

Pain, Sedation and Delirium Screening Standards

First: Perform Pain Assessment

- ✓ Assess for pain during initial assessment
 - Consider past pain history and medications
 - Self-report of pain is the 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, clinical change)
- ✓ Reassess pain following administration of prn analgesic or changes in infusion rates

Second: Perform Sedation Assessment

- ✓ Assess using VAMAAS or MAAS (unventilated patient) at the start of each shift
- ✓ Reassess VAMAAS q 4 h and prn (e.g. with changes in LOC, ventilator dysynchrony or agitation)
- ✓ Reassess VAMAAS/MAAS following administration of prn analgesic/sedative or changes in infusion rates

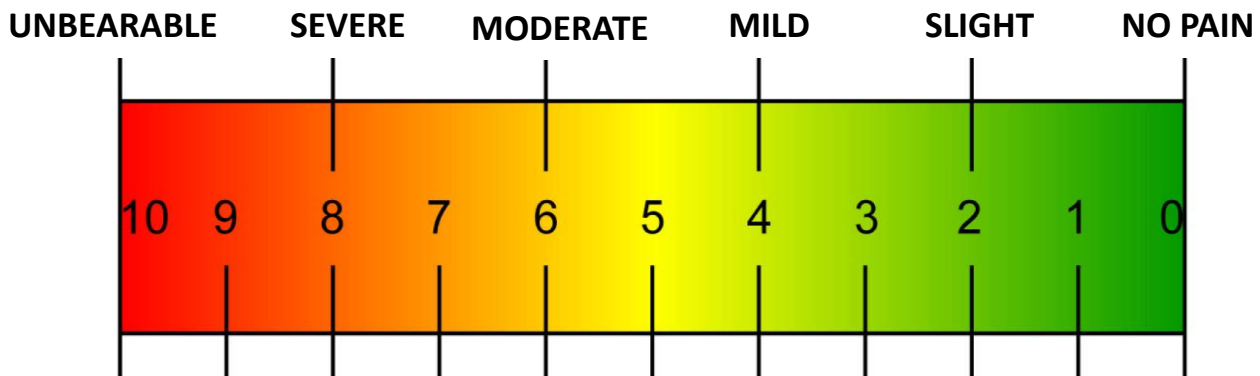
Third: Perform Delirium Assessment

- ✓ Screen all patients 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” and document reason in DAR note
- ✓ If MAAS is \geq 2, screen using Intensive Care Delirium Screening Checklist (ICDSC)

Pain Assessment: Able to Self-Report

An individual's self-report provides is the primary evidence for the determination of pain.

- The numeric (0-10 out of 10) or visual analogue (shown below) should be included in the pain assessment whenever the patient can self-report.
 - The actual score is not as important as the patient's perception of change during reassessment (worse or better).
 - When pain is reported by the patient, the characteristics of the pain should be evaluated using the PQRST mnemonic (next page). This will help to identify the cause of the pain and the most appropriate treatment plan.



Pain Assessment: Able to Self-Report

PQRST Mnemonic for Pain Assessment

P (provokes, precipitates):

- Location of pain
- What brings it on (e.g., activity, specific movement, eating, breathing)?
- What relieves it?

Q (quality):

- What is the quality of the pain (in the patient's own words)?
- Prompt only if necessary, to determine if pain is dull, sharp, stabbing, pins and needles, "electrical", etc.

R (radiation, referral):

- Does the pain move to any other spot?
- Are there any other symptoms with the pain (e.g., nausea, vomiting, shortness of breath)?

S (severity):

- How does the patient rate the severity of the pain on a scale of 1-10?

T (time):

- When did the pain start?
- Has this pain occurred before?
- Is the pain intermittent or constant?

Pain Assessment: Unable to Self-Report Critical-Care Pain Observation Tool (CPOT)

Score each item 0, 1 or 2 out of 2. Total the sum of the four items to
produce a CPOT score of 0-8/8

Indicator	Assessment	Score	Description
Facial Expression (score 0, 1 or 2)	Relaxed, Neutral	0	<ul style="list-style-type: none"> No muscle tension observed
	Tense	1	<ul style="list-style-type: none"> Presence of frowning, brow lowering, orbit tightening or contraction of upper eyelid; or, Any other change (e.g., opening eyes or tearing during noxious procedures)
	Grimacing	2	<ul style="list-style-type: none"> All above facial movements plus eyelids tightly closed (may present with mouth open or biting ETT)
Body Movement (score 0, 1 or 2)	Absence of movement/normal position	0	<ul style="list-style-type: none"> Does not move at all (doesn't necessarily mean absence of pain); or, normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection	1	<ul style="list-style-type: none"> Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness	2	<ul style="list-style-type: none"> Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Ventilator Compliance (ventilated patient) OR Vocalization (non-intubated) (score 0, 1 or 2)	Tolerating ventilator or movement; <i>or, talking in normal tone or no verbal sound</i>	0	<ul style="list-style-type: none"> Alarms not activated, easy ventilation; or, <i>Talking in normal tone or no sound</i>
	Coughing but tolerating ventilator; <i>or, sighing or moaning</i>	1	<ul style="list-style-type: none"> Coughing, alarms may be activated but stop spontaneously; or, <i>Sighing, moaning</i>
	Fighting ventilator; <i>or, crying out or sobbing</i>	2	<ul style="list-style-type: none"> Asynchrony, blocking ventilator, alarms frequently activated; or, <i>Crying out, sobbing</i>
Muscle Tension (evaluate by passive flexion and extension of upper limbs when patient is at rest or during turning) (score 0, 1 or 2)	Relaxed	0	<ul style="list-style-type: none"> No resistance to passive movements
	Tense, rigid	1	<ul style="list-style-type: none"> Resistance to passive movements
	Very Tense or rigid	2	<ul style="list-style-type: none"> Strong resistance to passive movements, incapacity to complete them
TOTAL SCORE		<u> </u> /8	Sum of scores from each of the 4 categories.

