

Nursing Management of a Patient with Delirium in the Intensive Care Unit: A Case Report

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Abstract

Delirium is an acute disturbance in attention, awareness, and cognition that frequently occurs among critically ill patients. Early identification and appropriate nursing management are essential because delirium may increase the risk of complications and prolong hospitalization. This case report describes the nursing management of a 68-year-old male who developed delirium during intensive care unit admission for severe community-acquired pneumonia and acute hypoxemic respiratory failure. On the 3rd day of hospitalization, the patient developed acute changes in mental status, fluctuating attention, disorientation, agitation, disturbed sleep, and visual hallucinations. Assessment using the Confusion Assessment Method for the Intensive Care Unit supported the presence of delirium. Comprehensive nursing interventions were implemented, including regular neurological and delirium assessment, maintenance of oxygenation, reorientation, therapeutic communication, environmental modification, sleep promotion, sensory support, pain assessment, hydration and nutritional support, early mobilization, prevention of injury, and family involvement. Potentially reversible contributing factors were identified and communicated to the multidisciplinary team. Following implementation of the nursing care plan and treatment of the underlying medical condition, the patient's cognitive status progressively improved. The case highlights the important role of medical-surgical and critical care nurses in early recognition, prevention of complications, and comprehensive management of delirium in critically ill patients.

Keywords: Acute confusion, critical care nursing, delirium, intensive care unit, nursing management, patient safety

INTRODUCTION

Delirium is a common acute neuropsychiatric syndrome characterized by disturbances in attention, awareness, and cognition that develop over a short period and fluctuate during the course of the day. Critically ill patients are particularly vulnerable due to severe illness, infection, hypoxemia, metabolic disturbances, sleep disruption, immobility, pain, unfamiliar surroundings, and exposure to multiple medications.

Delirium may present as hyperactive, hypoactive, or mixed forms and may adversely affect patient safety, recovery, and length of hospitalization.^[1,2]

Early recognition is an important component of critical care nursing. Nurses continuously observe patients and can identify changes in attention, behavior, orientation, consciousness, and sleep-wake patterns. Standardized assessment tools such as the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) can assist in systematic recognition of delirium.^[3]

Nursing management extends beyond controlling agitation. Identification of potentially reversible factors, maintenance of physiological stability, promotion of sleep, early mobilization, sensory support, appropriate pain management, environmental modification, nutritional and hydration support, and family engagement are important components of comprehensive care.^[4,5]

The present case report describes the assessment and nursing management of a critically ill patient who developed

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delirium during treatment for severe pneumonia and respiratory failure.

CASE PRESENTATION

Patient information

A 68-year-old male was admitted to the emergency department with a 4-day history of fever, productive cough, progressive shortness of breath, generalized weakness, and decreased oral intake. His medical history included hypertension for approximately 10 years and Type 2 diabetes mellitus for approximately 8 years.

On clinical evaluation, the patient was diagnosed with severe community-acquired pneumonia associated with acute hypoxemic respiratory failure. He was transferred to the intensive care unit for close monitoring and respiratory support.

Initial clinical assessment

At the time of ICU admission, the patient was conscious, cooperative, and oriented to person, place, and time. He was anxious due to respiratory distress but was able to communicate appropriately.

The initial observations were as follows

- Temperature: 38.7°C
- Heart rate: 112 beats/min
- Respiratory rate: 30 breaths/min
- Blood pressure: 148/86 mmHg
- Oxygen saturation: 88% on room air.

Respiratory examination revealed bilateral coarse crepitations. Laboratory investigations demonstrated leukocytosis and elevated inflammatory markers. Chest radiography demonstrated bilateral pulmonary infiltrates consistent with pneumonia.

The patient received prescribed antimicrobial therapy, oxygen supplementation, intravenous fluid therapy, antipyretic treatment, glycemic monitoring, and supportive management. Due to increasing respiratory distress, non-invasive respiratory support was initiated.

