2016 Iatrogenic Delirium Top Ten Checklist

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Use a validated tool to regularly assess patients for delirium.	☐	☐	☐	
Include Richmond Agitation Sedation Scale (RASS)/delirium screening (or a validated agitation scale) in multidisciplinary rounds and hand-off communication.	☐	☐	☐	
Treat pain before agitation using scheduled pain management protocol.	☐	☐	☐	
Avoid using benzodiazepines in patients at high risk for delirium.	☐	☐	☐	
Administer sedation using a goal according to a scale such as RASS or Modified Ramsey Score as ordered by a physician.	☐	☐	☐	
Develop a process that ensures daily reduction or removal of sedative.	☐	☐	☐	
Implement an early, progressive mobilization program.	☐	☐	☐	
Provide cognitively stimulating activities multiple times per day and enlist family engagement to provide a calm, familiar environment.	☐	☐	☐	
Implement a non-pharmacological sleep protocol.	☐	☐	☐	
Monitor incident reports for possible cases in which delirium may have been a factor.	☐	☐	☐	

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