Community-Based Primary Palliative Care Community of Practice Series 2

Delirium in Palliative Care

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Dr. Nadine Gebara

Presenters: Dr. Tiffany Lee

Date: February 15, 2023

Territorial Honouring

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness and their families.

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The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Project ECHO Palliative Care - Canada BY Pallium Canada

LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by the CFPC and Royal College.

Pallium Canada

LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

Objectives of this Series

After participating in this series, participants will be able to:

- Augment their primary-level palliative care skills with additional knowledge and expertise related to providing a palliative care approach.
- Connect with and learn from colleagues on how they are providing a palliative care approach.

Overview of Sessions

Session #	Session Title	Date/ Time
Session 1	Pain: Beyond the Basics	Nov 9, 2022 from 1-2pm ET
Session 2	Communication: Part 1	Nov 23, 2022 from 1-2pm ET
Session 3	Communication: Part 2	Dec.7, 2022 from 1-2pm ET
Session 4	Palliative Care and Substance Use Disorders	Jan 18, 2023 from 1-2pm ET
Session 5	GI Symptoms in Palliative Care	Feb 1, 2023 from 1-2pm ET
Session 6	Delirium	Feb 15, 2023 from 1-2pm ET
Session 7	Spiritual Care and Rituals around Death and Dying	Mar 1, 2023 from 1-2pm ET
Session 8	Palliative Sedation	Mar 15, 2023 from 1-2pm ET
Session 9	What's in store for Palliative Care in Canada: Policy, Advocacy and Implementation	Mar 29, 2023 from 1-2pm ET
Session 10	Grief and Bereavement: Beyond the Basics	Apr 12, 2023 from 1-2pm ET
Session 11	Practical Tips: Lessons from the Front Line	Apr 26, 2023 from 1-2pm ET

Welcome & Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from, your role and your work setting.
- Your microphones are muted. There will be time during this session when you can unmute yourself for questions and discussion.
- You are welcome to use the chat function to ask questions and add comments throughout the session.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session.
- This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **11 Mainpro+** credits.

Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Not-for-profit
- Funded by Health Canada

Disclosure

This program has received financial support from:

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

Facilitator/ Presenters:

- Dr. Nadine Gebara: Nothing to disclose
- Dr. Tiffany Lee: Nothing to disclose

Disclosure

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content

Introductions

Facilitator:

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Family Physician at Gold Standard Health, Annex

Panelists:

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Introductions

Panelists (continued):

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Introductions

Presenters:

Dr. Tiffany Lee, MD FRCPC

Palliative Care Physician at Abbotsford Regional Hospital and Cancer Centre, Fraser Health Authority

Dr. Tiffany Lee is a palliative care and intensive care physician working at the Abbotsford Regional Hospital and the University Hospital of Northern BC, in British Columbia. She completed her Internal Medicine residency at the University of Saskatchewan, and her Critical Care and Palliative Care training at the University of Toronto. No long land-locked, she's discovering that skiing involves real mountains and kayaking involves an actual ocean, which is all very exciting and terrifying. She is working on a Master's degree in Health Sciences education and enjoys baking cookies and water colour painting.

Delirium

Session Learning Objectives

Upon completing the session, participants will be able to:

- Describe how to screen for delirium.
- Identify pharmacological and non-pharmacological approaches to managing delirium.
- Describe how terminal delirium is managed.

Delirium in Palliative Care

Table 1. Diagnostic Criteria for Delirium.

Source of Criteria

DSM-5*

The presence of delirium requires all the criteria to be met:

- Disturbance in attention and awareness
- Disturbance develops acutely and tends to fluctuate in severity
- At least one additional disturbance in cognition
- Disturbances are not better explained by a preexisting dementia
- Disturbances do not occur in the context of a severely reduced level of arousal or coma
- Evidence of an underlying organic cause or causes

Confusion Assessment Method (CAM)†

The presence of delirium requires features 1 and 2 and either 3 or 4:

- Acute change in mental status with a fluctuating course (feature 1)
- Inattention (feature 2)
- Disorganized thinking (feature 3)
- Altered level of consciousness (feature 4)

