DELIRIUM PATHWAY for Screening and Management of Acute Brain Dysfunction

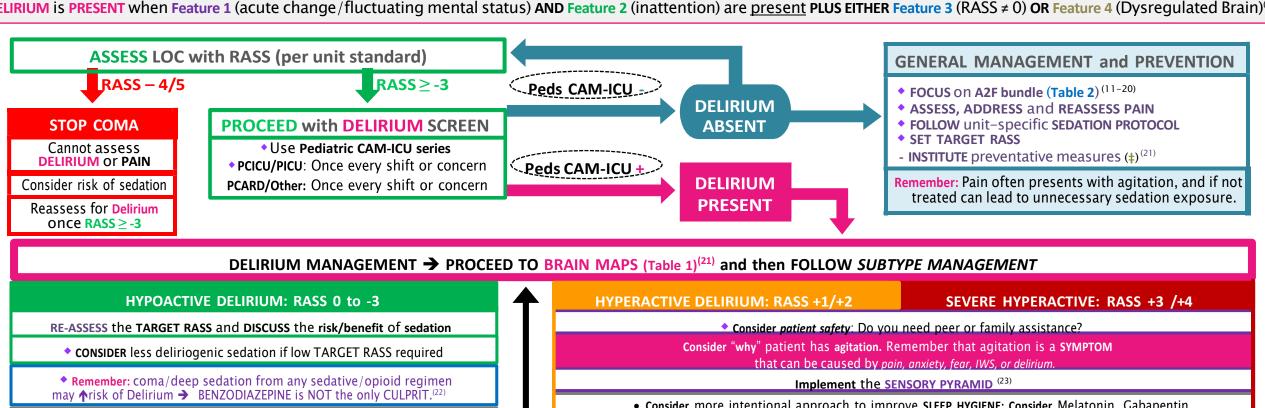
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Delirium is a clinical syndrome of brain dysfunction that can be assessed using valid and reliable screening tools. (1-3)



The Pediatric CAM-ICU Series (4) (PEDs CAM-ICU) combines the Preschool psCAM (newborn – developmentally 5 years of age) (5,6) and Pediatric pCAM (developmentally \geq 5 years of age).

DELIRIUM is PRESENT when Feature 1 (acute change / fluctuating mental status) AND Feature 2 (inattention) are present PLUS EITHER Feature 3 (RASS \neq 0) OR Feature 4 (Dysregulated Brain)^(8,9)



- ◆ Consider more aggressive approach to improve SLEEP HYGIENE • SEDATION is **NOT** SLEEP
- → OBTAIN Psychiatry Consultation if delirium persists despite rigorous implementation of BRAIN MAPS management considerations.
- An Atypical Antipsychotic may help manage refractory hypoactive delirium manifestations such as apathy/withdrawal from environment.

Remember: Antipsychotic use may be associated with WORSE outcomes. (24,25)

- → If persistent delirium or NO improvement of symptoms within 48 hours of antipsychotic initiation
- 1) Re-ASSESS BRAIN MAPS and implement new strategy if applicable.
- 2) Re-engage Psychiatry or implement the following:
- DISCONTINUE antipsychotic as it cannot mitigate risk from over-sedation or is not efficacious to decrease manifestations at this time.
- Work on sedation exposure, reorientation, family presence.
 - → If delirium resolves, STOP antipsychotic within 5 days of resolution.

- Consider more intentional approach to improve SLEEP HYGIENE: Consider Melatonin, Gabapentin SEDATION is NOT SLEEP
- → OBTAIN Psychiatry Consultation if delirium persists despite rigorous implementation of **BRAIN MAPS** management considerations.
- Haloperidol or Atypical Antipsychotic may help manage refractory hyperactive delirium manifestations such as inadequate patient-ventilator synchrony, refuses comfort measures, unawareness of surroundings/caregivers.

→ Threat to Safety Imminent:

- 1) Treat PAIN, provide SEDATION acutely
- 2) Consider BRAIN MAPS management considerations
 - → OBTAIN Psychiatry Consultation
- Consider initiation of Haloperidol or Atypical Antipsychotic to manage refractory hyperactive delirium manifestations such as combativeness, harm to self.

Remember: Antipsychotic use may be associated with WORSE outcomes. (24,25)

- → If persistent delirium or NO improvement of symptoms within 48 hours of antipsychotic initiation →
- 1) Re-ASSESS BRAIN MAPS and implement new strategy if applicable.
- 2) Re-engage Psychiatry Or implement the following:
 - DISCONTINUE antipsychotic as it is not currently efficacious to decrease delirium manifestations.
 - Consider latrogenic Withdrawal Syndrome, prior trauma, mental health (depression, anxiety, ADHD, autism)
 - Consider Anesthesia consult for management of a difficult-to-sedate patient.
 - → If delirium resolves, STOP antipsychotic within 5 days of resolution.

(*) PANDEM Clinical Guidelines (10)

Last updated 3/5/2025