DEMENTIA DOCTOR
For a Happier and Healthier Life Together

Delirium Observation Screening (DOS) Scale

	OBSERVATION Name Patiënt: Date:	Morning shift			Day shift			Night shift			TOTAL SCORE TODAY (0 - 39)
		never	sometimes - always	unable	never	sometimes - always	unable	never	sometimes - always	unable	
1	Dozes of 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 to be 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 event	1	0	-	1	0	-	1	0	-	
10	Is picking, disorderly, restless	0	1	-	0	1	-	0	1	-	
11	Pulls ivtubes, feeding tubes, catheters etc.	0	1	-	0	1	-	0	1	-	
12	Is easy or sudden 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 patients at the end-of-life. Delirium develops in a short period, and symptoms fluctuate during the day. The Delirium Observation Screening Scale is a 13-item observational scale of verbal and nonverbal behaviour. Do the observations during regular care. To optimise recognition of delirium, the recording of observations per shift is essential.

Rating

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

Sometimes -always — During this shift, in contacts with the patient the described behaviour always 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 behaviour 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 behaviour (CIRCLE THE -)

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
- Calculate the final DOS score by dividing the total score for today by 3; the DOS final score is between 0 and 1
- A DOS Scale final score < 3 means that the patient is most probably not delirious; a DOS Scale final score of ≥ 3 indicates 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).

Schuurmans MJ, Shortridge-Baggett LM, Duursma SA. The Delirium Observation Screening Scale: a screening instrument for delirium. Res Theory Nurs Pract 2003;17(1):31-50.