




Directions: Initiate CAM & PRISME for patients who are delirious or identified as high risk (3 or more risk factors) or show unexplained behaviors. Assess Q shift & PRN.

1. Use Confusion Assessment Method (CAM) assess for delirium						
CAM	1. ACUTE ONSET AND FLUCTUATING COURSE	<b>Does the abnormal behavior:</b> <ul style="list-style-type: none"> <li>• come and go?</li> <li>• increase/decrease in severity?</li> </ul>				
	2. INATTENTION	<b>Does the patient:</b> <ul style="list-style-type: none"> <li>• have difficulty focusing attention?</li> <li>• become easily distracted?</li> <li>• have difficulty following a conversation?</li> </ul>				
	3. DISORGANIZED THINKING	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><b>Is the patients' thinking</b></td> <td style="width: 50%;"><b>Does the patient have:</b></td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>• disorganized?</li> <li>• incoherent?</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>• rambling speech?</li> <li>• Illogical flow of ideas?</li> </ul> </td> </tr> </table>	<b>Is the patients' thinking</b>	<b>Does the patient have:</b>	<ul style="list-style-type: none"> <li>• disorganized?</li> <li>• incoherent?</li> </ul>	<ul style="list-style-type: none"> <li>• rambling speech?</li> <li>• Illogical flow of ideas?</li> </ul>
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4. ALTERED LEVEL OF CONSCIOUSNESS	<b>What is the patient's level of consciousness?</b> <ul style="list-style-type: none"> <li>• Vigilant (hyperalert)</li> <li>• Alert (normal)</li> <li>• Lethargic (drowsy, easy to arouse)</li> <li>• Stupor (difficult to arouse)</li> <li>• Coma (completely unarousable)</li> </ul>					
<p><b>LOC O'METER</b></p> 						
<p><i>KEY: Presence of features 1 &amp; 2 plus either 3 &amp;/or 4 is positive for delirium</i></p>						
2. Use PRISME to identify & address physiological, psychosocial & environmental factors						
P	<b>PAIN</b>	<ul style="list-style-type: none"> <li>• Provide regular analgesia &amp; nonpharmacological methods. Reassess pain control Q shift, especially with movement.</li> </ul>				
	<b>PSYCHOSOCIAL</b>	<ul style="list-style-type: none"> <li>• Assess mental health, dementia &amp; ability to cope with stress/stimuli</li> </ul>				
R	<b>RESTRAINT</b>	<ul style="list-style-type: none"> <li>• Avoid restraints. Use alternatives</li> </ul>				
	<b>RETENTION</b>	<ul style="list-style-type: none"> <li>• Palpate abdomen. Bladder scan PRN. I &amp; O catheter if essential. Remove bladder catheter ASAP. Regular toileting via commode or walking to toilet</li> </ul>				
I	<b>INFECTION</b>	<ul style="list-style-type: none"> <li>• Assess for UTI, pneumonia, C diff, purulent wound. Monitor VS. May have atypical presentation with no fever</li> </ul>				
	<b>IMPACTION</b>	<ul style="list-style-type: none"> <li>• Determine last BM. Palpate abdomen. Rectal check PRN. Prevent &amp; treat constipation. Bowel protocol as needed</li> </ul>				
	<b>IMPAIRED COGNITION</b>	<ul style="list-style-type: none"> <li>• No reality orientation. Use calm, gentle approach &amp; conversational cues to orientate patient to time &amp; place</li> </ul>				
	<b>INTAKE-ORAL</b>	<ul style="list-style-type: none"> <li>• Feed patient PRN. Assess dysphagia &amp; consult OT/Dietitian PRN</li> </ul>				
S	<b>SLEEP DISTURBANCE</b>	<ul style="list-style-type: none"> <li>• Ensure 4-hour sleep periods. No routine night turns. Naps OK</li> </ul>				
	<b>SENSORY CHANGE</b>	<ul style="list-style-type: none"> <li>• Ensure glasses, hearing aids &amp; dentures fit well and work</li> </ul>				
	<b>SOCIAL ISOLATION</b>	<ul style="list-style-type: none"> <li>• Promote family stays &amp; overnights PRN. Provide delirium pamphlet. Encourage familiar objects-pictures, blankets, pet visits</li> </ul>				
M	<b>MEDICATION</b>	<ul style="list-style-type: none"> <li>• Review recent med changes, drug levels, ETOH. Avoid medications of risk (ie, demerol, codeine, benzodiazepines)</li> </ul>				
	<b>METABOLIC</b>	<ul style="list-style-type: none"> <li>• Evaluate fluid balance/output/labs/oxygenation. If agitated, restart IV X 2 only-consider alternatives &amp; ensure agitation is treated</li> </ul>				
	<b>MOBILITY</b>	<ul style="list-style-type: none"> <li>• Encourage self-care; toileting; ambulation. Up for meals</li> </ul>				
E	<b>ENVIRONMENT</b>	<ul style="list-style-type: none"> <li>• Provide a quiet, supportive environment --↓ noise, lights &amp; people</li> <li>• Hypoactive-Increase stimuli as tolerated. Activate</li> <li>• Hyperactive-Reduce stimuli, especially at night</li> </ul>				