

Delirium

**T H E M I S T A K E N
C O N F U S I O N**

DEBRA CASON-MCNEELEY

PSI HEALTHCARE

Copyright © 2004

PESI HEALTHCARE, LLC
PO Box 1000
200 Spring Street
Eau Claire, Wisconsin 54702

Printed in the United States of America

ISBN: 0-9722147-9-8

PESI HealthCare strives to obtain knowledgeable authors and faculty for its publications and seminars. The clinical recommendations contained herein are the result of extensive author research and review. Obviously, any recommendations for patient care must be held up against individual circumstances at hand. To the best of our knowledge any recommendations included by the author or faculty reflect currently accepted practice. However, these recommendations cannot be considered universal and complete. The authors and publisher repudiate any responsibility for unfavorable effects that result from information, recommendations, undetected omissions or errors. Professionals using this publication should research other original sources of authority as well.

Continuing Education Self Study Credit Available: PESI HealthCare provides self study credit for this publication. Please see the information contained in the back of this book for details.

**For information on other PESI HealthCare products
and seminars, please call 800-843-7763**



www.pesihealthcare.com

This work is dedicated to the love of my life, Stephen

A B O U T T H E A U T H O R

Debra Cason-McNeeley, MSN, RNCS, began her nursing career 32 years ago and spent the initial 20 years in critical care before entering the mental health field. She completed her BSN at Grandview College, Des Moines, Iowa and received her MSN from the University of Northern Colorado, Greeley, Colorado. Debra has operated a private practice in massage therapy and geriatric assessment and counseling. She has taught and lectured nationally on topics related to the elderly, including end-of-life issues. Debra is currently certified as a Clinical Nurse Specialist in Adult Mental Health and Psychiatric Nursing through the American Nurses Credentialing Center. She is an adjunct professor in the BSN program at Mercy College of Health Sciences, and works part-time on an Inpatient Behavioral Health Unit.

TABLE OF CONTENTS

<i>Foreword</i>	.....	<i>vii</i>
<i>Preface</i>	.....	<i>xi</i>
Chapter 1	History	1
Chapter 2	Definition	3
Chapter 3	Clinical Features	5
Chapter 4	Pathophysiology	11
Chapter 5	Prevalence	13
Chapter 6	Prevention	15
Chapter 7	Diagnosis	19
Chapter 8	Risk Factors	21
Chapter 9	Clinical Course	23
Chapter 10	Causes	27
Chapter 11	Assessment	33
Chapter 12	Management	37
Chapter 13	Delirium with Acute Alcohol/Substance Intoxication/Withdrawal	45
Chapter 14	Delirium in the Critical Care Unit	49
Chapter 15	Delirium in the Emergency Room	53

viii *Table of Contents*

Chapter 16	Delirium in the Hospital	55
Chapter 17	Delirium in the Nursing Home	59
Chapter 18	Delirium at the End of Life	63
Chapter 19	Complications	65
Chapter 20	Conclusions	67
<i>Glossary</i>	.....	69
<i>References</i>	.....	75
<i>Appendix</i>	.....	79

F O R E W O R D

It is 3 am in the small community hospital's emergency room. "Liz," an 18 year-old girl, has just arrived presenting with psychomotor agitation requiring restraints, and loud, pressured and disorganized speech. The ER staff attempts to engage her for clinical evaluation. She is patently uncooperative, responding more to her own internal stimuli than the focused questions of the clinicians. Perhaps it is not surprising that the busy ER physician decides it is time for a psychiatric consultation.

The young psychiatric resident examines the girl rapidly. A brief interview with her parents reveals that her behavioral symptoms have appeared over the last two weeks and have dramatically escalated in the last twenty-four hours. Given the clear psychosis evident, her demographic profile, and negative UDS, he concludes that she is experiencing her first psychotic break. He orders Haldol 5mg IM with Cogentin and writes up her mental health hold. Surely in the psychiatric ward her condition will be appropriately addressed and respond favorably.

Yet in the following thirty-six hours she becomes at times increasingly agitated, catatonically immobile at others, and her hallucinations are more prominent. The staff administered higher doses of her potent anti-psychotic medication, but somehow things still keep getting worse.

