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

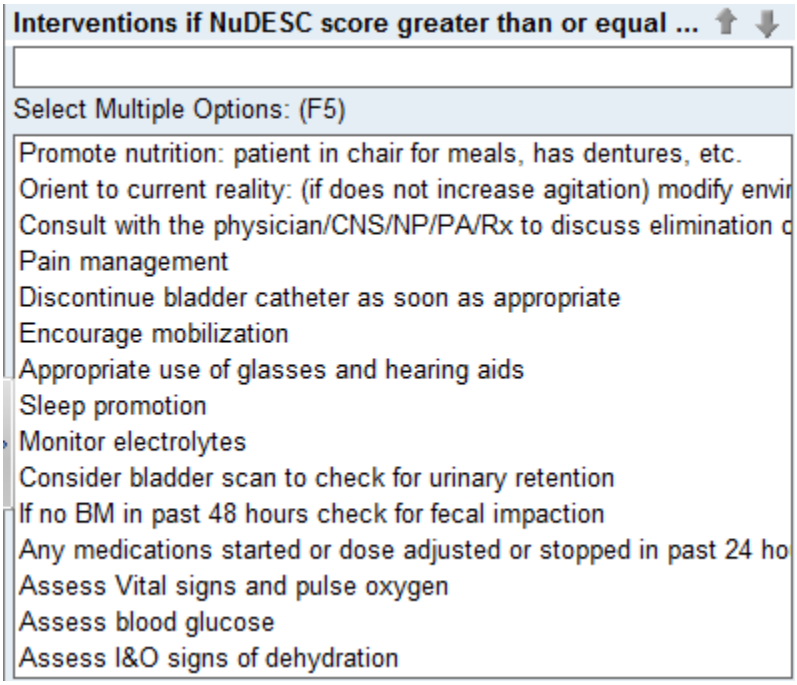
0=None
1=Delayed or slow responsiveness
2=Excessive sleeping, somnolent, lethargic

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

NuDESC Score

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

DELIRIUM INTERVENTIONS
Interventions if NuDESC score greater than or equal to 2:



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