pCAM-ICU Instru	iction Tool			
Step 1: Arousal Assessment (RASS): If RASS is ≥ - 3 then PROCEED to Step 2 Content Assessment (pCAM-ICU) If RASS is - 4 or - 5 then STOP and REASSESS patient later RASS			RASS	
Step 2: Content Assessment (pCAM-ICU) Features 1 – 4				
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	
		Feature 1 is POSITIVE when the answer to either of	question is 'yes.'	+ / —
FEATURE 2: Inattention → Attention Screening Examintion (ASE) with Letters or Memory Pictures				
It is normal to have some anxiety in "performing" the pCAM-ICU when you start. Do NOT try to memorize what to say when assessing inattention or disorganized thinking. Use the pCAM-ICU card during your evaluation of the patient and read directly from it for feature 2 and feature 4. The verbage we use is verbatim off the card.				
 Place your hand or finger in the palm of the patient's hand. Say, "Squeeze my hand when I say 'A'. Let's practice: A, B. Squeeze only on 'A'. During the practice squeeze on A and B, do not correct the patient's squeeze or lack there of. For pediatric patients, you are allowing the brain time to process the command twice. Then move on with the letter sequence. Read this 10 letter sequence without stopping: ABADBADAAY Use the card to read off the letter sequence so your attention is on the total number of arrange. Do NOT stop and report semmend when shill be a errorg. 			oremember them." over each picture for 2-3 seconds. ry pictures and say, "Here are r nod yes or no) if the picture res & 5 'other' pictures). Say the r 2-3 seconds.	
Feature 2 is POSITIVE when a patient demonstrates > 2 Errors on either the Vigilance A test <u>OR</u> ASE picture test ERRORs				+/-
Feature 3: Altered Level of Consciousness This feature determines the current level of consciousness (LOC) regardless of the patient's baseline mental status. Any validated sedation scale may be used to determine current LOC.				
Feature 3 is POSITIVE when the current LOC is anything other than 'Alert and Calm' (RASS score '0') Score RASS				+/-
Say, "I am going to ask you some questions. Say or nod yes or no to answer each question." Ask each question slowly and clearly, giving time for an answer. ■ Is sugar sweet? ■ Is ice cream hot? ■ Do birds fly? ■ Do birds fly? ■ Is an ant bigger than an elephant? ■ Is a giraffe smaller than a mouse? ■ Command: Say, "Hold up this many fingers." Demonstrate by holding up 2 fingers. Wait while the patient attempts to complete the command. Then say, "Now do that with the other hand," OR "Add one more finger." With this part of the command, do NOT demonstrate to the patient. Errors → Incorrect 'Yes' or 'No' response to questions or inability to complete the 2-step command. (4 points for questions and 1 point for 2-step command = 5 possible points) Feature 4 is POSITIVE when a patient demonstrates > 1 Error ERRORS				+/_
Delinione	Delirium is present when Feature 1	•	Present	
Delirium Outcome	AN Either a POSITIVE Fea	D	Absent UTA	