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Recommended Additions to the New APA Guideline for Prevention and Treatment of Delirium

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ABSTRACT

The updated APA guideline for prevention and treatment of delirium is consistent with previous research but does not specify assessment prior to hospital discharge as a standardized protocol. The frequency of delirium in hospitalized older adults and the risks associated with discharging patients with unassessed delirium indicate the necessity for a standardized pre-hospital discharge delirium assessment protocol, especially with older adults. Recommendations are made for standardized implementation of the updated guideline, including the use of specific instruments for quickly assessing delirium prior to hospital discharge.

Keywords: APA guideline; delirium; hospital discharge; assessment; older adults

Introduction

For more than four decades, delirium (defined as an acute confusional state) and has been observed in over in approximately 25% of hospitalized older adults and up to three quarters of ventilated ICU patients, especially following acute trauma, cardiac surgery, TIA, stroke, and the use of anesthesia.[1,2] These figures are likely underestimates because delirium is frequently unrecognized and underdiagnosed.[3] Undiagnosed delirium significantly increases risk for poor outcome and post-discharge complications including injury and death.[4] These risks can be mitigated by utilizing brief cognitive screening instruments prior to hospital discharge.[1]

The American Psychiatric Association (APA) is to be commended for releasing the updated guideline for preventing and treating delirium.[3] However, the APA updated guideline does not specify pre-hospital discharge assessment of delirium as a standardized protocol.

Methods

A review of the literature regarding the incidence of delirium, its association with trauma and hospitalization, and prevalence among older adults was conducted. The findings from that literature review were used to evaluate the adequacy of the updated APA guideline for prevention and treatment of delirium for reducing risks of poor medical outcomes and post-discharge complications in hospitalized older adults. The findings were then used to generate specific recommendations to reduce risks of poor medical outcomes and post-discharge complications in hospitalized older adults.

Delirium

Delirium is defined as an acute confusional state characterized by abrupt declines in attention, awareness, and mental function with rapid onset, typically within hours lasting several days.[2] Delirium has various precipitants that alone or in combination can include the use of anticholinergic or opioid medications, advanced age, sleep disruption, psychiatric conditions including cognitive impairment and/or prior episodes of delirium, medical conditions including metabolic disturbances, pneumonia and/or urinary tract infection, vitamin deficiencies and sensory impairments, acute trauma, cardiac surgery, TIA, stroke, and the use of anesthesia.[1,3]

Delirium has been associated with medical, cognitive and psychiatric complications prolonging hospital stays and creating significant financial and psychosocial burdens on patients and their families including increased risks of poor medical outcomes and post-discharge complications including injury and death.[3,4] Utilizing brief cognitive screening instruments prior to hospital discharge can identify delirium so that it can be treated, significantly reducing these risks.[5]

Brief Cognitive Screening Instruments for Delirium

The efficacy of numerous cognitive screening instruments has been evaluated for screening older adults for delirium.[2] Alphabetically, among these instruments are the 3-Minute Diagnostic Confusion Assessment Method (3D-CAM), 4AT Rapid Clinical Test for Delirium (4AT), Bedside Confusion Scale (BCS), Brief Confusion Assessment Method (bCAM), Chart-Based Delirium Identification Instrument (CHART-DEL), Clinical Assessment of Confusion – A (CAC-A), Clinical Assessment of Confusion – B (CAC-B), Confusion Assessment Method (CAM), Confusion Assessment Method for the ICU (CAM-ICU), Confusion Assessment Method for the Emergency Department (CAM-ED), Confusion Assessment Method – Severity (CAM-S), Communication Capacity Scale & Agitation-Distress Scale (CCS/ADS), Cognitive Test for Delirium (CTD) Confusion Rating Scale (CRS), Confusional State Examination (CSE), Delirium Diagnostic Tool – provisional (DDT-Pro), Delirium Index (DI), Delirium-O-Meter (DOM), Delirium Observation Screening Scale (DOSS), Delirium Rating Scale Revised-98 (DRS-R-98), Delirium Symptom Interview (DSI), Delirium Severity Scale (DSS), Family Confusion Assessment Method (FAM-CAM), Informant

