Appendix C: Delirium Screening and Assessment Tools – CAM & PRISME

Predisposing Risk Factors for Delirium:

- Cognitive impairment
- Over 80 years of age
- Chronic illness
- Multiple comorbid conditions
- Sensory deficits
- Alcohol abuse
- Immobility
- Insomnia
- Polypharmacy (5+ medications)

Delirium Screening Tool: Confusion Assessment Method (CAM)

Feature 1: Acute onset and fluctuating course

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? Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question:

- Did the patient have difficulty focusing attention, for example, being easily distracted, or having difficulty keeping track of what was being said?

Feature 3: Disorganized thinking

This feature is shown by a positive response to the following question:

- 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?

Feature 4: Altered level of consciousness

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), stupor (difficult to arouse), or coma (unarousable).

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4

Reference (adapted from): Inouye, S., van Dyck, C., Alessi, C., et al. Clarifying confusion: The confusion assessment method. Ann Intern Med.1990;113(12);941-948.

PRISME

PRISME is an acronym that can assist in identifying and relieving underlying factors that are modifiable and can contribute to the onset and perpetuation of delirium.

	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 • Monitor weight	**Pain** • Regular scheduled analgesia (not prn) • Non-pharmacological support: turning, re-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 • Occupational therapy (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 • Ensure person is well hydrated **Restraints** • Minimize use of restraint: physical/ chemical • Use only if patient is a danger to him/ herself or others • Involve substitute decision maker around informed consent • Engage multi-disciplinary team
I	**Infection/ Illness (new)** • Ongoing monitoring for urinary, chest, wound infection **Immobility** • Determine pre-morbid functional abilities	**Infection/ Illness (new)** • Monitor VS & O2 stats; compare to baseline (note as normal process of aging, temperature may remain normal); ↑↓ BP, postural ↓ BP • Request appropriate diagnostic/ lab tests (e.g. C7S, chest x-ray) **Immobility** • Encourage mobility; implement fall prevention strategies • OT/ Physiotherapy consult
S	**Sleep** • Assess for altered sleep/ wake cycles • Use a 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

	Assessment	Interventions
M	**Mental Status** • Monitor for sudden changes in ability or cognition • Other causes of behaviour • Grief, loss, emotional trauma **Medications** • Polypharmacy (> 5 meds) • Medication side effects • Withdrawal – alcohol, benzodiazepines, nicotine • Toxicity (digozin, dilantin) **Metabolic** • Monitor for abnormal lab results/ hemodynamic status	**Mental Status** • Maximize non-pharmacological behaviour strategies • 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 (e.g., volunteers/family, mobility, activities, familiar objects and photos, routines, clocks/calendar) **Medications** • Review med profile with pharmacist for recent changes, adverse effects, toxicity, drug interactions • Start Low, Go Slow! • Assess psychotropic med response & report side effects (e.g., ↑ anxiety/ agitation; Parkinson-like symptoms, postural ↓ BP) **Metabolic** • Evaluate lab results and notify physician of abnormalities
E	**Environment** • Self-care activities of daily living's ability • Relocation stress (e.g., unfamiliar surroundings/ routine)	**Environment** • Provide calm & safe environment • Promote normal activities of daily living routines; consistent staff • Encourage family/ support persons to provide support • Provide adequate lighting and exposure to daylight

Reference: Shaw M. PRISME [unpublished work]. Vancouver: Vancouver Coastal Health Authority, 2008.