

# Disassociating Delirium in the Pediatric Intensive Care Unit

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# Disclosures

- I have no relevant financial relations to report



# Objectives

- Review pathophysiology and risk factors for pediatric delirium
- Identify causes and assessment of delirium in pediatric patients
- Recommend non-pharmacologic and pharmacologic treatment options in pediatric patients
- Consider barriers in managing delirium in pediatric patients

# Timeline

Prugh  
1980

Turkel &  
Tavare  
2003

Schieveld  
2005

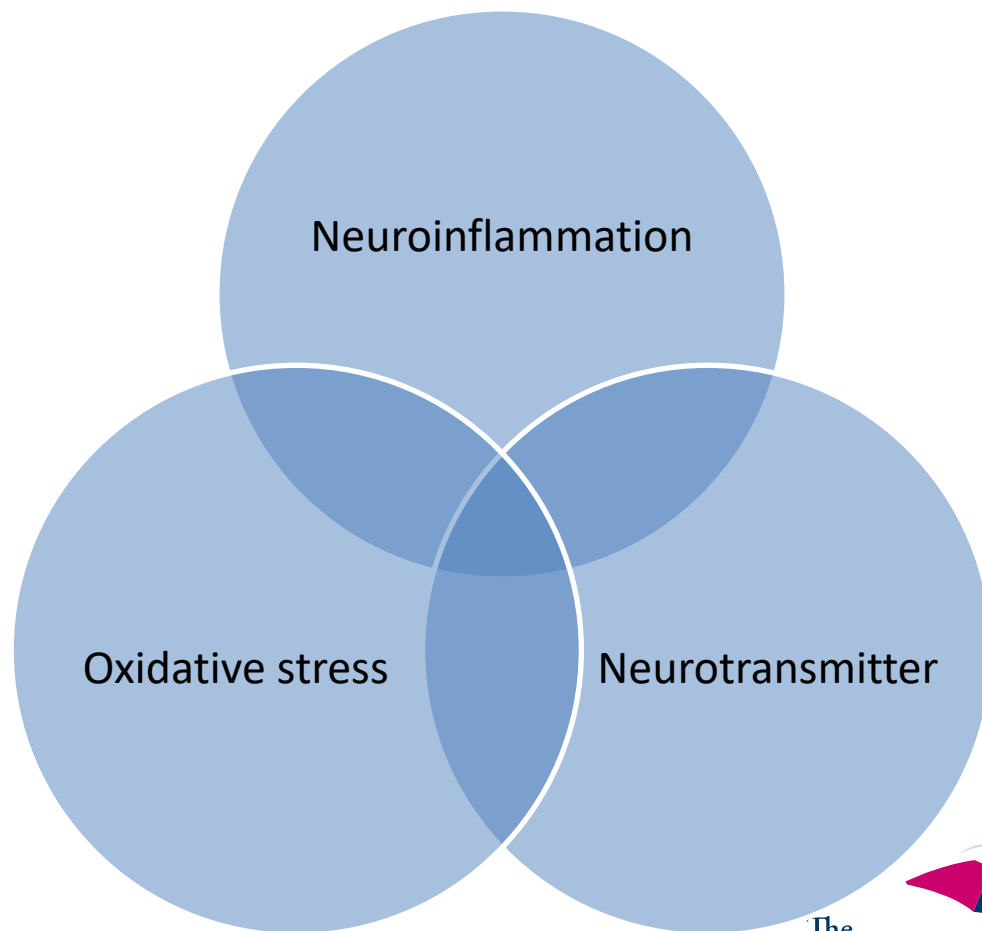
PANDEM  
2022

Prugh DG, et al. *Psychosom Med.* 1980;42(1):177-95.  
Turkel SB, et al. *J Neuropsychiatry Clin Neurosci.* 2003;15(4):431-5.  
Schieveld JNM, et al. *Intensive Care Med.* 2007 Jun;33(6):1033-40.  
Schieveld JNM, et al. *Intensive Care Med.* 2009 Sep;35(11):1843-9.  
*Ped Crit Care Med.* 2022,23:e73-e110.

# Background

- Form of acute brain dysfunction
- DSM-5/WHO: disturbance in
  - Attention
  - Emotion
  - Awareness
  - Sleep-wake cycle
  - Cognition
  - Perception
- All hospitalized patients are at risk
  - 12 to 65% of hospitalized pediatric patients
  - Up to 30% of pediatric patients in the PICU

# Pathophysiology



# Risk Factors

- Baseline characteristics
  - Developmental delay
  - Children < 5 years of age; << 2 years of age
  - Higher severity of illness
- Invasive mechanical ventilation
  - Deeper levels of sedation
- Medications
- Length of stay; > 5 days



# Causes of Delirium: I WATCH DEATH



<b>I</b>	Infections	Encephalitis, meningitis, urinary tract infection, pneumonia
<b>W</b>	Withdrawal	Alcohol, barbiturates, benzodiazepine, sedatives
<b>A</b>	Acute metabolic	Electrolyte imbalance, acidosis, hepatic or renal failure
<b>T</b>	Trauma	Head injury, burns, post-op
<b>C</b>	CNS pathology	Stroke, hemorrhage, tumor, seizure disorder
<b>H</b>	Hypoxia	Anemia, cardiac failure, pulmonary embolus
<b>D</b>	Deficiencies	Vitamin B12, folic acid, thiamine
<b>E</b>	Endocrinopathies	Thyroid, parathyroid, glucose, adrenal
<b>A</b>	Acute vascular	Shock, vasculitis, hypertensive encephalopathy
<b>T</b>	Toxic or drugs	Toxins, substance intoxication, medications
<b>H</b>	Heavy metals	Lead, mercury

