



## **Annals of Delirium November 2011 Editorial**

The topic of delirium always generates emotion. Faced with the facts about delirium clinicians rarely sit on the fence saying, “yes that is probably quite important, I’ll try to remember to look for it”. For instance in the intensive care arena, clinicians are strictly divided between believers– ICU delirium is a significant issue – and sceptics who maintain that the percentage incidence of ICU delirium may be less than 10%(actually its at least 65% in ventilated patients) and anyway is not important. Outside of critical care delirium experts are divided between those who will use antipsychotics early and those who use antipsychotics with extreme reluctance. Happily those clinicians who appreciate the devastating effects of delirium in the short and longer term are compassionate intelligent individuals who rarely resort to shouting. Instead we work on answers to support our opinions, on occasion having to revise them when the truth is discovered.

The theme of this 6<sup>th</sup> edition of Annals is opinions. Those of us who understand delirium all have opinions usually contrasting rather than conflicting. Importantly we first have a patients view, move to an ICU nurse campaigning for a paradigm shift in attitude, on to reflections on the educational aspect and then a hat trick of approaches based on opinions from Germany. Opinions to actions leading to change that could make a difference throughout Europe and beyond to your patients, to my patients. What is your opinion?

In addition there is news, a commentary on recent publications and information on how to join the European Delirium Association, strength in numbers. Finally this edition has been timed to coincide with the 6<sup>th</sup> Annual Congress of the EDA in Umeå . We will be nearer to the Arctic Circle than Stockholm. What progress can we make working together?

Send your contributions to the next Annals to [Valerie.page@whht.nhs.uk](mailto:Valerie.page@whht.nhs.uk)

## **Message from your Treasurer**

Dear EDA members,

As our society continues to develop it is important we place it on a sound financial footing. The EDA Board have formed a view that a modest annual subscription would be reasonable to formalise society membership.

The main benefits to society membership will be receipt of the Annals of Delirium (our newsletter), access to the member’s only section of the EDA website, and a reduction in the annual EDA conference registration fee equivalent to the membership subscription.

The annual fee has been set at a very modest 30 Euros. This fee will be used to support development of the website, the costs of online Board meetings (around 200 Euros, twice per year), to underwrite our annual meeting, and for other costs. All accounts will be published annually.

Payment may be by a standing order (form available by email), or by a cheque sent to me at my contact address listed at the end of this edition.

John Young  
Treasurer EDA  
Professor of Elderly Care Medicine

## **Patient experience of ICU by Catherine White**

In 2003 I was 12 weeks pregnant when I had a severe sore throat diagnosed as a strep throat.

Five days later I felt better, but then one night was suddenly very sick, had an upset stomach and a high temperature. In the morning I began to miscarry and went to hospital for a scan, then required a D and C procedure. We were so distressed at the miscarriage, but we and the hospital didn't think it was anything other than a normal miscarriage, and had no concerns for my health.

After the procedure I began to show signs of a serious illness and was taken to intensive care. I have some memories from the next 24 hours, having a very tight oxygen mask fitted, but don't really recall the conversations I had with family. I have flashes of memories, some true and some possibly not.

For the next 24 hours I was under heavy sedation and remember nothing.

### **Light sedation:**

The next three days after that was a living hell. I didn't know where I was or what was happening to me. I thought at first I was at home in bed, having a bad nightmare. But I was aware of time passing, though I slipped in and out of consciousness, and I began to think it was too long for one night and that my husband would have woken me up by now. I would spend hours trying to open both eyes-thinking if I could do that, I could get out of where I was - I would manage one and then slip away again and then try again. Though all my close family visited, I only recall my husband being there and hearing him talk to me sometimes. I knew I had to put him together with a wheelchair, be able to open my eyes and then I could escape.

