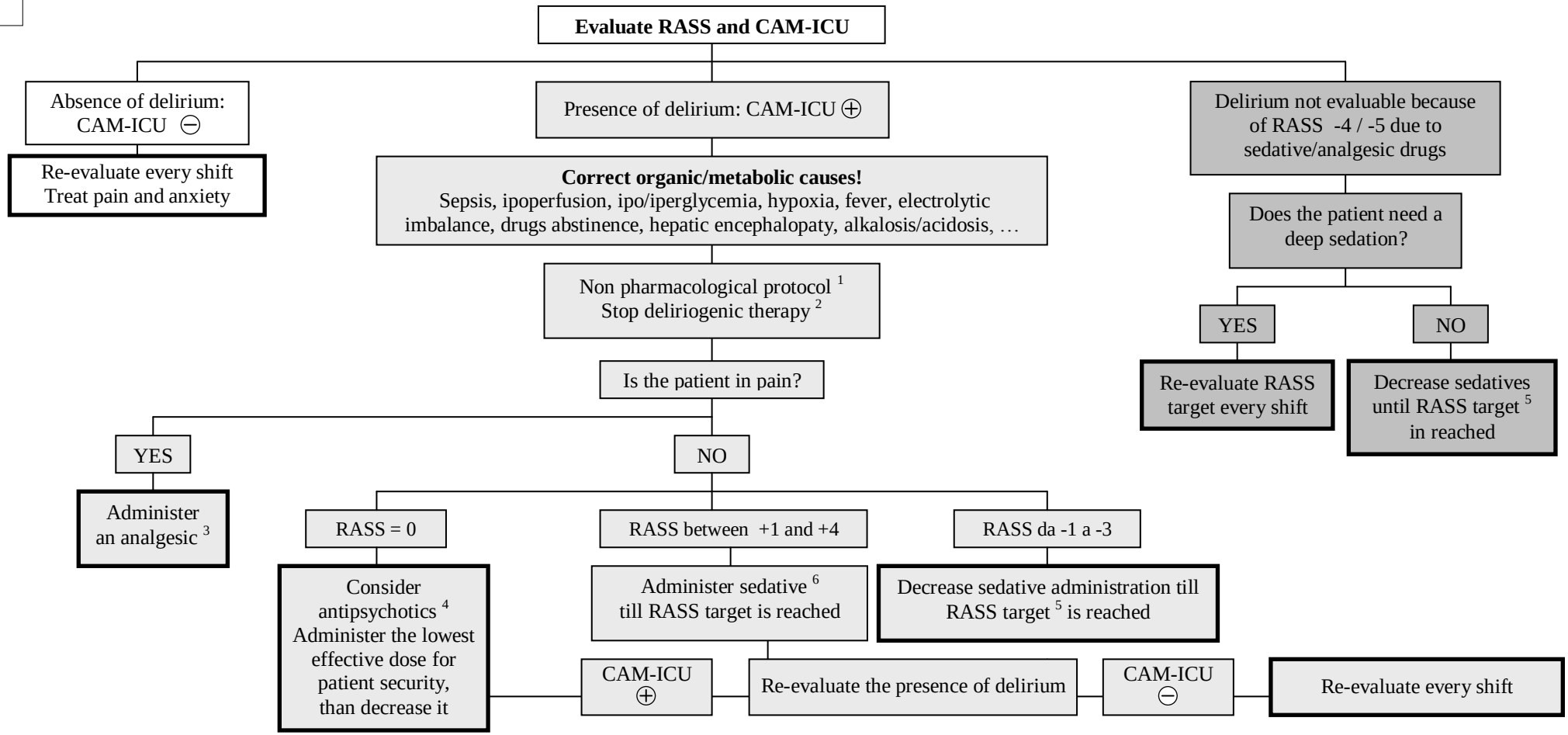
3

DELIRIUM MANAGEMENT IN ICU



[1] Non pharmacological protocol

Orientation

Use patient's visual and auditive aids.
Encourage the comunication calling the patient by name.
Availability of patient's personal belongs.
Coherence between physicians and nursering staff intervention.
Use music or TV during the daytime.

Environment

Lights off during the night, on during the daytime.
Orient patients' beds to allow the vision of the sunlight.
Discourage sleep during the daytime.
Patient mobilization and physiotherapy during the daytime.
Control excessive noise (staff, instrumentation, visitors) during the night.
Avoid medical and nursing procedures during the night.

[2] Consider to stop or decrease deliriogenc therapy: benzodiazepines, opiates, trcyclic antidepressant, propofol, anticholinergic drugs, (metoclopramide, inhibitor of protonic pump, promethazine, difenidramine), others neuroleptics.

[3] An adequate control of pain can reduce the delirium. Prefere bolus administration. Evaluate pain with validate instruments (VNR o BPS).

[4] **Haloperidol** 0.5 - 5 mg per os (0.5 - 1 mg if age > 65 years) every 8 hours. Maximal dose: 20 mg/die.
Stop if hyperpyrexia, long QT syndrome, muscular rigidity.
Consider **atypical antipsychotics**: olanzapine, clotiapine, quetiapine, risperidone, ziprasidone, aripiprazole.

[5] Always aim for RASS = 0 / -1 (patient awake and tranquil, well adapted despite invasivities and critical conditions / diseases).
If necessary, RASS target could range between -2 and -4.

[6] *Intravenous sedation*: Propofol (max 6 mg/kg*h) or Midazolam (max 0.2 mg/kg*h) in bolus or in continuous infusion: administer the lowest effective dose.
Enteral sedation: Hydroxizine (max 600 mg/die) and Lorazepam (max 16 mg/die): administer the lowest effective dose.
Melatonin 3 mg b.i.d. (8 p.m. – midnight) from ICU admission till discharge.