



Communication Checklist:

SIGNS AND SYMPTOMS OF DELIRIUM

- This tool should be used to gather information and communicate change of condition to medical providers for patients or residents with a change in mental status, a positive CAM© score and/or suspected delirium.
- This tool can be used with new employee education and orientation as well as ongoing education and competency assessment.
- This tool can be modified to align with facility specific policies and procedures.
- This tool can be used by the interdisciplinary team as a visual aid to cue critical thinking when a change is observed.
- This tool is part of a delirium toolkit, including care pathways and short videos located on the Alliant Health Solutions delirium webpage: (<https://quality.allianthealth.org/topic/delirium/>).

Patient/Resident: _____ Age: _____

Admitting Diagnosis: _____ Date: _____

Baseline Mental Status and Level of Function

Mental Status: (check all that apply)

Alert Oriented Calm Confused Cooperative Lethargic Existing diagnosis of dementia
 Prior history of delirium

Level of Function:

Dependent Extensive Assist Limited Assist Independent One Person Assist Two Person Assist

BIMS: Value _____ Date: _____

Current Mental Status and Level of Function

Mental Status:

Hyperactive (e.g., fidgety, restless, aggressive) Hypoactive (e.g., lethargic, quiet, withdrawn, slowed)
 Mixed (cycling between hyper and hypoactive)

Level of Function:

Dependent Extensive Assist Limited Assist One Person Assist Two Person Assist

Onset of Change: Days # _____ Weeks # _____

Vital Signs

Blood Pressure: _____ Heart Rate: _____ Respirations: _____

Temperature: _____ Baseline temperature: _____ (Note if patient is on any scheduled medications such as Acetaminophen that might mask an elevated temperature)

Pulse Oximetry: _____ Does resident use Oxygen? Yes No Liters: _____

Current mental status: Confusion Assessment Method (CAM©) score

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

Yes No
 Element 1 **and** 2

Element 2- Inattention

Yes No
 Element 2 **and** 1

Element 3- Altered level of Consciousness

Yes No
 Element 1 **and** 2 **and** 3 OR 4

Element 4- Disorganized thinking

Yes No
 Element 1 **and** 2 **and** 3 OR 4

Changes in signs, symptoms and treatments noted within the last two weeks

- New diagnoses?
- New medications? Missed medications?
- New change in habits (e.g. disrobing, hallucinating, restless)?
- Falls?
- Change in bowel habits?
- Change in urinary habits?
- Is there risk of intoxication or signs of withdrawal (alcohol, illicit substances, benzos, opioids)?
- Signs of rashes or skin ulcers

Nutrition and Hydration: (In last two weeks)

Change in appetite? Change in weight/nutrition? Change in level of assist/swallowing?

Pain: Are there signs or symptoms of pain? Is resident on routine or PRN pain medications? (In last two weeks)

New or worsening pain?
Changes in range of motion?

Potential Delirium Related Causes to Review

Resident/Patient Specific Notes

- | | |
|--|--|
| D - Drugs (any new medications or changes?) | |
| E - Eyes, Ears, Environment, Emotions (glasses, hearing aids, etc.) | |
| L - Liver failure, Low Pulse Oximetry, (consider MI, PE, CVA) | |
| I - Infection, Immobility | |
| R - Restraints, Respiratory | |
| I - Injury, Ictal state | |
| U - Unfamiliar Surroundings, Under Hydration, Urinary infection | |
| M - Metabolic | |

Next Steps: (e.g., Orders Received, Care Plan Recommendations, Convey in Shift Report)