Overview of the New Pain, Agitation, and Delirium Guidelines

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What’s Different about this Version of the PAD Guidelines? Methods

- Grade methodology
  - www.gradeworkinggroup.org
- More rigorous, transparent process for developing statements and recommendations
- Strength of recommendation based on BOTH strength of evidence and the relative risks & benefits of interventions
- Expert opinion NOT used as a substitute for making recommendations in the absence of evidence

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Effect on Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of evidence</td>
<td>Lower quality of evidence reduces the likelihood of a strong recommendation, and vice versa.</td>
</tr>
<tr>
<td>Uncertainty about the balance between desirable and undesirable effects</td>
<td>Higher degree of uncertainty about the balance between risks and benefits reduces the likelihood of a strong recommendation, and vice versa.</td>
</tr>
<tr>
<td>Uncertainty or variability in values and preferences across groups</td>
<td>Wide variability in values and preferences across groups reduces the likelihood of a strong recommendation, and vice versa.</td>
</tr>
<tr>
<td>Uncertainty about whether the intervention represents a wise use of resources</td>
<td>A higher overall cost of treatment reduces the likelihood of a strong recommendation, and vice versa.</td>
</tr>
</tbody>
</table>

Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit

Juliana Barr, MD, FCCM; Gilles L. Fraser, PharmD, FCCM; Kathleen Puntillo, RN, DNSc, FAAN; E. Wesley Ely, MD, MPH, FACP, FCCM; Céline Gélinas, RN, PhD; Joseph F. Dasta, MSc; Judy E. Davidson, DNP, RN; John W. Devlin, PharmD, FCCM; John P. Kress, MD; Aaron M. Joffe, DO; Douglas B. Courson, MD; Daniel L. Herr, MD, MS, FCCM; Avery Tung, MD; Bryce RH Robinson, MD, FACS; Dorrie K. Fontaine, PhD, RN, FAAN; Michael A. Ramsay, MD; Richard R. Riker, MD, FCCM; Curtis N. Sessler, MD, FCCP, FCCM; Brenda Pun, RN, MSN, ACNP; Yoanna Skrobik, MD, FRCP; Roman Jarecki, MD, MSc

Supporting Organizations:
American College of Critical Care Medicine (ACCM) under the oversight of the Society of Critical Care Medicine (SCCM) with review of the guidelines by the American Society of Health-System Pharmacists (ASHP)


<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Quality of Evidence</th>
<th>Type of Evidence</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>High</td>
<td>High Quality Randomized Controlled Trial (RCT)</td>
<td>Further research is unlikely to change our confidence in the estimate of effect.</td>
</tr>
<tr>
<td>B</td>
<td>Moderate</td>
<td>RCT with significant limitations (downgraded), or high quality Observational Study (OS) (upgraded)</td>
<td>Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.</td>
</tr>
<tr>
<td>C</td>
<td>Low</td>
<td>Observational study</td>
<td>Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.</td>
</tr>
</tbody>
</table>

Adapted from Guyatt GH et al. BMJ. 2008; 336:924-6.

What’s Different about this Version of the PAD Guidelines? Methods

- Anonymous online voting (E-survey) by all Task Force Members
- Standardized voting thresholds used
  - A recommendation in favor of an intervention (or the comparator) required at least 50% voting in favor, with ≤20% voting against; failure to meet these voting thresholds resulted in no recommendation being made.
  - For a recommendation to be graded as strong rather than weak, at least 70% of those voting had to vote for a strong recommendation, otherwise it received a weak recommendation.

Oversedation in the ICU is Common

- N=274 MICU patients
- 32% unarousable
- 21% no spontaneous motor activity

Payen JF et al. Anesthesiology. 2007; 106:687-95.

Early Deep Sedation is Associated with Both a Longer Duration of Mechanical Ventilation and Reduced 6-month Survival

Payen JF et al. Anesthesiology. 2007; 106:687-95.

