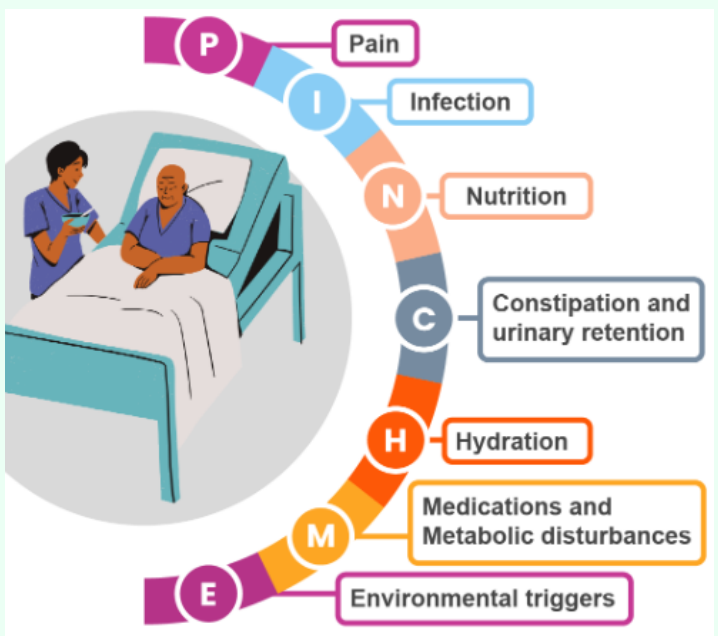




PINCH ME



Delirium prevention

Information and launch

Barnsley ICU
November 2025



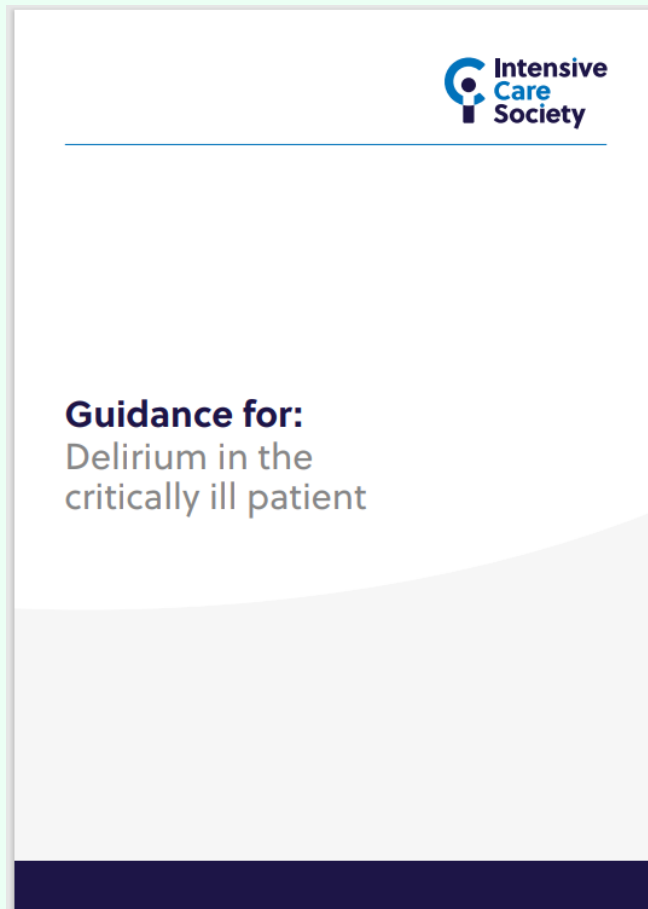
Samantha Farnsworth- ICU Sister
Joanne King – Lead Nurse Rehabilitation

Delirium

- Delirium is a sudden, reversible, acute state of confusion and severe inattention, typically lasting a few days to weeks.
- Delirium, particularly in the ICU setting (ICU delirium), is a serious condition that can cause significant distress for patients and their families. It is associated with increased morbidity and mortality and can also increase the length of hospital stay



Task and Finish Group Formed – After National Guidance Released



National guidance: guidance for :
Delirium in the critically ill patient -
Released in February 2025 by the
Intensive Care Society .

ICU Barnsley - not meeting
national bench marks.

Task and finish group formed in
March 2025 .



Task and Finish Group

Task and Finish Group Formed
members included:

- ICU Consultant
- ICU Rehabilitation Lead Nurse
- ICU Lead Nurse
- ICCA (ICU digital team)
- ICU Sister
- ICU Staff Nurse
- ICU Physiotherapist
- ICU Clinical Nurse Educator
- ICU Lead Pharmacist



Initial meeting in March 2025 , followed meetings in June and September 2025

Survey Results

Knowledge of delirium

- Good knowledge: 25.6%
- **Acceptable knowledge: 64.1%**
- Limited knowledge: 10.3%
- 75% identified a need for further training and education

Delirium Risk Factors

- **90%** recognised:
 - Predisposing risk factors
 - Precipitating risk factors
- Majority could provide rationale for identified risk

Subtypes of Delirium

80% correctly identified the proposed subtypes

Management of a Patient with Delirium

Good knowledge & confident in management: 15.4%

Adequate knowledge but would benefit from further training: 66.7%

Limited knowledge: 17.9%

80% would benefit from additional training in delirium prevention and management.

