Participant ID	

Initials of person entering data	

Staff email	

CONFIDENTIAL CASE REPORT FORM

Nursing Interventions for Disorientation
Series 29

IMPACCT Trials Coordination Centre (ITCC)
UTS IMPACCT Rapid Program
The case report form (CRF) is to be completed in compliance with
ITCC Standard Operating Procedures (SOP)

Disorientation Explanatory Notes
This Rapid Program series examines immediate nursing interventions for persons assessed as disorientated in any of the following domains: • Time • Place • Person • Situation (i.e. present circumstances) This series will help determine: 1. What nurses do in immediate response to patients who are disorientated; and 2. Whether these nursing interventions rapidly improve patients' orientation. **NB:** Because the focus of the series is on nurses' immediate actions and communication with patients who are disorientated, and patients' immediate responses (i.e. within four hours), only interventions that are likely to have this *immediate effect* are listed here. Other equally important nursing interventions - such as undertaking comprehensive assessment, including a medication review - are not being measured in this series because their mode of action is likely to be longer than four hours. However, if any other nursing interventions not listed in this case report form are undertaken, and you think they are important to report in this series, please give the details for these in the relevant sections on pages 6, 10 and 14.

Baseline (T_0) - Nursing Interventions for Disorientation	
Date of Assessment	DD/MM/YYYY

Demographics *(please tick)*

Gender ○ Male ○ Female ○ Other

Age (years)			
Weight (kg)		☐ Estimated	☐ Actual weight
Height (cm)		☐ Estimated	☐ Actual height

Tick ✓	Place of Care
	Acute hospital
	Palliative care unit/hospice
	Nursing home
	Other e.g. own home

Tick ✓	Primary life limiting illness (please choose only one)
	Advanced cancer
	End stage renal failure
	Hepatic failure
	Neurodegenerative disease
	Cardiac failure
	Respiratory failure
	AIDS
	Other; Please specify:_____

Tick ✓	Palliative Care Phase
	1. Stable Phase: The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.
	2. Unstable Phase: The person experiences the development of a new problem or a rapid increase in the severity of existing problems either of which requires an urgent change in management or emergency treatment.
	3. Deteriorating Phase: The person experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.
	4. Terminal Care Phase: Death is likely in a matter of days and no acute intervention is planned or required.

Tick ✓	Australian Modified Karnofsky Performance Scale (AKPS)
	100 - Normal; no complaints; no evidence of disease
	90 - Able to carry on normal activity; minor sign of symptoms of disease
	80 - Normal activity with effort; some signs or symptoms of disease
	70 - Cares for self; unable to carry on normal activity or to do active work
	60 - Requires occasional assistance but is able to care for most needs
	50 - Requires considerable assistance and frequent medical care
	40 - In bed more than 50% of the time
	30 - Almost completely bedfast
	20 - Totally bedfast and requiring extensive nursing care by professionals and/or family
	10 - Comatose or barely rousable
	0 - Dead
	Not able to determine

Charlson Comorbidity Index - Does the patient have any of the following? *(Please tick ✓ all that apply)*			
Tick ✓		**Tick ✓**	
	Myocardial Infarction (history, not ECG changes only)		Hemiplegia
	Congestive Cardiac Failure		Moderate or Severe Renal Disease
	Peripheral Vascular Disease (includes aortic aneurysm >= 6 cm)		Diabetes with End Organ Damage
	Cerebrovascular Disease (CVA with mild or no residual or TIA)		Any Tumour
	Dementia		Leukaemia (acute or chronic)
	Chronic Pulmonary Disease		Lymphoma
	Connective Tissue Disease		Moderate or Severe Liver Disease
	Peptic Ulcer Disease		Metastatic Solid Tumour
	Mild Liver Disease (without portal hypertension, includes chronic hepatitis)		AIDS (not just HIV positive)
	Diabetes (without organ damage) (excludes diet-controlled alone)		

Baseline – T0- Intervention Commencement	
Date and time of Assessment	D-M-Y H-M

Disorientation Domains *(Orientation to place is the person knowing **where** they are). Orientation to situation is the person understanding **what is happening** around them, or their circumstances. E.g., how they came to be in hospital.*	
Tick ✓	**Which disorientation domains are present in your patient?** *(tick all that apply)*
	Patient disorientated to Time
	Patient disorientated to Place
	Patient disorientated to Person
	Patient disorientated to Situation

