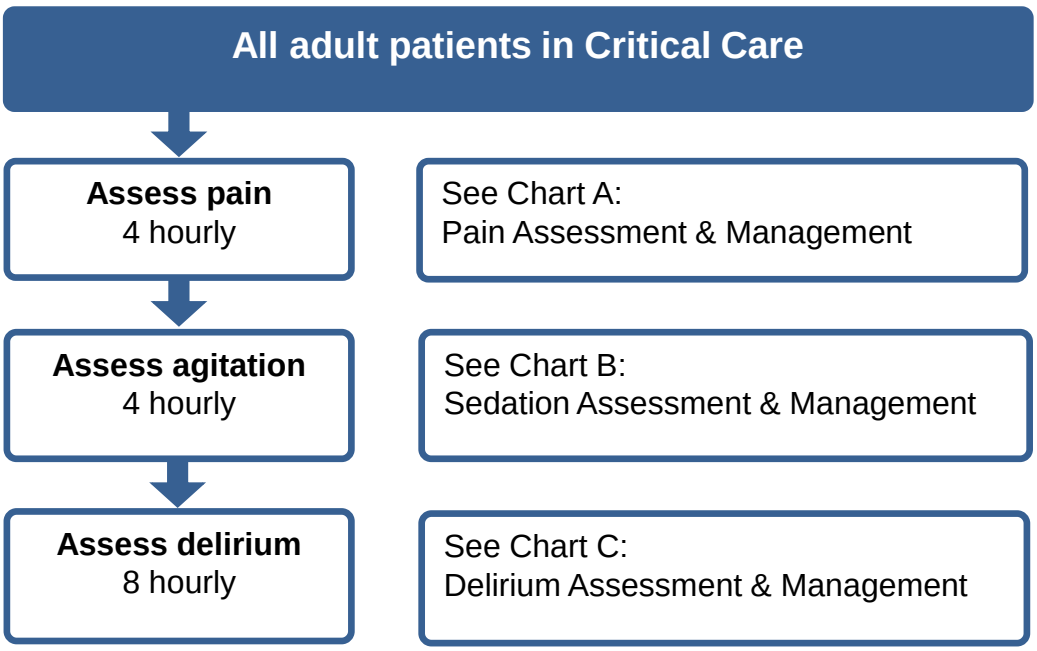
Academic Department of Critical Care
Queen Alexandra Hospital Portsmouth

Portsmouth Hospitals NHS
NHS Trust

Sedation and Delirium in Critical Care

Aim To provide guidance on the management of pain, agitation and delirium in Critical Care
Scope All adult patients in Critical Care.



Key Principles

Control pain first
Moderate-severe pain is common in ICU, even at rest in non-trauma patients.

Use the minimum sedation necessary
Excess sedation harms patients and delays extubation and discharge from ICU.

Optimise non-drug measures
Sedatives and antipsychotics are poor substitutes for good general care and control of excess noise, light and night-time disturbance.

Key Practices

Treat discomfort with careful positioning and attention to the causes of pain.

Give regular analgesia plus additional drugs as required for breakthrough pain.

Maintain light sedation only unless deeper sedation needed for specific clinical reason.

Daily sedation breaks unless contraindicated.

Maintain orientation with regular communication.

Minimise light, noise and disturbance between 22:00 and 06:00 to encourage natural sleep.

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University of Portsmouth

Chart A: Pain Assessment & Management

Assess pain 4 hourly for all patients in Critical Care

Self-Reported Pain Score
if communication is possible

Ask the patient if they have:

- No Pain?
- Mild Pain?
- Moderate Pain?
- Severe Pain?

The pain score is based on the patient's description of their own pain.

Behavioural Pain Score
if communication is not possible

Behaviour	No Pain	Mild Pain	Moderate Pain	Severe Pain
Restless	Quiet	Slightly restless	Moderately restless	Very restless
Tense muscles	Relaxed	Slight tenseness	Moderate tenseness	Extreme tenseness
Frowning / grimacing	No frowning / grimacing	Slight frowning / grimacing	Moderate frowning / grimacing	Constant frowning / grimacing
Patient sounds	Talking in normal tone / no sound	Sigh, groans, moans softly	Groans, moans loudly	Cries out or sobs

The pain score is based on the single highest behaviour observed.