CAM ICU Documentation and Completion

- CAM ICU completion for all awake patients
 - 33.3% Yes
 - 46.2% intermittently
 - 20.5% no

Reported Barriers to Completion

- GCS of the patient
- communication
- lack of time
- Sedation

Documentation Intubated and sedated patients

- 55.3% Yes
- 44.7% No

Baseline ICCA Audit data for CAM ICU Completion

15% of CAM ICU assessment completed
(Time frame 1 month)
MAY 2025

Actions Agreed

With the MDT Task and Finish Group :

- **Staff Education around delirium prevention and treatment**
- **Development of Guidelines** (non –pharmacological and pharmacological)
 - **Second staff survey around non pharmacological interventions**

Second Survey results

Integration of non- Pharmacological interventions in daily practice

YES : 12.8%
UNSURE: 33.3%
NO: 53.8%

Awareness and use of the PADIS Guidance:-

23.1% Yes.

76.9% No

Integrated into daily practice

23.1% Yes.

76.9% No

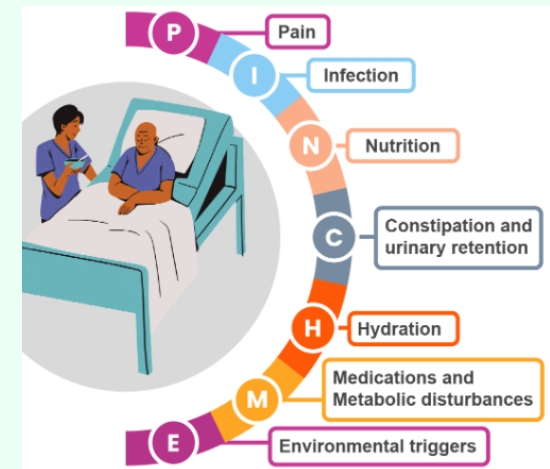
Awareness of non-pharmacological interventions :-

43.6% Yes

56.4% No

PINCH ME Information

- The "PINCH ME" mnemonic helps healthcare professionals remember potential causes of delirium, prompting a search for underlying medical issues that may be contributing to the confusion. These potential causes are also preventive measures that can be implemented by the nursing and medical team.
- PINCH ME subtitles : Pain , Infection , Nutrition, Constipation, Medication and Environment
- Clinical educators would help with staff awareness and education
- ICU digital team would add a section onto the Nursing and Medical documentation



Non- Pharmacological Guidelines

- *“Non-pharmacological prevention and management of delirium is imperative and should be first line before resorting to pharmacological therapies.”- **Guidance for: delirium in the critical ill patient***
- The non-pharmacological guideline are interventions that can be carried out by nursing and medical staff to help prevent and treat delirium.
- Each section of ‘PINCH ME’ should be reviewed daily by all members of the MDT, and any issues should be raised during the consultant ward round. Any issues that can be resolved or treated by Nursing staff should be addressed accordingly.
- **CAM ICU should still be completed each shift on all ICU patients.**

Example of the Non-Pharmacological Guidance

THINK DELIRIUM | **NHS** Barnsley Hospital NHS Foundation Trust

PINCH ME

Delirium, particularly in the ICU setting (ICU delirium), is a serious condition that can cause significant distress for patients and their families. The "PINCH ME" mnemonic helps healthcare professionals remember potential causes of delirium, prompting a search for underlying medical issues that may be contributing to the confusion. These potential causes are also preventive measures that can be implemented by the nursing and medical team.

This guideline are non-pharmacological interventions that can be carried out by nursing and medical staff to help prevent and treat delirium.

Non-pharmacological prevention and management of delirium is imperative and should be first line before resorting to pharmacological therapies. Guidance for delirium in the critical ill patient

Each section of 'PINCH ME' should be reviewed daily by all members of the MDT, and any issues should be raised during the daily examination or on the consultant ward round. Any issues that can be resolved or treated by Nursing staff should be addressed accordingly.

THINK DELIRIUM | **NHS** Barnsley Hospital NHS Foundation Trust

PINCH ME

PAIN

Complete the Pain assessment tool – on ICCA 4 hourly – is the patient in pain?

Regular oral PRN pain relief – use and record – escalate when necessary

Why is the patient in pain? Is it a new pain?

Tracheostomy suture pain – assess the site. Pain relief PRN (document when taken with the DR for there to be prescribed)

Reposition the patient – is this related to pressure, or is the patient uncomfortable?

Consider alternative therapies that may work for the patient's pain – reassurance (family), complementary if easy – (e.g. milk)

Post-surgical pain – wound assessment. Is the pain from a tender wound or a tube/drain?

