## 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 ≥ −3 → PROCEED to **Step 2 (ps/PCAM-ICU)**.

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<tr>
<td>−4</td>
<td>Deep Sedation</td>
<td>NO RESPONSE to VOICE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some movement or eye opening to TOUCH (physical stimuli)</td>
</tr>
<tr>
<td>−5</td>
<td>Unarouseable</td>
<td>NO RESPONSE to NOXIOUS stimuli</td>
</tr>
</tbody>
</table>

If RASS is −4 or −5 → STOP and REASSESS patient later.

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**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?
   2. Is ice cream hot?
   3. Do birds fly?
   4. Is an ant bigger than an elephant?
   (1 point each)   Alternate questions:
   1. Is a rock hard?
   2. Do rabbits fly?
   3. Is ice cream cold?
   4. 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 Present

Delirium Absent

Stop

Delirium Present

If neither (1) or (2) are present than STOP

Delirium Present

If unarousable and inconsequential present, then STOP

Inconsolability: Resists minor comforting measures OR does not respond/interact with caregiver OR does not recognize/interact with caregiver

Unarousable: Unresponsive to stimulations, sounds, or pain

(2) If SWC disturbance present then STOP

- Does not awaken easily to stimulation
- Does not respond to speak
- Difficulty getting to sleep
- Sleeps more than usual day

(1) Sleep-wake cycle (SWC) disturbance present (Presence of any one of the following)

FEATURe 4: Diagnosed brain injury

FEATURe 3: Altered level of consciousness (LOC)

FEATURe 2: Inattention

FEATURe 1: Acute change or fluctuating course of mental status

Preschool CAM-IICU (PSCAM-IICU): Delirium = Presence of Features 1 + 2 + Either 3 or 4

Stop - Delirium Absent

If both (1) and (2) then Feature 2 is ABSENT

Stop - Delirium Absent

(1) Did recent event(s) occur (e.g., surgery)? If yes, move to Feature 3

(2) Checklist: 8 or more pictures/mimic? If yes, move to Feature 3

(3) Did patient mean ED staff to make patient recall things said to them, switch picture? repeat? if times

(4) While showing pictures/mimic, look for the patient's source of ongoing stimulation

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No
Richmond Agitation Sedation Scale (RASS)

**Description**

RASS 1: Agitated Restless
RASS 2: Agitated
RASS 3: Very Agitated
RASS 4: Combative
RASS 0: Calm
RASS -1: Drowsy
RASS -2: Light Sedation
RASS -3: Moderate Sedation
RASS -4: Deep Sedation
RASS -5: Unarousable

**Scale**

-1 to +4

**Step 1: Arousal Assessment**

- Place the patient on a platform
- Monitor for eye opening

**Step 2: Content Assessment**

- Ask questions
- Note responses

**Pediatric Delirium Assessment**

- Assess for signs of agitation
- Monitor for changes in behavior
- Implement strategies to reduce agitation