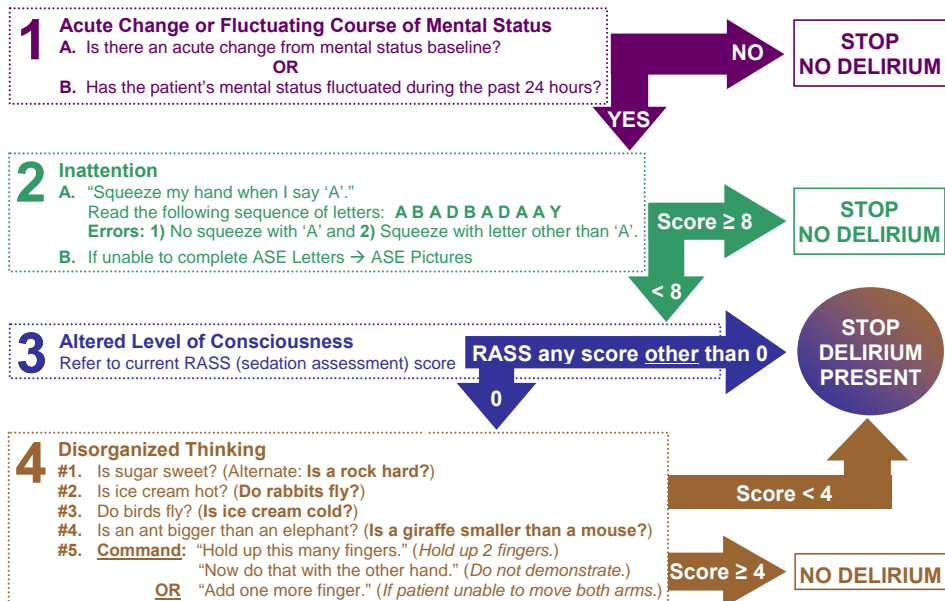


STEP 2 → Pediatric Confusion Assessment Method for the ICU (pCAM-ICU)

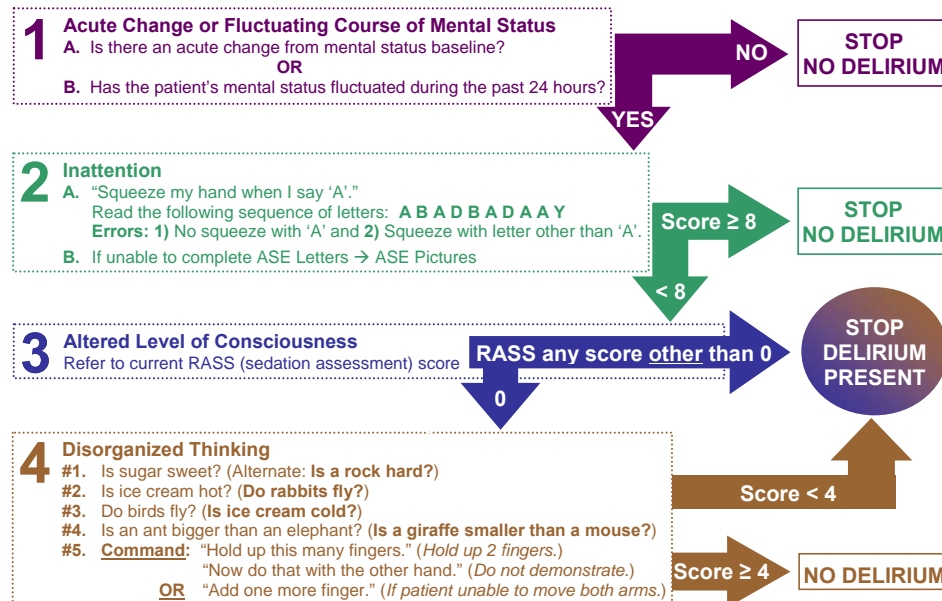
Delirium Diagnosis Requires = Feature 1 + Feature 2 + EITHER Features 3 OR 4