Also consider

POST-SURGICAL

Oral analgesia post-surgery. Education on mobilisation, the importance of deep breathing and coughing. Discuss post op and provide education around pain relief – PCA, early mobilisation.

De-monitor when able, prepare patients for the ward-level care and provide information around surgery. Refer to Pain team if required

Ensure patient has had a daily review and plan from the surgical team.

INFECTION

Monitor observation trends for clinical signs of infection: pyrexia – do they require active cooling? Are blood cultures required? Is lactate rising?

Monitor daily bloods including WCC, PCT and CRP trends.

Vital infections – such - invasive lines, pressure sores, tracheostomy sites. Any chesty signs? Any Suspected urine or stool infection.

Surgical wounds – any signs of infection? – is a swab required?

Give antibiotics prescribed and as due.

Monitor expiry date of essential tubing. (Ensure humidifier clear), catheter bags, ventilator filters, IV giving sets, transducers.

Monitor duration of catheter, Arterial lines, CVC, nasal cannula, PEG. Don – does the dressing require changing?

Daily turning damp dressing / clean environment

ISOLATION

Does the patient need to be in a cubicle? (Are they any known infections? know stocks?) Talk with DR and nurse in charge before sending a sample. Has the patient been transferred from another hospital?

Close samples to ensure minimum time in isolation.

Leave with extra clothing, if barrier needed – can they still go outside for mobilisation?

Allow visiting as much as possible

TV, local news and radio

Cards and photos from family – encourage families to bring in – inform them of the reason why

Activities (activities trolley) therapy, therapy dog / own pets

NUTRITION

Complete MDT and Check patient nutritional status (including weight and height)

Communicate with the patient regarding fibre and diet.

Commence food diary

Refer to dietitian – care flow correct

Is an NG required?

Follow emergency feeding regime. Is there any risk of re-feeding?

4 hourly NG aspirates – is the NG feed being absorbed – is prokinetics required? Follow the Gastric aspiration guideline

Read aspiration notes – will TPN be required – can this feed for a person with regurg or in the emergency TPN regime required.

Inform patient of nutrition plan

SALT related if needed – Managing bedside swallow assessments (DITTA TRAINING REC-3802)

SALT referral for all tracheostomy patient – refer on the day of tracheostomy insert as – to ensure SALT awareness of the patient.

Monitor electrolytes, Magnesium and vitamin D levels (completed as part of admission bloods) Talk with DR regarding if RSC. Note levels / re-feeding stocks require checking

NIGHT CYCLE

Oriente patient to day and night.

Complete Sleep Hygiene Bundle each night- this includes offering eye mask, ear plugs, head phones – looking at other ways in which we can help aid patient sleep. Also includes: Reducing Lighting and noise. Reduce noise from staff members - keep to a minimum.

Reduce noise on monitors and have appropriate alarm levels set.

If the patient is having trouble sleeping or looks scared, ask the patients questions, i.e. are they scared to go to sleep? Are you having nightmares? Are you hallucinating? (reassure patient)

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PINCH ME

CONSTIPATION + CONTINENCE

Monitor bowels – document on ICCA

Gather information from the patient – when was their last bowel movement? Was it a normal bowel movement?

Complete PR assessment if required.

Are there any new changes to their bowel habits? Any incontinence issues? Refer to continence nurse if a supply demo's pro – is a rectal required?

Leave with a pharmacist and check if any prescribed drugs could cause constipation.

Ask if IAP monitoring is appropriate – report readings

Are loose stools overflow? Leave with the Dr to discuss continence baseline if appropriate.

Leave with dietitian – does the NG feed require fibre? Dr best filter?

HYDRATION

Clinical signs of dehydration (dry mouth, feeling thirsty, low UOP, low BP, colour of urine, constipation) Does the patient require UOCD monitoring? Carry out a pinkie leg rate

Does the patient have an A&P?

Monitor fluid balance and urine output hourly, cumulative fluid balance. Consider oral hydration first but may require IV fluids.

Is the patient showing signs of being overloaded? WOB this affect rehabilitation and weaning off the ventilator?

METABOLIC STATES:

Hypermetabolic/Hypometabolic: - hyper: endocrine, thyroid etc. and Hypo: endocrine

-Bloods – thyroid, liver, U and E -ABC assessment -pharmacist to review medication for anticholinergic load

-Monitor sodium levels – report high urine output -Diabetic review – monitoring fluid balance, U and E, and sodium

HALLUCINATIONS

Monitor for non-verbal signs – reaching out, starting, scared and agitated.

Managing hallucinations - reduce stress, re-orientate and address underlying cause. Medication for hallucinations should only be considered if the patient poses a risk to themselves or others.

Do not ignore distressed behaviours – communicate, ask questions, and offer distract.

MEDICINES

Avoid caffeinated drinks

Avoid use of catabolic meds - antipsychotics and benzodiazepines

Clinical pharmacist involvement – Consider impact of polypharmacy. Regular medication review. Consider if medications are still needed or if they contribute to delirium.

Ensure important medication prescribed and given - i.e. Insulin and Parkinson medication.

