Confusion Assessment Method (CAM) Shortened Version Worksheet

Name of resident:	Date of Birth:				
Date: / /	Time:				
I. ACUTE ONSET AND FLUCTUATING CO	DURSE		BOX 1		
a) Is there evidence of an acute change the patient's baseline?	e in mental status from	No	Yes		
b) Did the (abnormal) behaviour fluctu tend to come and go or increase and		No	Yes		
II. INATTENTION					
Did the patient have difficulty focusing distractible or having difficulty keeping		No	Yes		
III. DISORGANISED THINKING			BOX 2		
Was the patient's thinking disorganised or incoherent, such as rambling or		No	Yes		
irrelevant conversation, unclear or illogical flow of ideas, or unpredictable					
switching from subject to subject?					
IV. ALTERED LEVEL OF CONSCIOUSNESS	3				
Overall, how would you rate the patien	t's level of consciousness?				
Alert (normal)					
BOX 3					
Vigilant (hyperalert)					
Lethargic (drowsy, easily aroused)					
Stupor (difficult to arouse)					
Coma (unarousable)					
Do any checks appear in box 3?		No	Yes		

If all items in Box 1 are ticked and at least one item in Box 2 is ticked a diagnosis of delirium is suggested.

Adapted from: Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI.
Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Ann Intern Med. 1990; 113: 941-948.
Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003,

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Modified Bereavement Risk Index

Name of Resident:

Name of family member: Relationship to resident:

Contact details of family member

Address:

Phone number: (H) (W)

	Risk Factor		Score
1	Anger	None	1
		Mild Irritation	2
		Moderate (occasional outbursts)	3
		Severe (spoiling relationships)	4
		Extreme (always bitter)	5
2	Self Reproach (Self blame/guilt, feeling bad and/or responsible for something)	None	1
		Mild (vague and general)	2
		Moderate (some clear self-reproach)	3
		Severe (preoccupied with self-blame)	4
		Extreme (major problem)	5
3	Current Relationships	Close intimate relationship with another	1
		Warm supportive family	2
		Family supportivve but lives at a distance	3
		Doubtful (patient unsure whether family members are supportive or not)	4
		Unsupportive	5
4	How will key person cope?	Well (normal grief and recovery without help)	1
		Fair (probably get by without specialist help)	2
		Doubtful (may need specialist help)	3
		Badly (requires specialist hellp)*	4
		Very badly (requires urgent help)*	5
		Total Score	

^{*}Will be automatically referred to specialist bereavement support

Low risk score (less than 7)

• Give a copy of the booklet – "Now What? Understanding Grief" (a copy is included in the PA Toolkit)

Moderate risk score (7-10)

- Give a copy of the booklet "Now What? Understanding Grief"
- Suggest they may like to contact one of the support agencies listed in the booklet

High risk score (10 or more)

- Encourage the person to contact a health professional e.g. GP, psychologist, counselling service, or bereavement counsellor
- Give a copy of the booklet "Now What? Understanding Grief"

Kristjanson LJ, Cousins K, Smith J, Lewin G (2005) Evaluation of the Bereavement Risk Index (BRI): A community hospice care protocol . Int J of Pall Nurs. 11 (12): 610-618

Self-directed learning package: Advanced nurses quiz

		True	False	Don't Know
1	The resident and/or family must provide the nurse with information concerning their wishes about end of life care at the initial assessment and care planning interview after admission.			
2	There is no way of recording treatment preferences for a resident who has advanced dementia and did not record their wishes on a legal document when they still had mental capacity.			
3	Regular reviews of advance care plans mean checking if there is a form in the clinical records from when the resident was admitted.			
4	The "Understanding the Dying Process" brochure is appropriate to give to family members at a palliative care case conference.			
5	It is appropriate to accept a careworker estimation of the severity of a resident's dyspnoea if they cannot remember what rating score a resident provided them.			
6	Attitudes and beliefs of residents, family and health professionals can be barriers to effective pain management.			
7	A resident with chronic pain that is moderate to severe intensity will look pale, perhaps be sweating and have changes in their heart rate and/or blood pressure.			
8	A tingling, burning pain that runs around one side of the chest wall between two ribs is most likely to be neuropathic in origin.			
9	It is up to the nurse to assess the condition of a resident's oral health each day.			
10	A resident with dementia exhibits fluctuating confusion and wakefulness. This is best attributed to the dementia itself.			
11	Alfred has not responded to environmental and nursing interventions for his delirium. You should question the GP's order of a dose of diazepam to help manage Alfred's hallucinations.			
12	Urinary tract infections that are the cause of a delirium should always be treated.			
13	The GP is responsible for initiating the use of an End of Life Care Pathway when a resident is expected to die in the next week.			
14	A resident born in India lists their religion as Buddhist. This means that they must not be given strong analgesics or sedatives, especially at the end of life as it is important for the mind to be clear.			
15	If Rhonda's Modified Bereavement Risk Index score is eleven, you only need to give her a copy of the "Now What? Understanding Grief" booklet.			