

**American Delirium Society 2nd Annual Conference
Program-at-a-Glance
Indianapolis, Indiana
June 3-5, 2012**

Sunday, June 3

6:00 – 8:00 pm Reception

Monday, June 4

8:00 am – 12:00 pm Pathophysiology and Biomarkers
8:00 am – 12:00 pm Delirium Measurement

12:00 – 1:00 pm Lunch w/Keynote Speaker
Sharon K. Inouye, MD, MPH

1:00 – 5:00 pm Post-Operative Delirium
6:00 – 8:00 pm Poster Session w/reception

Tuesday, June 5

8:00 am – 12:00 pm Long-Term Outcomes of Delirium
8:00 am – 12:00 pm Delirium Care: Pediatrics to Geriatrics

12:00 – 1:00 pm Lunch w/Keynote Speaker
Ann Kolanowski, PhD, RN

1:00 – 5:00 pm Clinical Trials Update

This issue

ADS 2nd Annual Conference P. 1

ADS Board Meeting P. 2

ADS Bylaws Completed and Ratified P.2

JAGS Supplement Highlights the Importance of Delirium P.3-6

The EDA Completes 6th Annual Scientific Congress P.7

News from ADS Members and Attendees of the 2011 ADS Conference P. 8

Save the Date

2nd American Delirium Society Conference



Deadline for symposium/oral presentation proposals
December 21, 2011 (5:00 pm EST)

Deadline for poster abstracts – March 15, 2012
Early registration ends April 15, 2012

Indianapolis, Indiana
Omni Hotel and Conference Center
June 3-5, 2012

NOTE: CME/CEU's will be offered for the conference

Visit us on our website at: <http://americandeliriumsociety.org/>

We are welcoming supporters and exhibitors at this time. Applications can be made on-line at www.americandeliriumsociety.org under the conference registration tab or in writing with the enclosed registration form to: American Delirium Society, c/o Roberta Manns, 410 West 10th Street, Suite 2000, Indianapolis, IN 46202

Joseph H. Flaherty
Editor-in-Chief
Saint Louis University

Ann Gruber-Baldini
Associate Editor
University of Maryland

Brooke Berglund
Editorial Assistant

American Delirium Society WORK

ADS Board Meeting

October 22-23, 2011

The Executive Board of the American Delirium Society met* in Baltimore, MD from noon Saturday, October 22 through 11:00 am the next day focusing on three important areas:

- Finalizing the organization's bylaws
- 2012 ADS Annual Conference
- Finances and fundraising
- Setting out some immediate as well as future goals.

Special thanks to Roberta Mann from Indianapolis University. She has kept the Board organized and on track from the beginning. Having her in Baltimore for the retreat was critical for the weekend accomplishments and we would like to thank her now for her future efforts (the long check list of "to do's"). Thank you, Roberta!

Thanks also to Ann Gruber-Baldini, who graciously hosted the group at the University of Maryland School of Medicine. Her time and effort to organize such an event were much appreciated. Thank you, Ann!

Other participants included Malaz Boustani, Noll Campbell, Joseph Flaherty, Sharon Gordon, Barbara Kamholz, Karin Neufeld, James Rudolph and Marianne Shaughnessy.

*This meeting was not supported by any funds from the ADS. Participants used their own resources to attend.

American Delirium Society Bylaws Completed and Ratified

Creating the bylaws has been a long arduous task but thanks to Marianne Shaughnessy and others on the Bylaws Committee, they have been completed and ratified by the Executive Board.

A few key components of the bylaws include:

Mission

The goals of the American Delirium Society are to foster research, education, quality improvement, advocacy & implementation science to minimize the impact of delirium on short and long-term health and wellbeing, and the effects of delirium on the health care system as a whole.