L FOR:

**EIN**

Medicine

# Causes of Delirium: BRAIN MAPS

Assessment & Evaluation		Management
<b>B</b>	<b>Bring oxygen:</b> hypoxemia, low cardiac output, anemia	O2 delivery, resolution of anemia
<b>R</b>	<b>Remove or reduce drugs</b> such as anticholinergics and benzodiazepines	Discontinue if possible
<b>A</b>	<b>Atmosphere:</b> room set up, restraint use, schedule/routine	Encourage consistent/normal schedule, familiar objects and people (caregivers)
<b>I</b>	Infection, immobilization, inflammation	Treat infection/fever
<b>N</b>	New organ dysfunction	Address end organ dysfunction
<b>M</b>	<b>Metabolic disturbances:</b> hypo/hyponatremia, hypo/hyperkalemia, hypocalcemia, alkalosis, acidosis	Normalize electrolytes
<b>A</b>	<b>Awake:</b> lack of a bedtime routine, disturbances of the sleep-wake cycle	Establish day/night schedule
<b>P</b>	<b>Pain:</b> under or over treated	Adjust analgesia to appropriate goal
<b>S</b>	<b>Sedation:</b> under or over sedated	Set sedation target

# Types of Delirium

Type	Signs
Hyperactive	Agitation, restlessness, hypervigilance, combative behavior
Hypoactive	Lethargy, inattention, decreased responsiveness
Mixed-type	Fluctuates between hyper and hypoactive delirium

Compared to adult delirium, pediatric delirium is

- Extremely subtle
- Complicated by developmental variability
- Difficult to differentiate



# Consequences of Delirium

- Increased
  - Hospital length of stay
  - Length of mechanical ventilation
  - Safety events
  - Use of restraints
  - Use of sedation
  - Morbidity and mortality
- Long term
  - Neuro-developmental complications
  - Behavioral consequences
  - Quality of life



# PANDEM Guidelines for Infants and Children

1) <i>We recommend</i> use of the preschool and pediatric Confusion Assessment Methods for the ICU or the Cornell Assessment for Pediatric Delirium as the most valid and reliable delirium monitoring tools in critically ill pediatric patients.	Strong	High
2) <i>We recommend</i> routine screening for ICU delirium using a validated tool in critically ill pediatric patients upon admission through ICU discharge or transfer.	Strong	High
3) Given low patient risk, and possible patient benefit to reduce the incidence and/or decrease duration or severity of delirium <i>we suggest</i> the following <i>non-pharmacologic strategies</i> : optimization of sleep hygiene, use of interdisciplinary rounds, family engagement on rounds, and family involvement with direct-patient care.	Conditional	Low
4) <i>We suggest</i> performing EM, when feasible, to reduce the development of delirium.	Conditional	Low
5) <i>We recommend</i> minimizing benzodiazepine-based sedation when feasible in critically ill pediatric patients to decrease incidence and/or duration or severity of delirium.	Strong	Moderate
6) <i>We suggest</i> strategies to minimize overall sedation exposure whenever feasible to reduce coma and the incidence and/or severity of delirium in critically ill children.	Conditional	Low
7) <i>We do not suggest</i> routine use of haloperidol or atypical antipsychotics for the prevention of or decrease in duration of delirium in critically ill pediatric patients.	Conditional	Low
8) <i>We suggest</i> that in critically ill pediatric patients with <i>refractory</i> delirium, haloperidol or atypical antipsychotics be considered for the management of <i>severe</i> delirium manifestations, with consideration of possible adverse drug effects.	Conditional	Moderate
9) <i>We recommend</i> a baseline electrocardiogram followed by routine electrolyte and QTc interval monitoring for patients receiving haloperidol or atypical antipsychotics.	Strong	Moderate

# Assessment

	pCAM-ICU	psCAM-ICU	CAPD
Age group	>5 years	6 months to 5 years old	0 to 21 years
Score range	+Delirium if 1 AND 2 AND either 3 OR 4 present		0 to 32 (9)
Sensitivity (%)	83	78	94
Specificity (%)	99	86	79
Other	<ul style="list-style-type: none"> <li>• Requires patient cooperation</li> <li>• 2 step assessment</li> <li>• Uses RASS or SBS</li> <li>• Brief assessment</li> </ul>		<ul style="list-style-type: none"> <li>• Completed through observation</li> <li>• Uses RASS</li> <li>• Longer assessment</li> </ul>

pCAM-ICU: Pediatric Confusion Assessment Method-Intensive Care Unit

psCAM-ICU: Preschool Pediatric Confusion Assessment Method-Intensive Care Unit

CAPD: Cornell Assessment of Pediatric Delirium



# pCAM-ICU – Step 1

Richmond Agitation Sedation Scale (RASS)