I didn't know I was ill and I didn't know I was in hospital. It was the closest

I could imagine to torture. I couldn't speak, I couldn't get out of bed and I was so thirsty, I thought I hadn't had a drink for days and days. Occasionally my mouth was wet with a sponge and I would put my head to the side just waiting for some more, but I didn't know when I would get some and I couldn't ask. But the worse thing was the tubes down my throat, which would come without warning (I was told I am sure, but wasn't aware of it) and I would retch and gag and gag and then it would stop for awhile, then happen again. One time I was laid on flat on my side (now I know it was to have my sheets changed) and I felt I couldn't breathe and I fought and fought - I thought I was being suffocated. Once it was over I would lapse into unconsciousness until the next time someone came near and did something. Some time later I needed to have my sheets changed again and I still remember the utter despair that it was happening again.

Once I remember the nurse coming in as I opened my eyes and introducing herself as Jane. I punched her. I didn't know where I was and I thought I had to physically fight to survive. Other times I just lay there and heard snatches of conversations, and tried to make sense of what was happening. Once I heard a choir singing on television and thinking that perhaps I had died and that there were angels singing in heaven.

My family and nursing staff had no idea what I was experiencing at this time. Most of the time I appeared unaware of my surroundings and I don't think anyone would have believed what I was going through. It is so important that staff and family talk to patients and tell them they are in hospital repeatedly and what is happening, even if they don't seem conscious, just in case it makes a difference.

Within a few days, I was diagnosed with Group A Streptococcus, which caused multi organ failure. I had a tracheostomy fitted. Four days in, I came out of the light sedation and began to have more awareness. I could write notes to communicate. I remember asking if I was intensive care, because I still didn't know. I remember missing my 3 year old son more

than I could bear and I kept asking about my baby and had to be told that I had miscarried, but then would forget and ask again.

### **ICU after light sedation**

I was in intensive care for another 11 days after the light sedation. Although I seemed a bit more aware of what was happening, I was very confused. I remember the nights seeming endless as I tried to sleep, but couldn't. When I did sleep, I had vivid, horrifying dreams which put together sounds that were around me. For example, once I think the nurses were ripping paper at the desk and a patient in the ward was crying. I thought a woman in the car park was destroying letters from her boyfriend by burning them and the building would burn down and I was stuck in it, but I couldn't tell anyone.

Even when I was 'awake' I had such clear hallucinations that even when the nurses told me they weren't true, I didn't believe them. I was used to trusting my own judgment and they were true to me. It was the closest I can imagine to mental illness. Even once I was home, it took some time to work out what did happen and what was a hallucination.

Everything that was so easy before suddenly was such a struggle. I would clean my face and teeth and then be exhausted. Even breathing felt difficult and frightening as I was slowly weaned off the ventilator and had to practice with a mask instead of the tubes. Eating, sitting and standing had to be relearned. And even latterly, when I was laid flat for my sheet change, I felt I couldn't breathe.

### **After ICU**

I was transferred to a general ward for two days and then discharged home. I didn't understand how ill I had been or what had happened. I couldn't walk because I was too weak and I had lost a lot of weight. I was devastated by the loss of the pregnancy, and traumatised by my illness and

treatment. I couldn't understand how I could be healthy, and then nearly die, and nobody around me could understand what I had suffered in intensive care. It felt like those World War One soldiers who came home from the trenches and no one knew what they had experienced, but they had to try and fit into normal life again.

I had excellent care while I was in intensive care, and they saved my life. The nurses showed me such kindness and it made all the difference at a time of such horror. But even so, it was an immensely harrowing experience. I came out with no medical or psychological follow up, no information to tell me what would help my recovery. It took me a year to get my physical strength back, much longer to recover mentally. There were times when I thought I would never be ok again. It affected my family too – my husband had a breakdown six months after my illness as a result of what he went through when I was ill.

I feel passionately that patients should get information after ICU, at the very least, to tell them about recovery and what would help them. I worked with Peter Gibb and Icesteps to produce an information leaflet, and hospitals have requested 65000 copies to date.