* The criteria are adapted from the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5).[5]

† The criteria are adapted from Inouye et al.[6]

1/3 patients have delirium on admission to a palliative care unit.
(Watt et al. 2017)

Delirium in advanced cancer: median of 3 delirium precipitants. ~50% episodes reversed.
(Lawlor et al. 2000)

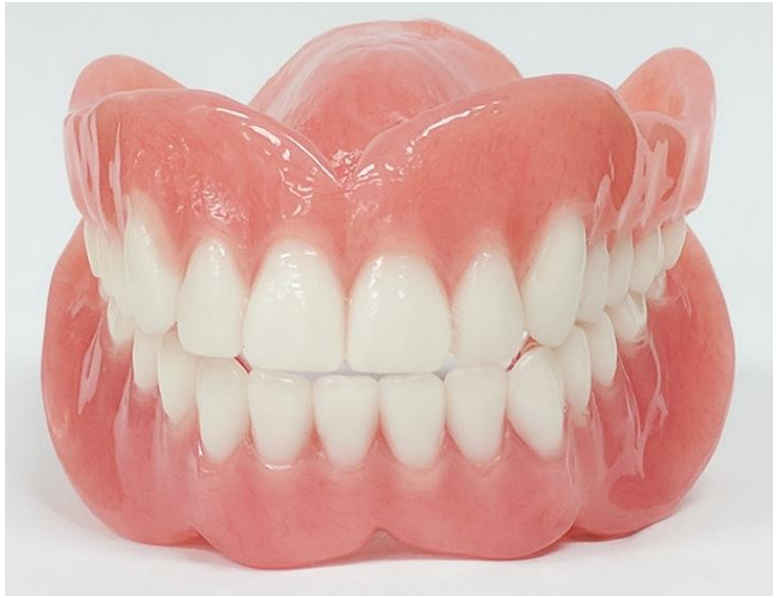
Marcantonio ER. Delirium in Hospitalized Older Adults. *N Engl J Med*. 2017;377(15):1456-1466. doi:10.1056/NEJMcp1605501

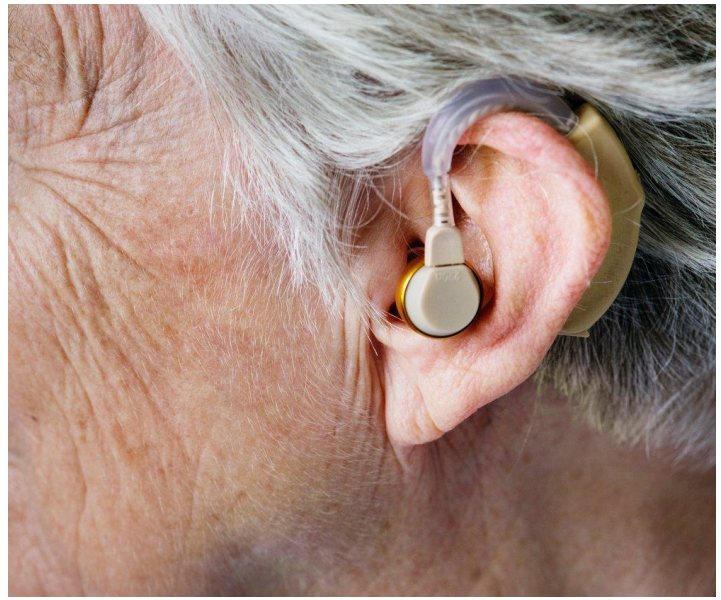
Delirium screening

1. Use Confusion Assessment Method (CAM) assess for delirium		
C	1. ACUTE ONSET AND FLUCTUATING COURSE	**Does the abnormal behavior:** • come and go? • increase/decrease in severity?
A	2. INATTENTION	**Does the patient:** • have difficulty focusing attention? • become easily distracted? • have difficulty following a conversation?
	3. DISORGANIZED THINKING	**Is the patients' thinking** • disorganized? • incoherent? **Does the patient have:** • rambling speech? • Illogical flow of ideas?
M	4. ALTERED LEVEL OF CONSCIOUSNESS LOC O'METER 	**What is the patient's level of consciousness?** • Vigilant (hyperalert) • Alert (normal) • Lethargic (drowsy, easy to arouse) • Stupor (difficult to arouse) • Coma (completely unarousable)
KEY: Presence of features 1& 2 plus either 3 &/or 4 is positive for delirium		

