**Inclusion Criteria:** All patients admitted to Medical/Surgical floors will be screened.

**Exclusion Criteria:** NICU, ambulatory, perioperative areas, ED, infusion patients, PICU

If in PICU, follow PICU protocol for screening and prevention.

Concurrent implementation of preventive strategies and delirium screening as outlined below

---

**Preventive Strategies**

- Environmental Considerations:
  - Provide orienting environment (proper use of Whiteboard, clearly visible clocks)
  - Promote healthy sleep
  - Ensure early mobility and exercise; involve PT/OT
  - Encourage family and developmentally appropriate engagement
  - Please refer to Inpatient Delirium Management

- Medication Considerations:
  - Re-evaluation/confirmation of home medications
  - Assess, prevent and manage pain effectively
  - Assess sedative medication need and effectiveness, wean as able
  - Monitor and prevent withdrawal
  - Minimize polypharmacy and deliriogenic medications as appropriate**

**Deliriogenic Medications:**
- Benzodiazepines
- Narcotics
- Anti-cholinergics
- Ondansetron (Zofran)
- Ranitidine (Zantac)
- Metoclopramide (Reglan)

---

**Delirium Screening**

- RN to perform routine delirium screening using CAPD (Cornell Assessment of Pediatric Delirium) q12hr (Appendix A) and document in medical record

- High clinical suspicion of delirium:
  1) CAPD ≥ 9
  2) Clinical recognition of delirium via the following features (≥1):
     - Acute mental status change
     - Acute onset of hallucination or delusions
     - Confusion or impaired memory
     - Alterations of attention or arousal
     - New catatonic features

---

**Continue prevention and ongoing monitoring via CAPD q12hr and standard clinical assessments**

- Notify provider from primary medical or surgical team.
- Provider to initiate a bedside assessment of patient and proceed to Inpatient Delirium Evaluation

---

**NEXT PAGE**
**CLINICAL PATHWAY:**

**Delirium – Inpatient Care: Evaluation and Work-Up**

*THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.*

**Inclusion Criteria:**
- Patient on inpatient unit with at least 1 of the following features: acute mental status change, acute onset hallucinations or delusions, confusion, impaired memory, alteration of attention or arousal, acute catatonia; OR with clinical suspicion of delirium based on 29 on Cornell Assessment of Pediatric Delirium (CAPD – Appendix A)

**Exclusion Criteria:**
- Patients located in PICU, perioperative, ambulatory clinics
- For patients in the Emergency Department, follow ED Delirium Pathway.

**Etiologies to consider:**
- CNS infection, fever, sepsis/end organ dysfunction (see Sepsis Pathway), hypoxemia, hypoglycemia, electrolyte abnormality, CNS abnormality, intoxication, autoimmune encephalitis, SLE, vasculitis, medication effect, drug withdrawal, metabolic disease, neoplasm

---

**Primary Work-Up:**

- Labs:
  - Stat chem 10, CBC, CRP, ESR, ammonia, PT/PTT/INR, TSH, free T4, VBG or CBG, AST, ALT, EtOH level, ANA
  - Toxicology screen

- Imaging:
  - Consider STAT head CT without contrast based on history and physical exam

**Specific etiology likely?**
- YES: Treat suspected etiology as appropriate and continue delirium management
- NO: Etiology determined?
  - YES: Treat suspected etiology as appropriate and continue delirium management
  - NO: Secondary Work-Up

---

**Secondary Work-Up**

- Blood and urine cultures
- Strongly consider UP: cell count with differential, protein, glucose, gram stain and culture, HSV PCR, enterovirus PCR, opening pressure. Ask lab to hold 3 mL CSF for further studies.
- Begin empiric antibiotics:
  - Ceftriaxone 100 mg/kg/day q12hr (max 2,000 mg/dose) x48 hours AND
  - Vancomycin 15 mg/kg/dose q6hr (max 1,000 mg/dose) x48 hours AND
  - Acyclovir 20 mg/kg/dose IV q8hr until HSV studies negative

