

Perceptions of palliative care community nurse specialists (CNS) of the feasibility and acceptability of routine delirium assessment in the community palliative care setting



Care and support through terminal illness

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Background

- Delirium is a complex brain syndrome that occurs suddenly and involves disturbances of consciousness, attention, perception, thinking, memory, and the sleep-wake cycle. Delirium prevalence in palliative care ranges between 26% - 88%.
- Delirium is distressing for the patient, family and clinicians. It leads to poorer outcomes such as falls, further cognitive decline and reduced communication which inhibits advance care planning discussions.
- Early identification of delirium is essential to optimise treatment. The 4AT (4 A's Test) is a brief delirium assessment tool which has been validated for use in acute settings (Figure 1). Previous work has established a role for the 4AT as an assessment tool for all admissions to the hospice^[1], however, little is known about how it might be used in a community specialist palliative care context.

Aim

To explore CNS perceptions of the feasibility and acceptability of introducing routine tool-based assessment of delirium by a community specialist palliative care team.

Section	Option	Score
[1] ALERTNESS	Normal (fully alert, but not agitated, throughout assessment)	0
	Mild sleepiness for <10 seconds after waking, then normal	0
	Clearly abnormal	4
[2] AMT4	No mistakes	0
	1 mistake	1
	2 or more mistakes/unreliable	2
[3] ATTENTION	Achieves 7 months or more correctly	0
	Starts but scores <7 months / refuses to start	1
	Unreliable (cannot start because unwell, drowsy, inattentive)	2
[4] ACUTE CHANGE OR FLUCTUATING COURSE	No	0
	Yes	4

Figure 1: The 4AT delirium assessment tool (www.4AT.com).

Method

Semi-structured interviews with 12 Palliative Care Community Nurse Specialists (CNS). All participants attended an educational session on delirium assessment and management in May 2018 and incorporated the 4AT into routine patient assessment after this. Interviews were conducted in June and July 2018.

Results

Community Palliative Care CNSs perceived the 4AT as easy to use and acceptable to patients. It facilitated early identification of delirium and helped rule out delirium where uncertainty existed. Routine delirium assessment on a first visit was considered appropriate. There was less consensus on when re-assessment should occur.

Assessment and management

“... I think when it’s monitored and acknowledged sooner, it’s easier to manage it and then look at the antecedents that have caused this.” [P1]

“... it (the 4AT) allowed me to rule out delirium,” [P10]

“I think it’s good because you’ve got evidence and ... something you can look back on ... if someone else came in, they can look back and see well he scored such and such on the 4AT then...” [P2]

Usability of 4AT tool

“I feel confident in using it. It seems fairly easy and straightforward to use.” [P5]

“I feel a slight awkwardness in terms of how do I introduce that (the 4AT tool)... I feel ... it ... doesn’t flow with your normal conversation ... although we’re asking lots of questions in the first visit, we’re also trying for it to be as conversational as possible.” [P12]

Acceptability of 4AT tool

“... some patients, absolutely fine ... if you explain why you’re doing it ... another patient asked me if I thought he was daft.” [P2]

“I asked her (the patient) at the end .. how she felt about using it and she said, ‘Oh, at least I know my heads alright.’” [P12]

Monitoring change

“... getting a baseline is really important and valuable ... then it’d be easier to do if, if you’re noticing a change.” [P3]

“I think it’s probably easier to use if it’s routinely used.” [P5]

“I’m not sure if doing it at every visit would be viable ... we’re aware of how they normally function or how they’ve been in the past. So ... I think, in terms of doing it, initially for the baseline so that then if in the future you feel actually things are changing, you can then do it again.” [P10]

Conclusions

- The 4AT tool is acceptable for use in a palliative care community setting.
- CNSs perceive the 4AT as brief, easy to administer and acceptable to community palliative care patients.
- Training was viewed as very helpful, and CNSs suggested that training be offered to the wider team that supports the community palliative care patient, including District Nurses.
- Routine delirium assessment on first visit is recommended, however further guidance on triggers to reassess is required.