Intensive Care Delirium Screening Checklist (ICDSC)

Give a score of "1" to each of the 8 items below if the patient clearly meets the criteria defined in the scoring instructions. Give a score of "0" if there is no manifestation *or* unable to score. If the patient scores ≥4, notify the physician. The diagnosis of delirium is made following clinical assessment; document in the Assessment and Intervention record (RN) and progress note (MD).

Assessment	Scoring Instructions	Score
1. Altered Level of Consciousness*	• If MASS portion of VAMASS is 0 (no response) or 1 (response to noxious stimulus only), record "U/A" (unable to score) and do not complete remainder of screening tool • Score "0" if MASS score is 3 (calm, cooperative, interacts with environment without prompting) • Score "1" if MASS score is 2, 4, 5 or 6 (MASS score of 2 is a patient who only interacts or responds when stimulated by light touch or voice – no spontaneous interaction or movement; 4, 5 and 6 are exaggerated responses)	
If MASS ≠ 0 or 1, screen items 2-8 and complete a total score of all 8 items.		
2. Inattention	"1" for any of the following: • Difficulty following conversation or instructions • Easily distracted by external stimuli • Difficulty in shifting focuses	
3. Disorientation	"1" for any obvious mistake in person, place or time	
4. Hallucination/ delusions/ psychosis	"1" for any one of the following: • Unequivocal manifestation of hallucinations or of behaviour probably due to hallucinations (e.g.catching non-existent object) • Delusions • Gross impairment in reality testing	
5. Psychomotor agitation or retardation	"1" for any of the following: • Hyperactivity requiring additional sedatives or restraints in order to control potential dangerousness (e.g. pulling out IV lines, hitting staff) • Hypoactivity or clinically noticeable psychomotor slowing (differs from depression by fluctuation in consciousness and inattention)	
6. Inappropriate speech or mood	"1" for any of the following (score 0 if unable to assess): • Inappropriate, disorganized or incoherent speech • Inappropriate display of emotion related to events or situation	
7. Sleep wake/cycle disturbance	"1" for any of the following: • Sleeping less than 4 hours or waking frequently at night (do not consider wakefulness initiated by medical staff or loud environment) • Sleeping during most of day	
8. Symptom fluctuation	"1" for fluctuation of the manifestation of any item or symptom over 24 hours (e.g., from one shift to another)	
TOTAL SCORE 0-8 / 8	A score ≥ 4 suggests delirium. A score > 4 is not indicative of the severity of the delirium	