KU DAT
(KU Delirium Assessment Tool)

STEP 1: If patient is unresponsive without sedation, STOP. The patient is unable to be assessed for delirium.
STEP 2: Titrate sedation to a MAAS level of 2 or 3 (responsive to touch or name; calm and cooperative)
STEP 3: Ensure proper pain control
STEP 4: Assess for delirium

I	**ALTERED LEVEL OF CONSCIOUSNESS**		YES	NO
Score "No" if patient:		Score "Yes" if patient:		
▪ Is unresponsive ▪ Responds to intense and repeated stimulation (loud voice and pain) ▪ Exhibits normal wakefulness or sleeping state that could easily be aroused		▪ Has acute changes or fluctuations in LOC ▪ Has exaggerated response to normal stimulation; hypervigilant (hyperalert)		

II	**INATTENTION**		YES	NO
Does the patient have difficulty focusing attention that is acute in onset or fluctuating (responds to <u>any</u> sound, movement, or event)? If so, score "Yes".		EXAMPLES: ▪ Difficulty following conversation or instructions ▪ Easily distracted by external stimuli ▪ Difficulty shifting focus		

III	**PSYCHOMOTOR AGITATION**		YES	NO
Is the patient's agitation or hyperactivity refractory to a reasonable amount of sedatives, and requires the use of additional sedative drugs or restraints in order to control potential danger to oneself or others? If so, score "Yes."		EXAMPLES: ▪ Pulling out IV lines ▪ Combative ▪ Crawling out of bed ▪ Picking at sheets, linens, etc.		

IV	**PSYCHOSIS (Hallucinations, Delusions)**		YES	NO
Does the patient exhibit acute or fluctuating psychotic behavior such as hallucinations (perception of something real that is not) or delusions (false beliefs), or Does the patient have prior psychiatric history requiring medication or history of ETOH abuse with possible DT? If so, score "Yes".		EXAMPLES: ▪ Example of hallucinatory behavior is trying to catch a non-existent object; pointing to a non-existent object, etc. ▪ Inappropriate, disorganized, or incoherent speech or thought process, such as unclear or illogical flow of ideas, or flight of ideas. ▪ Secondary psychosis from sleep deprivation or erratic sleep/wake cycle, or from medications (e.g. Reglan)		

OVERALL KU DAT Score. 2 or more (out of 4) "Yes" = POSITIVE Potential for delirium. Notify physician for further assessment and consider Delirium Protocol.	POSITIVE (+)	NEGATIVE (--)

Adapted from: Bergeron, N. et al. (2001). Intensive care delirium screening checklist: evaluation of a new screening tool. *Intensive Care Medicine,* 27: 859-864.