Daily sedation holds if appropriate

Also Target RASS if sedated

Involve the patient and family in medication decisions.

MOBILITY

PRDM (Painful Range of Movement) – physio lead

Early mobilisation

Cardiac rehab position in bed

Sit out of bed

Assisted wash

ARDM (Active Range of Movement)- encouragement

Standing

Gone outside

Activities – using activities trolley

Pat visits – guidelines to follow (form to complete)

MOTOMED: physio lead

THINK DELIRIUM | **NHS** Barnsley Hospital NHS Foundation Trust

PINCH ME

ENVIRONMENT

Regular orientation to time and place

Ensure clock visible

Ensure "About me" Document completed.

Has the patient recently moved bed space?

Avoid moving beds space more than necessary – (this can add to the risk of delirium) – MDT decision regarding moving bed space – is moving bed space beneficial for the patient?

Check there are within reach of the patient (personal items, water, nurse call buzzer).

Encourage the patient to get dressed in their own clothes when able.

Is the patient wearing their glasses? Is the patient wearing their hearing aid?

Daily planning – patient making decisions on their own care, giving autonomy. (Use form which daily planning sheets to write on.)

Remove unnecessary lines, catheters and restraints.

Therapeutic absence- when the patient is stepping down from ITU and going to the ward - if NOT advised.

Lack of structure to the day – complete daily planning with the patient.

No communication with staff- have a conversation, build up a rapport

Lack of visitors (can you fill in for visitors) – get involved in some conversations / activities/ trips outside

Lights too dim – ensure the patient is aware if it's daytime/ natural light

COMFORT

Several factors could contribute to a patient's feeling overall not best:

-Awake bed space

-Noise: too loud

-Alone and TV – this may be too much for the patient

-Staff talking

-Number of staff around the bed space

-Lights – can these be changed to

-Too many visitors

-Alarms Blinks too loud – check appropriate alarm levels

Under stimulation.

Several factors could contribute to a patient feeling under-stimulated or not cognitively engaged enough:

- Lack music (does the patient wish for music to be played? – filled out favourite music)

-Lack of TV- other TV or other media to watch

-Lack of Activities - activities trolley in the store room – different games to play)

-Lack of structure to the day – complete daily planning with the patient.

-No communication with staff- have a conversation, build up a rapport

Lack of visitors (can you fill in for visitors) – get involved in some conversations / activities/ trips outside

Lights too dim – ensure the patient is aware if it's daytime/ natural light

EMOTIONAL STRESSORS

PTSD – has the patient had previous trauma? Is ICU exacerbating the trauma? Are there interventions we can do to help?

Has the patient had a previous admission to ITU?

Triggers- reduce where possible

Could being in a cubicle on their own cause stress for the patient? Consider isolation instead vs. stress levels – it has not result to where possible to reduce isolation.)

Is the patient Scared to go to a keep? - Fear of not waking up? Give reassurance and explanations.

Would they like someone to sit with them while they fall asleep? Would they like to hold someone's hand?

Hallucinations – patients can be fearful of staff. Staff to raise the question first – if signs of hallucinations not lead.



THESE LISTS ARE NOT EXHAUSTIVE

Example – Placed in the nursing bed side folders in every bed space on ICU

Pharmacological guidelines

- Although Non –pharmacological interventions should be first line when treating and preventing delirium, we know realistically it is not always possible to stay away from medication. The Patients safety is paramount and if the patient is a danger to themselves or a danger to staff – medication is required, Therefore a Pharmacology guideline has also been developed by the ICU pharmacists.

Pharmacological guidelines

 
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PART TWO: PHARMACOLOGICAL MANAGEMENT

PAIN AND ANALGO-SEDATION

Chronic Pain History: Review the patient's past medical history for chronic pain diseases/ailments

- Ensure pre-admission chronic pain medication is reviewed with a pharmacist (see 'MEDICATION' section below for more details)
- Consider re-introducing other chronic pain medication cautiously depending on the clinical situation when patient is weaning off sedation infusions (e.g., baclofen, opioids, gabapentinoids) – discuss with the ICU consultant/ICU pharmacist
- If pre-admission methadone (either for pain/addiction), then split the usual daily dose symmetrically into a twice daily dose (to provide flexibility of not over-sedating the patient)
 - If unable to reconcile methadone dose (e.g., out-of-hours) then prescribe PRN Methadone PO 10mg 4-6hrly until the dose can be confirmed (Contact Pharmacy during working hours Mon-Fri 0900-1700; Sat-Sun community drug rehab services closed)
- Avoid drugs with significant antimuscarinic component (e.g., amitriptyline, nefopam)
- Transdermal patches may have impaired absorption when vasopressors used
- Similar principle can be applied to prescription drug abuse

Sedation: Review the propofol/midazolam:alfentanil infusion dosing ratio for patients who are expected to be on sedation for prolonged periods.

