

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