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LETTER

Humanizing Delirium Care

Peter Nydahl[1,2*], E. Wesley Ely[3] and Gabriel Heras-La Calle[4,5,6]

Dear Editor,

With great interest, we read Richard's report of his recovery after 6 weeks on an intensive care unit (ICU) [1]. Most of the time, he had been in coma and delirium. Afterwards, he remembered vivid dreams, such as gunshots, being in different places, being hunted, or sexual abuse. His former partner wrote an ICU diary for him, which helped him to cope with this existential period of his life. He also remembered one nurse who explained to him experiences of nightmares and hallucinations [1]. Someone who talked with him.

Delirium is defined as a cerebral dysfunction [2]. As clinicians in critical care, we are used to treating this organ dysfunction first with a focus on non-pharmacological measures, and, if the organ dysfunction persists, turning to safe pharmacological approaches, to preserve patients' health. And often, we are standing at the bedside, talking about the patient, possible causes, and discussing pros and cons of treatment options. Who is talking with a patient in delirium? Who is the nurse or clinician explaining these disturbing experiences to the person? Even with disturbed cerebral networks, the personality of patients still exists, and they put their experiences in their own, personal context. From the patient's view, interaction can be terrifying or soothing, and establishing trust should be as important as other medical procedures [3]. Delirium management has advanced during the last decade [4], and we think that it is time for a next level: humanizing delirium care.

In a highly specialized, technically best equipped environment, humanizing critical care is a multi-dimensional concept, addressing individual persons with own feelings, values, and history. The person is the center of every effort, cared for physical, mental, and spiritual needs, and encouraged to take an active role [5].

Based on a discussion about the meaning of humanizing delirium care during the fourth conference about post intensive care syndrome (PICS) in Madrid, organized by the Itaca-Group, a first approach has been developed (Fig. 1).

At the bedside, humanizing delirium care includes:

- Respect and trust: use patients name and titles, ensure safety
- Communication skills: personalized (non-)verbal communication techniques with (non-)speaking patients, mirroring, reassuring
- Empathy: consider patients' view, experiences
- Personality: ask and listen for experiences and patient's story
- Acceptance: re-orientate and re-frame
- Accompaniment: hold hand if appropriate, assess symptoms and tolerance
- Autonomy: offer feasible choices, e.g. sitting in a chair, or being in bed
- Resilience: ask for personal coping strategies, e.g. information, family, prayers, music
- Safety: continuous clinicians, explain environment, ensure vision/hearing aids
- Hope: integrate family, support personal coping

All patients like Richard who are suffering from delirium must have a holistic and humanistic approach. Humanizing delirium care means person-centered delirium-management, with compassionate and empathic clinicians at the bedside. Best care will entail immediate interventions to find reversible causes for ICU delirium and treat them accordingly. Additionally, symptom-orientated patient-centered interventions according to FRAMES (i.e. Feedback, Responsibility, Advice, Menu of behavioral change, Empathy and Self-efficacy) should be implemented. This results in empowerment of relatives and the inter-professional staff to support patients in these dire situations.

*Correspondence: Peter.Nydahl@uksh.de
[1] Nursing Research, University Hospital of Schleswig-Holstein, Kiel, Germany
Full author information is available at the end of the article

