

* CAPD Delirium (Insert Patient Sticker: Screening Record)

LIK PAEDIATRIC	Screen every	patier	nt once	per sh	ift, aft	er at lea	ast 4-6 l	nours of	observ	ation.
UK PAEDIATRIC DELIRIUM GROUP	Date:	21/3								
DELITION GITTOUT	Time:	18:30								
(Do not assess if COMFORT B ≤11)	COMFORT B SCORE	14								
PARENT/GARDIAN PARTICIPATION IN ASSESSMENT Y/N		7								
	4- NEVER									
1.Does the child make eye contact with their	3- RARELY									
caregiver?	2- SOMETIMES	2								
caregiver:	1- OFTEN									
	0- ALWAYS									
2. Are the child's actions purposeful?	4- NEVER									
	3- RARELY	3								
	2- SOMETIMES	V								
	1- OFTEN									
	0- ALWAYS									
2 leable shill seem (4- NEVER									
3. Is the child aware of	3- RARELY									
his/her surroundings?	-	7								
	2- SOMETIMES	7								
	1- OFTEN	1								
	0- ALWAYS									
4. Does the child	4- NEVER	•								
communicate needs and	3- RARELY	3								
wants?	2- SOMETIMES									
	1- OFTEN									
	0- ALWAYS									
5. Is the child restless?	0- NEVER									
	1- RARELY									
	2- SOMETIMES	2								
	3- OFTEN									
	4- ALWAYS									
6. Is the child inconsolable?	0- NEVER									
	1- RARELY									
	2- SOMETIMES	_2								
	3- OFTEN									
	4- ALWAYS									
7. Is the child underactive	0- NEVER	0								
– very little movement while awake?	1- RARELY									
	2- SOMETIMES									
	3- OFTEN									
	4- ALWAYS									
8. Does it take the child a	0- NEVER									
long time to respond to	1- RARELY	1								
interactions?	2- SOMETIMES									
	3- OFTEN									
	4- ALWAYS									
	TOTAL SCORE	15								
	ASSESSOR INITIALS	LMc								
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- 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
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- **B**ring oxygen (hypoxemia, decreased cardiac output, anaemia)
- Remove or Reduce deliriogenic drugs (anticholinergics, benzodiazepines)
- Atmosphere (lights, sounds, noise, restraints, absent family, 'strangers', out of routine)
- Infection, Immobilization, Inflammation
- New organ dysfunction (Neuro, Cardiovascular, Respiratory, Hepatic, Renal, Endocrine)
- Metabolic disturbances: alkalosis, acidosis, $\uparrow/\downarrow Na^+$, $\uparrow/\downarrow K^+$, \downarrow Glucose, $\downarrow Ca^{++}$
- Awake (No bedtime routine, sleep- wake cycle disturbance)
 Pain (too much & not enough drug OR paint treated and now too much drug)
- Sedation (Assess need and set patient specific COMFORT B target)

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TIME & DATE	NOTES