Editorial

The Delirium Experience

Three weeks ago I spoke at a fundraising delirium study day held by the UK Intensive Care Foundation, the national critical care research organisation. It was a unique event for me not only were the usual speakers, there were no less than two survivors of critical care and the wife of a survivor. One of the speakers at this event spoke so eloquently about his distress over the weeks he suffered delirium that I was moved beyond any story I have heard before.

There was also a speaker on cases of delirium states and their associated dreams that I confidently expected to dislike. Interpretation of dreams and delirium? What nonsense! However I found myself intrigued and persuaded that there is some common understanding we can make use of when trying to communicate with patients in the grip of a terrifying delirium. We do need some guidance. The second survivor was adamant that it would not have mattered what was said to him at the time, his reality was real. He had been furious when his wife failed yet again to bring their passports and so they had missed the plane. His delirious episode was more traumatic for his wife and her friend as they tried to manage his delusions. His wife speculated if she had brought in two squares of cardboard with passport written on them if that would have been enough - probably not. The point for the patient was that his plans to get on a plane and get out of the hospital were thwarted.

The very next day on our intensive care I was told by a delirious patient in a very small voice “they've taken over the plane” evidently imagining herself to be on a highjacked plane. I believe we are making progress in delirium research and in reducing the chances of our patients getting delirium. However the answers to decreasing patient distress, treating delirium or preventing it in our sicker or dying patients are not coming quickly enough for our patients now. Professor MacLullich once said that
regardless of its effects on outcomes, the distress delirium causes patients and families is justification enough to do something about it now.

After delirium it is important to give patients the opportunity to talk about their hallucinations if they want to, to let them know that they are common, more common than not in the critically ill patient. It does seem to be helpful at the time to listen to what they believe is happening with compassion rather than contradicting them or dismissing their concerns. If they do not have severe delirium sometimes getting them to try and focus can bring them back to our reality. However more often than not I am left feeling that I am failing to rescue my patients. But of course I’m not failing, no more than any of us are who take time to listen to our delirious patients. It may not be apparent to me but maybe I’m learning how to be a better doctor for the delirious patient.

A final thought, it is not all bad. One survivor is keen that I let clinicians know that his delirious experience was not distressing and by picking the events apart he has managed to explain where all his ideas came from, relating them to an interpretation of real events. He found this very helpful. Another critical care consultant told me that one patient told him in a follow up clinic he had spent his entire critical care stay on tour with Beyonce. He was somewhat disappointed to find out it never happened although in a way he did experience it, didn’t he?

This edition of the Annals includes a carer’s experience, a study that takes hospital patients home to manage delirium as well as a report on an international initiative. The EDA 2016 conference report is presented as a twitter feed, what do you think of that? @EDA_delirium.

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**Twitter at EDA 2016**

The 11th Congress of the European Delirium Congress was held in Vilamoura 3rd and 4th November. Joaquim Cerejeira was President of the local organizing committee. Meeting with him later, he told me the importance of delirium is not commonly known in Portugal and to host the meeting was a great opportunity to start and address this. So not an easy task and Hats off to Joaquim.

What follows are Tweets and a couple of images from the conference that gives a flavour of the content and experience of attending an EDA congress. Thanks to those who Tweeted. Tweet for yourself next year Oslo November 16th and 17th 2017.

- More people are surviving ICU but have significant morbidity afterwards.
- Emotional frailty? Low reserve for stressful events results in worse outcomes.
- Great venue.
- We need not just focus on survival but survivorship!
- Education is a protective factor for Post ICU syndrome and associated symptoms.
- Delirium tremens peak onset is 4-5 days after alcohol withdrawal.
- Moral of the talk again validates that benzodiazepines are bad news for delirium.
- When will we get to the day we are not talking about ‘off label’ delirium treatments?
- Scholfielf: Information is a care – misinformation about older peoples mental health is dangerous.
Schofield: policy-making re older peoples mental health is very dementia-centric. Why no delirium strategy?
We need to deliver education which changes delirium competence and care.
Australians feeling at home with eucalyptus, Vilamoura EDA.

