

DELIRIUM MATTERS

Delirium is a leading cause of preventable injury in critical care

DIY implementing delirium monitoring

In this document you will find everything you need to make delirium monitoring happen where you work. You will notice that there is no money provided – you won't need any. Your greatest battle will be fighting against the belief that making a change in critical care that involves a machine goes bibble, has 6 or 7 disposable items that need connecting in regimental order and preferably has the patient's blood circulation diverted through it! Delirium monitoring is quick, easy and is all about quality of care for your patient.

Time-wise about 2 weeks for steps 1 and 2, 4 to 6 weeks for steps 3 to 6, steps 4, 6 and 7 ongoing about 6 weeks bringing step 8 just over 3 months after you read this sentence.

Some of you may need longer, some already half-way there.

- Step 1: Crash course in delirium
- Step 2: Do it yourself first
- Step 3: If you are not a doctor – get a doctor on board
- Step 4: Spread the word
- Step 5: Gather the team
- Step 6: Words on the wall
- Step 7: Designer poster.
- Step 8: The big day
- Step 9: And again
- Step 10: A year later

Appendix 1: Worksheet

Appendix 2: Quote quiz: who said what about brains?

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Step 1: Crash course

Delirium in critical care is easy

Delirium associated with increased risk of death, prolonged stay, higher cost of care, and likely long-term brain deficits in survivors.

Delirium testing is easy, takes less than a minute and there are no ongoing costs.

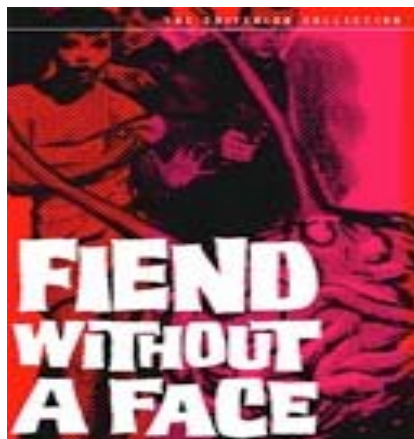
What we know:

- Delirium is intermittent acute brain failure
- Dementia is significantly increased in patients following delirium.
- Dementia is seen in younger patients with delirium than without.
- Up to 80% of intensive care patients develop delirium, often unrecognised.
- Delirium for the most part goes undiagnosed; so is untreated in critical care.

Organ failure?

Delirium is an indication of brain dysfunction in the same way that not passing urine may be an indication of kidney dysfunction.

BEWARE Delirium is often invisible



The condition occurs in 3 forms. Easiest to discern is agitated delirium. Harder to detect but more common among elderly patients is quiet delirium, which has a worse outcome. With it, patients become passive, withdrawn and unresponsive. If you don't look for it you won't see it.

Is your patient delirious?

You are looking for inattention, level of consciousness and disorganized thinking

1. You need a patient who opens their eyes when you clearly say their name – on sedation, off sedation it doesn't matter.
2. First ask them to squeeze your hand.
3. Then ask them to squeeze your hand only when you say the letter 'A'. The sequence of letters used is SAVE A HAART. More than 2 mistakes = inattention.
4. Are they drowsy or on the contrary, agitated? If so they are already CAM positive. Inattention plus altered conscious level equals delirium.
5. Ask them 4 questions that they normally would easily answer such as "are there fish in the sea?", "will a hammer cut wood?" – see CAM worksheet for sets.
6. A command – ask them to lift 2 fingers then to do the same (don't say lift 2 fingers again) with the other hand or to add one. Score 1 for that, 1 for each question answered correctly – less than 5 total, your patient is CAM positive. Inattention plus disorganized thinking equals delirium.

Come again?

Inattention plus altered conscious level equals delirium.

Inattention plus disorganized thinking equals delirium.

Inattention plus altered conscious level plus disorganized thinking equals delirium.

If they don't open their eyes or only open them briefly you cannot assess for delirium.
If they open their eyes but don't squeeze your hand at all or only once they are delirious.

What causes delirium?

What doesn't?! Seriously it is a temporary imbalance of neurotransmitters causing instability and unpredictable brain transmission. Benzodiazepines are the single most important modifiable cause. Otherwise "let me count the ways".

Elderly severe sepsis comorbidities preexisting cognitive impairment metabolic disturbance
cessle ep deprivation malnutrition anaemia alcohol malnutrition hearing visual impairment hyperbiliru
inaemia ARDS MODS drugs drugs drugs drugs.

How to manage the delirious patient?

That is down to you and your team. Suggestions include looking for a change in patient's condition such as a new infection or worsening hypoxia, think about the sedative drugs either changing the drug or the administration. You may decide to treat the delirium with anti-psychotics, haloperidol or one of the atypicals.

More information and references available at www.icudelirium.org

Step 2: Do the CAM scoring on your patients until you feel comfortable enough to show others.

There is a video on www.icudelirium.org to show you how easy it is.

Step 3: If you are a doctor go to step 4, if not get a doctor on board, preferably a consultant. This is a hot topic they will have heard about it and may be racked with guilt at not having acted already. You will be doing them a favour!

