Patient With Delirium
(psCAM/pCAM-ICU +) or (CAP-D ≥ 10)

Is the patient's level of consciousness (LOC) normal/depressed or elevated?

Normal or depressed LOC
(RASS 0 to –3) or (SBS 0 to –1)

Elevated LOC
(RASS +1 to +4) or (SBS +1 or +2)

Hypoactive Delirium

Evaluate possible causes of delirium ("BRAIN MAPS").

Use the Pediatric Road Map to guide discussion for goals during clinical rounds.

1. Where is my patient now? → Sedation scales, delirium monitoring.
2. How did they get there? → Seriously evaluate for over-sedation.
3. Where are they going? → Consider benefit of sedation as now risk high.
4. How do we get them there? → Consider titration of sedation.

Institute preventative measures for delirium if appropriate.

- Normalize sleep wake cycle if possible.
- Create/maintain a stable routine of patient care and periods of rest.

Obtain psychiatric or pharmacy consultation.

- Consider atypical antipsychotics such as risperidone to treat delirium symptoms such as apathy, withdrawal, and sleep wake cycle disturbances.
- Consider aggressive titration of highly deliriogenic drugs (benzodiazepines).
- Consider transition to less deliriogenic drugs (dexmedetomidine).

Hyperactive Delirium

Mild to Moderate Agitation: (RASS +1 to +2) or (SBS +1)

Evaluate possible causes of delirium ("BRAIN MAPS").

Use the Pediatric Road Map to guide discussion for goals during clinical rounds.

- Consider sources of patient's agitation.
- Aggressively re-evaluate adequacy of analgesia and adjust if needed.

Institute preventative measures for delirium if appropriate.

- Normalize sleep wake cycle if possible.
- Create/maintain a stable routine of patient care and periods of rest.

Obtain psychiatric or pharmacy consultation.

- Consider antipsychotics to improve periods of agitation and symptoms of delirium such as inconsolability, unawareness of surroundings, etc.
- Consider role of withdrawal from sedatives or opioids.
- Consider medical therapy to improve sleep-wake cycle.

Critically Elevated Level of Agitation: (RASS +3, +4) or (SBS +2, +3)

Ensure adequate analgesia immediately.

Ensure patient safety with acute sedative or antipsychotic administration such as haloperidol.

Obtain psychiatric or pharmacy consultation.

- Transition to antipsychotics and anxiolytics for directed treatment of anxiety and agitation in the setting of delirium, rather than deliriogenic sedatives used for general "sedation."

Smith HAB, Goben C, Pandharipande PP, Fuchs DC. (2014). Delirium in the Pediatric ICU. In *Current Concepts in Pediatric Critical Care* (pp. 125-36). Rigby MR, Graciano AL (Eds.), Mount Prospect, Ill, USA: Society of Critical Care Medicine.

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