Tick ✓			**Is patient aware of disorientation?**
Yes	**No**	**N/A**	*(please answer all domains by ticking appropriate response)*
			Patient aware disorientated to Time
			Patient aware disorientated to Place
			Patient aware disorientated to Person
			Patient aware disorientated to Situation

Richmond Agitation Sedation Scale-Palliative Version (RASS-PAL) *(tick the score that best describes the patient's level of agitation)*		
Tick ✓	**Score Term**	**Description**
	+4 Combative	Overtly combative, violent, immediate danger to staff (e.g. throwing items) +/- attempting to get out of bed or chair
	+3 Very agitated	Pulls or removes lines (e.g. IV/oxygen tubing) or catheter(s); aggressive; +/- attempting to get out of bed or chair
	+2 Agitated	Frequent non-purposeful movement +/- attempting to get out of bed or chair
	+1 Restless	Occasional non purposeful movement, but not aggressive or vigorous
	0 = Alert and calm	
	-1 Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (10 seconds or longer)
	-2 Light sedation	Briefly awakens with eye contact to voice (<10 seconds)
	-3 Moderate sedation	Any movement (eye or body) or eye opening to voice (but no eye contact)
	-4 Deep sedation	No response to voice, but any movement (eye or body) or eye opening to stimulation by light touch
	-5 Not rouseable	No response to voice or stimulation by light touch

Baseline Symptom/Harm Assessment *(Please grade all symptoms/harms; indicate that each harm has been assessed by ticking the square box next to each)*

☐ **Irritability**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

NCI Criteria
1. Mild; easily consolable
2. Moderate; limiting instrumental ADL; increased attention indicated
3. Severe abnormal or excessive response; limiting self-care ADL; inconsolable; medical or psychiatric intervention indicated

☐ **Anxiety**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

NCI Criteria
1.Mild symptoms; intervention not indicated
2. Moderate symptoms; limiting instrumental ADL
3. Severe symptoms; limiting self-care ADL; hospitalization indicated
4. Life-threatening consequences; urgent intervention indicated

☐ **Delusions**

○ 2 ○ 3 ○ 4 ○ 5 ○ Ungradable ○ No symptom

NCI Criteria
1. -
2. Moderate delusional symptoms
3. Severe delusional symptoms; hospitalization not indicated; new onset
4. Life-threatening consequences, threats of harm to self or others; hospitalization indicated
5. Death

☐ **Embarrassment**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

1. Mild
2. Moderate
3. Severe

☐ **Current other problem/harm (if exists)**

Please specify harm here _____

Grade:

○ 1 ○ 2 ○ 3 ○ Ungradable

1. Mild
2. Moderate; limiting instrumental ADL
3. Severe; limiting self-care ADL

NURSING INTERVENTIONS PROVIDED FOR DISORIENTATION *(Please tick 'yes' or 'no' to all interventions)*		
Tick ✓		**Orientation to time**
Yes	**No**	Ensure presence of clock, wristwatch, or electronic device with correct time of the day
		Ensure presence of calendar, newspaper, or electronic device with correct day of the week/date
		Ensure presence of a whiteboard with correct day of the week/date
		Ensure access to an outside view
Yes	**No**	**Orientation to place**
		Ensure adequate light
		Signs/explain layout of the care facility
		Signs/explain name of the care facility
		Signs/explain location of the person's room
		Signs/explain location of bathroom/toilet
		Use of orientating objects/symbols
		Ensure meaningful familiar objects are present
		Ensure minimal relocation/room changes
Yes	**No**	**Orientation to person**
		Call the person by his or her preferred name
		Introduce yourself (name and role)
		Encourage family/friends to visit/stay with the person
		Encourage/assist with audio/video calls to family/friends
Yes	**No**	**Orientation to situation**
		Explain preceding events
		Explain current activities
Yes	**No**	**Other**
		Use of orientating communication (i.e., integrating time/place/person into conversation with the person)
		Promote use of hearing aids
		Promote use of vision aids
		Provide reassuring communication to allay doubts and/or fears
		Reduce noise
		Arrange an interpreter
		Any other intervention/s provided (if any), please give details:

T_1 – 30-60 minutes after nursing intervention	
Date and time of Assessment	D-M-Y H-M

Tick ✓	**T_1: Assessed/Not assessed reason**
	Assessed today (continue to complete T_1) OR
	Died – record date of death below
	Not able to be contacted / located
	Too unwell
	Other