Assessment of Geriatric Delirium (I-AGeD), Intensive Care Delirium Screening Checklist (ICDSC), Inter Resident Assessment Acute Care (InterRAI AC) Memorial Delirium Assessment Scale (MDAS), modified Confusion Assessment Method for the Emergency Department (mCAM-ED), Neelon-Champagne Confusion Scale (NEECHAM), Nursing Delirium Screening Scale (NuDESC), Nursing Home Confusion Assessment Method (NH-CAM), Recognizing Acute Delirium as part of Routine (RADAR), Recoverable Cognitive Dysfunction Scale (RCDS), Visual Analog Scale for Acute Confusion (VAS-AC).[6] Among and in addition to the screening instruments suggested in the updated APA guideline document,[3] there are also brief delirium screening tools frequently used as part of a two-step or "rule out" screening process that include the Delirium Triage Screen (DTS), Single Question in Delirium (SQiD), Simple Question for Easy Evaluation of Consciousness (SQeeC), Ultra-Brief 2-Item Screener (UB-2) and the Ultra-Brief Confusion Assessment Method (UB-CAM).[6]

The Updated APA Guideline for Prevention and Treatment of Delirium

The executive summary of the updated APA guideline for preventing and treating delirium states that although up to 40% of delirium cases are preventable through multicomponent nonpharmacologic interventions, those interventions are not implemented consistently across institutions.[3] The authors also point to a growing body of evidence indicating that antipsychotics are not effective for reversing delirium.[3] To provide clinicians with a practical framework for improving patient outcomes, the authors make 12 evidence-based level-1 statements (recommendations) and 3 level-2 statements (suggestions) that can be applied across clinical settings including assessment, nonpharmacologic and pharmacologic interventions, and transitions of care.[3] Although the long-awaited APA updated guideline for assessing, preventing and treating delirium is consistent with previous literature recommending screening for delirium for hospitalized older adults,[1,2,5] the guideline does not specify pre-discharge assessment as a standard protocol.

Recommended Additions to the New APA Guideline for Prevention and Treatment of Delirium

The updated APA guideline preventing and treating delirium makes specific recommendations for consistent employment of multicomponent nonpharmacologic interventions including assessment, nonpharmacologic and pharmacologic interventions, and transitions of care across various clinical settings including hospitals to improve patient outcomes.[3] However, the APA updated guideline does not specify pre-hospital discharge assessment of delirium as a standardized protocol. Because older adults are an at-risk group for delirium following trauma and hospitalization,[10,11] it is specifically suggested that pre-hospital discharge assessment for delirium is adopted as a standard protocol, especially with the older adult population which is most at risk for delirium.[1,2]

Proactive patient initiative and health care advocacy are important components of readily retrieved health information now mandated in the United States.[7] In hospital settings, proactive communication and patient advocacy have demonstrated efficacy for improving healthcare outcomes and patient satisfaction.[8] However, older adults often do not fully participate in patient involvement in shared medical decision making, possibly as a consequence of the combination of their physical and cognitive vulnerability and their socialization during eras characterized by paternalistic approaches to patient care.[9] Accordingly, it is also suggested that a patient advocate is present during the hospital discharge process to ensure that information provided to the patient will be received by another person who can assist in patient consent decisions if necessary, especially when the patient exhibits signs of delirium.[2]

Finally, it is suggested that the APA guideline add to its list of brief delirium screening tools those already in use as part of a two-step or "rule out"

screening process, including the Delirium Triage Screen (DTS), Single Question in Delirium (SQiD), Simple Question for Easy Evaluation of Consciousness (SQeeC), Ultra-Brief 2-Item Screener (UB-2) and the Ultra-Brief Confusion Assessment Method (UB-CAM) [2,6]. Clinical implementation of the updated 15 guideline statements is encouraged, with the goals of improved treatment outcomes, and reduced risk of poor outcome including injury, death, and the consequent emotional and financial burdens on families and healthcare systems.

Author Contribution:

The authors warrant that they have reviewed and approved the manuscript prior to its submission, and assume responsibility for the contents of the manuscript.

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The authors declare no conflicts of interest in the manuscript, including financial, consultant, institutional, and other relationships that might lead to bias or a conflict of interest. The authors also declare no sources of funding for the manuscript.

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