Collaborative Regional Benchmarking Group

Delirium in Critical Care

Aim: To provide guidance on detection and management of delirium in Critical Care
Scope: All adult patients in Critical Care

ASSESS FOR DELIRIUM

- Using CAM-ICU for all Critical Care Patients – Level 2 or 3
- **8 hourly**
- If there is a change e.g. sedation hold

Definition of Delirium

- A disturbed level of consciousness
AND
- A change in cognition, of the development of perceptual disturbance.

Delirium can be hyperactive (agitation), or, more commonly, hypoactive (lethargy, confusion).

Standard of Care for all adult Critical Care Patients – ABCDEF bundle	
A	Assess, Prevent and Manage Pain
B	Both Sedation Holds and Spontaneous Breathing Trials
C	Choice of Analgesia and Sedation – Manage Pain First
D	Delirium – Assess, Prevent, Manage
E	Early Mobilisation
F	Family Engagement and Empowerment

Consider and Treat

- Withdrawal from:
  - alcohol
  - nicotine
  - benzodiazepines

Treatment of Delirium - THINK

- **T** – toxic situations (shock, dehydration, new organ failure, sedatives)
- **H** – hypoxaemia
- **I** – infection, immobility
- **N** – non-pharmacological (hearing aids, glasses, sleep protocols, clocks, radio, TV, noise control)
- **K** – correct electrolyte abnormalities

Please see your units full guidelines for more information

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West Yorkshire Critical Care & Major Trauma Operational Delivery Networks
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