



**NEECHAM ACUTE  
CONFUSION SCALE**

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**SCORING: Complete on admission and daily for 72 hours. If score less than 25, continue daily.**

Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initials	Date/Time/Initial	Date/Time/Initial
Level 1 _____	Level 1 _____	Level 1 _____	Level 1 _____	Level 1 _____	Level 1 _____
Level 2 _____	Level 2 _____	Level 2 _____	Level 2 _____	Level 2 _____	Level 2 _____
Level 3 _____	Level 3 _____	Level 3 _____	Level 3 _____	Level 3 _____	Level 3 _____
Total _____	Total _____	Total _____	Total _____	Total _____	Total _____

		Total Score of:	Indicates:
Level 1 Score:	Processing (0-14 points)	0-19	Moderate to severe confusion
Level 2 Score:	Behavior (0-10 points)	20-24	Mild or early development of confusion
		25-26	"Not confused" but at high risk for confusion
Level 3 Score:	Integrative Physiological Control (0-6 points)	27-30	"Not confused" or normal function

Neelon/Champagne/McConnell

**COMMENTS:**

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Initials	Signature	Title	Initials	Signature	Title	Initials	Signature	Title

Delirium is primarily multifactorial and identification of a single cause frequently leads to an incomplete plan of care. Three types of factors usually contribute to the development, severity, and duration of delirium. When score is 24 or less, consider the following:

Predisposing Factors <i>(Vulnerability factors that increase a patient's risk or likelihood of developing delirium)</i>	Precipitating Factors <i>(Physiological factors that are known to directly contribute to the development of delirium)</i>	Facilitating Factors <i>(Environmental, psychosocial, comfort, and functional issues that when present facilitate the onset, increase the severity or duration of delirium, but are generally not directly contributory without other physiological factors)</i>
Advance age 75 or older	Medications with CNS effects: sedatives, hypnotics, opioids	Immobility
Sensory Impairment	Fluid and electrolyte imbalances	Elimination
History of acute confusion	Metabolic changes e.g. hypoxia, hyper/hypo glycemia, decreased Hgb	Changes in the environment
Pre-existing cognitive impairment -dementia -Parkinson's disease -stroke -brain injury	Nutritional deficiencies	Pain and discomfort
Depression	Trauma	Anxiety
Substance abuse	Neurological event	Insufficient lighting
Cardiac disease and multiple chronic illnesses	Infections (e.g., pneumonia, UTI's)	Restraints
Functional impairment		Other tethering devices that tend to decrease the patient's mobility (e.g. IV, O2, cannula, Foley catheter, telemetry)
Fall in last 30 days		



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**LEVEL 1 - PROCESSING**

Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial
<b>PROCESSING - ATTENTION: (Attention - Alertness - Responsiveness)</b>					
4 <u>Full attentiveness/alertness:</u> Responds immediately and appropriately to calling of name or touch — maintains eye contact, head turns when calling their name; fully aware of surroundings, attends to environmental events appropriately.					
3 <u>Short or hyper attention/alertness:</u> Either shortened attention to calling, touch, or environmental events or hyper alert over-attentive to cues/objects in environment.					
2 <u>Attention/alertness inconsistent or inappropriate:</u> Slow in responding, repeated calling or touch required to elicit/maintain eye contact/attention; able to recognize objects/stimuli, though may drop into sleep between stimuli.					
1 <u>Attention/alertness disturbed:</u> Eyes open to sound or touch; may appear fearful, unable to attend/recognize contact, or may withdraw, or demonstrate combative behavior.					
0 <u>Arousal/responsiveness depressed:</u> eyes may/may not open; only minimal arousal possible with repeated stimuli; unable to recognize contact.					
Score	Score	Score	Score	Score	Score

<b>PROCESSING - COMMAND: (Recognition - Interpretation - Action)</b>					
5 <u>Able to follow a complex command:</u> "Turn on nurse's call light". (Must search for object, recognize object, perform command.)					
4 <u>Slowed complex command response:</u> Requires prompting or repeated directions to follow/complete a complex command. Performs complex command in "slow"/over-attending manner.					
3 <u>Able to follow a simple command:</u> "Lift your hand or foot Ms...". (Only use 1 object)					
2 <u>Unable to follow direct command:</u> Follows command prompted by touch or visual cue—drinks from glass placed near mouth. Responds with calming affect to nursing contact and reassurance or hand holding.					
1 <u>Unable to follow visually guided command:</u> Responds with dazed or frightened facial features, and/or withdrawal resistive response to stimuli, hyper/hypoactive behavior; does not respond to nurse gripping hand lightly.					
0 <u>Hypoactive, lethargic:</u> Minimal motor/responses to environmental stimuli.					
Score	Score	Score	Score	Score	Score

<b>PROCESSING - ORIENTATION: (Orientation - Short-term Memory - Thought/Speech Content)</b>					
5 <u>Oriented to time, place, and person:</u> Thought processes, content of conversation or questions appropriate. Short-term memory intact.					
4 <u>Oriented to person and place:</u> Minimal memory/recall disturbance, content and response to questions generally appropriate; may be repetitive, requires prompting to continue contact. Generally cooperates with requests.					
3 <u>Orientation inconsistent:</u> Oriented to self, recognizes family but time and place orientation fluctuates. Uses visual cues to orient. Thought/memory disturbance common, may have hallucinations or illusions. Passive cooperation with requests (cooperative cognitive protecting behaviors).					
2 <u>Disoriented and memory/recall disturbed:</u> Oriented to self/recognizes family. May question actions of nurse or refuse requests, procedures (resistive cognitive protecting behaviors). Conversation content/thought disturbed. Illusions and/or hallucinations common.					
1 <u>Disoriented, disturbed recognition:</u> Inconsistently recognizes familiar people, family, objects. Inappropriate speech/sounds.					
0 <u>Processing of stimuli depressed:</u> Minimal response to verbal stimuli.					
Score	Score	Score	Score	Score	Score



