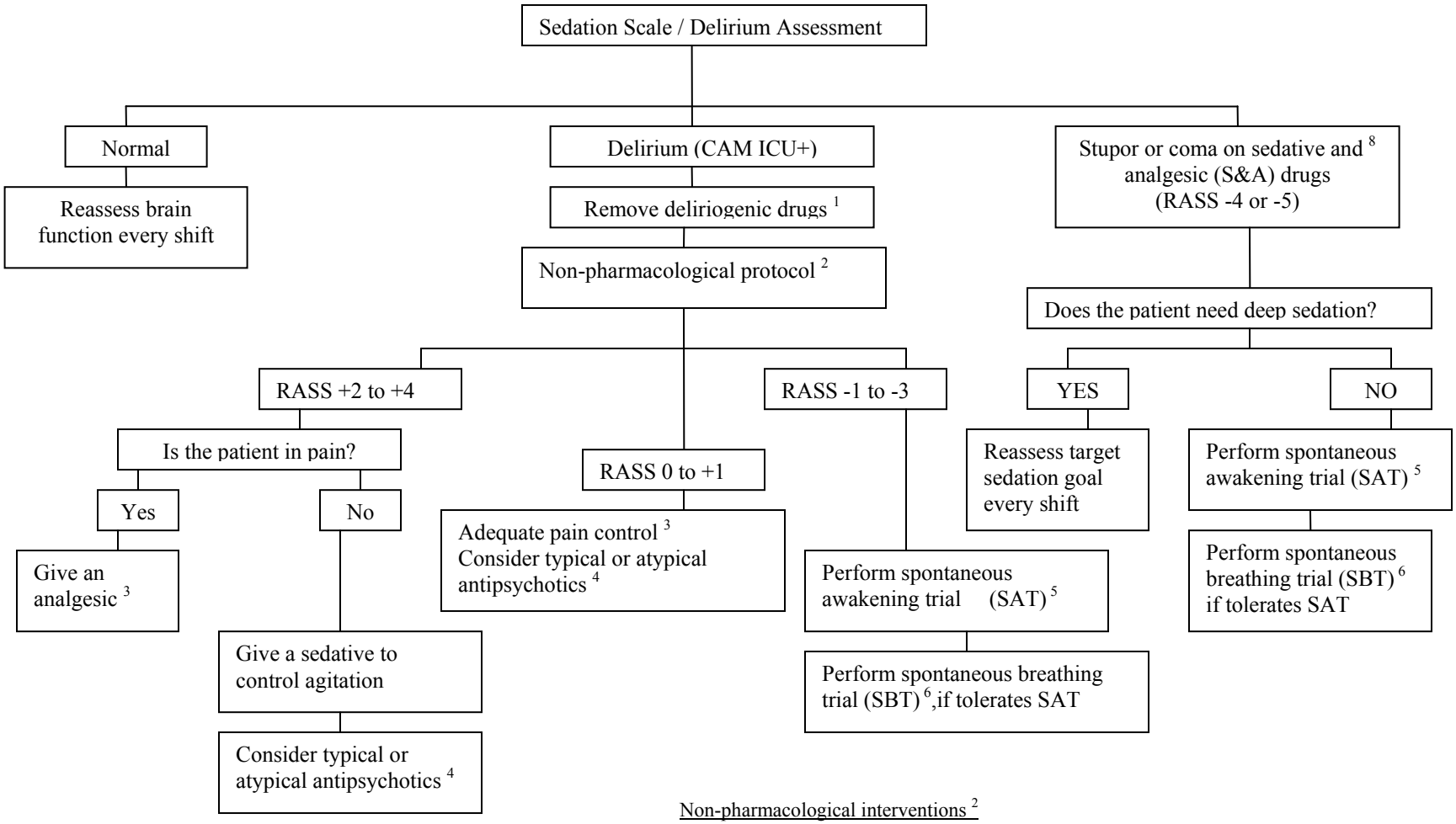
DELIRIUM PROTOCOL



1. Remove deliriogenic medications – Substitute meds such as benzodiazepines, anticholinergic medications (metochlorpromide, H2 blockers, promethazine, diphenhydramine), steroids etc
2. Non pharmacological interventions – see table
3. Analgesia – Adequate pain control may decrease delirium. Consider intermittent morphine if feasible.
4. Atypical or typical antipsychotics – may consider 1-2 mg haloperidol as starting doses in elderly. Usual maximum dose is 20 mg/day of haloperidol. Monitor EKG
5. Spontaneous Awakening Trial (SAT) – Stop sedation or decrease infusion by ½, especially benzodiazepines, till RASS 0 to –2, as tolerated.
6. Spontaneous Breathing Trial (SBT) – CPAP/PS trial if on <50% and ≤ 8 PEEP
7. S&A – Sedative and analgesics drugs – commonly benzodiazepines, propofol, fentanyl, or morphine

