

# Intensive Care Delirium Screening Checklist (ICDSC)

Screen all patients admitted > 24 hours Q 12 H. Screen during second half of shift.

**Step 1:** Screen for PAIN using Numeric Ratings Scale (able to self-report) or CPOT

**Step 2:** Screen for SEDATION using VAMAAS

**Step 3:** Screen for DELIRIUM using Intensive Care Delirium Screening Checklist (ICDSC).

## **First: Perform Pain Assessment**

- Screen all patient for pain during initial assessment
  - Consider past pain history and medications
  - Obtain self-report of pain as priority
  - If unable to self-report, use Critical Care Pain Observation Tool (CPOT)
- Reassess pain q 4 h and prn (e.g., with turning, procedures or clinical change)
- Reassess pain following administration of analgesia

## **Second: Perform Sedation Assessment**

- Screen all patients using VAMAAS or MAAS (unventilated patient) at the start of each shift
- Repeat VAMAAS q 4 h and before and after each prn dose of sedation

## **Third: Perform Delirium Assessment**

- Screen all patients with admitted for > 24 hours for delirium once per shift
- Screen in second half of shift and document time of assessment in neuro section of AI record
- Delirium screening requires pain, sedation and delirium assessment
- If MAAS is < 2 record “unable to assess” for delirium screen
- If MAAS is  $\geq$  2, screen using Intensive Care Delirium Screening Checklist (ICDSC)

# Intensive Care Delirium Screening Checklist (ICDSC)

Give a score of “1” to each of the 8 items below if the patient clearly meets the criteria defined in the scoring instructions. Give a score of “0” if there is no manifestation *or* unable to score. If the patient scores  $\geq 4$ , notify the physician. The diagnosis of delirium is made following clinical assessment; document in the Assessment and Intervention record (RN) and progress note (MD).

Assessment	Scoring Instructions	Score
1. Altered Level of Consciousness*	<ul style="list-style-type: none"> <li>If MAAS portion of VAMAAS is 0 (no response) or 1 (response to noxious stimulus only), record “U/A” (unable to score) and do not complete remainder of screening tool.</li> <li>Score “0” if MAAS score is 3 (calm, cooperative, interacts with environment without prompting)</li> <li>Score “1” if MAAS score is 2, 4, 5 or 6 (MAAS score of 2 is a patient who only interacts or responds when stimulated by light touch or voice – no spontaneous interaction or movement; 4, 5 and 6 are exaggerated responses).</li> </ul>	
<b>If MAAS <math>\neq</math> 0 or 1, screen items 2-8 and complete a total score of all 8 items.</b>		
2. Inattention	<p>“1” for any of the following:</p> <ul style="list-style-type: none"> <li>Difficulty following conversation or instructions</li> <li>Easily distracted by external stimuli</li> <li>Difficulty in shifting focuses</li> </ul>	
3. Disorientation	<p>“1” for any obvious mistake in person, place or time</p>	
4. Hallucination/ delusions/ psychosis	<p>“1” for any one of the following:</p> <ul style="list-style-type: none"> <li>Unequivocal manifestation of hallucinations or of behaviour probably due to hallucinations (e.g. catching non-existent object)</li> <li>Delusions</li> <li>Gross impairment in reality testing</li> </ul>	
5. Psychomotor agitation or retardation	<p>“1” for any of the following:</p> <ul style="list-style-type: none"> <li>Hyperactivity requiring additional sedatives or restraints in order to control potential dangerousness (e.g. pulling out IV lines, hitting staff)</li> <li>Hypoactivity or clinically noticeable psychomotor slowing. Differs from depression by fluctuation in consciousness and inattention.</li> </ul>	
6. Inappropriate speech or mood	<p>“1” for any of the following (score 0 if unable to assess):</p> <ul style="list-style-type: none"> <li>Inappropriate, disorganized or incoherent speech.</li> <li>Inappropriate display of emotion related to events or situation.</li> </ul>	
7. Sleep wake/cycle disturbance	<p>“1” for any of the following:</p> <ul style="list-style-type: none"> <li>Sleeping less than 4 hours or waking frequently at night (do not consider wakefulness initiated by medical staff or loud environment).</li> <li>Sleeping during most of day.</li> </ul>	
8. Symptom fluctuation	<p>“1” for fluctuation of the manifestation of any item or symptom over 24 hours (e.g., from one shift to another).</p>	
<b>TOTAL SCORE (0-8/8):</b>	<p>A score <math>\geq 4</math> suggests delirium. A score <math>&gt; 4</math> is not indicative of the severity of the delirium.</p>	

Adapted with permission (Skrobik, Y)  
Bergeon, et al, 2001, Intensive Care Medicine

# CAM ICU

The CAM ICU is a tool that may be used if you think that the ICDSC may be under or over scoring a patient. This tool may be most useful for patients with hypoactive delirium.

Feature 1: Acute Onset or Fluctuating Course	Score	Check here if Present		
<p style="text-align: center;">Is the pt different than his/her baseline mental status? OR</p> <p>Has the patient had any fluctuation in mental status in the past 24 hours as evidenced by fluctuation on a sedation scale (i.e., RASS), GCS, or previous delirium assessment?</p>	Either question Yes →	<input type="checkbox"/>		
Feature 2: Inattention				
<p><b>Letters Attention Test</b> (See training manual for alternate <b>Pictures</b>)</p> <p><i>Directions:</i> Say to the patient, "I am going to read you a series of 10 letters. Whenever you hear the letter 'A,' indicate by squeezing my hand." Read letters from the following letter list in a normal tone 3 seconds apart.</p> <p style="text-align: center;"><b>S A V E A H A A R T</b></p> <p><b>Errors are counted when patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."</b></p>			Number of Errors >2 →	<input type="checkbox"/>
Feature 3: Altered Level of Consciousness				
Present if the Actual RASS score is anything other than alert and calm (zero)	RASS anything other than zero →	<input type="checkbox"/>		
Feature 4: Disorganized Thinking				
<p><b>Yes/No Questions</b> (See training manual for alternate set of questions)</p> <ol style="list-style-type: none"> <li>1. Will a stone float on water?</li> <li>2. Are there fish in the sea?</li> <li>3. Does one pound weigh more than two pounds?</li> <li>4. Can you use a hammer to pound a nail?</li> </ol> <p><b>Errors are counted when the patient incorrectly answers a question.</b></p> <p><b>Command</b> Say to patient: "Hold up this many fingers" (Hold 2 fingers in front of patient) "Now do the same thing with the other hand" (Do not repeat number of fingers) *If pt is unable to move both arms, for 2<sup>nd</sup> part of command ask patient to "Add one more finger"</p> <p><b>An error is counted if patient is unable to complete the entire command.</b></p>			Combined number of errors >1 →	<input type="checkbox"/>
Overall CAM-ICU				
Feature 1 <u>plus</u> 2 <u>and</u> either 3 <u>or</u> 4 present = CAM-ICU positive	Criteria Met →	<input type="checkbox"/> <b>CAM-ICU Positive</b> (Delirium Present)		
	Criteria Not Met →	<input type="checkbox"/> <b>CAM-ICU Negative</b> (No Delirium)		