



Ontario Shores
Centre for Mental Health Sciences

**Falls Risk Assessment, Prevention and Management
Self Learning Package**

April 2010

Background:

High incidence of falls, serious injury of falls and detrimental effect of falls on quality of life has long been identified as a problem among the elderly population. Recently falls have been noted to have a more widespread effect on various populations of patients. At Ontario Shores Centre for Mental Health Sciences the risk of falls is evident among patients on all units. However the falls statistics show an increased incidence of falls on the Neuropsychiatry Rehab, Senior's Mental Health and Senior's Memory Disorders units compared to the other units at the facility. Accreditation Canada has established Falls Prevention as a Required Organizational Practice (ROP).

PATIENT SAFETY AREA 6: FALLS PREVENTION

Goal: Reduce the risk of injuries resulting from client falls.

ROP: Implement and evaluate a fall prevention strategy to minimize the impact of client falls.

Tests for compliance

- The team has implemented a fall prevention strategy.
- The strategy identifies the population(s) at risk for falls.
- The strategy addresses the specific needs of the populations at risk for falls.
- The team evaluates the fall prevention strategy on an ongoing basis to identify trends, causes and degree of injury.
- The team uses the evaluation information to make improvements to its fall prevention strategy

Definitions:

Fall: a sudden, unanticipated change (downward) in body position with or without physical injury. (Brandis, 1999)

Polypharmacy: the practice of administering many different medicines especially concurrently for the treatment of the same disease. (Medline Plus. Merriam-Webster, 2009)

Statistics:

Global/Canadian

Falls were the leading cause of serious injury for the total population in 2000/01. Among seniors, 53% of injurious falls were caused by slipping, tripping or stumbling (on a non-icy surface). Turcotte and Schellenberg, 2006, p. 49.

"It is estimated that 80% to 90% of nursing home residents suffer from mental illness and that 75 to 85% are cognitively impaired. One in three persons aged 85 years and older suffers from Alzheimer's disease (Standing Senate Committee, 2006)." (Canadian Nurses Association, 2008, p. 5)

- Half of seniors over the age of 65 who live in an institution will experience a fall annually
- Hip fractures and head trauma are the most common injuries resulting from a fall
- 40% of seniors hospitalized for a hip fracture never go home or live independently again and 25 % of those seniors die within one year of the fracture
- 90 % of falls can be prevented

- Interventions such as improving leg strength and balance (exercise), medication management, improving vision and environmental adjustments successfully reduce falls (Canadian Nurses Association, 2008, pp. 8-9)

Ontario Shores (October to December 2009)

- Of the 70 fall occurrences at Ontario Shores in this quarter, 53 of them occurred in Special Services, 11 in Assessment & Reintegration, 3 in Forensics, 1 in Adolescents/DDS and 2 off the unit.
- 7 of the falls occurred from a bed, 9 in the bathroom, 4 from a chair, 10 by slipping or tripping, 16 while walking, 9 were not witnessed, and 15 were unclassified.
- The most common contributing causes identified in the above 70 falls were gait disturbance, weakness, and mental status.
- Other less common contributing causes reported were postural hypotension, ice, faulty equipment, debris on floor, wet floor, or inappropriate footwear. Several did not cite a specific cause.

Prevention:

1. General Environmental Falls Reduction Strategies
2. Falls Risk Assessment upon Admission, anytime clinical status improves or deteriorates, and/or after any fall
 - Extrinsic Risk Factors
 - Intrinsic Risk Factors
3. Use of Individualized Treatment Care Plan to identify and provide care for patients at falls risk
 - MAP
 - MAP Kardex
4. Education
 - Staff Education
 - Patients and Family Education
5. Safety Reporting, Review and Data Analysis of Actual and Potential Falls
 - Data tracking, trending and analysis
 - Program evaluation

1. General Environmental Falls Reduction Strategies:

- Spills cleaned up immediately
- Decrease shine on floors
- Level floors (no step up or down into shower, bathroom, no area rugs)
- Even coloured floor
- Handrails distinctly different colour from walls
- Handrails and transfer poles clear for use
- Furniture secured to floor or moved so there is a clear path around it
- Safe around the bed environment (use of transfer poles, transfer assist rails)

- Bathrooms large enough to bring in wheelchairs and walking aids
- Adaptive equipment in bathrooms (vertical, horizontal, diagonal grab bars near toilet, shower; raised toilet seat or commode; rubber-backed bath mat; shower seat; hand-held showerhead)
- Sink, toilet, soap and paper towel holder at low enough level to reach from wheelchair or standing
- Chair/bench placed strategically in hallways to provide a rest area for person's with limited endurance

2. Falls Risk Assessment (Appendix A):

The Falls Risk Assessment (Appendix A) will be completed on all inpatient admissions, on transfer, each time there is an improvement or decline in patient condition, and after any fall. Some risk categories such as age are static. In each category the patient either receives the score or zero.