After two days this somewhat bemusing case takes a drastic and morbid turn. The adolescent goes into status epilepticus, her seizure terminated only after five long minutes. She is immediately sent back to the ER where she was initially categorized as a prototypical “psych patient.” Now it is all too evident that her presenting symptoms, felt at first to be representative of a psychiatric condition, are in fact part of a systemic medical crisis: delirium.

Delirium is a syndrome made of behavioral symptoms that without careful practice are easily misinterpreted as etiologically psychiatric. By definition, it is not. Indeed, delirium pertains to disrupted central nervous system function brought about by dire medical and neurologic pathology. It occurs across the range of demographic groups. Particularly susceptible are those with the neuro-degenerative changes of certain age-related conditions. Sadly, clinicians everywhere from primary care, ER and med-surg to nursing home settings all too often miss the clues.

Why is such misdiagnosis so frequent? Largely, clinical naïveté and the diagnostic ambiguity often inherent in these cases. With virtually any behavioral syndrome, the formulation of a differential diagnosis that includes delirium should be an essential element of the clinician’s professional competence.

As for “Liz,” an MRI and lumbar puncture aided in the diagnosis of Herpes Encephalitis. The status epilepticus, brought about by the collusion of seizure threshold lowering infection and anti-psychotic medication, had left her vegetative.

The clinicians now understood. The misdiagnosis not only had denied her proper and rapid treatment, but also prompted iatrogenic catastrophe. The clues had been there all along, only the professional awareness was partially lacking. Thoughtful examination would have highlighted prominent short-term memory and attentional deficits uncommon for pure psychiatric states. In-depth interview with the parents would have revealed a recent history of intermittent bouts of anterograde amnesia.

Liz's story is true, and cases such as hers are all too prevalent. Thankfully, Debra Cason presents us with a concise yet comprehensive summation of delirium. I applaud her for providing a ready reference for such a dangerously under-emphasized syndrome with common presentation and potentially morbid consequences. Using the practices gleaned herein, we can all begin to help hone our diagnostic acumen in a truly vital area of medical care.

Daniel Fisher, MD
Chief of Staff
Director of Geriatric Services
Centennial Peaks Hospital
Louisville, Colorado

P R E F A C E

Recently there was a story on the local news. The story told of an 80-year-old woman who had hired a couple to live with her to assist her in her daily cares. During the eight months that ensued the woman grew seriously ill. She became confused, her memory was impaired and she could no longer manage her activities of daily living. Her family took her to the emergency room a total of thirteen times in this eight-month period. Every time they encountered the health care system, the family was told that the mental changes were due to her dementia. She had no previous diagnosis of dementia. She was never admitted to the hospital for a work-up, nor was any formal mental status testing performed. She was returned home, experienced functional decline and her family took her back to the hospital once again. Her family was keenly aware that something was wrong with their mother.

As it turns out, the care providers, hired to care for this woman, were administering her daily doses of benzodiazepines, antidepressants and sleeping medications. These medications had not been prescribed for her. Thank goodness the caregivers were caught and are awaiting prosecution.

While listening to this story I was struck by the fact that her family was aware that something was acutely wrong with their mother.

They took her to the hospital thirteen times in an eight-month period. Each time they were told that their mother was just old and failing due to dementia.

There are many story lines represented in this case but the one that speaks the loudest is the medical personnel's failure to recognize this acute condition of delirium. The changes evidenced by this woman were sudden and her family was the only one who recognized the sudden changes in their mother's abilities. Dementia is characterized by slow, progressive changes. Delirium is characterized by sudden and rapidly fluctuating changes in behavior and mentation. What saddens me the most is the fact that had it not been for the perseverance of this woman's family, she would have needlessly died, primarily from lack of knowledge by the physicians and nurses of the clinical presentation of delirium.

Delirium is often the underlying cause of altered behavior in the medically ill individual. It is rarely diagnosed and therefore not adequately treated. Delirium is a condition that overlaps medicine and psychiatry but is not owned by either discipline.

