ANKARA BILKENT CITY HOSPITAL

ADULT INTENSIVE CARE UNIT SEDATION, ANALGESIA AND DELIRIUM MANAGEMENT GUIDELINE

Document basis	YB.PR.002 Sedation and Analgesia Application Procedure in Intensive Care Units, Revision 03
Guideline version	Institutional operational guideline, Version 1.0
Source revision date	27 March 2026
Evidence alignment date	7 August 2026
Status	Institutional guideline for Ankara Bilkent City Hospital
Recommended review	Within 3 years, or earlier after major evidence, regulatory, formulary, or safety change

Educational and operational guidance. Local approval is required before implementation.

This document does not replace national law, hospital policy, approved medication protocols, product information, or patient-specific clinical judgement.

How to Use This Guideline

PURPOSE OF THIS VERSION

This document converts Ankara Bilkent City Hospital procedure YB.PR.002 into a structured adult ICU operational guideline. The source procedure is preserved as the institutional basis, while recommendations are reorganized around pain-first care, individualized sedation targets, delirium screening, daily awakening and breathing coordination, mobility, sleep, medication safety, and audit. Where current evidence differs from wording in the source procedure, the source-derived item is retained in a clearly identified table or note and the evidence-aligned operational recommendation is stated separately.

Scope. This version is intended for adult intensive care units of Ankara Bilkent City Hospital. Pediatric and neonatal sedation require separate age-specific policies.

Meaning of Requirement Terms

Term	Operational meaning
MUST	Minimum safety, governance, or documentation requirement expected across adult ICUs unless a formally approved exception applies.
SHOULD	Recommended practice expected in most patients or units, with documented clinical reasons when not followed.
MAY	Context-dependent option that can be used according to patient need, local protocol, formulary, and clinician judgement.

IMPORTANT

MUST, SHOULD, and MAY express institutional operational priority. They are not formal GRADE evidence ratings.

Contents

1. Purpose and Scope

Purpose. To provide a consistent institutional approach to pain assessment, analgesia, sedation, agitation, delirium prevention and screening, sleep support, mobility, and related safety monitoring in critically ill adults.

Scope. Adult medical, surgical, cardiac, neurologic, transplant, respiratory, obstetric, and mixed intensive care units of Ankara Bilkent City Hospital, including mechanically ventilated and non-ventilated critically ill adults.

STANDARD 01 MUST	Every adult ICU patient MUST have pain, sedation/arousal, and delirium risk considered as linked domains rather than as separate medication problems.

STANDARD 02 MUST	The clinical team MUST identify and treat reversible causes of pain, agitation, reduced consciousness, or delirium before escalating sedative medication whenever feasible.

STANDARD 03 SHOULD	A patient-specific daily goal SHOULD be documented for pain control, sedation depth, delirium prevention, mobility, sleep, and ventilator liberation when applicable.

2. Guideline Basis and Adaptation Principles

Institutional source. YB.PR.002, Sedation and Analgesia Application Procedure in Intensive Care Units, Revision 03, dated 27 March 2026.

Evidence alignment. The operational wording has been aligned, where appropriate, with the SCCM 2018 PADIS guideline, the SCCM 2025 focused PADIS update, and ICU Liberation implementation resources. Source-procedure thresholds and medication examples are retained where they are important for institutional traceability, but they must be interpreted with current clinical judgement and approved local medication protocols.

LOCAL ADAPTATION PRINCIPLE
This is an Ankara Bilkent City Hospital guideline. “Local adaptation” means adaptation among the hospital’s adult ICU services, formularies, information systems, staffing models, and specialty workflows. It does not imply regional or cross-country implementation.

STANDARD 04 MUST	Each adult ICU MUST use the hospital-approved version of this guideline together with current pharmacy, medication safety, airway, mechanical ventilation, restraint, pain management, and emergency policies.

STANDARD 05 SHOULD	Unit-specific adaptations SHOULD preserve the same safety objectives and assessment frequencies unless a formally approved alternative is documented.

3. Core Principles and Governance

- Analgesia-first care: pain is assessed and treated before sedative escalation whenever possible.
- Goal-directed sedation: each patient has an explicit sedation target that is reassessed as clinical conditions change.
- Light sedation is preferred for most mechanically ventilated adults unless deeper sedation is clinically required.
- Delirium prevention is primarily non-pharmacologic and focuses on modifiable risk factors.
- Daily awakening and ventilator liberation assessments are coordinated whenever not contraindicated.
- Medication selection is individualized according to indication, organ function, hemodynamics, duration, adverse-effect profile, drug interactions, withdrawal risk, and local formulary.
- Family engagement, orientation, sleep protection, mobility, hearing and vision support are integral to delirium prevention and recovery.

