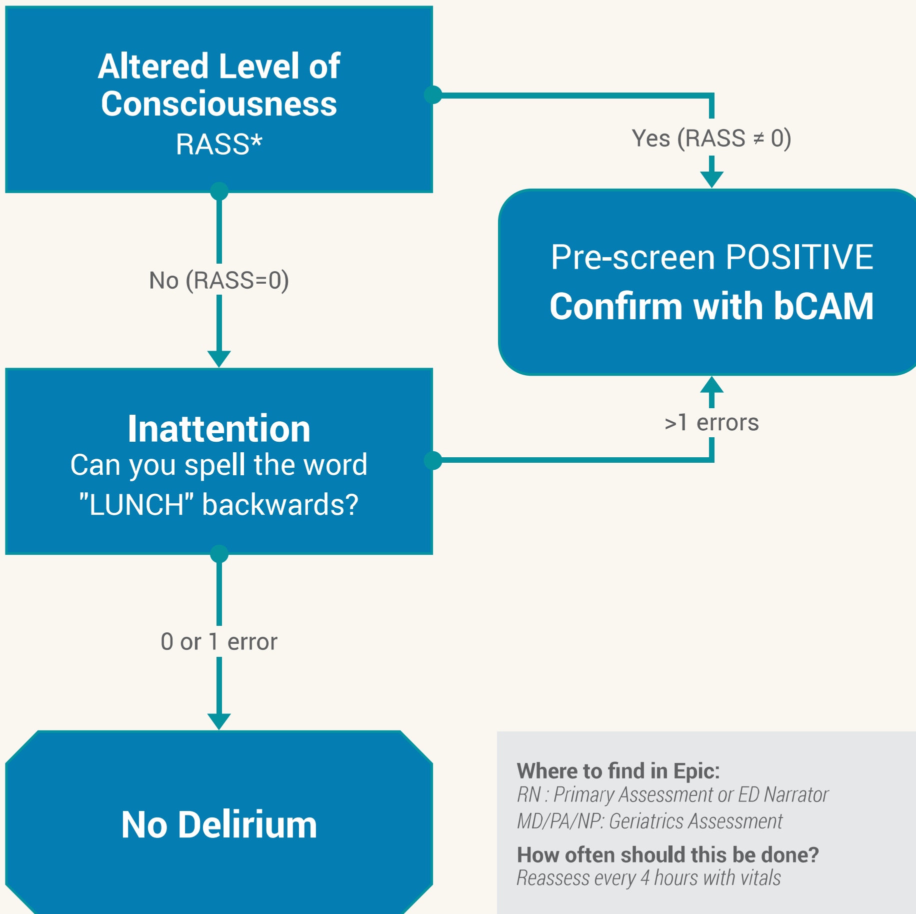
westhealth

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

ED Quick Delirium Screen

aka: Delirium Triage Screen (DTS)



Where to find in Epic:
RN : Primary Assessment or ED Narrator
MD/PA/NP: Geriatrics Assessment

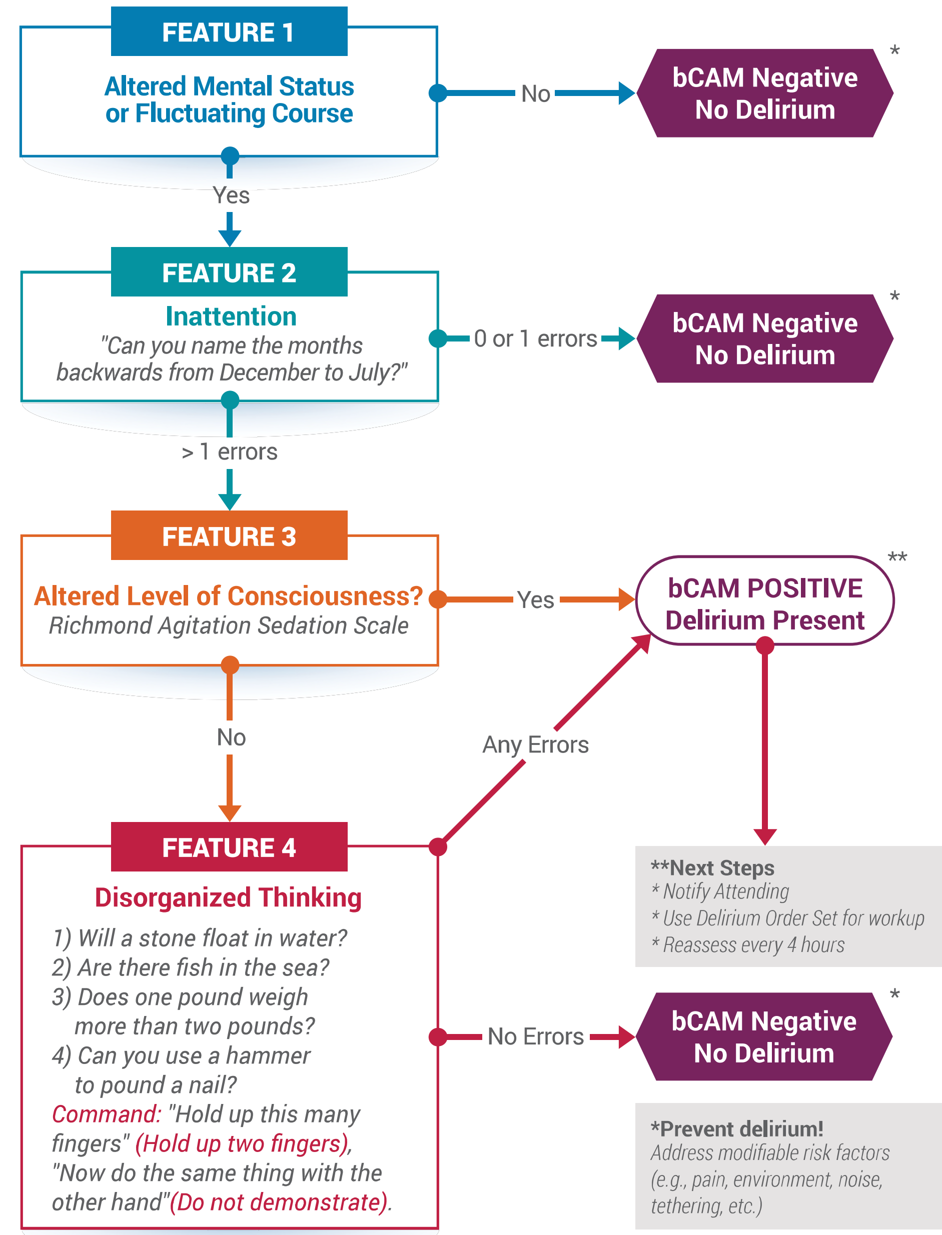
How often should this be done?
Reassess every 4 hours with vitals

*** Richmond Agitation Sedation Scale (RASS)**

-5	-4	-3	-2	-1	0	+1	+2	+3	+4
Unarousable	Deep Sedation	Moderate Sedation	Light Sedation	Drowsy	ALERT CALM	Restless	Agitated	Very Agitated	Combative

VOICE (-5 to -3) · TOUCH (-3 to -1)

Brief Confusion Assessment Method (bCAM) Flow Sheet



****Next Steps**
** Notify Attending*
** Use Delirium Order Set for workup*
** Reassess every 4 hours*

***Prevent delirium!**
Address modifiable risk factors (e.g., pain, environment, noise, tethering, etc.)

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