C1310: Signs and Symptoms of Delirium (from CAM©)

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)
Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

Enter Code ☐

A. Acute Onset Mental Status Change
Is there evidence of an acute change in mental status from the resident's baseline?
0. No
1. Yes

Coding:	↓	Enter Codes in Boxes
0. Behavior not present **1. Behavior continuously present, does not fluctuate** **2. Behavior present, fluctuates** (comes and goes, changes in severity)	☐	**B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	☐	**C. Disorganized Thinking -** Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	☐	**D. Altered Level of Consciousness -** Did the resident have altered level of consciousness, as indicated by any of the following criteria? ▪ **vigilant** - startled easily to any sound or touch ▪ **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** - very difficult to arouse and keep aroused for the interview ▪ **comatose** - could not be aroused

Adapted from: Inouye, S.K., et al. Ann Intern Med. 1990; 113: 941–948. Confusion Assessment Method. ©2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Item Rationale

Health-related Quality of Life

- Delirium is associated with:
  - — increased mortality,
  - — functional decline,
  - — development or worsening of incontinence,
  - — behavior problems,
  - — withdrawal from activities
  - — rehospitalizations and increased length of nursing home 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.

Planning for Care

- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection is essential in order to identify and treat or eliminate the cause.

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Steps for Assessment

1. Observe resident behavior during the **BIMS** items (C0200–C0400) for the signs and symptoms of delirium. Some experts suggest that increasing the frequency of assessment (as often as daily for new admissions) will improve the level of detection.
2. If the **Staff Assessment for Mental Status** items (C0700–C1000) were completed instead of the BIMS, ask staff members who conducted the interview about their observations of signs and symptoms of delirium.
3. Review medical record documentation during the 7-day look-back period to determine the resident's baseline status, fluctuations in behavior, and behaviors that might have occurred during the 7-day look-back period that were not observed during the BIMS.
4. Observe the resident's behavior during interactions and consult with other staff, family members/caregivers, and others in a position to observe the resident's behavior during the 7-day look-back period.

DEFINITION

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

Additional guidance on the signs and symptoms of delirium can be found in Appendix C.

Coding Instructions for C1310A, Acute Mental Status Change

- **Code 0, no:** if there is no evidence of acute mental status change from the resident's baseline.
- **Code 1, yes:** if resident has an alteration in mental status observed in the observation period that represents an acute change from baseline.

Coding Tips

- Examples of acute mental status change:
  - A resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
  - A resident who is normally quiet and content suddenly becomes restless or noisy.
  - A resident who is usually able to find their way around their living environment begins to get lost.

Examples

1. The resident was admitted to the nursing home 4 days ago. Their family reports that they were alert and oriented prior to admission. During the BIMS interview, they are lethargic and incoherent.

   Coding: Item C1310A would be **coded 1, yes.**
   Rationale: There is an acute change of the resident's behavior from alert and oriented (family report) to lethargic and incoherent during interview.

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2. The nurse reports that a resident with poor short-term memory and disorientation to time suddenly becomes agitated, calling out to their dead spouse, tearing off their clothes, and being completely disoriented to time, person, and place.

Coding: Item C1310A would be **coded 1, yes.**
Rationale: The new behaviors represent an acute change in mental status.

Steps for Assessment for C1310B, Inattention

1. Assess attention separately from level of consciousness. Evidence of inattention may be found during the resident interview, in the medical record, or from family or staff reports of inattention during the 7-day look-back period.
2. An additional step to identify difficulty with attention is to ask the resident to count backwards from 20.

Coding Instructions for C1310B, Inattention

- **Code 0, behavior not present:** if the resident remains focused during the interview and all other sources agree that the resident was attentive during other activities.
- **Code 1, behavior continuously present, did not fluctuate:** if the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary during the look-back period. All sources must agree that inattention was consistently present to select this code.
- **Code 2, behavior present, fluctuates:** if inattention is noted during the interview or any source reports that the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied during interview or during the look-back period or if information sources disagree in assessing level of attention.

DEFINITIONS

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

FLUCTUATION
The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look- back period. Fluctuating behavior may be noted by the interviewer, reported by staff or family or documented in the medical record.

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Examples

1. The resident tries to answer all questions during the BIMS. Although they answer several items incorrectly and respond "I don't know" to others, they pay attention to the interviewer. Medical record and staff indicate that this is their consistent behavior.

   Coding: Item C1310B would be **coded 0, behavior not present.**
   Rationale: The resident remained focused throughout the interview and this was constant during the look-back period.

2. Questions during the BIMS must be frequently repeated because the resident's attention wanders. This behavior occurs throughout the interview and medical records and staff agree that this behavior is consistently present. The resident has a diagnosis of dementia.