Development of delirium

On the 3rd day of ICU admission, the nursing staff observed a sudden change in the patient's mental status. He became restless and repeatedly attempted to remove the oxygen interface and intravenous line. He was unable to maintain attention during conversation and repeatedly asked where he was.

During other periods, the patient became unusually quiet and drowsy. He reported seeing people in the room who were not present. His symptoms fluctuated during the day and became more prominent during the evening and nighttime.

The nursing assessment revealed acute change from baseline mental status, impaired attention, disorientation, fluctuating level of consciousness, intermittent agitation, visual hallucinations, and disturbed sleep-wake pattern.

The CAM-ICU was used for systematic assessment, and the findings were consistent with delirium.^[3] The change in mental status was immediately communicated to the treating medical team.

NURSING ASSESSMENT

A comprehensive nursing assessment was performed to identify potential precipitating and contributing factors.

Neurological assessment

The patient's level of consciousness, orientation, attention, behavior, ability to follow commands, and changes in cognition were assessed at regular intervals. Particular attention was given to fluctuations between agitation and reduced responsiveness.

Respiratory assessment

Respiratory rate, oxygen saturation, respiratory effort, breath sounds, and response to respiratory support were monitored closely. Maintaining adequate oxygenation was considered an important component of the patient's overall management.

Cardiovascular assessment

Heart rate, blood pressure, peripheral perfusion, and signs of hemodynamic instability were assessed regularly.

Pain assessment

Pain was assessed using an appropriate pain assessment scale. The patient was monitored for both untreated pain and excessive sedation.

Sleep assessment

The patient's sleep pattern was assessed. Frequent nighttime interruptions, environmental noise, ICU alarms, artificial lighting, and clinical procedures were identified as factors potentially contributing to sleep disturbance.

Hydration and nutritional assessment

Fluid intake and output, oral intake, blood glucose levels, and nutritional status were monitored. The patient's reduced oral intake before and during hospitalization was considered an additional risk factor.

Medication assessment

The medication profile was reviewed with the treating team to identify medications that could potentially contribute to sedation or altered cognition. Medication-related risk factors were considered as part of the overall clinical assessment.

NURSING MANAGEMENT

Regular delirium assessment

The patient's cognitive status was assessed regularly using a standardized approach. Changes from his baseline cognitive function were documented and communicated to the multidisciplinary team.

Maintenance of oxygenation

Prescribed oxygen and respiratory support were maintained. Oxygen saturation and respiratory status were monitored

closely. The patient was positioned appropriately to promote respiratory function and comfort.

Reorientation

Frequent reorientation was provided using short, simple statements. The patient was reminded of his name, location, reason for hospitalization, and current time. A clock and calendar were placed within his visual field.

Therapeutic communication

The nurse used a calm, reassuring, and non-threatening approach. The patient was not confronted or argued with when experiencing hallucinations. Instead, his concerns were acknowledged while reality-based information was gently provided.

Environmental modification

Unnecessary environmental stimulation was reduced. Noise was minimized where possible, appropriate lighting was maintained, and unnecessary room changes were avoided. Familiar objects were kept within the patient's view when available.

Sleep promotion

A day-night routine was encouraged. During nighttime, unnecessary lights and noise were reduced, non-urgent nursing activities were clustered, and uninterrupted periods of sleep were promoted where clinically feasible.

Sensory support

The patient's visual and auditory needs were assessed. His routinely used eyeglasses and hearing aids, when applicable, were made available to improve communication and orientation.

Pain management

Pain was assessed regularly, and prescribed analgesic therapy was administered as indicated. The patient was monitored for excessive sedation and changes in cognitive status.

Hydration and nutritional support

Fluid intake and output were monitored. The patient's nutritional intake was assessed, and prescribed nutritional support was provided. Assistance with feeding was offered when required.

Early mobilization

After stabilization of the patient's respiratory and cardiovascular status, progressive mobilization was initiated. Range-of-motion exercises, assisted sitting, and gradual activity were encouraged according to tolerance.