### **September 2011**

## AN OPINION ON THE DELIRIUM MINDSET!

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With the increased recognition of delirium in the Critical Care setting, its assessment, treatment and ultimately its prevention, this is an excellent time to highlight the value of good critical care nursing skills and their central role in the management of the patient with hyperactive delirium. Great expertise is required to manage the very sick patient with multiple inotropes, mechanical support and variable level of stability. Identification of problems that require immediate and appropriate intervention or referral to medical staff is an essential part of critical care nursing. A nurse who can look after critical care patients safely whilst maintaining high standards of basic nursing care and supporting the family is valued highly by colleagues and the wider team.

The nurse who can look after the patient with hyperactive delirium (agitated, inadequate compliance with essential oxygen therapy, trying to pull out their intravenous access which delivers essential medications etc), is utilizing a range of adaptable skills altering moment by moment to adjust to a changing situation. Essential nursing skills will lead to keeping the patient adequately oxygenated and sufficiently perfused to maintain organ function, preventing the situation from deteriorating and needing sedation and intubation, keeping patient and staff safe, supporting the family and employing other techniques or treatments likely to resolve the delirium and agitation ..... One may suggest these are the 'real' critical care nurses as they rely almost wholly on clinical judgement and assessment skills rather than technology.

Too often, these skills may be inadequately valued in such a technical environment. The whole team needs to review its mindset and acknowledge the skills of these staff. Instead of being the nurse in the 'lonely' bedspace or barrier nursed room with the patient that everyone

tried to avoid being allocated, they can then be regarded as the role model who their colleagues should support and emulate.

As the team on the Critical Care Unit at Papworth are working together to improve delirium assessment and treatment, we are starting to see staff taking pride in being able to manage a patient with hyperactive delirium without resorting to sedation unless there is no other option to maintain safety for patient or staff. This skill is being valued by the wider team. This makes these skills ones that nurses wish to develop.

The mindset required is different to that required to deal with a fully sedated 'sick' critical care patient. It is essential that senior staff support this by 'giving permission' for this alternative approach. For example, sometimes the best thing the nurse can do is to sit with the agitated patient and watch the patient's favourite TV programme with them or look at the patient's photos with them or read their 'Get Well Soon' cards with them. Doing such tasks are not indicating that the nurse is 'taking it easy'. It requires skill as the agitated patient is unlikely to behave consistently and the nurse must be ready to adapt their approach at any time. This strategy contributes to the patient's progress and may prevent respiratory deterioration leading to intubation, therefore the nurse's contribution in meeting the patient's needs is as important as that of the nurse looking after the patient on a ventilator in the next bedspace.

Further, the nurse requires excellent judgement skills regarding care or interventions. Some may be flexible in timing, so can be delayed until a suitable opportunity for the patient to comply and some could be omitted at present or referred to the medical staff for review. Whilst the medical team and allied health professionals are supporting the patient through this episode, it is the nurse who is in the bedspace, confronted (sometimes literally!) by the patient and who may have to make a snap judgement to

prevent the situation deteriorating. Much of this can be identified as good nursing care.

In the high tech, fast-moving world of critical care it is easy to overlook the knowledge and skills which are needed to look after the hyperactive delirious patient. When the team acknowledges and supports the staff demonstrating these skills, the unit culture can begin to embrace the delirium mindset.

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### **Organisational learning: A Senior Managers perspective**

*Delirium education is challenging and far from straightforward. For the learner the messy ward environment may prevent implementation of good delirium care and lead to a sense of disempowerment. For the educator an awareness that, even with a greater “bank” of knowledge about Delirium, staff attitudes towards the delirious patient may block positive behaviour change.*

*A suggested approach to overcome the notorious know-doing gap is to adopt a broader and more strategic approach to education. Accordingly, education should be aligned at an individual and organisational level.*

*But what do we mean by organisational learning and how can we engage those in management positions to learn about delirium? This article presents the opinion of an Executive Director working within an organisation that has successfully positioned delirium on the board agenda. Ms Annie Laverty is Director of Patient Experience at Northumbria Healthcare NHS Foundation Trust, UK and describes some of the positive initiatives she has taken forward as well as offering clinicians advice with regards to engaging at an organisational level.*

### **The Senior Manager’s perspective**

Ms Annie Laverty, Director of Patient Experience, Northumbria Healthcare Trust, UK.

