

Delirium

ORG: M-590 (ISC)

[Link to Codes](#)

MCG Health

Inpatient & Surgical
Care
30th Edition

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Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Admission to Inpatient Care

Note: Some patients may be appropriate for Observation care. For consideration of observation care, see Delirium: Observation Care [↗](#) ISC.

- Admission to **Inpatient Level of Care for Adult** (LOCUS Level 6 - Medically Managed Residential Services, Composite Score 28 or more) is indicated due to **1 or more** of the following[A][B][C][D](16)(17)(18)(19)(20):[N](#)
 - Delirium due to alcohol or sedative (eg, benzodiazepines, barbiturates) withdrawal[E]
 - Delirium that persists despite observation care

See Behavioral Health GRG [↗](#) GRG for other issues (eg, imminent danger to self) as appropriate.

Supplemental Medicare Criteria

Note: These criteria are to be considered for Medicare patients if none of the standard Clinical Indications for Admission to Inpatient Care apply.

- Patient with Medicare coverage requires inpatient admission, as indicated by **1 or more** of the following(30):
 - Admitting clinician expects patient to require hospital care for less than 2 midnights but, based on complex medical factors documented in medical record, judges that inpatient care is necessary (case-by-case exception). The medical record must contain sufficient documentation to make clear the rationale for the exception.
 - Patient has need for intubation and mechanical ventilation that is new (ie, did not present to hospital already on mechanical ventilation).
 - Treatment plan for hospital admission includes procedure designated by CMS as inpatient only (ie, on Inpatient Only List).
 - Patient has already received medically necessary hospital care that meets 2-midnight benchmark (excluding activities such as triage/intake, delays in provision of care, or time added due to patient or family convenience). The medical record must contain

sufficient documentation to make clear the medical necessity for hospital care across 2 or more midnights.

Alternatives to Admission

- Alternatives include, for delirium that is resolving or due to a known treatable cause(17)(19):[\[I\]](#)
 - Outpatient care
 - Home healthcare
 - Recovery facility
- Observation. See Delirium: Observation Care [\[J\]](#) ISC guideline as appropriate.

Hospitalization

Optimal Recovery Course

Day	Clinical Status	Interventions	Medications	Evaluation	Therapy
1	Clinical Indications met[F] - Social Determinants of Health Assessment - Begin Discharge planning	- Orienting and environmental measures[G] - Possible IV fluids, medications Close observation or possible one-to-one - Possible physical restraint for safety[H]	- Benzodiazepine for delirium due to alcohol or sedative withdrawal[E] - Thiamine if alcohol misuse is suspected[I]	- Medical, psychiatric, social, and substance use histories - Mental status and physical examinations[J] - Possible head CT scan or MRI[K] - Laboratory studies[L] - Condition assessed multiple times per shift	Frequent reorientation[M]
2	Functional status improving No dangerous behavior[N] for at least 24 hours - Social Determinants of Health Assessment	Close observation - Orienting and environmental measures[G] - Possible IV fluids, medications - Possible physical restraint for safety	Medication review, adjustment	Evaluation completed and reviewed - Condition assessed multiple times per shift	Frequent reorientation[M]
3	Delirium resolving or of known treatable cause No dangerous behavior[N] for at least 24 hours - Social Determinants of Health Assessment	Close observation at reduced intensity - Orienting and environmental measures[G] - Oral hydration - No need for physical restraint for safety	Medication review, adjustment	Symptoms assessed at decreasing frequency with clinical improvement	Frequent reorientation
4	Delirium resolved or manageable[O] Thoughts of suicide or Harm absent or manageable/treatable at lower level of care Supports understand follow-up treatment and crisis plan	- Orienting and environmental measures - No need for physical restraint for safety - Review follow-up treatment and crisis plan with	Medication review, adjustment		

