

Trauma Delirium Management Guideline

- **Diagnosis and Monitoring**

- **Delirium is a clinical diagnosis and should be made by the trauma team based on a global assessment of patient's injuries, GCS, RASS, and CAM-ICU score**
- The Glasgow Coma Score (GCS), Richmond Agitation Sedation Scale (RASS) and Confusion Assessment method for the ICU (CAM-ICU) should be monitored each shift and reported to the team during rounds
 - CAM-ICU cannot be assessed in RASS –4 or –5 and should ONLY be reported as **Unable to Assess**
 - Goal and actual RASS should be specified on **ALL** patients
 - If delirium is suspected, consider differential diagnosis (TBI, hypoxia, sepsis, encephalopathy, over-sedation, delirium) and correct any concurrent diagnoses
- In severe TBI, CAM-ICU score is not solely diagnostic of presence or absence of delirium. Consider use of additional adjuncts to diagnosis delirium in these patients.
- **Suggested Documentation**
 - Avoid “at risk for” diagnoses in problem list. Document only conditions that are currently present
 - **Use .ticudelirium, .ticuagitationtbi or .ticuencephalopathy**

Hypoactive delirium (CAM+, RASS –3 to 0, GCS >9)

- Non-pharmacological management (see below)
- Minimize sedating medications

Hyperactive or mixed hyper/hypoactive delirium (CAM+, RASS +1 to +4, GCS >9)