I was appointed as Director of Patient Experience in December 2009 – a new senior leadership role for Northumbria. Ensuring a positive patient experience is a strategic, commissioning and financial imperative for our Trust and we have identified good delirium care as being central to improve the experience for both patients and carers alike.

At a corporate level, I contribute to the effective leadership and management of the organisation as an attending member of the Trust Board. Together with other members of the Executive Management Team, I share a key responsibility for the quality of service and care provided to patients, the strategic direction of the Trust and delivery of performance and financial targets. With influence, time and resources members of the Executive Team can often effectively remove barriers that get in the way of improvement.

At a ward level, my role enables me to work closely with multidisciplinary teams to redefine relationships, highlight gaps and strengths in our care, learn from each other and discover creative solutions to the challenges we face. On a weekly basis, I experience the reality of a complex, fast paced hospital environment. I witness the conflict of competing priorities and pressures that staff are under and remind myself of the value and importance of the real, human and messy business of caring for people, such as those with delirium, who are particularly vulnerable

Recent work to promote a more person centred pathway for people with delirium has taught me a lot. It has improved my own awareness and understanding of the importance of early and accurate diagnosis. It has also forced me to take a much closer look at the services we offer and how

effectively these are tailored around the needs of frail, older people who are cognitively impaired or at risk of delirium.

Every month we interview over 300 patients about their care. The results of these conversations are fed back to clinical teams within 24 to 48 hours. Through this work, I have learnt about the limitations of our hospital environments – the isolation of single rooms post infection, inadequate signage designed to confuse, the physical hazards on our wards that compromise safety and increasing shortage of communal areas such as dining rooms or lounges to support socialisation.

I have learnt about the importance of ownership – caring for older people and ensuring equal access to prompt and appropriate management is our core business and yet this is not always recognised by hospital managers and clinical staff.

At a corporate level, I am aware of the focus and importance given to reducing length of stay and pulling people through the system. With greater scrutiny of our experience data I am equally aware that it will be older patients, with multiple long term problems who are most likely to be moved between wards potentially negatively impacting on their care.

I have been reminded about the importance of developing our staff to ensure they are equipped to provide the type of care they would want for themselves and their families. If improving the patient experience lies at the heart of high quality care, it is essential that we give equal and sustained attention to improving the staff experience too. Our clinical teams will have unique and valuable insight of their own as to how current workloads, task-focused priorities and team dynamics interact with their ability to communicate effectively with patients and families.

Working with the Director of Nursing, we have successfully piloted an innovative training and education programme, promoting best practice for people with cognitive impairment in the hospital. The success of the

programme rests on the fact that it is evidence based and underpinned by research conducted within the Trust on the learning needs of hospital staff in relation to delirium care. Ongoing funding for this programme will need to be supported, together with the urgent call for mandatory induction and training for all staff in the provision of dignified care and the needs of older people.

A recent event focusing on Dementia and Delirium in the acute hospital setting provided a very useful forum for staff from all disciplines and all parts of the hospital and community to reflect on the care we currently provide. Patients, carers and families were also given the opportunity to recount their experience of their illness and healthcare. Learning from patients and carers is key.

One of the stories we listened to on the day involved a fascinating account of delirium given by a sixty seven year old gentleman. He was able to provide a very vivid description of the terror he felt at the time of his admission and his desire to escape from a clinical team he believed were intent on causing him harm.