Optimise non-drug measures for pain management including:

- Re-positioning
- Relief of gastric distension
- Reassurance
- Relief of urinary retention

No Pain

Repeat pain score after 4 hours (or sooner if new signs develop)

Mild Pain

Review analgesia and adjust if needed.

Repeat pain score after 4 hours (or sooner if new signs develop)

Moderate Pain

Consider bolus analgesia +/- increased regular analgesia.

Repeat pain score after 30 minutes.

Severe Pain

Seek medical review, give bolus +/- increased regular analgesia.

Repeat pain score after 30 minutes.

Chart B: Sedation Assessment & Management

Assess and treat pain first (see Chart A)

Assess Richmond Agitation and Sedation Score (RASS) 4 hourly in all patients

Score	Term	Description
+4	Combative	Overly combative, violent, immediate danger to staff
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive
+2	Agitated	Frequent non-purposeful movement, fights ventilator
+1	Restless	Anxious but movements not aggressive or vigorous
0	Alert & calm	
-1	Drowsy	Not fully alert, but sustained awakening (eye opening/ eye contact to **voice** >10 secs)
-2	Light sedation	Briefly awakens with eye contact to **voice** (<10 seconds)
-3	Moderate sedation	Movement or eye opening to **voice** (but no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to **physical** stimulation
-5	Unarousable	No response to voice or physical stimulation

If using IV sedation, titrate based on RASS

Score	Adjustment
+4	Bolus & increase infusion by 30%
+3	Bolus & increase infusion by 30%
+2	Bolus & increase infusion by 20%
+1	Bolus & increase infusion by 10%
0	No change
-1	No change
-2	Reduce infusion by 20%
-3	Reduce infusion by 30%
-4	Reduce infusion by 75%
-5	Hold infusion

Manage agitation according to goals

- Control pain first
- Optimise non-drug measures
- Use the minimum sedation necessary
- Titrate constantly to achieve **green light**

Daily sedation break unless contraindicated eg by:

- Neuromuscular blockade (paralysis)
- Severe CVS / respiratory instability
- Sedation for neuro-protection/ cooling

Standard drugs for continuous IV analgesia & sedation

- Morphine and Propofol are the first-line agents in Critical Care
- Use Alfentanil instead of Morphine if eGFR <20 or anuric and not receiving RRT
- Consider Midazolam instead of Propofol if CVS instability or risk of Propofol Infusion Syndrome (Propofol >3-4 mg/kg/hr, metabolic acidosis & cardiac dysfunction +/- raised CK or renal failure)
- Consider adding regular Clonidine to other sedatives in difficult to sedate patients

Chart C: Delirium Assessment & Management

Assess and treat pain & agitation first (see Charts A & B)

Assess CAM-ICU 8 hourly in all conscious patients

Feature 1: Acute onset or fluctuating course	Score
Is the patient different from his/her baseline mental status? OR Has the patient had any fluctuation in mental status over the past 24 hours as evidenced by fluctuation in RASS, GCS, or previous delirium assessment?	Feature 1 is present if "Yes" to either question.
Feature 2: Inattention	
Say to the patient, *"I am going to read you a series of 10 letters. Whenever you hear the letter "A," indicate by squeezing my hand."* Read letters from the following list in a normal tone 3 sec apart: S A V E A H A A R T Errors are counted when a patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."	Feature 2 is present if more than 2 errors.
Feature 3: Altered level of consciousness	
Present if the current RASS score is anything other than alert and calm (zero)	Feature 3 is present if RASS is not zero.
Feature 4: Disorganised thinking	
Ask: 1. Will a stone float on water? 2. Are there fish in the sea? 3. Does one kilogram weigh more than two kilograms? 4. Can you use a hammer to hit a nail? Errors are counted when the patient incorrectly answers a question Say: "Hold up this many fingers" (hold 2 fingers in front of patient) "Now do the same with the other hand". If the patient is unable to move both arms, for second part of command ask patient to "Add one more finger". An error is counted if the patient is unable to complete the entire command	Feature 4 is present if the combined number of errors is more than 1.

CAM-ICU is positive (delirium present) if Features 1 & 2 and *either* 3 *or* 4 are present.