Question: Should adult ICU patients be maintained at a light level of sedation? (actionable)

Answer: Maintaining light levels of sedation in adult ICU patients is associated with improved clinical outcomes (e.g., shorter duration of mechanical ventilation and a shorter ICU length of stay) (B). We recommend that sedative medications should be titrated to maintain a light rather than deep level of sedation in adult ICU patients, unless clinically contraindicated (+1B).


Which of the following has been shown in studies to be an outcome of maintaining mechanically ventilated adult patients at a light (rather than deep) level of sedation?

- A greater incidence of post-traumatic stress disorder.
- A greater incidence of patient-initiated device removal (e.g., self-extubation).
- A shorter duration of mechanical ventilation.


Impact of a Combined SAT-SBT Strategy on Patient Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>SBT</th>
<th>SAT+S BT</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator-free days</td>
<td>12</td>
<td>15</td>
<td>0.02</td>
</tr>
<tr>
<td>Coma, days</td>
<td>3</td>
<td>2</td>
<td>0.002</td>
</tr>
<tr>
<td>Time-to-event, days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Successful extubation</td>
<td>7</td>
<td>5</td>
<td>0.05</td>
</tr>
<tr>
<td>ICU discharge</td>
<td>13</td>
<td>9</td>
<td>0.01</td>
</tr>
<tr>
<td>Hospital discharge</td>
<td>19</td>
<td>15</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Compliance with SAT and SBT components of protocol in this controlled study was ≥ 90%
SAT = Spontaneous Awakening Trial
SBT = Spontaneous Breathing Trial

The Pharmacist’s Role in Implementing the New Pain, Agitation, and Delirium Guidelines in the Critical Care Setting
The Pharmacist’s Role in Implementing the New Pain, Agitation, and Delirium Guidelines in the Critical Care Setting

Perceived Barriers to Use of Daily Sedation Interruption: Engaging the Bedside RN is the Key!

<table>
<thead>
<tr>
<th>Barrier</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of physician order</td>
<td>3.4%</td>
</tr>
<tr>
<td>Lack of nursing acceptance</td>
<td>15.0%</td>
</tr>
<tr>
<td>Prefer more control than a protocol offers</td>
<td>15.0%</td>
</tr>
<tr>
<td>Use may cause oversedation</td>
<td>14.6%</td>
</tr>
<tr>
<td>Protocol not accessible when needed</td>
<td>15.6%</td>
</tr>
<tr>
<td>Protocols are difficult to use</td>
<td>10.0%</td>
</tr>
<tr>
<td>Inconvenient to coordinate</td>
<td>14.0%</td>
</tr>
<tr>
<td>Not appropriate for select patients*</td>
<td>10.0%</td>
</tr>
<tr>
<td>Possibility for underdetection</td>
<td>10.0%</td>
</tr>
<tr>
<td>No proven benefit</td>
<td>10.0%</td>
</tr>
</tbody>
</table>


Nurse

Perform Daily Awakening

Note: Nurses automatically evaluate all mechanically ventilated patients receiving continuous sedation and/or opiates for a DA trial EACH MORNING unless MD writes an order NOT to complete DA in the patient

Nurse

Physician

Nursing-Implemented Sedation Protocol:
Barnes Jewish Pilot United States


Hourly Protocol + SAT (DIS)/SBT versus Hourly Protocol + SBT alone

Question: Should a protocol that includes either daily sedative interruption or a light target level of sedation be used in mechanically ventilated adult ICU patients? (actionable)

Answer: We recommend either daily sedation interruption or a light target level of sedation be routinely used in mechanically ventilated adult ICU patients (+1B).

**Duration of Mechanical Ventilation**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Mechanical Ventilation</th>
<th>Non-Mechanical Ventilation</th>
<th>Total</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hours</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>9.0</td>
<td>9.5</td>
</tr>
<tr>
<td>48 Hours</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>72 Hours</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

*Question:* Should non-benzodiazepine-based sedation, instead of sedation with benzodiazepines, be used in mechanically ventilated adult ICU patients? *(actionable)*

*Answer:* We suggest that sedation strategies using non-benzodiazepine sedatives (either propofol or dexmedetomidine) may be preferred over sedation with benzodiazepines (either midazolam or lorazepam) to improve clinical outcomes in mechanically ventilated adult ICU patients (+2B).

