|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Enable if INPT\_FE Flag = 1** | | | | |
|  |  | **Assessment of Delirium Risk** |  |  |
| 1 | docdel | Did the physician/APN/PA document a current problem of delirium or the following equivalent terms in the History and Physical, ED note, or admission note?  **equivalent terms for the presence of delirium:**   * agitation * encephalopathy * hallucinations * lethargy * unresponsive   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 any physician/APN/PA documentation of a current problem of delirium in the History and Physical (H&P),** **ED note, and admission note documentation.**  Review all noted data sources and if delirium or any of the equivalent terms are documented, select value “1” or yes.  **Examples:**   * Patient is evaluated by Psych in the ED and the provider documents in the History and Physical: “No acute delirium noted, patient does not appear to be at risk for delirium,” select value “2” or no as documentation indicates no delrium. * Admission note states, “patient agitated and having hallucinations”, select value “1” as agitation and hallunicinations are equivalent terms for the presecne of delirium.   **NOTE: Dementia is NOT the same as delirium**  **NON-equivalent terms for delirium:**   * alcohol or substance withdrawal * dementia * falls * incontinence * mild cognitive impairment * not able to answer questions * poor historian * sedated * seizures * specific psychiatric syndromes * stroke |
| 2 | dochgms | Did the physician/APN/PA document a current change in the patient’s mental status (e.g. altered mental status (AMS)) in the History and Physical, ED note, or admission note?  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 (e.g. altered mental status (AMS) or change from baseline) in the History and Physical, ED note, or admission note.**  **Documentation of a change in mental status, altered mental status, or other similar wording is acceptable.** |
| 3 | doconf | Did the physician/APN/PA document a current problem of confusion in the History and Physical, ED note, or admission note?  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 History and Physical, ED note**, **or admission note**. |
| 4 | docorient | Did the physician/APN/PA document a current problem of disorientation in the History and Physical, ED note, or admission note?  **Examples of acceptable terms for disorientation include but are not limited to:**   * A&O x 2 * Disoriented * Oriented to self and place but not year   1. Yes  2. No | 1,2 | **Disorientation = patient is not oriented to person, place, and/or 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 History and Physical,** **ED note,** **or admission note.**  **Examples of acceptable physician/APN/PA documentation include but are not limited to:**   * A&O x 2 * Disoriented * Oriented to self and place but not year |
| 5 | rskdeli | In the admission History and Physical, ED note, or admission note, did the physician/APN/PA document the patient was assessed or screened for delirium?  1. Yes  2. No | 1,2 | **The intent of this question is to look for physician/APN/PA documentation in the History and Physical,** **ED note, or admission note that the patient was assessed or screened for delirium. An admission screening note by the provider is an acceptable note to use.**  Examples of acceptable physician/APN/PA documentation include but are not limited to:   * “Patient is dehydrated and tachycardic --at risk for delirium;” * “Patient was screened for delirium and found to be at low risk;” * “Assessed patient for delirium and patient is not at risk.” * “Patient’s orientation assessed (e.g. A&O x3) and does not have delirium” * “Patient is at risk for delirium and was assessed for mental status change, confusion, and disorientation. No symptoms of delirium, mental status change, confusion, disorientation.”   If there is documentation the patient was assessed or screened for delirium, enter value “1”.  If there is no physician/APN/PA documentation in the History and Physical, ED note, or admission note that the patient was assessed or screened for delirium, enter value “2”. |