

1) Assessment of agitated or delirious patient

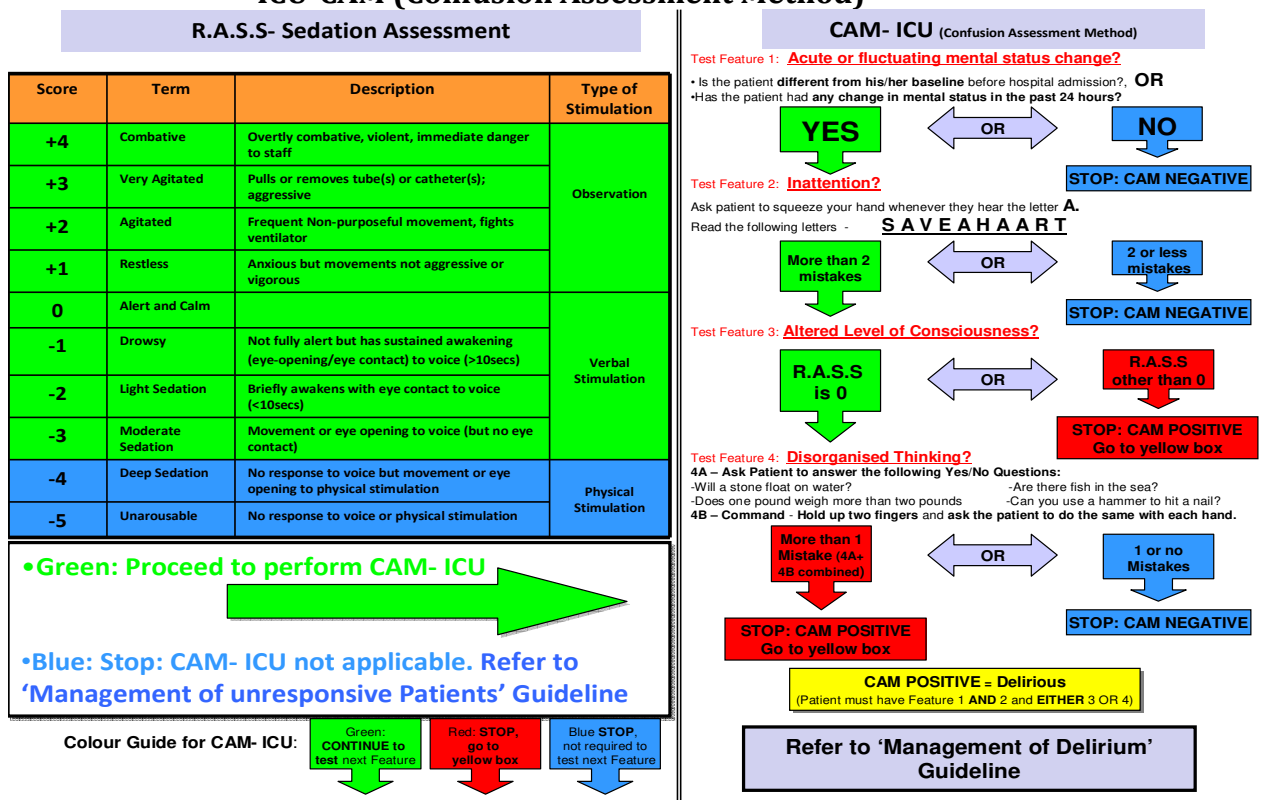
a) Risk Assessment

- Is the patient verbally or physically threatening?
- Is the nurse feeling intimidated?
- Does the patient have a previous episode of violence? (present or past admission)
- Is there information from police or family that patient may be violent?

If 'yes' to at any of the above immediately discuss with a senior nurse whether patient should be managed as 'high risk of violence' (see specific protocol)

b) Assessment of Agitation (RASS) and Delirium (CAM-ICU)

RASS (Richmond Agitation and Sedation Score) and
ICU-CAM (Confusion Assessment Method)



c) Check list of treatable causes of agitation

First, attempt to identify medical causes of agitation / confusion / delirium

- Does the patient have a metabolic cause of confusion?
Causes include hypoxaemia, hypercapnea, hypoglycaemia, hyponatraemia and hypercalcaemia.
- Does the patient have a systemic illness causing confusion or delirium?
Examples include infection, hepatic encephalopathy, uraemia
- Does the patient have a new or existing CNS illness
Examples include stroke, dementia, CNS infection, seizures/post ictal

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Critical Care Guidelines FOR CRITICAL CARE USE ONLY

Second, systematically review common ICU causes of agitation.
Remember 'SAD is BAD' for causes of agitation

- **S** Synchronization
 - Is the patient dyssynchronised with ventilator?
 - Review ventilation with medical team
- **A** Analgesia
 - Is the patient in pain?
 - If yes treat pain
- **D** Delirium
 - Is patient delirious? (CAM-ICU positive)
 - See avoid precipitating factors for delirium (see management)
 - Treat drug/alcohol withdrawal first (see drug withdrawal)
 - Consider treatment with haloperidol **Starting dose:** elderly 1mg, all other patients 2.5mg IV doses may be doubled and repeated at 20 minute intervals up to total of 20mg. The total dose given should be then given in 4 divided doses over 24 hours.
- **B** Bowels and Bladder
 - Does the patient have constipation or urinary retention?
- **A** Anxiety
 - Is the patient anxious?
 - Provide reassurance and consider anxiolytic. Benzodiazepines are deliriogenic and should only be prescribed after discussion with senior doctor.
- **D** Drug withdrawal
 - Have any drugs been started or withdrawn?
 - Particularly consider alcohol ([link to management of alcohol withdrawal policy](#)) or benzodiazepine withdrawal. Assess for history of drug dependence

Drugs which may cause withdrawal

benzodiazepine
opioid
antidepressant
recreational
drugs

- Alcohol, nicotine
- *Anticholinergics*
 - Hyoscine
 - Diphenhydramine
 - Hydroxyzine
- *Psychedelics*
 - 3,4-methylenedioxymethamphetamine (MDMA, ecstasy, adam)
 - Lysergic acid diethylamide (LSD, blotter)
 - Psilocybin (magic mushrooms)
- *Stimulants*
 - Amphetamine (hearts, speed, crystal)
 - Cocaine (crack, coke)
 - Methylphenidate (White dragon)

AGITATED OR DELIRIOUS PATIENT