The Falls Risk Assessment categorizes risk areas to which specific interventions will be linked (Risk Area & Intervention Guide, Appendix B). The Risk Area & Intervention Guide is not an exhaustive list of all possible interventions, and interventions must always be customized to meet each individual patient's needs to decrease risk.

Risk Factors included in the Falls Risk Assessment:

Age:

- In general, patients over 80 years old are at higher risk for falls.
- After age 85 years statistics show a large increase in mobility and cognition concerns. (Statistics Canada, 2007)

Altered mental status:

- Patients with major mental illness will often show a risk score in this category.

Attempts to Get Out of Bed or Chair Unsafely:

- Patients with impaired mobility or weakness, who demonstrate poor judgment or who experience acute delirium (e.g. climb over side rail, forget to request or wait for assistance), have a positive risk in this category.
- This category is valued the highest risk.
- Poor Judgement is often a concern in patients with frontal lobe disease or damage.

Previous Fall in the Past Month Related to Patient's Condition:

- Patients who have fallen in the past month because of weakness, impaired mobility, confusion, or acute illness receive a positive score in this category.
- If the fall was related to environmental reasons (such as slipped on wet floor) this category is scored at zero.

Impaired Mobility, Balance or Gait:

- If the patient takes shuffling, small steps, has a slow pace, uses gait aids, holds onto people or furniture when walking or is unsteady when standing or sitting they receive a positive score in this category.

Generalized Weakness:

- The patient receives a positive score when one or more of the following conditions are met:
 - The patient verbalizes feeling weak, dizzy,
 - is unable to sit or stand unassisted on side of bed, or
 - the patient has muscle weakness/fatigue that impairs their ability to perform 2 or more activities of daily living (toileting, bathing, dressing, transferring, walking and self- feeding)
 - This is most common with older patients or with patients experiencing acute physical illness. However many medications can cause postural hypotension and dizziness.

Alterations in Urinary Elimination:

- Patients who experience urinary frequency, urgency, nocturia and/or are being treated with additional fluids (IV therapy) or are receiving medications such as diuretics which are resulting in increased urinary output, score positive in this category.

Medications in the Last 24 Hours:

- Most patients at Ontario Shores will score positively in this category.
- Medications taken that increase risk of falls include psychiatric medication (e.g. antidepressants, antipsychotics, benzodiazepines, mood stabilizers), cardiovascular medication (e.g. antihypertensives, diuretics, antiarrhythmics), and narcotic analgesics (opiates).
- If the patient is on 5 or more medications they also score positive in this category as this is polypharmacy.

Immobile:

- If the patient is unable to initiate movement to get out of bed or is not able to do any self-movement they score negative 5 in this category as their risk is significantly lowered.

Patients at high risk have a total score of greater than or equal to 5 when adding up the score attained from evaluating each of the above risk factors on the Falls Risk Assessment Tool.

A. Extrinsic Risk Factors: Factors that surround the individual and that they may or may not have control over. These are the conditions of the environment.

1. Environmental:

Environmental concerns would include aggression of other patients, and environmental adaptations which aren't met as identified under "**General Environmental Falls Reduction Strategies**" on p. 2 and 3. Work with the Occupational Therapist to identify, reduce, and/or compensate for a patient's environmental risk factors.

2. Physical restraints

- Evidence shows that using physical restraints to prevent falls can cause deconditioning, increased anxiety and impairment of skin integrity.
- All side rails up is considered a restraint and increases falls as patients may try to climb over them, or become entangled or entrapped in them.

- Use least restraint possible as a last resort if person at serious risk to themselves or others
- Meeting requirements cited in the Patient Restraints Minimization Act, Mental Health Act and Hospital Policy & Procedure with respect to the use of chemical or physical restraint.