Alpha-2 agonists: Clonidine/dexmedetomidine provides some analgesic effect as well as anxiolytic/sedative effect

Paralysis and Monitoring: Confirm/review need for any ongoing neuromuscular blockade

- Clearly document desired BIS (Bi-spectral index) range on ward round and inform the nursing staff

Post-Operative (Non-Intubated/Extubated) Patients: Use the WHO pain ladder carefully

- Ensure regular dosing of paracetamol is prescribed, if appropriate
- Review any epidural/paravertebral/regional analgesia infusion sites and dosing rates
- Ensure the patient understands how to use/is using their PCEA/PCA (patient-controlled epidural analgesia/ patient-controlled analgesia) correctly
- Re-counsel pain expectation or addiction concerns
- Consider NSAIDs cautiously – consider seeking surgical parent team advice on bleed risk



Long-Stay Patients:

- Consider acute vs chronic pain for long-stay patients – e.g., gabapentinoids

CONSTIPATION – see Trust guideline on Laxative Use on the ICU

HYPO-/HYPERGLYCAEMIA – see Trust guideline on Glucose Management

December 2025, The ICU MDT Delirium Working Group (Review contacts: Hung-Sang Chan (Vince), Samantha Farnsworth, Sharon Moss, Tim Wenham, and Joanne King). Date of Review: May 2028
This Guideline is intended for use in Intensive Care only

 
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MEDICATIONS – Review the patient's medication history

Analgesia: Review pre-admission analgesia and ensure appropriate adjustment (see above)

Antimuscarinics: Avoid administering unnecessary agents (e.g., solifenacin, Mebeverine)

- Glycopyrrolate is the 1st choice antimuscarinic for bradycardia and secretions due to its minimal CNS penetration

Parkinson's Disease

- Check for the most recent Parkinson's specialist review
- Match inpatient prescription to exact pre-admission regime
- Antipsychotics are relatively contraindicated in Parkinson's disease

Antidepressants: Reintroduce cautiously when clinically stable (e.g. "trache" wean, extubated, ward stepdown), or if withdrawal symptoms suspected (e.g. abrupt stop, short half-life of the antidepressant)

- Relative contraindication – consider the 'serotonin load' of concurrent medications (e.g., fentanyl, linezolid use within the previous 7 days)

Alcohol Withdrawal and Delirium Tremens: See below for further details

- Prescribe thiamine 400mg TDS IV for at least 5-7 days

Benzodiazepines/Z-Drugs:

- Review pre-admission use and monitor for withdrawal. Consider cautiously re-introducing at low dose if clinically indicated – discuss with the ICU consultant/ICU pharmacist
- If propofol/midazolam is used, re-introduction of pre-admission benzodiazepine(s) is not usually necessary, as withdrawal is unlikely unless weaning infusion within the expected withdrawal period, depending on the half-life of the benzodiazepine

Opioid Withdrawal: Consider opioid withdrawal if the patient has recently been weaned off prolonged (~14 days) opioid infusion (e.g., alfentanil) – discuss with the ICU consultant/ICU pharmacist

Nicotine Replacement Therapy (NRT):

- Nicotine withdrawal is covered by alpha-2 agonists – therefore NRT is not needed if continuous clonidine/dexmedetomidine infusion is running
- Consider prescribing PRN nicotine inhalator for the behavioural component of the addiction, if appropriate
- Ensure the nicotine patch is prescribed clearly to instruct the nurses to take the patch off at 20:00 every night to ensure sleep is not affected by nicotine

Psychiatric Medications:

- Review any long-term psychiatric medications with the patient's usual psychiatrist, or refer the patient to psychiatry for advice – discuss with the ICU consultant/ICU pharmacist
- Consider the patient's baseline behaviour and psychiatric status

December 2025, The ICU MDT Delirium Working Group (Review contacts: Hung-Sang Chan (Vince), Samantha Farnsworth, Sharon Moss, Tim Wenham, and Joanne King). Date of Review: May 2028
This Guideline is intended for use in Intensive Care only

An example of the pharmacological guidelines – still awaiting medicine management approval.

– However has been approved by members of the Critical Care MDT

Launch Week

- 10th November 2025
- Full week dedicated to PINCH ME launch including unit walk arounds – informing staff of PINCH ME (showing the pharmacological and NON - pharmacological guidelines)
- Information placed on Barnsley ICU Education website.
- Email to send out informing staff of the PINCH ME launch (including the new guidelines for the unit and also a copy of the national guidance for: delirium in the critically ill patient)

Notice Board



Notice board display on the entrance to ICU –

To help promote the launch of PINCH ME,

Along with information for staff and relatives

Information station in staff resource room



Pocket cards

*If a person's mental health gets suddenly much worse it **could** be:*
DELIRIUM

Delirium means the cause is physical. This PINCH ME card can help you identify the cause of delirium.

PINCH ME

Does the person have problems with ...