   Coding: Item C1310B would be **coded 1, behavior continuously present, does not fluctuate.**
   Rationale: The resident's attention consistently wandered throughout the 7-day look-back period. The resident's dementia diagnosis does not affect the coding.

3. During the BIMS interview, the resident was not able to focus on all questions asked and their gaze wandered. However, several notes in the resident's medical record indicate that the resident was attentive when staff communicated with them, and family confirmed this.

   Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**
   Rationale: Evidence of inattention was found during the BIMS but was noted to be absent in the medical record. This disagreement shows possible fluctuation in the behavior. If any information source reports the symptom as present, C1310B **cannot be coded as 0, Behavior not present.**

4. The resident is dazedly staring at the television for the first several questions. When you ask a question, they look at you momentarily but do not answer. Midway through questioning, they seem to pay more attention and try to answer.

   Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**
   Rationale: Resident's attention fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2.**

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Coding Instructions for C1310C, Disorganized Thinking

DEFINITION

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

- **Code 0, behavior not present:** if all sources agree that the resident's thinking was organized and coherent, even if answers were inaccurate or wrong.
- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the resident's responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the resident unpredictably switched from subject to subject.
- **Code 2, behavior present, fluctuates:** if, during the interview or according to other data sources, the resident's responses fluctuated between disorganized/incoherent and organized/clear. Also code as fluctuating if information sources disagree.

Examples

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

   Coding: C1310C would be **coded 1, behavior continuously present, does not fluctuate.**
   Rationale: All sources agree that the disorganized thinking is constant.

2. The resident responds that the year is 1837 when asked to give the date. The medical record and staff indicate that the resident is never oriented to time but has coherent conversations. For example, staff reports they often discuss their passion for baseball.

   Coding: C1310C would be **coded 0, behavior not present.**
   Rationale: The resident's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

3. The resident was able to tell the interviewer their name, the year and where they were. They were able to talk about the activity they just attended and the residents and staff that also attended. Then the resident suddenly asked the interviewer, "Who are you? What are you doing in my child's home?"

   Coding: C1310C would be **coded 2, behavior present, fluctuates.**
   Rationale: The resident's thinking fluctuated between coherent and incoherent at least once. If as few as one source notes fluctuation, then the behavior should be **coded 2**.

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Coding Instructions for C1310D, Altered Level of Consciousness

- **Code 0, behavior not present:** if all sources agree that the resident was alert and maintained wakefulness during conversation, interview(s), and activities.
- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the resident was consistently lethargic (difficult to keep awake), stuporous (very difficult to arouse and keep aroused), vigilant (startles easily to any sound or touch), or comatose.
- **Code 2, behavior present, fluctuates:** if, during the interview or according to other sources, the resident varied in levels of consciousness. For example, was at times alert and responsive, while at other times resident was lethargic, stuporous, or vigilant. Also code as fluctuating if information sources disagree.

DEFINITIONS

ALTERED LEVEL OF CONSCIOUSNESS

VIGILANT – startles easily to any sound or touch;

LETHARGIC – repeatedly dozes off when you are asking questions, but responds to voice or touch;

STUPOR – very difficult to arouse and keep aroused for the interview;

COMATOSE – cannot be aroused despite shaking and shouting.

Coding Tips

- A diagnosis of coma or stupor does not have to be present for staff to note the behavior in this section.

Examples

1. Resident is alert and conversational and answers all questions during the BIMS interview, although not all answers are correct. Medical record documentation and staff report during the 7-day look-back period consistently noted that the resident was alert.

   Coding: C1310D would be **coded 0, behavior not present.**
   Rationale: All evidence indicates that the resident is alert during conversation, interview(s) and activities.

2. The resident is lying in bed. They arouse to soft touch but are only able to converse for a short time before their eyes close, and they appear to be sleeping. Again, they arouse to voice or touch but only for short periods during the interview. Information from other sources indicates that this was their condition throughout the look-back period.

   Coding: C1310D would be **coded 1, behavior continuously present, does not fluctuate.**
   Rationale: The resident's lethargy was consistent throughout the interview, and there is consistent documentation of lethargy in the medical record during the look-back period.

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3. Resident is usually alert, oriented to time, place, and person. Today, at the time of the BIMS interview, resident is conversant at the beginning of the interview but becomes lethargic and difficult to arouse.

Coding: C1310D would be **coded 2, behavior present, fluctuates.**
Rationale: The level of consciousness fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2, fluctuating**.

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 **OR** Item D = 1 OR 2

SECTION D: MOOD

Intent: The items in this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. Social isolation refers to an actual or perceived lack of contact with other people and tends to increase with age. It is a risk factor for physical and mental illness, is a predictor of mortality, and is important to assess in order to identify engagement strategies.