Vision

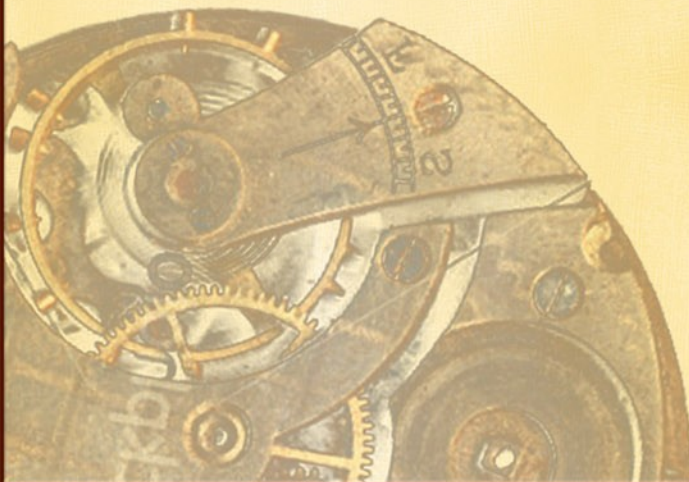
The American Delirium Society will fulfill the leadership role in the United States for advancing professional, consumer, governmental and health-industry knowledge concerning delirium and the most promising strategies for minimizing its human and capital costs.

As part of the bylaws, the following Standing Committees will exist:

- Research Committee
- Annual Conference Planning
- Bylaws and Procedures
- Communications and Education
- Finance
- Membership

We invite all members to consider becoming involved. Look for information concerning this important area of ADS at the 2nd Annual Conference (or see below).

Thanks to all the members of the Bylaws Committee for all their hard work on this mountainous and momentous task.



GET INVOLVED: Join a committee

The ADS would like to invite you to be part of its exciting growth. We hope that the benefits of working with your peers in this burgeoning area will far outweigh the time commitment necessary to make the ADS a success. Please join this cadre of current and future leaders in delirium, while helping the ADS! (see next page)

JAGS Supplement Highlights
the Importance of Delirium as a Science
November 2011

Journal of the American Geriatrics Society
 Volume 59, Issue Supplement s2
 Pages S233–S304



+



Thanks to the efforts of ADS members Marianne Shaughnessy and James L. Rudolph (co-editors), the John A. Hartford Foundation for their support, the staff at Wiley-Blackwell for providing editorial assistance and all the authors, several of whom are ADS members, the November 2011 supplement to the Journal of the American Geriatrics Society has been published.

Titled, “*Advancing Delirium Science: Systems, Mechanisms and Management*,” the supplement details the vision of the ADS. After an opening article by ADS member Barbara Kamholz which discusses several areas “ripe for collaborative or multisite work” (the European-United States collaborations, education, the ethics of consenting cognitively impaired subjects for research and psychopharmacological approaches to treating and managing delirium), ADS members James L. Rudolph, Malaz Boustani, Barbara Kamholz, Marianne Shaughnessy and Kenneth Shay, on behalf of the American Delirium Society, detail a strategic plan to advance the science of delirium, with the individual at the forefront of all recommendations.

The four goals outlined in that article are:

1. Improve clinical care related to delirium

Goal 1a: Every patient should be screened for delirium risk, upon every transition of care, employing a validated prediction rule.

Goal 1b: Every patient at intermediate or high delirium risk should have an individualized preventive strategy implemented and regularly scheduled surveillance.

Goal 1c: Every patient should be evaluated for prevalent delirium upon each transition of care, and monitoring systems should be developed and validated for identifying incident delirium.

Goal 1d: Nontoxic treatments for delirium should be developed that improve patient morbidity and mortality.

Goal 1e: Every patient who develops delirium should have an individualized plan for rehabilitation and recovery.

2. Improve delirium education

Goal 2a: Public education should be undertaken to improve the understanding that a change in mental status in an older adult is a medical emergency.

Goal 2b: A curriculum for delirium recognition, prevention, and treatment should be developed and demonstrated effective.

Goal 2c: People who provide direct care to older adults should have training sufficient to screen for delirium risk, monitor for delirium, employ delirium prevention strategies, and institute the non-pharmacological treatment of delirium that does develop.

3. Invest in delirium science

Goal 3a: Delirium should be on equal footing for research funding with other geriatric syndromes that threaten the independence of older adults.

Goal 3b: Particular investment should be made in the translation of research into clinical care leading to improved outcomes.

Goal 3c: Systemic measures of performance should be developed that accurately reflect delirium prevention, recognition, treatment, and outcomes.

4. Develop a network of delirium professionals

Goal 4a: Foster collaboration among professionals who care for older adults at risk for delirium to improve clinical practice, education, and delirium science.

Goal 4b: Advocate on behalf of individuals with delirium.



