Confusion Assessment Method in the ICU

**Delirium Assessment (CAM-ICU):** 1 AND 2 AND (Either 3 OR 4)

1. **Acute Onset or Fluctuating Course**
   - An acute change from mental status baseline?
   - Or Patient’s mental status fluctuating during the past 24hrs

2. **Inattention**
   - Please read the following ten letters: S A V E A H A A R T
   - Scoring: Error: when patient fails to squeeze on the letter “A”
   - Error: when the patient squeezes on any letter other than “A.”

3. **Altered Level of Consciousness (“actual” RASS)**
   - If RASS is zero, Proceed to next step
   - If RASS is other than zero

4. **Disorganized Thinking**
   - 1. Will a stone float on water? (Or: Will a leaf float on water?)
   - 2. Are there fish in the sea? (Or: Are there elephants in the sea?)
   - 3. Does one pound weigh more than two pounds? (Or: Do two pounds weigh more than one?)
   - 4. Can you use a hammer to pound a nail? (Or: Can you use a hammer to cut wood?)
   - 5. **Command:**
     - Say to patient: “Hold up this many fingers” ( Examiner holds two fingers in front of patient)
     - “Now do the same thing with the other hand” (Not repeating the number of fingers).
     - If patient is unable to move both arms for the second part, ask patient “add one more finger”

**RASS is above - 4 (-3 through +4)**

- Proceed to next Step

**If RASS is -4 or -5**

- Stop
- Reassess patient at later time

**If RASS is above -4**

- No delirium

**If RASS is -4 or -5**

- < 3 Errors
  - Stop
  - No delirium

- ≥ 3 Errors
  - Patient is Delirious

**If RASS is zero**

- Proceed to next Step

- < 2 Errors
  - Stop
  - No delirium

- ≥ 2 Errors
  - Patient is Delirious