Prevention of injury

Due to fluctuating cognition and intermittent agitation, measures were implemented to reduce the risk of falls and accidental removal of medical devices. The bed was maintained in a safe position, essential items were kept within reach, and appropriate supervision was provided during periods of increased agitation.

Restrictive measures were avoided unless clinically necessary and consistent with institutional policy.

Family involvement

Family members were encouraged to participate in the patient's care when appropriate. They were instructed to communicate calmly, provide familiar reassurance, and assist with orientation.

Multidisciplinary collaboration

The nursing team communicated the patient's changes in mental status to the treating physicians and other members of the multidisciplinary team. Potential contributing factors, including infection, hypoxemia, metabolic disturbances, pain, medication effects, sleep disturbance, immobility, and nutritional problems, were reviewed [Table 1].

Nursing care plan

Acute confusion related to critical illness and physiological disturbance was managed with regular cognitive assessment, reorientation, therapeutic communication, and environmental modification to improve orientation and attention. The patient's attention and orientation progressively improved.

Risk for injury related to altered cognition and agitation was addressed through safety measures, supervision, environmental modification, and family involvement to prevent falls and accidental device removal. No falls or accidental device removal occurred.

Disturbed sleep pattern was managed by reducing nighttime noise and light, clustering care, and maintaining a day-night

Table 1: Nursing care plan for the patient with ICU delirium

Nursing diagnosis/problem	Goal	Nursing interventions	Outcome
Acute confusion related to critical illness and physiological disturbance	Improve orientation and attention	Regular cognitive assessment, reorientation, therapeutic communication, environmental modification	Attention and orientation progressively improved
Risk for injury related to altered cognition and agitation	Prevent falls and accidental device removal	Safety measures, supervision, environmental modification, family involvement	No fall or accidental device removal occurred
Disturbed sleep pattern	Promote restorative sleep	Reduce nighttime noise and light, cluster care, establish day-night routine	Sleep pattern gradually improved
Impaired physical mobility	Maintain and improve mobility	Range-of-motion exercises and progressive mobilization	Activity tolerance improved
Risk for deficient fluid volume	Maintain adequate hydration	Monitor intake and output and provide prescribed fluid therapy	Hydration status remained stable
Anxiety related to critical illness and unfamiliar ICU environment	Reduce anxiety and agitation	Reassurance, therapeutic communication, orientation, family involvement	Anxiety and agitation decreased

ICU: Intensive care unit

routine to promote restorative sleep. The patient's sleep pattern gradually improved.

Impaired physical mobility was managed through range-of-motion exercises and progressive mobilization to maintain and improve mobility. Activity tolerance improved.

Risk for deficient fluid volume was managed by monitoring intake and output and providing prescribed fluid therapy to maintain adequate hydration. Hydration status remained stable.

Anxiety related to critical illness and an unfamiliar ICU environment was managed through reassurance, therapeutic communication, orientation, and family involvement to reduce anxiety and agitation. Anxiety and agitation decreased [Table 1].

Outcome^[6-7]

Following implementation of the individualized nursing care plan and treatment of the underlying medical condition, the patient's mental status gradually improved.

The frequency and severity of agitation decreased over the following days. The patient became increasingly attentive during conversations and was able to recognize familiar people and his surroundings. Visual hallucinations were no longer reported.

His sleep pattern gradually improved, and he became more cooperative with nursing interventions and physiotherapy. Respiratory status also improved, allowing gradual reduction of respiratory support.

Progressive mobilization was tolerated with assistance. No fall, pressure injury, or accidental removal of medical devices occurred during the period of ICU observation.

After clinical stabilization and improvement in cognitive status, the patient was transferred from the ICU to the medical ward for continued treatment and rehabilitation.^[8]

DISCUSSION

Delirium is an important complication of critical illness and may develop rapidly in patients with severe infection, respiratory failure, and other forms of physiological stress.^[1,2] In the present case, the patient developed acute changes in attention, awareness, behavior, and cognition during ICU admission for severe pneumonia and respiratory failure.