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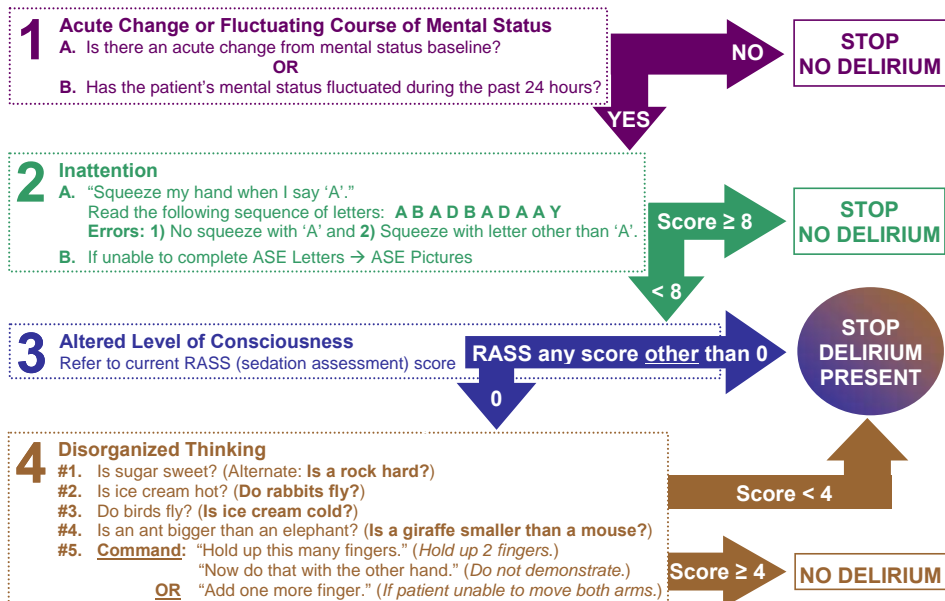
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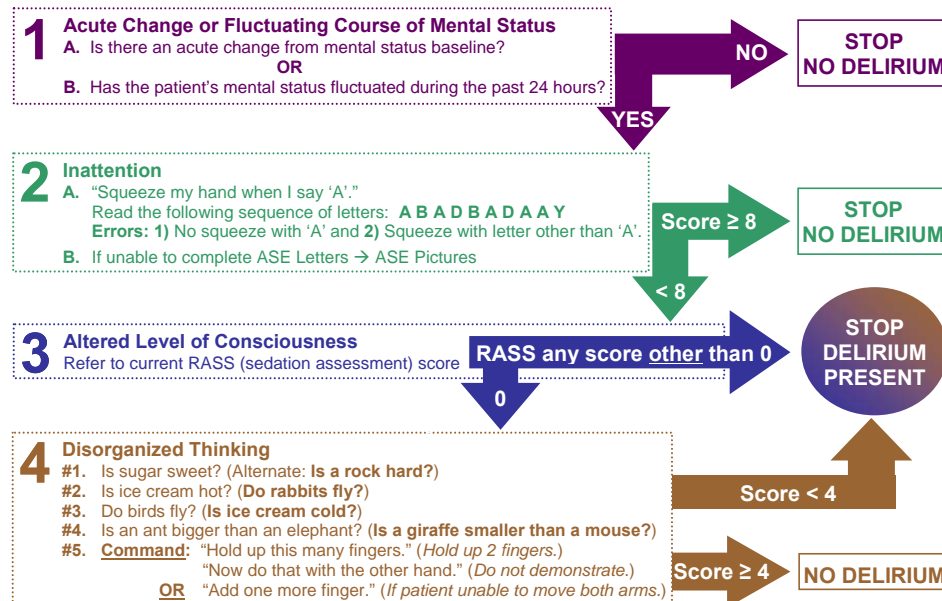
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PEDIATRIC DELIRIUM ASSESSMENT
STEP 1 (Sedation Assessment) + STEP 2 (pCAM-ICU)

SCALE	LABEL	DESCRIPTION	
+4	COMBATIVE	Combative, violent, immediate danger to staff	
+3	VERY AGITATED	Pulls to remove tubes or catheters: aggressive	
+2	AGITATED	Frequent non-purposeful movement, fights ventilator	
+1	RESTLESS	Anxious, apprehensive, movements not aggressive	
+0	ALERT & CALM	Spontaneously pays attention to caregiver.	
-1	DROWSY	Not fully alert, but has sustained awakening to voice (eye opening & contact >10 sec)	VOICE
-2	LIGHT SEDATION	Briefly awakens to voice (eye open & contact <10 sec)	
-3	MODERATE SEDATION	Movement or eye opening to voice (No eye contact)	
<p align="center">If RASS is > -3 then proceed to STEP 2 (pCAM-ICU)</p>			
-4	DEEP SEDATION	No response to voice Movement or eye opening to physical stimulation	TOUCH
-5	UNAROUSEABLE	No response to voice or physical stimulation	
<p align="center">If RASS is -4 or -5 → STOP and REASSESS patient later</p>			

Sessler, et al., *Am J Respir Crit Care Med* 2002, 166: 1338-1344;

Ely, et al., *JAMA* 2003; 286, 2983-2991

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