Non-pharmacological interventions [2]

Orientation

Provide visual and hearing aids
Encourage communication and orientation to day/time/location by nurses and family
Have familiar objects from patients home in the room
Attempt consistency in nursing staff
Allow television during day with daily news
Non-verbal music

Environment

Sleep hygiene: Lights off at night, on during the day. Consider sleep aids (zolpidem, mirtazipine)
Control excess noise (staff, equipment, visitors) at night
Ambulate or mobilize patients

Clinical parameters

Maintain systolic blood pressure > 90 mm Hg
Maintain saturations >90%
Treat underlying metabolic derangements and infections
Discontinue any unnecessary and potentially deliriogenic medications

RASS and CAM-ICU Worksheet

Step One: Sedation Assessment

The Richmond Agitation and Sedation Scale: The RASS*

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to *voice* **(≥10 seconds)**	Verbal Stimulation
-2	Light sedation	Briefly awakens with eye contact to *voice* **(<10 seconds)**	Verbal Stimulation
-3	Moderate sedation	Movement or eye opening to *voice* **(but no eye contact)**	Verbal Stimulation
-4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation	Physical Stimulation
-5	Unarousable	No response to *voice or physical* stimulation	Physical Stimulation

Procedure for RASS Assessment

1. **Observe patient**
   a. Patient is alert, restless, or agitated. **(score 0 to +4)**
2. **If not alert, state patient's name and *say* to open eyes and look at speaker**.
   a. Patient awakens with sustained eye opening and eye contact. **(score –1)**
   b. Patient awakens with eye opening and eye contact, but not sustained. **(score –2)**
   c. Patient has any movement in response to voice but no eye contact. **(score –3)**
3. **When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.**
   a. Patient has any movement to physical stimulation. **(score –4)**
   b. Patient has no response to any stimulation. **(score –5)**

If RASS is -4 or -5, then **Stop** and **Reassess** patient at later time
If RASS is above - 4 (-3 through +4) then **Proceed to Step 2**

*Sessler, et al. AJRCCM 2002; 166:1338-1344. Ely, et al. JAMA 2003; 289:2983-2991.

Step Two: Delirium Assessment

Feature 1: Acute onset of mental status changes or a fluctuating course

And

Feature 2: Inattention

And

Feature 3: Disorganized Thinking OR **Feature 4:** Altered Level of Consciousness

= DELIRIUM

CAM-ICU Worksheet

Feature 1: Acute Onset or Fluctuating Course Positive if you answer 'yes' to either 1A or 1B.	**Positive**	**Negative**
1A: Is the pt different than his/her baseline mental status? Or **1B:** Has the patient had any fluctuation in mental status in the past 24 hours as evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment?	**Yes**	**No**
Feature 2: Inattention Positive if either score for 2A or 2B is less than 8. Attempt the ASE letters first. If pt is able to perform this test and the score is clear, record this score and move to Feature 3. If pt is unable to perform this test or the score is unclear, then perform the ASE Pictures. If you perform both tests, use the ASE Pictures' results to score the Feature.	**Positive**	**Negative**
2A: ASE Letters: record score (enter NT for not tested) Directions: Say to the patient, *"I am going to read you a series of 10 letters. Whenever you hear the letter 'A,' indicate by squeezing my hand."* Read letters from the following letter list in a normal tone. **S A V E A H A A R T** Scoring: Errors are counted when patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."	**Score (out of 10): _____**	
2B: ASE Pictures: record score (enter NT for not tested) Directions are included on the picture packets.	**Score (out of 10): _____**	
Feature 3:Disorganized Thinking Positive if the combined score is less than 4	**Positive**	**Negative**
3A: Yes/No Questions (Use either Set A or Set B, alternate on consecutive days if necessary)**:** **Set A** 1. Will a stone float on water? 2. Are there fish in the sea? 3. Does one pound weigh more than two pounds? 4. Can you use a hammer to pound a nail? **Set B** 1. Will a leaf float on water? 2. Are there elephants in the sea? 3. Do two pounds weigh more than one pound? 4. Can you use a hammer to cut wood? **Score ___**(Patient earns 1 point for each correct answer out of 4) **3B:Command** Say to patient: "Hold up this many fingers" (Examiner holds two fingers in front of patient) "Now do the same thing with the other hand" (Not repeating the number of fingers). *If pt is unable to move both arms, for the second part of the command ask patient "Add one more finger) **Score___**(Patient earns 1 point if able to successfully complete the entire command)	**Combined Score (3A+3B): _____ (out of 5)**	
Feature 4: Altered Level of Consciousness Positive if the Actual RASS score is anything other than "0" (zero)	**Positive**	**Negative**
Overall CAM-ICU (Features 1 and 2 and either Feature 3 or 4):	**Positive**	**Negative**