SCALE	LABEL	DESCRIPTION	
+4	COMBATIVE	Combative / VIOLENT / Immediate danger to staff	LOOK
+3	VERY AGITATED	Pulls to remove tubes or catheters / AGGRESSIVE	
+2	AGITATED	Frequent non-purposeful movement / FIGHTS VENTILATOR	
+1	RESTLESS	ANXIOUS / Apprehensive / Movements NOT aggressive	
+0	ALERT & CALM	SPONTANEOUS ATTENTION to caregiver	TALK
-1	DROWSY	Not fully alert, but has SUSTAINED AWAKENING to VOICE Eye opening and Eye contact > 10 sec	
-2	LIGHT SEDATION	BRIEFLY awakens to VOICE / Eyes open but contact < 10 sec	
-3	MODERATE SEDATION	Movement or eye opening to VOICE / NO eye contact	TOUCH
-4	DEEP SEDATION	NO RESPONSE to VOICE Some movement or eye opening to TOUCH (physical stimuli)	
-5	UNAROUSEABLE	NO RESPONSE to NOXIOUS stimuli	

**If RASS is  $\geq$  (-3) → PROCEED to STEP 2 (ps/pCAM-ICU).**

**If RASS is (-4) or (-5) → STOP and REASSESS patient later.**

Sessler, et al. Am J Respir Crit Care Med 2002. Ely, et al. JAMA 2003.

State Behavioral Scale (SBS)

SCALE	LABEL	DESCRIPTION
+2	AGITATED	UNABLE to console / Increased movement (thrashing, kicking legs) UNSAFE (biting ETT, pulling lines) / Fights ventilator
+1	RESTLESS (Difficult to Calm)	Increased Movement (RESTLESS) / Asynchrony when on ventilation Does NOT consistently calm despite 5 min attempt
+0	AWAKE (Able to Calm)	Spontaneous ATTENTION RESPONSE to VOICE / Able to calm with touch or voice
-1	RESPONSIVE (Gentle Touch/Voice)	RESPONSE to VOICE or LIGHT TOUCH BRIEF attention with stimulation / Able to comfort
-2	RESPONSIVE (Noxious Stimuli)	RESPONSE to NOXIOUS stimuli Occasional movement of extremities / UNABLE to pay attention
-3	UNRESPONSIVE	NO response to NOXIOUS stimuli Does NOT move / Does NOT distress with ANY procedure

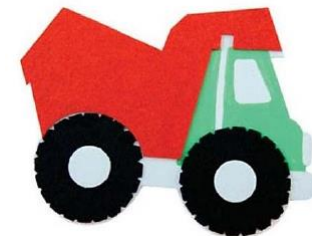
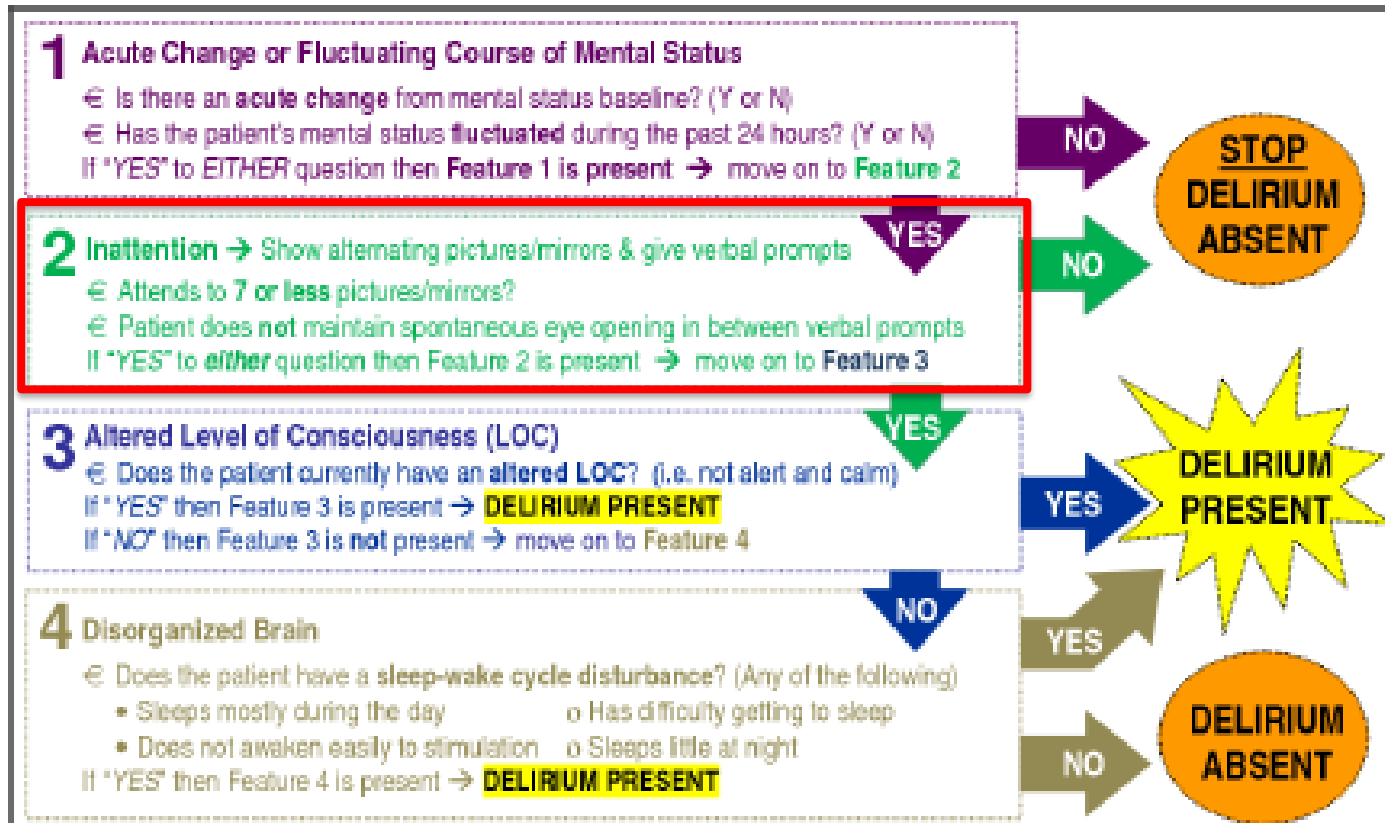
**If SBS is  $\geq$  (-1) → PROCEED to STEP 2 (pCAM-ICU).**

