

Delirium Prevention Bundle

A structured, multicomponent **nonpharmacologic** protocol for the critically ill adult – orientation, sleep, sensory support, early mobility, pain control and light sedation – delivered reliably, every shift, by the whole team.

KEY POINTS

- ✓ Prevention is **multicomponent and nonpharmacologic** – targeting sleep, sensory input, mobility, cognition and modifiable risk.
- ✓ A reliably delivered protocol **cuts delirium incidence and duration**, and shortens ICU stay.
- ✓ No drug is recommended for **routine delirium prophylaxis** in critically ill adults.
- ✓ Family engagement and consistent staff delivery **drive bundle compliance** and outcomes.

Q SCREEN, THEN PREVENT

Assess every patient for delirium at least once per shift with a validated tool – CAM-ICU or ICDSC. Detection and prevention run together.

THE BUNDLE

Nonpharmacologic core components

Nine domains, each pairing the bedside intervention with the reason it works. Deliver them together – the effect is in the bundle, not any single element.



DOMAIN 01

Cognitive orientation & stimulation

- ✓ Reorient to time, place and situation each interaction – visible clock and calendar, staff introductions by name and role.
- ✓ Encourage meaningful conversation and cognitively stimulating activity during the day.

WHY · Minimises confusion and helps maintain cognition through a disorienting admission.



DOMAIN 02

Sleep promotion

- ✓ Maintain a day–night lighting cycle; cluster care to protect overnight rest.
- ✓ Reduce overnight noise, alarms and non-essential procedures; offer earplugs, eye masks or relaxing music.
- ✓ Avoid nocturnal sedatives unless specifically indicated.

WHY · Sleep fragmentation raises delirium risk; earplug and eye-mask protocols lower its prevalence.



DOMAIN 03

Sensory optimization

- ✓ Ensure hearing aids and eyeglasses are present, charged and in use.
- ✓ Correct reversible sensory deficits — clear cerumen, adjust lighting for visual clarity.

WHY · Sensory deprivation is a consistent, correctable delirium trigger.



DOMAIN 04

Early mobility

- ✓ Engage physical and occupational therapy within 48 h when safe.
- ✓ Progress daily along a mobility ladder: passive ROM → sitting → standing → ambulation.

WHY · Counters immobilisation-driven delirium and ICU-acquired weakness.



DOMAIN 05

Medication review

- ✓ Identify and minimise deliriogenic drugs — benzodiazepines, anticholinergics, opioids, high-dose corticosteroids.
- ✓ Substitute less deliriogenic alternatives and deprescribe daily.

WHY · Limits iatrogenic, modifiable contributors to delirium.



DOMAIN 06

Pain control

- ✓ Assess pain regularly with a validated scale — CPOT or BPS.
- ✓ Treat with multimodal, opioid-sparing regimens wherever possible.

WHY • Uncontrolled pain provokes agitation and precipitates delirium.



DOMAIN 07

Hydration, nutrition & elimination

- ✓ Maintain adequate hydration and nutrition.
- ✓ Prevent urinary retention and constipation; review lines and catheters daily.

WHY • Addresses reversible physiologic contributors that commonly tip a patient into delirium.



DOMAIN 08

Family engagement & continuity

- ✓ Welcome family presence at the bedside and on rounds.
- ✓ Educate families on delirium and enlist them in reorientation and comfort.

WHY • Familiar voices reduce fear and provide continuous, trusted reorientation.



DOMAIN 09

Sedation & ventilation practices

- ✓ Target light, protocolised sedation (RASS -1 to 0); reassess the need on every round.
- ✓ Pair daily spontaneous awakening and breathing trials (SAT + SBT).

WHY • Minimises coma days and shortens delirium duration.

PHARMACOLOGIC CONSIDERATIONS

Drugs are not the bundle

No agent is recommended for routine prophylaxis. Where evidence exists, it is narrow — keep prevention nonpharmacologic.



NOT RECOMMENDED FOR PROPHYLAXIS

Haloperidol, atypical antipsychotics, dexmedetomidine, statins and ketamine should **not** be used to prevent delirium in critically ill adults.



POSSIBLE SELECTIVE USE

Nocturnal low-dose dexmedetomidine may reduce delirium in selected post-surgical patients — but the evidence is limited and it is not a routine measure.



INSUFFICIENT EVIDENCE

Melatonin and ramelteon lack sufficient data to recommend for ICU delirium prevention.

IMPLEMENTATION

Make it reliable

1

Build it into the workflow

Deliver the interventions as one structured bundle, embedded in daily ICU rounds and the electronic checklist — not as optional extras.

2

Measure and audit

Track delirium incidence with CAM-ICU and audit bundle compliance shift by shift; feed results back to the team.

3

Sustain it

Keep it alive through team education, nurse-driven implementation and active family partnership.

Educational use only — not a substitute for clinical judgement at the individual-patient level.

Synthesised from SCCM 2018 PADIS guidelines, APA 2023 and current ICU Liberation practice.

ICU REACH · SPREADING KNOWLEDGE