STANDARD 06 MUST	Medical and nursing leadership MUST define who sets the sedation target, who documents RASS/SAS and CAM-ICU, how protocol deviations are escalated, and how medication-related adverse events are reviewed.

STANDARD 07 SHOULD	Pharmacy participation SHOULD be available for prolonged infusions, complex organ failure, suspected toxicity, withdrawal risk, or difficult medication transitions.

4. Assessment Before Analgesia or Sedation

STANDARD 08 MUST	Before initiating or increasing sedative medication, the team MUST assess for pain and urgent reversible causes of agitation or altered mental status.

Domain	Examples to assess
Pain	Surgical or traumatic pain, invasive devices, wounds, positioning, procedures, ischemia, distension, immobility.
Respiratory	Hypoxemia, hypercapnia, dyspnea, ventilator dyssynchrony, airway obstruction, secretion burden.
Neurologic	Acute brain injury, seizure, intracranial hypertension, stroke, withdrawal, encephalopathy.
Hemodynamic / metabolic	Shock, anemia, fever, hypoglycemia or hyperglycemia, electrolyte disturbance, acidosis, organ failure.
Environment / communication	Noise, light, sleep disruption, fear, inability to communicate, language barrier, hearing or visual impairment.
Medication / withdrawal	Opioids, benzodiazepines, anticholinergic burden, corticosteroids, substance withdrawal, recent medication changes.

5. Pain Assessment and Analgesia-First Care

STANDARD 09 MUST	Pain MUST be assessed at baseline, at clinically appropriate intervals, before and after potentially painful procedures, and after analgesic interventions.

Preferred assessment approach. Use patient self-report when reliable (for example, a numeric rating scale). In patients unable to self-report, use a validated behavioral tool such as the Critical-Care Pain Observation Tool (CPOT) or Behavioral Pain Scale (BPS) according to the approved local documentation system.

- Analgesic therapy should be titrated to pain response and adverse effects rather than to a fixed sedative target.
- Opioid exposure should be reviewed daily for oversedation, respiratory depression, ileus, delirium risk, immunologic effects, accumulation, and withdrawal.
- Non-opioid or regional analgesic strategies may be incorporated when clinically appropriate and supported by local protocols.

STANDARD 10 SHOULD	Patients whose agitation is plausibly pain-driven SHOULD receive adequate analgesia before adding or increasing sedative infusions.

6. Sedation Targets and Monitoring

STANDARD 11 MUST	A sedation target MUST be prescribed or documented for each patient receiving sedative medication and reviewed at least daily and after major clinical change.

STANDARD 12 MUST	Sedation depth MUST be assessed with a validated or institutionally approved scale at least every 4 hours while continuous sedation is being administered, and more frequently when clinically indicated.

Default target. For most adults, light sedation is preferred. The source procedure uses a RASS target of -2 to +1 and defines light sedation as RASS >= -2.

INSTITUTIONAL SEDATION SCALES
RASS and the locally revised Riker Sedation-Agitation Scale (SAS) are both retained for institutional use. Each ICU should apply the scale adopted in its unit consistently, clearly identify the scale in bedside documentation, and ensure staff are trained in its scoring and interpretation.

6.1 Situations in which deeper sedation may be required

The source procedure lists the following examples. These criteria should prompt individualized consideration of deeper sedation; they are not automatic mandates for a fixed sedation depth.

Source-procedure situation	Source-procedure threshold / description
Traumatic brain injury	Deeper sedation when required for cerebral protection.
Septic shock with high vasoactive support	IV norepinephrine >0.15 mcg/kg/min, or dopamine >15 mcg/kg/min, or epinephrine >0.15 mcg/kg/min.
ARDS requiring mandatory ventilator support	FiO2 >0.60 and PEEP >12 cm H2O.
Tetanus	Deeper sedation may be required according to clinical severity and ventilatory needs.

STANDARD 13 MUST	When deep sedation is used, the indication, target depth, expected duration, and daily reassessment plan MUST be documented.

