderly people, unfortunately, is a lot more common in elderly people, and that they are getting everything that they need. Also, like addressing in the infections and stuff like that needs to happen as well. And I think just kind of a real proactive kind of approach on health in general is the way maybe to treat delirium. I

know you're saying about, different hospitals and things like that, you have infection prevention control and things like that that need to come into play. There's so many other factors for making hospitals more homely and environment and things, but I think just addressing the cognitive kind of impairment and clear clocks and all those visible signs, and try to make it as easy for them as you can, really.

Will: And it's about sort of, as you said, identifying quite early on in the patient's journey when you think that there could be episodes of delirium coming. Having quite a low threshold for that, because I know from my personal experience, anyway, on geriatric wards, there is quite a lot of signposting around the wards reminding staff to think about delirium. They are quite on the ball on them wards. But it's not just, even though they are the most common population, it is not just something that is restricted to older people. Delirium is seen in younger patients, postoperative patients, critical care patients, and staff on those wards may not be as tuned into identifying those factors. so as you were saying about education, about sort of identifying those things early on, being aware can really help.

Tania: Perfect. Does anyone else want to add anything?

How do you solve problems like delirium? Well, that's the real question

Okay, so moving on then. How do you solve a problem like delirium?

Louise: Well, that's the real question that we're all here for. I think it's kind of like a, ah, team effort. the collaboration between all healthcare professionals, the doctors, the

nurses, the pharmacists, the ots, the physiotherapists. I think it's kind of everybody has to come together and just figure out a plan and really get a comprehensive understanding of the patient's condition and kind of work from there. I think a really thorough assessment of the patient and identifying, maybe even before they have a delirium, are they going to be at risk of delirium? Is that maybe something that could be introduced into, I don't know, a news sheet or newscore or something? Are they going to be at a certain risk? Yeah, I think it's kind of. There's so many ways about it, really.

Will: And it's about respecting different people's roles and the different interactions that, people like, different healthcare professions have with patients. Obviously, pharmacy is very much in tune with the medication side of things in the polypharmacy and the relationship between doctors and nurses, in terms of doctors really taking seriously nursing staff's concerns when it comes to potential delirious, patients, because they are the ones, at the end of the day, who spend the most time with the patients. And then those interactions, then with doctors, looking at medical histories, medical records, it's.

Will: Really important to respect everyone's role and respect the individual expertise that everyone brings, and that is really, what can lead to the better outcomes for those patients.

Louise: Communication, then, real absolute key, I think, at the moment where there's a pilot or whatever going on about the encompass, that's going to be huge for us for communicating with different members of the team, because on a ward, we mightn't see each other. We mightn't see each other very often. So it's very important that our communication, I think, is just really on the ball if we have any sort of, if we suspect anything at all, really.

Tania: Yeah. No. I just want to add that empathy and understanding, obviously, is a big thing, because we have spoken about delirium and how it is like a distorted reality, causing hallucinations and confusion. So, obviously, Ariola, you did mention approaching the situation with empathy, remembering that the patient is actually experiencing what they are experiencing in that moment in time. And we need to empathize with that. Even though we can't see it, we still need to empathize with that and, understand, try to understand what they're going through.

Will: It's really important as well to note the individuality of each case of delirium. I mean, every person is different with every medical problem, but that couldn't be more true than for delirium. So when it comes to solving someone's delirium, resolving it, it's really important to look at what are those specific factors unique to that patient, and that really guides your treatment and, your management of it. So it's really important to take that sort of individualized, patient centered approach when you're looking at it.

Tania: Yeah.

Adiola: Think also education and support. I think we've mentioned education a lot throughout this podcast, but just for caregivers, whether that be family or professional, it's really important to point them in the right direction in terms of resources and support groups because, yeah, it's going to be a difficult time for the patient, but it's also going to be a difficult time for anyone who has to take care of them in the future. and also just for them to know that once again, it's acute. And, once they become lucid again, they will remember everything. So it can't just be like, oh, yeah, that happened, if that makes any sense.

Tania: Yeah.

Louise: Things like preventative measures here as well. from my placements, I've seen a lot of say, like liaison nurses and district nurses, and they're keeping the general, elderly and people out of hospitals, which is also probably quite good because they're not really interfering with their environment and things like that. So maybe utilizing those kind of services like district nurses, and I know I was a fracture liaison nurse before as well. and just kind of maybe keeping people out of hospitals as much as you can. Obviously, I know if you have a severe infection, you're going to hospital, but if it can be treated at home, I don't see why not. Kind of maybe prevent it a little bit.

Tania: Yeah. Okay, so just to wrap it up then, that was our podcast for delirium from everybody today, and thank you for joining us.

Louise: Bye.