Nurse interventions in case of delirium in the intensive care unit
NURSE INTERVENTIONS IN CASE OF DELIRIUM IN THE INTENSIVE CARE UNIT

The occurrence of delirium in the intensive care unit is a medical, social and economic problem. Access to the patient is required and requires timely detection and treatment of delirium. Increasing patient mortality with delirium points to the importance of systemic and holistic approach. Medical staff with their interventions and the health care plan prevents the occurrence of delirium, allows early recognition of the first signs of delirium and shortens the patient's stay in the intensive care unit. Monitoring the latest guidelines and work in accordance with protocols is the foundation of good practice. The aim of the paper is to present the nurse interventions according to the symptoms that can occur in a delirium patient and to learn with a specific delirium scale for medical staff, the Nu-DESC scale. Every easy understanding and understanding of the delirium danger in the intensive care unit extends the patient's agony. A Vital-Endangered Patient is defined as any patient who, by reason of his condition, is placed in an Intensive Care Unit. Care for such a patient is very demanding, so a systematic and holistic approach to assessing the condition of a patient and further in providing care is essential. Healthcare workers working in an intensive care unit must be particularly educated about therapy, care, use of electro medicine devices, and be prepared for urgent changes in an individual's health. Aggressive treatment in the intensive care unit with an emphasis on mechanical ventilation and sedation of the patient, predisposing factors for delirium. Delirium delusion is a predictor of the poor outcome of patients treated in the intensive care unit because it is estimated that 25% of non-respiratory supportive patients will develop delirium symptoms, while the number of those who are addicted to
respiratory support is significantly higher, as much as 80% (Wass, Webster & Nair, 2008). Vitamin-endangered patients on mechanical ventilation require the use of benzodiazepines and opiates to improve oxygenation and relieve anxiety. The use of long-term sedatives in comparison to short-term and high daily sedation rates compared to low doses increases the risk of developing delirium in patients in intensive care unit. Therefore, an ideal sedative should have the following features: leading to hypnosis / sleep, causing anxiolytics, amnesia, an anticonvulsive effect, no it causes a respiratory and cardiovascular depression, is not metabolically dependent on liver and kidney function, does not accumulate in the body, has a fast start and rapid recovery after it is released, has no prolonged effect on memory, has no long-acting mental effect and is not too expensive. Delirium is a multifactorial neurobehavioral syndrome characterized by a disturbance of consciousness and reduced ability to focus, maintain and move attention (Bhat & Rockwood, 2007). Epidemiologically considered the most common mental form of distress in JIL. Risk factors for delirium development, in intensive care unit, which may be affected by the use of psychoactive drugs, previous sedation, coma, mechanical ventilation and the use of ducts, tubes and catheters. Predisposing factors that cannot be affected by previous chronic diseases, hypertension, depression, cognitive disorders, and patients who were previously dependent on alcohol and cigarette consumption. According to the clinical picture delirium can be defined as hypoactive (43.5%), hyperactive (1.6%) and mixed form (50.4%). Delirium features are a disorder of consciousness that is primarily qualitative, and is manifested by disorientation in time and space and towards people, deception of the senses in the form of illusion and hallucinations - primarily visual, disturbances of the cycle of alertness and sleep, psychomotor disorder, manifested by
in the emergence of the first problems. Emphasis is put on the use of score scales such as are the Intuitive Care Delirium Screening Checklist (ICDSC), the Nursing Delirium Screening Scale (Nu-DESC) and the other. One of the most credible scales that is standardized and most commonly used is CAM-ICU, by Sharon K. Inouye. However, from the sisters' point of view, the Nu-DESC scale was prepared for 4 estimates of the occurrence of delirium by nurses. The scale is suitable for use in intensive care units when assessing the presence of delirium in non-psychiatric patients. After assessing the presence of delirium using the aforementioned scale, care planning is needed for the patient. Determining the main problems and defining goals and interventions are one of the main tasks of nurses. The most common symptoms of patients with developed delirium resulting from sedation retardation are psychomotor disorders, changes in vital signs (increase in blood pressure, tachycardia, hyperventilation), sweating, dilatation of pupils, disorientation in time and space, visible hallucinations and disorders of the cycle of alertness and sleeping. Each of the above symptoms presents a separate problem and requires a special set of interventions to ease the patient's condition and provide adequate protection in aggressive patients. Nurses are daily involved in caring for the patient, and awareness of necessary interventions greatly facilitates work and ensures continuity in caring for care. Interventions need to be carried out in a timely manner to ensure that the goal is achieved, or in order to solve the problems present. Changes in vital signs are manifested as hypertension, tachycardia, and hyperventilation. It is important to correctly assess the presence of pain in a patient using VAS or a numerical scale to exclude the possibility of changes in vital signs as a result of pain. Any change in the vital signs in the patient leads to a deterioration of
discomfort, hyperactivity, dyslexic movements and actions, emotional disorder in anxiety, irritability, euphoria and vegetative symptoms such as tachycardia, sweating, rapid breathing, increased pressure, pupil dilation and facial redness. Patients in hypoactive delirium are seldom noticed because in the clinical picture dominates calmness, anxiety, hallucinations but without visible reactions. In contrast to this picture, patients with hyperactive form are presented with agitation and aggressiveness. Patients in the JIL often change the aforementioned forms. The development of delirium in a patient in the Intensive Care Unit is a major problem because it often remains unrecognizable, leading to an extended hospital stay and an elevated morbidity and mortality rate. To reduce the aforementioned complications, it is important to detect delirium as early as possible and initiate adequate treatment. For patients who are on prolonged sedation therapy there are measures to prevent symptoms of diarrhea: replacement of continuous infusion at single, predetermined doses, the use of long-acting sedatives of the same grade, reduction of total daily dose by 10%, change of route of administration from intravenous to enteral route, α2-agonist, e.g., clonidine. While in patients with delirium developed, the recommended therapeutic therapy involves the use of antipsychotics where haloperidol is the first choice medicine. Current protocols of sedation in intensive units include simultaneous sedation, pain therapy and delirium therapy. The appearance of delirium in JIL is a major problem, and the care of such a patient poses a challenge specially to nurses, especially when the hyperactive form is present. Subjective assessment of delirium by health personnel requires special education in early detection and measurement of delirium. The nurses' interventions are aimed at identifying the first symptoms and their adequate response and help
the general condition, which may result in prolonged stay in the intensive care unit and an increase in mortality. Nursing interventions are focused on: assessment of vital signs (blood pressure, pulse, breathing, body temperature), continuous monitoring / monitoring of the patient (noticing the onset of atypical ventricular tachycardia), in the event of hypertension, inform the doctor and administer the medication in case of occurrence tachycardia drug use according to doctor's order, adequate volume compensation, microclimatic conditions, securing a calm and safe environment, monitoring of laboratory findings on the patient's interference with non-pharmacological procedures (Ackley & Ladwing, 2002).

REFERENCES