- **Provider and supports sufficiently available at lower level of care** patient and supports
- **Patient can participate (eg, verify absence of plan for harm) in needed monitoring**
- **Functional status impairment absent or adequate self-care support planned at lower level of care**
- **Medical comorbidities, adverse medication events, and substance use absent or manageable/treatable at available lower level of care**
- Social Determinants of Health Assessment
- Complete Discharge planning
- Discharge

(3)(4)(6)(16)(19)(20)(37)(38)[N](#)

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: 3 days

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Extended Stay

Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Extended stay beyond goal length of stay may be needed for(3)(19)(38):
 - Failure to meet discharge criteria (recovery milestones within final day in Optimal Recovery Course)
 - Expect brief stay extension.
 - Delayed resolution of delirium(19)(39)
 - Expect prompt reassessment steps, including:
 - Reassessment of presumed contributors to delirium[P]
 - Consideration of possible underlying dementia, a risk factor for prolonged delirium(41)
 - Review of necessity of each prescribed medication[Q]
 - Review of orienting and environmental measures[G]
 - Assessment of vision and hearing[R]
 - Anticipate treatment measures, including as appropriate:[N](#)
 - Correction or treatment of all potential contributors to delirium
 - Dose reduction or discontinuation of medications that may be contributing to delirium
 - Improvement of orienting and environmental measures
 - Provision of visual or hearing aids
 - Expect brief to moderate stay extension.
 - Persistent dangerous behavior[N]
 - Expect prompt reassessment steps, including:
 - Identification of precipitants of dangerous behavior
 - Review of adequacy of delirium treatment, including:
 - Reassessment of presumed contributors to delirium
 - Review of necessity of each prescribed medication[Q]
 - Review of orienting and environmental measures[G]
 - Review of medication used to treat agitation, including:
 - Benzodiazepine, for delirium due to alcohol or sedative withdrawal(6)(27)
 - Antipsychotic medication if used[N](#)
 - Anticipate treatment measures, including as appropriate:
 - Correction or treatment of all potential contributors to delirium

- Dose reduction or discontinuation of medications that may be contributing to delirium
- Improvement of orienting and environmental measures
- Adjustment of medication to reduce agitation
- One-to-one observation(63)
- Physical restraint for safety[H]
- Expect brief to moderate stay extension.
- Persistent inability to perform essential function[S] that cannot be managed at lower level of care
 - Expect prompt reassessment steps, including:
 - Review of adequacy of delirium treatment, including:
 - Reassessment of presumed contributors to delirium
 - Review of necessity of each prescribed medication[Q]
 - Review of orienting and environmental measures[G]
 - Consideration of possible underlying dementia, a risk factor for prolonged delirium(41)
 - Assessment of ability of support system to manage functional impairment at lower level of care
 - Anticipate treatment measures, including as appropriate:
 - Correction or treatment of all potential contributors to delirium
 - Dose reduction or discontinuation of medications that may be contributing to delirium
 - Improvement of orienting and environmental measures
 - Expect brief to moderate stay extension.

See Common Complications and Conditions [ISC](#) for further information.

Hospital Care Planning

- Hospital evaluation and care needs may include(3)(16)(19)(43):
 - Diagnostic test scheduling and completion, including:
 - Head CT scan or MRI[K]
 - Laboratory tests[L]
 - Lumbar puncture[T]
 - EEG[U](64)
 - Treatment and procedure scheduling and completion, including:
 - Orienting and environmental measures[G][N]
 - Benzodiazepine for delirium due to alcohol or sedative withdrawal[E][V](6)(27)(32)
 - Antipsychotic medication if used[I]
 - Thiamine for known or suspected alcohol misuse[I]
 - Consultation, assessment, and other services scheduling and completion, including:
 - Neurology consultation
 - Medical specialty consultations[J]
 - Psychiatry consultation
 - Substance use assessment
 - Social services consultation for placement or housing(66)(67)
 - Monitoring patient's status for deterioration and comorbid conditions (see Inpatient Monitoring and Assessment Tool [SR](#)); key items include(43):
 - Visual or hearing impairment
 - Adverse cognitive effects of prescribed medications[Q]
 - Complications due to immobility (aspiration, pressure sores, DVT)
 - Falls due to oversedation or ataxia
 - Injury to patient or another due to agitation or impaired reality testing

