This is a Sample version of the

The Confusion Assessment Protocol (CAP)

The **full version** of the The Confusion Assessment Protocol (CAP) comes without ‘sample’ watermark.

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The full complete version includes –

- Overview
- Administration/Scoring Guide
- Complete questionnaire/Test Kit this includes –
    - Confusion Assessment Protocol (CAP)
    - Galveston Orientation and Amnesia Test (GOAT)
    - Agitated Behavior Scale (ABS)
    - Clinician Rated Items (DRS-R and Additional Items)
    - Delirium Symptom Checklist for DSM-IV Diagnosis

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The Confusion Assessment Protocol (CAP)

Overview:

The Confusion Assessment Protocol (CAP) is a combination of objective measures of orientation and cognition and clinician ratings of other symptoms of early confusion after traumatic brain injury (TBI). The CAP was developed by Mark Sherer, Risa Nakase-Thompson, and Stuart A. Yablon for use in investigations of early recovery from TBI. This measure is still in an early phase of development with several investigations still ongoing. Patients in early recovery from TBI frequently are acutely confused. The term Post-traumatic Amnesia (PTA) has been used to describe this state. However, commonly used measures of PTA primarily assess orientation and memory and fail to assess other symptoms of confusion. More recently, Stuss and colleagues (Stuss et al., 1999) proposed the term Post-traumatic Confusional State (PCS) to describe this early period of recovery after TBI. Stuss and colleagues noted the similarity of this period of recovery to delirium. These researchers recommended a focus on assessment of attentional skills in confused patients.

The CAP was developed to assess a broad range of symptoms of PCS. In constructing the CAP, scales previously used to assess PTA and delirium were administered to a sample of patients with TBI who were in inpatient rehabilitation. These scales included the Galveston Orientation and Amnesia Test (GOAT; Levin, O'Donnell, & Grossman, 1979), the Agitated Behavior Scale (ABS; Corrigan, 1989), the Delirium Rating Scale – Revised (DRS-R; Trzepacz, Mittal, Torres, Kanary, Norton, & Jimerson, 2001), the Cognitive Test for Delirium (CTD; Hart, Levenson, Sessler, Best, Schwartz, & Rutherford, 1996) and the Toronto Test of Acute Recovery from TBI (TOTART; Stuss et al., 1999).

Patient responses to each item of each scale were reviewed by 2 clinicians. Items were retained if they differentiated patients meeting DSM- IV criteria for delirium from those not meeting DSM-IV criteria and if, in the judgment of the clinicians, they provided clinically significant information. Items were deleted if they were redundant or did not discriminate patients who met DSM-IV delirium criteria from those who did not. Some items were modified. Based on this analysis, 7 key symptoms of PCS were identified. These are: (1) disorientation, (2) cognitive impairment, (3) restlessness, (4) fluctuation in presentation, (5) nighttime sleep disturbance, (6) decreased daytime level of arousal, and (7) psychotic-type symptoms. CAP items assess all 7 of these symptoms. Note that all patients in our sample showed some degree of cognitive impairment. The scoring criteria for the cognitive items were set to identify those patients with levels of cognitive impairment that could be seen in patients with delirium.

Refference

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SAMPLE

Confusion Assessment Protocol

Patient Name:____________________________ Date:________________

Age:___________ Education___________ Handedness_______

Name of Rater____________________________

TOTART Attentional Subtest (TAS): ***Now I want you to …***

A. ***… count forward from 1 to 20 as quickly as you can.***
_____correct _____incorrect

B. ***… count backwards from 20 to 1.*** (can cue 20, 19, 18, …)
_____correct _____incorrect

C. ***… recite the months of the year.***
_____correct _____incorrect

D. ***… recite the months of the year backwards.***
_____correct _____incorrect

*** TAS Test Completion Codes (circle one): 0 1 2 3 4 5 6 9**

CTD Vigilance (V1): ***I am going to read you a long series of letters. Whenever you hear the letter H, indicate by raising your hand at the wrist*** (demonstrate) ***and then putting it back down. Let's try these letters to practice, B H D.*** Note whether patient follows instructions on this sample and repeat as necessary.

Read the letter list at the rate of one letter per 2 seconds. Put a slash mark through each letter the patient responds to and circle omissions (/ = response, O = omission). Circle form used. Alternate between forms on different administrations.

Form A: H E G H F E H D H F H C B F H A D H C E H I H G D H
C E B H E G H I H C H E H F C I H E B H G F D H B E

Form B: H B H A E H B H C F A H F H G H C G D H C B A H G D
E H C H B E H D G H D A F H B I F H E B H D H E H G

CTD Vigilance Score = Hits (correct targets identified) X 2 – Commissions (incorrect targets identified)

***V1 Test Completion Code (circle one): 0 1 2 3 4 5 6 9**

This is the end of the sample version of the CAP. The full complete version has all these assessments – Confusion Assessment Protocol (CAP), Galveston Orientation and Amnesia Test (GOAT), Agitated Behavior Scale (ABS), Clinician Rated Items (DRS-R and Additional Items),Delirium Symptom Checklist for DSM-IV Diagnosis and scoring guides.

SAMPLE