

Trauma Delirium Management Guideline

- **Monitoring and Treatment**

- The confusion assessment method for the ICU (CAM-ICU) should be monitored each shift and reported to the team during rounds
 - CAM-ICU should ONLY be reported as unable to assess is RASS <-3
 - If CAM positive, consider differential diagnosis (hypoxia, sepsis, CHF, over-sedation, deliriogenic medications)
 - **Hypoactive delirium – CAM positive and RASS 0 to -3**
 - Non-pharmacological management
 - Minimize sedating medications
 - **Hyperactive or mixed hyper/hypoactive delirium – CAM positive and RASS -3 to +4**
 - See algorithm on next page
 - Goal RASS should be specified on **ALL** patients

- **Non-pharmacologic management**

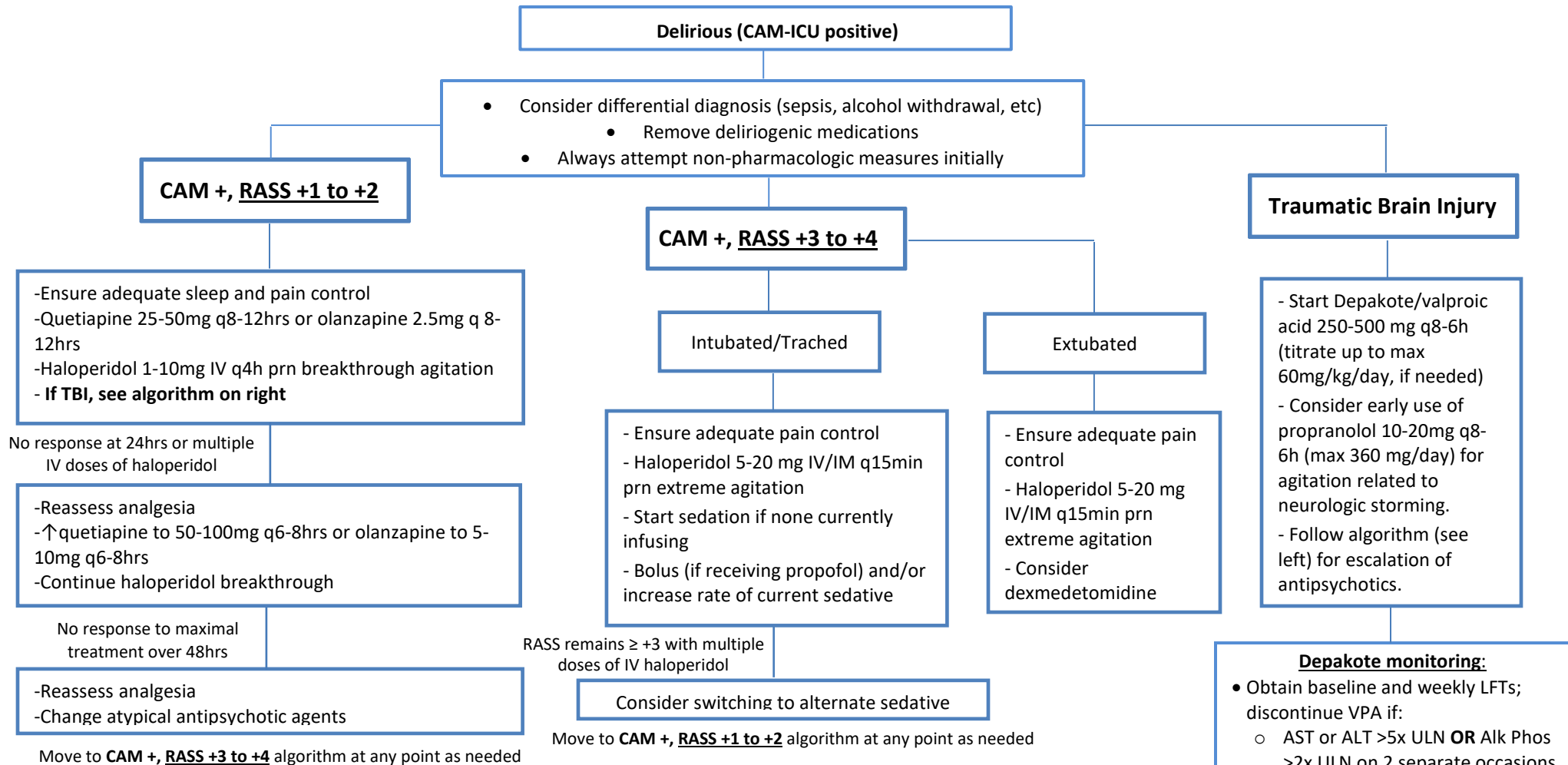
- **Orient patient** (provide visual/hearing aids, re-orient, encourage communication, encourage proper sleep hygiene, and provide cognitively stimulating activities during the day)
- **Environment** (Mobilize patients early and often, provide familiar objects in patient's room, minimize noise at night, and remove unnecessary lines/drains)
- **Adjunctive** (perform SATs daily, provide adequate pain management, correct dehydration and electrolyte disturbances)

