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| --- | --- | --- | --- | --- |
| **Enable if age >= 65 and catnum = 10, 29, 41, 42, 53, or 55** | | | | |
|  | delidone | Delirium Risk review was previously completed for this case for the same episode of care.If checked, disable Delirium Risk Module.If not checked, enable Delirium Risk Module. |  |  |
|  |  | **History of Impairment** |  |  |
| 1 | hxcogimp1  hxcogimp2  hxcogimp3  hxcogimp4  hxcogimp5  hxcogimp6  hxcogimp7  hxcogimp8  hxcogimp9  hxcogimp10  hxcogimp11  hxcogimp12  hxcogimp99 | During the first 24 hours after arrival, does the record document a history of cognitive impairment?  **Indicate all that apply:**   1. Dementia or demented 2. Memory loss 3. Alzheimer’s Disease 4. Poor historian 5. Delirium 6. Unarousable 7. Uncooperative 8. Change in mental status (from baseline) 9. Disoriented 10. Confused 11. Lethargic or obtunded 12. Encephalopathy   99. None of the above | 1,2,3,4,5,6,7,8,9,  10,11,12,99  Cannot enter 99 with any other number | **The intent of the question is to determine if there is historical evidence of cognitive impairment documented during the first 24 hours after arrival.** Do NOT include documentation of a new problem of cognitive impairment. Do NOT use the assessment and plan (A/P) section of the History & Physical as a data source for this question.  **Suggested data sources:** ED notes, History and Physical (History of Present Illness, Past Medical History, Physical Exam), Nursing assessment/admission notes, problem list |
| 2 | visimpair | During the first 24 hours after arrival, does the record document a history of vision impairment as evidenced by documentation of one of the following?   * Visual Loss * Vision abnormal * Low vision * Cataract * Vision impairment * Decreased vision * Blindness * Blurred vision * Wears glasses   1. Yes  2. No | 1,2 | **The intent of the question is to determine if there is historical evidence of vision impairment documented during the first 24 hours after arrival.**  Do NOT include documentation of a new problem of vision impairment. Do NOT use the assessment and plan (A/P) section of the History & Physical as a data source for this question.  **History of Vision Impairment includes documentation of any of the following:**  Visual Loss  Vision abnormal  Low vision  Cataract  Vision impairment  Decreased vision  Blindness  Blurred vision  Wears glasses  **Suggested data sources:** ED notes, History and Physical (History of Present Illness, Past Medical History, Physical Exam), Nursing assessment/admission notes, problem list |
| 3 | hearimp | During the first 24 hours after arrival, does the record document a history of hearing impairment as evidenced by documentation of one of the following?   * Hearing Loss (Partial, Bilateral, or severe) * Sensorineural hearing loss * Conductive hearing loss * Problems with hearing * Mixed hearing loss * Central hearing loss * Deafness * Meinere’s Disease * Hard of hearing * Wears hearing aids * Presbycussis   1. Yes  2. No | 1,2 | **The intent of the question is to determine if there is historical evidence of hearing impairment documented during the first 24 hours after arrival.**  Do NOT include documentation of a new problem of hearing impairment. Do NOT use the assessment and plan (A/P) section of the History & Physical as a data source for this question.  **History of Hearing impairment includes documentation of any of the following:**  Hearing Loss (Partial, Bilateral, or severe)  Sensorineural hearing loss  Conductive hearing loss  Problems with hearing  Mixed hearing loss  Central hearing loss  Deafness  Meinere’s Disease  Hard of hearing  Wears hearing aids  Presbycussis  **Suggested data sources:** ED notes, History and Physical (History of Present Illness, Past Medical History, Physical Exam), Nursing assessment/admission notes, problem list |
|  |  | **Apache** |  |  |
| 4 | apache | During the first 24 hours after arrival, does the record document an APACHE score?  1. Yes  2. No | 1,2  If 2, auto-fill apacscor as zz, and go to hxmets | The APACHE (Acute Physiology and Chronic Health Evaluation) is a severity of disease classification system. There are several versions of the APACHE (e.g. I, II, and III) and any version is acceptable. The score ranges from 0 to 71 and is computed based on several measurements; higher scores imply a more severe disease and a higher risk of death.  Suggested Data Sources: ED notes, History and Physical, admission note, consultation |
| 5 | apacscor | Enter the APACHE score documented in the record. | **\_\_ \_\_**  Will be auto-filled as zz if apache = 2  If >16, go to arrvbun; else go to hxmets   |  | | --- | | Whole numbers only 0 to 71 | | The APACHE score must be documented in the record. |
| 6 | hxmets | During the first 24 hours after arrival, does the record document a history of metastatic cancer?  1. Yes  2. No | 1,2 | **The intent of the question is to determine if there is historical evidence of metastatic cancer documented during the first 24 hours after arrival.**  Do NOT include documentation of a new diagnosis of metastatic cancer. Do NOT use the assessment and plan (A/P) section of the History & Physical (or other data sources) to answer this question.  **Suggested data sources:** ED notes, History and Physical (History of Present Illness, Past Medical History), problem list |
| 7 | hxcomp1  hxcomp2  hxcomp3  hxcomp99 | During the first 24 hours after arrival, does the record document a history of any of the following diagnoses?  **Indicate all that apply:**  1. Lymphoma  2. Leukemia  3. AIDS  99. None of the above | 1,2,3,99  Cannot enter 99 with any other number | **The intent of the question is to determine if there is historical evidence of a diagnosis of lymphoma, leukemia, or AIDS documented during the first 24 hours after arrival.**  Do NOT include documentation of a new diagnosis of the specified condition. Do NOT use the assessment and plan (A/P) section of the History & Physical (or other data sources) to answer this question.  **Suggested data sources:** ED notes, History and Physical (History of Present Illness, Past Medical History), problem list |
