Alberta Health Services
Critical Care Strategic Clinical Network™

Intensive Care Delirium Screening Checklist

For any component of the checklist, if you are unable to assess, answer No = Score 0
A total ICDSC score greater or equal to 4 has a 99% sensitivity for a psychiatric diagnosis of delirium.

Score at time of assessment

Altered level of consciousness			Assessment Considerations
RASS = +1 to +4	Exaggerated response	Score = 1	Assess level of consciousness at the time of ICDSC scoring. May need to delay assessment if prn analgesic/sedation recently administered. For continuous sedation/long acting sedatives, score for patient's current condition.
RASS = 0	Normal wakefulness / calm / cooperative	Score = 0	
RASS = -1 to -2	Responds to mild stimulation	Score = 1	
RASS = -3	Responds to moderate stimulation	Score = 1	
RASS = -4 to -5	Responds only to intense repeated stimulation **OR** No response to noxious stimulation	**STOP ASSESSMENT**	

Inattention		Assessment Considerations
Difficulty following simple commands	Yes = Score 1	Attention needs to be held for a minimum of 10 seconds. Does the patient have the ability to organize their thoughts? Does the patient have difficulty focusing attention or difficulty tracking you? Ask the patient to hold up two fingers…and then ask them to hold up two more fingers. While spelling out "HAVE A HAART" get the patient to squeeze your hand on every "A", the patient needs to have 8/10 correct. Have the patient recite the months of the year backwards.
Attentive and focused	No = Score 0	
Unable to assess	No = Score 0	

Disorientation		Assessment Considerations
Disorientated to person, place or time	Yes = Score 1	For intubated patients use easy yes/no questions. Can the patient recognize family/caregivers? Do they know what kind of place they are in (hospital)?
Oriented or unable to assess	No = Score 0	

Hallucination, delusion or psychosis		Assessment Considerations
Visual, auditory or tactile hallucinations	Yes = Score 1	Hallucinations: Perception of something in the absence of stimuli. Delusions: False beliefs with no feasible/reasonable reason. Psychosis: Difficulty telling what is real and what is not. Do you hear someone speaking to you other than me? Do you see anything or anyone other than me? Do you believe someone is trying to harm you?
Delusions	Yes = Score 1	
Psychosis	Yes = Score 1	
No apparent hallucinations, delusion or psychosis or unable to assess	No = Score 0	

Observe throughout shift

Psychomotor agitation or retardation		Assessment Considerations
Agitation or retardation	Yes = Score 1	Hyperactivity: Heightened arousal. Can be restless, agitated or aggressive. Hypoactivity: Flat affect, withdrawn, decreased responsiveness, slowed speech, and/or apathetic.
Relaxed and cooperative or unable to assess	No = Score 0	

Inappropriate mood or speech		Assessment Considerations
Inappropriate mood, disorganized thoughts or inappropriate shouting	Yes = Score 1	Is the patient's speech or mood appropriate to the current situation? Is the patient inappropriately demanding? Consider asking family/friends if this is typical for the patient.
Appropriate speech/mood or unable to assess	No = Score 0	

Sleep wake cycle disturbance		Assessment Considerations
Slept more than 4 hours total during the day	Yes = Score 1	Based on primary caregiver assessment within the past 24hrs.
Slept less than 4 hours total during the night or frequent waking	Yes = Score 1	
Sleeping **at least 4 hours** at night or unable to assess	No = Score 0	

Fluctuations		Assessment Considerations
WORSENING of any indicators in the **last 24 hours** (see previous shift)	Yes = Score 1	Worsening of an indicator which is not related to an intervention. For example, patient is less rousable due to sedative for procedure.
No change or IMPROVEMENT of delirium indicators	No = Score 0	

Source: Bergeron N et al. Intensive Care Med 2001; 27: 869-64 Last Revised: June 2018 by CCSCN Delirium Initiative- ICDSC Working Group