From the Office of Health Informatics

Oracle Health (Cerner) Millennium - Adult Delirium Assessment

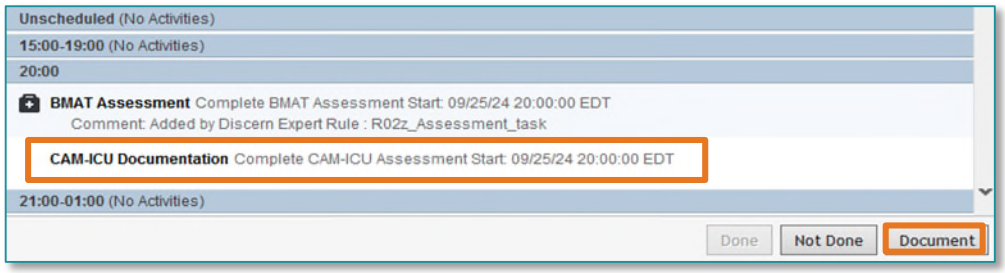
April 22, 2025

Assessing patients for symptoms of delirium, implementing Universal Preventable Measures, and Positive Interventions if delirium develops, will help patients have a better outcome. bCAM should be performed every shift on all Med/Surg patients 65 years old and above. CAM-ICU should be performed every shift on all patients in the critical care areas. bCAM and CAM-ICU Universal Preventable Measures, Result, and Positive Interventions populates in the Patient Plan of Care form increasing the awareness of delirium.

CAM-ICU

Part of a routine assessment of the **ICU/CCU** patient includes the **CAM-ICU** and **RASS** to assess for delirium on admission, once a shift, and with a change in mental status.

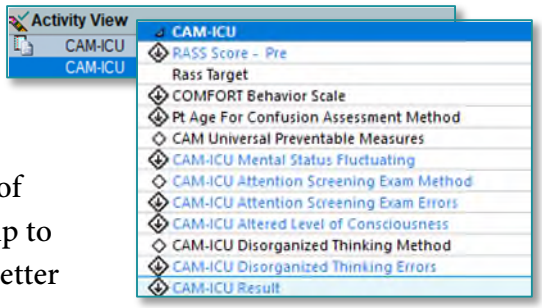
NOTE: **Tasking for CAM-ICU assessments go to CareCompass for all Critical Care areas.**



STEP 1: Select the **CAM-ICU Documentation task** in **CareCompass** and click **Document.**

STEP 2: Document **RASS Score**.

STEP 3: Document **Pt Age for Confusion Assessment Method**.



STEP 4: Select appropriate **Universal Preventable Measures**.

- Implementing the preventable measures from the time of admission to ICU and throughout the ICU stay may help to prevent delirium giving the patient the possibility of a better outcome.
- **Early Mobilization** is one of the **Universal Preventable Measures**. Patients should be out of bed as soon as possible unless contraindicated.

STEP 5: Document **CAM ICU Mental Status Fluctuating**.

- Use the reference text to assist in determining if the patient has a fluctuating mental status. It is important to obtain, from family or institution, what the patient's mental status was prior to hospitalization to accurately document whether the patient has a fluctuating Mental Status.
- If patient is in stupor or coma state, document **Unable to Assess**.

STEP 6: Document **CAM ICU Attention Screening Exam Method**.

- Use the reference text to assist with the words to spell out, asking the patient to squeeze your hand each time the letter A is spoken.
- Keep track of how many mistakes the patient makes. If it is necessary to use pictures, the reference text can be printed when needed.

STEP 7: Document **CAM ICU Attention Screening Errors.**

- Use the reference text to assist in determining if the number of errors indicates a positive or negative screening.
- The screening is positive if the patient has 3 or more errors when Letters are used and 2 or more errors when pictures are used.
    - If the patient makes up to 2 errors, select 0 to 2.
    - If the patient made more than 2 errors, select >2.
    - If the patient has a RASS Score of -3/-5, attention screening is not able to be assessed and this option should be selected.
    - If the patient is agitated or refused, that option should be selected as the patient is not able to be assessed.

STEP 8: Document **CAM ICU Altered Level of Consciousness**.

- Use the reference text to guide how to complete a RASS assessment and what each of the options in the RASS Score mean.
    - If the RASS score was just documented, select the option in which the patient's RASS score falls in.

STEP 9: Document **CAM ICU Disorganized Thinking Method**.

