Delirium Observation Screening (Dos) Scale
(version 0 - 1)

Date:
Patient Name:

	OBSERVATION The patient	Day shift			Evening shift			Night shift			TOTAL SCORE TODAY (0 - 39)
		Never	sometimes - always	unable	never	sometimes - always	unable	never	sometimes - always	unable	
1	Dozes off during conversation or activities	0	1	-	0	1	-	0	1	-	
2	Is easily distracted by stimuli from the environment	0	1	-	0	1	-	0	1	-	
3	Maintains attention to conversation or action	1	0	-	1	0	-	1	0	-	
4	Does not finish question or answer	0	1	-	0	1	-	0	1	-	
5	Gives answers that do not fit the question	0	1	-	0	1	-	0	1	-	
6	Reacts slowly to instructions	0	1	-	0	1	-	0	1	-	
7	Thinks they are somewhere else	0	1	-	0	1	-	0	1	-	
8	Knows which part of the day it is	1	0	-	1	0	-	1	0	-	
9	Remembers recent events	1	0	-	1	0	-	1	0	-	
10	Is picking, disorderly, restless	0	1	-	0	1	-	0	1	-	
11	Pulls IV tubing, feeding tubes, catheters etc.	0	1	-	0	1	-	0	1	-	
12	Is easily or suddenly emotional	0	1	-	0	1	-	0	1	-	
13	Sees/hears things which are not there	0	1	-	0	1	-	0	1	-	
	TOTAL SCORE PER SHIFT (0 - 13)										
	DOS SCALE FINAL SCORE = TOTAL SCORE TODAY / 3										

DOS SCALE Final Score	< 3	Not delirious
	≥ 3	Probably delirious

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INSTRUCTIONS

Introduction

Delirium is one of the most frequent forms of psychopathology in elderly patients and inpatients at the end-of life. Delirium develops in a short period of time and symptoms fluctuate during the day. The Delirium Observation Screening Scale is a 13-item observational scale of verbal and nonverbal behavior. The observations can be done during regular care. To optimize recognition of delirium, recording of observations per shift is important.

Rating

never During this shift, in contacts with the patient the described behavior was not observed (CIRCLE THE APPROPRIATE NUMBER IN THIS COLUMN)

sometimes- always During this shift, in contacts with the patient the described behavior was observed once, or a few times or even all the time (CIRCLE THE APPROPRIATE NUMBER IN THIS COLUMN)

unable During this shift, in contacts with the patient the described behavior was not observed since the patient was asleep or did not give necessary verbal responses OR the rater does not find himself/herself competent to observe the absence or presence of the behavior (CIRCLE -)

Score

- For each shift the total score is calculated by counting the circled ratings; the total score per shift is a minimum of 0 and a maximum of 13
- Adding the total scores per shift gives the total score for today; the total score for today is a minimum 0 and a maximum of 39
- The DOS Scare final score is calculated by dividing the total score for today by 3; the DOS final score is between 0 and 13
- A DOS Scale final score < 3 means that the patient is most probably not delirious; a DOS Scale final score of ≥ 3 means that the patient is most probably delirious*

* In a study of 18 delirious patients in a group of 92 hip fracture patients, 94.4% (sensitivity of the DOS Scale) of the delirious patients had a DOS Scale final score of 3 or more; 76.6% (specificity of the DOS Scale) of the non-delirious patients had a DOS Scale final score of less than 3. (Schulman's, 2001)

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