PAIN, AGITATION AND DELIRIUM
MORE THAN JUST AN APP: RESOURCES AND COLLABORATIVES
VINAY DHINGRA CLINICAL LEAD CRITICAL CARE BCPSQC
Topic Background

• Identified as a high priority item for Patient Safety and Quality by a number of regulatory bodies including:
  • Society of Critical Care Medicine
  • Canadian Patient Safety Institute
• BC ICU practitioners identified PAD as a major area for quality improvement
Topic Description

• Provincial survey 30 ICU’s from all Health Regions

• A gap between current PAD practice and ideal practice as outlined by the Society of Critical Care Medicine guidelines
Measures: Agreement with MOH, HA, pCCWG, BCPSQC

Database Updates and Train Informatics Nursing

BC Critical Care PAD Education Day

Standardized Reporting of Quality Metrics to Drive QI
The following metrics will be collected within the provincial ICU database and used to identify opportunities for local improvement at each clinical site:

**Quality Improvement Process, Outcome, and Balancing Metrics**

**Pain**
- Pain assessment/monitoring occurs q4H & PRN* (Numeric Rating Scale (NRS) or Behavioral Pain Scale (BPS) (process)
- % of measurements that indicate significant pain (i.e. NRS ≥4 or BPS ≥6) (outcome)

**Agitation**
- Richmond Agitation Sedation Scale (RASS) is measured q4H & PRN* (process)
  - For each value:
    - Target RASS
    - Actual RASS
  - Difference between target and actual RASS (outcome)
  - Balancing Measure: Incidence of unplanned extubations.

**Delirium**
- Delirium is assessed 1x/12 hour shift & PRN* (process)
- % of measurements in which Confusion Assessment Method for the ICU (CAM-ICU) is positive or Intensive Care Delirium Screening Checklist (ICDSC) ≥ 4 (outcome)

*PRN – a point when a provider thinks a change in clinical status may be due to pain, agitation or delirium OR a follow-up measure is required because the patient has just received an intervention for one of these.
# Summary of Admissions, ICU Days & Collected Data

FY 2015/16 Q1 (ending June 18, 2015)

## Hospital A

<table>
<thead>
<tr>
<th>All Days</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>&gt; Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases in the Unit</td>
<td>331</td>
<td>331</td>
<td>318</td>
<td>268</td>
<td>208</td>
<td>168</td>
<td>139</td>
<td>117</td>
</tr>
<tr>
<td>Total ICU Days*</td>
<td>2639</td>
<td>331</td>
<td>318</td>
<td>268</td>
<td>208</td>
<td>168</td>
<td>139</td>
<td>117</td>
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</table>

## Hospital B

<table>
<thead>
<tr>
<th>All Days</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>&gt; Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases in the Unit</td>
<td>149</td>
<td>149</td>
<td>140</td>
<td>119</td>
<td>101</td>
<td>89</td>
<td>75</td>
<td>64</td>
</tr>
<tr>
<td>Total ICU Days*</td>
<td>1117</td>
<td>149</td>
<td>140</td>
<td>119</td>
<td>101</td>
<td>89</td>
<td>75</td>
<td>64</td>
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## Hospital C

<table>
<thead>
<tr>
<th>All Days</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
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<th>Day 6</th>
<th>Day 7</th>
<th>&gt; Day 7</th>
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</thead>
<tbody>
<tr>
<td>Total Cases in the Unit</td>
<td>67</td>
<td>67</td>
<td>61</td>
<td>55</td>
<td>46</td>
<td>44</td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td>Total ICU Days*</td>
<td>602</td>
<td>67</td>
<td>61</td>
<td>55</td>
<td>46</td>
<td>44</td>
<td>36</td>
<td>31</td>
</tr>
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</table>

## Hospital D

<table>
<thead>
<tr>
<th>All Days</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>&gt; Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases in the Unit</td>
<td>45</td>
<td>45</td>
<td>44</td>
<td>32</td>
<td>25</td>
<td>18</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Total ICU Days*</td>
<td>204</td>
<td>45</td>
<td>44</td>
<td>32</td>
<td>25</td>
<td>18</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