Date of Death*	DD/MM/YYYY

End survey here

Disorientation Domains	
Tick ✓	**Which disorientation domains are present in your patient?** *(tick all that apply)*
	Patient disorientated to Time
	Patient disorientated to Place
	Patient disorientated to Person
	Patient disorientated to Situation

Tick ✓			**Is patient aware of disorientation?**
Yes	**No**	**N/A**	*(please answer all domains by ticking appropriate response)*
			Patient aware disorientated to Time
			Patient aware disorientated to Place
			Patient aware disorientated to Person
			Patient aware disorientated to Situation

Richmond Agitation Sedation Scale-Palliative Version (RASS-PAL) *(tick the score that best describes the patient's level of agitation)*		
Tick ✓	**Score Term**	**Description**
	+4 Combative	Overtly combative, violent, immediate danger to staff (e.g. throwing items) +/- attempting to get out of bed or chair
	+3 Very agitated	Pulls or removes lines (e.g. IV/oxygen tubing) or catheter(s); aggressive; +/- attempting to get out of bed or chair
	+2 Agitated	Frequent non-purposeful movement +/- attempting to get out of bed or chair
	+1 Restless	Occasional non purposeful movement, but not aggressive or vigorous
	0 = Alert and calm	
	-1 Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (10 seconds or longer)
	-2 Light sedation	Briefly awakens with eye contact to voice (<10 seconds)
	-3 Moderate sedation	Any movement (eye or body) or eye opening to voice (but no eye contact)
	-4 Deep sedation	No response to voice, but any movement (eye or body) or eye opening to stimulation by light touch
	-5 Not rouseable	No response to voice or stimulation by light touch

Tick ✓	**What proportion of time since baseline did the person have someone with them?**
	Less than one third
	Between one and two thirds
	More than two thirds
	All the time

Tick ✓	**Who was with the person?** *(tick all that apply)*
	Family member
	Nurse/s
	Other

T_1 – Adverse Event/Harm Assessment
(Please grade all harms regardless of whether they are attributable to the interventions of interest or not; indicate that each harm has been assessed by ticking the square box next to each)

☐ **Irritability**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

NCI Criteria
1. Mild; easily consolable
2. Moderate; limiting instrumental ADL; increased attention indicated
3. Severe abnormal or excessive response; limiting self-care ADL; inconsolable; medical or psychiatric intervention indicated

☐ **Anxiety**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

NCI Criteria
1.Mild symptoms; intervention not indicated
2. Moderate symptoms; limiting instrumental ADL
3. Severe symptoms; limiting self-care ADL; hospitalization indicated
4. Life-threatening consequences; urgent intervention indicated

☐ **Delusions**

○ 2 ○ 3 ○ 4 ○ 5 ○ Ungradable ○ No symptom

NCI Criteria
1. -
2. Moderate delusional symptoms
3. Severe delusional symptoms; hospitalization not indicated; new onset
4. Life-threatening consequences, threats of harm to self or others; hospitalization indicated
5. Death

☐ **Embarrassment**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

1. Mild
2. Moderate
3. Severe

☐ **Current other problem/harm (if exists)**

Please specify harm here _____

Grade:

○ 1 ○ 2 ○ 3 ○ Ungradable

1. Mild
2. Moderate; limiting instrumental ADL
3. Severe; limiting self-care ADL

Tick ✓	**What is the intended intervention based on the current (T_1) assessment?**
	No change to interventions/continue current care
	Interventions ceased
	Intervention/s frequency increased (please specify)
	Other new intervention (i.e. any intervention in addition to what was provided at baseline – complete table below

*Tick only the **new** interventions that apply*.

Tick ✓	**Orientation to Time**
	Ensure presence of clock, wristwatch or electronic device with correct time of the day
	Ensure presence of calendar, newspaper or electronic device with correct day of the week/date
	Ensure presence of a whiteboard with correct day of the week/date
	Ensure access to an outside view
	Orientation to place
	Ensure adequate light
	Signs/explain layout of the care facility
	Signs/explain name of the care facility
	Signs/explain location of the person's room
	Signs/explain location of bathroom/toilet
	Use of orientating objects/symbols
	Ensure meaningful familiar objects are present
	Ensure minimal relocation/room changes
	Orientation to person
	Call the person by his or her preferred name
	Introduce yourself (name and role)
	Encourage family/friends to visit/stay with the person
	Encourage/assist with audio/video calls to family/friends
	Orientation to situation
	Explain preceding events
	Explain current activities
	Other
	Use of orientating communication (i.e. integrating time/place/person into conversation with the person)
	Promote use of hearing aids
	Promote use of vision aids
	Provide reassuring communication to allay doubts and/or fears
	Reduce noise
	Arrange an interpreter
	Any other intervention/s provided (if any), please give details:

T_2 – 4 hours after nursing intervention	
Date and time of Assessment	D-M-Y H-M

Tick ✓	T_2: Assessed/Not assessed reason
	Assessed today (continue to complete T_2) OR
	Died – record date of death below
	Not able to be contacted / located
	Too unwell
	Other

Date of Death*	DD/MM/YYYY

End survey here

Disorientation Domains	
Tick ✓	**Which disorientation domains are present in your patient?** *(tick all that apply)*
	Patient disorientated to Time
	Patient disorientated to Place
	Patient disorientated to Person
	Patient disorientated to Situation

Tick ✓			**Is patient aware of disorientation?**
Yes	**No**	**N/A**	*(please answer all domains by ticking appropriate response)*
			Patient aware disorientated to Time
			Patient aware disorientated to Place
			Patient aware disorientated to Person
			Patient aware disorientated to Situation

Richmond Agitation Sedation Scale-Palliative Version (RASS-PAL) *(tick the score that best describes the patient's level of agitation)*		
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	0 = Alert and calm	
	-1 Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (10 seconds or longer)
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	-4 Deep sedation	No response to voice, but any movement (eye or body) or eye opening to stimulation by light touch
	-5 Not rouseable	No response to voice or stimulation by light touch

Tick ✓	**What proportion of time since baseline did the person have someone with them?**
	Less than one third
	Between one and two thirds
	More than two thirds
	All the time

Tick ✓	**Who was with the person?** *(tick all that apply)*
	Family member
	Nurse/s
	Other

T_2 – Adverse Event/Harm Assessment
(Please grade all harms regardless of whether they are attributable to the interventions of interest or not; indicate that each harm has been assessed by ticking the square box next to each)

☐ **Irritability**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

NCI Criteria
1. Mild; easily consolable
2. Moderate; limiting instrumental ADL; increased attention indicated
3. Severe abnormal or excessive response; limiting self-care ADL; inconsolable; medical or psychiatric intervention indicated

☐ **Anxiety**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

NCI Criteria
1.Mild symptoms; intervention not indicated
2. Moderate symptoms; limiting instrumental ADL
3. Severe symptoms; limiting self-care ADL; hospitalization indicated
4. Life-threatening consequences; urgent intervention indicated

☐ **Delusions**

○ 2 ○ 3 ○ 4 ○ 5 ○ Ungradable ○ No symptom

NCI Criteria
1. -
2. Moderate delusional symptoms
3. Severe delusional symptoms; hospitalization not indicated; new onset
4. Life-threatening consequences, threats of harm to self or others; hospitalization indicated
5. Death

☐ **Embarrassment**

○ 1 ○ 2 ○ 3 ○ Ungradable ○ No symptom

1. Mild
2. Moderate
3. Severe

☐ **Current other problem/harm (if exists)**

Please specify harm here _____

Grade:
○ 1 ○ 2 ○ 3 ○ Ungradable

1. Mild
2. Moderate; limiting instrumental ADL
3. Severe; limiting self-care ADL

Tick ✓	**What is the intended intervention based on the current (T_2) assessment?**
	No change to interventions/continue current care
	Interventions ceased
	Intervention/s frequency increased (please specify)
	Other new intervention (i.e., any intervention in addition to what was provided at **T_1** – complete table below

*Tick **only the new** interventions that apply.*

Tick ✓	**Orientation to Time**
	Ensure presence of clock, wristwatch, or electronic device with correct time of the day
	Ensure presence of calendar, newspaper, or electronic device with correct day of the week/date
	Ensure presence of a whiteboard with correct day of the week/date
	Ensure access to an outside view
	Orientation to place
	Ensure adequate light
	Signs/explain layout of the care facility
	Signs/explain name of the care facility
	Signs/explain location of the person's room
	Signs/explain location of bathroom/toilet
	Use of orientating objects/symbols
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	Call the person by his or her preferred name
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	Orientation to situation
	Explain preceding events
	Explain current activities
	Other
	Use of orientating communication (i.e., integrating time/place/person into conversation with the person)
	Promote use of hearing aids
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	Provide reassuring communication to allay doubts and/or fears
	Reduce noise
	Arrange an interpreter
	Any other intervention/s provided (if any), please give details: