**Neecham Confusion Tool**

### Confusion Risk Screen

<table>
<thead>
<tr>
<th>Date/Time/Initials</th>
<th>Reason for Screen admission, daily, status change</th>
<th>Age ≥ 75 years?</th>
<th>History of Acute Confusion?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**If any Yes Boxes are checked, complete the Neecham Confusion Scale.**

### Neecham Confusion Scale

<table>
<thead>
<tr>
<th>Date/Time/Initials</th>
<th>Score</th>
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<th>Score</th>
<th>Score</th>
</tr>
</thead>
</table>

#### Level One – Processing – Attention
- 4 – Full attentiveness/alertness
- 3 – Short or hyper attention/alertness
- 2 – Attention/Alertness inconsistent or inappropriate
- 1 – Attention/Alertness disturbed
- 0 – Arousal/responsiveness depressed

#### Level One – Processing – Command
- 5 – Able to follow a complex command
- 4 – Slowed complex command response
- 3 – Able to follow a simple command
- 2 – Unable to follow a direct command
- 1 – Unable to follow visually guided command
- 0 – Hypoactive, lethargic

#### Level One – Processing – Orientation
- 5 – Oriented to time, place, and person
- 4 – Oriented to person and place
- 3 – Orientation inconsistent
- 2 – Disoriented and memory/recall disturbed
- 1 – Disoriented, disturbed recognition
- 0 – Processing of stimuli depressed

#### Level One – Processing – Command
- 5 – Able to follow a complex command
- 4 – Slowed complex command response
- 3 – Able to follow a simple command
- 2 – Unable to follow a direct command
- 1 – Unable to follow visually guided command
- 0 – Hypoactive, lethargic

#### Level Two – Behavior – Appearance
- 2 – Controls posture, maintains appearance, hygiene
- 1 – Either posture or appearance disturbed
- 0 – Both posture and appearance abnormal

#### Level Two – Behavior – Motor
- 4 – Normal motor behavior
- 3 – Motor behavior slowed or hyperactive
- 2 – Motor movement disturbed
- 1 – Inappropriate, disrupted movements
- 0 – Motor movement depressed

### Scoring

- **Level 1 Score:** Processing (0-14 points)
- **Level 2 Score:** Behavior (0-10 points)
- **Level 3 Score:** Physiological Control (0-6 points)

<table>
<thead>
<tr>
<th>Scoring</th>
<th>Total Score of</th>
<th>Indicates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>0-19</td>
<td>Moderate to severe confusion</td>
</tr>
<tr>
<td>Level 2</td>
<td>20-24</td>
<td>Mild to early development of confusion</td>
</tr>
<tr>
<td>Level 3</td>
<td>25-26</td>
<td>“Not confused”, but at high risk of confusion</td>
</tr>
<tr>
<td></td>
<td>(VS, O2 sat, urinary continence)</td>
<td>27-30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initials</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Circle points that apply and add total</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>D</td>
</tr>
</tbody>
</table>

**SAFETY:** NO SIGNIFICANT PERCEPTUAL DEFICITS. NO COMMUNICATION BARRIERS. STEADY ON FEET.  
Siderails: # Call light within reach = ✓

Patient observation: (frequency throughout shift)  
See Patient Restraint Flowsheet

**Hendrich II falls Risk Model**  
Complete 8 hour shift, changed condition, or transfer

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion/Disorientation/Impulsiveness</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Depression (Nursing staff assesses patient or patient states “depressed”)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Altered Elimination (leakage of urine or stool, “can’t wait” or gets up 4 or more times/night)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dizziness/Vertigo (reported by patient)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gender (Male)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Any antiepileptics Carbamazepine (Tegretol, Carbatrol), divalproex (Depakote), fosphenytoin (Cerebyx injection) gabapentin (Neurontin), lamotrigine (Lamictal), levetiracetam (Keppra), mephobarbital, (Mebaral) oxcarbazepine (Trileptal), Phenobarbital, (phenytoin), (Dilantin), topiramate (Topamax) and valproic acid (Depakene)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Any benzodiazepines: (Alprazolam (Xanax), chlordiazepoxide (Librium, Librax) clonazepam (Klonopin), diazepam (Valium), flurazepam (Dalmame), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), and triazolam (Halcion)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Get-Up-And-Go Test (Choose One):**
- Rises in a single movement
- Pushes up in one attempt
- Multiple Attempts, successful
- Unable to rise without assist

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td></td>
<td>1</td>
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<tr>
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<td>3</td>
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<tr>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
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</table>

ADD TOTAL POINTS (>5 points = High Risk):

Check box if patient is on Fall Prevention Pathway

**Get-Up-And-Go Test**: Instructions: With patient sitting in a chair (preferred location) or on the side of the bed, place hands in lap and ask the patient to stand. **Score of 0:** Patient is able to stand and begin stepping in a single movement using only his/her legs. **Score of 1:** The patient can rise and begin stepping in a single attempt if utilizes his/her arms or a walker to push up. **Score of 3:** Patient requires more than one attempt to stand with or without use of hands, arms and walker. **Score of 4:** Patient cannot stand without assistance.

**INTRAVENOUS**: No evidence of redness, tenderness, swelling or increased warmth at IV site or surrounding tissue.

**IV #1**: Type of IV access and location (see MAR for flushes)

Describe IV site skin condition (every 8 hours)

**Dressing / Action / Measurement if non-tunneled line**

**IV #2**: Type of IV access and location (see MAR for flushes)

Describe IV site skin condition (every 8 hours)

**Dressing / Action / Measurement if non-tunneled line**

INIT. / SIGNATURE / TITLE: PRIMARY CARE GIVER, for shift worked

Other care givers sign each page, Initial and Time add’l entries
Fall Prevention: Inpatient –
Patient Care Policy

APPENDIX A

Familiar Environment Worksheet

Patient Full Name: __________________________
Patient Preferred Name: ______________________
Current/Past Occupation: ______________________

Family/Friends/Pets

Name                                                                 Relationship
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Familiar belongings/pictures from home?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Visiting Plan

Day                          Time                  Visitor
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Home Routines/Habits

Wake Time________________ Bed Time____________ Nap Time(s)________________

Special routines to promote rest? (please describe)__________________________

Night Light? ______________

Frequency of use of bathroom at night: ______________________________

Prefer bath or shower? __________ How Often? __________ Time of Day __________

Meal Times: Breakfast_________ Lunch_________ Dinner_________________ Snacks_________

Favorite foods/beverages? ________________________________________________

Mealtime routines? ______________________________________________________

Free-time activities (hobbies/interests):____________________________________

Favorite TV/radio programs? _____________________________________________

Favorite books/magazines? ______________________________________________

The above information would be most helpful to all caregivers if posted in your room.

Is this acceptable to you?  Yes____ No ____ ____________

Initials ______ Relationship (if patient unable) __________________________ Date __________

**If patient/family declines, keep with pathway

Eye Glasses☐ Babador☐ Dentures☐

Hearing Aid:   R☐   L☐   Both☐

Walker☐   Cane☐

Other assistive devices: __________________________

Usual temperature in home: __________________________