Total 592 Cases with 4,562 Days in ICU

**RASS Records**
- 10,543 Target RASS
- 23,398 Actual RASS

**Delirium Records**
- 5,530 Delirium Assessments

*ICU Days are distinct calendar days and not length of stay
RASS Data
Target RASS Documentation & Compliance

Requirement: At least 1 Daily Target or PRN

Hospital A

- Total ICU days: 2,639
- Days 1-7: 331, 318, 268, 208, 168, 139, 117
- Days 8+: 1,090
- % Days: 88%, 88%, 87%, 91%, 93%, 94%, 91%, 93%

Hospital B

- Total ICU days: 1,117
- Days 1-7: 149, 140, 119, 101, 89, 75, 64
- Days 8+: 380
- % Days: 48%, 58%, 59%, 51%, 47%, 46%, 45%, 42%, 40%
Actual RASS Documentation & Compliance

Requirement: Minimum 3 Assessment per 12 hr Nursing Shift or PRN

Hospital C
- Total: 88% (64% with scores, 65% compliant)
- Day: 83% (65% with scores, 63% compliant)
- Night: 93% (63% with scores, 63% compliant)

Hospital D
- Total: 97% (87% with scores, 87% compliant)
- Day: 97% (87% with scores, 87% compliant)
- Night: 98% (87% with scores, 87% compliant)
Average Target to Actual RASS

Average Target RASS
Per case per ICU day
All ICU Days

Average Actual RASS
Per case per ICU day
All ICU Days
Delirium Data
Hospital A Delirium Measurements

- Total: 4,374
  - Expected # of Shifts: 1,971 (45%)
  - Documented # of Shifts: 2,229 (37%)
  - % Shifts with Documentation: 53%

- Day: 2,145
  - Documented # of Shifts: 834
  - % Shifts with Documentation: 37%

- Night: 1,137
  - Documented # of Shifts: 1,137
  - % Shifts with Documentation: 53%
Presence of Delirium Assessment as % of ICU Days: Hospital B

- **All Days:** 149 Cases, 1906 Records
  - Delirium: 31%
  - No Delirium: 46%
  - Not Applicable: 15%
  - Unknown: 8%

- **Day 1:** 149 Cases, 168 Records
  - Delirium: 23%
  - No Delirium: 26%
  - Not Applicable: 8%
  - Unknown: 15%

- **Day 2:** 140 Cases, 254 Records
  - Delirium: 21%
  - No Delirium: 52%
  - Not Applicable: 19%
  - Unknown: 5%

- **Day 3:** 119 Cases, 207 Records
  - Delirium: 27%
  - No Delirium: 50%
  - Not Applicable: 14%
  - Unknown: 3%

- **Day 4:** 101 Cases, 175 Records
  - Delirium: 33%
  - No Delirium: 42%
  - Not Applicable: 12%
  - Unknown: 8%

- **Day 5:** 89 Cases, 167 Records
  - Delirium: 38%
  - No Delirium: 46%
  - Not Applicable: 8%
  - Unknown: 5%

- **Day 6:** 75 Cases, 128 Records
  - Delirium: 41%
  - No Delirium: 48%
  - Not Applicable: 8%
  - Unknown: 5%

- **Day 7:** 64 Cases, 965 Records
  - Delirium: 39%
  - No Delirium: 48%
  - Not Applicable: 8%
  - Unknown: 5%
Incidence of Delirium Assessment: Hospital B

**Incidence in All ICU Cases**

**Incidence in Documented ICU Cases**
Prevalence of Delirium among ICU Cases

**Hospital A**
Total 331 Cases

- At least 1 Day in Delirium: 46%
- No Days in Delirium: 31%
- All Days Not Documented: 2%
- Some Days with Non Documentation: 21%

**Hospital B**
Total 149 Cases

- At least 1 Day in Delirium: 55%
- No Days in Delirium: 24%
- All Days Not Documented: 8%
- Some Days with Non Documentation: 13%

**Hospital C**
Total 67 Cases

- At least 1 Day in Delirium: 37%
- No Days in Delirium: 33%
- All Days Not Documented: 8%
- Some Days with Non Documentation: 22%

**Hospital D**
Total 45 Cases

- At least 1 Day in Delirium: 58%
- No Days in Delirium: 15%
- All Days Not Documented: 18%
- Some Days with Non Documentation: 9%
RESOURCES AND COLLABORATIVES
WHAT THE PEOPLE WANT...