Pain	<i>(Look for non-verbal signs restless, crying out)</i>
Infection	<i>(Signs in urine, Chest, Wound? Blood test?)</i>
Nutrition	<i>(Eating well? Weight OK?)</i>
Constipation	<i>(Appetite loss? Tummy pain? Breath smells?)</i>
Hydration	<i>(Dark or smelly urine? Dry lips/skin? Headache?)</i>
Medication	<i>(Side effects? New drugs?)</i>
Environment	<i>(Changed surroundings? Is it noisy/busy? Too hot?)</i>

Front of the card



For further information please refer to the PINCH ME Document in the bedside folder

Back of the card

Little pocket cards provided to staff if they wished ,

A quick reference of what PINCH ME stands for – and where to find further information.

PINCH ME Champion Stickers



Stickers were handed out to the staff once they were informed about PINCH ME –

This then continued to be a visual awareness and helped promote the launch further on the unit.

Cupcakes to Help Engage Staff in the Launch



Repeat survey post launch results :

Knowledge of delirium

Good knowledge: 42.9%

Acceptable knowledge: 57.1%

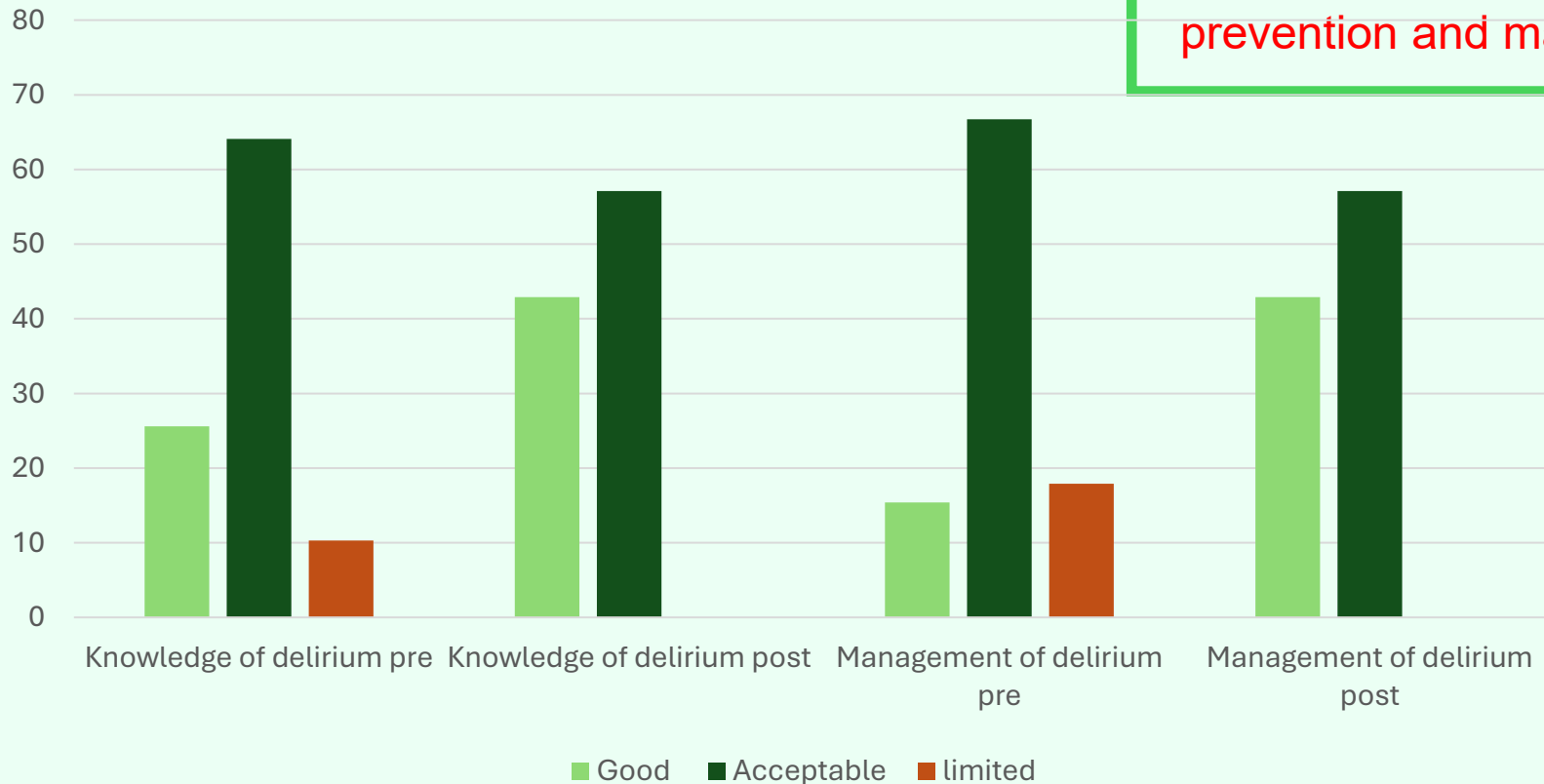
Management of a Patient with Delirium

Good knowledge & confident in management: 42.9%

Adequate knowledge but would benefit from further training: 57.1%

Limited knowledge: 0%

57.1% would benefit from additional training in delirium prevention and management.



