Confusion Assessment Method (CAM® or CAM-ICU®)

Element 1
Acute onset of mental status change from baseline or fluctuating mental status

Element 2
AND
Inattention

Element 3
AND either
Altered level of consciousness
Rass ≠ 0

Element 4
OR
Disorganized thinking

Positive = 1 + 2 + 3 OR 4

Unable to assess = RASS or mRASS -4 or -5

Potential Etiologies of Delirium

D - Drugs
E - Eyes, ears, environment, emotions
L - Liver failure, low PO₂ (MI, PE, anemia, CVA)
I - Infection, immobility
R - Restraints, respiratory
J - Injury, ictal state
U - Unfamiliar surroundings, under hydration
M - Metabolic

Deliriogenic Drugs to Limit/Avoid

Diphenhydramine (Benadryl)
- Alternative for allergic Rx is Claritin (Loratadine)

Lorazepam (Ativan)
- Use only in patients dependent upon benzodiazepines or with potential ETOH withdrawal or terminal delirium

Zolpidem (Ambien)
- Use 2.5 mg at bedtime if nonpharmacological measures fail

Metoclopramide

Promethazine

Prochlorperazine (Reglan, Phenergan, Compazine)
- Alternative is Ondansetron (Zofran)

Famotidine (Pepcid)
- Alternative is PPI except with Plavix, or Pantoprazole (Protonix)

Fentanyl
- Alternative is Hydromorphone (Dilaudid), Acetaminophen (Tylenol), or Tramadol (Ultram)

Medications to Not Stop Abruptly

- Acetylcholinesterase inhibitors
- Antiepiletics
- Benzodiazepines
- Opioids/narcotics
- Sedatives/hypnotics
- SSRIs
- Steroids

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Modified Richmond Agitation Sedation Scale (mRASS)

+4 Combative
- No attention, overly combative, violent, immediate danger to staff

+3 Very Agitated
- Pulls tube(s) or catheter(s); fights environment/not people, difficult to get patient to pay or sustain attention

+2 Agitated
- Frequent non-purposeful movement, uncooperative, loses attention rapidly

+1 Restless
- Anxious but movements not aggressive or vigorous, cooperative, pays attention most of the time

0 Alert and Calm
- Pays attention, makes eye contact, responds immediately

-1 Wakens Easily
- Not fully alert, but has sustained awakening > 10 sec. Slightly drowsy

-2 Wakens Slowly
- Briefly awakens with eye contact to voice < 10 sec. Very drowsy

-3 Difficult to Awaken
- Movement or eye opening to voice but no eye contact

-4 Can’t Stay Awake
- No response to voice but displays movement or eye opening to physical stimulation. Arousable but no attention

-5 Unarousable
- No response to voice or physical stimulation

Delirium and Acute Encephalopathy are associated with Death, Disability, Deterioration and Discharge Difficulties

Save a Brain

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Delirium & Acute Encephalopathy Care Pathway

Sponsored by ADAPT Actions for Delirium Assessment Prevention & Treatment
1. Deter
   - No harmful drugs*
   - Avoid abrupt discontinuation* (Drugs, ETOH, nicotine)
   - Avoid/limit Devices (catheters, lines, leads)

2. Detection
   - Review CAM/CAM-ICU & RASS/mRASS Scores
   - Daily cognitive assessment
   - Determine baseline mental status

3. Diagnosis / Do
   - Physical exam
   - Med review
   - Determine potential causes*
   - Differential diagnosis
   - Document acute encephalopathy
   - Activate Delirium order set in EPIC

4. Discuss
   - Provider + Nursing
     - +/- Pharmacist
   - Huddle
   - Make Plan

5. Daily Care
   - CAM or CAM-ICU every 8 hours + prn
   - Discontinue/ Disguise devices
   - Family teaching - brochure
   - Provide Distractors (music, flashball, animal)
   - T-A-D-A (Tolerate, Anticipate, Don’t Agitate)
   - Reassurance
   - Individualize plan of care in EPIC
   - Nurse - Nurse handoff
   - Nurse - PCA handoff

6. Daily Dialogue
   - Provider + Nursing
     - +/- Family
   - Progression Rounds
   - Is Patient Improving?

7. Discharge
   - Document course and cause of Delirium if known
   - Degree of resolution
   - Discontinue unnecessary psychotropics
   - Follow up for Delirium if not resolved
   - Document on W10/After Visit Summary

Risk Factors
- Age > 65
- Dementia
- Substance Dependency
- Hx Delirium
- ICU/SD
- Impaired vision/hearing

1. Deter
   - Mobilize to maximum
   - Uninterrupted night-time rest (noise, bundle care, eye shields, earplugs)
   - Eyeglasses/hearing aids
   - Whiteboard up to date
   - Daily goals of care
   - Calendar-clock/familiar items
   - Assist with food/fluids
   - Comfort
   - “HHC Cares About Me” poster
   - Family as partners
   - Volunteers for social interaction

2. Detection
   - CAM every 8 hours and prn
   - Determine baseline mental status
   - Notify provider immediately of first positive CAM or CAM-ICU and activate “Acute Confusion” CFG

3. Do
   - Fall prevention
   - Discontinue/ Disguise devices
   - Family teaching - brochure
   - Provide Distractors (music, flashball, animal)
   - T-A-D-A (Tolerate, Anticipate, Don’t Agitate)
   - Reassurance
   - Individualize plan of care in EPIC
   - Nurse - Nurse handoff
   - Nurse - PCA handoff

4. Discuss
   - Provider + Nursing
     - +/- Pharmacist
   - Huddle
   - Make Plan

5. Daily Care
   - CAM or CAM-ICU every 8 hours + prn
   - Comfort/calm/consistent
   - Toileting
   - Feed/hydrate
   - Mobilize to maximum
   - Maintain normal sleep/wake cycle
   - Touch/backrub
   - Assess response to medications
   - Family & volunteer involvement
   - Alternative therapies (Reiki, Pet, Art, Music)
   - Document progress

6. Daily Dialogue
   - Provider + Nursing
     - +/- Family
   - Progression Rounds
   - Is Patient Improving?

7. Discharge
   - Document successful strategies
   - Discuss ongoing needs
   - Discharge with one time use Distracters (doll, animal)
   - Discuss follow-up with family
   - Document individualized care needs on W10/After Visit Summary

*see back of brochure for more information
1 Flaherty, 2011