MALAZ BOUSTANI, MARIANNE SHAUGHNESSY, BARBARA KAMHOLTZ, JAMES RUDOLPH; AMERICAN DELIRIUM SOCIETY EXECUTIVE COMMITTEE

Contact the chair via email if you are interested in joining a committee:

Conference Planning: Malaz Boustani, mboustan@iupui.edu

Bylaws Committee: Marianne Shaughnessy, mshaughn@grecc.umaryland.edu

Financial Committee: Barb Kamholz Barbara.Kamholz@va.gov

Communications Committee: (co-chairs) Joe Flaherty, flahertyinchina@yahoo.com;

Ann Gruber-Baldini, abaldin@epi.maryland.edu

***JAGS Supplement Highlights the Importance of
Delirium as a Science
November 2011
continued***

Other peer-reviewed articles in the supplement (with a brief description) include:

The Importance of Delirium: Economic and Societal Costs (pages S241–S243)

Douglas L. Leslie and Sharon K. Inouye

This article outlines the existing literature related to long-term sequelae and costs associated with delirium. It also stresses the importance of such research in prompting recognition, prevention, and treatment efforts that could reduce the effect of delirium and improve quality of life for older adults and their caregivers

The Johns Hopkins Delirium Consortium: A Model for Collaborating Across Disciplines and Departments for Delirium Prevention and Treatment (pages S244–S248)

Karin J. Neufeld, O. Joseph Bienvenu, Paul B. Rosenberg, Simon C. Mears, Hochang B. Lee, Biren B. Kamdar, Frederick E. Sieber, Sharon K. Krumm, Jeremy D. Walston, David N. Hager, Pegah Touradji and Dale M. Needham

This article focuses on the Johns Hopkins Delirium Consortium, which includes members from the disciplines of nursing, medicine, rehabilitation therapy, psychology, and pharmacy within the departments and divisions of anesthesiology, geriatrics, oncology, orthopedic surgery, psychiatry, critical care medicine, and physical medicine and rehabilitation at the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. It details some of the processes involved in developing functional collaboration around delirium and highlights projects, opportunities, and challenges resulting from them.

Delirium and Sedation Recognition Using Validated Instruments: Reliability of Bedside Intensive Care Unit Nursing Assessments from 2007 to 2010 (pages S249–S255)

Eduard E. Vasilevskis, Alessandro Morandi, Leanne Boehm, Pratik P. Pandharipande, Timothy D. Girard, James C Jackson, Jennifer L. Thompson, Ayumi Shintani, Sharon M. Gordon, Brenda T. Pun and E. Wesley Ely

This prospective cohort study at a tertiary care academic medical center of 510 ICU patients describes the reliability and sustainability of the CAM-ICU and the RASS of bedside ICU nurses. Based on 6,198 CAM-ICU and 6,880

RASS measurement pairs obtained on 3,846 patient-days, agreement between bedside and research nurses was substantial for CAM-ICU measurements, (weighted kappa = 0.67, 95% confidence interval (CI) = 0.66–0.70) and stable over 3 years of data collection, and substantial for RASS measures (weighted kappa = 0.66, 95% CI = 0.64–0.68), and stable across all years of data collection. The sensitivity of delirium nurse assessments was 0.81 (95% CI = 0.78–0.83), and the specificity was 0.81 (95% CI = 0.78–0.85).

Biomarkers for Delirium—A Review (pages S256–S261)

Babar A. Khan, Mohammed Zawahiri, Noll L. Campbell and Malaz A. Boustani

The authors performed a comprehensive literature review (English, since 2000). Although they found no evidence to support the clinical use of any delirium biomarker, they write that, “certain biomarkers such as S-100 beta and insulin-like growth factor-1 and inflammatory markers have shown some promising results that need to be evaluated in future studies with appropriate sample size, prospective designs, and in a more-generalizable population.” Of note, figure 1 in the article is a thought-provoking diagram of the complex interplay between inflammatory mediators and cholinergic system in delirium pathogenesis.

Vulnerability: The Crossroads of Frailty and Delirium (pages S262–S268)

Nicky Quinlan, Edward R. Marcantonio, Sharon K. Inouye, Thomas M. Gill, Barbara Kamholz and James L. Rudolph

This article does an excellent job of exploring the clinical overlap of frailty and delirium. It details the possible pathophysiological mechanisms linking the two, and proposes research opportunities to further knowledge of the interrelationships between these important geriatric syndromes. This article is a must for clinicians caring for older patients at risk of these syndromes and researches in the area of aging.



As a young organization, we depend on the help and support of members to help us maintain and grow our financial strength so that our mission can be achieved.

