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

- Use validated tool for critical care for all critical care Patients
- At least daily or on changes/ fluctuations of behaviour

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 Care for Delirium Prevention and Management	
1	Daily screening for evidence of delirium using a validated method
2	Assess sedation level at least 4 hourly using Richmond Agitation-Sedation Scale or Riker sedation agitation scale.
3	Pain assessment at least 4 hourly and managed as per local protocol
4	Promote good sleep patterns, minimising light and noise
5	Early mobilisation including a range of exercises for those with limited mobility
6	Patient and family engagement & empowerment, with written information provided
7	Patient orientation must be frequent and communication aids provided
8	Daily review of medication, nutrition and hydration status

Consider and/or Treat

- Daily sedation holds / spontaneous breathing trial
- 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
North Yorkshire & Humberside Critical Care Network NHS
NHS Operational Delivery Network noECCN North of England Critical Care Network
South Yorkshire and Bassetlaw Critical Care Operational Delivery Network