# Pediatric Delirium Assessment

## Step 1: Arousal Assessment

<table>
<thead>
<tr>
<th>Scale</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 2</td>
<td>Agitated</td>
<td>Unable to console / Increased movement (thrashing, kicking legs) / <strong>Unsafe</strong> (biting ETT, pulling lines) / Fights ventilator</td>
</tr>
<tr>
<td>+ 1</td>
<td>Restless</td>
<td>Increased Movement (Restless) / Asynchrony when on ventilation / Does Not consistently calm despite 5 min attempt</td>
</tr>
<tr>
<td>+ 0</td>
<td>Awake</td>
<td>Spontaneous Attention / Response to Voice / Able to calm with touch or voice</td>
</tr>
<tr>
<td>- 1</td>
<td>Responsive</td>
<td>Response to Voice or Light Touch / Brief attention with stimulation / Able to comfort</td>
</tr>
<tr>
<td>- 2</td>
<td>Responsive</td>
<td>Response to Noxious Stimuli / Occasional movement of extremities / Unable to pay attention</td>
</tr>
<tr>
<td>- 3</td>
<td>Unresponsive</td>
<td>No response to Noxious Stimuli / Does Not Move / Does Not Distress with ANY procedure</td>
</tr>
</tbody>
</table>

If SBS is ≥ (− 1) ⇒ Proceed to **Step 2 (pCAM-ICU)**.

If SBS is (− 2) or (− 3) ⇒ **Stop** and REASSESS patient later.

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**Pediatric CAM-ICU (pCAM-ICU): DELIRIUM = Presence of FEATURES 1 + 2 + either 3 or 4**

**FEATURE 1: Acute Change or Fluctuating Course of Mental Status**
1. Is there an acute change from mental status baseline? (Y or N)
2. Has the patient’s mental status fluctuated during the past 24 hours? (Y or N)
   - If “YES” to EITHER question then Feature 1 is PRESENT → move on to FEATURE 2

**FEATURE 2: Inattention**
Say: “Squeeze my hand when I say ‘A’. Let’s practice: A, B. Squeeze only on A.”
Read this letter sequence: A B A D B A D A A Y
   - Did the patient make 3 or MORE ERRORS? (Error = No squeeze with ‘A’ or Squeeze with other letters)
   - If “YES” then Feature 2 is PRESENT → move on to FEATURE 3

**FEATURE 3: Altered Level of Consciousness (LOC)**
- Does the patient currently have an altered LOC? (i.e. not alert and calm)
  - If “YES” then STOP → DELIRIUM PRESENT
  - If “NO” then Feature 3 is NOT present → move on to FEATURE 4

**FEATURE 4: Disorganized Thinking**
Say: “I am going to ask you some questions.” (Tell patient to answer yes/no by voice, head nod, etc.)
Questions: 1. Is sugar sweet? Alternate questions: - Is a rock hard?
   - Is ice cream hot?
   - Do birds fly?
   - Is an ant bigger than an elephant?
(1 point each)
Command: 5. Two-step command: Say, “Hold up this many fingers.” Demonstrate by holding up 2 fingers.
   - Then say, “Now do that with the other hand.” Do NOT demonstrate this part of the command.
   - Did the patient make 2 or MORE ERRORS? (Error = Answer question incorrectly, doesn’t follow command, etc.)
   - If “YES” then DELIRIUM PRESENT

STOP DELIRIUM ABSENT
YES
NO
DELIRIUM PRESENT
YES
NO
DELIRIUM ABSENT
YES
NO
C5
1. Does the patient have a sleep-wake cycle disturbance? (Presence of any of the following):
   - Sleeps mostly during the day
   - Sleeps only a little at night
   - Does not awaken easily to stimulation

2. Does the patient have a sleep-wake cycle disturbance? (Presence of any of the following):
   - Sleeps mostly during the day
   - Sleeps only a little at night

3. Has difficulty getting to sleep

4. Sleeps only a little at night

If "YES" then DELIRIUM PRESENT

If "NO" then STOP

If "YES" then DELIRIUM PRESENT

If "NO" then Feature 3 is NOT present; move on to Feature 4

**Feature 4: Disorganized Brain**

**Feature 3: Altered Level of Consciousness (LOC)**

**Feature 2: Illusion or Hallucination**

**Feature 1: Acute Change or Fluctuating Course of Mental Status**

Presence of Features 1 + 2 + Either 3 or 4 = Presence of Features CAM-ICU (PSCAM-ICU): DELIRIUM PRESENT = DELIRIUM PRESENT

**Preschool CAM-ICU (PSCAM-ICU): DELIRIUM PRESENT = DELIRIUM PRESENT**
<table>
<thead>
<tr>
<th>Description</th>
<th>Scale Label</th>
</tr>
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<tbody>
<tr>
<td>State Behavioral Score (SBS)</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 1: Arousal Assessment</strong> + <strong>STEP 2: Content Assessment</strong></td>
<td></td>
</tr>
<tr>
<td>PEDIATRIC DELIRIUM ASSESSMENT</td>
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</tbody>
</table>

**If SBS is \(-2\) or \(-3\):** STOP and REASSESS patient later.

- Does NOT move / Does NOT distress with ANY procedure
  - No response to NOXIOUS stimuli
  - Occasional movement of extremities / UNABLE to pay attention

**UNRESPONSIVE**

-3

**RESPONSIVE**

-2

**If SBS \( \geq -1 \):** PROCEED to **STEP 2: (P-CAM-ICU)**

- Brief attention with stimulation / Able to comfort
  - Response to voice / Light touch

**RESPONSIVE**

-1

- Spontaneous attention

**AWAKE**

0

- Does NOT consistently calm despite 5 min attempt
  - Increased movement (RESTLESS) / Syncrhythm when on ventilation
  - UNSAFE (biting ETT, pulling lines) / Fights ventilator
  - UNABLE to console / Increased movement (thrashing, kicking, legs)

**RESTLESS**

+1

**AGITATED**

+2

**DIFFICULT TO CALM**

+3

**NON-RESPONSIVE**

-4

**UNCONSCIOUS**

-5