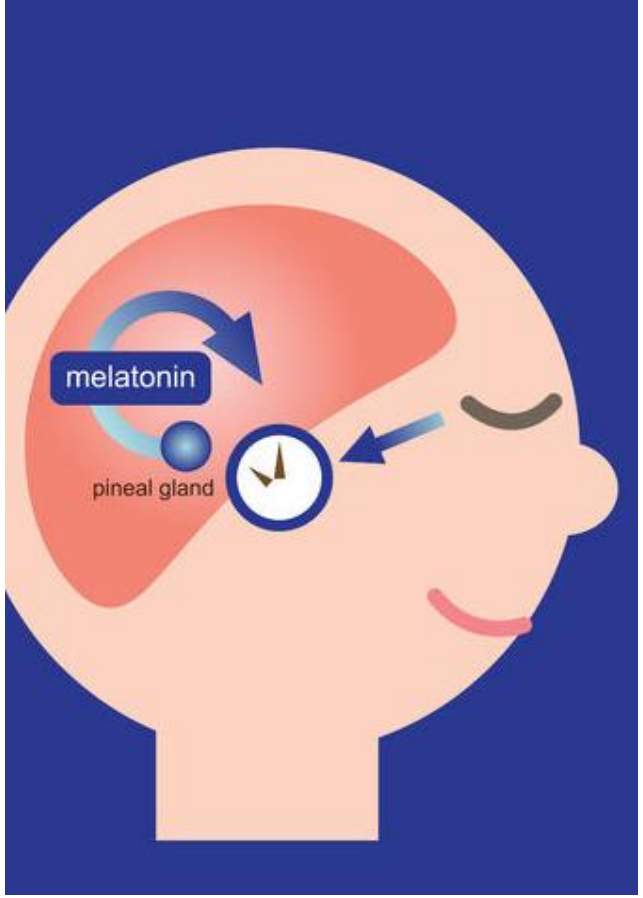
Comprehensive approach

2. Use PRISME to identify & address physiological, psychosocial & environmental factors		
P	**PAIN**	• Provide regular analgesia & nonpharmacological methods. Reassess pain control Q shift, especially with movement.
	PSYCHOSOCIAL	• Assess mental health, dementia & ability to cope with stress/stimuli
R	**RESTRAINT**	• Avoid restraints. Use alternatives
	RETENTION	• Palpate abdomen. Bladder scan PRN. I & O catheter if essential. Remove bladder catheter ASAP. Regular toileting via commode or walking to toilet
I	**INFECTION**	• Assess for UTI, pneumonia, C diff, purulent wound. Monitor VS. May have atypical presentation with no fever
	IMPACTION	• Determine last BM. Palpate abdomen. Rectal check PRN. Prevent & treat constipation. Bowel protocol as needed
	IMPAIRED COGNITION	• No reality orientation. Use calm, gentle approach& conversational cues to orientate patient to time & place
	INTAKE-ORAL	• Feed patient PRN. Assess dysphagia & consult OT/Dietitian PRN
S	**SLEEP DISTURBANCE**	• Ensure 4-hour sleep periods. No routine night turns. Naps OK
	SENSORY CHANGE	• Ensure glasses, hearing aids & dentures fit well and work
	SOCIAL ISOLATION	• Promote family stays & overnights PRN. Provide delirium pamphlet. Encourage familiar objects-pictures, blankets, pet visits
M	**MEDICATION**	• Review recent med changes, drug levels, ETOH. Avoid medications of risk (ie, demerol, codeine. benzodiazepines)
	METABOLIC	• Evaluate fluid balance/output/labs/oxygenation. If agitated, restart IV X 2 only-consider alternatives & ensure agitation is treated
	MOBILITY	• Encourage self-care; toileting; ambulation. Up for meals
E	**ENVIRONMENT**	• Provide a quiet, supportive environment --↓ noise, lights & people • Hypoactive-Increase stimuli as tolerated. Activate • Hyperactive-Reduce stimuli, especially at night