Discharge

Discharge Planning

- Discharge planning includes[W]:
 - Assessment of needs and planning for care, including(69)(70):
 - Develop and modify treatment plan (involving multiple providers) as needed.
 - Evaluate and address preadmission functioning as needed.
 - Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment [SR](#) for further information.
 - Evaluate and address social determinants of health (eg, housing, food). See Social Determinants of Health Screening Tool [SR](#) for further information.(71)
 - Evaluate and address patient or caregiver preferences as indicated.(72)

- Identify skilled services needed at next level of care, with specific attention to:
 - Medication management, adherence instruction, and side effects assessment(73)(74)
 - Neurologic status assessment(75)
 - Pain management(76)
 - Psychosocial assessment, management, and referrals(77)
 - Significant chronic condition exacerbation with need for clinical intervention and monitoring(76)
- Early identification of anticipated discharge destination; options include(70)(78):
 - Home; considerations include:
 - Home safety assessment. See Home Safety Assessment [SR](#) for further information.
 - ☐ Patient safe to go home; examples include(79)(80)(81):
 - Medical status stable for patient's condition
 - Functional care can safely be provided with available resources.
 - Mental status stable for patient's condition
 - Medication availability confirmed and reconciliation complete
 - Patient/caregiver education completed with written discharge instructions provided
 - Community resources identified and referrals made, as needed
 - Home care arranged, if indicated
 - Necessary medical equipment delivery arranged or available in home, if indicated
 - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated
 - Access to follow-up care
 - Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment [SR](#) for further information.
 - Caregiver need, ability, and availability(72)
 - Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool [SR](#) for further information.
- Transitions of care plan complete, including(70)(78)(82):
 - Patient and caregiver education complete.
 - See Teach-Back Tool [SR](#) for further information.
 - See Delirium: Patient Education for Clinicians [SR](#) for further information.
 - ☐ Medication reconciliation completion includes(74)(83):
 - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
 - Assess each medication for correlation to disease state or medical condition.
 - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
 - Provide reconciled medication list to all treating providers.
 - Confirm that patient or caregiver can acquire medication.
 - Educate patient and caregiver.
 - Provide complete medication list to patient and caregiver.
 - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
 - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(84)
 - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
 - See Medication Reconciliation Tool [SR](#) for further information.
 - Plan communicated to patient, caregiver, and all members of care team, including(85):
 - Inpatient care and service providers
 - Primary care provider
 - All post-discharge care and service providers
 - Appointments planned or scheduled, which may include:
 - Primary care provider(66)(67)(86)
 - Behavioral health provider(66)(67)
 - Neurologist(23)
 - Specialists for management of comorbidities as needed(19)
 - Other
 - Outpatient testing and procedure plans made, which may include:
 - Other
 - Referrals made for assistance or support, which may include:
 - Alcohol and other drug abuse or dependence treatment(23)
 - Behavioral health services (eg, counseling)(87)
 - Financial, for follow-up care, medication, and transportation(23)

- Social services (eg, social programs, advance directives)(88)(89)
- Tobacco use treatment(90)(91)
- Other
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
 - Other

Discharge Destination

- Post-hospital levels of admission may include:
 - Home.
 - Recovery facility care. See Recovery Facility Care Indications for Admission Section [RFC](#) in Delirium guideline in Recovery Facility Care.