- See algorithm on next page

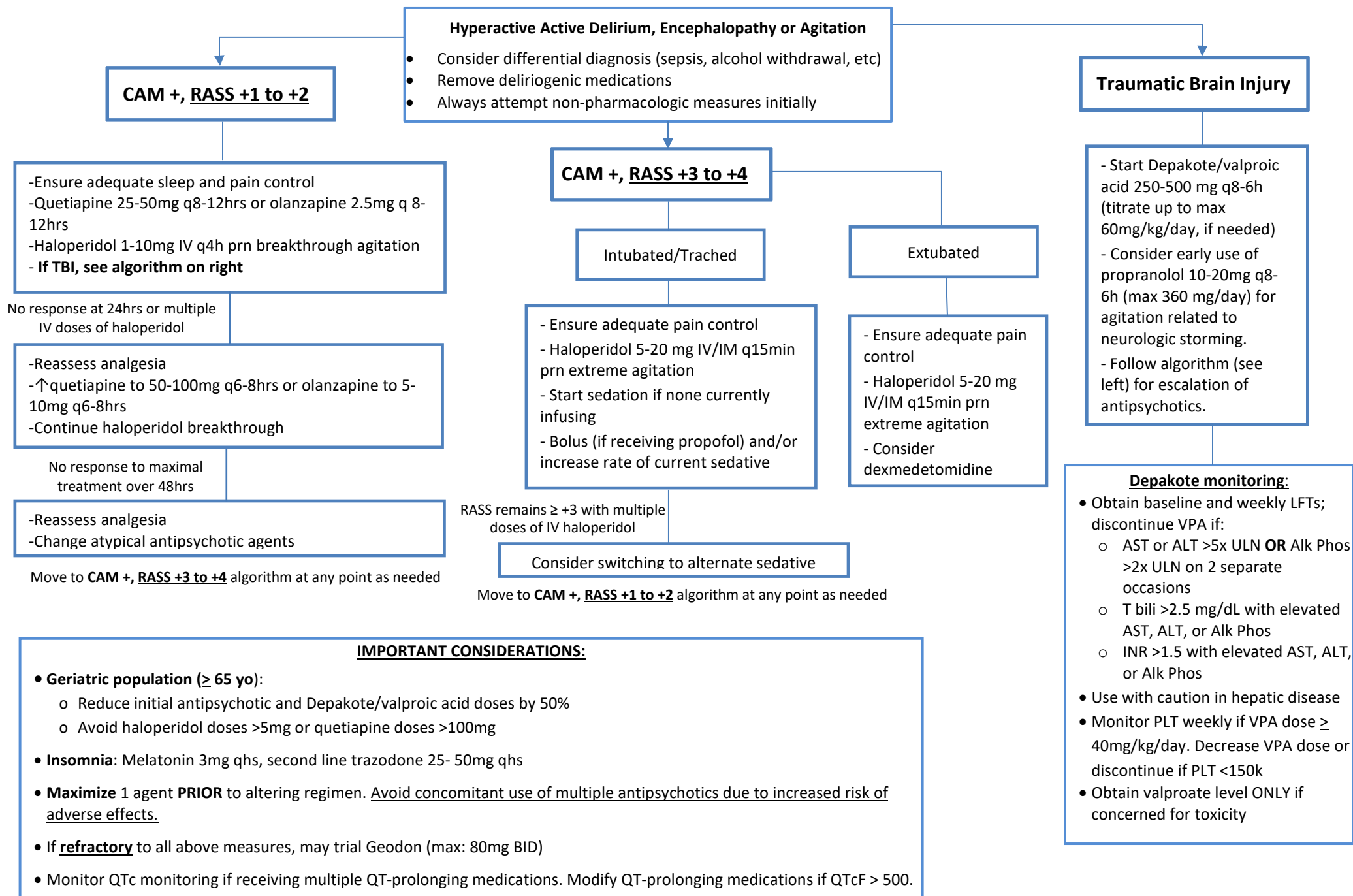
- **Non-pharmacologic treatment**

- **Orient patient** (provide visual/hearing aids, re-orient, encourage communication, encourage proper sleep hygiene, and provide cognitively stimulating activities during the day)
- **Environment** (Mobilize patients early and often, provide familiar objects in patient's room, minimize noise at night, and remove unnecessary lines/drains)
- **Adjunctive** (perform SATs daily, provide adequate pain management, correct dehydration and electrolyte disturbances)

- **Discontinue and/or Minimize Deliriogenic Medications**

- Benzodiazepines
- Anticholinergics (diphenhydramine, glycopyrrolate, TCAs, cyclobenzaprine)
- Steroids
- Others (metoclopramide, H2 blockers, cefepime)
- Pain medications (if pain is not cause of agitation/delirium)
 - Decrease opioid dose
 - Utilize multimodal pain regimen

Hyperactive Delirium, Acute Encephalopathy and/or Agitation due to Severe Neurocognitive Disorder due to TBI



References:

1. Devlin J, Skrobik Y, Gélinas C, et al. Guidelines for the Prevention and Management of Pain, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult Patients in the ICU. *Crit Care Med*. 2018; 46:825-873.
2. Lewis K, Balas MC, Stollings JL, et al. A Focused Update to the Clinical Practice Guidelines for the Prevention and Management of Pain, Anxiety, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult Patients in the ICU. *Crit Care Med*. 2025 Mar 1;53(3):e711-e727.
3. Girard T, Exline M, Carson S, et al. Haloperidol and Ziprasidone for Treatment of Delirium in Critical Illness. *N Engl J Med*. 2018;379(26):2506-2516.
4. Hughes CG, Mailloux PT, Devlin JW, et al. Dexmedetomidine or propofol for sedation in mechanically ventilated adults with sepsis. *NEJM*. 2021; 384:1424-1436.
5. Marra A, Wesley E, Pandharipande P, et al. The ABCDEF Bundle in Critical Care. *Crit Care Clin*. 2017; 33(2):225-243.
6. Plantier D, Luauté J; SOFMER group. Drugs for behavior disorders after traumatic brain injury: Systematic review and expert consensus leading to French recommendations for good practice. *Ann Phys Rehabil Med*. 2016 Feb;59(1):42-57. doi: 10.1016/j.rehab.2015.10.003.
7. Williamson D, Frenette A, et al. Pharmacological interventions for agitated behaviors in patients with traumatic brain injury: a systematic review. *BMJ Open* 2019;9:e029604
8. Ko CH, Kong CK, Tse PW. Valproic acid and thrombocytopenia: cross-sectional study. *Hong Kong Med J*. 2001 Mar;7(1):15-21.
9. Soja SL, Pandharipande PP, Fleming SB, Cotton BA, Miller LR, Weaver SG, Lee BT, Ely EW. Implementation, reliability testing, and compliance monitoring of the Confusion Assessment Method for the Intensive Care Unit in trauma patients. *Intensive Care Med*. 2008 Jul;34(7):1263-8. doi: 10.1007/s00134-008-1031-x. Epub 2008 Feb 23. PMID: 18297270; PMCID: PMC3773486.
10. Bebawi E, Deslauriers L, Tessier AA, Frenette AJ, Perreault MM, Delisle MS, Bertrand JC, Desjardins M, Bernard F, Rico P, Khwaja K, Burry L, Williamson DR. Validating and comparing the CAM-ICU and the ICDSC in mild and moderate traumatic brain injury patients: a multicenter prospective study. *Crit Care*. 2014;18(Suppl 1):P475. doi: 10.1186/cc13665. Epub 2014 Mar 17. PMCID: PMC4069822.
11. Wilson LD, Maiga AW, Lombardo S, Nordness MF, Haddad DN, Rakhit S, Smith LF, Rivera EL, Cook MR, Thompson JL, Raman R, Patel MB. Prevalence and Risk Factors for Intensive Care Unit Delirium After Traumatic Brain Injury: A Retrospective Cohort Study. *Neurocrit Care*. 2023 Jun;38(3):752-760. doi: 10.1007/s12028-022-01666-1. Epub 2023 Jan 31. PMID: 36720836; PMCID: PMC10750768.

[CAM ICU Assessment](#)

Revised: 6/2026, 5/2024, 4/2023,
3/2021

Authors:

Jill Streams, MD

Bradley Dennis, MD

Abby Luffman, MSN, APN, AGACNP-BC

Chelsea Tasaka, PharmD

Jennifer Beavers, PharmD

Elizabeth Emerson, PharmD