Let them see and hear



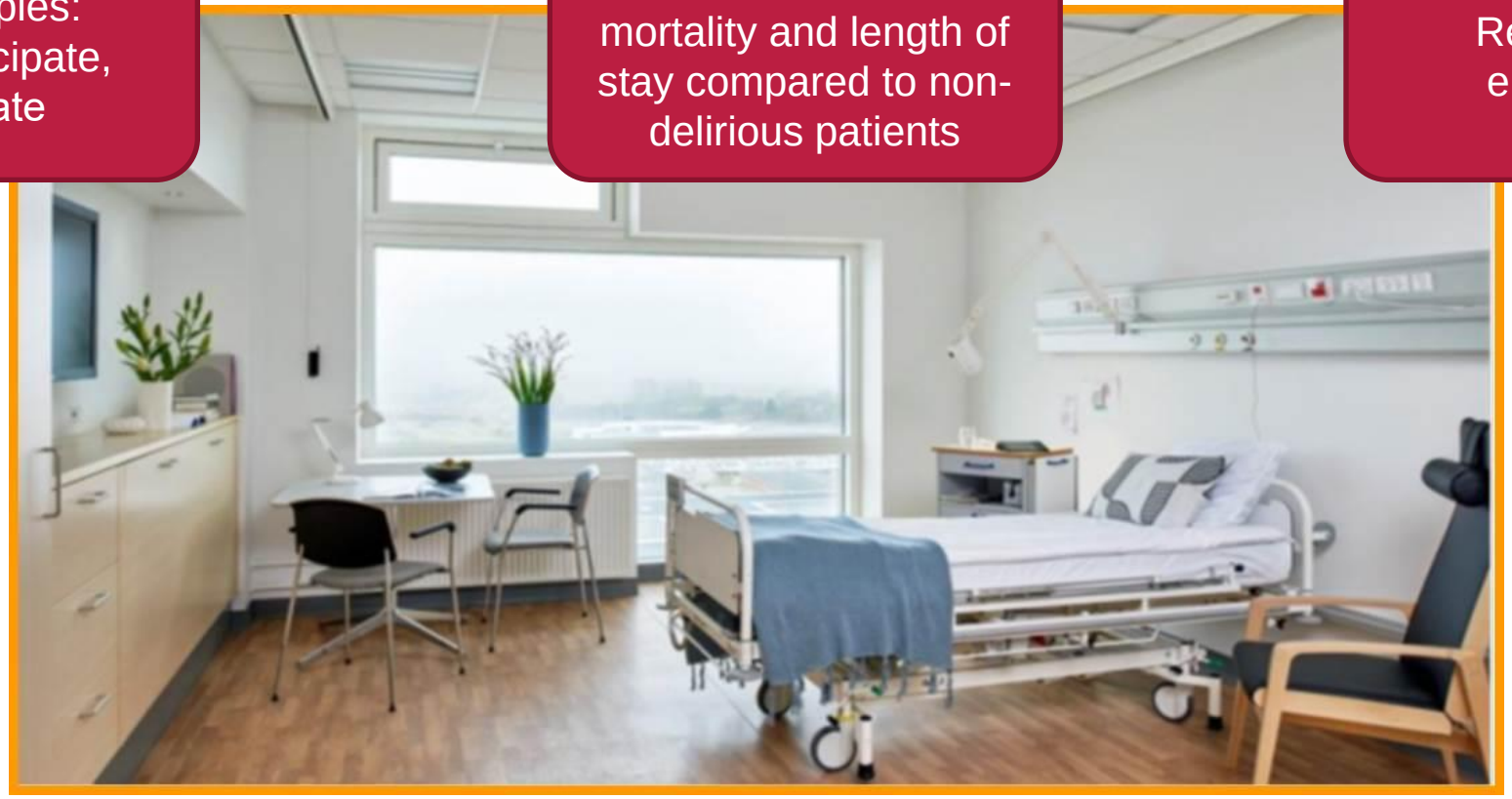
Preserve sleep, treat insomnia

Delirium Room - Geriatrics

TADA principles: Tolerate, Anticipate, Don't Agitate

No difference in mortality and length of stay compared to non-delirious patients

Restraint-free environment



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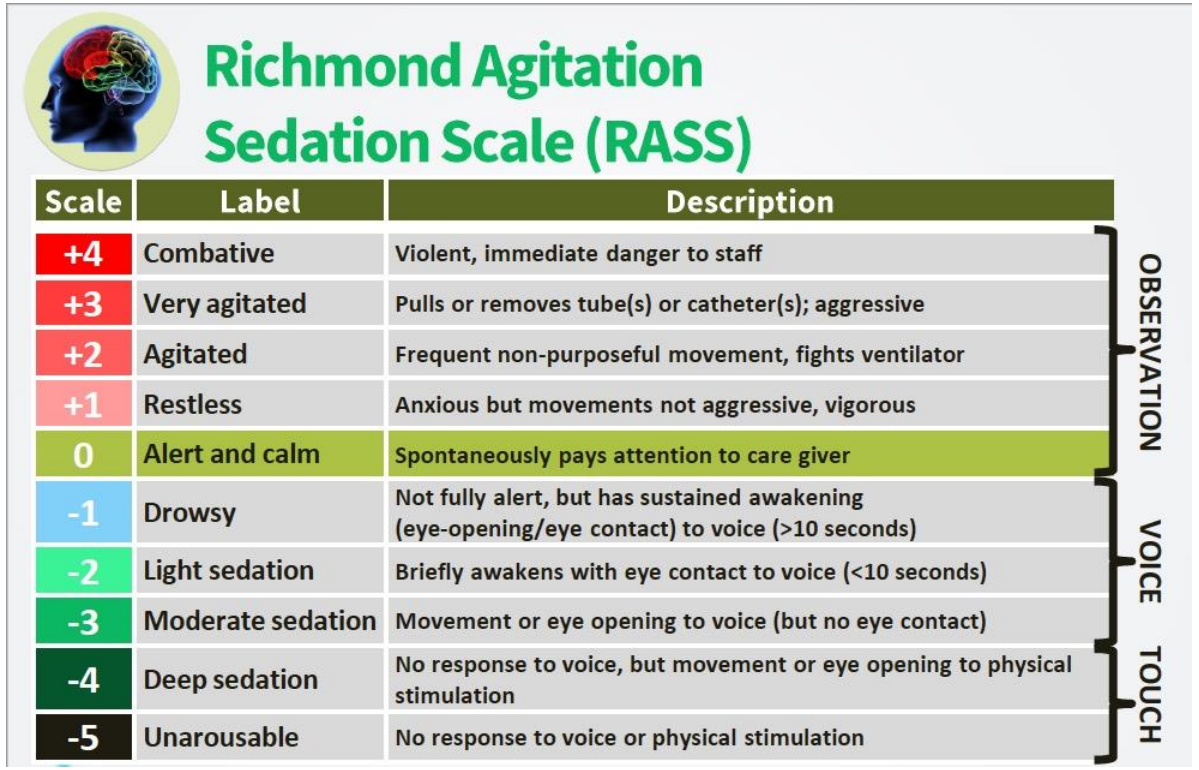
Family engagement

Pharmacologic Therapy

- Multimodal interventions (re-orientation, ↓ sensory deprivation, mobilization, ↓ lines and tubes) to *prevent* delirium are effective in acute care and geriatrics – **LESS EFFECTIVE** in palliative care, but still worth trying! (Gagnon et al. 2012)
- Neuroleptics haloperidol, risperidone etc. do not prevent delirium in palliative patients. In mild-to-moderate delirium, associated with **WORSE** delirium scores. (Agar et al. 2017)
- If the goals is to alleviate the symptoms of severe terminal agitation on the ward, a strategy of combining neuroleptics with benzodiazepines will achieve targeted sedation score sooner. Studied with 2 mg haloperidol, 3 mg lorazepam. (Hui et al. 2017)
- Tip: when starting sedating neuroleptics, have a conversation with the family and interdisciplinary team about the *targeted* level of sedation, using the RASS as a guide.