**Etiology determined?**
- YES: Treat suspected etiology as appropriate and continue delirium management
- NO: Tertiary Work-Up

---

**Tertiary Work-Up**

- Consult Infectious Disease
- Infectious Encephalitis Panel:
  - Blood: Mycoplasma IgM/IgG, bartonella IgM/IgG, lyme IgM/IgG, West Nile IgM/IgG (June-Nov), Anaplasma Phagocytophilum IgG/IgM (June-Nov), Anaplasma (Ehrlichia) blood smear (June-Nov), Rickettsial Disease Panel (June-Nov, travel to endemic area)
  - CSF: (add on to previously obtained CSF), Meningitis/Encephalitis PCR panel (Biofire; if criteria for use met), EBV PCR, Adenovirus PCR, VDRL (at risk patients), Arbovirus Ab panel (June-Nov)
  - Respiratory: Viral Respiratory Culture (Dec-May)
- Consider evaluation for Autoimmune Encephalitis
  - Brain MRI
  - Blood: ANA, Anti-ENA, Anti-DNA, Anti-phospholipid antibodies, ANCA, Von Willebrand Factor or antigen, ACE level, TPO
  - CSF: (add on to previously obtained CSF) Autoimmune Encephalitis Panel

**Treat suspected etiology as appropriate and continue delirium management**

---

**Cont.**

**RETURN TO THE BEGINNING**
CLINICAL PATHWAY:
Delirium – Inpatient Care: Management

Treat suspected etiology
- Treat suspected etiology per primary and consulting teams, as appropriate

Modifies medication list:
- Re-evaluate/confirm home medications
- Minimize deliriogenic meds (including benzodiazepines, narcotics, ondansetron, metoclopramide, anticholingerics, ranitidine)
- Optimize pain control with non-pharmacologic strategies
- Monitor and prevent withdrawal
- Assess sedative medication need and effectiveness, wean as able
- Melatonin for sleep optimization
- Antipsychotics PRN agitation, in consultation with psychiatry if appropriate

Assessment:
- Consult Physical Therapy
- Involve Child Life

Monitoring and Safety
- Vitals per unit policy
- Continue monitoring for delirium via q 12 hour CAPD (Appendix A)
- Assess fall and self-harm risk
- Ensure safe transfers
- Seizure precautions if necessary
- Bed rest + compression boots if necessary
- Reduce or avoid physical restraints
- Engage and educate parents

How to optimize
- Daily schedule for routine treatments/interventions
- Address patient by name
- Avoid startling/surprising patient
- Reassure & reorient frequently
- Explain treatments in simple language
- Provide clocks within line of sight
- Normalize day & night routine
- Involve Child Life & music therapy
- Promote regular bowel & bladder function

Symptoms improving?

NO
- Broaden differential and obtain further diagnostic testing and consults as indicated
- Continue to optimize environment and medications
- Multidisciplinary family meeting as indicated

YES
- Continue to optimize environment specifically as noted above
- Wean antipsychotic medications, in consultation with psychiatry
- Engage Rehab services as indicated
- Begin discharge planning
- Multidisciplinary family meeting as indicated

Discharge Criteria & Plan:
- Etiology of delirium determined with treatment plan in place, OR delirium resolved
- Outpatient treatment plan in place
- Clearance by Physical Therapy
- Safety of ambulation and ongoing care ensured
- Safety of discharge or transfer ensured
- Outpatient Rehab services in place if indicated
- Appropriate PCP and sub-specialty follow-up appointments in place
- Update PCP at the time of discharge
- Ensure family understanding of ongoing plan
Appendix A: Cornell Assessment of Pediatric Delirium (CAPD) Score

Please see Appendix B – Developmental Anchors, to reference normative behaviors based on age and developmental level.
### CLINICAL PATHWAY: Delirium – Inpatient Care