- Early mobilization possible with patient on ventilator.
- Demonstrating power of a hearing aid and some glasses in non-pharmacological management of delirium.
- ABCDE bundle in surgical ICU. Associated with less delirium.
- Early mobilization most impactful outcome.
- Share resources please – Ask not what the EDA can do for you but what you can do for EDA.
- Time for delirium to be considered and treated as a medical emergency.
- Celebrating Gideon Caplan, winner of the AjA book award.
• This session is in Portuguese but with English slides – I’m hoping this is where I learn some proper Portuguese by osmosis.
• Just like muscles, the brain needs exercise too. Cognitive rehab in older people.
• ‘Italian Delirium Day’ great idea to replicate in other countries to raise awareness & assess prevalence.
• High prevalence in delirium in neurology found in ‘Italian delirium day’.
• DelApp in action
• Measurement of delirium is major challenge, lack of standardization, delirium not well defined in studies, says A_MacLullich
• Delirium tools cannot assess people who cannot speak – major limitation as tool needs to capture whole spectrum of patients.
• Why is ‘brain care’ and bedside tests for delirium in a highly resourced ICU so difficult? Culture important.
• Massive push for education and advocacy is the best way to improve delirium care and capacity.
• 2 talks describing delirium superimposed on delirium. Bright future & building capacity in UK delirium research.
• Some great discussion about motor function in positive delirium – could this be a discriminatory feature?
• Things to think about designing a delirium clinical trial.
• Family engagement key to detect delirium in older adults.

• Well done to all the Edinburgh Delirium Research Group.

So great to meet so many people who are so passionate and knowledgeable about delirium. Feeling very inspired!

Valerie Page and numerous Tweeters.
The Delirium Recovery Programme (DRP): Evaluation of an Innovative Service Providing Cognitive Enablement at Home Following Hospital Admission.

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Abstract

Delirium is prevalent amongst older adults in hospital. Some people recover physically but cognitively and functionally remain impaired; professionals are reluctant to discharge these patients home due to arising safety concerns. This study designed a 21 day pathway to provide cognitive enablement at home with 24 hour live in carer and support more rapid recovery from delirium in a more familiar home setting. Patients were identified by consultant physician and psychiatrist and an individual care plan was produced. Patients were discharged onto a virtual ward with a 24-hour live in carer and reviewed at day 4 by Occupational Therapist (OT) and day 7 by OT and social worker (SW). Day 10 patients attended ambulatory care for joint review of physical and mental health. 51 patients were discharged with the DRP: all improved functionally. On completion of the DRP, 36 remained at home and 15 required residential placement. The multidisciplinary team determined 24 care home placements were avoided (13 long term and 11 short-term enablement). Highly supported early discharge from hospital for patients with delirium is effective and enables patients to regain cognitive function and remain at home when they would otherwise have required placement from hospital. It is cost effective to provide time-limited 24 hour care.

Strategies to help regain and recover cognitive function may be as important as treatment measures to support people with delirium.

Background:

Delirium in acute hospitals can affect up to 60% of frail elderly in-patients [1]. Patients with delirium often experience long hospital stays (LOS) [1,2,3,4], whilst we wait for the delirium to resolve. Whilst remaining in hospital, patients risk further hospital acquired morbidity including hospital acquired infections and falls due to unfamiliar surroundings [4, 5, 6, 7]. Patients may recover physically and no longer need acute hospital-based interventions but have persistent cognitive and functional deficits which cause both clinicians and carers great concerns regarding the safety of discharge home. Standard care packages are unable to provide sufficient support for fluctuating behaviours over twenty four hours. To date the options for this group have been limited, including intermediate care/ rehabilitation or bed based enablement or short term residential care placement. None of these provide a familiar environment, and patients risk becoming institutionalised. Patients with delirium discharged to rehabilitation settings are also more likely to experience complications, rehospitalisation and death as compared to patients without delirium [8, 9].

Accurate prediction of cognitive and functional performance of patients on return home is challenging. Some cognitive and behavioural episodes in hospital are situational and would not arise at home, other patients may remain disorientated even in a familiar home environment. Based on the principles of cognitive reserve theory [3] it was postulated that rapid recovery of cognitive function could be achieved by a fully supported discharge and provision of cognitive enablement in a familiar home environment.
The study aimed to:

1. Reduce LOS in hospital.
2. Reduce number of direct placements from hospital.
3. Reduce hospital readmissions.
4. Improve patient experience and functional outcomes.
5. Ensure appropriate antipsychotic prescribing including a discontinuation plan.
6. Determine whether the cost of short-term high tariff care is offset by reduction in LOS and reduction in residential placements.

