CAPD Delirium Screening Record

UK PAEDIATRIC DELIRIUM GROUP

Insert Patient Sticker:

Screen every patient once per shift, after at least 4-6 hours of observation.

	Date:								
	Time:								
(Do not assess if COMFORT B ≤11)	COMFORT B SCORE								
PARENT/GARDIAN PARTICIPATION IN ASSESSMENT *Y/N*									
1.Does the child make eye contact with their caregiver?	4- NEVER								
	3- RARELY								
	2- SOMETIMES								
	1- OFTEN								
	0- ALWAYS								
2. Are the child's actions purposeful?	4- NEVER								
	3- RARELY								
	2- SOMETIMES								
	1- OFTEN								
	0- ALWAYS								
3. Is the child aware of his/her surroundings?	4- NEVER								
	3- RARELY								
	2- SOMETIMES								
	1- OFTEN								
	0- ALWAYS								
4. Does the child communicate needs and wants?	4- NEVER								
	3- RARELY								
	2- SOMETIMES								
	1- OFTEN								
	0- ALWAYS								
5. Is the child restless?	0- NEVER								
	1- RARELY								
	2- SOMETIMES								
	3- OFTEN								
	4- ALWAYS								
6. Is the child inconsolable?	0- NEVER								
	1- RARELY								
	2- SOMETIMES								
	3- OFTEN								
	4- ALWAYS								
7. Is the child underactive – very little movement while awake?	0- NEVER								
	1- RARELY								
	2- SOMETIMES								
	3- OFTEN								
	4- ALWAYS								
8. Does it take the child a long time to respond to interactions?	0- NEVER								
	1- RARELY								
	2- SOMETIMES								
	3- OFTEN								
	4- ALWAYS								
	TOTAL SCORE								
	ASSESSOR INITIALS								

CAPD Delirium Screening

- **Compare behaviour with the CAPD Developmental Anchor Points tool for their age!**
- **Patient to be assessed** by the bedside nurse **with their parent/ guardian input** at least halfway through the 12-hour day/night shift to capture fluctuations in behaviour indicating delirium.
- CAPD is a screening tool. **CAPD score ≥9** indicates the need for further evaluation for delirium.
- **Do not continue** with CAPD assessment in an intubated child with a **COMFORT B score ≤11.** They are too sedated to display behavioural cues indicative of delirium.

If delirium suspected think…

B **B**ring oxygen (hypoxemia, decreased cardiac output, anaemia)

R **R**emove or **R**educe deliriogenic drugs (anticholinergics, benzodiazepines)

A **A**tmosphere (lights, sounds, noise, restraints, absent family, 'strangers', out of routine)

I **I**nfection, **I**mmobilization, **I**nflammation

N **N**ew organ dysfunction (Neuro, Cardiovascular, Respiratory, Hepatic, Renal, Endocrine)

M **M**etabolic disturbances: alkalosis, acidosis, ↑/↓Na^+, ↑/↓ K^+, ↓ Glucose, ↓ Ca^{++}

A **A**wake (No bedtime routine, sleep- wake cycle disturbance)

P **P**ain (too much & not enough drug OR paint treated and now too much drug)

S **S**edation (Assess need and set patient specific COMFORT B target)

Developed with permission of Dr Chani Traube & UK Paediatric Delirium Group

TIME & DATE	NOTES