The Confusion Assessment Method (CAM)

(1) Acute onset and fluctuating course
Is there an acute change from the patient's baseline as reported by family/caregiver/healthcare provider? Does the changed behavior alternate in clarity and confusion, come and go over time, increase or decrease in severity over time?
(2) Inattention
Does the patient have difficulty focusing on topic? Can the patient not count back from 10, recite months of year backward or spell WORLD backward?
(3) Disorganized thinking
Does the patient have rambling or incoherent speech? Do they unpredictably switch from subject to subject?
(4) Altered level of consciousness
Is the patient's level of consciousness hyperalert (agitated), drowsy, stuporous or comatose?

A diagnosis of delirium requires the presence of features 1, 2, and either 3 or 4

Adapted from: Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med* 1990; 113(12):941-8

Why use the CAM?

- Easy to administer (5 minutes or less)
- Accurate
  - 86% Sensitive
  - 93% Specific
- High interobserver reliability (Kappa >0.8) so can be done by any healthcare provider
- Helpful at both ruling-in and ruling-out delirium:
  - +LR 9.6 (95% CI: 5.8-16)
  - -LR 0.16 (95% CI: 0.08-0.29)

Ref: Wong CL, Holroyd-Leduc J, Simel DL and Straus SE. Does this patient have delirium? Value of bedside instruments. JAMA 2010; 304:779-786.