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 ≥ 2, screen using Intensive Care Delirium Screening Checklist (ICDSC)

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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).

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Scoring Instructions</th>
<th>Score</th>
</tr>
</thead>
</table>
| 1. Altered Level of Consciousness*             | • 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). |       |
| 2. Inattention                                  | “1” for any of the following:                                                                                                                        |       |
|                                                | • Difficulty following conversation or instructions  
  • Easily distracted by external stimuli  
  • Difficulty in shifting focuses                                                                                                                                                        |       |
| 3. Disorientation                               | “1” for any obvious mistake in person, place or time                                                                                                   |       |
| 4. Hallucination/delusions/psychosis           | “1” for any one of the following:                                                                                                                   |       |
|                                                | • 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        | “1” for any of the following:                                                                                                                        |       |
|                                                | • 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                 | “1” for any of the following (score 0 if unable to assess):                                                                                           |       |
|                                                | • Inappropriate, disorganized or incoherent speech.  
  • Inappropriate display of emotion related to events or situation                                                                                                                       |       |
| 7. Sleep wake/cycle disturbance                 | “1” for any of the following:                                                                                                                        |       |
|                                                | • 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                         | “1” for fluctuation of the manifestation of any item or symptom over 24 hours (e.g., from one shift to another).                                                                                         |       |
| TOTAL SCORE (0-8/8):                            | A score ≥ 4 suggests delirium. A score > 4 is not indicative of the severity of the delirium.                                                        |       |

Adapted with permission (Skrobik, Y) 
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**

<table>
<thead>
<tr>
<th>Score</th>
<th>Check here if Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Either question Yes →</td>
<td>□</td>
</tr>
</tbody>
</table>

**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 | 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.”

**Feature 3: Altered Level of Consciousness**

<table>
<thead>
<tr>
<th>Score</th>
<th>Check here if Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>RASS anything other than zero →</td>
<td>□</td>
</tr>
</tbody>
</table>

**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 2nd part of command ask patient to “Add one more finger”*

  - An error is counted if patient is unable to complete the entire command.

**Overall CAM-ICU**

<table>
<thead>
<tr>
<th>Criteria Met →</th>
<th>CAM-ICU Positive (Delirium Present)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria Not Met →</td>
<td>CAM-ICU Negative (No Delirium)</td>
</tr>
</tbody>
</table>

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