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**Framework for Risk**

- **Baseline Vulnerability:** High
- **Delirium Likelihood:** High
- **Precipitating Stimulus:** Noxious
- **Return to Independent Functional Status at d/c:** 59% in intervention group, 35% in control group (p=0.02)

*Question:* Which instruments available for delirium monitoring have the strongest evidence for validity and reliability in ventilated and non-ventilated medical and surgical ICU patients? *(descriptive)*

*Answer:* The Confusion Assessment Method for the ICU (CAM-ICU) and the Intensive Care Delirium Screening Checklist (ICDSC) are the most valid and reliable delirium monitoring tools in adult ICU patients (A).

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**Strategies to Boost Delirium Recognition in the ICU**

- Sedation assessment (i.e., SAS or RASS) should be occurring regularly and reliably
- Need buy-in from both nurse and physician managers
- Education
  - Both didactic (e.g., classroom/web) and bedside
  - Both nurses and pharmacists can deliver this education
- Deliver education to all nurses (i.e., both day and night shift), physicians, and pharmacists
- Ensure that clinicians are comfortable with “not being able to evaluate” components of delirium at certain times
- Documentation of delirium evaluation
- Mandatory discussion of delirium evaluation during daily rounds

*SAS=Sedation-Agitation Scale
RASS=Richmond Agitation-Sedation Scale

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**Early Mobilization**

Return to independent functional status at d/c
- 59% in intervention group
- 35% in control group (p=0.02)

Early Mobility Study Results

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Intervention (n=49)</th>
<th>Control (n=50)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functionally independent at discharge</td>
<td>29 (59%)</td>
<td>19 (35%)</td>
<td>0.02</td>
</tr>
<tr>
<td>ICU delirium (days)</td>
<td>2.0 (0.0-6.0)</td>
<td>4.0 (2.0-7.0)</td>
<td>0.03</td>
</tr>
<tr>
<td>Time in ICU with delirium (%)</td>
<td>33 (0-58)</td>
<td>57 (33-69)</td>
<td>0.02</td>
</tr>
<tr>
<td>Hospital delirium (days)</td>
<td>2.0 (0.0-6.0)</td>
<td>4.0 (2.0-8.0)</td>
<td>0.02</td>
</tr>
<tr>
<td>Barthel index score at discharge</td>
<td>75 (7.5-95)</td>
<td>55 (0-85)</td>
<td>0.05</td>
</tr>
<tr>
<td>ICU-acquired paresis at discharge</td>
<td>15 (31%)</td>
<td>27 (49%)</td>
<td>0.09</td>
</tr>
<tr>
<td>Ventilator-free days</td>
<td>23.5 (4.5-23.8)</td>
<td>21.1 (0-23.8)</td>
<td>0.08</td>
</tr>
<tr>
<td>Length of stay in ICU (days)</td>
<td>5.9 (4.5-13.2)</td>
<td>7.9 (6.1-12.9)</td>
<td>0.08</td>
</tr>
<tr>
<td>Length of stay in hospital (days)</td>
<td>13.5 (8.0-23.1)</td>
<td>12.9 (9.9-19.8)</td>
<td>0.93</td>
</tr>
<tr>
<td>Hospital mortality</td>
<td>9 (18%)</td>
<td>14 (25%)</td>
<td>0.53</td>
</tr>
</tbody>
</table>


Question: Should a non-pharmacological delirium protocol in the ICU be used to reduce the incidence or duration of delirium? (actionable)

Answer: We recommend that early mobilization of adult ICU patients be performed whenever feasible to reduce the incidence and duration of delirium (+1B).

