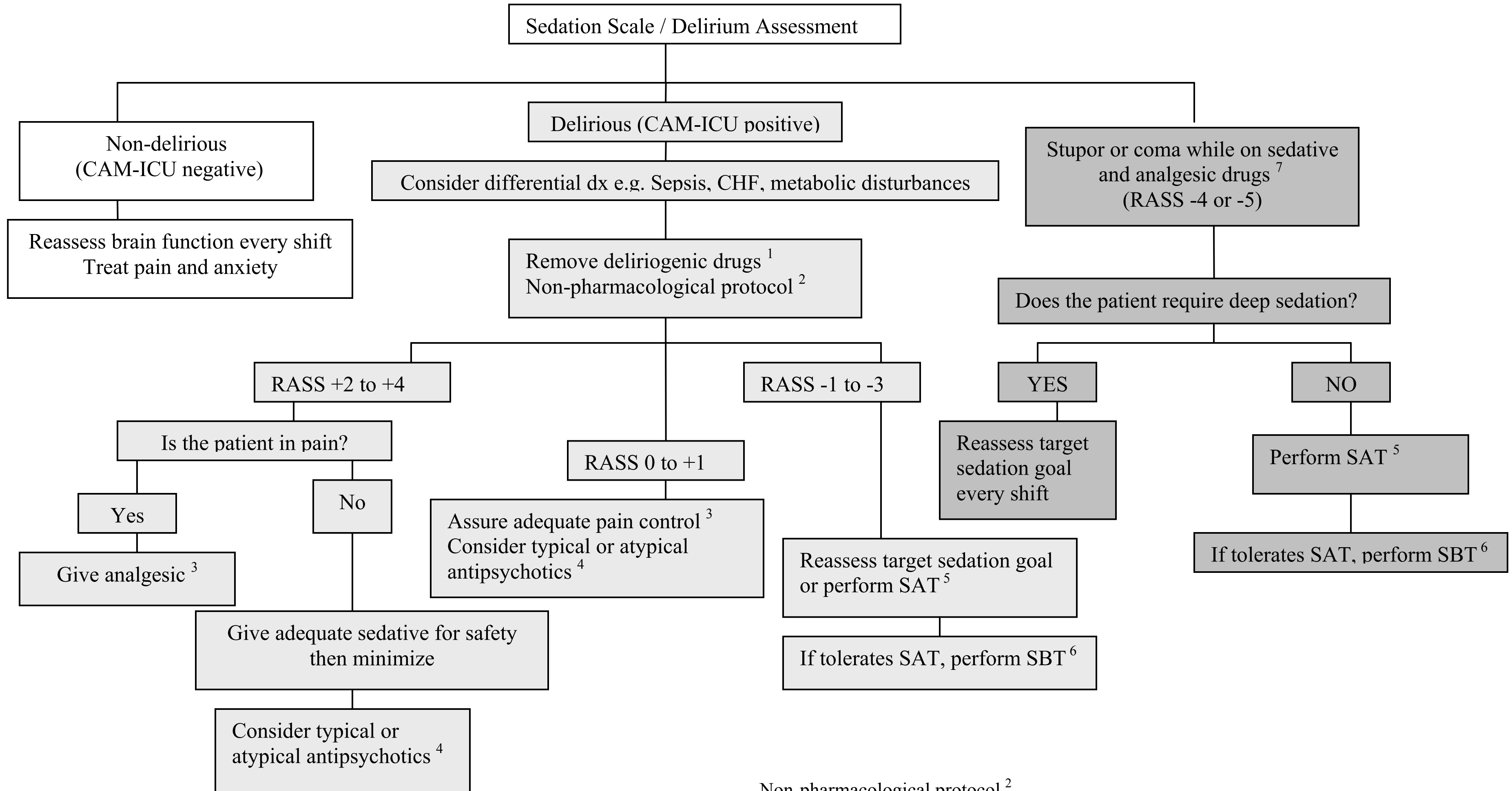
DELIRIUM PROTOCOL



1. Consider stopping or substituting for deliriogenic medications such as benzodiazepines, anticholinergic medications (metochlorpromide, H2 blockers, promethazine, diphenhydramine), steroids etc
2. See non pharmacological protocol – at right
3. Analgesia – Adequate pain control may decrease delirium. Consider intermittent narcotics if feasible. Asses with objective tool.
4. Typical or atypical antipsychotics- While tapering or discontinuing sedatives, consider haloperidol 2 to 5 mg IV initially (0.5-2 mg in elderly) and then q 6 hours. Guideline for max haloperidol dose is 20 mg/day due to ~60% D_2-receptor saturation. May also consider using any of the atypicals (e.g. olanzapine, quetiapine, risperidone, ziprasidone, or abilifide). Discontinue if high fever, QTc prolongation, or drug-induced rigidity.
5. Spontaneous Awakening Trial (SAT) – Stop sedation or decrease infusion (especially benzodiazepines) to awaken patient as tolerated.
6. Spontaneous Breathing Trial (SBT) – CPAP trial if on ≤50% and ≤ 8 PEEP and Sats 90%
7. Sedatives and analgesics may include benzodiazepines, propofol, dexmedetomidine, fentanyl, or morphine

Non-pharmacological protocol [2]

Orientation
- Provide visual and hearing aids
- Encourage communication and reorient patient repetitively
- Have familiar objects from patient's 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 day. Sleep aids (zolpidem, mirtazipine)?
- Control excess noise (staff, equipment, visitors) at night
- Ambulate or mobilize patient early and often

Clinical parameters
- Maintain systolic blood pressure > 90 mm Hg
- Maintain oxygen saturations >90%
- Treat underlying metabolic derangements and infections

Last updated 01-30-07
www.ICUdelirium.org