Midland District Health Boards

Patient Label

Name: _____ or patient details

NHI: _____ DOB: _____ dd/mm/yy

Address: _____

Confusion Assessment Method (CAM)

May need to be assessed over a 24hr period to capture fluctations.

	Date / Time		Date / Time		Date / Time	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
1. Acute onset in change of mental state and/or fluctuating course a) Is there evidence of an acute change in mental status from the patient's baseline for monitoring? b) Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go or increase and decrease in severity?						
2. Inattention Did the patient have difficulty focusing attention, for example, being easily distracted or having difficulty keeping track of what was being said?						
3. Disorganised thinking Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?						
4. Altered level of consciousness Overall, how would you rate the patient's level Alert (normal)						
Vigilant (hyperalert)						
Lethargic (drowsy, easily aroused)						
Stupor (difficult to arouse)						
Coma (unarousable)						
Name						
Signature						
Designation						

The diagnosis of delirium requires the presence of features 1 and 2 plus either 3 or 4.

Adapted from Inouye SK et al, Clarifying Confusion: The Confusion Assessment Method. A New Method for Detection of Delirium. Ann Intern Med. 1990; 113:941-8.

Delirium prevention and management Essential Care Bundle

Essential Care Bundle 1: Prevention

All patients to have:

- Orientation to ward
- Adequate hydration and nutrition (including snack programme if available)
- Call bell in reach, located as per patient preference, answered promptly
- Personal items within reach
- Hearing and visual aids worn at all times during daylight hours
- Exercise and early mobilisation (supervised/supported)
- Pain relief given at charted time and as required
- Assistance with toileting or a timed toileting regime, as per care plan
- Normalise sleep patterns

Essential Care Bundle 2: Patients with delirium

In addition to the above, patients who have delirium **MUST** have:

- Single room (preferably, or cohort in double room if needed)
- Adequate lighting, especially at night
- A 'change of status sticker'/ CAM tool in the clinical record if the delirium is new
- Staff who introduce themselves often and are knowledgeable about delirium care
- A full medication review to minimise/remove medications that cause/exacerbate delirium
- Increased communication with families and family involvement in decisions
- Fluid balance chart, urinalysis prn, bowel chart in place
- Falls prevention strategies in place including non-slip socks and/or well fitting footwear, a low bed, crash mat and an invisibeam
- Monitoring for infection/UTI, low oxygen levels

Strongly recommended to be in place:

- This is me or the delirium sunflower to enhance understanding of patient and their needs
- Cognitively stimulating activities e.g. conversation, groups, shared meals in dining room
- A clock and calendar in the room
- Music therapy and familiar photos in the room if possible

Essential Care Bundle 3: Escalated care

Patients who have delirium **may need**:

- A family member staying with them
- An health care assistant watch/special if patient is a safety risk i.e. wandering, aggressive, impulsive. Preferably this is a ward staff member who is familiar to the patient and is only to be used if other options are not sufficient to keep patient safe.

Providing the best care for our most vulnerable patients

Midland District Health Boards

04/15TM