
Stanford Hospital aims to identify early patients with delirium

BY DIANE ROGERS



Kathleen Turner-Hubbard teaches staff at Stanford Hospital to spot sudden changes in a patient's mental status that could signal the onset of delirium. Photo by Norbert von der Groeben.

When a nurse in the orthopedic unit asked her new post-operative patient where she was, the response had a pleasant ring: “I’m at a spa.”

But that answer sent the nurse straight to the phone. She called Kathleen Turner-Hubbard, MS, NP, and asked her to come to the D-ground unit, in a hurry.

A specialist in caring for elderly patients, Turner-Hubbard is a nurse practitioner trained to quickly spot the sudden changes in mental status that signal the onset of the sudden, severe confusion known as delirium. She knows the hospital “triggers” that can bring on fluctuations in behavior: blood loss during surgery, anesthesia, pain medications and anti-anxiety drugs, infections, dehydration, IV lines and catheters, as well as being immobilized for an extended period of time.

Turner-Hubbard also knows that some patients with delirium can become agitated, incoherent and combative, while other, so-called “pleasantly confused” patients—like the “spa” woman who had undergone a major orthopedic procedure—can appear lethargic and apathetic. “We look for patients who were fine yesterday, and suddenly, today, they don’t know where they are or what day it is,” she said.

Nationwide, an estimated 30 percent of all hospitalized patients over age 65 develop delirium. In intensive care units, the percentage is closer to 80. But in spite of the prevalence of symptoms, delirium often isn’t recognized, or is mistaken for dementia. “And you can get delirium on top of being demented,” Turner-Hubbard explained. “You

can have a little memory problem, and then you get a urinary tract infection and you're really confused, especially if you're 80."

When she responded to the phone call from the orthopedic nursing unit, Turner-Hubbard learned that the 75-year-old patient had been successfully managing arthritic pain for years, taking only Tylenol. According to her friends, the woman had been alert and active before coming to [Stanford Hospital & Clinics](#). But after surgery, they said, she'd starting having hallucinations, seeing people who weren't in the room. Nor could they make any sense of what she was saying.

"She had narcotics on board for her pain, and her surgeon had also prescribed Ativan, a powerful benzodiazepine, for the anxiety he'd observed," Turner-Hubbard said after reading the patient's chart.

She called the surgeon and suggested that the Ativan was enough to "tip" the patient's brain chemistry and bring on delirium. "So he took away the Ativan and cut back on her pain meds," Turner-Hubbard said. "And when I went to see her the following morning, she was completely fine." The woman was able to leave the hospital on the scheduled discharge day.

It was another successful case of delirium identified and treated quickly. "Delirium can persist, and you can have cognitive decline over time," Turner-Hubbard added. "Which is why we want to get to them early."

Turner-Hubbard was hired six months ago by the hospital's Aging Adult Services to develop a "delirium project." Guided by clinical psychologist Rita Ghatak, PhD, director of Geriatric Health Services and [Aging Adult Services](#), and working closely with medical director Yusra Hussein, MD, Turner-Hubbard is designing the project to help nurses identify patients with delirium and intervene on their behalf—say, by recognizing the drugs that can cause problems for elderly patients.

"Nurses are the patients' advocates, and this is a hospital that supports the notion that nurses do have that responsibility," Turner-Hubbard said. "If a physician orders diphenhydramine (Benadryl) to help an elderly patient sleep, it's OK for a nurse to say that there's a lot of data showing that older adults become more confused, and are more likely to fall, on that drug, And the nurse can then request a different medication."

Every morning Turner-Hubbard reviews a list of patients who have been assigned "sitters," nursing aides who stay at bedsides 24 hours a day to monitor the most vulnerable. Sitters protect patients—especially those who try to remove IV lines—from themselves. "If you're delirious, you don't understand why there's a line poking out of your arm or leg, or why you have a Foley catheter."

On her daily rounds, Turner-Hubbard meets with each sitter, to explain the symptoms of delirium and to encourage the sitter to read to confused patients, play recorded music or generally engage them in conversation. She also talks about delirium with all newly hired nurses, as part of their orientation to the hospital.

Turner-Hubbard meets frequently with nurse educators and clinical nurse specialists and holds informal teaching sessions in the units. She hands out small laminated cards that many nurses use as reminders of the kinds of changes in mental status they should look for: inattention, altered levels of consciousness, disorganized thinking, rambling speech.

Turner-Hubbard also has been teaching nurses to use a “confusion assessment method” to elicit responses that can help to identify patients who have or may be at risk of developing delirium: What is the reason for your staying here? Tell me which hospital, which city and which state we are in. Spell the word “world” backwards.

Once a new computerized system is up and running in the spring of 2010, Turner-Hubbard said it will be even easier for nurses to continually enter data to monitor patients. “They will have a screen that also will help identify the types of patients who are at high risk of developing delirium,” she added. “And those patients will be checked every shift.”