With his agreement we made a video of his experience. At the end of the film he describes the long term consequences of his delirium and shares his fear that this may return. His emotional response has stayed with me – an important reminder of just how frightened people can feel in hospital and that the work we have to do to improve experience for all our patients is not a cosmetic effort.

It's not about customer service. Patients with delirium are sick, scared, out of their element, and vulnerable. Staff need to be trained in how to manage patients with complex illnesses like delirium. We have a responsibility as senior managers to learn about the conditions our patients have and ultimately make the environment easier for our staff to do the right thing. However this learning will only proceed if clinicians can

successfully engage at board level and inform management colleagues of the current drivers for good delirium care.

It is a difficult challenge. However if successful a closer relationship will potentially create a healing environment and go a long way to providing the truly exceptional experience for patients with delirium.

### **Commentary:**

Dr Andrew Teodorczuk,  
Consultant Liaison Psychiatrist and Honorary Senior Lecturer,  
Northumbria Healthcare Trust, European Delirium Association Board member

As a Consultant Psychiatrist working at Northumbria I have been fortunate enough to have witnessed a paradigm shift towards the management of patients with delirium. Two years ago I supervised the production of a carer information sheet on delirium and was informed that the leaflet needed to be significantly revised as it would falsely raise carers' expectations. All that we described within the leaflet was good delirium care in line with the NICE guidelines. As I write I am delighted that we are now in the process of disseminating the original leaflet and throughout the Trust. Clinicians are recognizing and treating delirium in a more proactive fashion. No longer is delirium invisible.

What has led to this sea change? In part, I suspect it is the fact that the Trust have learnt as an organization about delirium. Through active engagement with Senior Executives, changes have been implemented which have filtered down to ward staff and improved delirium care. Now, through events such as the Dementia and Delirium day, the rewards are being celebrated and good practice showcased.

How did we chart our way through the organizational jungle and bring about systems learning?

Reflecting on the opinion piece offered by Annie Lavery various themes emerge. Firstly there is the recognition by the Trust Board that good delirium care is at the heart of good patient experience. Secondly, the close relationship between staff and patient experience is acknowledged and as such the need to develop staff and remove blocks within the system addressed. Thirdly, the importance of having an organization that is willing to learn as a driver for good practice emerges.

Creating an expansive climate with a willingness to learn is crucial. The Senior Manager's perspective suggests that a combination of both real time data and stories is required to bring about this learning. On the one hand data can help measure progress however on the other hand the power of patient stories is needed to win hearts as well as minds. I suspect that videos which were played in the Board Room have been crucial in addressing this learning.

Lastly, the opinion piece suggests that there exists considerable overlap between the learning needs of staff and organisations. For example, a lack of ownership or failure to recognise delirium at an individual level is mirrored at an organisational level (and policy makers). This point highlights the important need to strategically target education processes at ward and board levels. Ultimately, Ms Annie Lavery's fascinating perspective reminds me that Senior Managers have the power to bring about changes however we as clinicians have a duty to help them decide where within the "swampy lowlands" of clinical practice to direct them.

## Elderly patients with psycho-organic syndromes in the hospital - different models of care in Germany

### Context

Elderly patients with psycho-organic syndromes as primary diagnoses or co-morbidity are challenging regarding placement in an optimal hospital department or subspecialty. In Germany, departments specialized on geriatric psychiatry often are located in more rural areas and are less frequently available in big inner-city hospitals. The interdisciplinary approach to the elderly patient with delirium is often difficult in stand alone psychiatric hospitals. At the biannual meeting of the Deutsche Gesellschaft für Gerontopsychiatrie und –psychotherapie DGGPP (German Association of Geriatric Psychiatry and Psychotherapy <http://www.dggpp.de>) in Berlin in May 2011, a symposium highlighted different approaches to collaborate care for elderly patients with acute disease and concomitant psychiatric symptoms.

