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U.S. Small Business Administration

Manufacturer of the Year for New England and Vermont 2024

Q1 2026

The Quarterly

INSIDE THIS ISSUE:

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- Penny

Employee Spotlight

Meet Penny

This newsletter's Employee of the Quarter is actually more of a volunteer - well, maybe more of a pet. Penny started coming to work because of sitter issues, but we soon realized that she added a welcome vibe to our team.

Penny can't wait to come to work. Each morning, she flies in the door and immediately goes office to office greeting people.

She intuitively knows about staying away from manufacturing zones, so she met with approval from our Production Manager, and she can't wait for a meeting in the conference room. I guess we don't need the morale boost - note the photos from our pumpkin carving contest and our holiday party, but we do welcome the pure joy.

Did You Know?

Delirium Isn't Just a Critical Care Problem

It is well documented that up to 80% of ICU patients are suffering from delirium—a medical emergency, stemming from the commonality of circumstances in the ICU wherein a patient is immobilized, isolated, and cognitively impaired—the three independent factors which lead to delirium. Most hospitals by now have deployed delirium reduction practices in their ICUs which address these variables. For example, early/enhanced mobilization, restraint reduction, regular cognitive and agitation screening, and increased family and staff engagement are all measures common to delirium reduction initiatives for critical care environments. However, did you know that delirium is also common outside of the ICU?

"As with delirium in hospital settings, immobility, isolation, and cognitive impairment can occur anywhere, and with the right cocktail of illness/injury and drugs, delirium can occur."

Recent studies indicate that at least 20-30% of patients outside of the ICU (ED, post-surgery, medical units) are experiencing delirium, and more often than not, are undiagnosed. The same factors are present in these environments, although usually to a lesser extent than in the ICU. The more vulnerable patients, and especially elderly patients with dementia, are particularly prone to delirium in these settings, but the delirium is often misdiagnosed or justified as a pre-existing condition such as dementia, alcoholism, or mental illness. As the data become more clear, more hospitals are extending their delirium reduction programs outside of the ICU, which typically starts with establishing regular assessments such at the CAM, 4AT, or other cognitive tests (e.g., MMSE/MoCA) in these settings.

With the rise in outpatient pharmaceutical therapies and the proliferating complexity of drug interactions, it is increasingly evident that delirium is growing outside of care settings. As with delirium in hospital settings, immobility, isolation, and cognitive impairment can occur anywhere, and with the right cocktail of illness/injury and drugs, delirium can occur. This scenario is especially scary as it is still a medical emergency, but is almost certain to go undiagnosed. Research in this area is growing, and could point to an even more challenging public health issue in the face of an aging population and modern modalities for care delivery.

Given the broad net that the spectre of delirium casts, it behooves all care staff to understand and recognize the vulnerabilities in a patient that could lead to delirium and apply special attention specific to delirium prevention to those patients--any patient suffering from dementia should be flagged as a delirium risk, regardless of care setting. Assessment methods are readily available and require little training, but simply being actively aware of the applicable risks of delirium for a specific patient's profile is a step anyone engaging that patient can take, including family and loved ones.

A Message from C4 (Chief Culture Change Catalyst)

Okay, we talk about the ICU all the time, and sometimes we forget that there is life (and death) outside the ICU, so lets take a quick minute and try to blend environments. We know how important maintaining cognition and mobility is in the ICU, the location that sees patients at there most vulnerable mentally and physically. And we know what to do: minimize sedation, maximize mobilization, minimize delirium risk, and involve family. Now one would think that the whole process would be easier in a less critical environment, but is it? There is a saying that goes something like, "If you have something important to get done, give it to a busy person." which basically means that organized & focused locations have an easier time accomplishing tasks, which goes against the notion that if there is more availability, things will get done faster and better.

What does this mean for our ICU and non-ICU environments? Well, firstly, I don't want to imply that the non-ICU environment is less busy – it's just less acute. In the post-ICU setting, this can mean that priorities like cognition and mobility take a back seat to getting patients on their home meds and going through other discharge planning activities. In the pre-ICU setting, patients are usually deteriorating and it's just not the time for mobilization and cognition efforts. But do we really want to see all the hard work we did in the ICU go to waste? The post-ICU setting is an incredible opportunity to get logarithmically better results from the same input. In many institutions, therapy departments have different protocols for the non-ICU space, and if it is not a surgical case which is prioritized for bed turnover, patients can fall behind.