Evidence Summary

Background

Delirium is characterized by an acute onset (over hours or days) and fluctuating course of disturbed consciousness and reduced ability to sustain or shift attention, with accompanying cognitive impairment or perceptual disturbance.(3)(16)(17)(18)(19) **(EG 2)** Alcohol or sedative withdrawal, substance intoxication, a wide array of medical conditions (eg, acute illness, increased age, frailty, postoperative status, dementia), and medications, either alone or in combination, may cause or contribute to delirium. Identification and treatment of the underlying cause is essential to appropriate management.(3)(16)(18)(19)(21)(22) **(EG 2)** Delirium is a serious condition that is estimated to affect 11% to 25% of patients admitted to a hospital. Delirium has been associated with increased mortality, functional decline, need for institutionalization, length of hospital stay, and healthcare costs.(23)(24)(25)(26) **(EG 2)**

Criteria

The evidence for the clinical indications found in this guideline includes 9 published peer reviewed articles, 5 specialty society or other evidence-based guidelines, and 9 book sections.

An emergency medicine textbook states that while some patients with delirium due to acute drug intoxication or hypoglycemia may improve with observation or emergency department care, most patients with delirium will require inpatient care.(17) **(EG 2)** A practice guideline states that withdrawal delirium requires inpatient care and often treatment in the intensive care unit.(6) **(EG 2)**

Length of Stay

Analysis of national hospital discharge data shows 40% of hospitalized patients with the principal diagnosis of delirium were discharged in 3 days or fewer.(38) **(EG 3)**

Treatment

Treatment - Nonpharmacologic: Nonpharmacologic interventions are recommended for both the prevention and treatment of delirium. They include staff education, reorientation, minimization of sensory impairments, mobilization, sleep hygiene, and avoidance of restraints and culprit medications (eg, benzodiazepines, other sedatives, anticholinergic agents). The evidence supporting efficacy of nonpharmacologic measures is greater in the setting of prevention than for treatment of delirium that already has developed.(3)(16)(19)(33)(44) **(EG 2)** A systematic review (35 studies with 25,283 patients, including 11 randomized controlled trials) and meta-analysis (15 studies included) found that nonpharmacologic interventions were effective in decreasing delirium duration and occurrence in the ICU setting but not ICU length of stay or mortality.(45) **(EG 1)** A systematic review and meta-analysis including 22 randomized controlled trials (5718 adults) of nonpharmacologic interventions for delirium prevention in non-ICU inpatient settings concluded that multicomponent nonpharmacologic interventions significantly reduced incidence of delirium and may reduce length of stay as compared with usual care, despite no evidence of an effect on mortality.(46) **(EG 1)** A systematic review and meta-analysis of 26 studies (7035 patients) of nonpharmacologic interventions to reduce incidence and duration of delirium in critically ill patients found that multicomponent nonpharmacologic strategies are the optimal interventions for significantly reducing duration of delirium and length of ICU stay.(47) **(EG 1)** A systematic review and meta-analysis (8 studies, 2105 patients) found that multicomponent nonpharmacologic interventions significantly decreased the incidence of delirium during hospitalization.(48) **(EG 1)** A practice guideline recommended that older adults undergoing surgery be screened for risk factors for postoperative delirium, that the results of this screening be shared with the entire care team, and that multicomponent nonpharmacologic interventions be initiated in all patients judged to be at risk for postoperative delirium.(49) **(EG 2)**

Treatment - Pharmacologic: A systematic review of 14 randomized controlled trials (9247 patients) found no difference in delirium incidence or duration or hospital length of stay with haloperidol as compared with placebo in preventing delirium in hospitalized adults.(50) **(EG 1)** A systematic review (including 16 randomized controlled trials and 10 observational studies, 5607 participants) of antipsychotics for treating delirium in hospitalized adults found no statistical differences between haloperidol or second-generation antipsychotics as compared with placebo in delirium severity, duration, or hospital length of stay.(51) **(EG 1)** A multicenter randomized controlled trial of 1000 patients admitted to an intensive care unit compared haloperidol with placebo for the treatment of delirium and

