head of the bed at least to 30 degrees, and practice diligent handwashing. The surgeon and nurses will also watch very closely for other threats, such as infection at the site of the incision.

After extubation, you will be rapidly pushed toward self-sufficiency, even jollied out of bed. "They got him up in a chair right in the ICU!" marvels Adams's wife, Joanne, laughing. Just hours earlier, the evening after his surgery, the family had visited Adams, still unconscious, in the ICU. He could have looked worse. "There were tubes running everywhere," says Joanne. "He was pale but not as ghastly gray-looking as they'd said he'd be." ●

7 ON THE FLOOR

Out of the SICU and recuperating in your room, you will have little to do but read, chat with visitors, watch TV, and lament your new virtuous, heart-healthy, bland diet. Much of the time, that is. Nurses, doctors, specialists, and therapists will be frequent company. Each will have a particular mission—and the hospital where caregivers communicate seamlessly has yet to be discovered. Information can and will fall through the cracks. That spiral notebook should be at the ready to record the name of everyone who comes in, the time, and what they do or what directions they give. "If you can't remember who told you what, it's lost," says Nash.

That invites mistakes. In *Preventing Medication Errors,* a 2006 report by the Institute of Medicine, which advises Congress on health matters, a key finding was that "on average, a hospital patient is subject to at least one medication error per day"—wrong drug, wrong time, wrong administration (such as giving a drug by IV instead of orally). And, of course, wrong patient. If your blood thinner came at noon one day and at 3 p.m. the next, asking whether that's OK is appropriate. The nurse should faithfully identify all medications and match the patient name on the order to your ID band. Few of these slip-ups cause harm, but "vigilance is critical," says Nash.

That applies to the need for caregivers to disinfect their hands before touching

Their Altered Mental States

THE CONFUSION OF DELIRIUM

Especially if they are older and in intensive care, some patients go through episodes of delirium—a word that may suggest shouting and thrashing, but it's more a state of confusion. It may not be obvious at all. It may reveal itself as disorientation, inattentiveness, or difficulty in following instructions. Or it may be more extreme—paranoid statements, claims of bugs crawling on the body, or sudden efforts to rip out wires and IV tubes. Less frequently, younger patients who are neither in intensive care nor on a ventilator are affected.

While enormously distressing to families, these occurrences typically are written off as benign, just one of those problems that come and go. Often the symptoms do fade quickly. But in the

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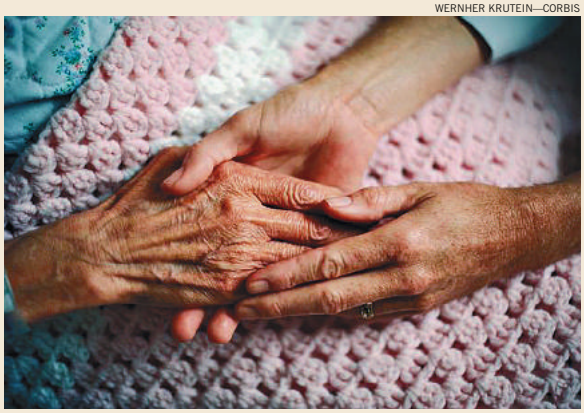

past few years, researchers have unearthed evidence that "sundowning," as delirium states are nicknamed because of their timing, may be far from benign and could have lasting effects. "Delirium is a predictor of death, a longer hospital stay, and increased costs," says Wesley Ely, a critical-care specialist who founded the ICU Delirium and Cognitive Impairment Study Group at Vanderbilt University School of Medicine. It may also be a risk factor for dementialike illness.

A key finding of Ely's group is that delerium is far more likely to affect patients who are sedated and ventilated. These cases often go undiagnosed, says Ely, because the breathing tube prevents the patients from talking. He developed a quick nonverbal way to check such patients' mental state: For example, they are instructed to squeeze a nurse's hand only when she comes to an *A* as she spells "save a heart" out loud.

Disrupted sleep. Diagnosis is crucial, because delirium signals other issues. Ely is studying possible problems posed by common sedatives. Established factors include pneumonia, infection, low blood oxygen, a specific drug or combination of medications, too much fluid in the body, and out-of-balance electrolytes. A suddenly changed sleep cycle may induce delirium. The disruption could be due to sedation or, as happens too often, because a patient is awakened during the night for a routine chore such as getting a bath or having blood drawn. What's more, "it's fairly rare that you'd see a single factor causing the delirium," says Laura Fochtmann, professor of psychiatry and behavior science at Stony Brook University in New York.

Family and friends can help keep patients oriented. Remind them every day where they are and what is going on, says Ely. Bringing familiar or helpful items from home—glasses, hearing aid, clock, calendar—can better anchor them in reality.

After a bout of delirium, caregivers can be pressed to hunt down and address the cause. A psychiatric specialist can be consulted, a ban on late-night wake-ups can be requested, and the need for a prescribed psychoactive drug can be re-evaluated. The biggest problem, says Ely, is that too often "doctors are focused only on the organs that got the patient into the hospital." *–S.B.*