BPG 05: Delirium

Statement of Best Practice

All patients who are or become delirious receive appropriate care to meet their individual needs, optimising comfort and with minimal adverse effects.

1: Introduction

Critically ill patients are often at higher risk of developing delirium due to the severity of their illness. Carrying out a comprehensive assessment using appropriate tools, incorporating preventative strategies and developing tailored multicomponent individual treatment plans are essential in providing quality patient care.

2: Risk Factor Assessment

Patients should be assessed within 24hrs of admission to the critical care unit. If any of the following risk factors are present the patient is at risk of delirium:

- Age 65 yrs. or older
- Cognitive impairment past or present and / or dementia
- Current hip facture
- Severe illness (a clinical condition that is deteriorating or is at risk of deterioration)

Three stage process:

Assessment

- Assess and manage the patient's pain as appropriate
- Perform a sedation hold 8 / 12 hours in accordance with local trust guidelines / protocol
- Perform and document the Richmond Agitation Sedation Score (RASS) or other Sedation score hourly
- If RASS score is ≥-3 the CAM-ICU assessment should be performed and documented once every 8 / 12 hours or if the RASS score changes. (Appendix 1)

Prevention

- Monitor and record bowel movements and treat constipation / diarrhoea according to trust guidelines / protocol
- Monitor fluid balance and prevent dehydration
- Daily review of medications. Remove deliriogenic drugs (Appendix 2), consider non-pharmacological agents if possible according to local trust policy / guideline.
- Optimise patient orientation
    - Staff introduction, date, time, place, (clocks)
    - Reassurance and explanation of care
    - Communication aids: hearing aids, glasses, dentures, pen/paper speaking valve
    - Visiting / information : letters, phone calls
    - Familiar objects: Cards, photographs
    - Television, radio, music , newspaper
    - Diurnal rhythm (day/night) with appropriate lighting, awareness of noise levels
    - Routine: washing, mobility, passive movements
    - Promote sleep where possible – arrange treatments to allow maximum periods of uninterrupted sleep

Management

- Consider underlying causes
- Perform effective communication and reorientation
- For patients who are distressed and considered a risk to themselves or others and verbal and non-verbal de-escalation techniques are ineffective or inappropriate, consider short term pharmacological agents as per trust policy / protocol.

Assessment

Sedation Hold if appropriate as per trust protocol / guideline

Perform a RASS or Sedation score hourly

Step 1 Level of Consciousness: RASS

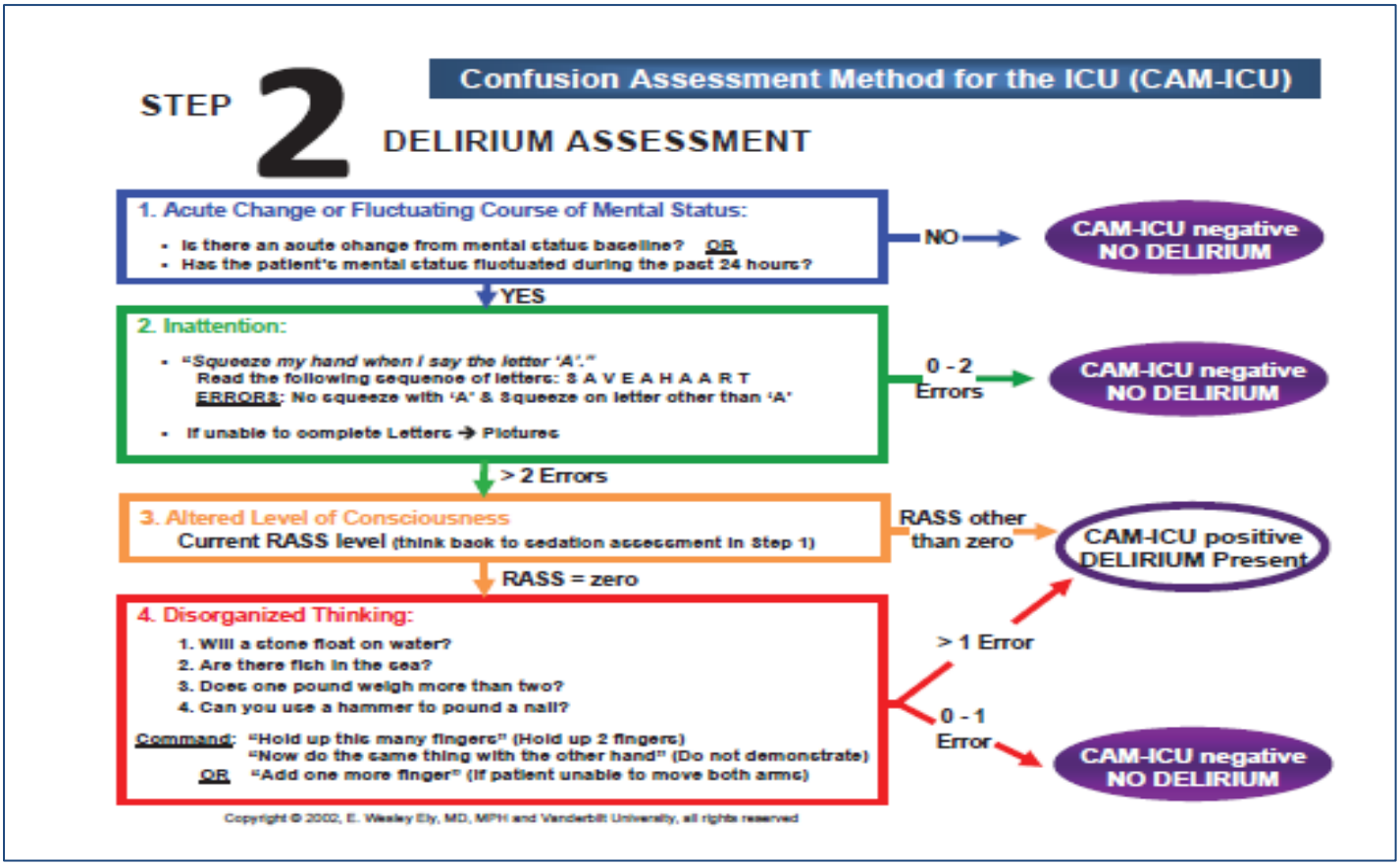
Scale	Label	Description	
+4	COMBATIVE	Combative, violent, immediate danger to staff	VOICE
+3	VERY AGITATED	Pulls to remove tubes or catheters; aggressive	
+2	AGITATED	Frequent non-purposeful movement, fights ventilator	
+1	RESTLESS	Anxious, apprehensive, movements not aggressive	
0	ALERT & CALM	Spontaneously pays attention to caregiver	
-1	DROWSY	Not fully alert, but has sustained awakening to voice (eye opening & contact >10 sec)	
-2	LIGHT SEDATION	Briefly awakens to voice (eyes open & contact <10 sec)	
-3	MODERATE SEDATION	Movement or eye opening to voice (no eye contact)	

If RASS is ≥ -3 proceed to CAM-ICU (Is patient CAM-ICU positive or negative?)

-4	DEEP SEDATION	No response to voice, but movement or eye opening to physical stimulation	TOUCH
-5	UNAROUSEABLE	No response to voice or physical stimulation	

If RASS is -4 or -5 → STOP (patient unconscious), RECHECK later

Confusion Assessment Method for the ICU (CAM-ICU) Flowsheet



Benchmarking Group: July 2016
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