Appendix B: Developmental Anchors

<table>
<thead>
<tr>
<th>Activity</th>
<th>NB</th>
<th>4 weeks</th>
<th>6 weeks</th>
<th>8 weeks</th>
<th>28 weeks</th>
<th>1 year</th>
<th>2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Are the child’s actions purposeful?</td>
<td>Moves head to side, dominated by primitive reflexes</td>
<td>Reaches (with some coordination)</td>
<td>Symmetric movements, will passively grasp hand</td>
<td>Reaches with coordinated smooth movement</td>
<td>Reaches and manipulates objects, tries to change position, if mobile may try to get up.</td>
<td>Reaches and manipulates objects, tries to change position, if mobile may try to get up and walk.</td>
<td>Prefers primary parent, then other familiar caregivers. Comforted by familiar objects, especially favorite blanket or stuffed animal</td>
</tr>
<tr>
<td>3. Is the child aware of his/her surroundings?</td>
<td>Calm awake time</td>
<td>Awake alert time</td>
<td>Increasing awake alert time</td>
<td>Facial brightening or smile in response to nodding head, brow to bell, coos</td>
<td>Vocodates indicates about needs, e.g., hunger, discomfort, curiosity in objects, or surroundings</td>
<td>Uses single words or signs</td>
<td>3 to 4 word sentences, or signs. May indicate toilet needs, calls self or me</td>
</tr>
<tr>
<td>4. Does the child communicate needs and wants?</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
<td>Cries when hungry or uncomfortable</td>
</tr>
<tr>
<td>5. Is the child restless?</td>
<td>No sustained awake alert state</td>
<td>No sustained calm state</td>
<td>No sustained calm state</td>
<td>No sustained awake alert state</td>
<td>No sustained calm state</td>
<td>No sustained calm state</td>
<td>No sustained calm state</td>
</tr>
<tr>
<td>6. Is the child incoordinated?</td>
<td>Not soothed by parental rocking, singing, feeding, comforting actions</td>
<td>Not soothed by parental rocking, singing, feeding, comforting actions</td>
<td>Not soothed by parental rocking, singing, feeding, comforting actions</td>
<td>Not soothed by parental rocking, singing, feeding, comforting actions</td>
<td>Not soothed by usual methods, e.g., singing, holding, talking</td>
<td>Not soothed by usual methods, e.g., singing, holding, talking, reading</td>
<td>Not soothed by usual methods, e.g., singing, holding, talking</td>
</tr>
<tr>
<td>7. Is the child underactive—very little movement while awake?</td>
<td>Little if any flexed and then relaxed state with primitive reflexes (child should be sleeping comfortably most of the time)</td>
<td>Little if any reaching, kicking, grasping (may be somewhat disorganized)</td>
<td>Little if any reaching, kicking, grasping (may begin to be more coordinated)</td>
<td>Little if any purposeful grasping, control of head and arm movements, such as pushing things that are noxious away</td>
<td>Little if any reaching, grasping, moving around in bed, pushing things away</td>
<td>Little if any play, efforts to sit up, pull up, and if mobile crawl or walk around</td>
<td>Little if any more elaborate play, efforts to sit up and move around, and if able to stand, walk, or jump</td>
</tr>
<tr>
<td>8. Does it take the child a long time to respond to interactions?</td>
<td>Not making sounds or reflexes active as expected (grasp, suck, moor)</td>
<td>Not making sounds or reflexes active as expected (grasp, suck, moor)</td>
<td>Not kicking or crying with noxious stimuli</td>
<td>Not cooing, smiling, or focusing gaze in response to interactions</td>
<td>Not babbling or smiling/laughing in social interactions (or even actively rejecting an interaction)</td>
<td>Not following simple directions. If verbal, not engaging in simple dialogue with words or jargon</td>
<td>Not following 1–2 step, simple commands. If verbal, not engaging in more complex dialogue</td>
</tr>
</tbody>
</table>

**RETURN TO THE BEGINNING**
# Vanderbilt Assessment for Delirium in Infants and Children (VADIC)

## Clinician: 

## Patient ID: 

### Age: 

Patient Intubated?  □ YES  □ NO  Date/Time: 

### Pertinent medication exposure ≤ 24 hrs. prior to assessment (DRUG / DOSE)

1.  