To become a member, go to www.americandeliriumsociety.org

***JAGS Supplement Highlights the Importance of
Delirium as a Science
November 2011
continued***

Other peer-reviewed articles in the supplement (with a brief description) include:

Antipsychotics in the Treatment of Delirium in Older Hospitalized Adults: A Systematic Review (pages S269–S276)

Joseph H. Flaherty, Jeffrey P. Gonzales and Birong Dong
This article examines the evidence of the efficacy of antipsychotics in the treatment of delirium in older hospitalized adults through a systematic literature review using MEDLINE (1980–2010) and Cochrane Databases. Study selection criteria included prospective design, >10 participants, mean age ≥ 60 , standardized criteria for diagnosing delirium, and validated delirium rating scales for reporting outcomes. Thirteen articles met selection criteria: six single-agent and seven comparison studies. Only one study was a placebo-controlled study, in which no statistically significant differences in mean delirium severity scores were found at individual time points (Days 2, 3, 4, 7, 10). The other 12 studies reported improvements in delirium severity or resolution of delirium based on cutoff scores of the scales, but it was not clear from these studies what the natural course of delirium would have been without use of antipsychotics. The authors conclude that “due to severe methodological limitations, the studies in this review do not support the use of antipsychotics in the treatment of delirium in older hospitalized adults, and additional well-designed randomized placebo-controlled trials are needed.”

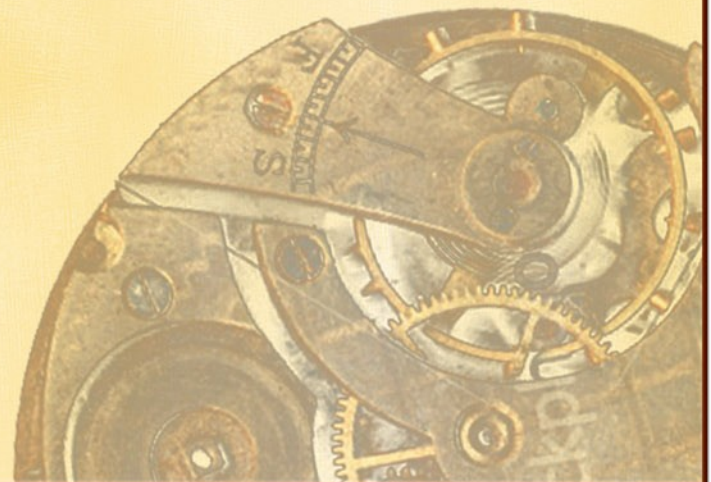
Association Between Prescribing of Anticholinergic Medications and Incident Delirium: A Cohort Study (pages S277–S281)

Noll Campbell, Anthony Perkins, Siu Hui, Babar Khan and Malaz Boustani
In this observational cohort study the authors examine the association between anticholinergic medications and incident delirium. Anticholinergic medication orders were identified using the Anticholinergic Cognitive Burden Scale and delirium was assessed using the CAM. Of 147 patients (age ≥ 65 years with baseline cognitive impairment who screened negative for delirium at the time of admission to a general medical ward), the incident rate for delirium was 22%. After adjusting for confounding variables, the OR for developing

delirium in those with orders for possible anticholinergic medications was 0.33 (95% CI = 0.10–1.03) and the OR for developing delirium among those with orders for definite anticholinergic medications was 0.43 (95% CI = 0.11–1.63). The authors conclude that, “The results did not support the hypothesis that pre-prescription of anticholinergic medications increases the risk of incident delirium in hospitalized older adults with cognitive impairment.”

Pilot Randomized Trial of Donepezil Hydrochloride for Delirium After Hip Fracture (pages S282–S288)

Edward R. Marcantonio, Kerry Palihnich, Paul Appleton and Roger B. Davis
In this pilot double-masked randomized placebo-controlled trial of 16 patients (age ≥ 70 years), the authors examined whether donepezil hydrochloride (5 mg, initiated within 24 hours of surgery and continued for 30 days or until side effects or the clinical situation required termination) could reduce the prevalence and severity of delirium in older adults undergoing hip fracture repair. Delirium presence and severity were measured during daily hospital interviews and at 2, 4, and 6 weeks after surgery. In longitudinal models, the authors found that there were no significant differences between the donepezil and placebo arms with regard to delirium presence over time (based on the CAM, OR = 0.9, 95% CI = 0.4–2.3) or delirium severity over time (effect size = -0.2 on 30-point MDAS scale, 95% CI = -1.5 – 1.2). Participants in the donepezil arm experienced significantly more side effects. The authors conclude that “sufficient evidence was not found from this pilot study to warrant a definitive Phase III trial.”



