1. Purpose
   1.1. To identify, minimize and treat symptoms of delirium/confusion in the Intensive Care Unit (ICU) setting. To improve patient safety and patient outcomes.

2. Scope
   2.1. Nursing Division

3. Definitions
   3.1. RASS-(Richmond Agitation-Sedation Scale): To objectively access sedation level.
   3.2. CAM-ICU- (Confusion Assessment Method-Intensive Care Unit): To objectively access four key features of delirium:
       3.2.1. Change or fluctuation in mental status from baseline.
       3.2.2. Inattention.
       3.2.3. Disorganized Thinking.
       3.2.4. Altered Level of Consciousness.

4. Policy
   4.1. The Richmond Agitation-Sedation Scale (RASS) and the Confusion Assessment Method (CAM) ICU delirium scale shall be used for the assessment of delirium.
   4.2. All ICU patients shall be assessed with the RASS every 4 hours and as needed (PRN), and with the CAM-ICU every 12 hours and PRN.
   4.3. The Registered Nurse (RN) is responsible for obtaining and recording the patients score.

5. Procedure
   5.1. Step One: Determine the RASS Score (See Attached RASS assessment tool).
       5.1.1. If -4 or -5, then stop and reassess, consider lower sedation if possible and reassess patient at a later time. Document in electronic medical record.
       5.1.2. If RASS is -3 through +4, then proceed to Step 2.
   5.2. Step Two: Perform the CAM-ICU (See Attached CAM-ICU assessment tool).

5.3 Feature 1: Acute Onset or Fluctuating Course
5.3.1. Is there an acute change from patient’s baseline mental status. (Baseline determined based on patients past medical history, family observations, previous shift report.)

5.3.2. Has there been a fluctuation in the patient’s mental status in the past 24hrs, as evidenced by fluctuation in the RASS (need for significantly more/less sedation), Glasgow Coma Scale, or previous delirium assessment?

5.3.3. If the answer is NO to both questions-CAM-ICU is Negative, record findings in electronic medical record and reassess in 12 hrs or sooner if needed. If the answer to EITHER question is YES-continue to Feature 2.

5.3. Feature 2: Inattention

5.3.1. Perform the Attention Screening Examination (ASE) Letters first. If the patient makes 2 or more errors (out of possible 10) the test is considered POSITIVE. If the patient is unable to perform this test or the score is unclear; perform the ASE Pictures exam.

5.3.2. Perform the ASE Picture Exam if necessary. If the patient makes 2 or more mistakes (out of possible 10) the test is considered POSITIVE. If you use both tests, use the ASE Picture results to score Feature 2.

5.3.3. IF the Score is NEGATIVE, CAM-ICU is Negative. Record findings in electronic medical record and reassess in 12 hrs or sooner if needed.

5.3.4. If the Score is POSITIVE, continue to Feature 3.

5.4. Feature 3: Altered Level of Consciousness

5.4.1. Scored POSITIVE if Patient’s current level of consciousness is anything other than alert (e.g. RASS other than “0” at time of assessment). If RASS other than zero then CAM-ICU is positive. Record findings in electronic medical record. Assess risk factors and treatments for delirium. If RASS is zero, continue to Feature 4.

5.5. Feature 4: Disorganized Thinking

5.5.1. Ask patient YES/NO questions and Commands (see CAM-ICU Flow Sheet). The Feature is considered POSITIVE if the patient makes 2 or more errors. Record findings in electronic medical record. Assess risk factors and treatments for delirium. If the patient makes 0-1 errors the CAM-ICU is negative. Record findings and reassess in 12hrs or sooner if needed.

6.0 If CAM+: Notify physician for consideration of pharmacological/physiological causes.

7.0 Pharmacist to review current medication list.

7.1. Treatment efforts should focus on identifying the etiology of delirium. Often this can be done by assessing for the presence of known risk factors. Both prevention and treatment should focus on the minimization and/or elimination of predisposing and precipitating factors.
Nursing interventions to minimize risk factors:
- Repeated reorientation of patients
- Cognitively stimulating activities multiple times a day
- Sleep Protocol
- Early mobilization activities
- Use of eye glasses/hearing aides
- Early correction of dehydration
- Use of a scheduled pain management protocol

8.0. References
8.1. MHA Keystone Initiative (mhakeystonecenter.org)
8.2. Vanderbilt University and Medical Center-Intensive Care Unit (ICU) Delirium and Cognitive Study Group (icudelirium.org)

Previous Revisions: n/a

Supersedes Policy: n/a

Approvals:

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