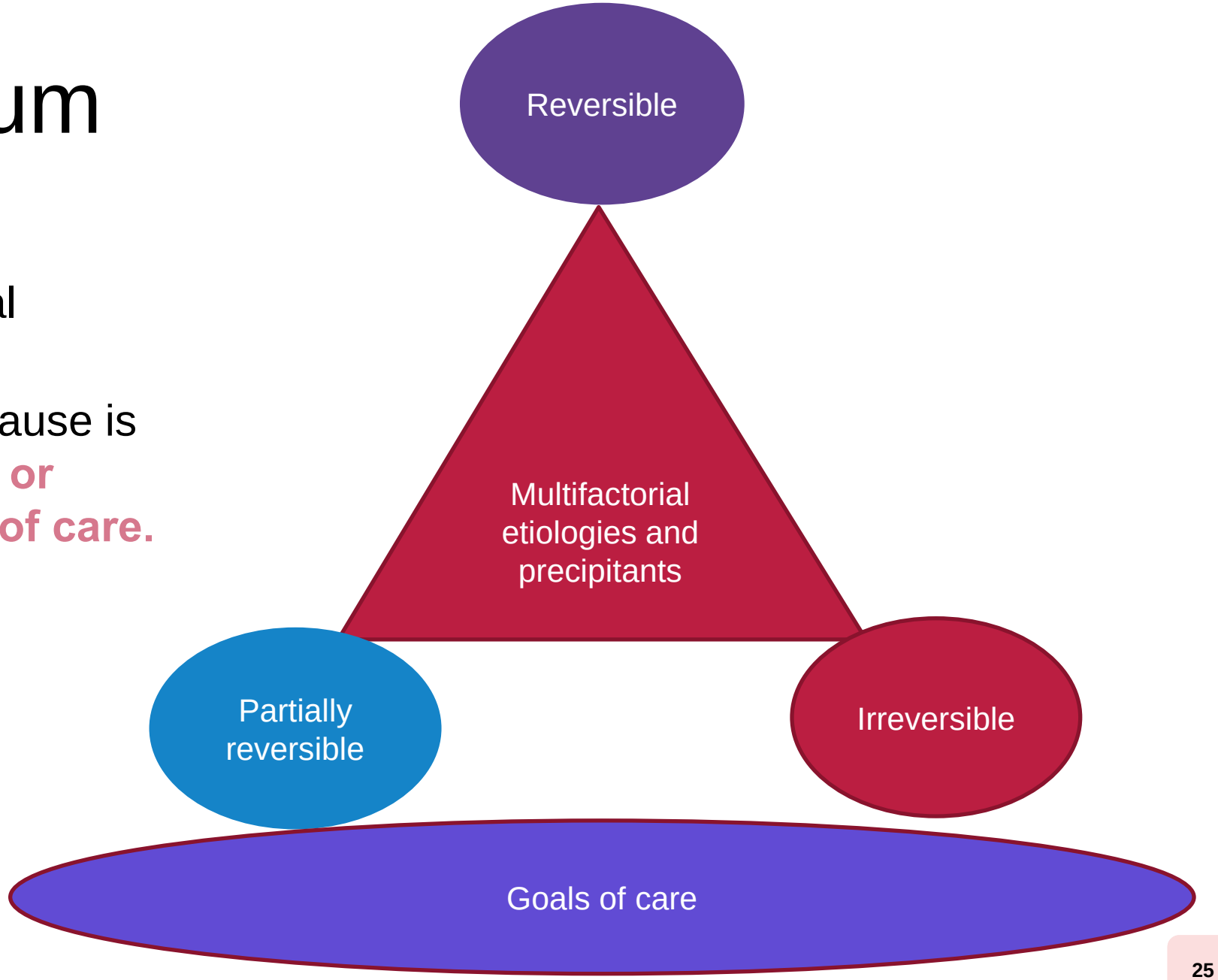


Richmond Agitation Sedation Scale (RASS)