Special thanks to the Conference Planning Committee for all their hard work and time so far, and the efforts they are continuing to put out to make the conference a success.

Conference Committee
Malaz A. Boustani, MD, MPH, Chairman
Indiana University School of Medicine
Indiana University Center for Aging Research
Regenstrief Institute, Inc.

James L. Rudolph, MD, SM
Harvard Medical School
VA Boston Healthcare System

Yesne Alici, MD, Central Regional
Hospital, Butner, North Carolina →

**JAGS Supplement Highlights the Importance of
Delirium as a Science
November 2011
continued**

Other peer-reviewed articles in the supplement (with a brief description) include:

Validation of a Medical Record-Based Delirium Risk Assessment (pages S289–S294)

James L. Rudolph, Mary Beth Harrington, Michelle A. Lucatorto, Jennifer G. Chester, Joseph Francis and Kenneth J. Shay, on behalf of the Veterans Affairs and Delirium Working Group

In this prospective cohort study at a tertiary Veterans Affairs hospital, the authors describe the development of a chart abstraction tool for delirium risk and validate the tool against clinical expert diagnosis of delirium. While admitted, each participant underwent serial assessments for delirium by a clinical expert. Using the four criteria of a validated delirium prediction rule (cognitive impairment, sensory deficit, severe illness, and dehydration), chart review terms were selected for each criterion, and delirium risk was the sum of criteria present (range: 0–4; 4 = worst). After discharge, a nurse blinded to the expert's diagnosis completed the chart tool.

The authors found that the chart abstraction tool was effective at identifying overall delirium risk [11% in participants with 0 risk factors, 18% in those with 1–2 risk factors, and 50% in those with 3–4 risk factors ($P = .01$; c-statistic 0.65, 95% confidence interval (CI) = 0.54–0.76)] but not incident delirium risk [11%, 13%, and 25% for 0, 1–2, and 3–4 risk factors, respectively ($P = .53$; c-statistic 0.56, 95% CI = 0.42–0.74)].

Matching the Environment to Patients with Delirium: Lessons Learned from the Delirium Room, a Restraint-Free Environment for Older Hospitalized Adults with Delirium (pages S295–S300)

Joseph H. Flaherty and Milta O. Little

This article describes a management model for delirium, called the Delirium Room (DR): a 4-bed patient room (within an Acute Care for Elders (ACE) Unit) that provides 24-hour nursing care, emphasizes nonpharmacological approaches, and is completely free of physical restraints. They describe their core principles of the nonpharmacological approach as the T-A-DA method (“tolerate, anticipate, and don't agitate”). Their observational data suggests that negative outcomes associated with delirium, such as loss of function, longer hospital stay, and greater mortality, can be decreased to levels seen in individu-

als without delirium; and based on limited data, it appears that the rate of falls is at least not higher in the DR than in the ACE unit overall. The limitations of the DR model include lack of randomized controlled trials and the inability to determine which component of the model provides its benefits.

Postoperative Delirium and Functional Decline After Noncardiac Surgery (pages S301–S304)

Nicky Quinlan and James L. Rudolph

In this secondary analysis of a prospective study of 1,218 patients (age ≥ 60 years), undergoing noncardiac surgery (13 hospitals in 8 countries), the authors determine whether delirium after noncardiac surgery is associated with functional decline 3 months postoperatively. Of 948 participants who completed functional assessment at 3 months, 20% ($n = 189$) had a decline in function. In unadjusted analysis, postoperative delirium increased the odds of functional decline (OR = 2.4, 95% confidence interval (CI) = 1.4–4.2). After adjustment for age, sex, education, cognition, and surgery duration, delirium remained associated with functional decline (OR = 2.1, 95% CI = 1.2–3.8). The authors conclude that delirium can have lasting functional consequences and that “clinicians should give strong consideration to preoperative delirium risk assessment, delirium prevention strategies, and delirium surveillance programs after noncardiac surgery.”