found, at 90-day follow-up, that there were no differences between groups in mortality, length of hospital stay, days without delirium or coma, days without mechanical ventilation, serious adverse reactions, or use of rescue medications. The authors noted that issues with generalizability, potential confounders, and attrition limited their findings.(52) **(EG 1)** A pre-planned secondary analysis of this trial data found high probabilities of clinical benefit for haloperidol as compared with placebo with respect to days alive and out of hospital (92%), mortality (99%), days without delirium or coma (98%), days without mechanical ventilation (95%), and the use of rescue medication (91%). The authors noted that the arbitrariness of clinical benefit thresholds and the limitations of secondary analyses limited their findings, and additional research was recommended.(53) **(EG 1)** A pre-planned analysis of long-term outcome data of the same trial found that, at 1-year follow-up, haloperidol was associated with lower mortality compared with placebo, but there were no differences between groups in health-related quality of life. The authors noted that missing data and issues of generalizability limited their findings.(54) **(EG 1)** A meta-analysis (21 randomized controlled trials) of dexmedetomidine for delirium in 6328 surgical patients age 60 years and older found that dexmedetomidine was associated with reduced incidence of delirium in noncardiac surgical patients, shorter length of ICU and hospital stays, lower mortality, and high incidence of bradycardia.(55) **(EG 1)** A meta-analysis (10 randomized controlled trials) of 1387 patients undergoing cardiac surgery found that administration of perioperative dexmedetomidine significantly decreased the incidence of postoperative delirium as compared with control but was associated with a greater incidence of postoperative bradycardia.(56) **(EG 1)** A randomized controlled trial (120 patients) comparing postoperative placebo and IV acetaminophen (every 6 hours for 48 hours) in adult patients who underwent cardiac surgery and were treated with IV propofol or dexmedetomidine (for sedation) found that IV acetaminophen reduced the incidence of delirium (10% vs 28%), median days with delirium (1 vs 2 days), ICU length of stay (30 hours vs 46 hours), and 48-hour need for morphine analgesia.(57) **(EG 1)** A systematic review and meta-analysis (14 studies, 1712 patients) of melatonin and ramelteon for delirium prevention in hospitalized patients found melatonin and ramelteon significantly reduced the incidence of delirium in surgical patients and patients in the ICU but did not reduce delirium duration, length of stay, or mortality. Researchers noted adverse effects within the treatment group of nightmares, hallucinations, and gastrointestinal side effects.(58) **(EG 1)** A systematic review and meta-analysis of 9 studies (1211 patients, 2 trials in meta-analysis) evaluated melatonin or ramelteon for the treatment of delirium and found that melatonin was associated with a shorter duration of delirium as compared with placebo. Melatonin and ramelteon appeared to reduce the intensity of delirium and the need for rescue medications, but those conclusions were very uncertain due to the quality of the available evidence. The authors noted that the high degree of heterogeneity and potential bias in included studies limited their findings, and additional research was recommended.(59) **(EG 1)** A systematic review and meta-analysis of 6 studies (2374 patients) evaluated melatonin for the prevention of delirium in patients admitted to an ICU and found that melatonin did not reduce the incidence of delirium as compared with placebo in patients admitted to a general ICU, but a secondary analysis found that melatonin reduced the incidence of delirium in patients admitted to a cardiovascular care unit. There were no differences between groups in all-cause mortality, length of ICU stay, or length of hospital stay. The authors noted that heterogeneity and potential confounders in included studies limited their findings, and additional research was recommended.(60) **(EG 1)** A practice guideline weakly recommended low-dose haloperidol for the treatment of postoperative delirium if nonpharmacologic measures fail, but benzodiazepines should be avoided except for the treatment of alcohol withdrawal delirium.(49) **(EG 2)** The management of delirium in children and adolescents is often based on extrapolations from the adult literature, given the more limited available evidence specific to pediatric patients.(61)(62) **(EG 2)**

Level of Care

When delirium fails to respond to treatment in an emergency department or urgent care setting or its cause is unclear, inpatient admission is generally necessary.(31) **(EG 2)**

Rationale

Use of this MCG care guideline helps the clinician identify patient-specific complex clinical factors that make it reasonable to expect a necessity for hospital care across 2 or more midnights. The evidence-based clinical criteria assist the clinician in the decision to appropriately admit a patient to inpatient care. For Medicare enrollees, MCG care guidelines also support the clinician in the decision to appropriately admit a patient to inpatient care when there is not an expectation of 2 or more midnights of hospital care (eg, CMS' Two-Midnight Rule exceptions).