Sedation Assessment: VAMAAS

Ventilator Adjusted: Motor Activity Assessment Scale

For unventilated patients, score MAAS only. If MAAS ≥ 2 , screen for delirium.

MAAS Score	Description of MAAS	VA Score	Description of VA
0	Unresponsive to pain Does not move to noxious stimulus.	A	Minimal coughing; few alarms; tolerates movement
1	Opens eyes and/or moves to pain only Opens eyes OR raises eyebrows OR turns head towards stimulus OR moves limbs with noxious stimulus.	B	Coughing, frequent alarms when stimulated; settles with voice or removal of stimulus
2	Opens eyes and/or moves to voice Opens eyes OR raises eyebrows OR turns head towards stimulus OR moves limbs when touched or name is spoken.	C	Distressed, frequent coughing or alarms; high RR with normal/ low PaCO ₂
3	Calm and cooperative No external stimulus is required to elicit movement AND patient is adjusting sheets or clothes purposefully and follows commands.	D	Unable to control ventilation; difficulty delivering volumes; prolonged coughing
4	Restless but cooperative; follows commands No external stimulus is required to elicit movement AND patient is picking at sheets or tubes OR uncovering self & follows commands		
5	Agitated; attempts to get out of bed; may stop behaviour when requested but reverts back No external stimulus is required to elicit movement AND patient is attempting to sit up OR moves limbs out of bed AND does not consistently follow commands (e.g. will lie down when asked but soon reverts back to the attempts to sit up or move limbs out of bed).		
6	Dangerously agitated; pulling at tubes or lines, thrashing about; does not obey commands No external stimulus is required to elicit movement AND patient is attempting to sit up OR thrashing side to side OR striking staff OR trying to climb out of bed AND doesn't calm down when asked.		

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 ≥ 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"> • 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. • Score “0” if MAAS score is 3 (calm, cooperative, interacts with environment without prompting) • 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). 	
If MAAS \neq 0 or 1, screen items 2-8 and complete a total score of all 8 items.		
2. Inattention	<p>“1” for any of the following:</p> <ul style="list-style-type: none"> • Difficulty following conversation or instructions • Easily distracted by external stimuli • Difficulty in shifting focuses 	
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"> • Unequivocal manifestation of hallucinations or of behaviour probably due to hallucinations (e.g. catching non-existent object) • Delusions • Gross impairment in reality testing 	
5. Psychomotor agitation or retardation	<p>“1” for any of the following:</p> <ul style="list-style-type: none"> • Hyperactivity requiring additional sedatives or restraints in order to control potential dangerousness (e.g. pulling out IV lines, hitting staff) • Hypoactivity or clinically noticeable psychomotor slowing. Differs from depression by fluctuation in consciousness and inattention. 	
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"> • Inappropriate, disorganized or incoherent speech. • Inappropriate display of emotion related to events or situation. 	
7. Sleep wake/cycle disturbance	<p>“1” for any of the following:</p> <ul style="list-style-type: none"> • Sleeping less than 4 hours or waking frequently at night (do not consider wakefulness initiated by medical staff or loud environment). • Sleeping during most of day. 	
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>	
TOTAL SCORE (0-8/8):	<p>A score ≥ 4 suggests delirium. A score > 4 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
Is the pt different than his/her baseline mental status? OR 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?	Either question Yes →	<input type="checkbox"/>
Feature 2: Inattention		
Letters Attention Test (See training manual for alternate Pictures)		
Directions: 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. S A V E A H A A R T Errors are counted when patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."	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		
Yes/No Questions (See training manual for alternate set of questions)		
1. Will a stone float on water? 2. Are there fish in the sea? 3. Does one pound weigh more than two pounds? 4. Can you use a hammer to pound a nail? Errors are counted when the patient incorrectly answers a question. Command 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 nd part of command ask patient to "Add one more finger" An error is counted if patient is unable to complete the entire command.	Combined number of errors >1→	<input type="checkbox"/>
Overall CAM-ICU	Criteria Met →	<input type="checkbox"/> CAM-ICU Positive (Delirium Present)
Feature 1 <u>plus</u> 2 <u>and</u> either 3 <u>or</u> 4 present = CAM-ICU positive	Criteria Not Met →	<input type="checkbox"/> CAM-ICU Negative (No Delirium)