### Transfers to and from psychiatric hospital

Prof. Tilman Wetterling (Vivantes Klinikum, Berlin-Hellersdorf) reviewed the transfers of elderly patients between his psychiatric hospital and various hospital departments in the vicinity. He reports 233 (18.5 %) transfers of patients, aged 65 and older, within the last 3 years. The most frequent reason for a transfer *to geriatric psychiatry* was delirium (45 %), while depression accounted for 11.6 % of patients diagnoses. In contrast, 285 (21.8 %) of patients had to be transferred *from geriatric psychiatry*, mainly to geriatric and medical wards (12.4%). Those transfers were usually for cardiac disease requiring treatment. Multiple transfers were necessary in 10% of cases, indicating a salient need for a continuous interdisciplinary care. These numbers are in line with recently reported data from other parts of Germany (Hewer & Stark, 2010). Patients' transfers are frequent in geriatric psychiatry. They once more indicate that the clientele of general hospitals, geriatric departments and psychogeriatric units are overlapping. In the light of the expected demographic changes

that will result in a fastly growing proportion of oldest-old with a high prevalence of psychogeriatric disorders, these results emphasise the need of cooperation between general hospitals, geriatric psychiatry departments and specialized outpatient treatment.

Another option to take care of patients with somatic disease is the involvement of a psychiatric consultation service, where psychiatry specialists provide advice for other specialties of the general hospital. As psychiatry consultations do not involve complicated technology, they are often not well reimbursed within the hospital. On the other hand a special training program and certificate for psychiatrists in consultation-services has been available since 2009 by the Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde (German Society for Psychiatry and Psychotherapy (<http://www.dgppn.de/english-version/aboutus.html>)) which emphasizes the significance of psychiatric diagnosis and treatment in general hospitals. Psychiatric comorbidity has been shown to be devastating in coronary syndromes, strokes and many more diseases. Geropsychiatric problems have a significant share in these consultations. It is not clear however, whether this type of service is adequate in delirium detection and care. Delirium patients suffer from acute morbidity and mortality, experience the loss of activities of daily living and face nursing home placement more often. Delirium detection and treatment therefore is beneficial for patients and health care systems alike.

### Psychiatric consultative service

Dr. Christine Thomas and Dr. Stefan H. Kreisel reported on their psychiatric consultation service reflecting the psychiatric care as it really is in all 3 hospitals (2400 beds) serving the 320.000 city population of Bielefeld, North-Rhine-Westfalia. Within a 2 year period (2008-2009),

2117 individual consultations were completed, which reflected a 4-fold increase since 2004 (248 consultations). 55 % of cases were older than 60 years, 18 % referred to the oldest-old, 80+ patients, who represent 5% of the German population (60+ are 25%). Psycho-organic syndromes (ICD-10: F0) thus were the main psychiatric diagnoses (60%), depression was diagnosed in 25%, 10% had adjustment disorders and only 5% of cases were without psychiatric disease. Delirium was detected in 364 cases, 30% were considered multifactorial and 25% had one specific cause like post surgical delirium (F05.8). 15% were classified as F05.1 –delirium with dementia.

In elderly patients, delirium is the most often diagnosed psychiatric disease in the general hospital. However, when compared to the requests of psychiatric consultations, most orders came from medical wards, while surgical departments accounted for only 17%; and 9% of cases originated from neurology. In comparison to the prevalence figures of delirium (Young & Inouye, 2007) this distribution is shifted towards medical specialties. Delirium is more common in surgical patients (Inouye, 2006), however, psychiatric consultation is less often requested. Acute psycho-organic symptoms are still misinterpreted as dementia or regarded as an inevitable, but transient consequence of anaesthesia and surgery. It has been suggested that up to 60% of delirium cases are missed by clinicians. Thus special training is necessary for clinicians and nurses for the detection of delirium. A psychiatric consultation service can only recommend treatment and assist in the detection of delirium causes when the psycho-organic syndrome is recognized as such. However, to improve quality of medical care, delirium prevention is the main task.