Which of the following is MOST true about the role of antipsychotic therapy for either the prevention or treatment of delirium in the ICU?

- Haloperidol is approved by the FDA for the treatment of delirium in the ICU.
- Quetiapine has been shown in one randomized, controlled trial to prevent delirium in the ICU.
- Neither of the above.

Question: Should haloperidol or atypical antipsychotics be used prophylactically to prevent delirium in ICU patients? (actionable)

Answer: We do not suggest that either haloperidol or atypical antipsychotics be administered to prevent delirium in adult ICU patients (-2C).

Haloperidol: A Sigma-1 Receptor Antagonist

- The Sigma-1 ligand PPBP protects the brain from ischemia.
- Haloperidol is a Sigma-1 receptor antagonist.
- Low dose haloperidol (0.05 mg/kg) when administered after an induced transient cerebral artery occlusion in rats decreased ischemic lesion volume by 50%.
- Assuming that delirium is mediated by a diffuse, low-level ischemia, associated with critical illness, this Sigma-1 receptor antagonism may be an important mechanism by which haloperidol may prevent delirium in the critically ill.


<table>
<thead>
<tr>
<th></th>
<th>Haloperidol (n=229)</th>
<th>Placebo (n=228)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>74.0 ± 5.8</td>
<td>74.9 ± 7.0</td>
<td>0.50</td>
</tr>
<tr>
<td>APACHE 2</td>
<td>8.7 ± 3.0</td>
<td>8.6 ± 2.8</td>
<td>0.58</td>
</tr>
<tr>
<td>Intubated (%)</td>
<td>78.6</td>
<td>77.6</td>
<td>0.80</td>
</tr>
</tbody>
</table>

**SEDCOM Trial: Delirium Resolution**

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Dexmedetomidine (n = 152)</th>
<th>Morphine (n = 147)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with delirium, n(%)</td>
<td>13 (8.6)</td>
<td>22 (15.0)</td>
<td>0.088</td>
</tr>
<tr>
<td>Delirium days, median (IQR)</td>
<td>2 [1-7]</td>
<td>5 [2-12]</td>
<td>0.031</td>
</tr>
<tr>
<td>Patients with IABP and delirium, n(%)</td>
<td>3/20 (15)</td>
<td>9/25 (36)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

IABP = intraaortic balloon pump

**Use of Antipsychotic Therapy to Treat Delirium Remains High in American ICUs**

<table>
<thead>
<tr>
<th>Year</th>
<th>Antipsychotics</th>
<th>Benzodiazepines</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>634</td>
<td>201</td>
</tr>
<tr>
<td>2007</td>
<td>691</td>
<td>154</td>
</tr>
</tbody>
</table>

**Question:** Should dexmedetomidine be used prophylactically to prevent delirium in ICU patients? (actionable)

**Answer:** We provide no recommendation for the use of dexmedetomidine to prevent delirium in adult ICU patients, as there is no compelling evidence regarding its effectiveness in these patients (0,C).

**Question:** For mechanically ventilated, adult ICU patients with delirium who require continuous IV infusions of sedative medications, is dexmedetomidine preferred over benzodiazepines to reduce the duration of delirium? (actionable)

**Answer:** We suggest that in adult ICU patients with delirium which is not related to either alcohol or benzodiazepine withdrawal, continuous intravenous infusions of dexmedetomidine rather than benzodiazepine infusions be administered for sedation in order to reduce the duration of delirium in these patients (+2B).
Efficacy and safety of quetiapine in critically ill patients with delirium: A prospective, multicenter, randomized, double-blind, placebo-controlled pilot study

John W. Devlin, PharmD; R opener J. Roberts, PharmD; Jeffrey J. Fong, PharmD; Yoona S. Park, MD; Richard R. Viner, MD; Nicholas S. Hig, MD; Travis Robtiz, MD; Erin Garavet, MD

- **n=36 (18 quetiapine, 18 placebo) with delirium based on ICDSC assessment**
- **QUETIAPINE 50mg PO/tube bid (max 200mg bid) vs. PLACEBO**
- PRN IV haloperidol could be used to treat agitation in either group
- **Baseline characteristics between groups were similar**
- **Primary Outcome**
  - Time to first resolution of delirium was significantly less with quetiapine 1 day vs 4.5 days (p=0.003)


### Question: Does treatment with haloperidol reduce the duration of delirium in adult ICU patients? (descriptive)

**Answer:** There is no published evidence that treatment with haloperidol reduces the duration of delirium in adult ICU patients (No Evidence).