Driver Diagram
Online Web Resources
Clinical Conference
Webinars
Canadian Collaborative
PAD Application
**PAIN**

**Prevent pain caused by routine care and procedures.**
- Identify and reduce (where possible) the underlying causes of pain in your patient.
- Provide pre-emptive analgesia before known painful procedures such as traction, suctioning and enemas.
- Have simple tools available at the bedside to help your patient voice concerns about pain.
- Talk about pain for each patient in rounds.

**Assess and monitor pain at routine intervals.**
- Use the Numeric Rating Scale (NRS) or Behavioral Pain Scale (BPS) to assess pain and titrate medications as per PRN (e.g., NRS 1-10 or BPS 0-2 indicates significant pain).
- Use tools and resources at the bedside for pain measurement and management (NRS or BPS tools).
- Create simple documentation tools for pain assessment and management (document meds or treatment and effectiveness in revisiting/managing care).

**Treat pain as required using the appropriate non-pharmacologic and pharmacologic interventions.**
- Align the use of analgesics with the NRS or BPS scores.
- Coordinate with health practitioners to assist with non-pharmacologic pain control.
- Understand which non-pharmacologic therapies such as talk therapy, music or massage may work for each individual patient and clearly identify these at the head of the bed.
- Ensure that non-pharmacologic therapies are easily accessible.

**AGITATION**

**Prevent agitation by assessing underlying causes.**
- Identify and reduce (where possible) the underlying causes of agitation in your patient (e.g., pain, dyspnea, hypoxemia, confusion, and respiratory asphyxia).
- Provide patients and families with tools to help them communicate with patients about agitation and possible causes.

**Set daily targeted level of sedation for each patient at least once per day.**
- Provide the Richmond Agitation Sedation Scale (RASS) tool at the bedside for easy access. Assess actual RASS at least 1x and PRN.
- Display the targeted RASS score visually at the bedside and discuss goals with ICU team, family members, and caregivers.
- Provide RASS score at start of ICU flow sheet.
- Create simple documentation tools for agitation assessment and management (document meds or treatment and effectiveness in revisiting/managing agitation).

**Treat agitation to reach target goal.**
- Discuss the target and actual RASS in daily rounds to ensure patient-directed, goal-oriented sedation.
- Use the least sedative possible to keep the patient from being agitated.
- Purchase non-pharmacologic therapy kits for use in ICUs for patients and families (e.g., iPods, music, pads, massage oils and massage mats, white noise machines).

**DELIURIIUM**

**Identify risk factors for delirium and take steps to prevent them.**
- Be proactive about prevention—it is easier to prevent than treat. Talk about delirium risks for each patient in daily rounds.
- Provide a risk assessment tool for delirium in critically ill patients—use the tool to assess for known risks such as delirium, hypoxemia, hypotension, and high severity of illness at baseline.
- Remove clinicians from a timely manner.
- Pursue an optimal daily mobilization care plan for each patient including spontaneous breathing exercises.
- Provide patients with their eyeglasses and hearing aids if needed.
- Optimize patient’s environments using strategies to control light and noise.
- Review patient care activities.
- Decrease stimuli at night to prevent patients’ sleep cycles.
- Orientate patients to daily time, date, activities and surroundings with help of families and caregivers.
- Provide families/guardians cognitive stimulation such as music and photos of loved ones at bedside.
- Allow families and patients to see non-pharmacologic measures provided by the units (e.g., iPods, music, pads, massage oils and massage mats, white noise machines).
- Provide families and caregivers with tools to create a daily snapshot of the patient journey to share with patient during recovery—social media, tools, and cameras.

**Assess delirium at regular intervals.**
- Use the CAM-ICU or Intensive Care Delirium Screening Checklist (ICDCSC) once per 12 hour shift and links to assess delirium.
- Display the tool at the bedside for easy access.

**Treat delirium appropriately.**
- Reverse underlying causes of delirium (pain, hypoxemia, hypotension, dehydration) rapidly and appropriately.
- Use appropriate evidence-based pharmacologic therapy to treat delirium.