Delirium prevention is a multifaceted operation which involves the detection of patients at risk, activation and mobilisation of the elderly and the adaptation of hospital structures and procedures to the needs of elderly patients. This task can be supported by a consultation service but regular visits by specialized nurses as well as individualized basic care for elderly have to be added. There are several models to improve delirium

prevention and care. Delirium rooms have been proposed (Flaherty, et al., 2003) and a hospital wide prevention program (Hospital elder Life program –HELP (Rubin, Neal, Fenlon, Hassan, & Inouye, 2011) ) has been proven to be successful in reducing delirium and delirium costs significantly and thus has been implemented in more than 60 American hospitals by now. To improve psychiatric care in the general hospital for elderly individuals thus needs more than a geriatric psychiatry specialist to consult. Structural changes, education for nurses and physicians as well as active interventions are promising. However, the hospital elder life program has to be evaluated in the German health care system for efficiency and practicability, as volunteer engagements are less common and cost reimbursement is different to the US.

### **Integration**

A different approach was chosen by Dr. Heidi Müssigbrodt, who reported on her 2 year experiences in developing a combined psychiatric- geriatric unit at the local community hospital (364 beds) in Hennigsdorf, Berlin-Brandenburg, a region with a high percentage of older people. They integrated geriatric care into a psychiatric setting, thus providing physio- and occupational therapy on the unit, a day room, where all meals are served and a large patio. An open setting was chosen, but the door is hidden by a picture of a book shelf discouraging wandering patients to leave the ward unintended. The 16 bed unit provided care for 341 patients in 2010, average length of stay was 17 days. The 146 psychiatric cases were admitted mostly directly, while the 195 geriatric patients were predominantly transferred from other medical units. Psycho-organic diseases (ICD-10 F0) were the most common admission diagnoses (31%, on third of those were classified as ICD-10 delirium) in the unit. Geriatric diagnoses included exsiccosis, heart failure NYHA IV, pneumonia, stroke, diabetes and UTI.

While geriatric patients are reimbursed via the DRG system as most other diseases in the German health care system, health insurances pay daily

fees for psychiatric patients. This difference is a special advantage of combined units involving geriatric psychiatry care. Although there is an attempt to adjust the DRG system also to psychiatric diseases, which will change the situation again, the reimbursement will stay different between psychiatry and geriatrics. The advantage of avoidance of transfers is obvious in this model. In this example 4% of patients (10) switched the specialty department while staying on the unit, only 5 % (12) of psychiatric patients had to be transferred to another medical specialty outside of the unit. Moreover a geriatric psychiatry unit in a general hospital can provide additional psychiatric care to other medical units while meeting the somatic needs of their patients.

Interdisciplinary units are new to the German system. A recent publication lists 12 units with a special focus on patients with cognitive deficits (Rosler, et al., 2010). Most of them involve geriatric psychiatry or geriatric neurology. They are intended to improve acute medical care for demented patients with behavioural disorders predominantly but are also very suitable for patients with delirium.

### **Winning Hat-trick?**

The three lectures covered three completely different approaches to older patients with psycho-organic syndromes. The different models indicate different needs of those patients but also make clear that the current system of transferring patients to any given subspecialty is increasing medical costs. On the other hand patients with cognitive disorders and delirium patients often deteriorate with a transfer. An optimal model for the elderly patient with seems to include a combination of models. A focus of delirium prevention on every ward provided by multiprofessional geriatric specialists and a specialized unit for highly demanding cognitively impaired seems to be the optimum of interdisciplinary care for the growing elderly population in Germany.

**Dr. Christine Thomas November 2011**

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## Recent publications

Two noteworthy papers chosen and comments by Dr Meera Agar, EDA board member, Consultant in palliative care in Sydney, Australia.

