

pictures.) He is instructed to remember them. The patient is then shown a second picture of 5 objects and immediately given the following instructions. To nod if the answer is yes or shake his head if the answer is no. You will point to each of the objects in the picture and ask the patient if he was just shown a picture of that object. You will then show him the original picture of five objects and point to each object in turn and ask the patient if he has been shown the object before. A perfect score is 5 yes and 5 no.

Inattention is present if the patient has fewer than 3 correct answers in either the visual component or the auditory component and its fewer than 8 if you perform both tests.

Feature 3: Disorganized thinking

Disorganized thinking can be assessed by asking the following questions: "Do you know what year it is? What season are we in? Do you know today's date? Do you know what month it is? About what time is it right now? Where are we?" Patients with disorganized thinking will be incoherent, ramble, evade answering the question, have an illogical flow of ideas, switch from subject to subject, give paranoid statements or evidence of hallucination. If your patient cannot talk ask him one of the following two sets of questions. Instruct him to nod his head for yes or shake his head for no and demonstrate as you instruct him.

Set A: Will a stone float on water?, Are there fish in the sea?, Does 1 pound weigh more than 2 pounds?, and Can you use a hammer to pound a nail?

Set B: Will a leaf float on water?, Are there elephants in the sea?, Do 2 pounds weigh more than 1 pound?, and can you use a hammer to cut wood?

Instruct your patient to follow the following commands:
Hold up this many fingers. (Nurse holds up 2 fingers.)
Now do the same thing with the other hand. (Not repeating the same number of fingers.)

Disorganized thinking is present if the patient cannot answer at least 2 of the 4 questions correctly and cannot complete simple commands.

Feature 4: Altered level of consciousness

If the patient's level of consciousness is determined to be anything other than alert the patient is considered to have an altered level of consciousness. Your choices are: (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

Delirium is present when both features 1 and 2 and either features 3 or 4 are present.

How to chart your delirium assessment score

Individual feature documentation will help with compliance and accuracy of the overall assessment. Remember not to chart the initials UTA for unable to assess. You must write out the whole sentence.

Step One: Sedation Assessment (RASS)

If RASS is -4 or -5 Stop and Reassess patient later.

If RASS is above -4 then proceed to step 2.

Step Two: Delirium Assessment (CAM)

Feature 1: Change in mental status from baseline or a status that fluctuates

and

Feature 2: Inattention

and

Feature 3: Disorganized thinking

or

Feature 4: Altered level of consciousness

= Delirium