Use of these evidence-based clinical criteria to support decision making around the need for inpatient treatment is of clinical benefit to the patient and is crucial for quality patient care. Use of evidence-based clinical criteria ensures patients receive the most appropriate care for their specific condition, reduces unnecessary risks, promotes recovery, and provides a standard that can reduce disparities in care. Evidence-based clinical criteria not only help align treatment decisions with best practice, but they can also help reduce unwarranted variation in care by fostering consistency and equality in healthcare provision across regions and facilities. Appropriate use of the evidence-based clinical criteria in conjunction with the Supplemental Medicare Criteria ensures Medicare patients receive full access to Medicare benefits (eg, inpatient care), without risk of delay or decreased access, based on variables such as clinical severity of illness, length of provision of medically necessary hospital-level care, or satisfaction of specified Medicare criteria as directed by CMS. Use of these criteria will help ensure that the patient receives necessary care in the appropriate setting.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 412.3(30); 42 CFR 419.22(92); 42 CFR 422.101(93)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(94); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B(95); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services(96); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment(97)

Medicare Coverage Determinations: Medicare Coverage Database(98)

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Footnotes

[A] While patients with a history of mental illness who present with signs and symptoms of delirium may be admitted to a psychiatric unit, evaluation and management on a medical unit may be more appropriate.(1)(2)(3) [A in Context Link 1]

[B] For patients undergoing alcohol withdrawal, ICU admission is indicated for delirium tremens, hemodynamic instability, arrhythmias, uncontrolled seizures, need for anesthetic agent to control agitation, or respiratory depression with need for, or high likelihood of requiring, mechanical ventilation.(4)(5)(6) [B in Context Link 1]

[C] The purpose of the care guidelines is to promote evidence-based care across the continuum of care to enhance the delivery of quality healthcare. Indications are presented for different levels of care. These indications help define the optimal level of care and can assist in developing alternatives to higher levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for transition of patients from one level of care to another. Relevant professional society guidelines are foundational content for evaluation and treatment of behavioral health disorders at

different levels of care and are complemented by the best available published evidence.(7)(8)(9)(10)(11)(12)(13)(14)(15) [C in Context Link 1]

[D] Composite score does not replace clinical judgment and is meant as a guide to assist in determining needed level of care. Extreme risk of harm, severe functional impairment, or severe comorbidity may independently necessitate placement at inpatient level of care.(7) [D in Context Link 1]

[E] The term "sedative" is used in this guideline to refer collectively to sedatives, hypnotics, and anxiolytics, and it includes drugs such as benzodiazepines, barbiturates, and "Z-drugs" (eg, eszopiclone, zolpidem, zaleplon).(27)(28)(29) [E in Context Link 1, 2, 3]

[F] See Clinical Indications for Admission to Inpatient Care in this guideline. [F in Context Link 1]

[G] Orienting and environmental measures include locating a clock, a calendar, and familiar objects at the patient's bedside; providing lighting appropriate to the time of day; minimizing nighttime sleep interruptions; promoting frequent visits from family and friends; avoiding room changes; and limiting the number of different staff members who interact with the patient.(32)(33)(34) [G in Context Link 1, 2, 3, 4, 5, 6, 7]

[H] Restraint (a method or device that immobilizes or restricts movement) is an intervention of last resort when patients are at imminent risk of harm to self or others. Restraints are reserved for psychiatric emergencies, used to prevent injury to self or others, when verbal, environmental, and pharmacologic interventions are not successful.(32)(35) [H in Context Link 1, 2]