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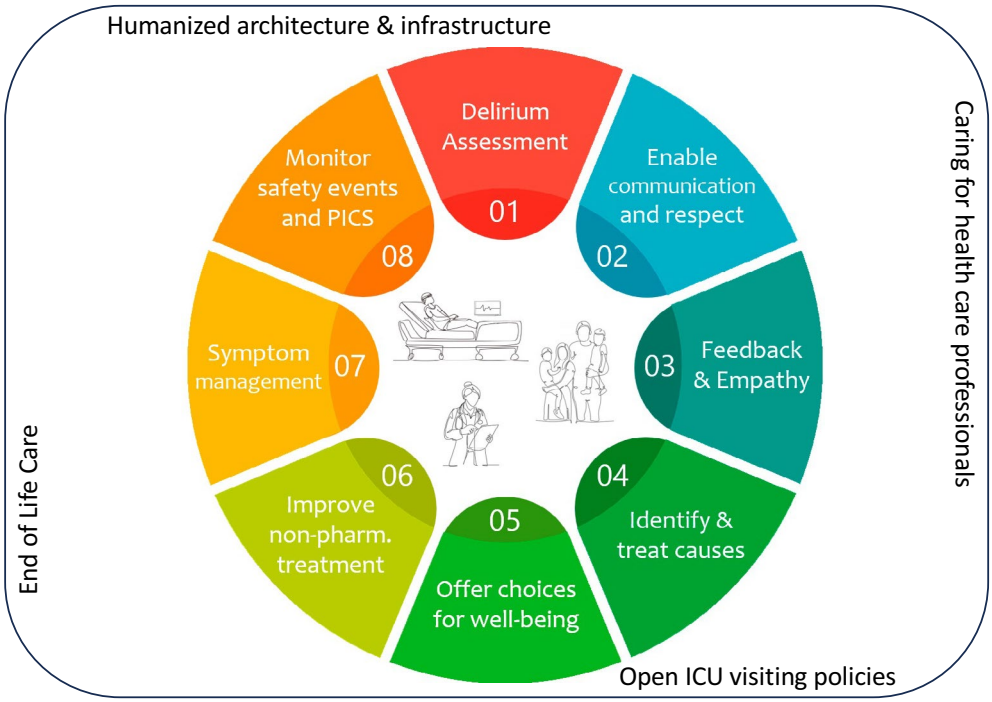

1. Perform frequent and valid (re-) assessments of consciousness, pain, delirium, thirst, anxiety, fatigue, immobility.
2. Enable communication by hearing/vision/mobility aids, use of non-vocal communication aids, show respect and use patient's name; establish trust.
3. Give feedback about delirium and show empathy, ask patient for experiences & listen, mirror feelings, inform about common delirium experiences
4. Identify and treat causes of delirium, according to guidelines
5. 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 frequent, pro-active re-assessments
6. Perform family integration incl. family education and encouragement, out-of-bed mobilisation, address thirst and excretion, write ICU Diaries to reduce Post-Intensive-Care Syndrome, improve sleep by considering personal habits, reducing lights & noise, and more
7. Perform symptom management and address agitation, vegetative symptoms, psychotic symptoms, anxiety, sleep disorders by non-pharmacological interventions; in case of no improvement, use specific drugs for specific symptoms, reduce drugs with side-effects on delirium
8. Monitor unwanted safety events such as physical restraints, immobility, pain, thirst, fall, removal of lines/tubes, frightening experiences, and monitor Post-Intensive-Care Syndrome (PICS)

Fig. 1 How to perform humanizing delirium care

Author details
[1] Nursing Research, University Hospital of Schleswig-Holstein, Kiel, Germany. [2] Institute of Nursing Science and Development, Paracelsus Medical University, Salzburg, Austria. [3] Critical Illness, Brain Dysfunction, and Survivorship (CIBS) Center at Vanderbilt University Medical Center and the VA Geriatric Research Education Clinical Center (GRECC), Nashville, TN, USA. [4] Director of the International Research Project for the Humanization of Intensive Care Units (Proyecto HU-CI), Madrid, Spain. [5] President of Humanizing Healthcare Foundation, Madrid, Spain. [6] Intensive Care Unit, Hospital Universitario de Jaén, Jaén, Spain.

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References
1. Richards D (2023) Transitioning to reality: the diary of an ARDS survivor. Intensive Care Med. https://doi.org/10.1007/s00134-023-07233-2
2. Wilson JE, Mart MF, Cunningham C, Shehabi Y, Girard TD, MacLullich AMJ, Slooter AJC, Ely EW (2020) Delirium. Nat Rev Dis Prim 6:90
3. Falk A, Stenman M, Kåhlin J, Hultgren R, Nymark C (2023) Suffering in silence - Cardiac surgery patients recalling hypoactive delirium a qualitative descriptive study. Intensive Crit Care Nurs 79:103493
4. Kotfis K, van Diem-Zaal I, Roberson SW, Sietnicki M, van den Boogaard M, Shehabi Y, Ely EW (2022) The future of intensive care: delirium should no longer be an issue. Crit Care 26:200
5. Heras La Calle G, Oviés ÁA, Tello VG (2017) A plan for improving the humanisation of intensive care units. Intensive Care Med 43:547–549