3. Dignity of risk

People have the right to make a choice about the risk they will take. The role of the clinician and health care team is to fully inform people about their risk. In situations when the person is not capable to make a decision, the substitute decision maker (SDM) will make the choice. SDMs are required to make a care decision on behalf of the incapable patient based on the expressed wishes made by the patient when they were capable, or if this is unknown, based on best interests.

4. Footwear

- Ensure shoes fit properly, are low-heeled, non-slip, and completely encase the foot
- Bare feet is better than socks
- If socks are used please use socks designed with non slip surface on both sides of sock

5. Clothing

- Ensure clothing does not interfere with walking and transferring (i.e. long gowns, long pants are a hazard)

B. Intrinsic Risk Factors: Personal risk factors physiological or medical in nature coming from within the individual. These are the conditions of the individual.

1. History of falls

- This is the number one risk factor.
- If the cause of the fall is not determined and removed the risk remains high.
- When people fall, they fear falling again and will often hold potentially unstable objects to move about in their environment.
- Often people mobilize less in fear of falling again. This leads to deconditioning, muscle atrophy and weakness.

2. Dizziness

- Vertigo, light-headedness and dizziness are not the same thing.
 - Vertigo is a feeling of the room spinning or the person spinning. This is often related to inner ear concerns. Occasionally too much cerumen (wax) in the ears can lead to vertigo. This is a frequent occurrence in the older person. As we age the cerumen holds less water which becomes hard and impacts the ear canal.
 - Postural Hypotension reflects a drop in systolic blood pressure with a change in body position usually noted when the person moves from lying to sitting or sitting to standing. With the increased pull of gravity blood moves down (to the feet when standing) from the brain. This occurs as a normal part of aging, but can also be caused by medications including antihypertensive medications.
 - Loss of consciousness/drop attacks:
 - These conditions are serious and usually reflect an acute cardiac condition (MI) or seizure activity.
- (Samy, & Hamid, 2010)

3. Polypharmacy

- Review medications on a regular basis
- Right drug for patient (individualized prescription reviewing desired effect vs. adverse effects)
- Involve pharmacist to identify potential drug interactions or side effects which could increase risk falls
- Alternatives to help person sleep as opposed to pharmacological sleep aids
- De-escalation through the therapeutic alliance or calming alternatives specific for each individual rather than use of psychopharmacology
- As we age hepatic function and renal function decline as a normal part of aging. (Ebersole, Hess, & Luggen, 2004).
- The liver, responsible for metabolizing most medications (inactivating the effects of the drug) decreases in size. Less blood flow reaches the liver, decreasing its effectiveness and efficiency in metabolizing medications.
- The kidneys, responsible for eliminating most medications, experience a decrease in blood flow by 50%. This alone does not significantly affect function. In the elderly fluid and electrolyte imbalances are common and kidney damage occurs from many of the medications taken. (Ebersole, Hess, & Luggen, 2004).
- In older persons medications remain active in the body for longer periods of time. For this reason for all medications dosing should begin low and increased dosing should proceed slowly.
- Many patients living with a mental illness are on antipsychotic and antidepressant medications. Most of these medications have sedating effects. Many have anticholinergic effects.
- Medications given for hypertension may cause postural hypotension. A blood pressure reading should be taken before administering these medications.

4. Cognition: (Altered Mental Status: Disinhibition, poor judgment, hallucinations, delusions and illusions)

- Person's with damage to their frontal lobe experience poor executive functioning, problems in problem solving, and poor judgment.
- It is important to recognize where the brain damage is and through behaviours recognize how patients may be at risk for falls.
- Often persons who react without thinking do so because they are anxious, confused or depressed. The behavioural profile is a valuable tool in assessing what triggers a patient to behave a certain way, what helps to calm them and what interventions in treatment do they request to assist them in keeping safe.
- What patients perceive as a result to their mental status may influence sudden moments and reactions which may heighten falls risk.
- Hallucinations, delusions and illusions can increase a person's agitation and lead to unsafe behaviours to "escape" to perceived threat. Find out what these perceptions mean to the patient, what helps calm them.

Delirium:

- Delirium is an acute, confused state characterized by acute confusion with a fluctuating course, inattention, disorganized thinking and changes in level of consciousness. It can be diagnosed by administering the Confusion Assessment Measure tool and getting a positive result (see Appendix C for CAM tool).