**Mobilization.**
- Focus on purposeful movement.
- Coordinate movement schedule as a team (ARF holidays).
- Be flexible—adapt to patient’s schedule, rather than practitioners schedules.
- Adapt hours for better IT coverage—increase off support.
- Include patients and family/tangibles in mobility plan—give family an active role.
- Break down barriers/acculturation among mobilizing and ward patients—work on changing the culture.
- Create tools to follow protocols for mobilizing the ventilated patient.
- Allow good rest periods and good night time sleep patterns so your patient is rested and ready for daily mobilization.

**CHANCE IDEAS**

- **Use simulation to practice using local tools responding to PAD scenarios as an interdisciplinary team.**
- **Initiate PAD bundles (briefs and debriefs) for real-time feedback and education.**
- **Display PAD poster for awareness.**
- **Display driver diagram and build on change ideas with your team.**
- **Ask your team to self-identify a physician and nursing TC leader or champion.**
- **Join the Critical Care Community of Practice at https://courses.ucsf.ca/clinical-improvement/care-of-critically-ill-patients**

**Promote interdisciplinary teamwork and sharing of information.**
- **Develop a coordinated care plan which involve and maximize the efficiency and effectiveness of the interdisciplinary team.**
- **Use a locally shared hard tool for critically ill patients which include components to identify and discuss the care plan for PAD.**
- **Use a hard tool that includes scores for RASS, BPS, or NRS, and CAM-ICU or Intensive Care Delirium Screening Checklist (ICDCSC).**
- **Provide patients/staff from your local context—both good and challenging experiences to learn from.**
- **Encourage point of care staff involved in any tool development.**
- **Reinforcement for change culture—resources, advice, time, leadership to remove barriers.**
- **Real time audits of information be used for quality improvement—collect simple data.**
- **Create enthusiasm (get the early adopters to lead the way to engage the early majority) allows groups to start small and lead, develop a culture where it is US to fail.**
- **Shadow exemplary sites.**
- **Create mechanisms for continual access sites in HAI to reduce duplication.**
- **Use interdisciplinary strategies—ie ES works with ICU.**
- **Provide quick and simple information and education on PAD accessible as online resources.**

**Develop and support an environment of respect and open communication with families and caregivers.**
- **Provide support for the psychological wellbeing of families of loved ones who are critically ill.**
- **Include discussions about PAD in family meetings.**

**Inform and involve family and caregivers to recognize, understand and take appropriate roles in reducing PAD in their loved ones.**
- **Help families recognize PAD in their loved one.**
- **Involves families and caregivers to participate in the care of patients who are at risk of or who are experiencing PAD.**
- **Provide family and caregiver with informational PAD pocket cards.**
- **Use standardized language to provide best practices and share best practices in terms of adherence in communication with patients and families experiencing issues with PAD.**
- **Create space for face to face and involve families and caregivers to the bedside during routine care.**
- **Invite family and caregivers members to be part of ICU rounds.**
- **Invite families to bring in familiar music, photos and items from home to aid in cognitive orientation.**
- **Invite families to assist in non-pharmacologic treatment of pain and agitation (relaxation techniques, massage, talk therapy, music).**
- **Invite families to provide support in mobilization of patients.**
- **Provide families and caregivers to use non-pharmacologic resources provided by the units (e.g., iPods, music, pads, massage oils and massage mats, white noise machines).**

**Definitions**

Primary Drivers: Key areas that research shows we need to address in order to reach our aim.

Secondary Drivers: Actions we can take to successfully implement primary drivers.

Change Ideas: Suggestions to help us implement secondary drivers.

**Process Measure:** A process measure shows how the parts or steps in the system are performing as planned. Are we on track in our efforts to improve the system?

**Outcome Measure:** An outcome measure shows if the system improves the health and wellbeing of patients. Are we meeting the intended aim for our patients?

**Balancing Measure:** A balancing measure shows if changes designed to improve one part of the system are causing new problems/improvements in other parts of the system.

**References**


Care of Critically Ill Patients

Timely, appropriate, effective and safe care for every patient in an ICU in BC is our vision. With a focus on both clinical and performance improvement, we are moving towards achieving our goal.