### Question: Does treatment with atypical antipsychotics reduce the duration of delirium in adult ICU patients? (descriptive)

**Answer:** Atypical antipsychotics may reduce the duration of delirium in adult ICU patients (C).


<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quetiapine (n=18)</th>
<th>Placebo (n=18)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to resolution of delirium (days)</td>
<td>36 (12-87)</td>
<td>120 (60-195)</td>
<td>0.006</td>
</tr>
<tr>
<td>Time spent agitated (SAS ≥ 5) (hours)</td>
<td>6 (0-38)</td>
<td>36 (11-66)</td>
<td>0.02</td>
</tr>
<tr>
<td>Percent of time spent in delirium after ICU discharge</td>
<td>8 (0-6)</td>
<td>14 (0-43)</td>
<td>0.35</td>
</tr>
<tr>
<td>Subject placement after hospital discharge (%)</td>
<td>Home/ rehabilitation facility 89 56</td>
<td>44 0.96</td>
<td>36 (66)</td>
</tr>
</tbody>
</table>
Role of the Pharmacist in Implementing the New Pain, Agitation, and Delirium Guidelines

Gilles L. Fraser, Pharm.D., FCCM
Professor, School of Medicine, Tufts University
Director, PGY2 Critical Care Residency, Maine Medical Center
Outcomes Team Leader, SCCM PAD Guidelines

Learning Objectives
The Pharmacist Will

- Accept a leadership role to create an ICU that is a more humane environment to heal and to die
- Evaluate AND understand the rationale for PAD management recommendations
- Successfully adapt the guidelines to local clinical resources and goals
- Organize a multifaceted interdisciplinary approach to implement adaptation of these guidelines

What We’ve Learned:
Goals for Our ICU Patients

- THEN: Survival and discharge
- NOW: Don’t fix patients and break them at the same time
  - Complications extend beyond hospital discharge
    - Delirium
    - Long-term cognitive impairment
    - PTSD

Gestational Period

- Mouse = 20 days
- Human = 9 months
- Elephant = 22 months
- PAD guidelines = 80 months

2006-13 SCCM Guidelines for the Management of Pain, Agitation, and Delirium

<table>
<thead>
<tr>
<th>Sedation</th>
<th>Analgesia</th>
<th>Delirium</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>J Barr, Chair</td>
<td>K Puntillo, Lead</td>
<td>W Ely, Lead</td>
<td>G Fraser, Lead</td>
</tr>
<tr>
<td>D Fontaine</td>
<td>D Coursin</td>
<td>B Pun</td>
<td>J Dasta</td>
</tr>
<tr>
<td>M Ramsay</td>
<td>C Gelinas</td>
<td>C Sessler</td>
<td>J Davidson</td>
</tr>
<tr>
<td>R Riker</td>
<td>D Herr</td>
<td>Y Skrobik</td>
<td>J Devlin</td>
</tr>
<tr>
<td>B Robinson</td>
<td>A Joffe</td>
<td></td>
<td>JP Kress</td>
</tr>
</tbody>
</table>

2013 PAD Guidelines

- Focus is on the patient, these are NOT sedation guidelines
- 12 pharmacologic recommendations
- Surprises
  - No recommendation on haloperidol
  - Either daily sedation interruption OR careful titration
  - Benzo’s as potential risk for delirium
  - Dexmedetomidine
The Pharmacist’s Role in Implementing the New Pain, Agitation, and Delirium Guidelines in the Critical Care Setting

Yes/No Poll

- Our ICU uses
  - A sedation protocol
  - A behavioral pain scale
  - A delirium screening tool

### Perceived vs. Actual Practice

- Survey 85 ICUs = 24-h practice snapshot
- Sedation protocols used in 50% ICUs
- Sedation interruption reported in 66% ICUs
  - Performed in 36% patients
- Delirium monitoring reported in 25% ICUs
  - Performed in 10% of patients


Ever Feel Like You Are Going in Circles?