2.  

3.  

4.  

5.  

6.  

### LEVEL OF CONSCIOUSNESS (check one)

- **Combative**  □ YES 
  - State of current mental status – Check one option
    - □ At Baseline
    - □ Acute Change
    - □ Chronic Change

- **Agitated**  □ YES 
  - Pattern of mental status – past 24 hours
    - □ Stable
    - □ Fluctuating

- **Restless**  □ YES 

- **Alert and Calm**  □ YES 

### MENTAL STATUS

#### PERCEPTION

- **Drowsy:** Not fully alert but easily demonstrates sustained awakening with stimulation only from voice  □ YES  
  - Hallucinations: □ auditory □ visual  
    - □ N/A  □ NO  □ YES

- **Lethargy:** Aroused to voice but difficult to maintain the aroused state  □ YES  
  - Hyperacusis present? Comments:  
    - □ N/A  □ NO  □ YES

- **Obtundation:** Responds to stimulation other than pain. May briefly open eyes or have movement, doesn’t interact with person or environment  □ YES  
  - Atypical response to normal stimuli?  
    - (stuffed animals, familiar toys)  
    - □ N/A  □ NO  □ YES

- **Stupor:** Responsive only to pain  □ YES  
  - Unable to soothe when fearful stimuli removed?  
    - □ N/A  □ NO  □ YES

- **Coma:** Unresponsive to pain  □ YES  
  - Comments:

### ATTENTION and COGNITION

<table>
<thead>
<tr>
<th>DECREASED ability to:</th>
<th>Focus attention:</th>
<th>□ NO  □ YES</th>
<th>Sustain attention:</th>
<th>□ NO  □ YES</th>
<th>Shift attention:</th>
<th>□ NO  □ YES</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ORIENTATION:</th>
<th>□ Person  □ Place  □ N/A</th>
</tr>
</thead>
</table>

Comments:

---


CONTACTS: EMILEE LEWIS, MD | LISA NAMEROW, MD
LAST UPDATED: 10.10.19

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### CLINICAL PATHWAY:
Delirium – Inpatient Care
Appendix C: Vanderbilt Assessment for Delirium in Infants and Children (VADIC)

**THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.**

<table>
<thead>
<tr>
<th>SLEEP-WAKE CYCLE</th>
<th>AFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Nap Patterns (Q2-4h infants, Q6h toddlers, QD preschool)</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>Nocturnal Disturbance: (initial, middle, terminal insomnia, phase shift)</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>Day-Night Reversal (more difficult to recognize in infants)</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>Excessive energy for age and context/environment?</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>Irritability or anger</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>Inconsolability</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>Inappropriate Affect</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>Describe Affect:</td>
<td></td>
</tr>
<tr>
<td>Confounders present?</td>
<td>□ Anxiety □ Pain □ Volitional □ None</td>
</tr>
</tbody>
</table>

### LANGUAGE and THOUGHT
- □ Not Present (immature development or developmental delay)
- □ Present

**Receptive Language:**
- One - Step Command | □ NO □ YES
- Two - Step Command | □ NO □ YES
- Three - Step Command | □ NO □ YES

Does not follow commands (check reason below):
- □ Unable due to immaturity/illness (intubated)
- □ Inappropriately not following commands

Describe baseline speech and language per parent/nurse if available:
- □ Appropriate
- □ Decreased amount
- □ Decreased spontaneity
- □ Increased latency
- □ Change from baseline
- □ Circumstantial
- □ Tangential
- □ Obstructed due to disease or device

### IS ACUTE DELIRIUM PRESENT?
- □ UTA When LOC severely depressed, unable to directly clinically assess patient AND prior clinical assessment not available.
- □ NO If NO consider → Subsyndromal delirium(SS) (Delirium probable but NOT all criteria met): □ NO □ YES
- □ YES If YES then choose type → □ HYPOACTIVE □ HYPERACTIVE □ MIXED Drug Withdrawal? □ N/A □ NO □ YES

