Acute change or fluctuating course of mental status
Is the patient different than his/her baseline mental status?  
or  
Has the patient had any fluctuation in mental status in the past 24 hours as evidenced by fluctuation on a sedation/level of consciousness scale (i.e., RASS, SAS, or GCS) or previous delirium assessment?

Inattention
Letters Attention Test (See training manual for alternate Pictures)
Directions: Say to the patient, “I am going to read you a series of 10 letters. Whenever you hear the letter ‘A,’ indicate by squeezing my hand.” Read letters from the following letter list in a normal tone 3 seconds apart.
SAVEHAART or CASABLANCA or ABAABADAAY
Errors are counted when patient fails to squeeze on the letter “A” and when the patient squeezes on any letter other than “A.”
• If the patient squeezes on all letters, consider all incorrect (i.e. 10 errors)
• If the patient does not squeeze on any letters, consider all incorrect (i.e. 10 errors)

Altered level of consciousness
Present if the actual RASS score is anything other than alert and calm (zero)

Disorganized thinking
Yes/No Questions (See training manual for alternate set of questions)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?
Errors are counted when the patient incorrectly answers a question.
Command
Say to patient: “Hold up this many fingers” (Hold 2 fingers in front of patient)
“Now do the same thing with the other hand” (Do not repeat number of fingers) *If the patient is unable to move both arms, for 2nd part of command ask patient to “Add one more finger”
An error is counted if patient is unable to complete the entire command.

Both Features 1 and 2 and either Feature 3 or 4 are present  
Delirious  
Otherwise  
Not Delirious

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