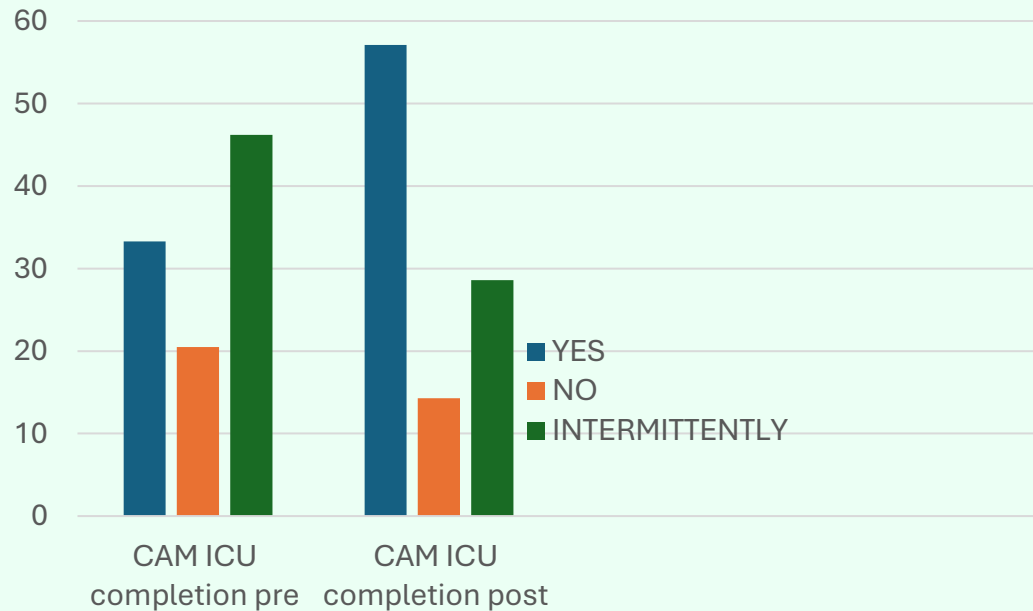
CAM ICU Documentation and Completion

CAM ICU completion for all awake patients :