Individuals who demonstrate acute confusion are often dealing with a physical or mental illness known as delirium. If delirium is recognized and treated early, the course is temporary and reversible. The disorders that trigger delirium are diverse and plentiful. These triggers include deprivation of oxygen to the brain, diseases of other body systems, poisons, electrolyte imbalances, acute infections, and medications. If an individual has a pre-morbid brain condition, the likelihood of developing delirium increases significantly. Certain sectors of individuals are at a higher risk for the development of delirium than others, specifically the elderly.

The elderly are at the greatest risk for the development of delirium. Delirium also affects one in ten of patients who are hospitalized, whether for medical or psychiatric illnesses. Although these numbers reflect a high number of hospitalized patients, the diagnosis is often absent from the medical record. Due to the clinical presentation of confusion with increased anxiety and agitation, the individual is usually medicated to address the behavior not the underlying cause. These interventions often complicate the diagnosis and course of recovery.

It is imperative for all health care providers, regardless of their area of practice to educate themselves to the clinical presentation of delirium to facilitate early recognition and appropriate treatment. The intent of this book is to facilitate this learning process.

History

The earliest Greek and Roman writers described conditions where febrile and toxic illnesses caused changes in perception, cognition, behavior and mood (Rabinowitz, 2002). Two terms were utilized to describe these changes. *Phrenitis* is the term for an agitated condition and *lethargus* described the condition represented by inactivity and somnolence. The literature states that there are at least fifty-two names and/or phrases utilized that describe delirium. This is part of the difficulty in recognizing its presentation. Delirium is a serious medical condition. When it is merely identified as confusion with a possible modifier such as acute, the impetus for treating such status change as emergent is lost (Rockwood & Lindesay, 2002). This vast amount of descriptions also makes it difficult to conduct reliable research. In order to conduct valid and reliable research, variables must be accounted for. When delirium is not identified by its medical name, even if the clinical presentation meets the criteria, the ability to conduct respectable research is lost.

Historically, patients who are over 65 years of age represent one-third of hospital admission and 40% of physician office visits. With aging comes the decreased ability to maintain the delicate balance of equilibrium required for the body to function at its optimum. When this homeostatic balance is disrupted cognitive changes are commonly

2 *History*

observed. This ability to maintain homeostasis is essential for the elderly individual to remain independent in the community. Independence allows the person to continue playing a contributing role in the community's development and progression. Independence enhances quality of life and contributes to a sense of integrity that is necessary during this stage of life.

Definition

The DSM-IV TR defines delirium according to the following criteria:

- A. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.
- B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.
- C. The disturbance develops over a short period of time (actually hours to days) and tends to fluctuate during the course of the day.
- D. There is evidence by history, physical examination, or laboratory findings that is caused by:
 - 1. A general medical condition
 - 2. Substance intoxication
 - 3. Substance withdrawal
 - 4. Multiple etiologies
 - 5. Not otherwise specified

Clinical Features

Delirium signifies a medical emergency. It is an acute, fluctuating change in mental status, with inattention and altered states of consciousness. It occurs suddenly, with noticeably significant decline from the individual's previous level of functioning. This sudden change in the level of functioning is not related to a preexisting condition or a developing dementia. Although the symptoms are wide ranging and non-specific, the fluctuating nature is a classic indicator of delirium. Cognitive changes, behavioral changes and depression are not part of the normal aging process. They are however, common. Distinguishing the underlying cause of these changes is the immediate goal.

When describing the cognitive or behavioral status of a person, the word "confused" is often used. Utilizing the term confusion, or documenting that a person is confused does not have the clinical pertinence as does stating that a person exhibits symptoms of delirium. Simply replacing the word confusion with the term delirium may prompt immediate interventions aimed at identifying the underlying cause of the change in the behavior that is displayed.

6 *Clinical Features*

Symptoms of delirium typically become worse at night and this further clouds the clinical picture. Nurses report an increase in symptoms during the night and physicians see an entirely different individual during their daytime rounds. Accurate description of objective and subjective information provides the physician with the clinical picture necessary to identify delirium. When documentation includes the writer's bias or frustration, information is skewed, tainting the clinical picture.

