You are safe. Communication with patients in delirium

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Patients with delirium often suffer from frightening experiences and hallucinations. At the same time, they experience communication impairments having difficulties to express their needs or understanding information. Communication with patients in delirium requires an empathic, patient centred approach.

Introduction

For patients in intensive care units and their families, delirium can be a frightening condition (1). Due to hallucinations and delusional experiences, a lot of patients report that they experienced anxiety, stress, felt being captured, tortured, or even abused (2). Spiders on the ceiling, worms on and in the body, and nurses changing into vampires sucking patient's blood. For some patients these experiences can be remembered for years in every detail and senses (3). As medical staff, we often avoid communication with hallucinating patients, and rather think about pharmacological interventions. From the patients' viewpoint, though, patient-centred communication is often a turning point in delirium and should be considered as equal important as any other medical procedure (2, 4).

For this purpose, we use the approach of Humanizing Delirium Care and give practical examples how to communicate with fictious Mr. Smith in delirium (5).

Mr. Smith

Mr. John Smith retired last year from his work as a builder and enjoys life with his beloved wife Marry, two children and three grandchildren. He has diabetes and some problems with his heart, but he had no time yet to make an appointment with his General Practitioner. He and his wife own a house close to the city, and since his retirement he took care of their grandchildren and the garden. Last week, when cutting the apple tree, he got a deep cut to his leg with following infection and sepsis. With high infection parameters, he was admitted to the hospital a few days ago and yesterday to the Intensive Care Unit. Given his age and infection, he developed delirium. Today, Mr. Smith is sweaty, has temperatures, receives antibiotics and seems to worry because he could not sleep, or concentrate, mentions butterflies occasionally flying through the room, and has difficulties to follow a conversation.

Humanizing Delirium Care

Humanizing delirium care entails person-centred management, with compassionate and empathetic clinicians present at the bedside (6). Humanized care involves open visiting policies, architecture and infrastructure designed to meet human needs, appropriate end-of-life care, and support for healthcare professionals. Humanizing critical care is a multidimensional approach that recognizes the individuality of each patient, including their emotions, values, and personal history. The individual is the focal point of every effort, receiving attention for their physical, mental, spiritual, and social well-being, and being encouraged to actively participate in delirium management and their overall care (7). In this manner, the concept includes eight steps, and in each one communication is essential. We apply this concept to Mr. Smith.

General considerations for communication

Delirium leads to cognitive impairment and likely has an impact on speech and its understanding. Delirious patients use fewer words in communication and description than non-delirious patients.

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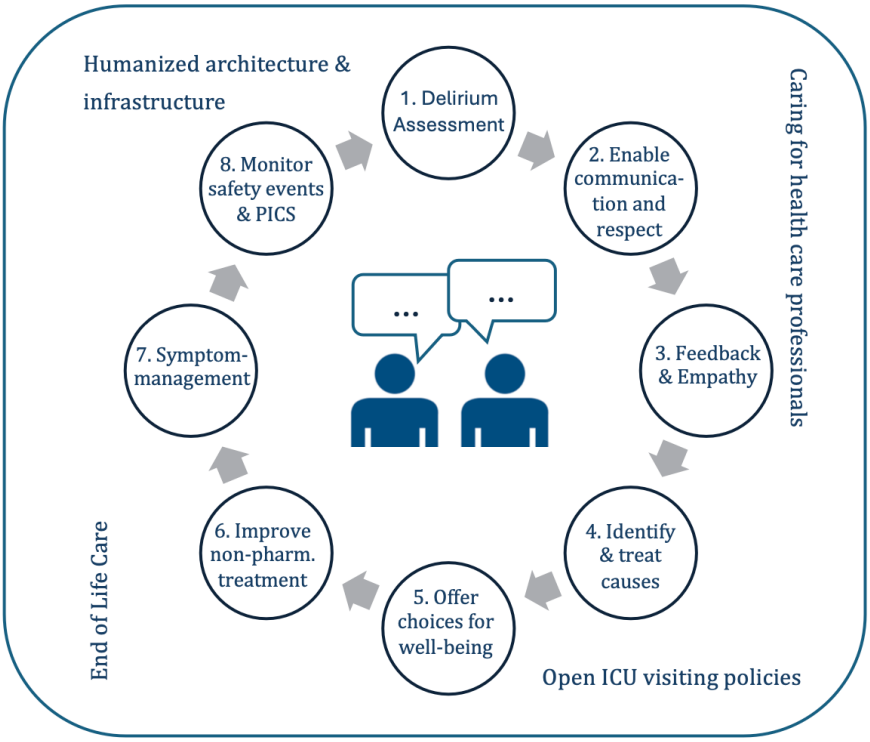
They do not understand long, convoluted sentences as well as usual. When communicating with them, we are using short sentences to convey information. No double meanings, no irony, no run-on sentences, no long lists, no baby-talk. Nurse Susan Jones approaches to Mr. Smith, speaks to him and establishes eye-contact.