Conference Committee cont'd

Sharon Gordon, Psy.D.
Meharry Medical College, Nashville, TN, VA Tennessee Valley Healthcare System

Ann Kolanowski, PhD, RN,
FGSA, FAAN
Hartford Center of Geriatric Nursing Excellence
Penn State University

Karin Neufeld, MD, MPH
Johns Hopkins Hospital

Noll Campbell, PharmD,
FASCP, Purdue University
Indiana University

Barbara Kamholz, MD
Duke University
Durham VA Medical Center

Sue Fosnight, R.Ph., BCPS
Northeastern Ohio Med Univ —>

The European Delirium Association Completes 6th Annual Scientific Congress Umeå, Sweden, November 17-18, 2011



The following was sent to us by Dr. Daniel Davis, of the EDA: "Umeå had the honour of hosting the sixth congress of the European Delirium Association. We were delighted that almost 100 delirium professionals made the trip to northern Sweden, especially in winter. The conference was well attended by persons with a wide range of clinical backgrounds, and delegates came from as far away as Australasia and North America.

The first key-note speaker, Dr Edward Marcantonio (Harvard), reviewed the literature on delirium prevention and intervention studies, adding valuable insights from his own work. The second key-note speaker, Dr Yoanna Skrobik (Montreal), focused on her studies in the ICU, demonstrating how it is possible to change attitudes toward delirium management through empowering staff. Both talks were very enthusiastically received.

We were keen to encourage as much new delirium science as possible. In addition to the 20 invited speakers, 19 submitted abstracts were presented orally and the poster exhibition included 15 presentations this year.

The conference dinner included some adventure! After a merry bus ride (furnished with Swedish glogg wine), we arrived at an Elk Farm and museum. We met domesticated elks (moose, for our North American cousins) that were happy to be stroked. We were then served elk stew (different to the ones we had just petted) and a wonderful dessert of elk cheese. Though we didn't get to see the Northern Lights, the overall experience at Umeå was very enriching.

We now look forward to the next EDA conference in Bielefeld, Germany on October 18-19, 2012. All delirium researchers and clinicians from around the world are welcome! Enquiries to: europeandelirium@gmail.com and further information on our website: www.europeandeliriumassociation.com"

Here are just a few examples of the areas our European colleagues are pursuing within the realm of delirium:

From pathophysiology to the bedside: 25 years of delirium research in Umeå. Yngve Gustafson, Umeå University, Sweden

Stress and sex steroid effects in the brain and on behavior. Torbjörn Bäckström, Umeå University, Sweden

Hormones and the ageing brain. Tommy Olsson, Umeå University, Sweden

Creation of a risk profile for delirium in orthopaedic and trauma patients in a Swiss University Hospital. Natalie Zimmerman, University Hospital of Bern, Switzerland

Predictors and outcomes of delirium in hospitalised older adults. Niamh O'Regan, University of Limerick, Ireland

Symptom profile of postoperative delirium in patients with and without dementia. Maria Lundström, Department of Nursing, Umeå University, Sweden

Outcomes from a shared care unit for older people with delirium. Joanna Cox, North Tyneside Hospital, Northumbria Healthcare Trust, North Shields, England

A novel hypothesis for the pathophysiology of delirium: Acutely compromised pathways of cerebral glucose utilization. Caroline Broadhurst, Betsi Cadwaladr University Health Board, Wrexham, Wales

Polymorphisms in the melatonin receptor 1B gene and the risk of delirium. Annemarieke de Jonghe, University of Amsterdam, The Netherlands

E-learning as an onsite educational tool to improve skills and knowledge of healthcare providers in delirium prevention and treatment. Koen Milisen, Catholic University Leuven, Belgium

Memory and MRI imaging of the brain. Lars Nyberg, Umeå University, Sweden

Neuroimaging studies in delirium. Karen Ferguson, University of Edinburgh, Scotland

Cholinergic depletion and acute inflammation combine to produce acute cognitive dysfunction. Colm Cunningham, Trinity College Dublin, Ireland

Delirium and non-convulsive status epilepticus: clinical aspects. Christine Thomas, Gerontopsychiatrie Klinik, Evangelisches Krankenhaus, Bielefeld, Germany

Neuroprotection in delirium. Alessandro Morandi, Ancelle della Carità Hospital, Cremona, Italy

Replication analysis for composition of the delirium motor subtype scale (DMSS) in a referral cohort from Northern India. Sandeep Grover, Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh, India

Temporal course of serum anticholinergic activity in the elderly after hip fracture: A biomarker for delirium? Stefan Kreisel, Krankenhaus, Bielefeld, Germany

