NEECHAM CONFUSION SCALE

NAME/ID:_____ **DATE:**_____ **TIME:**_____

SCORED BY:_____

LEVEL I – PROCESSING

PROCESSING – ATTENTION: (Attention-Alertness-Responsiveness)

4 **Full attentiveness/alertness:** responds immediately and appropriately to calling of name or touch – eyes, head turn, fully aware of surroundings, attends to environmental events appropriately

3 **Short or hyper attention/alertness:** either shortened attention to calling, touch, or environmental events or hyper alert, over-active to cues/objects in environment

2 **Attention/alertness inconsistent or inappropriate:** 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 **Attention/alertness disturbed:** eyes open to sound or touch; may appear fearful, unable to attend/recognize contact, or may show withdrawal/combative behavior

0 **Arousal/responsiveness depressed:** eyes may/may not open; only minimal arousal possible with repeated stimuli; unable to recognize contact

PROCESSING – COMMAND: (Recognition-Interpretation-Action)

5 **Able to follow a complex command:** "Turn on nurse's call light" (Must search for object, recognize object, perform command)

4 **Slowed complex command response:** requires prompting or repeated directions to follow/complete command. Performs complex command in "slow" /over-attending manner

3 **Able to follow a simple command:** "Lift your hand or foot Mr. …." (Only use 1 object)

2 **Unable to follow direct command:** follows commands prompted by touch or visual cue—drinks from glass placed near mouth. Responds with calming affect to nurse contact and reassurance or handholding

1 **Unable to follow visual guided command:** 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 **Hypoactive, lethargic:** minimal motor/responses to environmental stimuli

PROCESSING – ORIENTATION: (Orientation, Short-term Memory, Thought/Speech Content)

5 **Oriented to time, place, and person:** thought processes, content of conversation or questions appropriate. Short-term memory intact

4 **Oriented to person to place:** minimal memory/recall disturbance, content and response to questions generally appropriate; may be repetitive, requires prompting to continue contact. Generally cooperates with requests

3 **Orientation Inconsistent:** 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 **Disoriented and memory/recall disturbed:** 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 **Disoriented, disturbed recognition:** inconsistently recognizes familiar people, family, objects. Inappropriate speech/sounds.

0 **Processing of stimuli depressed:** minimal responses to verbal stimuli

LEVEL 2 – BEHAVIOR

BEHAVIOR – APPEARANCE:

2 **Controls posture, maintains appearance, hygiene:** appropriately gowned or dressed, personality tidy, clean. Posture in bed/chair normal.

1 **Either posture or appearance disturbed:** some disarray of clothing/bed or personal appearance, or some loss of control of posture, position.

0 **Both posture and appearance abnormal:** disarrayed, poor hygiene, unable to maintain posture in bed

BEHAVIOR – MOTOR:

4 **Normal motor behavior:** appropriate movement, coordination and activity, able to rest quietly in bed. Normal hand movement.

3 **Motor behavior slowed or hyperactive:** overly quiet or little spontaneous movement (hands/arms across chest or at sides) or hyperactive (up/down, "jumpy"). May show hand tremor.

2 **Motor movement disturbed:** restless or quick movement. Hand movements appear abnormal—picking at bed objects or bed covers, etc. May require assistance with purposeful movements.

1 **Inappropriate, disruptive movements:** pulling at tubes, trying to climb over rails, frequent purposeless actions.

0 **Motor movement depressed:** limited movements unless stimulated; resistive movements.

BEHAVIOR – VERBAL:

4 **Initiates speech appropriately:** able to converse, can initiate and maintain conversation. Normal speech for diagnostic condition, normal tone.

3 **Limited speech initiation:** responses to verbal stimuli are brief and uncomplex. Speech clear for diagnostic condition, tone may be abnormal rate may be slow.

2 **Inappropriate speech:** may talk to self or not make sense. Speech not clear for diagnostic condition.

1 **Speech/sound disturbed:** altered sound/tone. Mumbles, yells, swears or is inappropriately silent.

0 **Abnormal sounds:** groaning or other disturbed sounds. No clear speech.

LEVEL 3 – PHYSIOLOGIC CONTROL

PHYSIOLOGICAL MEASUREMENTS:

Recorded Values:	**Normal:**	
_____ Temperature	(36-37°)	_____ Periods of apnea/hypopnea present? 1=yes, 0=no
_____ Systolic BP	(100-160)	_____ Oxygen therapy prescribed? 0=no, 1=yes, but not on, 2= yes on now
_____ Diastolic BP	(50-90)	
_____ Heart Rate (HR) Regular/ Irregular	(60-100) (circle one)	
_____ Respirations	(14-22) (Count for one full minute)	
_____ O_2 saturation	(93 or above)	

VITAL FUNCTION STABILITY: (Count abnormal SBP and/or DBP as one value; count abnormal and/or irregular HR as one; count apnea and/or abnormal respiration 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

OXYGEN SATURATION STABILITY:

2 O_2 sat in normal range (93 or above)

1 O_2 sat 90 to 92 or is receiving oxygen

0 O_2 sat below 90

URINARY CONTINENCE CONTROL:

2 Maintains bladder control

1 Incontinent of urine in last 24 hours or has condom cath

0 Incontinent now or has indwelling or intermittent catheter or is anuric

_____ **LEVEL 1 Score:** Processing (0-14 points)

_____ **LEVEL 2 Score:** Behavior (0-10 points)

_____ **LEVEL 3 Score:** Integrative Physiological Control (0-6 points)

_____ **TOTAL NEECHAM** (0-30 points)

Total Score of:	Indicates:
0-19	Moderate to severe confusion
20-24	Mild or early development of confusion
25-26	"Not Confused," but at high risk of confusion
27-30	"Not Confused," or normal function