STEP 10: Document **CAM ICU Disorganized Thinking Errors**.

- Use the reference text to assist in determining if the number of errors indicates a positive or negative screening.

STEP 11: Document **CAM ICU Result.**

- Use the reference text to assist in determining if the results indicate the patient's screening is positive or negative for delirium.

STEP 12: Document **CAM Positive Interventions**.

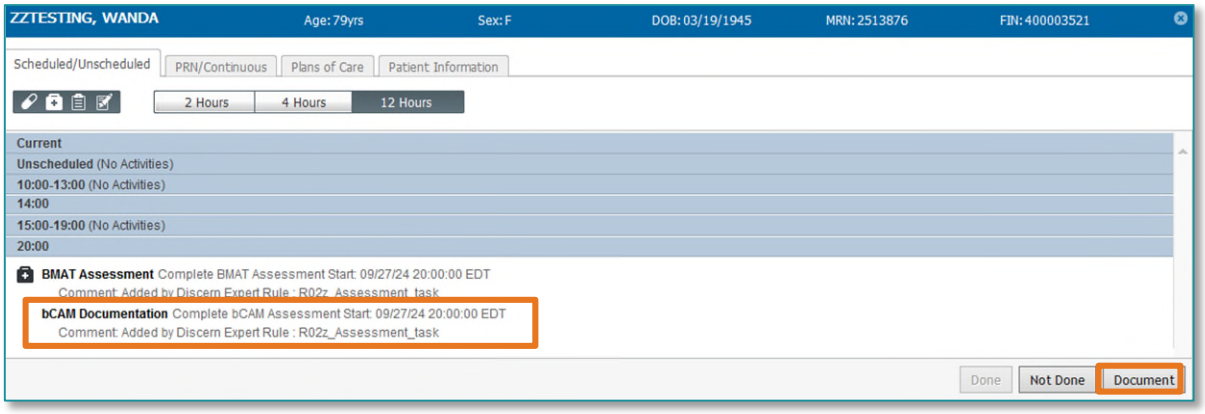
- These should be implemented and documented whenever the CAM-ICU Result is positive.

STEP 13: Sign Documentation.

Documenting bCAM (Brief Confusion Assessment Method) on Med/Surg Patients

The bCAM assessment should be completed on admission, once a shift, and with a change in mental status for all patients 65 and over.

NOTE: **If the patient is under age 65 and had a positive CAM-ICU result, the bCAM should be assessed while on the Med/Surg unit.**



STEP 1: Select the **CareCompass task** for **bCAM Documentation** and click **Document.**

NOTE: **Existing patients will have the CAM Documentation task name in CareCompass and will open to bCAM in Activity View.**

STEP 2: Document **Universal Preventable Measures.**

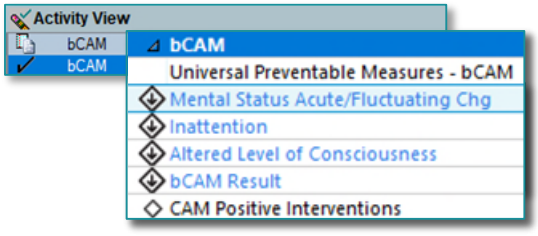
- Implementing the preventable measures from the time of admission and throughout the hospital stay may help to prevent delirium giving the patient the possibility of a better outcome.
- **Early Mobilization** is one of the **Universal Preventable Measures**. Patients should be out of bed as soon as possible unless contraindicated.

STEP 3: Document **Mental Status Acute/Fluctuating.**

- Use the reference text to assist in determining if the patient has a fluctuating mental status.

STEP 4: If it is determined there *is* a fluctuation or change in mental status, document **Inattention**.

- Use the reference text to assist in determining if the patient has inattention.



STEP 5: Document **Altered Level of Consciousness**.

- Use the reference text to guide for how to complete an assessment of level of consciousness.

STEP 6: Document **bCAM Result**.

- Use the reference text to assist in determining if the results indicate the patient's screening is positive or negative for delirium.

STEP 7: Document **CAM Positive Interventions**.

STEP 8: **Sign** Documentation.

Patient Plan of Care

- The following information from the **bCAM** and **CAM-ICU** assessments flows to the **Alteration in Neuro Status Care Plan**:
    - Universal Preventable Measures
    - Result
    - Positive Interventions