# PEDIATRIC DELIRIUM ASSESSMENT

**STEP 1** Arousal Assessment + **STEP 2** Content Assessment

## Richmond Agitation Sedation Scale (RASS)

<table>
<thead>
<tr>
<th>SCALE</th>
<th>LABEL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 4</td>
<td>COMBATIVE</td>
<td>Combative / VIOLENT / Immediate danger to staff</td>
</tr>
<tr>
<td>+ 3</td>
<td>VERY AGITATED</td>
<td>Pulls to remove tubes or catheters / AGGRESSIVE</td>
</tr>
<tr>
<td>+ 2</td>
<td>AGITATED</td>
<td>Frequent non-purposeful movement / FIGHTS VENTILATOR</td>
</tr>
<tr>
<td>+ 1</td>
<td>RESTLESS</td>
<td>ANXIOUS / Apprehensive / Movements NOT aggressive</td>
</tr>
<tr>
<td>+ 0</td>
<td>ALERT &amp; CALM</td>
<td>SPONTANEOUS ATTENTION to caregiver</td>
</tr>
<tr>
<td>− 1</td>
<td>DROWSY</td>
<td>Not fully alert, but has SUSTAINED AWAKENING to VOICE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eye opening and Eye contact &gt; 10 sec</td>
</tr>
<tr>
<td>− 2</td>
<td>LIGHT SEDATION</td>
<td>BRIEFLY awakens to VOICE / Eyes open but contact &lt; 10 sec</td>
</tr>
<tr>
<td>− 3</td>
<td>MODERATE SEDATION</td>
<td>Movement or eye opening to VOICE / NO eye contact</td>
</tr>
</tbody>
</table>

If RASS is $\geq (-3)$ $\rightarrow$ PROCEED to **STEP 2** (ps/pCAM-ICU).

| − 4   | DEEP SEDATION | NO RESPONSE to VOICE                                                        |
|       |                | Some movement or eye opening to TOUCH (physical stimuli)                    |
| − 5   | UNAROUSABLE    | NO RESPONSE to NOXIOUS stimuli                                              |

If RASS is $(-4)$ or $(-5)$ $\rightarrow$ **STOP** and REASSESS patient later.

Pediatric CAM-ICU (pCAM-ICU): DELIRIUM = Presence of FEATURES 1 + 2 + either 3 or 4

FEATURE 1: Acute Change or Fluctuating Course of Mental Status
1. Is there an acute change from mental status baseline? (Y or N)
2. Has the patient’s mental status fluctuated during the past 24 hours? (Y or N)
   ➔ If “YES” to EITHER question then Feature 1 is PRESENT ➔ move on to FEATURE 2

FEATURE 2: Inattention
Say: “Squeeze my hand when I say ‘A’. Let’s practice: A, B. Squeeze only on A.”
Read this letter sequence: A B A D B A D A Y
   ➔ Did the patient make 3 or MORE ERRORS? (Error = No squeeze with ‘A’ or Squeeze with other letters)
   ➔ If “YES” then Feature 2 is PRESENT ➔ move on to FEATURE 3

FEATURE 3: Altered Level of Consciousness (LOC)
   ➔ Does the patient currently have an altered LOC? (i.e. not alert and calm)
   ➔ If “YES” then STOP ➔ DELIRIUM PRESENT
   ➔ If “NO” then Feature 3 is NOT present ➔ move on to FEATURE 4

FEATURE 4: Disorganized Thinking
Say: “I am going to ask you some questions.” (Tell patient to answer yes/no by voice, head nod, etc.)
Questions:
1. Is sugar sweet? Alternate questions: - Is a rock hard?
   (1 point each) 2. Is ice cream hot? - Do rabbits fly?
   3. Do birds fly? - Is ice cream cold?
   4. Is an ant bigger than an elephant? - Is a giraffe smaller than a mouse?
Command: 5. Two-step command: Say, “Hold up this many fingers.” Demonstrate by holding up 2 fingers.
   Then say, “Now do that with the other hand.” Do NOT demonstrate this part of the command.
   ➔ Did the patient make 2 or MORE ERRORS? (Error = Answer question incorrectly, doesn’t follow command, etc.)
   ➔ If “YES” then ➔ DELIRIUM PRESENT
Delirium: CAM-ICU (PSCAM-ICU) = Presence of Features ≥ 2 OR Either 1 and 3 or 4

1. Has there been a recent change from mental status baseline? (Y or N)
2. Has the patient’s mental status fluctuated during the past 24 hours? (Y or N)
3. Does the patient currently have an altered LOC? (i.e., not alert and calm)
4. Does the patient have a sleep-wake cycle disturbance? (Presence of any ONE of the following)
   1. Sleeps mostly during the day
   2. Does not awaken easily to stimuli
   3. Has difficulty getting to sleep
   4. Sleeps only a little at night

Feature 2: Attention

Feature 3: Altered level of consciousness (LOC)

Feature 4: Disorganized Brain

**Stop Delirium**

**Absent Delirium**

**Present Delirium**

YES

NO
If RASS is (-4) or (-5) STOP and REASSESS patient later.

**NO RESPONSE TO NOXIOUS STIMULI:**
- 5 UNAROUSABLE
- 4 DEEP SEDATION
- 3 MODERATE SEDATION
- 2 LIGHT SEDATION
- 1 DROWSY

**MOVEMENT OR EYE OPENING TO VOICE:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

**SPONTANEOUS ATTENTION TO CAREGIVER:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

**ANXIOUS / APPRAHENSIVE / MOVEMENTS NOT AGGRESSIVE:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

**FREQUENT NON-PURPOSFUL MOVEMENT / FIGHTS VENTILATOR / PULLS TO REMOVE TUBES OR CATHETERS / AGGRESSIVE:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

**Not fully alert but has sustained awakening to voice:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

**Eye opening and eye contact < 10 sec:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

**Briefly awakens to voice / eyes open but contact > 10 sec:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

**No movement or eye opening to voice / no eye contact:**
- 0 ALERT & CALM
- 1 RESTLESS
- 2 AGITATED
- 3 VERY AGITATED
- 4 COMBATIVE

If RASS is > (-3) PROCEED TO STEP 2 (PS/PACM-ICU).

**STEP 1 Arousal Assessment + STEP 2 Content Assessment**

Pediatric Delirium Assessment

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