Three subtypes of delirium have been identified in the literature. These classifications are based on the level of activity observed. There is no established etiologic difference between the three subtypes. Hyperactive delirium occurs in about twenty-five percent (25%) of cases and exhibits as an increase in psychomotor activity and agitation. It is often misdiagnosed as anxiety or individual behaviors become troublesome and the patient is medicated to effect sedation. Individuals who display quiet behavior or a change from more active, alert involvement in their environment, to a more subdued and uninvolved interaction, typically do not receive the notice that people who display outwardly loud and challenging behavior do. If this hypoactive state is noticed, it is often misdiagnosed as depression. Treatment involves initiation of medication to treat the depression. This addition of medication contributes to exacerbating and complicating the delirium. Hypoactive delirium also represents twenty-five percent (25%) of cases and is evidenced by a decrease in psychomotor activity. Hypoactive delirium is misdiagnosed as depression or may be undetected. Hypoactive delirium carries with it a worse prognosis due to the changes displayed. These changes represent a quiet decline in the individual that puts them at risk for increased severity of illness, longer hospital stays, persistent delirium and higher death rates. Mixed delirium is a combination of hypoactive and hyperactive psychomotor activity and represents thirty-five percent (35%) of cases. About fifteen percent (15%) of individuals demonstrate normal psychomotor activity.

It is important to note that while mood disorders in the elderly are not uncommon, psychosis is. The person who is demented is not psychotic, particularly the individual with Alzheimer's disease. Due to the damage in the brain, people exhibit misidentifications and misrepresentations.

tations. These altered expressive and receptive mechanisms are not due to psychosis but to the neuronal death that accompanies Alzheimer's disease. Symptoms of psychosis seen in the elderly should immediately prompt suspicion of delirium.

Individuals who are experiencing delirium demonstrate a reduced level of lucidity but they do not reach the level of stupor or coma. Initially the person may appear disoriented which will progress to confusion. Their environment will appear unfamiliar. In addition, individuals will be unable to focus, sustain or shift their attention. Being easily distracted is often observed.

Disturbances in perception are common. These include illusions (misperceptions) and hallucinations (false perceptions or misidentifications). Typically hallucinations are of the visual variety but auditory hallucinations and other sensory modalities have been reported.

Other areas of cognitive function are also affected. These can include memory and visuoconstructional impairment, disorientation, or language disturbance. Recent memory is the most commonly influenced. Disorientation relates to time and/or place. Individuals believe they are in their home rather than the hospital or nursing home, or that it is day instead of night. Other people may not be recognized but disorientation to self is rare. Performing an assessment is challenging due to the person's inability to remain focused. However, regardless of how confused the individual might be, attempts at assessing must be made. Information obtained from the confused person is just as valuable as the information received from a more reliable source. Areas of impairment demonstrated by the confused person speak to the areas of the body affected by the condition of delirium and guide the practitioner towards suspected causes and treatment.

Delirium and dementia are defined in the DSM-IV TR but are also defined as medical conditions. Family members bring their loved ones to the medical clinic, psychiatric clinic or emergency room because of changes observed in the behavior of their loved ones. Chief complaints are often vague, i.e., he/she is just not their selves, or "one minute they are fine and the next they are wild."

In a study conducted by Fick and Foreman (2000), it was found that family members recognized abrupt changes in their loved ones.

8 *Clinical Features*

However, Fick and Foreman also describe how physicians did not communicate with family members about these changes. Their study goes on to say that eighty-eight percent of people who demonstrate delirium superimposed on dementia were not recognized by health care providers.

Nurses and physicians specifically identified lack of knowledge as the reason for their lack of recognition of delirium. Observes in the study found that mental status was not assessed using formal instruments. If formal instruments are not used to identify changes from the person's baseline, delirium is unrecognized and the individual's condition continues in a downward spiral.

