The Need for Delirium Education and Psychosocial Care after Discharge: A Realist Analysis of Interviews with Key Stakeholders

AUTHORS

Dr. Shruti Raghuraman
Dr. Ellen Richards
Dr. Aseel Mahmoud
Dr. Sarah Morgan-Trimmer
Prof. Linda Clare
Prof. Rob Anderson
Prof. Vicki Goodwin
Prof. Louise Allan

AFFILIATIONS

University of Exeter, Faculty of Health and Life Sciences
Royal Devon and Exeter NHS Trust
NIHR Applied Research Collaboration South-West Peninsula

RecoverED
Recovery after an episode of delirium

INTRODUCTION

In 2020, the overall prevalence of delirium among older adults in hospital settings was found to be 23% (1). Delirium is associated with a range of negative outcomes in older people including increased length of stay in hospital, hospital acquired complications, distress, poor functional recovery and increased mortality(2,3,4,5,6,7). Treatment trials for delirium have mainly focussed on the inpatient episode and most have not or researched or documented rehabilitation of delirium.

Research has highlighted that people who recover poorly after delirium require an increased level of care or institutionalisation, which points towards higher societal and economic costs in post-acute settings (6,8). However, there is limited understanding of long-term, non-pharmacological treatment of delirium care after discharge from acute settings.

OBJECTIVE

This research sought to investigate the clinical and rehabilitation needs of older people with delirium and their carers in order to develop a community-based intervention.

DESIGN

A realist approach (9) was used for the development and evaluation of a programme theory underlying the intervention. Following a synthesis of findings from a rapid realist review of literature, a qualitative investigation of the older people's needs after an episode of delirium in the hospital was conducted in order to identify features of an effective intervention. Forty-one realist semi-structured interviews were conducted with key stakeholders.

- Persons with delirium (N=7)
- Family carers (N=14)
- Health and social care professionals (N=24)

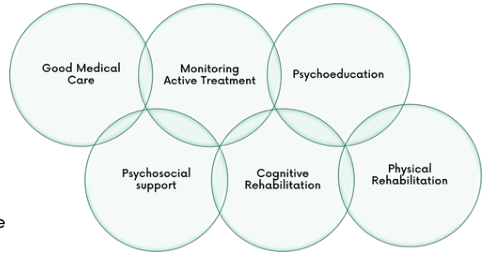
ANALYSIS

A realist analytic approach was employed in analysing the interview data, drawing on existing theory and coding inductively to identify novel areas. Context-mechanism-outcome configurations were refined iteratively to guide the development of a programme theory of what works to help improve recovery after delirium, for whom and in what circumstances and how.

RESULTS

Several, interrelated and complementary components were identified as crucial for long-term recovery after delirium. It is expected that these components will interact with each other in complex, non-linear ways to produce desirable outcomes for delirium recovery.

This poster presents the findings related to psychoeduation. Through a depiction of context-mechanism-outcome configurations, the importance of psychoeducation in delirium recovery is demonstrated.



Psychoeducation

Knowledge of delirium detection, diagnosis and care is currently lacking among healthcare professionals.

Delirium is poorly understood by people due to a lack of awareness and information received at the time of diagnosis or discharge

Persons with delirium and their carers experienced fear and anxiety in managing delirium after discharge

Mechanism Resources

An educational component at the start of the intervention consisting of information, resources signposting, and one-on-one support

Persons with delirium + Their carers

Outcomes

- Better understanding of delirium
- Better uptake of & engagement with the intervention
- Reduced illness-related anxiety and fear of the future
- Greater confidence in illness management
- Normalisation & legitimisation
- Improved interpersonal relationship

Delirium is also associated with feelings of **psychological distress, social isolation, reduced engagement with friends and family and a lack of confidence in social interactions.**

Mechanism Resources

Psychoeducation can be a means of fostering relationship continuity with staff carers.