If no delirium, repeat CAM-ICU after 8 hours

If delirium is present, treat first with non-drug measures

Treat potential causes of delirium
- Hypoxia & Hypercapnia
- Hypoglycaemia
- Sepsis & hypotension
- Drug, alcohol & nicotine withdrawal

Optimise environmental factors
- Reduce noise, reassure & re-orientate
- Use communication aids
- Encourage normal sleep by minimising excess light & disturbance overnight.

If non-drug measures fail and patient unsafe, consider drug therapy

Haloperidol (short term use only)
- Standard first-line antipsychotic for ICU delirium, although evidence very limited.
- Contraindicated if risk of Torsades des Pointes (long QT_c, other QT_c-prolonging drugs, history of Torsades des Pointes)

Benzodiazepines (Lorazepam /Midazolam)
- 2nd line, eg if Haloperidol contraindicated or ineffective despite adequate dose.
- May be effective for short-term patient safety but can contribute to more delirium later.

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1. INTRODUCTION

Analgesia, sedation and delirium are important but easily overlooked aspects of critical care medicine. Pain, over-sedation and delirium are significant problems amongst patients on an ICU and its treatment has become a priority. Analgesia based sedation is now advocated by many of the critical care societies across the world. Regular assessment of pain, conscious level and delirium is essential necessary to guide treatment effectively. The aim of this guideline is to ensure patients are comfortable and calm in ICU, improving their experience and clinical outcomes.

2. PURPOSE

To provide guidance on the management of pain, sedation and delirium on adult patients in the Department of Critical Care.

3. SCOPE

This guideline is for use in the Department of Critical Care. This guideline is subject to professional judgement and accountability. The ability to comply with this guideline should be maintained during an infection outbreak, flu pandemic or major incident.

4. DEFINITIONS

Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage[1].

Sedation: The inducement of a relaxed state,

Delirium: A common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course.

ICU: Intensive Care Unit.

BPS: Behavioural Pain Score

CAM-ICU: Confusion Assessment Method - ICU. Tool for assessing the presence of delirium.

GFR: Glomerular filtration rate

5. DUTIES AND RESPONSIBILITIES

The decision to implement this guideline is at the discretion of the on-call critical care consultant. Implementation of this guideline is the joint responsibility of appropriate critical care medical/ nursing staff. This guideline is subject to professional judgment and accountability.

6. PROCESS (Recommendations & Justification)

Pain, sedation and delirium should be assessed regularly

Recommendation (Action)	Justification (Rationale)
Pain should be assessed every 4 hours, or more frequently if severe.	Pain is common in ICU patients. Multiple factors such as the disease process, surgery or injuries as well as the interventions done to them such as endotracheal intubation, mechanical ventilation, vascular access and invasive monitoring can result in pain and discomfort. In one study, over 60% of patients on a mixed medical-surgical ICU were found to have moderate to severe pain.[2] Pain assessment in ICU is difficult due to confounding factors such as sedative drugs and mechanical ventilation. The consequence of pain experienced in ICU continues after discharge, with many patients reporting the memory of pain during their time on the ICU.[3] This can result in chronic psychological and physical disturbances.[4,5] Regular pain assessments in ICU are associated with improved clinical outcomes. Pain assessment, especially if protocolised, has been associated with significantly reduced in the use of analgesic medications, ICU length of stay (LOS), and duration of mechanical ventilation.[6,7] Regular pain assessment is essential to direct appropriate treatment and is strongly recommended by the Society of Critical Care Medicine in their 2013 guidelines.[8]
Sedation should be assessed every 4 hours.	Regular assessment of sedation is necessary to ensure sedative drugs are used in a balanced and appropriate way in ICU. Sedation using drugs is often necessary to reduce stress and agitation, and to facilitate therapies such as mechanical ventilation. Excess use of sedative drugs has been shown to worsen outcome including length of stay, length of mechanical ventilation and rates of nosocomial infections.[9,10] A balance must be struck between the need for sedation in certain circumstances and the risks of oversedation.

The presence of delirium should be tested for every 8 hours.	Delirium is an important problem in ICU. Potentially reversible problems such as sepsis, pain, hypoxia, electrolyte or metabolic disturbance can manifest as delirium. Delirium can interfere with other care in ICU and can result in adverse events such as unplanned removal of medical devices. The presence of delirium is an independent risk factor for morbidity and mortality in ICU.[12,13] Delirium may not be apparent unless specifically tested for. Regular testing is needed to ensure that delirium is recognised and managed appropriately.

