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)

R.A.S.S- Sedation Assessment

Score	Term	Description	Type of Stimulation
+4	Combative	Overtly combative, violent, immediate danger to staff	Observation
+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 and Calm		Verbal Stimulation
-1	Drowsy	Not fully alert but has sustained awakening (eye-opening/eye contact) to voice (>10secs)	
-2	Light Sedation	Briefly awakens with eye contact to voice (<10secs)	
-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	Physical Stimulation
-5	Unarousable	No response to voice or physical stimulation	

•Green: Proceed to perform CAM- ICU

•Blue: Stop: CAM- ICU not applicable. Refer to 'Management of unresponsive Patients' Guideline

Colour Guide for CAM- ICU: Green: **CONTINUE to test** next Feature | Red: **STOP,** go to **yellow box** | Blue **STOP,** not required to test next Feature

CAM- ICU (Confusion Assessment Method)

Test Feature 1: **Acute or fluctuating mental status change?**

• Is the patient **different from his/her baseline** before hospital admission?, **OR**
•Has the patient had **any change in mental status in the past 24 hours?**

YES — OR — NO

NO → STOP: CAM NEGATIVE

Test Feature 2: **Inattention?**

Ask patient to squeeze your hand whenever they hear the letter **A.**
Read the following letters - **S A V E A H A A R T**

More than 2 mistakes — OR — 2 or less mistakes

2 or less mistakes → STOP: CAM NEGATIVE

Test Feature 3: **Altered Level of Consciousness?**

R.A.S.S is 0 — OR — R.A.S.S other than 0

R.A.S.S other than 0 → STOP: CAM POSITIVE Go to yellow box

Test Feature 4: **Disorganised Thinking?**

4A – Ask Patient to answer the following Yes/No Questions:
-Will a stone float on water? -Are there fish in the sea?
-Does one pound weigh more than two pounds -Can you use a hammer to hit a nail?
4B – Command - Hold up two fingers and **ask the patient to do the same with each hand.**

More than 1 Mistake (4A+ 4B combined) — OR — 1 or no Mistakes

More than 1 Mistake → STOP: CAM POSITIVE Go to yellow box

1 or no Mistakes → STOP: CAM NEGATIVE

CAM POSITIVE = Delirious
(Patient must have Feature 1 **AND** 2 and **EITHER** 3 OR 4)

Refer to 'Management of Delirium' Guideline

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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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)