Methods:

Patients were selected by consultant geriatrician, psychiatrist and OT. All patients were considered who had any reversible component to their cognitive impairment. The person was also required to
- Live in Trust catchment area.
- Have a second bedroom for live in carer; (alternatively 12 hour carers were arranged).
- Consent / best interests decision to enter the DRP
- Sufficient physical functioning to require assistance of only 1 carer.

An individual care plan and risk assessment was developed by the OT with the patient and relatives. A multidisciplinary meeting was arranged with family, social workers and care agency staff and scripted discussion was led by clinician. This included explanation of delirium and our recovery pathway (Figure 1). The patient was discharged home with discharge summary; regular and “as required” medication on a medication policy, individualised care plan and 24 hour live in carer. The OT provided day to day management of the programme and acted as the focal point for contact of carers and clinicians.

Patients were discussed at consultant-led board rounds three times per week. On arrival home the number of contact hours with the carer was initially high and was weaned down over the course of 3 weeks. The OT home visits were used to modify the care plan after evaluating the patient’s progression. On day 10 patients attended the ambulatory unit with the live-in carer who provided feedback about all aspects of care at home including sleep, continence and observed behaviour. The decision about place of care after 21 days was taken by the MDT in conjunction with patient and family and a financial assessment for any ongoing care needs was undertaken by the social worker. If long term placement was required this was arranged from the community and not via hospital admission.

Several assessment tools were reviewed to select an appropriate measure for evaluation of the DRP. The Bristol Activities of Daily Living Scale (BADLS) [10] has been designed to cover a wide range of functional activities for people living with cognitive impairment. It is carer rated and
easy to administer. Low scores indicate functional independence, high scores denotes maximum dependence. However this scale does not include other aspects of patient experience which may impact on function during delirium such as hallucinations.

**Results:**
The DRP supported 51 patients home following acute hospital admission between February 2014 and July 2015. The average LOS was 28 days (range 6-59 days). 36 out of 51 (71%) were able to remain at home at the end of the programme and 15 (29%) required residential placement. There was only one hospital readmission (2%) during the programme due to confirmed urinary infection and the patient continued with the DRP following hospital treatment, this compared to our hospital readmission rate of 14%.

The multidisciplinary team determined 24 care home placements were avoided (13 long term and 11 short- term enablement). 1 year follow up data revealed 5 patients had died later in the year, 24 had entered a care home and 22 remained at home. This indicates the true frailty of the patients who were supported home. (Figure 2)

The average BADLS score in hospital was 16/60 (27% dependency) and on discharge from the DRP average score was 10/60 (17%). This confirms the DRP patients were physically functioning at a good level – most were independently mobile or requiring supervision. However this does not capture the need for support regarding other symptoms including visual hallucinations, confusion and agitation in evenings/ overnight. It is these latter symptoms which concern care givers most. Feedback was extremely positive. (Table 1)

Cost Benefit analysis:

2 care agencies provided the live-in carers at a tariff of £750 per week, the cost of 21 days on the DRP was £2250 per patient. This compares to the £2100 per week cost of stay in hospital and ongoing fees of £580 per week for a residential care home placement in Hertfordshire. Most financial gains realised relate to avoidance of long term placement in residential care. Full 1 year financial data is available for the first 21 patients and shows mean saving of £10,342 per patient, (median £9776). The maximum saving was £24000, there were savings in care costs for all but one patient.
**Feedback from relatives included following comments**

- ‘it gave us piece of mind that she would be alright at home;
- ‘We couldn’t imagine how she (mum) would manage’
- ‘she’s so much better- not seeing the squirrels and ducks – well only the once since she’s been home’
- ‘I feel extremely grateful to Watford General Hospital...I could see (my husband) declining in hospital...coming home gave him a real boost and he responded very well – and rapidly!’
- ‘It’s a marvellous scheme, no ones ever heard of anything like it!’

