Sedation and Delirium Assessment

It is important to recognize delirium because delirium is an indication that marked physiological and metabolic changes have occurred that could lead to organ dysfunction.

The following patient behaviors should trigger an assessment: Agitation or lethargy, fluctuating or altered LOC, memory impairment or disorganized thinking, wandering, uncooperativeness or failure to follow instructions, change in behavior or function, and inattentiveness.

The confusion assessment method (CAM) is a standardized method to identify delirium quickly. The CAM-ICU is designed to assess the non-verbal mechanically vented patient.

Step one

Determine if your patient is alert enough to participate in a delirium assessment by choosing a score on the Richmond agitation-sedation scale. If your patient rates a -3 or higher score then you proceed to the step two.

Step two

Feature 1: Change in mental status from baseline or a status that fluctuates

The patient's current mental status must be compared with the baseline information obtained at the time of admission. This information can be obtained from the patient, his friends or family, and from the chart. Ask if there has been a change in the patient's usual behavior and ask if the abnormal behavior tends to come and go. If the answer is yes then feature number one is present.

Feature 2: Inattention

Attention refers to the ability to attend to a specific stimulus without being distracted by extraneous stimuli. If the patient is having difficulty keeping track of what was being said then he is inattentive. Assess attention by asking your patient to spell the word world backwards, recite seven digits forward or five digits in reverse, count backwards from 20 to one, or recite the days of the week backward. If your patient cannot speak, then perform the attention screening exam (ASE). The ASE has a visual and an auditory component. A patient must be able to perform the basic commands of "nod your head" or "squeezmy hand" in order to test for inattention. Validation studies proved that the majority of the time, patients had similar scoreson both tests (ASE pictures and ASE auditory). As a result, you do not have to use both tests in each assessment. Attempt the ASE letters first. If the patient is able to perform this test, and the score is clear, record this score and move to feature 3.

For the auditory component of the ASE, you will read a series of letters to the patient in a normal tone at a rate of one letter per second and instruct him to squeeze your hand each time he hears the letter "A." You can spell out "SAVEAHAART" or "SAVEASMANYBABIES."

For the visual component of the ASE, the patient is shown a picture of 5 objects for 3 seconds. (You will have to draw the

Richmond Agitation-Sedation Scale (RASS)

+4	Combative	Combative, violent, immediate danger to staff
+3	Very Agitated	Pulls or removes tube(s) or catheter(s); aggressive
+2	Agitated	Frequent nonpurposeful movement, fights ventilator
+1	Restless	Anxious, apprehensive but movements are not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained awakening to voice (eye opening & conatct > 10 sec)
-2	Light sedation	Briefly awakens to voice (eye opening & contact < 10 sec)
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation
-5	Unaraousable	No response to voice or physical stimulation