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Delirium in ICU: Consumption of NSAIDs and Steroids by Critical Care Nursing and Assistants

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Letter to Editor

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Letter to Editor

Most healthcare professionals consider delirium in the intensive care unit a common and serious problem, although few actually monitor for this condition and most admit that it is under diagnosed [1]. Delirium is a common neurocognitive disorder with the hallmark of disturbed attention and awareness developing over a short period of time. Common predisposing risk factors for delirium are advanced age and dementia. Delirium causes functional impairment, increased falls, increased healthcare costs, prolonged hospitalization with an increased risk of placement in long-term care at discharge and increased risk of mortality [2]. Delirium also causes significant psychological distress for patient's families and healthcare providers. It has been estimated that aprox 30% of delirium episodes can be prevented and treated using multicomponent non-pharmacological strategies [3].

At present, clinical practice guidelines for the management of delirium in intensive care units are not very practical because of their complexity, which makes it difficult to use them in our daily clinical practice [4]. Bush, et al. [5] in your recent work, confirms the importance of systematic grey literature searches to source tangible delirium clinical practice guidelines, and to ensure important guidelines are not overlooked. Poor accessibility of a guideline reduces compliance, in addition to its complexity and length [5]. I find it interesting to report the use of oral NSAIDs and intramuscular steroids of nursing staff and assistants who treated patients with delirium during an 8-hour shift (15: 00-22: 00 h). There were 15 post-surgical patients in our Intensive Care Unit, 4 of whom were diagnosed of hyperactive delirium. The nurse/patient ratio was 1:3. The patients 1-2 received intravenous infusion at 0.4-0.7 microg / Kg per hour for dexmedetomidine, a third haloperidol on demand and the fourth a combination of propofol and opiods. The patients 1-2 were diagnosed of moderate respiratory insufficiency with non-invasive ventilation (NIV-CPAP) and were tied, so that the mask could not be removed, this meant constant attention by the nursing staff and the patient's continued positioning. The third patient removed the nasogastric tube and the arterial catheter, also was tied. The fourth patient evolved successfully. Patient 1 and 3 were morbid obesity II/III. The first two patients shared nurse and the same assistant. The third and fourth patients had different nurses and the same assistant. Nurse´s patients 1-2 presented exacerbation of a lumbociatalgia and migraine that needed oral NSAIDs and methylprednisolone im. Nurse´s patient 3 presented intense cluster headache, accurate NSAIDs and dexamethasone endovenous. Assistant´s patients 1-2: exacerbation of lumbociatalgia and hand tenosynovitis (oral NSAIDs). Assistant´s patients 3-4: exacerbation of collateral ligament knee injury and low back pain (oral NSAIDs). Elliot et al, in your study shows that nurses receive insufficient training in ICUs regarding delirium, and consequently they have a poor level of knowledge regarding the associated complications and risk factors [6]. Also, there is a tendency to not use a specific assessment tool on a daily basis for the detection of delirium.

Again the role of nursing is fundamental for the detection and proper management of the patient with delirium. For most nurses, doctors do not consider patients with delirium to be "urgent cases", often prescribing pharmacological doses below the therapeutic range and therefore the attention is delayed. Some of us use a wide range of pharmacological drugs according to our criteria and experience, without agreeing on a clear and continuous guideline through the different shifts. This result in some patients receives different treatments according to the doctor on shift. On the other hand, nurses have difficulty in applying verbal restraint and sleep management and there is a tendency towards the use of physical restraint while awaiting medical recommendations [7-9]. At the moment it is very necessary the involvement of both professionals to develop protocols and guidelines for this type of patients that adapt to the needs and resources of each ICU in particular (type of ICU, culture and values). From my point of view, intensive care nursing is a special staff that should have autonomy to detect and begin treatment of this type of patients, always according to protocols agreed between the two specialties (teamwork: doctor and nurse) and based on current and most recent scientific evidence.

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