Outcomes

- Positive social interaction
- Sense-making
- Better communication
- Improved psychological state

DISCUSSION

We found strong evidence for the need of an educational component to both inform and educate, as well as address the increased fear, anxiety, and loss of confidence that are experienced after an episode of delirium. This could involve opportunities for learning, support, and sense-making with skilled, trained professionals, as well as normalising and legitimising adverse and distressing responses to experiences of delirium. Psychoeducational interventions for delirium have found to be moderately effective in increasing confidence and competence, especially with decision-making (10), and reduce incidence of delirium and improve function in older medical patients (11). There is a dearth of research looking at the value of psychoeducation within multi-component delirium interventions targeted at the carers (12). We also present potential mechanisms and positive outcomes for the target population when psychoeducation is provided in the context of post-discharge rehabilitation.

CONCLUSION

There is a clear need for educating people with delirium and their carers after discharge from hospital to effect a range of beneficial outcomes associated with long-term recovery. Future research should investigate the effectiveness of including evidence-based psychoeducational components in interventions with the aim of reducing excess disability associated with the experience of delirium. In the next stage of this research, we are currently investigating the feasibility of a manualised multi-component rehabilitation ideliirum intervention in the community.

REFERENCES

1. Gibb, K., Seeley, A., Quinn, T., Siddiqi, N., Shenkin, S., Rockwood, K., & Davis, D. (2020). The consistent burden in published estimates of delirium occurrence in medical inpatients over four decades: a systematic review and meta-analysis study. Age and Ageing, 49(3), 352.
2. Andrew, M. K., Freter, S. H., & Rockwood, K. (2005). Incomplete functional recovery after delirium in elderly people: a prospective cohort study. BMC Geriatrics, 5. https://doi.org/10.1186/1471-2318-5-5
3. Bickel, H., Gradinger, R., Kochs, E., & Forstl, H. (2008). High risk of cognitive and functional decline after postoperative delirium. A three-year prospective study. Dementia and Geriatric Cognitive Disorders, 26(1), 26-31.
4. O'Keeffe, S., & Lavan, J. (1997). The Prognostic Significance of Delirium in Older Hospital Patients. Journal of the American Geriatrics Society, 45(2), 174-178
5. Partridge, J. S. L., Martin, F. C., Harari, D., & Dhesi, J. K. (2015). The delirium experience: What is the effect on patients, relatives and staff and what can be done to modify this? In International Journal of Geriatric Psychiatry (Vol. 28, Issue 8, pp. 804-812). Int J Geriatr Psychiatry
6. Siddiqi, N., House, A. O., & Holmes, J. D. (2006a). Occurrence and outcome of delirium in medical in-patients: a systematic literature review. Age and Ageing, 35(4), 350-364.
7. Witlox, J., Eurelings, L. S. M., De Jonghe, J. F. M., Kalisvaart, K. J., Eikelenboom, P., & Van Gool, W. A. (2010). Delirium in Elderly Patients and the Risk of Postdischarge Mortality, Institutionalization, and Dementia: A Meta-analysis. JAMA, 304(4), 443-451.
8. Leslie, D. L., & Inouye, S. K. (2011). The importance of delirium: Economic and societal costs. Journal of the American Geriatrics Society, 59(SUPPL. 2).
9. Pawson, R., & Tilley, N. (1997). Realistic evaluation . SAGE.
10. Gagnon, P., Charbonneau, C., Allard, P., Soulard, C., Dumont, S., & Fillion, L. (2002). Delirium in Advanced Cancer: A Psychoeducational Intervention for Family Caregivers.
11. Wand, A. P. F., Thao, W., Sciuriaga, H., Ting, V., Baker, J., & Hunt, G. E. (2014). A multifaceted educational intervention to prevent delirium in older inpatients: A before and after study. International Journal of Nursing Studies, 51(7), 974-982.

FUNDED BY

NIHR | National Institute for Health and Care Research

This study is funded by the National Institute of Health and Care Research Programme Grants for Applied Research Programme (NIHR202338). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care