SECTION C: COGNITIVE PATTERNS

Intent: The intent of the item in this section is to determine if the patient has signs and symptoms of delirium.

C1610: Signs and Symptoms of Delirium (from CAM©)

C1610. Signs and Symptoms of Delirium (from CAM©)
Confusion Assessment Method (CAM©) Shortened Version Worksheet (3-day assessment period)

CODING: 0. No 1. Yes	↓ Enter Code in Boxes	
		Acute Onset and Fluctuating Course
	☐	**A.** Is there evidence of an acute change in mental status from the patient's baseline?
	☐	**B.** Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?
	☐	**Inattention** **C.** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	☐	**Disorganized Thinking** **D.** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
		Altered Level of Consciousness
	☐	**E.** Overall, how would you rate the patient's level of consciousness? **E1.** Alert (Normal)
	☐	**E2.** Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)

Item Rationale

- Delirium is associated with:
  - Increased mortality,
  - Functional decline,
  - Development or worsening of incontinence,
  - Behavior problems,
  - Withdrawal from activities,
  - Rehospitalizations and increased length of stay.
- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.
- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection of delirium is essential to identify and treat or eliminate the cause.

DEFINITIONS

DELIRIUM
A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.

FLUCTUATION
The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of an interview/ discussion or the assessment period. Fluctuating behavior may be noted by staff or family or documented in the medical record.

Steps for Assessment for C1610A and C1610B, Acute Onset and Fluctuating Course

1. Assess for acute change in mental status. Evidence of acute change in mental status may be found during the patient interactions, in the medical record, or from family and/or staff reports of acute change in mental status.

Coding Instructions for C1610A, Acute Onset and Fluctuating Course

Complete only if A0250 = 01 Admission, A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

- Code 0, No, if there is no evidence of an acute change in mental status from the patient's baseline.
- Code 1, Yes, if there is evidence of an acute change in mental status from the patient's baseline.

Coding Instructions for C1610B, Acute Onset and Fluctuating Course

Complete only if A0250 = 01 Admission, A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

- Code 0, No, if the (abnormal) behavior did not fluctuate during the day (i.e., did not tend to come or go or increase/decrease in severity)
- Code 1, Yes, if the (abnormal) behavior fluctuated during the day (i.e., tended to come and go and/or increase/decrease in severity)

Examples

Acute Onset and Fluctuating Course

1. Mrs. P was admitted to the LTCH 1 day ago. Her family reports that she was alert and oriented prior to admission. During the interview, she is lethargic and incoherent.

   Coding: Item C1610A – Acute Onset would be coded 1, Yes.
   Rationale: There is an acute change of the patient's behavior from her alert and oriented status prior to admission (reported by her family) compared with her lethargic and incoherent status observed during the assessment interview.

2. The nurse reports that a patient who has been quiet and has short-term memory problems suddenly becomes agitated, calling out to her husband who died several years ago, removing her clothes, and being disoriented to time, person, and place.

   Coding: Item C1610A – Acute Onset would be coded 1, Yes.
   Rationale: The new behaviors represent an acute change in mental status compared with the patient's baseline status.

3. The certified nursing assistant reports that Mr. D is consistently confused about where he is and why he is at the facility. The certified nursing assistant reports to the nurse that Mr. D does not appear to recognize his family when they visit him. Mr. D's vision and

hearing do not appear to be impaired, thus not the causes of his confusion. The family confirms that this behavior is typical for Mr. D.

Coding: Item C1610A – Acute Onset would be coded 0, No.
Rationale: Throughout the 3-day assessment period the patient's behaviors represent his baseline mental status.

4. The nurse reports that Mrs. K was having an appropriate conversation with her family at 4:00 p.m., but at 6:00 p.m. she became agitated and disoriented. By 9:00 p.m., she was again having an appropriate conversation with her family.

   Coding: Item C1610B – Fluctuating Course would be coded 1, Yes.
   Rationale: The patient's behaviors fluctuated during the day from being coherent to being agitated and disoriented back to being coherent.

Steps for Assessment for C1610C, Inattention

1. Assess attention separately from level of consciousness. Evidence of inattention may be found during patient interactions, in the medical record, or from family and/or staff reports of inattention during the 3-day assessment period.
2. An additional step to identify difficulty with attention is to ask the patient to count backward from 20.

DEFINITION

INATTENTION
Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated, or darting attention).

Coding Instructions for C1610C, Inattention

Complete only if A0250 = 01 Admission, A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

- Code 0, No, if the patient remains focused, and was not easily distracted or having difficulty keeping track of what was said.
- Code 1, Yes, if the patient had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was said.

Examples

1. The Mrs. T tries to answer all questions during an interaction with the clinician. Although she answers several items incorrectly and responds "I don't know" to others, she pays attention to the clinician. The medical record and staff indicate that this is her consistent behavior during the assessment period.

