DELIRIUM PREVENTION

Avoid moving people within and between wards or rooms unless absolutely necessary

1. Stimulating the mind
2. Hydration
3. Constipation and urination
4. Hypoxia
5. Infection
6. Movement
7. Pain
8. Medication
9. Nutrition
10. Seeing and hearng
11. Sleep

LANDSPÍTALI

www.landspitali.is/orad - Gæðahandbók Landspítala: LSH-188, mars 2024

DOS
Delirium observation screening scale

	SOMETIMES OR ALWAYS (1 point)	NEVER (0 point)
1. Doses off during conversation or activities	☐	☐
2. Is easily distracted by stimuli from the environment	☐	☐
3. Loses attention to conversation or action	☐	☐
4. Does not finish question or answer	☐	☐
5. Gives answers that do not fit the question.	☐	☐
6. Reacts slowly to instructions.	☐	☐
7. Thinks they are somewhere else	☐	☐
8. Does not know which part of the day it is	☐	☐
9. Dos not remember recent events	☐	☐
10. Is picking, disorderly, restless	☐	☐
11. Pulls IV tubes, feeding tubes, catheters, etc.	☐	☐
12. s easily or suddenly emotional	☐	☐
13. Sees/hears things that are not there	☐	☐

Total:

Score of 3 or more indicates possible delirium