### 24-HOUR assessment → IS DELIRIUM PRESENT?
- □ PRESENT □ ABSENT □ SUBSYNDROMAL □ UTA

| 1. Acute change Mental Status | 3. Inattention present | 5. Change in Cognition | 7. Change in Affect |
| 2. Fluctuating Course | 4. Inconsolability | 6. Change in Language/Thought | 8. Change in Sleep/Wake Cycle |

**DELIRIUM = 1+2+3+5+7 AND 4 OR 6 OR 8**

*PSYCHOSOMATICS. 2017 ; 58(4): 355–363. DOI:10.1016/J.PSYM.2017.03.006*

CONTACTS: EMILEE LEWIS, MD | LISA NAMEROW, MD

LAST UPDATED: 10.10.19

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**Inclusion Criteria:** Patient in the Emergency Department with acute mental status change, acute onset hallucinations or delusions, confusion, impaired memory, alteration of attention or arousal, acute catatonia

**Exclusion Criteria:** Patient located in the inpatient units (follow the Inpatient Delirium Pathway), PICU, perioperative, ambulatory clinics

**Etiologies to consider:**
- CNS infection, fever, sepsis/end organ dysfunction (see Sepsis Pathway), hypoxemia, hypoglycemia, electrolyte abnormality, CNS abnormality, intoxication, autoimmune encephalitis, SLE, vasculitis, drug withdrawal, metabolic disease, neoplasm

**Initial Workup:**
- Labs:
  - iStat chem 10, CBC, CRP, ESR, ammonia, PT/PTT/INR, TSH, free T4, VBG or CBG, AST, ALT, EtOH level, ANA
  - Toxicology screen
  - Imaging:
    - STAT head CT without contrast
- If febrile:
  - Blood and urine cultures
  - Strongly consider LP: cell count with differential, protein, glucose, gram stain and culture, HSV PCR, enterovirus PCR, opening pressure.
  - Begin empiric IV antimicrobials
    - Ceftriaxone 100 mg/kg/day q12hr (max 2,000 mg/dose) x 48 hours AND
    - Vancomycin 15 mg/kg/dose q6hr (max 1,000 mg/dose) x 48 hours AND
    - Acyclovir 20 mg/kg/dose IV q8hr until HSV studies negative

**≥1 of the following?**
- Ongoing delirium.
- Etiology unclear and symptoms persist. Further workup, evaluation, and treatment required.
- Medical etiology identified, admission criteria met for that diagnosis.

**Consider ED Social Work and/or Psychiatric consult to help determine and support behavioral health needs and establish follow up plan.**

**Admit to Inpatient (Med/Surg vs PICU based on attending discretion.)**
- If Med/Surg, follow Inpatient Delirium Pathway
- Consider following consultations in ED as appropriate (may recommend LP, EEG, Brain MRI, further lab testing)
  - Neurology: if concern for seizure, abnormal EEG, movement disorder, abnormal neurological imaging or focal deficit, or other neurologic diagnosis
  - Rheumatology: if autoimmune process suspected
  - Psychiatry: to assist with recognition/diagnosis of delirium (utilizing the VADIC assessment tool – Appendix A); determine/confirm etiology; assist with pharm + non-pharmaceutical management
  - ID: concern for unidentified or known complicated infectious process

- Continue screening, evaluation, and treatment per the Inpatient Delirium Clinical Pathway
- Initiate Ongoing Delirium Management on admission

**YES**

**NEXT PAGE**
CLINICAL PATHWAY: Delirium – Emergency Room Care: Management

Treat suspected etiology
- Treat suspected etiology per primary and consulting teams, as appropriate