- Once a person is diagnosed as having delirium the following tests, interventions should be done to determine the cause:
- Medication review for changes
- History and physical exam (looking for medical conditions, recent trauma, changes in normal bodily function, changes in mental status)
- CBC, electrolytes and other laboratory tests as required
- Chest X-ray
- Urinalysis and urine for Culture and Sensitivity
- Swabs sent for culture for any open wounds, artificial through skin entry sites
- CT of head
- If and when the cause of the delirium is determined it should be treated immediately.
- Delirium is a medical emergency and can lead to death.

Cognitive impairment and memory loss:

- Persons with Dementia retain procedural and emotional memory in most cases. Work with people using individual strengths to build a safe environment. For example if a person with dementia has postural hypotension, consistently (in all interactions) teach the person to move from a lying position slowly. First they should sit up slowly, then remain seated for a few minutes and then stand slowly. If these instructions (and demonstration) are repeated consistently over time the patient will remember.

5. Bathroom pattern:

Incontinence, urgency, frequency and frequent Urinary Tract Infections:

- Assess for delirium – Urinary tract infections (UTI) are common in the elderly. Some medications can increase the risk for fluid retention (anticholinergic medications, like Gravol) which can lead to a UTI. A UTI causes frequency, burning and urgency. People may rush to the bathroom without thought to their safety.
- Clear path to bathroom – Concerns with visual acuity can lead to bumping into things or tripping. Keep the path to the bathroom clear, and ensure good lighting to the bathroom.
- 3-day voiding record and voiding program – re-evaluate frequently – People tend to have the same fluid intake pattern each day. Voiding programs where all patients are taken to the bathroom every 2 hours (for example) are not effective. Voiding programs must be individualized to the person.
- Non-slip socks or shoes – People may not have the time to put on shoes. If this is the case make non-slip socks available. (Tread should be on both sides in case the socks are loose and roll.
- Walking aids within reach – In cases of postural hypotension, weakness, poor gait and balance and other mobility issues walking aids specifically fitted for the patient should be available. If the device is new for the patient significant education on safe use of the device is necessary. Work with the Occupational Therapist and the Physiotherapist and the patient to ensure proper technique is used with devices, transferring and mobilization.

6. Impaired Balance and Gait:

- Some interventions to reduce risk of injury from falls related to impaired balance/gait:
 - Helmet
 - Hip protectors
 - Non slip socks

- High-low bed
- Referral to Occupational Therapy and Physiotherapy

7. Acute or Chronic illness:

- Acute illness or chronic illness causing pain and decreased mobility and energy can lead to a weakened state.
- Mobilization declines and this leads to deconditioning.

8. Insomnia or poor sleep pattern:

- This can lead to tiredness, decreased motivation to move, depression and irritability.
- Administering medications to assist with sleep is not recommended.
- Review with the person what their sleep pattern was in the past, what interventions worked to help them sleep and explore what other interventions may help to assist with relaxation and sleep.

9. Sensory Impairment:

- Encourage patient to wear visual aids.
- Patient should have their vision assessed annually and a current prescription of visual aid should be maintained.
- Patients with dementia have a change in their visual perception. Tunnel vision is common and decreases the ability for the person to note obstruction or danger in the peripheral fields (Ghent-Fuller, 2003; Alzheimer’s Association, 2004). Keeping a clear path with hand rails available is important.
- Hearing loss can add to confusion and inability to “hear danger coming”. If the person has hearing aids these should be functional. The battery life of most hearing aid batteries is 5 – 7 days.

10. Nutritional deficits:

- Muscles atrophy with poor nutrition, inactivity and impaired innervation.
- Encourage balanced meals, involve a dietician.

11. Substance Abuse:

On assessment it is important as part of the history taking to explore alcohol or drug abuse. Persons under the influence may exhibit cognitive impairment, disinhibited and risky behaviour. Gait and balance are also impaired.

3. Individualized Treatment Care Plan

Mutual Action Plan (MAP) Kardex:

- The risk status of the patient will be documented on the Map Kardex. A SOAPE note should also be written to note high risk for falls (if this is the case). The interprofessional team should be guided to review the Falls Risk Assessment tool (completed and in the Assessment section of the chart) and the Treatment Plan individualized for the patient (see below).

MAP Treatment Plan:

- Once high risk is noted using the Falls Risk Assessment tool (score > or = to 5) the interprofessional team members will discuss appropriate interventions to reduce risk of falls and injury from falls with the patient/SDM.

