

CP-OLDER — Older Adult Check (Group A)

Frailty, delirium and memory. **Links to:** A1-A8, P18

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Alertness	Normal	Sleepy or agitated	Hard to wake	
Attention (months backwards)	No errors	1-2 errors	Cannot start	
Change from usual self	No	Mild change	Sudden change	
Frailty (daily life)	Active	Needs help outside	Needs help at home	
Medicines	<5	5-9	≥10	
TOTAL				

Score	Level	Action
0-2	Low	Routine
3-5	Medium	Delirium prevention: glasses, aids, clock, sleep, fluids
≥6 or sudden change	High	Doctor review for delirium today

⚠ **Red flags — escalate at once regardless of score:** Sudden confusion

Score each item 0, 1 or 2 · add the total · follow the action band · any red flag = escalate (SBAR) · rescore after each intervention and at least once per shift.

Nursing notes / action taken:

Original tool, not yet validated. Pilot and review with clinicians before clinical decisions. Supports, but does not replace, clinical judgment, validated scales and local policy.