Managing Pain, Anxiety and Delirium

REFERENCE

ASSESS EACH SEPARATELY

- Differentiate pain from anxiety from delirium — assess each separately
- Use a quantitative tool for each and be goal-directed in interventions
- Pain, direct: ask the patient; use numeric or visual analog pain scales
- Pain, indirect: vital signs; tools CPOT and NVPS (adult non-verbal pain scale)
- Anxiety: RASS from +4 (violent, dangerous) to -5 (no response, not moving); typical goal 0, alert and calm
- Delirium screen: fluctuating/change in baseline? Inattention (SAVE A HAART, >2 errors)?
- Delirium screen: altered LOC (RASS not 0)? Disorganized thinking (>1 error)?

PREVENT

- Treat causes of pain; minimize procedures and interventions
- Position for comfort; premedicate before procedures; optimize ventilator mode/settings
- Prevent and treat pain to prevent anxiety; provide reassurance; have family present

TREAT — PAIN & ANXIETY

- Non-opiate adjunct: Toradol
- Opiates: Fentanyl, Dilaudid, Ketamine
- Many patients will not require any medications
- Benzodiazepine: Versed; dissociative: Ketamine

TREAT — DELIRIUM

- Use correct language, have family present, mobilize early and aggressively
- Use non-pharmacologic measures before medications where possible
- Stop possible offending medications before adding more agents
- Minimize deliriogenic meds; maintain day-night cycle; avoid restraints, tubes/lines, noise
- Optimize vision, hearing, mobility; meds listed: Haldol (typical), Seroquel (atypical), Melatonin

Take Home Message:

Assess pain, anxiety, and delirium separately with a tool for each — and treat with the lightest effective intervention first.