Scale	Label	Description	
+4	Combative	Violent, immediate danger to staff	OBSERVATION
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive, vigorous	
0	Alert and calm	Spontaneously pays attention to care giver	
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (>10 seconds)	VOICE
-2	Light sedation	Briefly awakens with eye contact to voice (<10 seconds)	
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)	
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation	TOUCH
-5	Unarousable	No response to voice or physical stimulation	

Terminal delirium

- Not a distinct diagnosis.
- Implies delirium in the final days/weeks of life.
- Treatment of underlying cause is **impossible, impractical, or inconsistent with goals of care.**



Continuous palliative sedation

- Use of ongoing sedation for symptom management, considered during the end of life when a patient is close to death and continued until the patient's death.
- Reserved for intolerable, refractory symptoms.

Continuous palliative sedation documentation:

- ❑ Refractory symptoms:____
- ❑ Expected prognosis: ___ (<2 weeks)
- ❑ GOC clearly documented i.e. in BC DNR M1
- ❑ SDM aware of *goals* and *intended depth* of sedation
- ❑ Hydration and nutrition addressed with SDM
- ❑ Management of non-refractory symptoms addressed with SDM
- ❑ SDM consent to continuous palliative sedation documented

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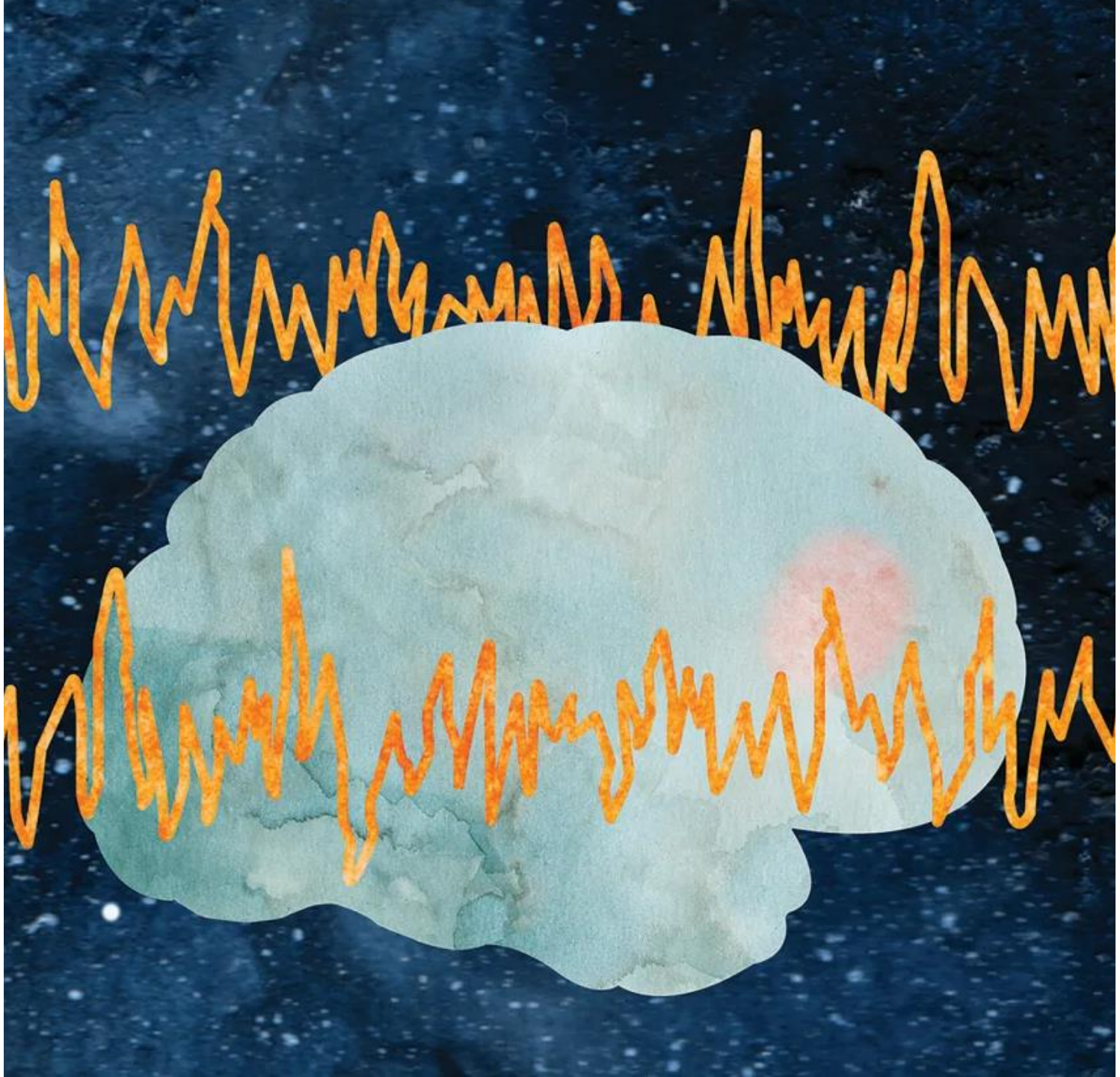
Case-Based Discussion