**Feedback from patients**

- ‘I hated hospital it was terrible, the nightmares have all gone’
- ‘it’s wonderful to be home, I really didn’t think I would get back’
- ‘I would like to thank you all for the opportunity’
- ‘I am not fully independent...however I believe that without this programme I would now need to be in a care home’

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**Conclusion:**

Literature search for ‘cognitive enablement’ and ‘delirium recovery’ yielded no comparable studies aimed at reduction in long term placement from hospital by early supported discharge of a delirium cohort.

Enablement (or reablement or re-enablement) is a short-term focussed intervention to help people re-learn the ability to complete everyday physical tasks [11] and benefits those who have lost functional skills or confidence due to ill health or hospital admission and have the potential to live more independently.

Cognitive enablement is an extension of this approach to patients suffering with reversible impairment of cognition. The principle is to stimulate procedural memory in the context of the patients home environment using this as a therapeutic intervention. The approach is to enable recovery of cognitive function by providing an individualised care plan structured around that persons usual routines and meaningful activities. Patients benefit from a graded care plan which enables the carer to engage the patient at the correct level and progress their function as recovery occurs.

The DRP patient case-mix included very complex patients who had been physically unwell and often displayed high levels of distress and agitation. We included two patients whose behaviour brought them to the verge of a psychiatric admission. Interestingly these were two of the patients who settled most rapidly when back in their home environment. In contrast some patients who the team felt had the greatest potential for functional recovery at home did not settle as expected. This confirmed the difficulty in predicting outcomes on discharge home.

The DRP was successful in most of the objectives it set out to achieve and reduced long term placements and transfers to care home directly from hospital. When care home placement was required it was clear that every attempt had been made to support return to home and the specific reasons this was not feasible. The readmission rate of participants was significantly less than would be expected. LOS was not reduced and this reflected delay to Dual frailty unit before entry on to DRP. Antipsychotic medication was used for the shortest possible duration to reduce distress of the patient. All medication was reviewed in Ambulatory Care, the majority of patients did not require any additional medication once they returned home. Financially this scheme is viable and local commissioners have agreed ongoing funding for the DRP.

Supported discharge home with an individualised cognitive enablement plan to support recovery from delirium may be as important as treatment as a management strategy for people with delirium.
**Funding:** Local County Council funded this scheme.

**Ethical approval:** Ethics Committee Approval not required, Medical Research Council guidance classifies this work as Service Evaluation all patients and carers fully consented to participation.

**Acknowledgements:** We wish to acknowledge thanks to our participants and their families and this pilot was possible due to the additional time and efforts of Adult Care social work colleagues, Care Agency staff, Commissioners, and the amazing Bluebell ward team!

**References:**


Maeve Leonard Award 2016

The ‘Leonard prize’ is named after Dr Maeve Leonard, an outstanding young delirium researcher from Limerick, Ireland who died 10th September 2015. Her work in the field of delirium, which includes almost fifty peer reviewed publications, contributed substantially to our understanding of how to best assess and manage psychiatric symptoms in hospitalised patients. Maeve was an immensely popular individual who straddled the worlds of clinical practice, teaching and research thereby providing endless encouragement and inspiration to all she encountered.

The EDA committee presents the Maeve Leonard Award to an individual for an outstanding contribution to delirium research or clinical care. It may be during the previous year or over a number of years and takes into account the challenges, resources and barriers individuals face as well as their achievements.

The board of the European Delirium association decided to award the first Maeve Leonard prize to Professor Yngve Gustafson. He is, by any measure, one of the leading researchers in the field of delirium. He published his first original article about the syndrome already almost 30 years ago (1987) and since then he has published about 200 peer reviewed original articles in numerous international scientific journals. All these years delirium has been one of his major interest area and he has approached the syndrome from all the angles; from epidemiology to prevention, assessment and rehabilitation. He has published numerous articles about delirium and falls, hip fractures, psychotropic drugs, mobility, restraints, stroke, depression, education, and more.

