DELIRIUM PROTOCOL

Perform Delirium Assessment via CAM-ICU

Non-delirious (CAM-ICU negative)

- Treat pain and anxiety if indicated via pain score or RASS

Delirious (CAM-ICU positive)

- Consider differential diagnosis (Dr. DRE or THINK)

  - Stupor or coma while on sedative or analgesic drugs (RASS -4 or -5)

  - Does the patient require deep sedation or analgesia?

  - Yes
    - Perform SAT
  
  - No
    - If tolerates SAT, perform SBT

Remove deliriogenic drugs

- Non-pharmacological protocol

  Orientation
  - Provide visual and hearing aids
  - Encourage communication and reorient
  - Have familiar objects from patient’s home in the room
  - Attempt consistency in nursing staff
  - Family engagement and empowerment

  Environment
  - Sleep hygiene: Lights off at night, on during day
  - Control excess noise (staff, equipment), earplugs
  - Early Mobilization and exercise
  - Treat pain and anxiety if indicated via pain score or RASS
  - Give adequate sedative for safety if required and titrate to goal RASS
  - Consider typical or atypical antipsychotics

  Non-delirious (CAM-ICU negative)

  - Reassess target sedation goal every shift
  
  - If tolerates SAT, perform SBT

RASS +2 to +4

- Is the patient in pain?

  - Yes
    - Give analgesic
  
  - No
    - Assure adequate pain control
    - Consider typical or atypical antipsychotics

RASS 0 to +1

- Reassess target sedation goal

Perform Delirium Assessment via CAM-ICU

RASS -1 to -3

- Reassess target sedation goal every shift

Give analgesic

- If tolerates SAT, perform SBT

Perform Delirium Assessment via CAM-ICU

RASS -4 or -5

- Does the patient require deep sedation or analgesia?

  - Yes
    - Perform SAT
  
  - No
    - If tolerates SAT, perform SBT

1. Dr. DRE:
   - Diseases: Sepsis, CHF, COPD
   - Drug Removal: SATs and stopping benzodiazepines/narcotics
   - Environment: Immobilization, sleep and day/night orientation, hearing aids, eyeglasses, noise
   - THINK:
     - Toxic Situations – CHF, shock, dehydration – Deliriogenic meds (tight titration) – New organ failure (liver, kidney, etc)
     - Hypoxemia;
     - Infection/sepsis (nosocomial), Immobilization
     - Nonpharmacological interventions
     - K+ or Electrolyte problems

2. Consider stopping or substituting deliriogenic medications such as benzodiazepines, anticholinergic medications (metoclopramide, H2 blockers, promethazine, diphenhydramine), steroids, etc.

3. See non-pharmacological protocol – see below

4. If patient is non-verbal assess via CPOT or if patient is verbal assess via visual analog scale

5. Analgesia – Adequate pain control may decrease delirium. Consider opiates, non-steroidal, acetaminophen or gabapentin (neuropathic pain)

6. Typical or atypical antipsychotics. There is no evidence that haloperidol decreases the duration of delirium. Atypical antipsychotics may decrease the duration of delirium.

7. Discontinue if high fever, QTc prolongation, or drug-induced rigidity.

8. Consider non-benzodiazepine sedation strategies (propofol or dexmedetomidine)

9. Spontaneous Awakening Trial (SAT) – If meets safety criteria (No active seizures, no alcohol withdrawal, no agitation, no paralytics, no myocardial ischemia, normal intracranial pressure, FiO2 < 70%)

10. Spontaneous Breathing Trial (SBT) – If meets safety criteria (No agitation, No myocardial ischemia, FiO2 < 50%, adequate inspiratory efforts, O2 saturation ≥ 88%, no vasopressor use, PEEP ≤ 7.5 cm)

Non-pharmacological protocol

Orientation

Environment

ABCDEF Bundle

http://www.icudelirium.org/medicalprofessionals.html