Several potential risk factors were present, including older age, acute infection, hypoxemia, sleep disruption, immobility, unfamiliar surroundings, reduced oral intake, and exposure to multiple medications. These factors may interact and increase susceptibility to delirium in critically ill patients.

A major challenge in delirium management is early recognition. Hyperactive delirium may be recognized due to agitation and restlessness, whereas hypoactive delirium may be overlooked because it can present as lethargy or reduced interaction. Regular systematic assessment is therefore important.^[2,3]

The CAM-ICU provides a structured method for assessing

delirium among critically ill patients and incorporates acute changes in mental status, inattention, altered level of consciousness, and disorganized thinking.^[3]

In this case, nursing assessment was central to recognizing the patient's change from baseline. Because nurses maintain continuous bedside contact with ICU patients, they are well positioned to identify changes in cognition and behavior at an early stage.

Management focused on both physiological stabilization and non-pharmacological nursing interventions. Maintenance of adequate oxygenation was particularly important because the patient had acute respiratory failure. Pain assessment, hydration and nutritional support, sleep promotion, sensory support, environmental modification, and early mobilization were incorporated into the nursing care plan.

Environmental modification and reorientation were particularly important. The patient was provided with a clock and calendar, received frequent orientation, and was cared for using calm and consistent communication. Family involvement also provided familiar interaction and reassurance.

Sleep disruption is common in the ICU due to noise, artificial lighting, frequent procedures, and disruption of normal circadian rhythms. Promoting nighttime sleep while encouraging appropriate daytime activity may help reduce factors associated with delirium.^[4,5]

Early mobility was introduced after clinical stabilization. Immobility and prolonged bed rest can contribute to physical weakness and may negatively influence recovery. Progressive mobility therefore formed an important component of the patient's nursing care.

The case also demonstrates the importance of multidisciplinary collaboration. Delirium is multifactorial and requires assessment of potentially reversible causes rather than management of agitation alone. Communication among nurses, physicians, pharmacists, physiotherapists, respiratory therapists, and family members can facilitate comprehensive care.

The patient's cognitive status improved progressively following treatment of the underlying illness and implementation of comprehensive nursing measures. Although a single case cannot establish causality or generalize outcomes to all critically ill patients, it demonstrates the practical role of systematic nursing assessment and individualized interventions in delirium management.

Clinical significance

This case emphasizes that delirium should be considered whenever a critically ill patient's mental status changes suddenly or fluctuates during hospitalization. Nurses should not consider agitation alone as the defining feature because delirium may also present with reduced activity and responsiveness.

Routine assessment, early recognition, patient-centered communication, environmental modification, sleep promotion, sensory support, mobility, adequate hydration and nutrition, pain management, patient safety, and family participation are important elements of comprehensive nursing care.

The case is particularly relevant to medical-surgical and critical care nursing because many patients admitted to medical and surgical ICUs have multiple simultaneous risk factors for delirium.

CONCLUSION

Delirium is a clinically significant complication among critically ill patients and requires early recognition and comprehensive management. In this case, systematic nursing assessment enabled early identification of acute cognitive changes, while individualized nursing interventions addressed physiological, environmental, psychological, and safety-related needs.

The case highlights the central role of medical-surgical nurses in recognizing delirium, maintaining patient safety, promoting orientation and sleep, supporting mobility and sensory function, managing pain and hydration, involving family members, and communicating changes to the multidisciplinary team.

A structured nursing approach, combined with appropriate treatment of underlying causes, can support recovery and improve the quality and safety of care for patients experiencing delirium in the ICU.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

FUNDING

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ETHICAL CONSIDERATIONS

The patient's privacy and confidentiality should be maintained throughout the preparation and publication of the case report. Written informed consent for publication should be obtained from the patient or an authorized representative before submission. Any identifying information should be removed from the manuscript and accompanying figures.

PATIENT CONSENT

Written informed consent for publication of the case report should be obtained from the patient or legally authorized representative. The consent documentation should be retained by the authors in accordance with institutional and journal requirements.

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