Confusion Assessment Method for the ICU (CAM-ICU) Flowsheet

1. Acute Change or Fluctuating Course of Mental Status:
   - Is there an acute change from mental status baseline?  **OR**
   - Has the patient’s mental status fluctuated during the past 24 hours?

   **YES**

2. Inattention:
   - “Squeeze my hand when I say the letter ‘A’.”
   - Read the following sequence of letters: S A V E A H A R T or C A S A B L A N C A or A B A D B A D A A Y
   - **ERRORS:** No squeeze with ‘A’ & Squeeze on letter other than ‘A’
   - If unable to complete Letters  ➔ Pictures

   **> 2 Errors**

3. Altered Level of Consciousness
   - Current RASS level

   **RASS = zero**

4. Disorganized Thinking:
   - 1. Will a stone float on water?
   - 2. Are there fish in the sea?
   - 3. Does one pound weigh more than two?
   - 4. Can you use a hammer to pound a nail?

   **Command:** “Hold up this many fingers” (Hold up 2 fingers)
   - “Now do the same thing with the other hand” (Do not demonstrate)
   - **OR** “Add one more finger” (If patient unable to move both arms)

   **CAM-ICU negative NO DELIRIUM**

   **CAM-ICU positive DELIRIUM Present**
   - **RASS other than zero**
     - **> 1 Error**
     - **0 - 1 Error**

   **CAM-ICU negative NO DELIRIUM**

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Richmond Agitation Sedation Scale (RASS) *

<table>
<thead>
<tr>
<th>Score</th>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>+4</td>
<td>Comatose</td>
<td>Overly combative, violent, immediate danger to staff</td>
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<tr>
<td>+3</td>
<td>Very agitated</td>
<td>Pulls or removes tube(s) or catheter(s); aggressive</td>
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<tr>
<td>+2</td>
<td>Agitated</td>
<td>Frequent non-purposeful movement, fights ventilator</td>
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<tr>
<td>+1</td>
<td>Restless</td>
<td>Anxious but movements not aggressive vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
<td>No response to voice or physical stimulation</td>
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<tr>
<td>-1</td>
<td>Drowsy</td>
<td>Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (≥10 seconds)</td>
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<tr>
<td>-2</td>
<td>Light sedation</td>
<td>Briefly awakens with eye contact with to voice (&lt;10 seconds)</td>
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<tr>
<td>-3</td>
<td>Moderate sedation</td>
<td>Movement or eye opening to voice (but no eye contact)</td>
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<tr>
<td>-4</td>
<td>Deep sedation</td>
<td>No response to voice, but movement or eye opening to physical stimulation</td>
</tr>
<tr>
<td>-5</td>
<td>Unarousable</td>
<td>No response to voice or physical stimulation</td>
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**Verbal Stimulation**

**Physical Stimulation**

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**Procedure for RASS Assessment**

1. Observe patient
   a. Patient is alert, restless, or agitated. (score 0 to +4)
2. If not alert, state patient's name and say to open eyes and look at speaker.
   b. Patient awakens with sustained eye opening and eye contact. (score -1)
   c. Patient awakens with eye opening and eye contact, but not sustained. (score -2)
   d. Patient has any movement in response to voice but no eye contact. (score -3)
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
   e. Patient has any movement to physical stimulation. (score -4)
   f. Patient has no response to any stimulation. (score -5)
