My Patient Has Delirium… Now What Do I Do?”

1) How Do I Recognize Delirium

- Symptoms range from a withdrawn state (“hypoactive delirium”) to severe agitation (“hyperactive delirium”), with irritability, delusions, day-night reversal, and increased sympathetic activity (hypertension, tachycardia)
- ICU Nurses screen for delirium using a standardized bedside tool (CAM-ICU)

2) Evaluate for Contributing Factors

Delirium typically results from the combination of severe primary illness and the ICU environment.

Look for other contributing factors including:

- Untreated infection
- Hypoxemia
- Inadequately treated pain
- Altered day/night cycle and poor sleep
- Medications: Top culprits are benzodiazepines, antihistamines, antiemetics

3) Management

- Non-pharmacologic interventions focused on orientation and the environment
  - Frequent reorientation during the course of the day
  - Encourage visitation from family (as able based on infection control restrictions)
  - Lights on in the room during the day, off at night
  - Minimize noise and stimulation at night
  - Remove catheters and physical restraints when able
  - Mobilize and do physical and occupational therapy as able
  - Ensure patient has their glasses and/or hearing aids
  - Consistency in the nursing staff as able

- Pharmacologic interventions
  - Stop benzodiazepines, anti-histamines other contributing medications, particularly those with anticholinergic side effects
  - Dexmedetomidine or propofol for sedation in intubated patients with target of alert or mildly sedated (RASS 0 to -1)
  - Consider pharmacologic intervention for sleep (e.g. trazodone, quetiapine) if non-pharmacologic measures are ineffective

Severe agitated delirium: Call for Help!

- As needed haloperidol (2.5-5 mg IV in repeated doses) if severe agitated delirium poses a risk of harm to the patient (e.g. discontinuation of lines or tubes) or the staff
- May consider scheduled oral quetiapine if severe agitated delirium persists despite prn haloperidol