Pain and sedation should be controlled whilst optimising non-drug measures

Recommendation (Action)	**Justification (Rationale)**
Control pain first	As described above, pain is a common problem in ICU. Effective management of agitation and delirium is very difficult without effective pain control. Analgesia-based sedation is recommended by the UK Intensive Care Society (UK)[14] and the Society of Critical Care Medicine (US).[8] Analgesia should be used pre-emptively when potentially painful procedures are planned.
Use the minimum sedation necessary	Excessive sedation reduces patients' ability to communicate and cooperate with care, and can increase the duration of mechanical ventilation, rates of nosocomial infections and ICU length of stay. Use of the minimum dose of a drug necessary to achieve a clinical goal is a widely-accepted principle in clinical practice.
Optimise non-drug measures	Many factors contribute to discomfort in ICU. Simple measures such as positioning, orientation and minimising and or grouping interventions helps to reduce the need for sedative drugs.

Pain assessment and management

Recommendation (Action)	Justification (Rationale)
Use of self reported pain score	Pain is a subjective symptom (see definition) that is best assessed by asking a conscious patient to describe their own pain. The use of a four-point scale simplifies this process and produces results compatible with the Behavioural Pain Score.
Use of Behavioural Pain Score	The Behavioural Pain Score (BPS) is validated for the assessment of pain in patients unable to communicate compared to other non-communicative pain scoring systems[8]. BPS showed good psychometric properties in terms of: inter-rater reliability, discriminant validity and criterion validity in a range of ICU patients including medical and post-surgical patients[15]. A BPS score >5 is thought to have a specificity and sensitivity of around 80% for patients experiencing pain[8]. Pain assessment is difficult when patients are unable to communicate verbally but the BPS appears to be the best tool currently available.
Opioid analgesia should be given for pain in addition to non-opioid analgesia	As discussed above, moderate to severe pain is a common problem in ICU. Morphine should be first line agent unless GFR<20ml/min. All opioids drugs have similar efficacy when titrated to response.[8,21] If there is significant renal dysfunction (eg calculated GFR<20ml/min), alfentanil should be used instead of morphine because morphine has active metabolites that are excreted in the urine.[22] Non-opioid adjunct analgesia such as paracetamol, non-steroidal anti-inflammatory drugs, and local or regional analgesia should also be considered. These may reduce the dose of opioids needed but will usually be insufficient on their own in patients who are mechanically ventilated.[8] Neuropathic pain (eg. following amputation) may be treated with atypical drugs such as gabapentin and amitriptyline.

Sedation assessment and management

Recommendation (Action)	Justification (Rationale)
Use of Richmond Agitation and Sedation Score (RASS)	The RASS is the best-validated tool for clinical assessment of sedation and agitation in ICU.[8] It has good inter-rater reliability[11] and has been studied in the greatest number of patients over a range of different clinical situations. RASS may be used in goal-directed protocols for titration of intravenous sedation.[2]
Use daily sedation breaks unless contraindicated	Daily breaks from continuous IV sedation reduce the duration of mechanical ventilation, ICU length of stay and requirement for neurological imaging with no increase in adverse events.[9]
Propofol is the first-line drug for intravenous sedation	Propofol has been used extensively for sedation on ICUs throughout the world. It has a short duration of action and permits relatively rapid emergence but can accumulate when given as a continuous infusion. The results of studies comparing propofol with benzodiazepines for intravenous sedation are conflicting. One meta-analysis suggests that the duration of mechanical ventilation is reduced when propofol is used instead of benzodiazepines for sedation, although this may not reduce ICU length of stay.[23] A more recent meta-analysis found a slight decrease in ICU length of stay with propofol.[8] Propofol also has a more favourable pharmacokinetic profile compared to midazolam in patients with hepatic and renal dysfunction and probably does not accumulate to the same extent. However, there is some evidence to suggest greater cardiovascular instability with propofol compared to midazolam. There is an association with benzodiazepines and delirium.[12,18] However, when rates of delirium with midazolam and propofol were compared, there were no statistically significant differences between the two groups.[24] Whilst a recent RCT comparing propofol to dexmetetomidine showed improved communication and reduced rates of delirium in patients receiving dexmetetomidine, the duration of mechanical ventilation and ICU length of stay were the same.[24] Although dexmedetomidine may offer some small advantages over propofol, there is less clinical experience of this drug and it is considerably more expensive. On balance, propofol currently seems to offer the best combination of cost-effectiveness and clinical effectiveness for routine use in ICU.