- A collaborative goal of decreasing falls and injury from falls is set and written on the Treatment Plan of the (Mutual Action Plan) MAP.
- Patient and interprofessional team notes are written identifying strengths and barriers.
- Together with the patient/SDM an action plan with individualized interventions is written. Information provided in Appendix B can provide some assistance in formulating an action plan.

4. Education

Staff Education:

- Patient Safety Handbook for Clinicians
- ROP brochure
- ROP PowerPoint slides
- Focused education for staff providing care to populations at risk
- Falls Risk Assessment, Prevention and Management Self Learning Package

Patient and Family Education:

- Use of equipment such as high-low bed, mobility aids
- Assess their own environment – what has helped before to decrease risk
- Know their medications and usual side effects they experience
- Postural hypotension – how to get up slowly
- How to get up safely from a fall to minimize injury
- Coping mechanisms when triggered, how to manage anxiety and agitation
- Orientation to new environment
- Falls Prevention Information on unit Patient Safety Bulletin Boards
- Patient Safety Brochure for Patients

5. Safety Reporting, Review & Data Analysis of Falls

- Staff witnessing or discovering fall or potential fall (good catch) to complete a “Patient Notification” safety occurrence report in Meditech
- Clinical Manager of unit receives all Safety Reports, and facilitates reviews for those occurrences with a moderate – serious Safety Assessment Code (SAC) rating
- Risk Management or Patient Safety will facilitate a Root Cause Analysis if fall safety occurrence results in critical harm to patient
- Process issues can be identified through the use of the new electronic review system, which can result in process based changes to reduce frequency and severity of falls
- Safety Occurrences are trended at the clinical unit level, clinical program level, and corporate wide, every quarter
- Trending reports are provided to the Clinical Manager, Administrative Director, and Senior Management Team, and appropriate Committees for review and discussion every quarter
- Falls data as a part of the Balanced Scorecard is provided to the Board Finance and Quality Committee every quarter

References

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Appendix A

Patient Demographics:

Falls Risk Assessment		
Reason for Completing Assessment <input type="checkbox"/> Admission <input type="checkbox"/> Transfer <input type="checkbox"/> Post Fall <input type="checkbox"/> Change of Status <input type="checkbox"/> initial assessment		
Instructions: For all risk factors present, assign the full corresponding score. Assign "0" to risk factors not present	Score	Score
Ages 65 -79	0.5	
Age 80 or Greater	1	
Altered Mental Status: Exhibits one or more of the following: unable to follow instructions, impaired short term memory, disorientation to time and place, impaired thought process (psychosis), or conditions that potentiate confusion or agitation such as delirium or septicemia	2	
Attempts to Get Out of Bed or Chair Unsafely: Impaired mobility or weakness AND demonstrates poor judgment or experiences acute delirium (e.g. climbs over side rail, forgets to request or wait for assistance)	5	
Previous Fall in the Past Month Related to Patient's Condition: Weakness, impaired mobility, confusion, or acute illness (not environmental)	1	
Impaired Mobility, Balance or Gait: Shuffling, small steps, slow pace, uses gait aids or holds onto people or furniture; unsteady when standing or sitting	1	
Generalized Weakness: One or more of the following conditions: verbalizes feeling weak or dizzy or unable to sit or stand unassisted at side of bed or muscle weakness/fatigue impairs ability to perform 2 or more activities of daily living (toileting, bathing, dressing, transferring, walking and self- feeding)	1	
Alterations in Urinary Elimination: Frequency, urgency, nocturia , incontinence, IV therapy, diuretics	1	
Medications in the Last 24 Hours: Psychiatric medication (e.g. antidepressants, antipsychotics, benzodiazepines, mood stabilizers), cardiovascular medication (e.g. antihypertensive, diuretics, antiarrhythmics), narcotic analgesics (opiates) or more than 5 medications	1	
Immobile: Unable to initiate movement to get out of bed or any self-movement	-5	
Total Score		
If the total score is ≥ 5 , the patient is at HIGH RISK for falls. Document High Risk on the Patient Kardex		
Date	Time	Initials

Adapted from: CAMH. (2007) which is adapted from Heslin, K., Towers, J., Leckie, C., Thornton-Lawrence, H., Perkin, I., Jacques, M., Mullin, J & Wick, L. (1992). Managing Falls: Identifying Population-Specific Risk Factors and Prevention Strategies. Springer Publishing 70-88.