- **Deliriogenic Medications**

- Benzodiazepines
- Anticholinergics (diphenhydramine, glycopyrrolate, metoclopramide, H2 blockers, TCAs, cyclobenzaprine)
- Steroids
- Pain medications (if pain is not cause of agitation/delirium)
 - Decrease opioid dose
 - Utilize multimodal pain regimen

Hyperactive Delirium

(includes mixed delirium with hyperactive component, ex: attempting to wean sedation)



IMPORTANT CONSIDERATIONS:

- Geriatric population (≥ 65 yo):**
 - Reduce initial antipsychotic and Depakote/valproic acid doses by 50%
 - Avoid haloperidol doses >5mg or quetiapine doses >100mg
 - Consider trialing trazodone 25-50 mg qhs before antipsychotics if agitation due to insomnia
- Maximize 1 agent PRIOR** to altering regimen.
- If **refractory** to all above measures, may trial Geodon (max: 40mg BID); if unsuccessful, consider Psychiatry consult
- Monitor QTc monitoring if receiving multiple QT-prolonging medications. Modify QT-prolonging medications if QTcF > 500.
- Avoid large doses of haloperidol in TBI

References:

1. Devlin J, Skrobik Y, Gélinas C, et al. Guidelines for the Prevention and Management of Pain, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult Patients in the ICU. *Crit Care Med*. 2018; 46:825-873.
2. Girard T, Exline M, Carson S, et al. Haloperidol and Ziprasidone for Treatment of Delirium in Critical Illness. *N Engl J Med*. 2018;379(26):2506-2516.
3. Hughes CG, Mailloux PT, Devlin JW, et al. Dexmedetomidine or propofol for sedation in mechanically ventilated adults with sepsis. *NEJM*. 2021; 384:1424-1436.
4. Marra A, Wesley E, Pandharipande P, et al. The ABCDEF Bundle in Critical Care. *Crit Care Clin*. 2017; 33(2):225-243.
5. Plantier D, Luauté J; SOFMER group. Drugs for behavior disorders after traumatic brain injury: Systematic review and expert consensus leading to French recommendations for good practice. *Ann Phys Rehabil Med*. 2016 Feb;59(1):42-57. doi: 10.1016/j.rehab.2015.10.003.
6. Williamson D, Frenette A, et al. Pharmacological interventions for agitated behaviors in patients with traumatic brain injury: a systematic review. *BMJ Open* 2019;9:e029604

[CAM ICU Assessment](#)

Revised: 5/2024, 4/2023, 3/2021

Authors:

Jill Streams, MD

Bradley Dennis, MD

Abby Luffman, MSN, APN, AGACNP-BC

Bethany Evans, RN, MSN, ACNP-BC

Leanne Atchison, PharmD