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)