

## **Confusion Assessment Method (CAM)**

The CAM is not meant to be a diagnostic tool, but is a useful screening tool for delirium. The diagnosis of delirium requires: a comprehensive review of a resident's cognitive status and medical history, a physical examination, laboratory investigations, and a medication review. In cases where the CAM suggests that delirium may be present, further evaluation to confirm the delirium is recommended.

### **Features**

1. The CAM has 2 parts:
  - a) a nine item questionnaire
  - b) a diagnostic algorithm for delirium
2. The CAM can be completed in 5 to 10 minutes by individuals without formal psychiatric training.
3. The CAM has high interrater reliability, is sensitive, and specific compared to the diagnosis of a psychiatrist. The CAM is a standardized and validated tool.
4. The CAM was designed to capture the cardinal features of delirium based on the Diagnostic and Statistical Manual of Mental Disorders (DSM - III - R)

### **Use of the CAM**

The CAM is not administered in a structured way. Information is gathered from multiple sources and this information is used to make a determination about each feature in the delirium algorithm.

The professional should:

1. assess the resident's mental health status several times during the same day or on consecutive days.
2. utilize all sources of information available such as the interview with the resident, the resident's chart, a proxy or the health care professionals.
3. obtain the resident's baseline (cognitive and functional status) to compare with present situation.
4. ask specific questions when clarifying resident's mental health status with others.
5. ask open-ended questions when assessing resident's mental health status.
6. observe the resident's behaviour carefully when assessing his / her mental health status.
7. have a good understanding of the aging process.

## The Confusion Assessment Method

Delirium should be suspected with the presence of Features 1 and 2 and either 3 or 4

Feature 1: <b>Acute Onset and Fluctuating Course</b>	This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Does the (abnormal) behaviour fluctuate during the day; that is, does it tend to come and go, or increase and decrease in severity?
Feature 2: <b>Inattention</b>	This feature is shown by a positive response to the following question: Does the patient have difficulty focusing attention; for example, is the patient easily distractible, or having difficulty keeping track of what's being said?
Feature 3: <b>Disorganized Thinking</b>	This feature is shown by a positive response to the following question: Is the patient's thinking disorganized or incoherent, as evidenced by rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
Feature 4: <b>Altered Level of Consciousness</b>	This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stuporous [difficult to arouse], or comatose [unarousable])?

Inouye, S.K. (1990). Clarifying confusion; the confusion assessment method. A new method for detection of delirium. *Ann Intern Med*, 113 (12): 941-8.

"The other features of delirium are not included in the algorithm because Inouye et al. (1990) reported that they add nothing to the sensitivity and specificity of the instrument.