Monday

- **Mrs. T is a 43-year-old woman with grade 4 glioblastoma multiforme (GBM).**
- **Diagnosed 1 year ago:** surgical resection, adjuvant radiation, temozolamide.
- **3 months ago:** disease progression, tumor debulking, prognosis documented “less than 6 months”.
- **Past 2 months:** increasing fatigue, 1 hospitalization for seizure, now more than >50% day in bed, low PO intake (PPS 40%).



Tuesday

- **Last night @ home:** 3 episodes of emesis, confused and agitated.
- **6 am:** has a fall, agitation is scaring 5 year-old daughter. Spouse brings patient to ER.
- **ER exam:** oriented x2, seems calm, answers basic questions.
- **CT head:** disease progression, 0.6 cm midline shift.
- **Delirium workup:** WBC elevated, UA suggests UTI, IV ceftriaxone and RL at 75 mL/h started.
- AM.

Wednesday

- **“It was a rough night”:** Agitation, nausea, and headache. Pulled out IV.
- **Palliative care consult:** regular subcut anti-emetics, PRN medications for agitated delirium, PRN opioids for pain.

Thursday

- **Overnight:** 3 doses of PRN haloperidol and 1 doses of “crisis” midazolam, on-call physician called for additional sedation.
- **9 AM:** No significant metabolic abnormalities on bloodwork, E.coli UTI sensitive to ceftriaxone, patient moaning and hallucinating, refusing PO meds and food.
- **10 AM Family meeting:** Team discusses concept of terminal delirium. Family recognizes that patient cannot go home, but still wishing for her to be as awake as much as possible. “Every time she opens her eyes, she just wants to hug her daughter. We can’t stop hoping for a miracle.”

Friday

- **Overnight:** Intractable distress despite PRN methotrimeprazine 12.5 mg x2, hydromorphone 0.5 mg x3, and midazolam 5 mg x1. Patient screaming and writhing in bed.
- **10 AM Family meeting (SW, RN, MD):** Continuous palliative sedation explained again, family consents. Midazolam 2-5 mg/h subcut CSCI infusion started.
- **1 PM:** Aunt from Winnepeg arrives and is distressed that patient is not being fed. RN de-escalates situation and provides education. Spiritual care practitioner and volunteers offer support.
- **Saturday 10 PM:** Patient dies with spouse and mother at bedside.

Points to Ponder

- The approaches we take in palliative care vary based on setting (community, general inpatient ward, hospice, palliative care unit)- what might be alternative pharmacologic approaches to managing this case?
- In your practice, how do *you* explain what delirium is to families?
- How do *you* coach patients' loved ones on how to respond to hallucinations or paranoid thinking associated with delirium?
- How do *you* introduce the idea of using antipsychotic medications to patients' loved ones who are resistant to the idea?

Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- We hope to see you again at our next session taking place **March 1, 2023 from 1-2pm ET** on the topic of **Spiritual Care and Rituals around Death and Dying.**
- Thank you for your participation!

Thank You

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