# Pediatric Delirium Assessment

## Step 1: Arousal Assessment + Step 2: Content Assessment

### State Behavioral Scale (SBS)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 2</td>
<td>Agitated (Difficult to Calm)</td>
<td>UNABLE to console / Increased movement (thrashing, kicking legs) / UNSAFE (biting ETT, pulling lines) / Fights ventilator</td>
</tr>
<tr>
<td>+ 1</td>
<td>Restless (Difficult to Calm)</td>
<td>Increased Movement (RESTLESS) / Asynchrony when on ventilation / Does NOT consistently calm despite 5 min attempt</td>
</tr>
<tr>
<td>+ 0</td>
<td>Awake (Able to Calm)</td>
<td>Spontaneous ATTENTION / RESPONSE to VOICE / Able to calm with touch or voice</td>
</tr>
<tr>
<td>− 1</td>
<td>Responsive (Gentle Touch/Voice)</td>
<td>RESPONSE to VOICE or LIGHT TOUCH / BRIEF attention with stimulation / Able to comfort</td>
</tr>
<tr>
<td>− 2</td>
<td>Responsive (Noxious Stimuli)</td>
<td>RESPONSE to NOXIOUS stimuli / Occasional movement of extremities / UNABLE to pay attention</td>
</tr>
<tr>
<td>− 3</td>
<td>Unresponsive</td>
<td>NO response to NOXIOUS stimuli / Does NOT move / Does NOT distress with ANY procedure</td>
</tr>
</tbody>
</table>

If SBS is \( \geq (-1) \) \( \rightarrow \) PROCEED to **Step 2 (pCAM-ICU)**.

If SBS is \((-2)\) or \((-3)\) \( \rightarrow \) **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? (1 point each)
2. Is ice cream hot?
3. Do birds fly?
4. Is an ant bigger than an elephant?

**Alternate questions:**
- Is a rock hard?
- Do rabbits fly?
- Is ice cream cold?
- 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
FEATURE 1: Acute Change or Fluctuating Course of Mental Status
1. Is there an acute change from normal mental status? (Y or N)
2. Has the patient's mental status changed during the past 24 hours? (Y or N)

FEATURE 2: Inattention
1. "Yes" to EITHER question then feature 1 is PRESENT (Y or N)
2. Does the patient make 3 or more ERRORS? (error = does not look at cards, even when eyes open)
3. Prompts the patient to look at the picture, then switch to the next picture and repeat. Ideal to 10 pictures.
4. Show each picture by slowly moving it in front of the patient's face on one side while verbally prompting them to look at the picture, then switch to the next picture and repeat. Ideal to 10 pictures.

FEATURE 3: Altered Level of Consciousness (LOC)
1. "Yes" to EITHER question then feature 2 is PRESENT (Y or N)
2. Did the patient have difficulty keeping their eyes open during MOST of the assessment period? (even if they closed it 8 or more times)
3. A patient should maintain eye opening for at least half of the assessment period. Even if they closed 8 or more times.

FEATURE 4: Disorganized Brain
1. "Yes" then feature 3 is NOT present move on to feature 4
2. Does the patient have a sleep-wake cycle disturbance? (Presence of any one of the following)
3. Sleeps only a little at night
4. Sleeps mostly during the day
5. Does not awaken easily to stimulation

FEATURE 5: Delirium Present
1. "Yes" (alert and calm) STOP Delirium Present
2. "Yes" then STOP Delirium Present
3. (i.e., not alert and calm)

Delirium Present

STOP Delirium Absent

Delirium Absent

YES

NO

feature 4

feature 3

feature 2

feature 1

feature 0

Preschool CAM-ICU (PSCAM-ICU): Delirium = Presence of Features 1 + 2 + Either 3 or 4 of Either Absent or Present
### Pediatric Delirium Assessment

#### Step 1: Arousal Assessment

<table>
<thead>
<tr>
<th>Score</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Awake</td>
<td>Able to calm with touch or voice</td>
</tr>
<tr>
<td>1</td>
<td>Restless</td>
<td>Increased movement ( restless ), asynchrony when on ventilator</td>
</tr>
<tr>
<td>2</td>
<td>Agitated</td>
<td>Unable to console, unsafe ( hitting ET, pulling lines ), frequent restless</td>
</tr>
<tr>
<td>3</td>
<td>Unresponsive</td>
<td>Occasional movement of extremities, unable to pay attention</td>
</tr>
</tbody>
</table>

#### Step 2: Patient Label

<table>
<thead>
<tr>
<th>Score</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-1</td>
<td>Response to voice or light touch (gentle touch/voice)</td>
</tr>
<tr>
<td>1</td>
<td>-2</td>
<td>Responsive (voice)</td>
</tr>
<tr>
<td>2</td>
<td>-3</td>
<td>Unresponsive (noxious stimuli)</td>
</tr>
</tbody>
</table>

#### Sub-Score (SBS)

If SBS is ( -2 ) or ( -3 ) STOP and REASSESS patient later.

If SBS is > ( -1 ) PROCEED TO STEP 2 (CAM-ICU).