

Intensive Care Delirium Screening Checklist Worksheet (ICDSC)

- Score your patient over the entire shift. Components don't all need to be present at the same time.
- Components #1 through #4 require a focused bedside patient assessment. This cannot be completed when the patient is deeply sedated or comatose (ie. SAS = 1 or 2; RASS = -4 or -5).
- Components #5 through #8 are based on observations throughout the entire shift. Information from the prior 24 hrs (ie, from prior 1-2 nursing shifts) should be obtained for components #7 and #8.

1. Altered Level of Consciousness	NO	0	1 Yes
Deep sedation/coma over entire shift [SAS= 1, 2; RASS = -4,-5]			= Not assessable
Agitation [SAS = 5, 6, or 7; RASS= 1-4] at any point			= 1 point
Normal wakefulness [SAS = 4; RASS = 0] over the entire shift			= 0 points
Light sedation [SAS = 3; RASS= -1, -2, -3]:			= 1 point (if no recent sedatives) = 0 points (if recent sedatives)
2. Inattention	NO	0	1 Yes
Difficulty following instructions or conversation, patient easily distracted by external stimuli. Will not reliably squeeze hands to spoken letter A: S A V E A H A A R T			
3. Disorientation	NO	0	1 Yes
In addition to name, place, and date, does the patient recognize ICU caregivers? Does patient know what kind of place they are in? (list examples: dentist's office, home, work, hospital)			
4. Hallucination, delusion, or psychosis	NO	0	1 Yes
Ask the patient if they are having hallucinations or delusions. (e.g. trying to catch an object that isn't there). Are they afraid of the people or things around them?			
5. Psychomotor agitation or retardation	NO	0	1 Yes
Either: a) Hyperactivity requiring the use of sedative drugs or restraints in order to control potentially dangerous behavior (e.g. pulling IV lines out or hitting staff) OR b) Hypoactive or clinically noticeable psychomotor slowing or retardation			
6. Inappropriate speech or mood	NO	0	1 Yes
Patient displays: inappropriate emotion; disorganized or incoherent speech; sexual or inappropriate interactions; is either apathetic or overly demanding			
7. Sleep-wake cycle disturbance	NO	0	1 Yes
Either: frequent awakening/< 4 hours sleep at night OR sleeping during much of the day			
8. Symptom Fluctuation	NO	0	1 Yes
Fluctuation of any of the above symptoms over a 24 hr period.			

TOTAL SHIFT SCORE: _____
(0 – 8)

<u>Score</u>	<u>Classification</u>
0	Normal
1-3	Subsyndromal Delirium
4-8	Delirium