Appendix B

Risk Area & Intervention Guide

Risk Category	Intervention
Age	<ul style="list-style-type: none"> • No interventions • Please assess for physiological age • Patient may be in poor health but younger so may not get points in this category • Work with patient as a team to improve medical conditions, improve nutritional status
Altered Mental Status	<ul style="list-style-type: none"> • Perform the CAM to rule out delirium • Provide a safe environment • Provide health teaching to patient re: getting up slowly; asking for assistance • Provide walking aids • Assess whether patient is having hallucinations and treat psychosis and offer support • Ensure that visual and auditory aids are in good condition and used
Attempts to get out of bed or chair unsafely	<ul style="list-style-type: none"> • Assess for safe mobility • Provide walking aids with education • Improve mobilization through physiotherapy • Improve environment (i.e. transfer aids) through occupational therapy • Provide repetitive safe practice and mobilization education • Provide specialized equipment such as a hi-low bed
Previous fall in past month (not related to environment)	<ul style="list-style-type: none"> • Find out the cause of the fall and put interventions in place to minimize risk • If conditions are such that the person will likely fall again explore use of helmet and hip protectors • Work with patient to improve strength in mobilization (such as physiotherapy) • Provide education to patient/SDM about safe mobilization interventions
Impaired mobility, balance and gait	<ul style="list-style-type: none"> • Provide walking and mobility aids • Involve OT and PT • Provide continued education and assist patient to practice safe mobilization based on the OT, PT assessment and recommendations
Generalized weakness	<ul style="list-style-type: none"> • Increase strength through therapy and increased mobilization • Use active ROM • Provide a safe environment such as a hi-lo bed • Treat acute illness that has lead to weakness (this may include major depression where the patient has not mobilized but stayed in bed for extensive periods of time)
Alterations in urinary elimination	<ul style="list-style-type: none"> • Determine type of incontinence or alteration • Begin a 3 day voiding record • Place person on an individualized voiding program • Ensure bathroom is accessible and environment clear of equipment • Ensure proper lighting especially at night • Provide access to walking aids • Ensure patient has proper footwear
Medications in last 24 hours	<ul style="list-style-type: none"> • Look beyond the 24 hours for medication changes • This can be a medication removed or a new one added • Be aware of kidney function • Note any concerns with absorption, distribution, metabolism or excretion of the medication • Be aware of any drug-drug, disease to drug or drug to food or alcohol interaction

CAM		CONFUSION ASSESSMENT METHOD	
THE DIAGNOSIS OF DELIRIUM BY CAM REQUIRES THE PRESENCE OF BOTH FEATURES A AND B			
A <input type="checkbox"/>	ACUTE ONSET AND FLUCTUATING COURSE	<p>Is there evidence of an acute change in mental status from patient baseline? Does the abnormal behavior:</p> <ul style="list-style-type: none"> ➢ COME AND GO? ➢ FLUCTUATE DURING THE DAY? ➢ INCREASE/DECREASE IN SEVERITY? 	
B <input type="checkbox"/>	INATTENTION	<p>Does the patient:</p> <ul style="list-style-type: none"> ➢ HAVE DIFFICULTY FOCUSING ATTENTION? ➢ BECOME EASILY DISTRACTED? ➢ HAVE DIFFICULTY KEEPING TRACK OF WHAT IS SAID? 	
AND the presence of EITHER feature C or D			
C <input type="checkbox"/>	DISORGANIZED THINKING	<p>Is the patient's thinking</p> <ul style="list-style-type: none"> ➢ DISORGANIZED ➢ INCOHERENT <p>For example does the patient have</p> <ul style="list-style-type: none"> ➢ RAMBLING SPEECH/IRRELEVANT CONVERSATION? ➢ UNPREDICTABLE SWITCHING OF SUBJECTS? ➢ UNCLEAR OR ILLOGICAL FLOW OF IDEAS 	
D <input type="checkbox"/>	ALTERED LEVEL OF CONSCIOUSNESS	<p>Overall, what is the patient's level of consciousness:</p> <ul style="list-style-type: none"> ➢ ALERT (NORMAL) ➢ VIGILANT (HYPER-ALERT) ➢ LETHARGIC (DROWSY BUT EASILY ROUSED) ➢ STUPOROUS (DIFFICULT TO ROUSE) ➢ COMATOSE (UNROUSABLE) 	