Intensive Care Delirium Screening Checklist (ICDSC)

1. Altered level of consciousness. Choose one from A to E		
A. Exaggerated response to normal stimulation	SAS = 5, 6, 7 or RASS = +1 to +4	(1 point)
B. Normal wakefulness	SAS = 4 or RASS = 0	(0 points)
C. Response to mild or moderate stimulation (follows commands)	SAS = 3 or RASS = −1 to −3	(1 point)
D. Response only to intense and repeated stimulation (e.g., loud voice and pain)	SAS = 2 or RASS = −4	Stop assessment[a]
E. No response	SAS = 1 or RASS = −5	Stop assessment[a]
2. Inattention (1 point if any present)		
A. Difficulty in following commands or		
B. Easily distracted by external stimuli or		
C. Difficulty in shifting focus		
Does the patient follow you with their eyes?		
3. Disorientation (1 point for any abnormality)		
A. Mistake in either time, place, or person		
Does the patient recognize ICU caregivers who have cared for him/her and not recognize those who have not? What kind of place are you in? (list examples)		
4. Hallucinations or delusions (1 point for either)		
A. Equivocal evidence of hallucinations or a behavior due to hallucinations (hallucination = perception of something that is not there with no stimulus) or		
B. Delusions or gross impairment of reality testing (delusion = false belief that is fixed/unchanging)		
Any hallucinations now or over past 24 hr? Are you afraid of the people or things around you? (fear that is inappropriate to the clinical situation)		
5. Psychomotor agitation or retardation (1 point for either)		
A. Hyperactivity requiring the use of additional sedative drugs or restraints in order to control potential danger (e.g., pulling IV catheters out or hitting staff) or		
B. Hypoactive or clinically noticeable psychomotor slowing or retardation		
Based on documentation and observation over shift by primary caregiver		
6. Inappropriate speech or mood (1 point for either)		
A. Inappropriate, disorganized, or incoherent speech or		
B. Inappropriate mood related to events or situation		
Is the patient apathetic to current clinical situation (i.e., lack of emotion)?		
Any gross abnormalities in speech or mood? Is patient inappropriately demanding?		
7. Sleep/wake cycle disturbance (1 point for any abnormality)		
A. Sleeping < 4 hr at night or		
B. Waking frequently at night (do not include wakefulness initiated by medical staff or loud environment) or		
C. Sleep ≥ 4 hr during day		
Based on primary caregiver assessment		
8. Symptom fluctuation (1 point for any)		
Fluctuation of any of the above items (i.e., 1–7) over 24 hr (e.g., from one shift to another)		
Based on primary caregiver assessment		
Total Intensive Care Delirium Screening Checklist score (add 1–8) _____		

[a]Delirium assessment can not be completed in patients who are stuporous or comatose.

SAS = Riker Sedation-Agitation Scale, RASS = Richmond Agitation-Sedation Scale.

Modified from Devlin JW, Marquis F, Riker RR, et al: Combined didactic and scenario-based education improves the ability of intensive care unit staff to recognize delirium at the bedside. *Crit Care* 2008; 12:R19.