**If SBS is (-2) or (-3) → STOP and REASSESS patient later.**

Martha A.Q. Curlev, et al. Pediatr Crit Care Med. 2006 March; 7(2): 107-114.



# psCAM-ICU – Step 2



# CAPD

RASS Score ____ (if -4 or -5 do not proceed)						
Please answer the following questions based on your interactions with the patient over the course of your shift:						
	Never	Rarely	Sometimes	Often	Always	Score
	4	3	2	1	0	
1. Does the child make eye contact with the caregiver?						
2. Are the child's actions purposeful?						
3. Is the child aware of his/her surroundings?						
4. Does the child communicate needs and wants?						
	Never	Rarely	Sometimes	Often	Always	
	0	1	2	3	4	
5. Is the child restless?						
6. Is the child inconsolable?						
7. Is the child underactive—very little movement while awake?						
8. Does it take the child a long time to respond to interactions?						
<b>TOTAL</b>						

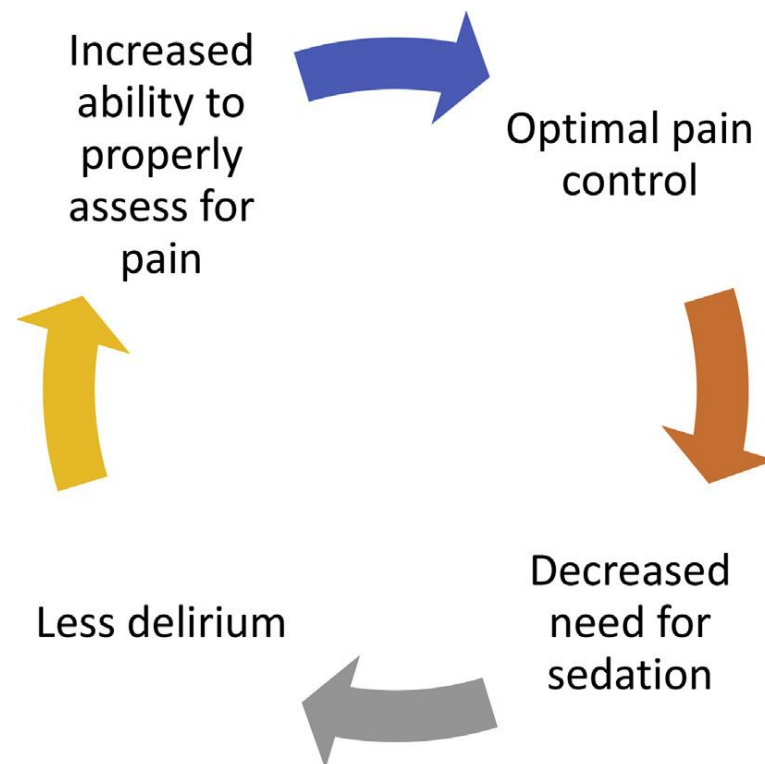
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# Preventative Measures

- Environmental modifications
  - Normal sleep-wake cycles
  - Cluster care
  - Quiet hours
- Family/caregiver involvement
- Pharmacologic optimization
  - Analgesic first approach
    - Analgo-sedation
- Early mobilization

