### 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

<table>
<thead>
<tr>
<th>Score NuDESC every shift, every day and if there is a change in mentation that occurs anytime during the shift.</th>
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</thead>
<tbody>
<tr>
<td>Each cell contains 3 descriptors to choose from.</td>
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<tr>
<td>This is an observational screening tool. Please use your best judgment as to what the patient is demonstrating.</td>
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<tr>
<td>Delirium can have fluctuating behaviors, one moment calm, and the other moment agitated. Please score tool again if behaviors change.</td>
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<tr>
<td>Use Family Caregiver Sheet if patient has cognitive impairment and is cared for by family members to give us insight to their needs.</td>
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<tr>
<td>Perceptual distortions accompanying delirium are usually visual.</td>
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<tr>
<td>Delirium can be hypoactive, hyperactive or mixed. Be aware that hypoactive is the least detected by clinical staff.</td>
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<tr>
<td>Score &gt; or = to 2 indicates patient is screening positive for delirium. Take action!</td>
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</tbody>
</table>

#### Disorientation

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

#### Inappropriate Behavior

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

#### Inappropriate Communication

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

#### Illusions/Hallucinations

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

#### Psychomotor Retardation

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

#### NuDESC Score

#### 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 in recognizing and treating delirium.

**Interventions if NuDESC score greater than or equal to 4:**

- **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 unnecessary 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 hr
Assess Vital signs and pulse oxygen
Assess blood glucose
Assess I&O signs of dehydration