The Delirium Observation Screening (DOS) Scale

OVERVIEW:
The Delirium Observation Screening (DOS) Scale, originally a 25-item measure, was developed to facilitate early recognition of delirium based upon Diagnostic and Statistical Manual (DSM)-IV criteria. It was subsequently shortened to a 13-item tool which can be rated by nurses or other caregivers based on observations made over the course of regular care.¹

AUTHORS/PRIMARY REFERENCE:

STRUCTURE OF THE TOOL:
The DOS consists of 13 items capturing early symptoms of delirium that can be observed over the course of care. Each item is rated as present or absent is and given a score of 0 or 1. A total score of 3 or more points is considered positive for delirium.

BASE OF EVIDENCE/PSYCHOMETRIC PROPERTIES:
- Sensitivity – 74-98% (95% confidence interval)²
- Specificity – 66-92% (95% confidence interval)²

TARGET POPULATION AND SETTING:
- Confused older people in hospital
- Inpatient Acute Units

INTENDED USER(S):
- The DOS Scale was developed for use by nurses who do not necessarily have specialized training in geriatric care – it is based on observations of the patient over the course of regular care

NOTES ON USING THE DOS SCALE:
- Administration of the DOS Scale takes less than 5 minutes
- While originally developed as a screening tool for delirium, the DOS Scale has also been shown to be able to measure the severity of delirium³

WHERE TO GET THE DOS SCALE:
- Both versions of the DOS scale, along with instructions for use, are temporarily provided at the following link: http://www.beldonor.be/internet2Prd/groups/public/@public/@dg1/@acutecare/documents/ie2divers/19074354.pdf
- The DOS scale comes from a copyrighted article. Copyright permissions for display on this site are pending. The following is the original citation and a link to the article’s abstract on Pubmed:

REFERENCES AND ADDITIONAL READING:

Updated May 6 2012