Appendix 1.

Delirium Observation Screening Scale (DOSS).

The patiënt:

1. Dozes during conversation or activities
2. Is easy distracted by stimuli form the environment
3. Maintains attention to conversation of action
4. Does not finish question or answer
5. Gives answers which do not fit the question
6. Reacts slowly to instructions
7. Thinks to be somewhere else
8. Knows which part of the day it is
9. Remembers recent event
10. Is picking, disorderly, restless
11. Pulls IV tubes, feeding tubes, catheters etc.
12. Is easy or sudden emotional (frightened, angry, irritated)
13. Sees/hears things that are not there

Absent is 0 points, Present is 1 point. Except for items 3, 8 and 9, which are scored in reverse.