Delirium assessment and management

Recommendation (Action)	Justification (Rationale)
Use of CAM-ICU scoring system for the assessment of delirium.	CAM-ICU demonstrates good validity and reliability when assessing for the presence of delirium. It has high levels of sensitivity and specificity when compared to the American Psychiatric Association's criteria for delirium[16] and is specifically designed for use in the ICU. The implementation of screening for delirium using this tool has been successful in many centres throughout the world CAM-ICU has been translated for use in over 20 languages. The presence of delirium, as assessed by CAM-ICU, is associated with increased morbidity and mortality.[12,13]
If delirium present address underlying causes.	An exhaustive list of causes of delirium is beyond the scope of this text. However, detection of delirium using CAM-ICU should trigger an investigation and management of the potential causes. Causes of delirium can be classified into modifiable and non-modifiable. Modifiable causes include hypoxia, sepsis, electrolyte disturbance, hypercarbia, medications, sleep deprivation and disturbance of the sleep-wake cycle. Non-modifiable causes include illness severity, alcohol abuse, pre-existing dementia, CNS disease and old age.[17] Common causes of delirium include drug or alcohol withdrawal. These causes have specific treatments, for example, benzodiazepines are used for the management of alcohol withdrawal.
If delirium is present despite attention to non-drug measures and the patient is unsafe, haloperidol is the first-line drug.	There is no evidence to support the prophylactic use of haloperidol or other antipsychotics in the prevention of ICU delirium.[20] Haloperidol is not a substitute for proper attention to underlying causes of delirium and should only be used for short-term management of refractory delirium, based on an individual risk-benefit analysis. This includes balancing the risk of increasing cerebrovascular adverse events against the severe distress or immediate risk of harm to the patient or others. Special care should be taken to avoid or minimise the use of haloperidol in patients at risk of dementia. Alternative, safer, measures to mitigate the risk of delirium may include the short-term use of mittens in agitated patients. When treatment is necessary for the patient safety reasons haloperidol is the first-line drug.[18,19] Haloperidol is not proven to reduce the duration of delirium but reduces agitation and aggressive behaviour. Doses should start at 1-2mg and if still unsafe after 30 minutes, the dose may be doubled.[18] Continuous cardiac monitoring should be used where feasible as haloperidol can prolong the QT_c interval and precipitate fatal dysrhythmias. Haloperidol is contraindicated in patients with a

	prolonged QTc, who are on other QTc-prolonging drugs, or who have a history of torsades-des-pointes VT. Other antipsychotics have been used in small clinical trials but these drugs are no more effective than haloperidol, may only be given enterally or have worse side-effect profiles.[18]
If patient with delirium remains unsafe despite use of haloperidol, consider the use of benzodiazepine.	Benzodiazepines have a role in the treatment of specific withdrawal syndromes, such as alcohol. In other circumstances, the use of benzodiazepines should be avoided in delirium as they may worsen or prolong the problem. In certain circumstances (eg patients who are a danger to themselves or staff, and where haloperidol has failed) gaining control outweighs the risks of increasing the duration of delirium. Haloperidol should be continued during this period and the benzodiazepine should be stopped at the earliest opportunity.[18]

7. TRAINING REQUIREMENTS

All Critical Care staff will be trained of the content of this guideline and how to access it via the Critical Care Guidelines and SOPs intranet page.

8. MONITORING COMPLIANCE WITH, AND THE EFFECTIVENESS OF, PROCEDURAL DOCUMENTS

This guideline will be reviewed initially at 6 months and thereafter 2 yearly by the Critical Care Governance Group. Measurement of compliance will be achieved by unit-based audit. Results reviewed will be fed back to members of the senior medical /nursing team and the Critical Care Governance Group.

