PreSchool CAM-ICU (psCAM-ICU) Instruction Tool

Step 1: Arousal Assessment (RASS):

- Delirium is a clinical diagnosis; therefore, the patient has to have an arousal state in which they have the opportunity to respond if the brain is working properly. Furthermore, younger children may also have a deeper level of sleep which when combined with illness and sedative exposure may require greater stimulation to assess arousal.

- If upon initial assessment a patient has a RASS of -3, -4, or -5; provide physical stimulation for about 15 seconds (this may include repositioning patient), then provide no stimulation for 15 seconds, and then reassess using the 3-steps of RASS: look, talk, touch.

- If RASS is ≥ − 3 then PROCEED to Step 2 Content Assessment (psCAM-ICU)

- If RASS is − 4 or − 5 then STOP and REASSESS patient later

Step 2: Content Assessment (psCAM-ICU)

**FEATURE 1: Change or fluctuation in Mental Status**

1. Is there an acute change from mental status baseline (MSB)? MSB is the patient’s pre-hospital mental status.
   - □ YES □ NO
2. Has there been a fluctuation in mental status over the past 24 hours? May use GCS, sedation scale, PE, or history.
   - □ YES □ NO

If ’YES’ to EITHER question then **FEATURE 1 is PRESENT** → move on to **FEATURE 2**

**FEATURE 2: Inattention**

- Show alternating pictures/mirrors & give verbal prompts
  - Hold the picture stack about 12 inches from the patient’s eyes to provide a good view of each picture.
  - Show the first picture to the patient and move it slowly towards the left or right side of their view while referring to the picture on the card. (i.e. Say, “Look at the balloons.”)
  - Switch to the next picture; slowly move the new picture in front of the patient’s eyes to the other side of their view while referring to the new picture. (i.e. Say, “Look at the truck.”)
  - Repeat this action until all 10 pictures have been shown to the patient (10 pictures). Each picture slowly moved to one side while verbally prompting them to look at the specific picture, then switching to the next picture and moving it to the other side.
  - You will assess how many pictures the patient directly looks at AND if they continually close their eyes in between your verbal prompts

1. Attends to 7 or less pictures/mirrors? (i.e. does not look at cards even when eyes open) ~~~~~~~~~~~~~~~~~~~~~~ □ YES □ NO

2. Patient does not maintain spontaneous eye opening in between verbal prompts? ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ □ YES □ NO

(i.e. Some patients who start with a RASS of -1, -2, or -3 will briefly open their eyes when you refer to the picture, possibly look directly at the picture, but then immediately close their eyes again. Even if they attend to 8 or more pictures, if the patient persistently loses attention and closes their eyes in between your verbal prompts to look at the next picture, they are demonstrating inattention. We expect that a patient can maintain spontaneous eye opening – in between verbal prompts to look at pictures - during at least half of the assessment period).

If ‘YES’ to EITHER question then **FEATURE 2 is PRESENT** → move on to **FEATURE 3**

**Delirium ABSENT**
### FEATURE 3: Altered Level of Consciousness

1. **Does the patient currently have an altered level of consciousness (LOC)? (i.e. NOT alert and calm)****

   Any validated sedation scale may be used to determine current LOC.

   If “NO” then **FEATURE 3 is NOT PRESENT → move on to FEATURE 4**

   - □ YES
   - □ NO

### Feature 4: Disorganized Brain

1. **Does the patient have a sleep-wake cycle disturbance? (Any of the following)**

   - Sleeps mostly during the day
   - Does not awaken easily to stimulation

   □ YES
   - □ NO

   If “NO” then **FEATURE 4 is NOT PRESENT → Delirium Absent**

   - Has difficulty getting to sleep
   - Sleeps only a little at night

   If ‘YES’ then **STOP DELIRIUM PRESENT**