**North Memorial  
Medical Center**

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Robbinston, MN 55422-2900

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**LEVEL 2 - BEHAVIOR**

Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial
<b>BEHAVIOR - APPEARANCE:</b>					
2 <u>Controls posture, maintains appearance, hygiene:</u> Appropriately gowned or dressed, personally tidy, clean. Posture in bed/chair normal.					
1 <u>Either posture or appearance disturbed:</u> Some disarray of clothing/bed or personal appearance, or some loss of control of posture, position.					
0 <u>Both posture and appearance abnormal:</u> Disarrayed, poor hygiene, unable to maintain posture in bed.					
Score _____	Score _____	Score _____	Score _____	Score _____	Score _____
<b>BEHAVIOR - MOTOR:</b>					
4 <u>Normal motor behavior:</u> Appropriate movement, coordination and activity, able to rest quietly in bed. Normal hand movement.					
3 <u>Motor behavior slowed or hyperactive:</u> Overly quiet or little spontaneous movement (hands/arms across chest or at sides) or hyperactive (up/down, "jumpy"). May show hand tremor.					
2 <u>Motor movement disturbed:</u> Restless or quick movements. Hand movements appear abnormal—picking at bed objects or bed covers, etc. May require assistance with purposeful movements.					
1 <u>Inappropriate, disruptive movements:</u> Pulling at tubes, trying to climb over rails, frequent purposeless actions.					
0 <u>Motor movement depressed:</u> Limited movement unless stimulated; resistive movements.					
Score _____	Score _____	Score _____	Score _____	Score _____	Score _____
<b>BEHAVIOR - VERBAL:</b>					
4 <u>Initiates speech appropriately:</u> Able to converse, can initiate and maintain conversation. Normal speech for diagnostic condition, normal tone.					
3 <u>Limited speech initiation:</u> Responses to verbal stimuli are brief and noncomplex. Speech clear for diagnostic condition, tone may be abnormal, rate may be slow.					
2 <u>Inappropriate speech:</u> May talk to self or not make sense. Speech not clear for diagnostic condition.					
1 <u>Speech/sound disturbed:</u> Altered sound/tone. Mumbles, yells, swears or is inappropriately silent.					
0 <u>Abnormal sounds:</u> Groaning or other disturbed sounds. No clear speech.					
Score _____	Score _____	Score _____	Score _____	Score _____	Score _____



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**LEVEL 3 - PHYSIOLOGIC CONTROL**

Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial
<b>PHYSIOLOGIC MEASUREMENTS:</b>		<b>Normals:</b>	Temp = 96.8-98.6	Systolic BP = 100-160	Diastolic BP = 50-90
<b>Recorded Values:</b>			Pulse 60 - 100	Respirations = 14-22	O <sub>2</sub> Sats = 93 or above
Temp	Temp	Temp	Temp	Temp	Temp
SBP	SBP	SBP	SBP	SBP	SBP
DBP	DBP	DBP	DBP	DBP	DBP
Pulse Reg or Irreg (circle one)	Pulse Reg or Irreg (circle one)	Pulse Reg or Irreg (circle one)	Pulse Reg or Irreg (circle one)	Pulse Reg or Irreg (circle one)	Pulse Reg or Irreg (circle one)
Resp. Yes No apnea	Resp. Yes No apnea	Resp. Yes No apnea	Resp. Yes No apnea	Resp. Yes No apnea	Resp. Yes No apnea
O <sub>2</sub> Sat / O <sub>2</sub> Therapy (circle) No Yes, but not on Yes, on now	O <sub>2</sub> Sat / O <sub>2</sub> Therapy (circle) No Yes, but not on Yes, on now	O <sub>2</sub> Sat / O <sub>2</sub> Therapy (circle) No Yes, but not on Yes, on now	O <sub>2</sub> Sat / O <sub>2</sub> Therapy (circle) No Yes, but not on Yes, on now	O <sub>2</sub> Sat / O <sub>2</sub> Therapy (circle) No Yes, but not on Yes, on now	O <sub>2</sub> Sat / O <sub>2</sub> Therapy (circle) No Yes, but not on Yes, on now

**VITAL FUNCTION STABILITY:** (Count abnormal SBP and/or DBP as one value; count abnormal and/or irregular pulse as one; count apnea and/or abnormal resp. as one, and abnormal temp. as one.)

- 2 BP, HR, TEMP, RESPIRATION within normal range with regular pulse
- 1 Any one of the above in abnormal range
- 0 Two or more in abnormal range

Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_

**OXYGEN SATURATION STABILITY:**

- 2 O<sub>2</sub> Sat in normal range (93 or above)
- 1 O<sub>2</sub> Sat 90 to 92 or is receiving oxygen
- 0 O<sub>2</sub> Sat below 90

Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_

**URINARY CONTINENCE CONTROL:**

- 2 Maintains bladder control
- 1 Incontinent of urine in last 24 hours or has condom cath
- 0 Incontinent or has indwelling or intermittent catheter or is anuric.

Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_ Score \_\_\_\_\_