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).

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<tr>
<th>Assessment</th>
<th>Scoring Instructions</th>
<th>Score</th>
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</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). 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)  

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