7. Sedative and Analgesic Medication Principles

General selection. The source procedure prioritizes non-benzodiazepine sedation with propofol or dexmedetomidine. Current SCCM guidance supports non-benzodiazepine approaches and, when light sedation and/or delirium reduction are high priorities in mechanically ventilated adults, conditionally favors dexmedetomidine over propofol.

STANDARD 14 SHOULD	Propofol or dexmedetomidine SHOULD generally be preferred to continuous benzodiazepine sedation when clinically appropriate; agent selection must account for hemodynamics, organ function, indication, target depth, expected duration, and adverse effects.

- Dexmedetomidine: monitor for bradycardia and hypotension; reduce or stop infusion when clinically significant adverse effects occur.
- Propofol: monitor for hypotension, hypertriglyceridemia where relevant, metabolic acidosis, rhabdomyolysis, cardiac dysfunction, and other features concerning for propofol infusion syndrome during prolonged or high-dose therapy.
- Benzodiazepines: avoid abrupt discontinuation after prolonged or high-dose exposure. The source procedure recommends tapering by approximately 10-30% per day when withdrawal risk is present; the actual taper must be individualized and approved by the treating team.
- Opioids: morphine, fentanyl, remifentanil, and tramadol are listed in the source procedure as analgesic options; selection and dosing must follow current hospital formulary and organ-function considerations.
- The source procedure notes remifentanil as an option in patients with renal or hepatic failure-associated encephalopathy; this should be considered only within an approved analgesia/sedation plan.

STANDARD 15 MUST	Continuous sedative and opioid infusions MUST have documented indication, target, current dose, adverse-effect monitoring, and a daily plan for continuation, reduction, interruption, or transition.

8. Daily Spontaneous Awakening and Breathing Coordination

STANDARD 16 SHOULD	Except when contraindicated by the clinical condition or sedation indication, continuous sedative infusions SHOULD be interrupted or actively reduced each day to assess neurologic status and readiness for lighter sedation.

Source-procedure operational detail. The original algorithm specifies a morning sedation interruption at 08:00 when not contraindicated. For implementation, each ICU may use the same time or another standardized morning workflow as long as responsibility and documentation are clear.

- During a spontaneous awakening trial (SAT), continue necessary analgesia and monitor for pain, agitation, respiratory distress, hemodynamic instability, and neurologic deterioration.
- If sedation must be restarted, the source algorithm recommends restarting at approximately 50% of the prior infusion dose when clinically indicated, followed by titration to the prescribed target.
- For mechanically ventilated patients, coordinate SAT and spontaneous breathing trial (SBT) eligibility whenever feasible.

STANDARD 17 MUST	A contraindication to SAT or SBT MUST be documented rather than assumed from the presence of mechanical ventilation alone.

9. Neuromuscular Blockade and Awareness Prevention

STANDARD 18 MUST	Patients receiving neuromuscular blocking agents MUST receive adequate analgesia and sedation before paralysis and throughout the period of neuromuscular blockade.

- Sedation depth cannot be inferred from motor response during paralysis.
- Use clinical context and, when available and appropriate, objective brain-function monitoring as an adjunct in patients receiving neuromuscular blockade.
- Review the continuing need for paralysis and deep sedation at least daily and whenever ventilatory or neurologic goals change.

10. Delirium Screening and Diagnosis

STANDARD 19 MUST	Eligible adult ICU patients MUST be screened for delirium with an approved validated instrument such as CAM-ICU at least every 8 hours or once per nursing shift, according to the institutional documentation workflow.

Eligibility in the source procedure. CAM-ICU screening is performed when the patient is sufficiently arousable: RASS > -3 or locally revised SAS > -2.

- Delirium is acute and fluctuating; a single negative screen does not exclude later delirium.
- Hypoactive delirium is easily missed without routine screening.
- Positive screening should trigger assessment for causes rather than immediate reflex prescribing.

STANDARD 20 MUST	A positive delirium screen MUST prompt review of hypoxemia, hypercapnia, infection, shock, metabolic disturbance, pain, urinary retention or constipation, withdrawal, medication effects, sleep disruption, sensory impairment, and neurologic disease as clinically relevant.

11. Delirium Prevention and Management

Risk factors listed in the source procedure include benzodiazepine exposure, blood transfusion, advanced age, dementia, pre-coma, emergency surgery before ICU admission, trauma, and high ASA or APACHE scores.

