DELIRIUM: SCREENING AND ASSESSMENT

PREDISPOSING RISK FACTORS:

- Cognitive impairment
- Over 80
- Chronic illness
- Multiple co-morbid conditions
- Sensory deficits
- Alcohol abuse
- Immobility
- Insomnia
- 5+ medications

SCREENING TOOL: CAMI

Presence of features 1 and 2 & either 3 or 4:

1. **Acute onset & fluctuating course**
2. **Inattention:**
   -difficulty focusing attention
   - easily distracted
3. **Disorganized Thinking:**
   -rambling speech
   - illogical flow of ideas
4. **Altered Level of Consciousness**
   - agitated
   - alert
   - lethargic
   - stuporous
   - comatose

	Identification:	Assessment:	Interventions:

P		Pain
		• Regular pain assessment & monitoring
		• Use consistent pain scale
		
		Poor Nutrition
		• Dehydration/malnutrition
		• ↓Albumin or protein levels
		• Swallowing difficulties
		• Electrolyte/glucose imbalance
		• Weight on admission and prn
			Pain
			• Regular scheduled analgesia (not prn)
			• Non-pharmacological support: turning, positioning
			• Document effect of analgesia
			
			Poor Nutrition
			• Fluid intake at least 1500cc/24hrs
			• Dietary consult:
			  • Recent wt loss/gain (>10lbs in last year)
			  • Total protein < 64 g/L and Albumin level < 35 g/L
			• OT Consult for swallowing difficulties

R		Retention • Determine continence ability; bowel pattern • Assess for urinary retention • Palpate abdomen for distention/impaction • Evaluate fluid balance/output Restraints • explore alternatives to restraints whenever possible to maximize functional status and safety	Retention • In/out catheterization if suspect retention • Nurse Continence Advisor consult if in retention • Regular toileting schedule (minimize use of Incontinence pads) • Initiate bowel protocol; refer to CPG on Continence • Ensure person is well hydrated Restraints • Refer to CPG on Maximizing Freedom and Least Restraint • Avoid restraints if possible. Use only if patient a danger to him/herself or others • Involve family members/support persons
I		Infection/Illness (new) • ongoing monitoring for UTI, chest infection, wound infection Immobility • Determine pre-morbid functional abilities	Infection/Illness (new) • Monitor VS & O2 sats; compare to baseline (note as normal process of aging, temperature may remain normal) • ↑↓ BP, postural ↓ BP • Request appropriate diagnostic/lab tests (e.g. C&S, chest x-ray) Immobility • Encourage mobility, sitting up in chair & maintenance of ADLs • OT/PT Consult; refer to CPG on Falls
S		Sleep • Assess for altered sleep/wake cycles • Use Sleep Pattern Record Skin • Assess for areas of skin breakdown • Braden Scale Sensory • Assess for sensory deficits and aides used	Sleep • Document changes in pattern – day/night reversal • implement non-pharmacological sleep promotion measures • intersperse activities during the day with planned rest periods Skin • Pressure reducing mattress as indicated, turn q2h • Refer to Wound/Continence Nurse if wound present Sensory • Ensure eyeglasses, hearing aids & dentures are working and used • Use Pocket talker to assist with communication/assessments
M		Mental Status • Monitor for sudden changes in ability or cognition • Other causes of behavior • Grief, loss, emotional trauma Medications • Polypharmacy (>5 meds) • Medication side effects • Withdrawal – alcohol, benzodiazepines, nicotine • Toxicity (digoxin, dilantin) Metabolic • Monitor for abnormal lab results/hemodynamic status	Mental Status • Refer to CPG on Agitated and Excessive Behaviour • Identify self; use a calm/gentle approach; use cues to orient • Acknowledge and validate fears related to changes in cognition • Use interdisciplinary interventions to support restoration of normal activity i.e. Volunteers/family, mobility, activities, familiar objects and photos, routines, clocks/calendar Medication • Review med profile with pharmacist for recent changes, adverse effects, toxicity, drug interactions • Start Low, Go Slow! • Assess psychotropic med response report any side effects (ie. ↑ anxiety/agitation; Parkinson-like symptoms, postural ↓ BP) Metabolic • Evaluate lab results and notify MD of abnormalities
E		Environment • Self-care ADL's ability • Relocation stress (eg. Unfamiliar surroundings/routine)	Environment • Provide calm & safe environment • Promote normal ADL routines; consistent staff • Encourage family/support persons to provide support • Provide adequate lighting and exposure to daylight

CAMI: screens for the presence of absence of a delirium
PRISME: an acronym that can assist in identifying and relieving underlying factors are modifiable and can contribute to the onset and perpetuation of delirium; adapted from VIHA