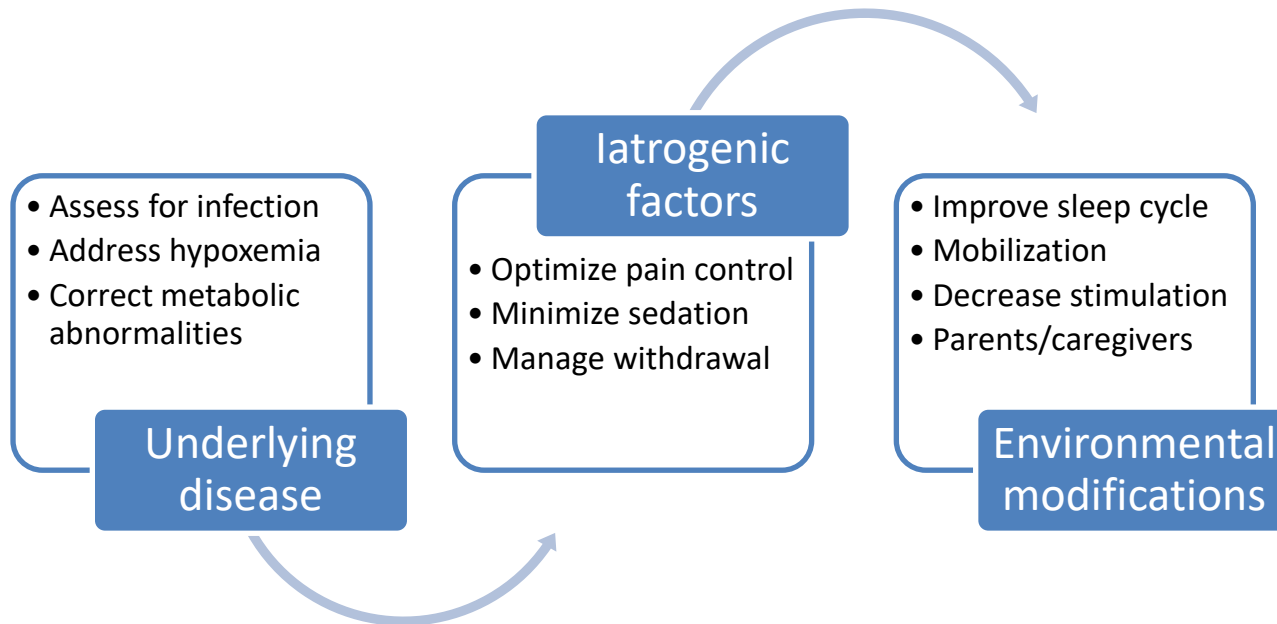


## Polling Question

Which of the following is NOT recommended to prevent pediatric ICU delirium?

- A. Analgesic first approach
- B. Delay mobilization
- C. Normal sleep-wake cycles
- D. Family/caregiver involvement

# Non-Pharmacologic Management



# Pharmacologic Management

- Quetiapine
- Risperidone
- Olanzapine
- Aripiprazole
- Melatonin

# Quetiapine as a Treatment for Delirium in Critically Ill Children: a case series

	Case 1	Case 2	Case 3	Case 4
<b>Age/gender</b>	8-month-old boy	3-year-old female	6-year-old boy	14-year-old boy
<b>Analgesics/sedatives/paralytics</b>	<ul style="list-style-type: none"> <li>Hydromorphone</li> <li>Midazolam</li> <li>Dexmedetomidine</li> </ul>	<ul style="list-style-type: none"> <li>Fentanyl</li> <li>Dexmedetomidine</li> <li>Lorazepam</li> </ul>	n/a	n/a
<b>Quetiapine Initial Dose</b>	1.5 mg/kg/DAY divided q8h	1.5 mg/kg/DAY (frequency not defined)	1.5 mg/kg/DAY divided q8h	Dose not defined
<b>Quetiapine Final Dose</b>	n/a	8 mg/kg/DAY (slowly titrated up)	Titrated up the next 3 days	Titrated up (not defined)
<b>Outcome</b>	Within 24 hours, delirium improved, and hydromorphone weaned	Improved agitation within 24 hours	Improvement in 24 hours; decreased agitation and increased sleep time	Improvement in delirium in 48 hours

# Quetiapine for Delirium Management

	Caballero A, et al 2023	Thielen JR, et al 2024
Objective	Evaluate quetiapine efficacy for treatment of delirium in critically ill pediatric patients and to describe quetiapine's safety profile	To investigate the short term effects of quetiapine, on opioid and benzo requirements, and any associated adverse events
Methods	<ul style="list-style-type: none"> <li>• Single center, retrospective</li> <li>• Patients <math>\leq 18</math> years</li> <li>• CAPD <math>\geq 9</math></li> <li>• Quetiapine for <math>\geq 48</math> hours</li> </ul>	<ul style="list-style-type: none"> <li>• Single center, retrospective</li> <li>• Cardiac intensive care unit</li> <li>• 72-hour pre and post quetiapine initiation analysis</li> </ul>
Results	<ul style="list-style-type: none"> <li>• N = 37 patients</li> <li>• 68% decrease in opioid use</li> <li>• 43% decrease in benzo use</li> <li>• Median CAPD 17 to 16 at 48-hour mark</li> <li>• 3 patients experienced QTc prolongation</li> </ul>	<ul style="list-style-type: none"> <li>• N = 13 patients</li> <li>• Significant reduction in opioid and benzo use</li> <li>• Significant reduction in number of PRNs used</li> <li>• No significant effect of quetiapine on QTc interval</li> </ul>

# Risperidone

## An Evaluation of Risperidone Dosing for Pediatric Delirium in Children Less Than or Equal to 2 Years of Age

<b>Objective</b>	To describe the dosing, safety, and tolerability of risperidone for ICU delirium in patients < 2 years of age
<b>Methods</b>	Retrospective descriptive study
<b>Results</b>	<ul style="list-style-type: none"><li>• 17 patients included with at least 1 dose of risperidone</li><li>• Initial daily dose ranged from 0.1 to 0.25 mg (0.01 to 0.04 mg/kg)</li><li>• 76.5% were on once daily dosing</li><li>• &gt;80% required a dose increase during their course</li><li>• Max daily dose ranged from 0.1 to 0.5 mg (0.01 to 0.1 mg/kg)</li><li>• Decrease in sedation requirements</li><li>• 7 patients had an EKG completed</li><li>• 3 patients were scored for CAPD</li></ul>



# Olanzapine

## Olanzapine Reduces Delirium Symptoms in the Critically Ill Pediatric Patient

### Objective

To determine the efficacy of olanzapine for the management of pediatric delirium

### Methods

- Retrospective longitudinal study; study (olanzapine) vs control group
- Patients admitted in the PICU or CTICU
- Infants = olanzapine 0.625 mg qhs to q12h
- Toddlers = olanzapine 1.25 mg qhs to q12h
- Adolescents = olanzapine 2.5 to 5 mg qhs to q12h

