Assessment and management of delirium in primary care

Jane Stephens  MRCP, DFFP, DTM&H

Our commentaries from the Primary Care Neurology Society (P-CNS) provide a primary care perspective on the neurology articles in Progress. Here, Dr Stephens considers ‘An overview of delirium for the community and hospital clinician’ (see p23).

Raju and Coombe-Jones’s paper is a fairly comprehensive overview of assessment and management of delirium, but is mainly orientated towards adults and what can be achieved within a secondary care setting. In this commentary, I will draw out aspects I believe to be relevant more to primary care and explore the barriers and opportunities I see to improving recognition and management of this disorder in primary care. Assessment of children will not be included, though many of the same principles apply.

There are two main take-home points. Firstly, as the authors suggest, delirium is under-recognised and the main issue is to consider it as part of the differential diagnosis. Secondly, the prognosis when treatment is delayed is poor, including a dramatic impact on functioning and death. Thus, it is a condition that requires recognition and prompt treatment to maximise a good clinical outcome.

Barriers to recognition of delirium in primary care

What stops us as clinicians from the prompt detection and management of this condition in primary care? Here are just a few issues:

• Access to appointments in general, is an increasing problem in general practice. For a doctor to be alerted to a potential diagnosis of delirium, one often needs to be able to negotiate and explain oneself clearly to reception staff.
• Elderly people in our society have become more isolated, and often live alone with no caregivers. Therefore, the problem may not come to our attention until the person is very sick.
• The enormous work burden in general practice also means that people who may require non-urgent home visits do not get them, thus missing an opportunity for early detection of problems.
• The person themselves may not recognise that they are becoming unwell, and primarily it is concerned caregivers or neighbours who alert GPs to a change in the persons’ condition.

• A lack of continuity of care, both in primary care and in care homes, means that any changes to a person’s baseline state are often not evident in the history or on assessment.
• Out of hours, a lack of access to medical records means that the assessing GP may not know the past medical or drug history, and cannot get a sense of a person’s baseline state. Also, one’s own safety in visiting can be an issue.
• Assessment of a patient presenting as confused generally takes longer than ten minutes; in the early stages, or if a patient is presenting with hypoactive delirium, it is not surprising the diagnosis is missed.

Coordinated care plans that I have seen out of hours, if available, may have a medical and drug history, but often do not detail a person’s baseline mental and social functioning or latest mini mental state examination (MMSE). For people recently discharged from hospital, a delay in receiving the discharge summary can mean that a GP may not even be aware of the admission or drug changes. If the differential diagnosis is another psychiatric condition, it is often not possible to arrange a community psychiatric assessment or for the police to attend promptly, if at all, in an out of hours setting.

Opportunities for detection in primary care

Having a named GP, a care plan, allied services visiting the home such as district nurses, and the involvement of neighbours and relatives, all assist in early detection. In care homes, having continuity of carers helps in detection and taking a collateral history. Arranging access and doing a combined home visit with the community psychiatric team is much easier to arrange during ‘usual’ working hours. Multidisciplinary meetings are an opportunity to identify and track people at risk.

Assessment in primary care – a quick guide

History: What is the change in functioning compared with normal (if available)?
What is the most likely cause? Consider past medical and drug history, alcohol and drug use, infection, poisoning, any previous psychiatric illness, any recent admissions or procedures, any changes in social circumstances or environment.

Physical assessment: Use of confusion assessment method (CAM) and MMSE: the former is helpful as a one-off but is not graded so is hard to use to compare over time; the latter can be helpful, particularly if you have a recent baseline score. Physical examination, including observations, use of the sepsis traffic light tool, blood sugar level and urine dipstick.

Decision making: Can I find a cause for this? Does the patient require admission for further assessment or treatment, or are they able to stay at home?

If you know the cause and can treat it, and the patient is clinically well enough to stay at home, is there enough support for their care in place or can you arrange this quickly? They will require regular review, which you will need to put in place.

If you think they require admission and refuse, engage any carers who may be able to persuade them, and if not, you may need to consider admission under the Mental Capacity Act.

It is rare, as a GP not in charge of a nursing home, to institute antipsychotics for delirium; this should be considered only once the cause is known and being treated, when the benefit outweighs the risk to the person, and when there is enough care in place at home for them to be monitored. If discharged from secondary care on antipsychotics with no psychiatric follow up, one needs to be vigilant and ensure that the person is brought off them in a timely and appropriate manner.

Recommendations
In primary care, you may need to allow more than 10 minutes to complete your assessment. Being in good communication with allied professionals and having continuity of care can be very helpful in establishing your diagnosis. Training staff in your local nursing home to use the CAM tool and requesting such results to be recorded in nursing notes could be time well spent. When deciding who needs care plans, consider including people at high risk of developing delirium and sepsis. Ensure those care plans have up-to-date MMSE and baseline functioning, and update local out of hours regularly.

Dr Stephens is a GP and Section 12 doctor with a number of special interests, including neurology and psychiatry, health promotion and international development. She is founder of the Green Tara Trust: www.greentaratrust.com

POEMs

Carotenoids and omega-3 fatty acids do not effect rate of cognitive function decline

Reference

Synopsis
As part of the Age-Related Eye Disease Study (AREDS) investigators identified adults, aged 50 to 85 years, at high risk for progression to advanced AMD with either bilateral large drusen or large drusen in one eye and advanced AMD in the other eye. Consenting patients (N = 3741) eligible for an add-on cognitive function study randomly received assignment (concealed allocation assignment) to 1 of 4 treatment groups: (1) omega-3 fatty acids (1g), (2) the carotenoids lutein (10 mg) and zeaxanthin (2 mg), (3) both the omega-3s and the carotenoids, or (4) matched placebo. All patients were also given varying combinations of vitamins C, E, beta carotene, and zinc. Individuals who assessed outcomes using a standard cognitive function battery test remained masked to treatment group assignment. Testing occurred 3 months after randomization and then approximately every 2 years. Using intention-to-treat analysis, the authors found no significant differences between the treatment groups in the rate of cognitive function decline for a mean of 4.9 years. Similarly, no significant difference in cognitive function decline occurred in high-zinc versus low-zinc groups nor in groups with or without beta carotene. The study was powered to have a 85% chance of detecting difference between treatments.