"Mr. Smith, my name is Susan Jones."
"I am your nurse today."
"I'll take care of you!".
"How do you feel today?"

Mr. Smith sighs, he does not feel well. Mr. Smith is developing delirium. It is therefore advisable to inform him about delirium and name the possible symptoms.

Fig. 1: **Humanizing Delirium Care**



Footnote: adapted from (5).

Step 1: Delirium Assessment
This dialogue emphasizes empathy, respect for the patient's autonomy, and clear communication about the purpose and process of the delirium assessment. It allows Mr. Smith to feel heard and understood while also ensuring his participation in his own care.

"Hello Mr. Smith, I'm here to make sure you're comfortable.".
"Mr. Smith, sometimes, when people are in the hospital, they can feel a bit confused or disoriented. Some cannot sleep, find it difficult to concentrate, a few even hallucinate. Have you noticed these symptoms that way at all?"
"Have you been having any unclear thinking while you are in this room?"
"Hello Mr. Smith, do you have a minute? We are on our routine round to check if all patients are doing well."
"Any question that troubles you?"
"I'm also going to test to see if you can follow a simple set of directions to see how clearly you are thinking today."

The nurse informs Mr. Smith that she will perform the CAM-ICU. In non-intubated patients, who can verbally communicate, the opportunity to assess 'disorientation' should be taken. This comprises the questions "Do know what today's date is?", and naming the year, date of birth, age as well as the current location. Most patients are secure in responding to these questions.

Mr. Smith is encouraged to describe, what happened (cut to his leg) and what actions were taken thereafter (admission to hospital).
Assessing 'disorientation' not only provides a thorough impression of our patients' mental condition, but also offers medical professionals to work on their patients' re-orientation, being thereby part of delirium prevention and treatment (8).

Step 2: Enable communication and respect
We facilitate communication by providing hearing/vision/mobility aids, utilizing non-verbal communication tools, showing respect, and build trust. Nurse Susan Jones takes a moment, maintaining a calm and reassuring tone. Throughout

the conversation, she calls him by his name and uses a special dialect what is known in the area, maintaining a respectful and person-centered approach.

"Do you normally wear glasses or use hearing aids?"
"We want you to be able to see and hear while you are here in the hospital with us."
"Seeing and hearing helps us communicate with you better."

Step 3: Provide feedback and empathy

We provide feedback regarding delirium and demonstrate empathy. Susan Jones asks Mr. Smith about his experiences and listens attentively. She reflects his feelings back to him and informs him about common delirium experiences. She demonstrates empathy by holding his hand, actively listening to his concerns, mirrors feelings he is showing, and provides information about delirium in a gentle and supportive manner.
It's important to approach Mr. Smith with patience and kindness, without talking to him as though he is a baby or unable to understand words. He will be able to understand what you are saying, but due to the delirium, may not digest your words fully.

"Hello Mr. Smith. My name is Susan and you are in Intensive Care. (Takes patients hand and comforts him, sitting beside them at eye level, NOT looking down at him). You are safe and I understand that you may feel very scared, but I am here, and you are safe.
"I know that you may be seeing strange and unusual things such as butterflies, but I want to remind you that you are safe. Would you like to talk to me about what you can see?"
"I understand that you have been seeing some scary and confusing things, that you are probably struggling to make sense of. I'd like to let you know that you are safe and the things you have been seeing are not real, although they may feel real."

This approach helps patients feel understood, validated, and reassured during a challenging time.

Step 4: Identify causes for delirium & treatment

Nurse Susan Jones and the physician Dr. Miller consider underlying medical conditions, medication issues, and environmental factors. They require a counsel of the antibiotic stewardship and change antibiotics, reduce anticholinergics and ask his wife for sleeping habits. They tailor interventions to Mr. Smiths' needs and involve him in decision-making and ensure continuity of care.