Since 1992 Yngve Gustafson has made his career as a professor of geriatrics at the University of Umeå, Sweden. During this time he has supervised over 20 dissertations – many of them about delirium. In his own work he has shown many of the endeavours of the European Delirium Association: He is truly multi professional by heart, supervising a variety of medical experts, such as physiotherapists, occupational therapists, nurses, nutritionists and doctors. He has also expanded his expertise in public. After performing in TV-programs, such as “The best nursing home in Sweden”, Yngve Gustafson has become a well-known and popular media person in Sweden, defending the rights of the old citizens.

Despite of his significant scientific work, public performances, roles in scientific committees and medical teaching, he has still found time to active involvement in the European Delirium Association. He is one of the few members, who have attended almost every one of the meetings (now eleven) and has submitted his own excellent work in all of them.

After 30 years of active research, Yngve Gustafson is still continuing his impressive work for the benefit of those with delirium. As one of the best role models he enables us see the growing possibilities within the wide field of delirium.

Jouko Laurila, University of Helsinki, Finland

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Our experience with ICU Delirium –Summer 2016

This story is written about my experience as the wife of someone who exhibited serious ICU delirium, after 7 days in ICU, in the midst of a 30 day stay in hospital after a catastrophic reaction to the first round of chemotherapy. The two brochures I was handed were a good starting point and really helpful for close relatives, carers, etc., like me to help understand more about what is happening to the patient and how they can contribute positively to their outcome. I had no previous personal experience of ICU.

I will explain that I am a health coach, with much experience of working with children and adults in a way that builds on their strengths and enables them to overcome very stressful events in their lives that effect their health and learning abilities. I have studied many complementary practices. But nothing prepared me for the story that evolved in front of my eyes, during our time in ICU and the 7 days after.

As his wife of 33 years I had a unique knowledge of how the situation evolved day to day, with knowledge of “this isn’t normal for him”. Whilst in ICU he was on dialysis, because of kidney failure and excessive loss of body fluids through his temporary stoma. In ICU he progressed and went back to the normal ward after 7 days. We didn’t realise until later the delirium he had experienced in ICU.

On returning to the ward he gradually got worse and worse with what the nurse in charge recognised as delirium, but the doctors were still searching for a cause. In those 7 days he had been singing (he never does this), manically running in his bed, then lost his ability to speak, drink, eat and had been severely sleep deprived for the whole time. He would seem to be awake and then suddenly crash out. He could only communicate through nodding or shaking his head in answer to questions. He seemed to be withdrawing into himself, the doctors were running tests to try and find out what was happening including an MRI scan of his brain. We noticed he had very cold hands and feet. He was hypersensitive and it was very distressing to have to hold him down for a couple of minor procedures that he wouldn’t normally have even noticed. A couple of times he was unresponsive was actually due to nobody putting his glasses on (very poor distance eyesight) and calling him by the wrong name (he has been known for 60 years by his second name).

Melt down day
On day 8 he had, what I can only describe as a complete melt down. The sister phoned me up quite early in the morning and said he was trying to make a run for it, pulling out all his tubes and could I possibly come in as “you seem to have a knack of calming him down”. Whilst I was driving I got a message to the sister to play his favourite music near him to try and help him locate himself in the present, or at least only a few years ago. This is a technique identified for Dementia patients – I am trained as a Dementia Champion.

When I met one of the doctors on the stairs, she said prepare yourself, he is on the end of the bed in a really poor state. I found him sitting on the edge of the bed, curled up, swaying and trembling all over, his whole body seemed to be closing down. He was clearly terrified and in much physical pain from his hallucinations and what appeared to be muscle seizures. He said afterwards he just wanted to take back control, as he didn’t want a Lumbar Puncture, which was the next planned test. When I saw the terror on his face and felt it manifest in his body I knew how much pain and confusion he was in. I have experience of how people revisit trauma as flashbacks so I set about not only guiding him out of them and also at the same time releasing the hallucinations so that they didn’t need to be stored for dealing with later.

The only thing that prepared me for the next 14 hours was my experience with learning difficulties and how trauma can manifest. For example I could see him focused on the dots on his pyjamas (an indication he had...
closed down peripheral vision) and he was swaying and trembling with locked muscles.

