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The Delirium Index

An instrument for measuring the severity of delirium

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THE DELIRIUM INDEX
AN INSTRUMENT FOR MEASURING THE SEVERITY OF DELIRIUM

The Delirium Index (DI) is an instrument for the measurement of severity of symptoms of delirium that is based solely upon observation of the individual patient, without additional information from family members, nursing staff or the patient's medical chart. The DI was designed to be used in conjunction with the Mini Mental State Exam (MMSE): at least the first five questions of the MMSE comprise the basis of observation. Additional questions may be necessary for scoring certain symptoms as noted.

1) Inattention

0. Attentive;
1. Generally attentive but makes at least one error in spelling 'WORLD' backwards;
2. Can generally answer questions, but subject is distractible and at times has difficulty keeping track of questions. May have some difficulty shifting attention to new questions, or questions may have to be repeated several times;
3. Unresponsive or totally unable to keep track of or answer questions. Has great difficulty in focusing attention and is often distracted by irrelevant stimuli;
9. Cannot assess (or patient refuses)

2) Disorganised thinking

0. Responses are logical, coherent, and relevant;
1. Responses are vague or unclear;
2. Thought is occasionally illogical, incoherent, or irrelevant;
3. Unresponsive or thought is fragmented, illogical, incoherent, and irrelevant;
9. Cannot assess (or patient refuses)

3) Altered level of consciousness

0. Normal level of consciousness
1. a) Hypervigilant,
   b) Hypovigilant; (glassy-eyed, decreased reaction to questions);
2. Drowsy/sleepy; Responds only to loud questions;
3. Unresponsive <u>or</u> comatose.

4) Disorientation in time and place

See MMSE questions 1-2. Additional questions on age, birth date, and birth place may be used.

0. Knows today's date (± 1 day) <u>and</u> the name of the hospital;
1. Does not know today's date (± 1 day) <u>or</u> does not know the name of the hospital;
2. Does not know the month or year <u>or</u> does not know that is in the hospital;
3. Unresponsive <u>or</u> does not know name or birth date;
9. Cannot assess (or patient refuses)

5) Memory impairment

0. Recalls three words <u>or</u> details of hospitalisation;
1. Cannot recall one of the words, <u>or</u> has difficulty recalling details of the hospitalisation;
2. Cannot recall two of the three words <u>or</u> recalls few details of the hospitalisation;
3. Unresponsive or cannot recall any of the three words <u>or</u> details of the hospitalisation;
9. Cannot assess (or patient refuses)

6) Perceptual disturbances

0. Unresponsive or no perceptual disturbances observed,
1. Misinterprets stimuli (for example, interpreting a door closing as a gunshot);
2. Has occasional non-threatening hallucinations;
3. Has frequent, threatening hallucinations.

7a) Psychomotor agitation

0. No psychomotor agitation;
1. Responds well to questions but moves frequently;
2. Moves continuously (and may be restrained);
3. Agitated, difficult to control (restraints are required)

7b) Psychomotor retardation

0. No psychomotor retardation;
1. Lethargic/sluggish
2. Moves slowly and little spontaneous movement
3. No voluntary movement

Scoring:

1. Total score is sum of 7 item scores.
2. If questions 1, 2, 4 or 5 are checked "9" replace 9 by the score of item 3.

References:

1. McCusker J, Cole M, Bellavance F, Primeau F. The reliability and validity of a new measure of severity of delirium. International Psychogeriatrics, 10(4): 421-433, 1998.

2. McCusker J, Cole M, Dendukuri N, Belzile E. The Delirium Index, a measure of the severity of delirium: New findings on reliability, validity, and responsiveness. Journal of the American Geriatrics Society, 52(10):1744-1749, 2004.