### PAD Interdisciplinary Team

![PAD Interdisciplinary Team Diagram](image)

Integrated PAD Management

![Integrated PAD Management Diagram](image)

Changing Practice Behaviors

- Multifaceted approach IS necessary
  - Champions
    - All disciplines should be represented
  - Education
    - A first step to inform and demonstrate relevance
  - Protocols
    - Efficient way to make it easy to do the right thing
  - Point of use reminders
    - For those who need a little help remembering nuances
  - Feedback loops
    - For those needing “encouragement” to do the right thing
Why is This So Important?

- Benefits of implementing guidelines
  - Reduced time on the ventilator and in the ICU
  - Lower rates of ICU complications
  - Improved quality of life after discharge
  - Less delirium and cognitive impairment

Facilitating Knowledge Transfer to the Bedside

- Use clinical practice guideline as a model
- Develop protocols for managing PAD
- Develop “order sets” based on institution specific protocols
- Create “bundles” for implementing essential components of practice guidelines
  - Consider daily rounding pharmacist or quality checklist with these elements
  - Offer real time clinical decision support
  - NOT to WORRY! We’ve got a plan!

Importance of Protocolization

- Brings “best practice” to the bedside
- Limits practice variation
- Reduces delays in management
  - Encourages regular assessment of pain, agitation, delirium
  - Facilitates pharmacologic interventions: drug choice, dosing, titration

Why are Protocols Not Used?

- Potential barriers
  - Nursing acceptance
  - Potential for medical device removal, airway compromise, and patient discomfort
  - ICU patients and protocols are too complex

Complex to Simple: ICU Care Bundles

- Examples: sepsis, central line placement, and now PAD!
- Elements should
  - Be easy to implement and measure
  - Have proven benefit
  - Be supported by sound scientific and clinical reasoning
  - Be relevant across a wide range of patient populations and health-care systems
- Metrics allow caregiver feedback and serve as part of a rapid-cycle change process improvement effort
The Pharmacist’s Role in Implementing the New Pain, Agitation, and Delirium Guidelines in the Critical Care Setting

ICU PAD Bundle Web-based Toolkit

- Educational Tools
  - PowerPoint presentations
  - PAD guideline staff education
  - PAD implementation strategies
- Implementation Tools
  - Instructional videos
  - Early mobility techniques
- Educational Tools
  - Use of pain, sedation, delirium assessment tools
- Implementation Tools
  - Instructional videos
  - Use of pain, sedation, delirium assessment tools

EXAMPLE
SCCM PAD Guidelines
Two-sided "pocket" card

EXAMPLE: Pain Bundle
Stepwise process
Incorporate valid pain monitoring tools
Address analgesia adequacy daily
Implement protocols to prevent and manage pain
Monitor adherence and effectiveness of these protocols
Track performance to understand barriers and identify strategies for improvement

SCCM PAD Bundle
Identify, Manage, Monitor
Available when guidelines are published

Some Things Are Easy
- Job #1 = Patient comfort, patient and caregiver safety, maintenance of oxygenation and perfusion
- Don’t complicate things
  - Avoid deliriogenic drugs
  - Avoid propofol in pancreatitis
  - Avoid morphine in renal disease, etc.
  - Avoid propofol and dexmedetomidine with high dose vasoactive therapy
- Initiate home medications IF and when appropriate

Cure sometimes
Comfort always

Armstrong & Crisp (Turkel)
New Horizons 1994:2:85