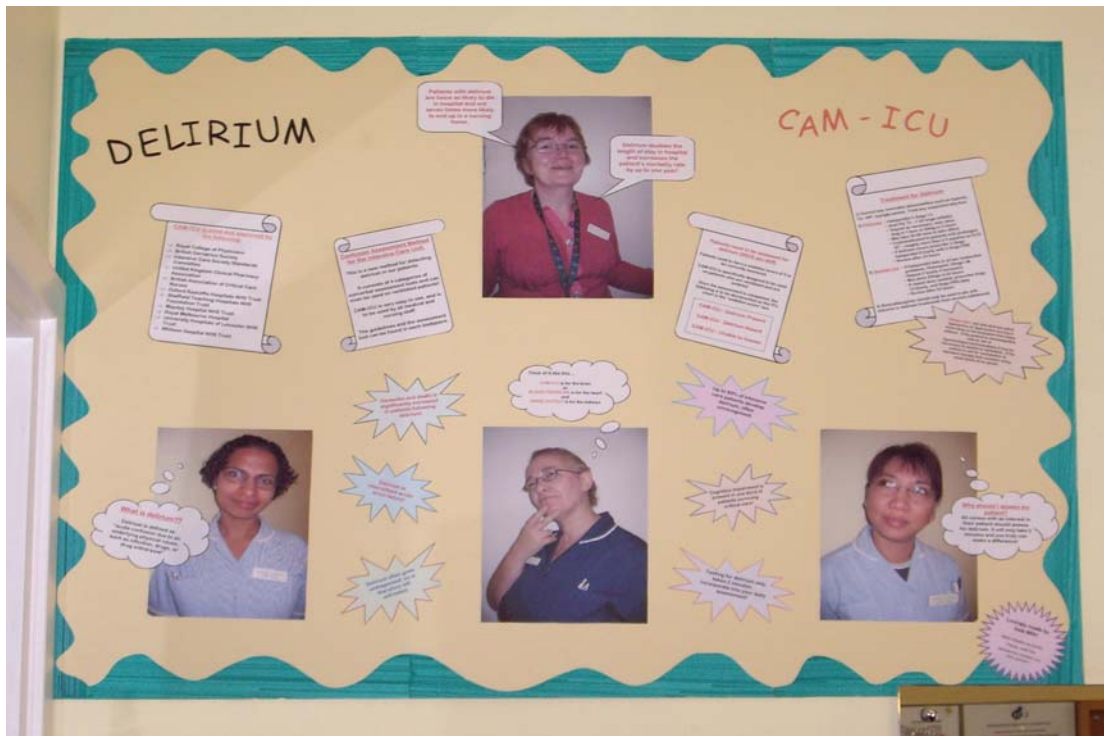
Step 4: Spread the word: If you haven't gone onto www.icudelirium.org do it now – go onto teaching resources to see a short video tutorial and a slide set to inspire you or to use as is. Present the facts to the clinicians – get an agenda slot on staff meetings, 5 minutes will do it. Offer a teaching session but don't spend longer than 20 minutes presenting at any meeting, find out what the audience thinks.

Step 5: Gather the team, by now you should have at least 2 other interested clinicians whether nurse, doctor of any grade or clinical pharmacist. Decide who will action steps 6 and 7, where to document the score and the launch date.

Step 6: Words on the wall (or similar) get a roll of fax paper and a permanent marker and write bold messages to stick on a wall prominent to the critical care unit; one at a time for a few days at a time. The idea is to get people intrigued and asking what it all means – getting the subject to stick. Use words like “inattention”, “disorganized thinking”, “you have to look” – once the word is out try “if you CAM-ICU you should”. Have fun. Put more robust messages where only staff can see them. Finish on “delirium matters”.



Step 7: Designer poster: Design a poster with photographs on it, individuals asking questions and having them answered. Address some of the questions you will already have been asked. Target it at your staff – tell them why it needs to be done.



Step 8: the big day

Make it a Monday on a week when you or another can visit the unit once a day, go around every patient to make sure the CAM-ICU has been done. And the next day and the next. If it hasn't been done show the nurse, get around as many patients as you can.

Just keep going around, don't get disheartened when after you have taken a well-deserved holiday you find no-one has even heard about the CAM-ICU. Remember "most people give up just as they are about to achieve success". If you have the resources monitor the testing – it will help.

Step 9: and again

Staff will move on, medical and nursing staff. Make sure that new staff know about the importance of delirium assessment and are confident in doing it.

Step 10: a year later

Audit the scoring and anything that may have come up during the past year which you think is important for your patient's outcome.

DELIRIUM MATTERS

Who said?

1. Blast medicine anyway! We've learned to tie into every organ in the human body but one. The brain! The brain is what life is all about.
2. The seat of the soul and the control of voluntary movement - in fact, of nervous functions in general, - are to be sought in the heart. The brain is an organ of minor importance.
3. The human brain weighs only three to four pounds but contains about 100 billion neurons. Although that extraordinary number is of the same order of magnitude as the number of stars in the Milky Way, it cannot account for the complexity of the brain. The liver probably contains 100 million cells, but 1,000 livers do not add up to a rich inner life.
4. Lately things don't seem the same,
Actin' funny, but I don't know why,
5. ...all the most acute, most powerful, and most deadly diseases, and those which are most difficult to be understood by the inexperienced, fall upon the brain.
6. I never came upon any of my discoveries through the process of rational thinking.

- A Hippocrates
- B Albert Einstein
- C Jimi Hendrix
- D Gerald D. Fischbach
- E Dr Leonard H. McCoy, Star Trek
- F Aristotle