YES : 57.1 %

NO : 14.3 %

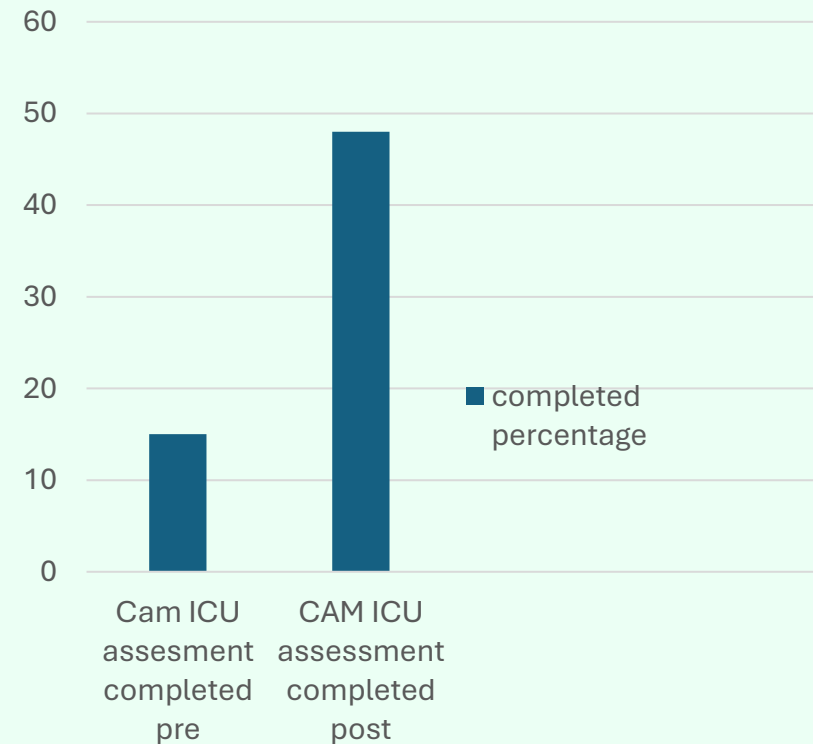
INTERMITTENTLY : 28.6 %



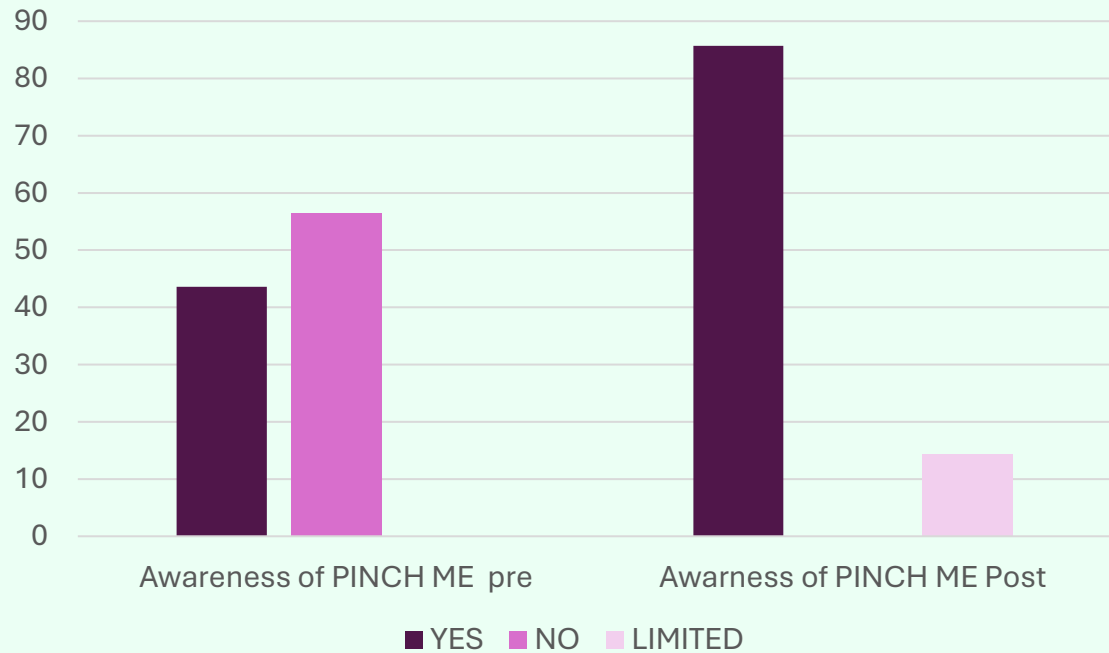
ICCA Audit data for CAM ICU Completion

48% of CAM ICU assessment completed
(Time frame 1 month)

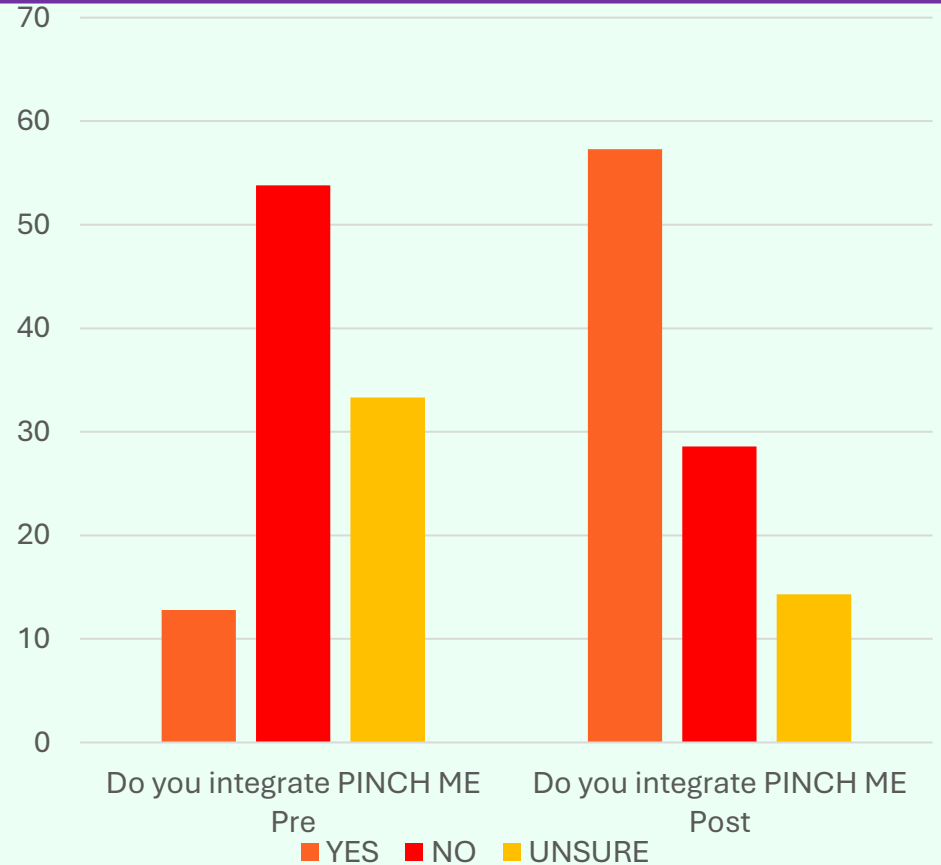
January 2026



Are you aware of PINCH ME ?
 YES: 85.7%
 NO: 0 %
 LIMITED : 14.3%



Do you integrate PINCH ME in your daily practice ?
 YES: 57.3%
 NO: 28.6%
 UNSURE: 14.3%



What's next :

- Continue to educate staff around PINCH ME and the importance of completing CAM ICU each shift or a change in mental state.
- Continue to audit
- ICU digital team – to audit when the PINCH ME section has been completed by staff members



ANY QUESTIONS ?