GERIATRICS TWITTER JOURNAL CLUB

#GeriJC

Comparative Accuracy and Efficiency of Four Delirium Screening Protocols

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Dr. Olivia Rengering, Geriatrics Fellow from University of Michigan leads discussion on this study (see video)

T1. What are the most interesting aspects of the paper?

@BERosensteinMD: Perhaps less a thought on the paper itself, but it's interesting we have an effective, 3 min screening tool – and that's too long. Is that more a reflection of the system in which the tool is used/studied.

T2. Were the analytical approaches used in the study appropriate?

@BERosensteinMD: A computer simulation always has to make certain assumptions. The ones to create the models, f.e. time per question, seem appropriate #GeriJC

@BERosensteinMD: Stepping back, excluding those with significant hearing loss (significant risk factor for delirium) in READI, less appropriate and may underestimate the time for UB2 by improving baseline cohort function #GeriJC

@GeriEducator: Difference in amount of time (Table 3) is not rigorous. Time with 95% CI would be much more helpful #GeriJC

@BERosensteinMD: Totally agree. Especially if delirium is already set in, even a couple questions could take a while.

@GeriEducator: Our stats expert Dr. Klug says "The CAMs (no UB-2) were more likely to have ADL (50% to 37% p=.003) and IADL (81% to 60% p<.001). UB-2 was given to higher functioning sample. They should have adjusted for this." #GeriJC

@drcavitale: Notably, dementia status in 3D-CAM group was assessed by expert panel while READI group had more robust screening with AD8 tool. We don't have a sense of the range of dementia severity among both groups, possibly affecting responses to 3D-Cam questions. #GeriJC

T3. Does the study add new knowledge to established foundations?

@WesGodfrey1: Maybe I'm a little slow, but I'm having trouble seeing how the UB-CAM adds much beyond what the 4AT already accomplishes? Administration speed is so variable depending on situation makes it hard to compare. Ability to recall tool w/o if/then protocol helps

@ORengeringDO: I think a benefit is that you may be able to quickly screen out cognitively intact patients (if both "UB" questions are answered correctly). But I agree, does ~1-2 minute decrease per patient change our ability to screen for delirium? #GeriJC

@BERosensteinMD: Overall, adds to the argument that detection of delirium is 1) important and 2) can be done pretty quickly in any of 4 ways #GeriJC

@WesGodfrey1: In some ways I wonder if "no time" is just the easiest/most obvious answer to the question of why many of us omit regularly screening for delirium. Seems we have several great tools for screening, all < 3 min. Maybe need to consider other barriers?

T4. What are the weaknesses of the study (design)?

@BERosensteinMD: Can't fault it for being a computer model, but that does limit it's applicability in practice. #GeriJC

@GeriEducator: Not so much a weakness but observation. No significant differences between 4 methods for sensitivity (detecting disease when present) and specificity (detecting no disease when none there) #GeriJC

T5. How would you introduce the findings in your practice?

@WesGodfrey1: Will be interesting to see how the prospective analysis pans out. Feedback from providers about usability beyond administration time alone would be helpful I think. Can non-providers administer with similar reliability of results?

@KahliGoBlue: This is a great question – I imagine the CAM-3D could be administered by non-clinicians (e.g. research assistants or non-clinical trainees) but would require training, particularly for the subset of questions pertaining to observer ratings. #GeriJC

@WesGodfrey1: For sure. It seems like the more we can equip bedside staff (who have a much better chance of recognizing fluctuating mental status than a one-time daily assessment by the provider on rounds) the higher likelihood of achieving timely dx and tx. Interesting.

@BERosensteinMD: Could provide the basis for QI initiatives to detect delirium, gaining buy-in given brevity of the tools. Especially if we're asking nurses or NAs to do this on multiple patients qShift #GeriJC

@drcavitale: I agree that 3D-CAM assessments would be a great way to address the Mentation (cognition) aspect of the Age-Friendly 4Ms framework for QI while also serving as a geriatric interprofessional teaching tool to increase delirium awareness #GeriJC

@WesGodfrey1: In any case, really great article. Thanks for leading @ORengeringDO and thanks to @Geriatrics JC for hosting! #delirium