## The Severity Scale for the Pediatric Confusion Assessment Method for the Intensive Care Unit (sspCAM-ICU)

	Steps	Assessment Instructions		Score	
1	Arousal Assessment (RASS)	If RASS is ≥ - 3 then PROCEED to Step 2 Content Assessment (sspCAM-ICU)			
		If RASS is – 4 or – 5 then STOP and REASSESS patient later			
2	Content Assessment (sspCAM- ICU) Features 1 – 4	FEATURE 1: Change or fluctuation in Mental Status			
		Is there an acute change from mental status baseline (MSB)? MSB is the patient's pre-hospital mental status.			
		Has there been a fluctuation in mental status over the past 24 hours? May use GCS, sedation scale, PE, or history.		0/5	
		Add 5 points to the score when the answer to either qu	estion is 'yes.'	3.'	
		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.			
		<ul> <li>Letters (Vigilance A Test)</li> <li>Place your hand or finger in the palm of the patient's hand.</li> <li>Say, "Squeeze my hand when I say 'A'. Let's practice: A, B. Squeeze only on 'A'.</li> <li>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.</li> <li>Read this 10 letter sequence without stopping: A B A D B A D A A Y</li> <li>Use the card to read off the letter sequence so your attention is on the total number of errors. Do NOT stop and repeat command when child has errors.</li> <li>Errors → No squeeze with 'A' or Squeeze with letter other than 'A'.</li> </ul> Memory pictures <ul> <li>Hold the memory picture stack in front of the patient.</li> <li>Say, "Here are some pictures. You need to remember them."</li> <li>Pause at the blank card following the 5 memory pictures and some more pictures. Tell me 'yes or no' (or nod yes or no) if t see was one you needed to remember."</li> <li>Show the patient 10 pictures (5 memory pictures &amp; 5 'other' p name of each object and show each picture for 2-3 seconds.</li> <li>Errors → 'No' response to a memory picture or 'Yes' respons picture</li> </ul>	say, "Here are he picture you bictures). Say the		
		Add 0.5 points for every error the patient demonstrates on either the Vigilance A test OR 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.			
		Add the respective number of points to the score: RASS $+4 = 4$ points; RASS $+3/-3 = 3$ points; RASS $+2/-2 = 2$ points; RASS $+1/-1 = 1$ points; RASS $0 = 0$ points.	RASS		
		Feature 4: Disorganized Brain			
		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 Set of questions  Alternate set of questions  Is a rock hard?  Is ice cream hot?  Do abbits fly?  Is ice cream cold?  Is a giraffe smaler than a mouse	answer.	0 - 5	
		• 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)			
		Add 1 points for every error the patient demonstrates.	ERRORs		
		6 - 19 points = Delirium present	TOTAL	0 - 19	