|  |  | **Vital Signs/Labs** |  |  |
| 8 | admrr | During the first 24 hours after arrival, does the record document a respiratory rate > 25? | 1,2 | Suggested data sources: Vital signs package, nursing assessment, H&P physical exam |
| 9 | admpulse | During the first 24 hours after arrival, does the record document a pulse > 120? | 1,2 | Suggested data sources: Vital signs package, nursing assessment, H&P physical exam |
| 10 | admsbp | During the first 24 hours after arrival, does the record document a systolic BP < 100 mmHg? | 1,2 | Suggested data sources: Vital signs package, nursing assessment, H&P physical exam |
| 11 | arrvbun | During the first 24 hours after arrival, does the record document a blood urea nitrogen (BUN) was obtained? | 1,2  If 2, auto-fill firstbun as zzz, and go to arrvcr | BUN test is a measure of the amount of nitrogen in the blood in the form of urea.  Suggested data source: Lab package |
| 12 | firstbun | Enter the value of the first BUN obtained following hospital arrival. | \_\_ \_\_ \_\_  Will be auto-filled as zzz if arrvbun = 2   |  | | --- | | Must be > 0 and < 125 | | Warning if > 99 | | Normal values may range from 7 – 20 mg/dL and may vary among different laboratories.  Suggested data source: Lab package |
| 13 | arrvcr | During the first 24 hours after arrival, does the record document a serum creatinine was obtained?  1. Yes  2. No | 1,2  If 2, auto-fill firstcr as zz.z, and if apacscor < = 16, go to admalb; else if 2 and apacscor > 16, go to docdel | The serum creatinine test is used to diagnose impaired renal function.  Suggested data source: Lab package |
| 14 | firstcr | Enter the value of the first serum creatinine obtained following hospital arrival. | \_ \_. \_  Will be auto-filled as zz.z if arrvcr = 2   |  | | --- | | Must be > 00.0 | | Warning if > 4 mg/dL | | Normal values: Male: 0.6-1.2 mg/dl; Female: 0.5-1.1 mg/dl. Possible critical values: >4mg/dl.  Suggested data source: Lab package |
| 15 | buncratio | **Computer will calculate and display the BUN/CR ratio.** | **\_\_ \_\_. \_\_: 1**  **Calculate if firstbun and firstcr are valid values**  If apacscor < = 16, go to admalb; else if apacscor > 16, go to docdel   |  | | --- | | Must be > 0 | | BUN/creatinine is the ratio of two serum laboratory values, the blood urea nitrogen (BUN) and serum creatinine. |
| 16 | admalb | During the first 24 hours after arrival, does the record document a serum albumin value < 2.5? | 1,2 | Suggested data source: Lab package |
| 17 | admbili | During the first 24 hours after arrival, does the record document a total serum bilirubin value > 2.9? | 1,2 | Suggested data source: Lab package |
|  |  | **Assessment of Delirium Risk** |  |  |
| 18 | docdel | Did the physician/APN/PA document a current problem of delirium in the History and Physical?  1. Yes  2. No | 1,2 | **Delirium is a mental disturbance characterized by confusion, disordered speech, and hallucinations.**  **The intent of this question is to look for physician/APN/PA documentation of a current problem of delirium in the assessment/plan section of the History and Physical.** Physician/APN/PA documentation of delirium in the assessment/plan of an ED note (e.g. 1010M) or admission note is acceptable. |
| 19 | dochgms | Did the physician/APN/PA document a current change in the patient’s mental status in the History and Physical?  1. Yes  2. No | 1,2 | **The intent of this question is to look for physician/APN/PA documentation of a current change in mental status in the assessment/plan section of the History and Physical.** Physician/APN/PA documentationof a change in mental status in the assessment/plan of an ED note (e.g. 1010M) or admission note is acceptable.  **Documentation of a change in mental status, altered mental status, or other similar wording is acceptable.** |
| 20 | doconf | Did the physician/APN/PA document a current problem of confusion in the History and Physical?  1. Yes  2. No | 1,2 | **The intent of this question is to look for physician/APN/PA documentation of a current problem of confusion (or confused) in the assessment/plan section of the History and Physical.** Physician/APN/PA documentation of confusion in the assessment/plan of an ED note (e.g. 1010M) or admission note is acceptable. |
| 21 | docorient | Did the physician/APN/PA document a current problem of disorientation in the History and Physical?  1. Yes  2. No | 1,2 | **Disorientation = patient is not oriented to person, place, and time.**  **The intent of this question is to look for physician/APN/PA documentation of a current problem of disorientation (or similar wording such as disoriented) in the assessment/plan section of the History and Physical.**  Physician/APN/PA documentation of disorientation in the assessment/plan of an ED note (e.g. 1010M) or admission note is acceptable. |
| 22 | rskdeli | In the admission History and Physical, did the physician/APN/PA document the patient was at risk for delirium? | 1,2 | **The intent of this question is to look for physician/APN/PA documentation in the assessment/plan section of the H&P that the patient was at risk for delirium.**  Physician/APN/PA documentation of delirium risk in the assessment/plan of an ED note (e.g. 1010M) or admission note is acceptable.  For example, in the admission H&P assessment, the physician documented, “Patient is dehydrated and tachycardic --at risk for delirium;” answer “1.” |