Medications & Assessment
- Modify medication list:
  - Re-evaluate/confirn home medications
  - Minimize deliriogenic meds (including benzodiazepines, narcotics, ondansetron, metoclopramide, anticholinergics, ranitidine)
  - Optimize pain control with non-pharmacologic strategies
  - Monitor and prevent withdrawal
  - Assess sedative medication need and effectiveness, wean as able
  - Melatonin for sleep optimization
  - Antipsychotics PRN agitation, in consultation with psychiatry if appropriate

Assessment:
- Consult Physical Therapy
- Involve Child Life

Nursing Care
- Monitoring and Safety:
  - Vitals per unit policy
  - Continue monitoring for delirium via q 12 hour CAPD
  - Assess fall and self-harm risk
  - Ensure safe transfers
  - Seizure precautions if necessary
  - Bed rest + compression boots if necessary
  - Reduce or avoid physical restraints
  - Engage and educate parents

Optimize environment
- How to optimize:
  - Daily schedule for routine treatments/interventions
  - Address patient by name
  - Avoid startling/surprising patient
  - Reassure & reorient frequently
  - Explain treatments in simple language
  - Provide clocks within line of site
  - Normalize day & night routine
  - Involve child life & music therapy
  - Promote regular bowel & bladder function

Symptoms improving?
- NO
  - Broaden differential and obtain further diagnostic testing and consults as indicated
  - Continue to optimize environment and medications
  - Multidisciplinary family meeting as indicated

- YES
  - Continue to optimize environment specifically as noted above
  - Wean antipsychotic medications, in consultation with psychiatry
  - Engage rehab services as indicated
  - Begin discharge planning
  - Multidisciplinary family meeting as indicated

Discharge Criteria & Plan:
- Etiology of delirium determined with treatment plan in place, OR delirium resolved
- Outpatient treatment plan in place
- Clearance by Physical Therapy
- Safety of ambulation and ongoing care ensured
- Safety of discharge or transfer ensured
- Outpatient Rehab services in place if indicated
- Appropriate PCP and sub-specialty follow-up appointments in place
- Update PCP at the time of discharge
- Ensure family understanding of ongoing plan

CONTACTS: EMILEE LEWIS, MD | ERIC HOPPA, MD | LISA NAMEROW, MD
LAST UPDATED: 10.10.19
# VANDERBILT ASSESSMENT FOR DELIRIUM IN INFANTS AND CHILDREN (VADIC)

<table>
<thead>
<tr>
<th>Clinician:</th>
<th>Patient ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Patient Intubated?</td>
</tr>
</tbody>
</table>

**Pertinent medication exposure ≤ 24 hrs. prior to assessment (DRUG / DOSE)**

<table>
<thead>
<tr>
<th>1.</th>
<th>4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>5.</td>
</tr>
<tr>
<td>3.</td>
<td>6.</td>
</tr>
</tbody>
</table>

**LEVEL OF CONSCIOUSNESS (check one)**

- **Combative**: □ YES  
  - State of current mental status – Check one option
  - □ At Baseline  | □ Acute Change  | □ Chronic Change

- **Agitated**: □ YES
  - Pattern of mental status – past 24 hours
  - □ Stable  | □ Fluctuating

- **Restless**: □ YES  
  - □ Alert and Calm

- **Drowsy**: Not fully alert but easily demonstrates sustained awakening with stimulation only from voice
  - □ YES
  - Hallucinations:
    - □ auditory  | □ visual  
  - □ N/A  | □ NO  | □ YES

- **Lethargy**: Aroused by voice but difficult to maintain the aroused state
  - □ YES
  - Hyperacusis present? Comments:
  - □ N/A  | □ NO  | □ YES

- **Obtundation**: Responds to stimulation other than pain. May briefly open eyes or have movement, doesn’t interact with person or environment
  - □ YES
  - Atypical response to normal stimuli
    - (stuffed animals, familiar toys)
    - □ N/A  | □ NO  | □ YES

- **Stupor**: Responsive only to pain
  - □ YES
  - Unable to soothe when fearful stimuli removed?
  - □ N/A  | □ NO  | □ YES