   Coding: Item C1610C – Inattention would be coded 0, No.
   Rationale: Mrs. T remained focused throughout the interaction, which was constant during the 3-day assessment period.

2. Questions during patient and clinician interactions must be frequently repeated because Mrs. W's attention wanders. This behavior occurs throughout interactions, and the

medical record notes and staff reports agree that this behavior is consistently present during the 3-day assessment period.

Coding: Item C1610C – Inattention would be coded 1, Yes.
Rationale: The patient had difficulty focusing her attention throughout the 3-day assessment period. Staff needed to frequently repeat information during interactions with Mrs. W.

3. Mr. N is diabetic and recovering from multiple fractures, urinary tract infections, and nonhealing wounds. During the assessment period, Mr. N often asks appropriate questions about his medical condition and responds appropriately to questions.

   Coding: Item C1610C – Inattention would be coded 0, No.
   Rationale: Mr. N's attention remains focused during interactions. He asks appropriate questions and responds appropriately, demonstrating his ability to focus his attention during the 3-day assessment period.

Steps for Assessment for C1610D, Disorganized Thinking

1. Assess for disorganized thinking**.** Evidence of disorganized thinking may be found during the patient interview, in the medical record, and/or from family or staff reports of disorganized thinking during the assessment period.

DEFINITION

DISORGANIZED THINKING
Evidenced by rambling, irrelevant, and/or incoherent speech.

Coding Instructions for C1610D, Disorganized Thinking

Complete only if A0250 = 01 Admission, A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

- Code 0, No, if the patient's thinking was organized and coherent, even if the answers were inaccurate or wrong
- Code 1, Yes, if the patient's thinking was disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject.

Examples

1. The clinician asks Mrs. L, who is often confused, to give the date, and the response is: "Let's go get the sailor suits!" The patient continues to provide irrelevant or nonsensical responses throughout the conversation, and medical record and staff indicate this is constant.

   Coding: C1610D – Disorganized Thinking would be coded 1, Yes.
   Rationale: All sources agree that the disorganized thinking is constant.

2. Mr. D responds that the year is 1937 when asked to give the date. The medical record notes and staff reports indicate that Mr. D has not been oriented to time, but has coherent conversations. For example, staff reports he often discusses his passion for baseball.

   Coding: C1610D – Disorganized Thinking would be coded 0, No.
   Rationale: The patient's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

Steps for Assessment for C1610E1 and C1610E2, Altered Level of Consciousness

1. Assess for altered level of consciousness during the assessment period. Evidence of altered level of consciousness may be found during patient and clinician interactions, in the medical record, and/or from family or staff reports of altered level of consciousness during the assessment period.

Coding Instructions for C1610E1, Altered Level of Consciousness

Complete only if A0250 = 01 Admission, A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

- Code 0, No, if the patient was not alert.
- Code 1, Yes, if the patient was alert.

Coding Instructions for C1610E2, Altered Level of Consciousness

Complete only if A0250 = 01 Admission, A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

- Code 0, No, if the patient did not exhibit any of the following:
  - vigilant (hyperalert): patient startles easily to any sound or touch; his or her eyes are wide open;
  - lethargy (drowsy, easily aroused): patient repeatedly dozes off while you are asking questions, and may be difficult to keep patient awake for interview, but does respond to voice or touch;
  - stupor (difficult to arouse): patient is very difficult to arouse and keep aroused for the interview, requiring shaking and/or repeated shouting; or
  - coma (unarousable): patient cannot be aroused despite shaking and shouting.
- Code 1, Yes, if the patient exhibited any of the following: vigilant (hyperalert), lethargy (drowsy, easily aroused), stupor (difficult to arouse) or coma (unarousable).

Examples

1. Mr. Q is alert and conversational and answers all questions during the discussion, although not all answers are correct. Medical record documentation and staff reports during the 3-day assessment period consistently note that the patient was alert.

Coding: C1610E1 would be coded 1, Yes, and C1610E2 would be coded 0, No.
Rationale: All evidence indicates that the patient is alert during conversations and activities.

2. Mr. B is lying in bed. He arouses to soft touch, but is only able to converse for a short time before his eyes close, and he appears to be sleeping. Again, he arouses to voice or touch, but only for short periods during the conversation. Information from other sources indicates that this was his condition throughout the assessment period.

   Coding: C1610E1 would be coded 0, No, and C1610E2 would be coded 1, Yes.
   Rationale: The patient's lethargy was consistent throughout the interaction, and there is consistent documentation of lethargy in the medical record during the assessment period.

3. Mr. Y cannot be aroused despite the many attempts by the nurse, certified nursing assistant, and family members to rouse him. Mr. Y does not wake when the clinicians and certified nursing assistant turn him and complete his daily activities.

   Coding: C1610E1 would be coded 0, No, and C1610E2 would be coded 1, Yes.
   Rationale: The patient cannot be aroused despite many attempts to rouse him throughout the assessment period.