Firstly I squashed myself between him and the end of the bed and started stroking his back and shoulders; a technique known as Havening. As I reiterated that he was safe, over and over again, I eventually got him to let me put his hand between my knees and exerting some pressure reinforced a feeling of safety, I had learned from my work with Autistic children. I used a technique known as Havening. It is achieved through simply stroking the patient on their shoulders, back, face or hands (in descending order of priority). This is very similar to how a mother would naturally stroke a baby.

Very very slowly the tremors reduced and I could guide him back onto his pillows, but most of his joints were frozen and this was clearly very painful and had to be done very slowly. He was actually stuck across the bed at this stage. He would settle for a few minutes and then another hallucination would arrive and he would start shaking violently again. He was also hyperventilating (breathing very fast only in the top of his lungs). I noticed how I was breathing, attempted to match his breathing and slowly reduce the speed, with a longer out breath than in breath. Luckily I had taught him about breathing before his stay in ICU and he seemed to recognise how I was trying to help. He couldn’t drink so I blew the herb Valerian on him to help reduce the anxiety and encourage sleep. After some time he would drift off into some sort of sleep and gaps started to appear between hallucinations that slowly became longer. If I left his side for a few moments when the doctors came in he would go straight back into another panic and the calming down had to start over again.

After 6 hours of continual support, a wonderful thing happened about 4 o’clock in the afternoon, the sister came by and said “Mr. Hickmott there is a dog downstairs and he is asking to see you”. He shot out of up, and frantically started trying to search his phone for pictures of his beloved golden retrievers. His hands were in too bad a state to use them due to massive peeling, so I helped and then found the picture in his bedside folder of Boz and Yogi. He must have studied this picture for 30 minutes and when the dog eventually arrived he didn’t take a lot of notice and just kept pointing to his picture. But the dog had shot him back into reality for which I shall always be eternally grateful. He also started to speak in short phrases.

By about 6pm he was getting approx. 15 minute gaps between incidents and as the evening went on the gaps became longer and his “sleep” more rested. During the evening I found I could tell him that I thought his dreams were videos he could tell them to STOP and then he could blow them away. This worked really well. By midnight it was OK for me to go home and I left him with a monitor.

The next morning at about 7am he phoned – he could talk, drink, eat and he thought he had had lots of sleep, but had no idea what had happened, and I assured him that I would tell him when he was ready, there was no need to discuss it now. He made steady progress and in 6 days he was home.

Coming home
I was really careful to take things very easily. When moving out of ICU into a ward I had learnt a big lesson. Going home, the need for sleep was huge as lack of sleep can in itself contribute to delirium. We also enlisted the help of some melatonin.

About 3 weeks later in the middle of the night, he says, “it is time now for me to know” so I gave him the summary. He has almost no recollection of the events in ICU or the following 7 days. His only memory is doors opening and closing in ICU and wondering who all these people were who kept passing him and why they didn’t stop to talk. A visit to ICU weeks later filled a few gaps and some very rewarding chats with Richard, Nhema and Rosalie. He discovered his bed had been next to the staff rest area and that is why so many people passed him by.
So not understanding why people were ignoring him, had such a simple solution. He seems to have had no flashbacks and his cognitive skills are good. And the very slight hesitation when he is talking sometimes is disappearing. I trust this will help other carers. I know every case is different but I am sure there are many parallels.....

Olive Hickmott

*Editors note: brochure on ICU delirium from UK ICUsteps free to download from their website www.icusteps.org. New edition due out 2017,

Young Delirium Researchers Meeting, September 2016, Belfast

Following on from the inaugural meeting in Birmingham in 2014 and the European Delirium Association (EDA) meeting in London last year young delirium researchers in the British Isles once again met recently, this time in Queen's University, Belfast. As previously the aim was to bring together early career delirium researchers to discuss shared challenges, highlight good practices and inform ongoing research efforts.

The delegates hailed from both academic and non-academic spheres and included those from medical, nursing and public health backgrounds. The keynote talk, regarding pharmacological therapies for delirium, was given by Professor Danny McAuley who was also happy to discuss the challenges faced by delirium research in the broader governance and funding contexts. Updates on active research into non-pharmacological interventions to prevent and treat delirium in the intensive care unit, delirium endotypes and outcomes in the acute medical population, the effect of delirium on populations characterised by frailty and the prediction of delirium in elective surgical populations were all presented by those researchers present. Potential study protocols for future work in the intensive care unit were proposed and discussed.