Brain-damage mechanisms associated with cardiac surgery and cardiopulmonary bypass. Karl Gunnar Engström, Umeå University, Sweden

Pain management in delirium. Meera Agar, Flinders University, Adelaide, Australia

Conference Committee cont'd

Ella Bowman, MD, MPH
Indiana University School of
Medicine

Jeffrey Silverstein, MD
Mount Sinai School of Medicine

Michelle Weckmann, MD
University of Iowa

Teresa McCarthy, MD
University of Minnesota

Jose Maldonado, MD, FAPM,
FACFE
Stanford University Sch Medicine

Roberta Manns – Staff
Indiana University Center
for Aging Research



News from ADS Members and Attendees of the 2011 ADS Conference

E. Wesley Ely, MD, MPH, Pulmonary and Critical Care and Health Services Research, Vanderbilt University and VA-GRECC
 “The MIND-USA trial, an NIA sponsored R01 multicenter, placebo-controlled trial of haloperidol vs. ziprasidone (3-groups) in ICU patients with delirium has begun enrollment. This study had over 15 sites from around the country and will enroll for over 3 years with one year follow-up. The Vanderbilt Coordinating Center (VCC) in conjunction with the Tennessee Valley GRECC is conducting this interventional, phase III investigation with numerous other collaborators from the U.S.”

Christine Waszynski, Geriatric Nurse Practitioner, Hartford Hospital, Hartford, CT. (cwaszyn@harthosp.org)
 “Hartford Hospital in Hartford, CT has taken on delirium prevention, identification and management as a priority and hospital wide focused initiative. Senior management has supported this initiative. We formed a multidisciplinary group representing most departments of the hospital (hospitalists, APRNs, nursing, pharmacy, case coordination, information systems, palliative care, communications, etc.) who have worked together to develop "Delirium Top 5". This concept outlines the top 5 risk factors, top 5 preventative strategies, top 5 meds to avoid in high risk patients, top 5 etiologies, top 5 management and treatment strategies once delirium occurs. We have worked closely with our information system specialists to support the staff in this effort. The CAM has been incorporated into regular nursing and provider assessments; nurses notify providers of any newly identified delirium; a provider/ nurse huddle occurs to plan the strategy for safety and resolution of the delirium. A formalized delirium note for the provider has been constructed. Outcome measures will be tracked. The marketing department is helping us to create publicity to support this project.”

Ann M. Kolanowski, PhD, RN, FGSA, FAAN, University of Pennsylvania. (amk20@psu.edu)
 “Our team recently published a study protocol : *Kolanowski, A, Fick, D, Litaker, M, Clare, L, Leslie, D, Boustani, M. (2011). Study protocol for the recreational stimulation for elders as a vehicle to resolve delirium superimposed on dementia. Trials [doi 10.1186/1745-6215-12-119], 12(119).* The study is a 5-year project funded by the National Institute of Nursing Research (NR012242).”

Sophia de Rooij, MD, PhD, University of Amsterdam, Amsterdam, the Netherlands, s.e.derooij@amc.uva.nl
 “By the end of May 2012 the MAPLE study (Melatonin Against PLacebo in Elderly patients with hip fracture) will end after including 451 elderly hip fracture patients in three hospitals in the Netherlands. This multicenter double blind randomised trial investigates possible effects of melatonin/placebo on delirium in hip fracture patients, a trial currently in progress. The aims of the study are to investigate whether prophylactic treatment with melatonin will lead to a reduction in the occurrence of delirium (severity) in hip fracture patients and to study whether melatonin prevents long-term adverse outcomes like dementia. See also: *de Jonghe A, van Munster BC, van Oosten HE, Goslings JC, Kloen P, van Rees C, Wolvius R, van Velde R, Levi MM, Korevaar JC, de Rooij SE; Amsterdam Delirium Study group. The effects of melatonin versus placebo on delirium in hip fracture patients: study protocol of a randomised, placebo-controlled, double blind trial. BMC Geriatr. 2011 Jul 5;11:34. www.effectieveouderenzorg.nl”*

If you would like to give us a sentence or a paragraph about something related to Delirium that you would like other members to know about, please email Dr. Joseph Flaherty, Editor-in-Chief, at flahertyinchina@yahoo.com and we will try to put it into the next newsletter.

It can be an update on your research, your clinical care, a conference, a recent lecture or something you've recently published. Or it can be something about Delirium (outside your work) that you think is important.