You can improve critical care delivery across the province:

Join our Critical Care Community of Practice

Our new, online network for all health care professionals delivering critical care in BC.

- Share resources and guidelines.
- Create and join discussions.
- Learn and share knowledge.
Canadian Critical Care Conference
Whistler, BC | March 1-5, 2016

Is a fun casual week of learning (and skiing) more your style? Register below for the Canadian Critical Care Conference in Whistler. They've included a PAD workshop this year. This is one event you can't miss!
Webinars ICU Liberation via SCCM

Family Engagement and Empowerment
An Invitation to Join a National Improvement Initiative: "PAD Your ICU"

Starts now! | From the Canadian ICU Collaborative
PAD APP (in development): Clinicians / Families

Opening Screen in App to go to either clinicians or families
Introduction to PAD
Pain
Agitation
Delirium
ABCDEF Bundle
Pharmacy
Early Mobility
Care Planning
Families - Part of the Care Team
Assess
Pain assessment should be routinely performed in all ICU patients q4H & PRN

NRS – Numeric Pain Rating Scale
BPS – Behavioural Pain Scale

Prevent and Treat
• Early goal directed sedation
• Pharmacy

Link to transactional tools - next two slides
## Behavioral Pain Scale (BPS) 3-12

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Facial expression</td>
<td>Relaxed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Partially tightened (eg, brow lowering)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fully tightened (eg, eyelid closing)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Grimacing</td>
<td>4</td>
</tr>
<tr>
<td>Upper limbs</td>
<td>No movement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Partially bent</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fully bent with finger flexion</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Permanently retracted</td>
<td>4</td>
</tr>
<tr>
<td>Compliance with ventilation</td>
<td>Tolerating movement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Coughing but tolerating ventilation for most of the time</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fighting ventilator</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Unable to control ventilation</td>
<td>4</td>
</tr>
</tbody>
</table>

Prevent and Treat
Pre-emptively treat for procedural pain.

Ongoing, use early goal directed sedation and pain management – a high prevalence of deep sedation in the first 48 hours after initiation of mechanical ventilation which was found to independently predict delayed time to extubation and increased long-term mortality. This information suggests interventions be delivered early with a strategy to facilitate light sedation.

Pharmacy

### TABLE 3. Pharmacology of Opiate Analgesics (1, 128, 440, 472) (p. 270)

### TABLE 4. Pharmacology of Nonopiate Analgesics (1, 91, 132, 440) (p. 272 from SCCM guidelines).

### TABLE 6. Clinical Pharmacology of Sedative Medications (1) (p. 276).

Pop-Up Information:
Suggest pre-emptively treating other types of procedural pain with analgesic and/or non-pharmacologic therapy
• Use opioids as first line therapy for treatment of non-neuropathic pain
• Suggest using non-opioid analgesics in conjunction with opioids to reduce opioid requirements and opioid-related side effects
• Use gabapentin or carbamazepine, in addition to intravenous opioids, for treatment of neuropathic pain
• Use thoracic epidural for postoperative analgesia in abdominal aortic surgery patients
• Suggest thoracic epidural analgesia be used for patients with traumatic rib fractures

NOTE: These are the tables we will want to translate to the app design format and then as per below have a link to the current Canadian CPS - this outlines the formats – all HAs would require access, which they do – we would need to figure out how this would work with the pharmacy expert group.
Assess
Patients should be evaluated for identifiable and avoidable delirium risk factors every day.

Therapeutic interventions should be assessed in terms of their likelihood of either causing or exacerbating delirium in individual patients (e.g., physical and chemical restraints).

CAM-ICU
Intensive Care Delirium Screening Checklist (ICDSC)

Prevent and Treat
1. Acute Change or Fluctuating Course of Mental Status:
   - Is there an acute change from mental status baseline? OR
   - Has the patient’s mental status fluctuated during the past 24 hours?

2. Inattention:
   - “Squeeze my hand when I say the letter ‘A’.”
     Read the following sequence of letters: SAVE A HA ART
     ERRORS: No squeeze with ‘A’ & Squeeze on letter other than ‘A’
   - If unable to complete Letters → Pictures

3. Altered Level of Consciousness
   Current RASS level

4. Disorganized Thinking:
   1. Will a stone float on water?
   2. Are there fish in the sea?
   3. Does one pound weigh more than two?
   4. Can you use a hammer to pound a nail?