STANDARD 21 SHOULD	Delirium prevention SHOULD use a multicomponent non-pharmacologic strategy that reduces modifiable risk factors and supports cognition, sleep, mobility, hearing, and vision.

- Avoid unnecessary deep sedation and minimize deliriogenic medication exposure.
- Reorient the patient to time, place, situation, and care plan; involve family when appropriate.
- Use glasses and hearing aids when available.
- Promote daytime wakefulness and early mobilization while protecting nighttime sleep.
- Reduce unnecessary catheters, restraints, alarms, noise, and nighttime interruptions.
- Correct hypoxemia, hypercapnia, acidosis, hemodynamic instability, infection, metabolic disturbance, and withdrawal syndromes.

Antipsychotics. The source procedure lists haloperidol, chlorpromazine, risperidone, olanzapine, and quetiapine as treatment options. The 2025 SCCM focused update found insufficient evidence to recommend for or against antipsychotics for delirium treatment. They should therefore not be used routinely for prevention, and any short-term use for severe distress or dangerous agitation should follow physician assessment, correction of reversible causes, ECG/QT and electrolyte review, drug-interaction assessment, and local medication policy.

Dexmedetomidine. It may be considered when agitation or delirium is preventing ventilator weaning or extubation, consistent with SCCM guidance and the source procedure.

STANDARD 22 MUST	Medication used for delirium-related agitation MUST have a documented indication, planned duration, safety monitoring, and reassessment for discontinuation.

12. Sleep, Environment, and Family Support

STANDARD 23 SHOULD	The ICU SHOULD protect normal sleep-wake cues and reduce avoidable nighttime light, noise, alarms, and care interruptions.

- Cluster non-urgent nighttime care when clinically safe.
- Maintain daytime orientation with natural light, communication, activity, and family engagement.
- Avoid using routine nighttime sedation as a substitute for sleep promotion.
- Melatonin may be considered according to patient factors and local medication policy; the 2025 SCCM focused update conditionally supports its use in adult ICU patients.
- Explain sedation and delirium to family members so that they can support orientation and report baseline cognition or new changes.

13. Early Mobility, Devices, and Restraint Minimization

STANDARD 24 SHOULD	Eligible patients SHOULD receive early and progressively enhanced mobilization or rehabilitation, with safety screening appropriate to their cardiovascular, respiratory, neurologic, and device status.

- Review whether catheters, lines, tubes, and physical restraints remain necessary each day.
- Use the least restrictive approach required for immediate safety and document the indication and reassessment plan.
- Agitation caused by pain, urinary retention, hypoxia, delirium, or communication barriers should be treated at the cause rather than managed solely with restraint or sedative escalation.

14. Special Clinical Situations

Situation	Operational considerations
Postoperative short-term ventilation	Some patients may require analgesia without continuous sedation. Reassess rapidly for wakefulness, pain control, and extubation readiness.
Acute brain injury / cerebral protection	Sedation target may need to be deeper and individualized to intracranial physiology, seizure control, ventilatory goals, and neurologic assessment needs.
Septic shock with high vasoactive support	The source procedure identifies high vasoactive thresholds as a situation in which deeper sedation may be used. Reassess sedation as perfusion stabilizes.
ARDS with high ventilatory support	The source procedure identifies FiO2 >0.60 with PEEP >12 cm H2O as a situation that may require deeper sedation. Reassess when oxygenation and synchrony improve.
Tetanus	Sedation and analgesia may need to be deeper and prolonged; autonomic instability and neuromuscular control require specialist management.
Renal or hepatic dysfunction	Select medications and active metabolites carefully; monitor accumulation, encephalopathy, hemodynamics, and withdrawal risk.

15. Documentation, Handover, and Safety Monitoring

STANDARD 25 MUST	Each shift handover MUST include pain control, current sedation target and score, delirium status, SAT/SBT status, current analgesic and sedative infusions, recent dose changes, adverse effects, withdrawal risk, mobility goal, and relevant restraints or devices.

- Document RASS or approved SAS at least every 4 hours during continuous sedation.
- Document CAM-ICU at least every 8 hours / nursing shift in eligible patients.
- Record reasons for deep sedation, SAT/SBT contraindication, or inability to assess delirium.
- Monitor for hypotension, bradycardia, respiratory depression, ileus, prolonged coma, unplanned device removal, withdrawal, QT prolongation when relevant, and suspected propofol infusion syndrome.
- Medication errors, oversedation events, unplanned extubations, self-extubations, and serious adverse drug reactions should enter the hospital safety-reporting and review pathway.

