Alberta Health Services

Critical Care Strategic Clinical Network™

Chinook Regional Hospital ICU

Delirium team members and poster contributors: Scott Groves, Alison Martin, Jamie Goldberg, Marci Neher-Schwengler, Dr. Janzen, Kathy Sassa

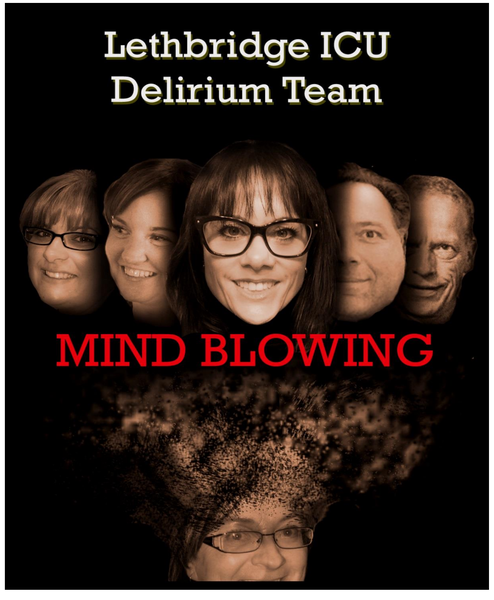
THE PAST

- Normalization/expectation of ICU patients “sometimes being confused” following recovering from a critical illness
- Belief that delirium ‘clears’ and is not harmful
- Little consideration of the patient ICU delirium experience
- Underappreciation of the importance of family presence

“It didn’t even dawn on us that delirium could have negative long term effects. We thought the delirium would pass in a couple of days & the patient would go on to live a normal life. When people are intubated, it is hard to see the person underneath. I guess we didn’t consider what they are feeling and thinking. We didn’t try to explain and comfort enough. We maybe didn’t do enough to consider their humanness. We used to think family presence was not essential to patient recovery. We didn’t think about having family see what was happening to their loved one.”

(ICU RN, 20 years experience)

OUR UNIT DELIRIUM TEAM



THE PRESENT

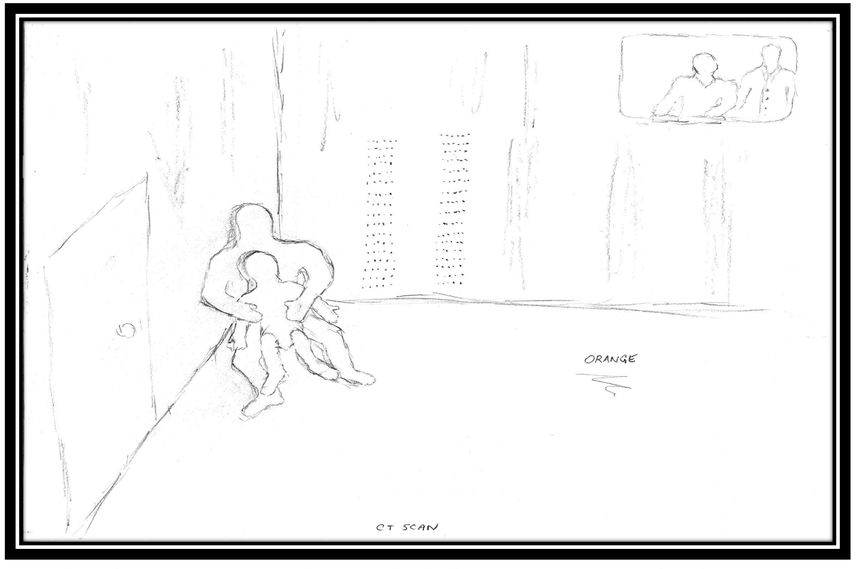
- Realization that delirium is **not** normal nor unavoidable
- Implementation of evidenced based strategies to screen for and prevent delirium
- Enthusiasm to better understand the patient’s delirium experience
- Modification of visiting regulations to encourage family presence

The following quotes and drawing were kindly shared by a 50 year old male, employed in the hospital, after experiencing a cardiac arrest, resuscitation, intubation and 6 day hospital stay:

“I thought I was a character in a movie. I didn't recognize where I was, i.e. in the ‘horse/human ICU’, on a boat/dinghy while in the ‘movie’, on the bridge of a ship that was fighting to launch with a French/Canadian captain, or in a hospital setting where everything/everyone was East Indian.”

“Any interactions with staff was dreamlike where to date I honestly can’t tell if some staff were real or imagined.”

“It was very important to have my wife and my daughters there with me though not initially. My earliest recollections after coming out of the anesthetic has me feeling a sort of mental/emotional paralysis whereby I simply couldn’t respond to anyone’s presence, hugs, encouragement or anything. It was like you were in a fog and you didn’t know how to respond to anything or anyone or even if you should.”



Drawing by a former ICU patient depicting his hallucinatory memory of undergoing a CT scan.

THE FUTURE

“The information we are receiving from the project is helping guide our care. I think we have progressed leaps and bounds from where we were. But it is easy to fall back on old patterns and not continue new ways of doing things. Having delirium information being reviewed, and having clear expectations is important. We need to advocate and ‘watch’ to make sure we can continue our work.”

ICU RN, 20 years experience

We commit to de-adopt:

Believing delirium is not harmful long term
The notion that family is not pivotal in the patients care and recovery

We will adopt:

Ongoing attention to delirium through the CRH ICU Best Practice Group
Sleep hygiene strategies
Mobilization Readiness tools
Patient and Family Centered Care practices
Standardized approach to Spontaneous Awakening trials (SATs) and to Spontaneous Breathing trials (SBTs)