9. REFERENCES AND ASSOCIATED DOCUMENTATION

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Appendix A

Checklist for the Review and Ratification of Procedural Documents and Consultation and Proposed Implementation Plan

To be completed by the author of the document and attached when the document is submitted for ratification: a blank template can be found on the Trust Intranet. Home page -> Policies -> Templates

CHECKLIST FOR REVIEW AND RATIFICATION		
TITLE OF DOCUMENT BEING REVIEWED:		**YES/NO, COMMENTS**
1	**Title**	
	Is the title clear and unambiguous?	Yes
	Will it enable easy searching/access/retrieval??	Yes
	Is it clear whether the document is a policy, guideline, procedure,	Yes
2	**Introduction**	
	Are reasons for the development of the document clearly stated?	Yes
3	**Content**	
	Is there a standard front cover?	Yes
	Is the document in the correct format?	Yes
	Is the purpose of the document clear?	Yes
	Is the scope clearly stated?	Yes
	Does the scope include the paragraph relating to ability to comply,	Yes
	Are the definitions clearly explained?	Yes
	Are the roles and responsibilities clearly explained?	Yes
	Does it fulfil the requirements of the relevant Risk Management	Yes
	Is it written in clear, unambiguous language?	Yes
4	**Evidence Base**	
	Is the type of evidence to support the document explicitly identi-	Yes
	Are key references cited?	Yes
	Are the references cited in full?	Yes
	Are associated documents referenced?	Yes
5	**Approval Route**	
	Does the document identify which committee/group will approve?	Yes
6	**Process to Monitor Compliance and Effectiveness**	
	Are there measurable standards or KPIs to support the monitoring	Yes

7	**Review Date**	
	Is the review date identified?	Yes
6	**Dissemination and Implementation**	
	Is a completed proposed implementation plan attached?	Yes
7	**Equality and Diversity**	
	Is a completed Equality Impact Assessment attached?	Yes

CONSULTATION AND PROPOSED IMPLEMENTATION PLAN	
Date to ratification committee	
Groups /committees / individuals involved in the development and consultation process	Critical Care Governance Group Multidisciplinary staff working in DCCQ
Is training required to support implementation?	Yes
If yes, outline plan to deliver training	1. Distribution of revised guideline via email, and uploading to intranet site. 2. Coverage at identified Friday multidisciplinary teaching session. 3. Targeted training via Education Team where appropriate
Outline any additional activities to support implementation	As above

Individual Approval

If, as the author, you are happy that the document complies with Trust policy, please sign below and send the document, with this paper, the Equality Impact Assessment and NHSLA checklist (if required) to the chair of the committee/group where it will be ratified. To aid distribution all documentation should be sent electronically wherever possible.

Name	**Dr N Richardson, Dr N Tarmey**	**Date**	17 Jan 14
Signature	*signed electronically*		

Committee / Group Approval

If the committee/group is happy to ratify this document, would the chair please sign below and send the policy together with this document, the Equality Impact Assessment, and NHSLA checklist (if required) and the relevant section of the minutes to the Trust Policies Officer. To aid distribution all documentation should be sent electronically wherever possible.

Name	**Dr N Tarmey, Critical Care Governance Group**	**Date**	17 Jan 14
Signature	*signed electronically*		

f answers to any of the above questions is ‘no’, then please do not send it for ratification.

Appendix B

Equality Impact Assessment

To be completed by the author of the document and attached when the document is submitted for ratification: a blank template can be found on the Trust Intranet. Home page -> Policies -> Templates

Title of document for assessment	Sedation and Delirium in Critical Care
Date of assessment	17 Jan 14
Job title of person responsible for assessment	Dr N Tarmey Consultant in Critical Care
Division/Service	DCCQ / CHAT CSC

	Yes/No	Comments
Does the document affect one group less or more favorably than another on the basis of:		
Race	No	
Gender (including transgender)	No	
Religion or belief	No	
Sexual orientation, including lesbian, gay and bisexual people	No	
Age (for HR policies only)	No	
Disability – learning disabilities, physical disabilities, sensory impairment and mental health problems	No	
Does this document affect an individual's human rights?	No	
If you have identified potential discrimination, are the exceptions valid, legal and/or justified?		

If the answers to any of the above questions is 'yes' you will need to complete a full Equality Impact Assessment (available from the Equality and Diversity website) or amend the policy such that only an disadvantage than can be justified is included. If you require any general advice please contact staff in the Equality and Diversity Department on 02392 288511