16. Quality Indicators and Audit

Indicator	Suggested measure
Sedation target documented	Percentage of sedated ICU patient-days with a documented target.
Sedation assessment compliance	Percentage of required 4-hour assessments completed with RASS/approved SAS.
Delirium screening compliance	Percentage of eligible shifts with CAM-ICU documented.
Deep sedation exposure	Patient-days with RASS -3 to -5 without a documented deep-sedation indication.
SAT documentation	Percentage of eligible ventilated patient-days with SAT completed or contraindication documented.
SAT-SBT coordination	Percentage of eligible ventilated patient-days with coordinated awakening and breathing assessment.

Indicator	Suggested measure
Benzodiazepine exposure	Continuous benzodiazepine sedation days and proportion with documented specific indication.
Delirium burden	Delirium-positive patient-days / eligible patient-days.
Restraint exposure	Physical restraint patient-days per 100 ICU patient-days.
Mobility	Percentage of eligible patient-days with a documented mobility goal and achieved mobility level.
Sedation-related adverse events	Hypotension/bradycardia requiring therapy, suspected PRIS, severe withdrawal, unplanned extubation, or other locally defined events.

Audit use. Indicators should be interpreted as improvement signals. A missed target or adverse event should trigger system review, not automatic individual blame.

17. Implementation and Local Adaptation

Institutional scope. This guideline is intended for implementation within the adult intensive care units of Ankara Bilkent City Hospital. Adaptation may reflect specialty population, approved medication formulary, monitoring technology, and electronic documentation, while preserving the safety requirements in this guideline.

17.1 Recommended institutional implementation process

1. Appoint medical, nursing, pharmacy, quality, and information-system leads for the sedation-analgesia-delirium pathway.
2. **Standardize sedation assessment using RASS and/or the locally revised Riker Sedation-Agitation Scale (SAS), according to unit practice. The selected scale must be clearly identified, consistently documented, and understood by all staff.**
3. Embed pain, RASS/SAS, CAM-ICU, SAT, SBT, mobility, and restraint fields in routine bedside documentation.
4. Link sedative and analgesic medications to approved dosing, monitoring, tapering, and adverse-event protocols.
5. Train staff using Appendix A and case-based scenarios for pain-driven agitation, deep-sedation indications, delirium, withdrawal, neuromuscular blockade, and ventilator liberation.
6. Pilot the workflow, review compliance and adverse events, and revise before final institutional approval.
7. Review selected quality indicators at 3, 6, and 12 months after implementation and at least annually thereafter.

APPROVAL POINTS TO COMPLETE BEFORE RELEASE
Confirm the hospital-approved RASS/SAS documentation method; approved pain tool(s); medication infusion concentrations and dose limits; propofol monitoring; benzodiazepine/opioid taper protocols; antipsychotic prescribing safeguards; CAM-ICU documentation form; SAT/SBT safety screens; and the responsible committees for final approval.

Appendix A. Daily ICU Pain-Sedation-Delirium Checklist

Domain	Daily check
Pain	Pain assessed with self-report or validated behavioral tool; analgesia adequate; recent painful procedures reviewed.
Sedation goal	Target RASS / approved SAS documented and appropriate for current indication.
Current depth	Current score compared with target; over- or undersedation addressed.
Medication review	Analgesic and sedative indication, dose, organ function, interactions, adverse effects, and withdrawal risk reviewed.
SAT	Eligible today? If no, contraindication documented. If yes, result and restart plan documented.
SBT	For ventilated patient: coordinated with SAT when eligible; outcome documented.
Delirium	CAM-ICU completed if sufficiently arousable; causes reviewed if positive.
Sleep / orientation	Day-night cues, hearing/vision aids, family orientation, and nighttime disruption reviewed.
Mobility	Mobility goal defined; barriers and devices reviewed.
Restraints / devices	Need for restraints, urinary catheter, lines, drains, and other devices reassessed.
Handover	Target, scores, medication changes, delirium, SAT/SBT, mobility, and safety issues communicated.