The major priorities for delirium research and suggested mechanisms for realising these were discussed with Dr Thomas Jackson engaging the audience to produce those responses outlined in Figures 1 and 2. Ongoing social media efforts and future plans for public engagement were lauded.

The key areas of prediction, prevention and education were identified as research priorities with themes of multidisciplinary working, accurate recognition of symptoms, identification of aetiological mechanisms and the stratification of risk, based on comprehensive patient assessment once again agreed upon by the group. Suggested requirements for reaching these goals are outlined in Figure 2. The potential gain to be had by
considering those patient groups who remain delirium-free in the face of potent deliriogenic insults was also discussed.

This informal meeting of active early career delirium researchers was once again enjoyable and productive, informing as it has ongoing research efforts. It was therefore judged a success. Any active researchers who would like to be included in future meetings are encouraged to contact the authors.

Emma Cunningham and Leona Bannon, on behalf of

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iDelirium (a.k.a. International-Delirium)

Over the past decade there has been a surge of scientific inquiry investigating mechanisms and outcomes of delirium. Research has spanned from the pediatric to the extreme older adult population. There is also growth in published or forthcoming guidelines from professional organisations and national bodies, including from the American Geriatrics Society, the Australian Commission, the European Society of Anaesthesiology, and the Scottish Intercollegiate Guidelines Network. To provide a means of research collaboration and knowledge translation, three major international interdisciplinary delirium societies have been formed in Europe, North America and Australasia. More recently, there has been an increasing number of public interest in delirium in social media and popular press. In 2015, following the European Delirium Association Annual meeting in London, several leaders in delirium research and advocacy set out with the goal of addressing the global need for delirium awareness and advocacy. For these initial meeting, iDelirium (a.k.a. International-Delirium) was launched (www.idelirium.org).

In the following months, a series of teleconferences were held with key stakeholders from each of the three main delirium societies to further formalize a mandate for the vision and mission for iDelirium. Subsequent face-to-face meetings have been held in conjunction with the annual conferences of the American Delirium Society in June and the European Delirium Association in November of 2016. The agreed upon mission of this international consortium is providing a unified voice for advancing care and to increase public health efforts to address delirium worldwide. In essence, it is anticipated that iDelirium will provide the speaking voice for all three societies.

Following a round table discussion at the annual European Delirium Association meeting in Vilamoura, several key priorities for iDelirium were identified:

1. An urgent need to develop consistent and clear messages to both healthcare professionals and the public.
2. A need to remove the “stigma” that may be associated with delirium by raising awareness of the syndrome and educating healthcare professionals and the public.
3. Provide information for healthcare policy-makers and managers.
4. The development of international delirium awareness activity through events, a website, and social media campaigns.

In this regard, the society has already achieved some success with two associated publications over this past year.


Over the next year, iDelirium will plan to facilitate a "World Delirium Day" and other important international awareness and educational activity for patients, caregivers, professionals, and policy makers about delirium.

Rakesh Arora, Dept of Surgery, University of Manitoba, Winnipeg.
International Meetings 2017

American Delirium Society
June 4–6, 2017 | Nashville, TN

http://www.cvent.com/events/7th-annual-american-delirium-society/event-summary-cd74fed5605a4918bc0a9c0e28561bac.aspx

European Delirium Association

12th Annual Meeting

16th-17th. November 2016

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Guidelines for authors

*Annals of Delirium Care* is a publication of the European Delirium Association which seeks to advance knowledge in the field of delirium. It is published three times a year (March, July, November). We especially welcome opinion pieces, reviews and research articles in the field.

Please send your ideas for contributions to the next Annals to valerie.page@whht.nhs.uk, or a.teodorczuk@griffith.edu.au

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Annals of Delirium Announcement

As from the next edition Spring 2017 the Annals of Delirium will be a joint publication between the European Delirium Association and the Australasian Delirium Association. The Annals of Delirium has been published since March 2010, being dedicated exclusively to delirium with an eclectic mix of articles, papers and news. We look forward to developing this journal with our Australian and New Zealand colleagues, building on its success to date.

www.delirium.org.au