[I] Patients with suspected or known alcohol misuse or dependence should be treated with thiamine (eg, 500 mg intravenously once or twice daily) for at least 3 to 5 days to prevent or treat Wernicke encephalopathy.(4)(6) [I in Context Link 1, 2]

[J] Assessment for delirium should include the use of a formal assessment tool (eg, the Confusion Assessment Method).(19) [J in Context Link 1, 2]

[K] Indications for neuroimaging in a patient with delirium include head trauma, new focal neurologic signs, fever or other evidence of encephalitis, and absence of an identifiable cause of the delirium.(17) [K in Context Link 1, 2]

[L] Findings from medical history and physical examination will usually suggest possible causes of the delirium and determine what laboratory assessments are needed.(17) [L in Context Link 1, 2]

[M] Reorientation, which should be conducted at frequent intervals, involves reminding the patient of the date, time of day, location, and reason for hospitalization.(32) [M in Context Link 1, 2]

[N] Behavior is considered dangerous if it has imminent potential to cause death, disability, or significant harm to the patient or someone else.(7)(36) [N in Context Link 1, 2, 3]

[O] Delirium is manageable if it is steadily resolving or its cause is known and it is treatable in an available lower level of care.(16) [O in Context Link 1]

[P] The incidence of delirium is very high (80%) in ICU and terminally ill cancer patients.(32)(40) [P in Context Link 1]

[Q] A variety of medications can contribute to delirium, particularly those with anticholinergic or psychotropic effects.(16)(19)(42) [Q in Context Link 1, 2, 3, 4]

[R] Visual or hearing impairment can contribute to disorientation and delay resolution of delirium.(43) [R in Context Link 1]

[S] Essential functions are those that are necessary to sustain life, such as feeding and hydrating oneself.(7) [S in Context Link 1]

[T] Indications for lumbar puncture in a patient with delirium include meningismus and fever of unknown origin.(43) [T in Context Link 1]

[U] Indications for obtaining an EEG include differentiating delirium from depression, psychosis, or other psychiatric etiologies of mental status changes; or suspicion that an occult seizure disorder is causing delirium.(3) [U in Context Link 1]

[V] A systematic review did not support benzodiazepine use in treating hospitalized patients with delirium not related to alcohol withdrawal.(65) [V in Context Link 1]

[W] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(68) [W in Context Link 1]

Definitions

Discharge planning

- Discharge planning includes **ALL** of the following(1)(2)(3)(4)(5)(6):
 - Identification of needed internal and external resources and services (eg, medical/care providers, care manager, housing, transportation, financial support)
 - Patient, family, guardian, and other supports involved in plan development as appropriate
 - Communication of current information to next level of care providers
 - Identification of contacts and their responsibilities at next level of care

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Evaluation completed and reviewed

- Completion of appropriate evaluation includes **ALL** of the following(1)(2)(3):
 - Psychiatric history and evaluation
 - Mental status examination
 - Evaluation of precipitants
 - Observation and symptom assessment completed or not needed
 - Physical examination completed or not indicated for level of care

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Harm

- Harm to self or another is considered serious if it has a substantial likelihood of causing death, disability, or major disfigurement.(1)(2)(3)(4)(5)

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Observation care

- When a Clinical Indication says "...despite (or beyond) observation care," the intent is to signify that, despite an attempt to address a sign, symptom, finding, or treatment need in observation care, a continued need for hospital-based care persists beyond the observation care time frame (ie, Observation Care Discharge Criteria are not met). The time frame of observation care is determined by regulation (eg, CMS's Two-Midnight Rule) or payer-provider contractual agreement. MCG's understanding of observation care is that it must be finite and of short duration. The Two-Midnight Rule for Medicare patients (inpatient is defined as medical necessity for hospital-based care across 2 or more midnights) provides a good example of what is meant by a short duration (ie, observation care should not continue beyond the second midnight).

