Grey Bruce Health Network

# FRACTURE HIP CLINICAL PATHWAY

## Confusion Assessment Method Tool

**SITE: South Bruce Grey Health Centre**

*PATIENT ID*

*You will be able to answer the following questions after a few conversations with the patient, discussing patient behaviours with staff and family, and/or reading the chart.*

**Scoring: Patient diagnosed with Delirium if has a positive response to Sections 1 AND 2, as well as EITHER Sections 3 OR 4. Section 5 will help substantiate the diagnosis, but is not diagnostic criteria. If patient is diagnosed with Delirium, refer to Delirium Management Checklist, see back of page.**

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|---|---|
| **1. Acute Onset** | |
| Is there evidence of an acute change in mental status from the patient's baseline? | Yes ☑ No ☐ |
| **2. Inattention** | |
| Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was said? | Not at any time ☐<br>Sometimes, in mild form ☐<br>Sometimes, in marked form ☑<br>Uncertain ☐ |
| If present or abnormal, did the behaviour fluctuate during the conversation, that is tend to come and go, or increase/decrease in severity? | Yes ☑ No ☐<br>Uncertain ☐ Not applicable ☐ |
| If present or abnormal, please describe this behaviour: not able to focus on questions | |
| **3. Disorganized Thinking** | |
| Was patient's thinking disorganized or incoherent, i.e. rambling/irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? | Yes ☑ No ☐ |
| **4. Altered Level of Consciousness** | |
| How would you rate the patient's level of consciousness?<br>(positive response is any response other than Alert (normal)) | Alert (normal) ☑<br>Vigilant (hyper alert, overly sensitive to stimuli, startled easily) ☐<br>Lethargic (drowsy, easily aroused) ☐<br>Stupor (difficult to arouse) ☐<br>Coma (unarousable) ☐ |
| **5. Other Clinical Descriptors that often accompany delirium:** | |
| Disorientation: Was the patient disoriented at any time during conversation, such as thinking that he/she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day? | Yes ☑ No ☐ |
| Memory Impairment: Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions? | Yes ☑ No ☐ |
| Perceptual Disturbance: Did the patient have any evidence of perceptual disturbance, for example hallucinations, illusions, or misinterpretations (such as thinking something was moving when it was not)? | Yes ☐ No ☑ |
| Psychomotor Agitation (one of A or B):<br>A) At any time, did the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent sudden changes in position?<br>B) At any time, did the patient have any unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time, or moving very slowly? | Yes ☐ No ☑ |
| Altered Sleep-Wake Cycle: Did the patient have evidence of disturbance of the sleep wake cycle, such as excessive daytime sleepiness with insomnia at night? | Yes ☐ No ☑ |

| If Delirium is positively identified, do the following: | |
|---|---|
| 1. Address immediate safety (self, others) | ☑ |
| 2. Investigate cause | |
| a) Medications:<br>- Review existing medications<br>- Discontinue non-essential medications, especially analgesics, anticholinergics, sedatives | ☑<br>☑ |
| b) Metabolic Imbalance:<br>- Check for high or low levels of Sodium, Sugar, Calcium – lytes ☑<br>- Check for dehydration<br>- Check for organ failure | ☑<br>☑<br>☑ |
| c) Infection:<br>- Identify and treat systemic infection, e.g. UTI, pneumonia | ☑ |
| 3. Ensure optimal sensory input:<br>- Eyeglasses on and clean<br>- Hearing aid working and in use<br>- Avoid excessive stimulation, e.g. light, noise<br>- Use night-light at night | ☑<br>☑<br>☑<br>☑ |
| 4. Encourage:<br>- Familiar persons to visit<br>- Consistent staffing, preferably primary nursing<br>- Familiar objects at bedside, e.g. pictures | ☑<br>☑<br>☑ |
| 5. Mobilize early | ☑ |
| 6. Implement a toileting routine | ☑ |
| 7. Provide comfort measures to reduce pain, anxiety, or agitation | ☑ |
| 8. Avoid restraints (restraining a delirious patient invariably increases agitation) | ☑ |
| 9. Provide adequate nutrition including fluid replacement, nutritional intake | ☑ |
| 10. Enhance sleep: if conservative measures fail, a short/intermediate acting benzodiazepine, e.g. Lorazepam 0.5-1 mg | ☑ |
| 11. Manage agitation: pharmacological management may involve a small dose of typical and atypical neuroleptics and small doses of short acting benzodiazepines. Because of the risk of side effects, these medications are used only when severity of symptoms place patients and others at risk. Re-evaluate the need for these medications daily. | ☑ |