"Mr. Smith, we want you to understand that your mental condition is something quite often here."
"It as an overshooting attempt of your brain to fight this infection off."
"We protect you and reduce any additional stress, unnecessary catheters, wires and drugs."
"Of course, we will get you out of bed."
"Your family is welcome at any time."
"We have rooming in for a family member, if that is an option for you."

This approach integrates guidelines with person-centered care principles for effective management.

Step 5: Offer choices for wellbeing

We offer opportunities for well-being and reducing delirium burden by addressing stressing experiences or hallucinations, enable personal habits and coping, ensure safety and confidence, perform primary nursing and perform frequent, pro-active re-assessments.

"Hello Mr. Smith, my name is Susan Jones, I am the night nurse. It is 10.00 p.m. now and your wife told me that is your regular bedtime. Shall I prepare everything for your night´s rest?"
"I will give you your i.v. antibiotics and then you tell me on which side you would like to fall asleep."
"Your wife brought your little sleeping pillow from home."
"All sounds and voices you are hearing support the improvement of your condition and health.
"I will check on you regularly and see if you need anything."
"You can relax and sleep."

Improving well-being and reducing of delirium related stress enables capabilities for coping and cooperation with the team.

Step 6: Improve non-pharmacological treatment

We facilitate the involvement of Mr. Smith's family by providing education and support, encouraging mobilization, addressing hydration and needs, writing ICU diaries to mitigate Post-Intensive-Care Syndrome (PICS), enhancing sleep quality through personalized approaches, minimizing environmental disruptions such as light and noise, and implementing additional measures.

"Hello, Mr. Smith. It is me, nurse Susan Jones. How do you feel today"?
"Your son told me that you like classical music, should I get your iPod and you listen to some music while you sit in the armchair?"
"Would you like to lift a chair out of bed? Would you like to leave the ICU this afternoon for a short walk?"

Most ICU teams are already offering multifaceted intervention bundles for preventing and treating delirium. Adapting these to the personality and habits of Mr. Smith is the next level!

Step 7: Symptom management

Mr. Smith has no severe symptoms, except for sleeplessness last night. We must take care of his delirium risks and assess likely symptoms. These may include agitation, vegetative symptoms, psychotic symptoms, anxiety, and sleeplessness. Apart from non-pharmacological interventions first symptom-specific medications may be appropriate. These may include low-dose highly potent antipsychotics against hallucinations or intermediate potent neuroleptics for sleep-promotion

"Mr. Smith, how did you sleep last night?"
"Did you experience any disturbances in your sleep or hallucinations last night?"
"How can we improve your sleeping habits here in the ICU?"
"Are you using any drugs for sleeping?"
"I would like to talk with you about sleeping drugs, to improve your mood and cognition."
"I am giving you a sleeping medicine. You will fell asleep in a couple of minutes. I will take care of you the whole night and protect you!"

The talk has to be adapted to patient's symptoms. The answers will help to improve symptom management and do not always lead to a pharmacological intervention. Involving patients in symptom management stimulates their cognition, dignity and self-confidence, and might help in coping.

Step 8: Avoid safety events and PICS

Mr. Smith is experiencing delirium, and due to our communication, he is well informed and seems to be able to cope with the situation. Nevertheless, we track adverse safety incidents such as the use of physical restraints, immobility, pain, thirst, falls, removal of lines/tubes, frightening experiences, and monitor for Post-Intensive-Care Syndrome (PICS).

"I understand this is confusing, Mr. Smith. You are in the hospital and experiencing delirium, but we are here to help you. Take deep breaths and know that you are safe. I am a nurse, and I will take good care of you. You are safe."
"Mr. Smith, we need to use these soft restraints to ensure you don't accidentally remove your IV lines. These are like gloves; they are warm and protective."
"Do you need any more information about it?"
"It's for your safety, and we'll check on you frequently to make sure you're okay. And as soon as possible, these will be removed!"

Delirium experiences can last for years, and there are several feasible interventions to reduce the risks for PICS and delirium experiences.

Mr. Smith

We invited the family to share information with us. His wife and son spend hours with him, made jokes with him, helped in mobilization and drinking, and sometimes, protected his naps. In the late evening, they went home for sleeping, but had a short video call from home to say good night. Mr. Smith was satisfied and confident, he could sleep with some interruptions, but without drugs, and the butterflies flew away. Next day, his condition

improved, and he wondered what happened. We offer him reading his ICU diary.

Communication is key (9, 10). Humanizing Delirium Care is a pro-active approach, considering patient's view and personality, and integrating the patient as active partner in the prevention and treatment of delirium.

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