Social Determinants of Health Assessment

- Risk of poor health outcomes may be increased by the presence of **1 or more** of the following social determinants of health(1)(2)(3):
 - Housing insecurity, as indicated by **1 or more** of the following:
 - Individual or caregiver's current living situation is **1 or more** of the following(4):
 - Does not have own housing (eg, staying in a hotel, shelter, or with others)
 - Has own housing (eg, house, apartment), but at risk of losing it in the future (ie, behind on rent or mortgage)
 - Has own housing (eg, house, apartment), but has lived in 3 or more places in past year
 - Current housing has **1 or more** of the following:
 - Electrical appliances (eg, stove, refrigerator) not working or unavailable
 - Insufficient heating or cooling
 - Insufficient ventilation
 - Lead paint or pipes
 - Mold
 - Pests (eg, bugs) or rodents
 - Smoke detectors not working or unavailable
 - Food insecurity, as indicated by **1 or more** of the following(5):
 - In the past year, individual or caregiver ran out of food and did not have money to buy more food.
 - In the past year, individual or caregiver worried that they would run out of food before they received money to buy more food.
 - Insufficient transportation, as indicated by **1 or more** of the following(6):
 - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of transportation.
 - In the past year, individual or caregiver missed nonmedical activities, work, or could not get things needed for daily living due to lack of transportation.
 - Insufficient utilities, as indicated by **1 or more** of the following(7):
 - Utilities (eg, electricity, water, gas, or oil) are currently shut off or unavailable.
 - In the past year, electric, water, gas, or oil company threatened to shut off services.
 - Personal safety risk, as indicated by **2 or more** of the following(5):
 - Individual is sometimes or frequently physically hurt by another person (including family member).
 - Individual is sometimes or frequently insulted or talked down to by another person (including family member).
 - Individual is sometimes or frequently threatened with physical harm by another person (including family member).
 - Individual is sometimes or frequently screamed or cursed at by another person (including family member).
 - Insufficient dependent care, as indicated by **1 or more** of the following:
 - In the past year, individual or caregiver was unable to work due to lack of dependent care.
 - In the past year, individual or caregiver was unable to work more (additional) hours due to lack of dependent care.
 - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of dependent care.
 - In the past year, individual or caregiver missed nonmedical activities (eg, school, church, social activity) due to lack of dependent care.
 - Depression risk, as indicated by **ALL** of the following(8):
 - In the past 2 weeks, individual had little interest or pleasure in normal activities on at least several days.
 - In the past 2 weeks, individual felt down, depressed, or hopeless on at least several days.

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Thoughts of suicide

- Thoughts of suicide or suicidal ideations are defined as "thoughts of serving as the agent of one's own death," to be distinguished from thoughts of death that do not involve actively bringing death about.(1)(2)(3)

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Codes

ICD-10 Diagnosis: F05, F10.121, F10.221, F10.231, F10.921, F11.121, F11.221, F11.921, F12.121, F12.221, F12.921, F13.121, F13.221, F13.231, F13.921, F13.931, F14.121, F14.221, F14.921, F15.121, F15.221, F15.921, F16.121, F16.221, F16.921, F18.121, F18.221, F18.921, F19.121, F19.221, F19.231, F19.921, F19.931 [Hide]

DSM-5: F05, F10.121, F10.221, F10.231, F10.921, F11.121, F11.221, F11.921, F12.121, F12.221, F12.921, F13.121, F13.221, F13.231, F13.921, F13.931, F14.121, F14.221, F14.921, F15.121, F15.221, F15.921, F16.121, F16.221, F16.921, F18.121, F18.221, F18.921, F19.121, F19.221, F19.231, F19.921 [Hide]

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Inpatient & Surgical Care 30th Edition
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Last Update: 1/25/2026 6:28:11 AM
Build Number: 30.0.2026012500524.025256