Pain, Agitation and Delirium (PAD) 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 while awake and prn (e.g., with turning, procedures, clinical change)
- ✓ Reassess pain following administration of prn analgesic or changes in infusion rates

Second: Perform Agitation Assessment

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

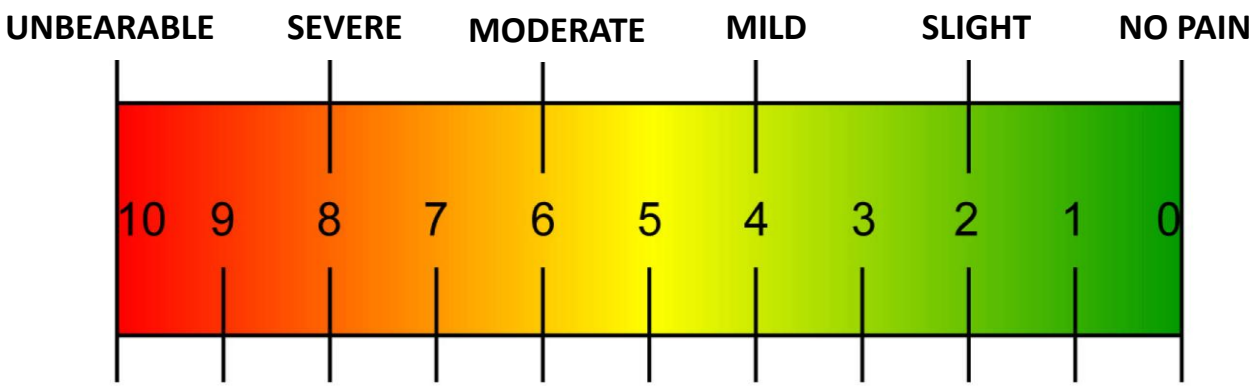
Third: Perform Delirium Assessment

- ✓ Screen all patients admitted for > 24 hours for delirium once per shift
- ✓ Screen and document results during second half of shift
- ✓ Delirium screening requires pain, sedation and delirium assessment
- ✓ If MAAS is < 2 record “unable to assess” for delirium screen; document whether due to sedation or neurological abnormality
- ✓ 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. This is the **S**everity component of the PQR**S**T.

- 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	• No muscle tension observed
	Tense	1	• 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	• 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	• 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	• Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness	2	• 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; *or, talking in normal tone or no verbal sound*	0	• Alarms not activated, easy ventilation; or, *Talking in normal tone or no sound*
	Coughing but tolerating ventilator; *or, sighing or moaning*	1	• Coughing, alarms may be activated but stop spontaneously; or, *Sighing, moaning*
	Fighting ventilator; or, *crying out or sobbing*	2	• Asynchrony, blocking ventilator, alarms frequently activated; or, *Crying out, sobbing*
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	• No resistance to passive movements
	Tense, rigid	1	• Resistance to passive movements
	Very Tense or rigid	2	• Strong resistance to passive movements, incapacity to complete them
TOTAL SCORE		**__/8**	Sum of scores from each of the 4 categories.

Agitation 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 PaCO2
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.		

Last reviewed July 8, 2025 (BM)

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 or MAAS

Step 3: Screen for DELIRIUM using Intensive Care Delirium Screening Checklist (ICDSC). CAM ICU can be used as an alternate.

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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).

Assessment	Scoring Instructions	Score
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).	
If MAAS ≠ 0 or 1, screen items 2-8 and complete a total score of all 8 items.		
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.	

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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 →	☐
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 →	☐
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 →	☐
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.**	Combined number of errors >1→	☐

Overall CAM-ICU		
Feature 1 plus 2 and either 3 or 4 present = CAM-ICU positive	**Criteria Met →**	☐ **CAM-ICU Positive** (Delirium Present)
	Criteria Not Met →	☐ **CAM-ICU Negative** (No Delirium)

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