

Nursing Delirium Screening Scale-NuDESC

Replaces Confusion Risk Screen and NEECHAM delirium screening tool on the Adult M/S flowsheet in Excellian

NURSING DELIRIUM SCREENING SCALE

Disorientation
Inappropriate Behavior
Inappropriate Communication
Illusions/Hallucinations
Psychomotor Retardation
NuDESC Score

Score NuDESC every shift, every day and if there is a *change in mentation* that occurs *anytime* during the shift.

Disorientation

0=Alert, oriented to person, place, time
1=Disoriented but easily reoriented
2=Disoriented x2 or x3 not easily oriented

Each cell contains 3 descriptors to choose from.

This is an observational screening tool. Please use your best judgment as to what the patient is demonstrating.

Inappropriate Behavior

0=Calm Cooperative
1=Restless and cooperative
2=Agitated pulling at devices climbing over side rails

Delirium can have fluctuating behaviors, one moment calm, and the other moment agitated. Please score tool again if behaviors change.

Inappropriate Communication

0=Appropriate
1=Unclear thinking or rambling speech
2=Incoherence, nonsensical or unintelligible speech

Use Family Caregiver Sheet if patient has cognitive impairment and is cared for by family members to give us insight to their needs.

Illusions/Hallucinations

0=None Noted
1=Paranoia, fears
2=Hallucinations, distortions of visual objects

Perceptual distortions accompanying delirium are usually visual.

Psychomotor Retardation

0=None
1=Delayed or slow responsiveness
2=Excessive sleeping, somnolent, lethargic

Delirium can be hypoactive, hyperactive or mixed. Be aware that hypoactive is the least detected by clinical staff.

NuDESC Score

DELIRIUM INTERVENTIONS

Interventions if NuDESC score greater than or equal to 2:

Score > or = to 2 indicates patient is *screening* positive for delirium. Take action!

Interventions if NuDESC score greater than or equal to 10

Select Multiple Options: (F5)

- Promote nutrition: patient in chair for meals, has dentures, etc.
- Orient to current reality: (if does not increase agitation) modify environment
- Consult with the physician/CNS/NP/PA/Rx to discuss elimination of medications
- Pain management
- Discontinue bladder catheter as soon as appropriate
- Encourage mobilization
- Appropriate use of glasses and hearing aids
- Sleep promotion
- Monitor electrolytes
- Consider bladder scan to check for urinary retention
- If no BM in past 48 hours check for fecal impaction
- Any medications started or dose adjusted or stopped in past 24 hours
- Assess Vital signs and pulse oxygen
- Assess blood glucose
- Assess I&O signs of dehydration

Updated interventions for patients screening positive for delirium. Nursing interventions can make a difference in recognizing and treating delirium.