NHS
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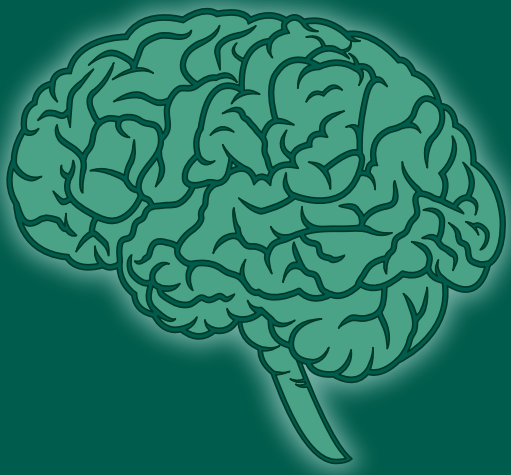
Delirium in Adult Critical Care

Information for patients & families



Adult Critical Care

What is delirium?

Delirium is a sudden change in a patient's state of mind, also known as an 'acute confusion'. It can start suddenly, and can be distressing for patients and relatives.

It is reported up to 80% of critical care patients suffer from delirium.

The three subtypes

There are three types of delirium:

HYPERACTIVE - Includes a heightened arousal, agitation and aggression, often associated with hallucinations or delusions.

HYPOACTIVE - Consists of sleepiness, lack of interest, being quiet and withdrawn. This type of delirium is often underdiagnosed in patients.

MIXED - Patient switches between both hyperactive and hypoactive.

Delirium varies individual by individual. There can be many levels of delirium, some people have very mild delirium with minimal symptoms and slight disorientation. Other patients may experience some extreme symptoms and be very unsettled and disoriented. Along with different levels of delirium, everyone also experience delirium for varying lengths of times - between days and weeks.

Symptoms of delirium

Symptoms include:

- Confusion
- Hallucinations
- Behaviour changes
- Paranoid beliefs
- Sudden mood changes
- Fluctuating conscious level
- Difficulty maintaining attention

What causes delirium?

D - Drugs/dehydration

E - Electrolyte imbalance (e.g. low sodium)

L - Level of pain

I - Infection/Inflammation

R - Respiratory failure

I - Impaction of faeces

U - Urinary retention

M - Metabolic disorder

S - Subdural haematoma/ Sleep deprivation

There are also other risk factors such as:

- Advanced age
- Malnutrition
- Poor eyesight
- Poor hearing
- Underlying brain disease
- Undertreated pain
- Immobilisation including restraints

How do we assess delirium?

Each day we assess patients with a CAM ICU (Confusion Assessment Method for ICU patients) assessment tool.

The assessment requires nurses to ask patients a series of questions in order to assess whether the patient has delirium.

Nursing staff can explain the assessment to you however it is important to let the staff complete the assessment and not complete it yourself.

To assess delirium we follow a tool called the CAM-ICU. To start with we will hold your/your relatives hand and spell out the phrase SAVEAHAART. During the spelling we will ask you/your relative to squeeze out hand every time we say the letter A. If there are 0-2 mistakes then delirium is not present. Anymore than 2 mistakes then we move onto the next part of the test.

The second part involves disorganised thinking. We will ask a series of questions, for example ‘are there fish in the sea?’, and ask for a couple of simple commands, such as ‘hold up two fingers’. If there is more than one mistake at the stage, then delirium is present. If there is only one mistake or no mistake then there is no delirium.

Delirium Treatment:

Do's:

- Medication - reviewing medications that may cause delirium and sometimes starting new drugs to treat it
- Ensuring patient is well hydrated - including IV fluids or encouraging oral fluids
- If your relative is able to eat and drink - check with the nursing staff
- Re-orientation and reassurance - reassure the patient that they are safe and orientate them to date, time and place
- Monitoring and treating pain - we use pain scales and a pain ladder to assess pain on a regular basis
- Minimum sensory impairment - ensure glasses and hearing aids are available for patient use if they are needed, it can be quite daunting for patients if they cannot see or hear properly
- Optimising nutrition - encourage oral intake of foods the patient likes, and use of NG feeding if appropriate
- Promote a normal sleep pattern - we encourage a rest period, have sleep champions during night shifts, and optimise quiet environments during sleep periods
- Bringing in photos and personal belongings that are familiar from home is great for patients

Do not's:

- Argue/confront - do not argue with patients, reassure and orientate in a calm manner
- Expose to excess noise/light disturbances - we have dedicated rest periods with the lights down allowing natural light to be let in to allow a natural rest for the patients
- Use antipsychotics unnecessarily - each patient is assessed daily with the medical team on ward round and medication to help with delirium is prescribed as required
- Use physical restraint - restraint mittens are only used in patients who are at risk of causing themselves or others injury
- Move wards/bedspaces - patients are only moved if they are clinically needed to (eg for infection or safety reasons) or to progress them on to the next stage of their recovery
- Do not ignore nicotine withdrawal - it is important to let your relatives nurse know if they usually smoke so that we can give them a nicotine patch

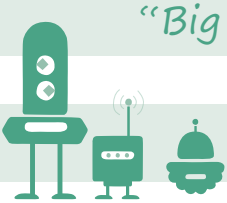
There is no timescale that we can give you as relatives as to how long delirium will last for, it does get easier and does start to resolve. Please ask your bedside nurse or nurse in charge if you have any questions. We can also ask the medical team to sit down with you to discuss if you require

Once you or your relative leaves ICU/HDU they will be seen by outreach on the ward as a follow up, they will continue to have rehab and be seen by the rehab teams. On some of the units in Adult Critical Care we have follow up clinics following discharge, please ask your bedside nurse what is available and they can give you the information appropriate to the Adult Critical Care unit you are on.

Patient quotes

Below are some quotes from patients explaining their experiences:

"Big dog on the end of the bed"



"Robots passed by"

"Weird dreams"

"Aliens killing me"

"Noise awful"

"Could not shut my eyes as I thought I would die"

"Had bugs all over me "

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