### Results

- N = 59; olanzapine group = 31, control group = 28
- Study group had more severe symptoms
- Greater improvement in symptoms in olanzapine group vs control
- No significant adverse effects noted



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# Melatonin

## Evaluation of Melatonin Practices for Delirium in Pediatric Critically Ill Patients

<b>Objective</b>	To determine melatonin's role as either prophylaxis or first-line or second-line treatment for delirium in the PICU
<b>Methods</b>	Retrospective, single-center chart review
<b>Results</b>	<ul style="list-style-type: none"><li>• 63 patients included</li><li>• 39 patients had antipsychotic use after melatonin initiation</li><li>• No difference in sedation exposure in pre vs post melatonin groups</li><li>• Decrease in RASS score in post vs pre melatonin group</li><li>• Role of prophylactic role needs to be further studied</li></ul>

# Adverse Effects

## Evaluation of QTc Interval Effects of Antipsychotic Medications for Intensive Care Unit Delirium in Pediatric Patients

<b>Objective</b>	To determine the incidence and risk factors for QTc interval prolongation in critically ill children treated with antipsychotics for ICU delirium
<b>Methods</b>	Retrospective chart review
<b>Results</b>	<ul style="list-style-type: none"> <li>• 29 patients included in the analysis</li> <li>• Risperidone (25/29), haloperidol (2/29), quetiapine (1/29), olanzapine (1/29)</li> <li>• Median change in QTc was 4 msec</li> <li>• No occurrences of arrhythmias</li> <li>• Two patients had QTc prolongation             <ul style="list-style-type: none"> <li>• Patient 1 = risperidone 0.03 mg/kg/DAY for 18 days on 7 concomitant QTc prolonging medications, QTc from 434 to 451 msec</li> <li>• Patient 2 = risperidone 0.08 mg/kg/DAY for 4 days on 4 concomitant QTc prolonging medications, QTc from 376 to 450 msec</li> </ul> </li> </ul>

# Adverse Effects

## The Effect of Antipsychotic Medications on QTc and Delirium in Pediatric Cardiac Patients with ICU Delirium

<b>Objective</b>	To determine the effect of quetiapine and risperidone in treating delirium and QTc prolongation in postop pediatric cardiac patients
<b>Methods</b>	Retrospective chart review
<b>Results</b>	<ul style="list-style-type: none"><li>• 139 patients included in the analysis<ul style="list-style-type: none"><li>• 115 received risperidone and 24 received quetiapine</li></ul></li><li>• No occurrences of arrhythmias</li><li>• No significant change in QTc after antipsychotic administration (<math>p = 0.064</math>)</li><li>• Mean CAPD score decreased (<math>p &lt; 0.001</math>)</li><li>• Quetiapine had the most improvement in delirium (<math>p = 0.002</math>)</li></ul>

## Polling Question

Which of the following agents has the highest risk of causing QTc prolongation?

1. Haloperidol
2. Quetiapine
3. Risperidone
4. Olanzapine

# Current Practices

## Management of Pediatric Delirium in Pediatric Cardiac Intensive Care Patients

<b>Objective</b>	To describe how pediatric cardiac intensive care clinicians assess and manage delirium in patients following cardiac surgery
<b>Methods</b>	Web based survey Pediatric intensive care units
<b>Results</b>	<ul style="list-style-type: none"> <li>• 173 clinicians, from 13 countries, completed survey</li> <li>• Clinical impression of delirium in 25% of patients</li> <li>• 75% reported that routine delirium screening does not occur</li> <li>• 8% had a protocolized approach to assessing and managing delirium</li> <li>• Predominant use of pCAM-ICU (39%) and CAPD (31%)</li> <li>• Antipsychotics were not widely prescribed; risperidone predominately</li> </ul>



# Current Practices

## Delirium Assessment Treatment Strategies in Critically Ill Pediatric Patients: A Pediatric Pharmacy Association Practice-Based Research Network Survey Study

<b>Objective</b>	To describe the screening, prevention, and treatment for pediatric delirium at various NICUs, CICUs, and PICUs from the PPA membership
<b>Methods</b>	<ul style="list-style-type: none"> <li>• Cross-sectional questionnaire was distributed to PPA members from 2/2022 to 3/2022</li> </ul>
<b>Results</b>	<ul style="list-style-type: none"> <li>• Completed by 84 respondents at 62 sites</li> <li>• 61 respondents noted their units routinely screen for delirium</li> <li>• 33 respondents had a defined delirium protocol</li> <li>• Most common agents used: quetiapine and risperidone</li> <li>• 74 respondents monitored EKGs to assess QTc, however there was variability</li> </ul>