Appendix B. Richmond Agitation-Sedation Scale (RASS)

Score	Term	Description
+4	Combative	Overtly combative or violent; immediate danger to staff.
+3	Very agitated	Pulls or removes tubes/catheters; aggressive behavior.
+2	Agitated	Frequent non-purposeful movement or patient-ventilator dyssynchrony.
+1	Restless	Anxious or apprehensive but movements not aggressive or vigorous.
0	Alert and calm	Spontaneously pays attention to caregiver.
-1	Drowsy	Not fully alert; sustained awakening to voice with eye contact >10 seconds.
-2	Light sedation	Briefly awakens to voice with eye contact <10 seconds.
-3	Moderate sedation	Movement or eye opening to voice but no eye contact.
-4	Deep sedation	No response to voice, but movement to physical stimulation.
-5	Unarousable	No response to voice or physical stimulation.

Appendix C. Locally Revised Riker Sedation-Agitation Scale From YB.PR.002

Note: This scale is reproduced from the institutional source procedure for traceability and is retained as an institutional sedation-assessment option. It differs numerically from the conventional 1-7 Riker Sedation-Agitation Scale and should therefore always be clearly identified as the locally revised Riker SAS.

Score	Source-procedure term	Source-procedure description
+3	Agitated and restless	Awake; attempts to pull the endotracheal tube and/or catheters; physical restraint may be required.
+2	Awake but mildly agitated	Anxious and mildly agitated; tries to get up but settles with verbal reassurance.
+1	Arousable to voice and calm	Awakens to verbal stimulus, remains awake, and follows commands.
0	Awake and calm	Awake, calm, and readily follows commands.
-1	Arousable to touch / strong voice	Awakens to strong verbal or tactile stimulus; maintains eye contact for at least 10 seconds and may follow simple commands.
-2	Arousable to painful stimulus	Flexion or localization to pain; no meaningful interaction or command following.
-3	Unarousable	Extension to painful stimulus, minimal response, or no response.

Appendix D. CAM-ICU Operational Summary

Assess only when the patient is sufficiently arousable. The source procedure uses RASS > -3 or local revised SAS > -2 as the eligibility threshold.

Feature	Operational description
Feature 1: Acute change or fluctuating course	Acute change from baseline mental status or fluctuation during the previous 24 hours.
Feature 2: Inattention	Use the approved attention test (for example, letter-recognition testing). More than 2 errors indicates inattention in the source algorithm.
Feature 3: Altered level of consciousness	RASS other than 0 (or corresponding locally approved SAS abnormality).
Feature 4: Disorganized thinking	Use the approved questions/commands; more than 1 error is abnormal in the source algorithm.

CAM-ICU POSITIVE
The operational logic is: Feature 1 AND Feature 2 AND either Feature 3 OR Feature 4. Use the hospital-approved CAM-ICU worksheet or electronic form for the exact bedside assessment sequence.

Appendix E. Source-Procedure Medication and Deep-Sedation Examples

These items are included because they appear in YB.PR.002. They are not universal prescribing instructions. Doses, indications, contraindications, ECG monitoring, organ-function adjustment, and formulary status must be confirmed by Ankara Bilkent City Hospital before clinical use.

E1. Deep-sedation examples from the source procedure

Situation	Source value
Septic shock / high vasoactive support	Norepinephrine >0.15 mcg/kg/min OR dopamine >15 mcg/kg/min OR epinephrine >0.15 mcg/kg/min.
ARDS	FiO2 >0.60 and PEEP >12 cm H2O.
Traumatic brain injury	Deep sedation when required for cerebral protection.
Tetanus	Deep sedation according to clinical requirement.

E2. Delirium medication examples reproduced from YB.PR.002

Drug	Source-procedure example
Haloperidol IV	<60 years: 5-10 mg every 4-6 h; >60 years: 2.5-5 mg every 4-6 h.
Chlorpromazine	12.5-25 mg every 6-8 h.
Risperidone	0.5-1 mg every 12 h.
Dexmedetomidine IV	0.2-1.5 mcg/kg/h, particularly when agitation prevents sedation withdrawal.
Olanzapine	5-10 mg every 12-24 h.
Quetiapine	50-100 mg every 12 or 24 hours. The dosing interval is determined by the treating physician according to the patient's clinical condition, indication, response, tolerability, and overall treatment plan.

QT AND DRUG-SAFETY NOTE

The source procedure warns that, apart from dexmedetomidine, the listed delirium medications may prolong the QT interval. Before any antipsychotic use, review ECG/QT, electrolytes, interacting drugs, contraindications, and the current hospital medication policy. Current SCCM guidance does not support routine antipsychotic treatment for all ICU delirium.

References and Supporting Guidance

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