So what's the solution? Well, the obvious answer is to continue ICU cognition and mobilization efforts as fast and furiously as in the ICU, but the more muddled discussion is how to get that done. We all wish that common sense could float uphill, but it doesn't, and we bedside staff have to take the long route and create a financial and logistical case for staff allocation and automated protocols. Lots of hard work but there are not many other initiatives we could take on that would have the kind of impact this would have for our patients. So start thinking, friends – is there a way to instate a "post-ICU patient status" so that therapists can continue their more intense and automated pace? The answer is yes, but only after you gather up all the literature evidencing the immense cost savings for your proposal. The ICU Rehab or ICU Liberation references should suffice but you will have to be a champion and have dogged determination to go against the status quo. But that's where the most precious results live. Change your world. Maybe 2026 will be a good year, but don't sit back and idly hope kindness will ensue – get out there and (peacefully and intelligently) stay on it 'til it's done!

Happy New Year,

Marie Pavini

Marie Pavini, MD, FCCM, FCCP

"Is there a way to instate a "post-ICU patient status" so that therapists can continue their more intense and automated pace?"

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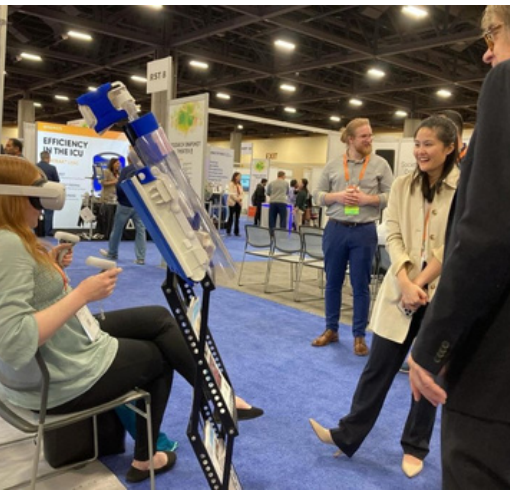

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"... where common sense meets healthcare..."

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A Few Good Mentions

Q4 conferences and health awareness days

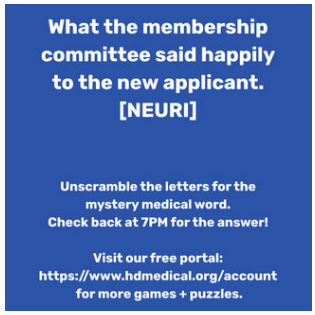
3/18 **NYC Metropolitan NICHE Conference,** New York, NY
3/22-24 **SCCM Critical Care Congress,** Chicago, IL

January	February	March
National Blood Donor Month **Thyroid Awareness Month** **International Quality of Life Month**	**American Heart Month** **National Cancer Prevention Month**	**Developmental Disabilities Awareness Month** **Brain Injury Awareness Month**
3rd : International Mind-Body Wellness Day **4th**: World Braille Day **25th**: World Leprosy Day	**2nd**: Rheumatoid Awareness Day **4th**: World Cancer Day **8-14:** Heart Failure Awareness Week **20th**: National Caregivers Day	**9-15**: Patient Safety Awareness Week **16-22**: Brain Awareness Week **20th**: World Oral Health Day

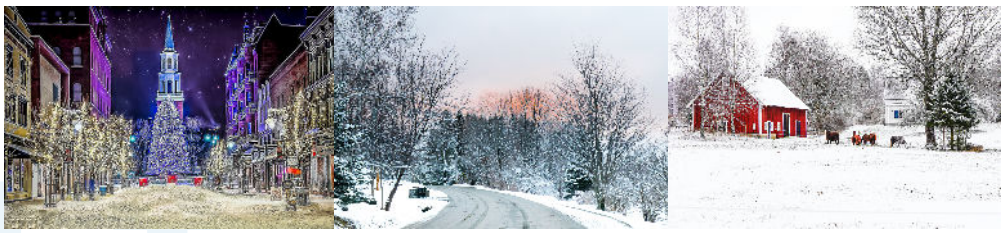
In the News

FDA Clears First AI-Powered Delirium Screening Device: The FDA has granted 510(k) clearance to Ceribell's AI-powered delirium monitoring solution, making it the first FDA-cleared device for continuous, objective delirium screening in critically ill patients by analyzing EEG patterns in real time and addressing limitations of subjective bedside assessments. Read more here.

HD***medical*** is growing on social media. Follow our Medhead series and more.



Home in Vermont



Winter in Vermont comes on with a hush, snow folding over the landscape like a thick quilt. Roads slow down, ski mountains wake up, and dinner leans hearty—stews, bread, something warm in a mug. The air bites, but the stars feel nearer, and every breath hangs like a small confession. Windows glow earlier, neighbors check in more often, and the world outside softens to white while the inside fills with warmth.

Here's to a season that slows us down and gathers us in.