# Barriers

## Pediatric Delirium: Early Identification of Barriers to Optimize Success of Screening and Prevention

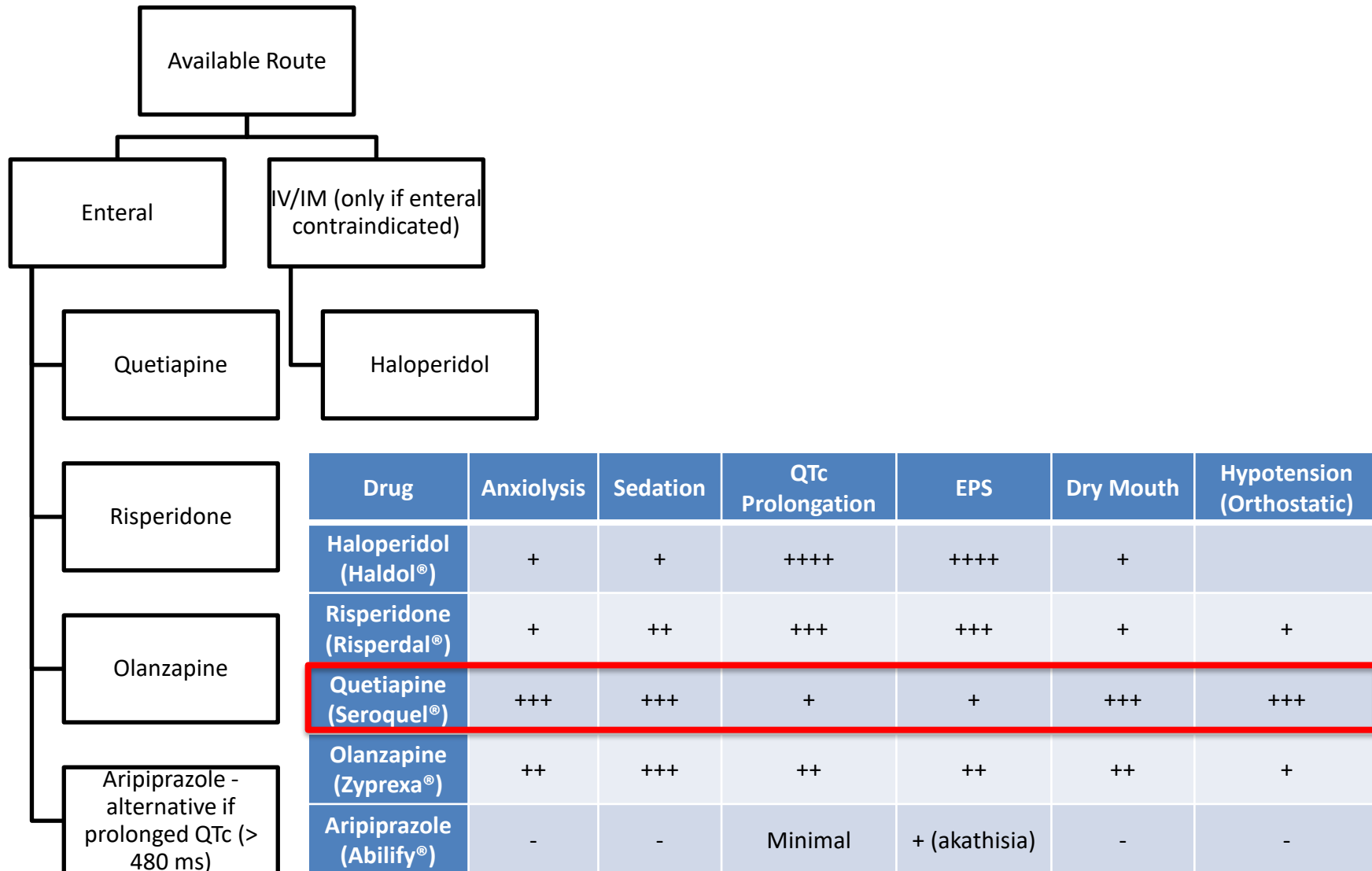
<b>Objective</b>	To evaluate the impact/effect of implementing nonpharmacologic nursing bundles on the incidence of pediatric delirium
<b>Methods</b>	Implementation of nonpharmacologic nursing bundle in 2-18 years of age Pediatric intensive care units CAPD screening tool
<b>Results</b>	<ul style="list-style-type: none"> <li>• CAPD screening tool not built into EHR</li> <li>• Standard screening times not ideal with nursing workflow</li> <li>• Difficulties understanding the screening for patients requiring sedation and/or intubation, younger patients, and patients with developmental delay</li> <li>• Lack of trust in medical team to treat the delirium when identified</li> </ul>



## Prior Barriers @ CHAM

- Education to all team members
- Utilization of CAPD with SBS
- Development of CAPD into EPIC
- Development of quetiapine oral solution into EPIC
- Incorporation in Daily Rounding Safety Checklist

# CHAM - Pharmacologic Management



# CHAM – Pharmacologic Management Dosing

Drug	Route	Starting Dose	PRNs	Titration	Max Dose
<b>Haloperidol (Haldol®)</b>	IV/IM/ PO (tablet, oral solution)	0.02 mg/kg/dose q8hrs Max = 2 mg/dose	Can use up to two 0.02 mg/kg/dose RPNs per day	Can increase each dose in 0.02 mg/kg increments	0.15 mg/kg/day or 5 mg/day
<b>Risperidone (Risperdal®)*</b>	PO (tablet, ODT, oral solution)	< 1y = 0.05 to 0.1 mg once or twice daily	Can use one PRN dose per day (same dose as the around the clock dose)	May titrate to lowest effective dose every 1 to 2 days	< 20 kg = 1 mg/day
		1-5y = 0.1 to 0.2 mg once or twice daily			20-45 kg = 2.5 mg/day
		≥ 5y = 0.2 to 0.5 mg once or twice daily			> 45 kg = 3 mg/day
<b>Quetiapine (Seroquel®)</b>	PO (tablet, oral solution)	0.5 mg/kg/dose q8hrs Max = 50 mg/dose	Can use up to two 0.25-0.5 mg/kg PRNs per day	Can increase each dose in 0.5 mg/kg increments	3 mg/kg/day or 300 mg/day
<b>Olanzapine (Zyprexa®)</b>	PO (tablet, ODT)	3-6y = 1.25 mg qhs	Can use one PRN per day (1/2 the dose as nighttime dose)	Can increase each day in increments of starting dose	3-6y = 5 mg/day
		7-12y = 2.5 mg qhs			7-12y = 10 mg/day
		>12y = 5 mg qhs			>12y = 15 mg/day
<b>Aripiprazole (Abilify®)</b>	PO (tablet)	3-6y = 0.5 mg once a day	Can use one PRN per day (same dose as the daily dose)	3-6y = to 1 mg than 2 mg 7-12y = to 2 mg than 5 mg >12y = to 5 mg than 10 mg	3-6y = 2 mg/day
		7-12y = 1 mg once a day			7-12y = 5 mg/day
		>12y = 2 mg once a day			>12y = 10 mg/day

