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)

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.	

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

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