**Devlin JW, Bhat S, Roberts RJ, Skrobik Y: Current perceptions and practices surrounding the recognition and treatment of delirium in the intensive care unit: a survey of 250 critical care pharmacists from eight States. *Ann Pharmacother*; 2011 Oct;45(10):1217-29**

This is an interesting study and highlights the crucial role pharmacists could play in delirium risk assessment and also recommendation of treatment. This study survey pharmacist members of the Society of Critical Care Medicine, or the American College of Clinical pharmacy, who spend 25% or more time providing Intensive care clinical pharmacy services. 250 out of 457 (55%) responded. Very few pharmacists utilised a delirium screening tool (7%), and felt that this was a nursing role. More than 85% felt delirium should be managed pharmacologically, and 68% felt two or more medications should be utilised. This paper suggest some crucial work is needed to engage hospital based pharmacists in delirium prevention and assessment; and to provide develop some crucial links in delirium assessment between the "medication chart and the patient".

**Uthamalingam, Shanmugam. Gurm, Gagandeep S. Daley, Marilyn. Flynn, James. Capodilupo, Robert. Usefulness of acute delirium as a predictor of adverse outcomes in patients >65 years of age with acute decompensated heart failure. *American Journal of Cardiology*. 108 (3). 402 – 8.**

This study explored 883 patients with acute decompensated heart failure (ADHF), aged over 65 years. The development of delirium was independently associated with increased risk of 30-day and 90-day rehospitalizations for ADHF and higher nursing home placement in multivariate logistic regression analysis, adjusting for age, gender, cardiac

risk factors, dementia, activities of daily living, instrumental activities of daily living, coronary artery disease, atrial fibrillation, left ventricular ejection fraction, angiotensin-converting enzyme inhibitor and/or angiotensin receptor blocker, beta blockers, Charlson co-morbidity index, and other potential confounders.

This study will bring delirium to the forefront for our cardiology colleagues, with improved delirium recognition, prevention and early management potentially having a significant impact in heart failure care. The crucial aspects of this study were adjusting for known factors associated with heart failure mortality and morbidity. It would be interesting for future studies to compare the additional survival benefit obtained from preventing a delirium episode, versus pharmacological therapy of heart failure alone.

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## News and resources

### Update on facebook delirium

The EDA facebook page is gathering momentum. Exchanges vary from questions regarding managing the delirious patient, recommended resources and causal modelling (!) to whether ski jackets are needed for the meeting in Umeå. An opportunity to network outside the annual meeting!

<http://www.facebook.com/EDA.delirium>

### **Training video – patient experience**

A new video has been uploaded onto the EDA website which can be used freely as a teaching tool. The patient is keen to share his experience to help increase the recognition and management of delirium. We are extremely grateful to him, we can recognise his contribution by listening to him.

The video was made by Dave Cave in March 2011 by Northumbria Healthcare Foundation Trust in, England. The project was overseen by Dr Andrew Teodorczuk, Consultant Psychiatrist and Honorary Senior Lecturer and by Ms Annie Laverty, Executive Director of Patient Experience at Northumbria. It highlights the distressing nature of delirium, intensity of the symptoms and impact of simple reassurance.

<http://www.europeandeliriumassociation.com/news/patient-experience-of-delirium-teaching-video/>

### **Delirium book well received**

Delirium in Critical Care, the book written by Dr Valerie Page (Editor of this publication!) and Professor Wes Ely, was given the ultimate accolade in a review published in August British Journal of Anaesthesia “I couldn’t put it down”. Also recommended by the Cambridge Delirium Group – see EDA facebook page. Available from Amazon and all good bookshops.

### **Applications for EDA membership now welcome**

The European Delirium Association has now matured to the stage where membership is now available. Details are in this publication – see letter from the treasurer.

Payment may be by a standing order (form available by email), or by a cheque sent to me at my contact address below.

The bank account is as follows:  
Royal Bank of Scotland, East Parade, Leeds, LS1 5PS, UK.

Account no: 10147495  
Sort Code: 16-23-17  
IBAN& SWFT No: BG64RBOS16231710147495

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