# CHAM - CAPD Screening

SBS Score ____ (if -2 or -3 do not proceed)						
Please answer the following questions based on your interactions with the patient over the course of your shift:						
	Never	Rarely	Sometimes	Often	Always	Score
	4	3	2	1	0	
1. Does the child make eye contact with the caregiver?						
2. Are the child's actions purposeful?						
3. Is the child aware of his/her surroundings?						
4. Does the child communicate needs and wants?						
	Never	Rarely	Sometimes	Often	Always	
	0	1	2	3	4	
5. Is the child restless?						
6. Is the child inconsolable?						
7. Is the child underactive—very little movement while awake?						
8. Does it take the child a long time to respond to interactions?						
<b>TOTAL</b>						

# CHAM – CAPD Documentation

View Doc Flowsheet (completed rows are filtered out)

Search: 024+Comma

Hide All Show All

	1100	1200	1300
Motor Response			
General Motor Response			
Pupils			
Pupil PERSELA			
Pupil Size Left			
Pupil Shape Left			
Pupil Reaction Left			
Pupil Accommodation Left			
Pupil Size Right			
Pupil Shape Right			
Pupil Reaction Right			
Hand Grip/Ankle Strength			
Hand Grip, Left			
Hand Grip, Right			
Confusion: Left			
Confusion: Right			
Confusion Assessment Method-ICU (CAM-ICU)			
Delirium (Delirium)			
Hand Grip/Ankle Strength			
Hand Grip, Left			
Hand Grip, Right			
Confusion: Left			
Confusion: Right			

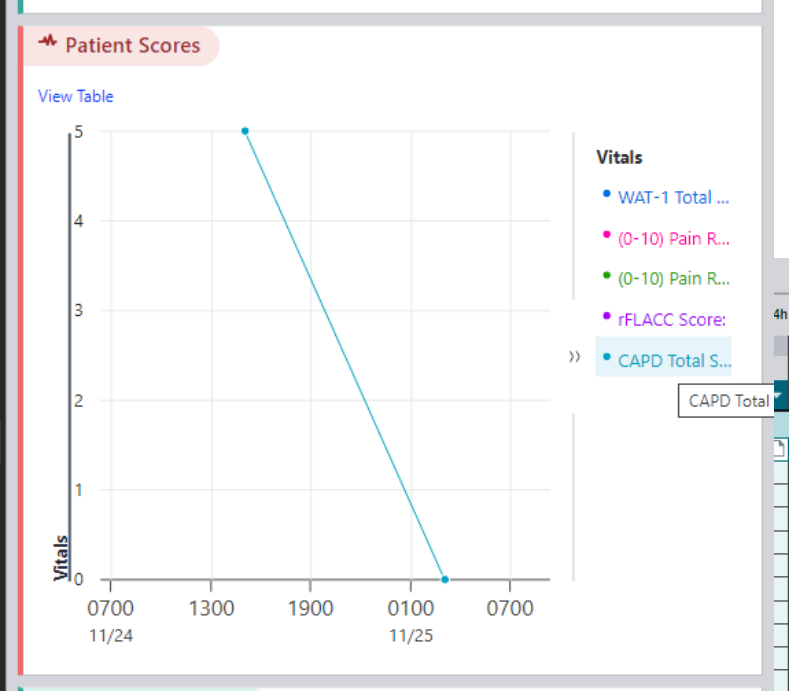
Vital Signs **Peds PCS Body System** Intake/Output Adult PCS Body System Adult Patient Profile All Lines/Drains/Airways Pre-Procedure Checklist

Search (Alt+Comma)

Hide All Show All

Accordion Expanded  View All

	0200	0400
<b>Cornell Assessment for Pediatric Delirium (CAPD)</b>		
Is the patient under neuromuscular blockade?	No, proceed to scoring	
1. Does the child make eye contact ...	0 (Always)	
2. Are the child's actions purposeful?	0 (Always)	
3. Is the child aware of his/her surroundings?	0 (Always)	
4. Does the child communicate needs?	0 (Always)	
5. Is the child restless?	0 (Never)	
6. Is the child inconsolable?	0 (Never)	
7. Is the child underactive - very little movement?	0 (Never)	
8. Does it take the child a long time to respond to commands?	0 (Never)	
CAPD Total Score (Calculated)	0	0
CAPD Total Score (Calculated)	0	0
CAPD Score Interpretation (Calculated)	Negative screen for delirium	



# Summary

- Pediatric delirium is an under-recognized and high-risk diagnosis that can lead to several complications
- Standardized institutional protocols of assessing and managing pediatric delirium can help improve outcomes

# Questions?