   Command: “Hold up this many fingers” (Hold up 2 fingers)
   “Now do the same thing with the other hand” (Do not demonstrate)
   OR “Add one more finger” (If patient unable to move both arms)
Suggest pre-emptively treating other types of procedural pain with analgesic and/or non-pharmacologic therapy
Use opioids as first line therapy for treatment of non-neuropathic pain
Suggest using non-opioid analgesics in conjunction with opioids to reduce opioid requirements and opioid-related side effects
Use gabapentin or carbamazepine, in addition to intravenous opioids, for treatment of neuropathic pain
Use thoracic epidural for postoperative analgesia in abdominal aortic surgery patients
Suggest thoracic epidural analgesia be used for patients with traumatic rib fractures

Target the lightest possible level of sedation and/or use daily sedative interruption
Use sedation protocols and checklists to facilitate ICU sedation management
Suggest using analgesia-first sedation for intubated and mechanically ventilated ICU patients
Suggest using non-benzodiazepines for sedation (either propofol or dexmedetomidine) rather than benzodiazepines (either midazolam or lorazepam) in mechanically ventilated adult ICU patients

Avoid using rivastigmine to reduce the duration of delirium in ICU patients
Suggest avoiding the use of antipsychotics in patients who are at risk for torsades de pointes
Suggest not using benzodiazepines in ICU patients with delirium unrelated to ETOH/benzodiazepine withdrawal

Invite families to support non-pharmacologic therapies in coordination with pharmacologic therapies
(Families – How You Can Help)
The patient condition will dictate how involved the might be and the critical care team will be best at deciding how and when to involve the family for the safety and quality of care of the patient.

Some ways to invite families into the care team: Your care team will need to decide which of these you would like to try to include – and how.

- Eliminate formal visiting hours
- Allow families to orientate patient to time and place
- Gentle massage and music therapy
- Patient/Family Inclusion in Rounds
- Patient/Family Debrief Meetings
- ICU Diary’s
- Help with Early Mobility
- End-of-Life Care: Keepsakes and Mementos
Family

Introduction to Pain, Agitation and Delirium (PAD)
   ABCDEF Bundle
   How you can help

The ICU Environment

The Care Team

Why Does my Loved One Look Like This?

Participating in Care
   Asking Questions
   Making Decisions

ICU Survivorship

Jason’s Story
Erica’s Story

Each can be clicked on and will open the information page for each
Why Does my Loved One Look This Way?

http://jama.jamanetwork.com/article.aspx?articleid=183625#ICUCA
RETIAI
What should I say to my loved one?
Speak normally. The patient might not be able to respond to you, but your voice will be reassuring and familiar.

Is it okay to touch my loved one?
Yes. Touching is usually comforting. The nursing staff will let you know if this is interfering with rest or care.

How long should I visit?
In general, you need to visit as long as it is helpful – check with the staff for specific visiting policies.

Should I bring anything from home? It is best to limit bringing too many items from home for infection control reasons, however, familiar things are often comforting to a patient. You should check with the nurse before bringing anything into the ICU. Photographs may be helpful. Many ICUs may have the capability to play favorite music or videos.
There will be times when decisions about care should be made jointly between the care team and the patient/family.

Many decisions must be made for patients by physicians and the care team. For example, which kinds of medications to use.

Some decisions will require your input.

**Examples of Decisions:**

- Surgeries and Procedures
- Life Support
- Other Common Questions and Decisions
- Making Confident Decisions
- My Questions and Notes
- Other Resources
PAD stands for:
Pain / Agitation / Delirium

These are common issues for ICU patients. They may occur together or alone.

The critical care team use evidence-based guidelines to prevent and treat PAD in ICU patients. These guidelines are called the ABCDEF Bundle.

The ABCDEF Bundle provides advice on how to take care of the patient both physically and mentally.
There are many issues to address during recovery from critical illness.

Common issues include:

- Physical weakness
- Difficulty thinking
- Anxiety or depression
- Emotions including frustration, anger, sadness

Your loved one’s doctor can help with these issues.

Resources for ICU Survivorship

THANK YOU

Questions/Discussion