- **Coma**: Unresponsive to pain
  - □ YES
  - Comments:

**ATTENTION and COGNITION**

<table>
<thead>
<tr>
<th>DECREASED ability to:</th>
<th>Focus attention:</th>
<th>□ NO</th>
<th>□ YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustain attention:</td>
<td>□ NO</td>
<td>□ YES</td>
<td></td>
</tr>
<tr>
<td>Shift attention:</td>
<td>□ NO</td>
<td>□ YES</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORIENTATION:</th>
<th>□ Person</th>
<th>□ Place</th>
<th>□ N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**REFERENCES**


---

**CONTACTS:** EMILEE LEWIS, MD | ERIC HOPPA, MD | LISA NAMEROW, MD

**LAST UPDATED:** 10.10.19

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**CLINICAL PATHWAY:**
Delirium – Emergency Room Care

**Appendix A: Vanderbilt Assessment for Delirium in Infants and Children (VADIC)**

### Sleep-Wake Cycle

<table>
<thead>
<tr>
<th>Pattern/Phase</th>
<th>Normal Nap Patterns (0-4h in infants, 6h toddlers, QO)</th>
<th>24-hr Disturbance</th>
<th>Day-Night Reversal (more difficult to recognize in infants)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
</tr>
</tbody>
</table>

### Affect

<table>
<thead>
<tr>
<th></th>
<th>Excessive energy for age and content/environment?</th>
<th>Irritability or anger</th>
<th>Inconsolability</th>
<th>Inappropriate Affect</th>
<th>Describe Affect:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
<td>□ NO □ YES</td>
<td>Confounders present?</td>
</tr>
</tbody>
</table>

### Language and Thought

<table>
<thead>
<tr>
<th>Language/Thought</th>
<th>Receptive Language:</th>
<th>Describe baseline speech and language per parent/nurse if available:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One-Step Command</td>
<td>□ Appropriate</td>
</tr>
<tr>
<td></td>
<td>Two-Step Command</td>
<td>□ Decreased amount</td>
</tr>
<tr>
<td></td>
<td>Three-Step Command</td>
<td>□ Decreased spontaneity</td>
</tr>
<tr>
<td></td>
<td>Does not follow commands (check reason below):</td>
<td>□ Increased latency</td>
</tr>
<tr>
<td></td>
<td>□ Unable due to immaturity/illness (intubated)</td>
<td>□ Change from baseline</td>
</tr>
<tr>
<td></td>
<td>□ Inappropriately not following commands</td>
<td>□ Circumstantial</td>
</tr>
</tbody>
</table>

### Is Acute Delirium Present?

<table>
<thead>
<tr>
<th>UTA</th>
<th>When LOC severely depressed, unable to directly clinically assess patient AND prior clinical assessment not available.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>If NO consider → Subsyndromal delirium (SD) (Delirium probable but NOT all criteria met): □ NO □ YES</td>
</tr>
<tr>
<td>YES</td>
<td>If YES then choose type → HYPOACTIVE □ HYPERACTIVE □ MIXED Drug Withdrawal? □ N/A □ NO □ YES</td>
</tr>
</tbody>
</table>

### 24-HOUR assessment → Is Delirium Present?

<table>
<thead>
<tr>
<th>Present</th>
<th>Absent</th>
<th>Subsyndromal</th>
<th>UTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Acute change Mental Status</td>
<td>□ 3. Inattention present</td>
<td>□ 5. Change in Cognition</td>
<td>□ 7. Change in Affect</td>
</tr>
<tr>
<td>□ 2. Fluctuating Course</td>
<td>□ 4. Inconsolability</td>
<td>□ 6. Change in Language/Thought</td>
<td>□ 8. Change in Sleep/Wake Cycle</td>
</tr>
</tbody>
</table>

DELIRIUM = 1+2+3+5+7 AND 4 OR 6 OR 8


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LAST UPDATED: 10.10.19

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