Interior Health

# Confusion Assessment Method (CAM) with PRISME

**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

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| C | **1. ACUTE ONSET AND FLUCTUATING COURSE** | **Does the abnormal behavior:**<br>• come and go?<br>• increase/decrease in severity? |
| A | **2. INATTENTION** | **Does the patient:**<br>• have difficulty focusing attention?<br>• become easily distracted?<br>• have difficulty following a conversation? |
| | **3. DISORGANIZED THINKING** | **Is the patients' thinking**<br>• disorganized?<br>• incoherent?<br>**Does the patient have:**<br>• rambling speech?<br>• Illogical flow of ideas? |
| M | **4. ALTERED LEVEL OF CONSCIOUSNESS**<br>**LOC O'METER**  | **What is the patient's level of consciousness?**<br>• Vigilant (hyperalert)<br>• Alert (normal)<br>• Lethargic (drowsy, easy to arouse)<br>• Stupor (difficult to arouse)<br>• Coma (completely unarousable) |

***KEY: Presence of features 1& 2 plus either 3 &/or 4 is positive for delirium***

## 2. Use PRISME to identify & address physiological, psychosocial & environmental factors

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| P | **PAIN** | • Provide regular analgesia & nonpharmacological methods. Reassess pain control Q shift, especially with movement. |
| | **PSYCHOSOCIAL** | • Assess mental health, dementia & ability to cope with stress/stimuli |
| R | **RESTRAINT** | • Avoid restraints. Use alternatives |
| | **RETENTION** | • Palpate abdomen. Bladder scan PRN. I & O catheter if essential. Remove bladder catheter ASAP. Regular toileting via commode or walking to toilet |
| I | **INFECTION** | • Assess for UTI, pneumonia, C diff, purulent wound. Monitor VS. May have atypical presentation with no fever |
| | **IMPACTION** | • Determine last BM. Palpate abdomen. Rectal check PRN. Prevent & treat constipation. Bowel protocol as needed |
| | **IMPAIRED COGNITION** | • No reality orientation. Use calm, gentle approach& conversational cues to orientate patient to time & place |
| | **INTAKE-ORAL** | • Feed patient PRN. Assess dysphagia & consult OT/Dietitian PRN |
| S | **SLEEP DISTURBANCE** | • Ensure 4-hour sleep periods. No routine night turns. Naps OK |
| | **SENSORY CHANGE** | • Ensure glasses, hearing aids & dentures fit well and work |
| | **SOCIAL ISOLATION** | • Promote family stays & overnights PRN. Provide delirium pamphlet. Encourage familiar objects-pictures, blankets, pet visits |
| M | **MEDICATION** | • Review recent med changes, drug levels, ETOH. Avoid medications of risk (ie, demerol, codeine. benzodiazepines) |
| | **METABOLIC** | • Evaluate fluid balance/output/labs/oxygenation. If agitated, restart IV X 2 only-consider alternatives & ensure agitation is treated |
| | **MOBILITY** | • Encourage self-care; toileting; ambulation. Up for meals |
| E | **ENVIRONMENT** | • Provide a quiet, supportive environment --↓ noise, lights & people<br>• Hypoactive-Increase stimuli as tolerated. Activate<br>• Hyperactive-Reduce stimuli, especially at night |