Following is a list of symptoms that would suggest delirium:

- Develops over short period of time, usually hours to days
- Fluctuates over the course of the day
- Direct result of general medical condition, substance intoxication or withdrawal, use of a medication, toxin exposure or combination of these
- Reduced awareness of environment
- Impaired ability to focus, sustain or shift attention
- Easily distracted
- Change in cognition (memory impairment, disorientation or language disturbance)
- Perceptual disturbance (misrepresentations, delusions or hallucinations)
- Speech and language disturbances (dysarthria, dysnomia, dysgraphia or aphasia)
- Disturbed sleep-wake cycle
- Disturbed psychomotor behavior
- Emotional disturbances

All behavior has meaning. It is a behavioral approach to fulfill an unmet need. All behavior is goal-directed. When people are born into this world, they lack verbal language skills. Humans make their needs known through their behavior. Parents quickly learn to recognize the

subtleties of each cry, movement, squirm and smile. As children begin to grow, they relate their needs with increased non-verbal behavior. Temper tantrums are not uncommon. What is the physical, emotional or psychological need being expressed? Once again the parent who attends their child readily recognizes if the child is wet, tired, thirsty, sad, etc. This attention to detail of non-verbal communication is required of the care provider who cares for the client with cognitive impairment.

All behaviors, whether described as disturbing or delightful, should be understood to be a manner of communication. Disruptive behaviors may be an adaptive endeavor to preserve autonomy or may indicate the existence of other problems. Every behavior demonstrated by a person who is cognitively impaired has meaning. The responsibility of health care providers is to decipher the meaning and make every attempt to meet the expressed need. Using all five senses is crucial to interpreting what is being said through behavior.

Burgener & Dickerson-Putman (1999) found a significant relationship between negative feelings of staff toward the cognitively impaired client and the productive behaviors of the client. Healthcare providers who did not report episodes of aggressive behavior failed to do so because they felt the behavior was a result of a personal failure. If a change in behavior is not reported, delirium cannot be identified. The need to instantly end behaviors often overshadows the completion of a thorough assessment. Without an accurate assessment, treatment usually involves the administration of a chemical or physical restraint.

R E F E R E N C E S

- Brown, T. M. & Boyle, M. F. (2002). Delirium. *Behavioral Management Journal*; vol. 325(21), 644–647.
- Burgener Sandy C, Dickerson-Putman Jeannette. (1999). Assessing patients in the early stages of irreversible dementia; the relevance of patient perspective. *Journal of Gerontological Nursing*, February, 33–41.
- Cobb, J., Glantz, M., Martin, E., Paul-Simon, A., Cole, B., & Corless, I. (2000). Delirium in patients with cancer at the end of life. *Cancer Practice*, vol. 8(4) 172–177.
- Culp, K, Mentes, J, & McConnell, E. (2001). Studying acute confusion in long-term care: Clinical investigation or secondary data analysis using the minimum data set? *Journal of Gerontological Nursing*, vol. 27(4) 41–48.
- Fick, D. & Foreman, M. (2000). Consequences of not recognizing delirium superimposed on dementia in hospitalized elderly individuals. *Journal of Gerontological Nursing*, vol. 26(1), 30–40.
- Flacker, J., Marcantonio, E. (1998). Delirium in the elderly. *Aging*, 13(2), 119–130.

76 References

- Foreman, M., Wakefield, B., Culp, K., & Milisen, K. (2001). Delirium in elderly patients: An overview of the state of the science. *Journal of Gerontological Nursing*, vol. 27(4) 12–20.
- Inouye, S. K., van Dyck, C. H., Alessi, C. A., Balkin, S., Siegal, A. P., & Horwitz, R.I. (1990). Clarifying confusion: The confusion assessment method. A new method for detection of delirium. *Annals of Internal Medicine*, 113(12), 941–948.
- Inouye, S. K., Viscoli, C. M., Horwitz, R. I. et al. (1993). A predictive model for delirium in hospitalized elderly medical patients based on admission characteristics. *Annals of Internal Medicine*, 119: 474–481.
- Inouye, S. K. (2002). Foreword. In J. Lindesay, K. Rockwood, & A. Macdonald, (Eds.), *Delirium in Old Age* (pp. v–vi). Oxford: Oxford Press.
- Insel, K. C., & Badger, T. A. (2002). Deciphering the 4 D's: cognitive decline, delirium, depression and dementia—a review. *Journal of Advanced Nursing*, vol. 38(4), 360–368.
- Justice, Marcia. (2000). Does “ICU psychosis” really exist? *Critical Care Nurse*, 20(3), 28–39.
- Hayes, K. S. (2000). Challenges in emergency care: The geriatric patient. *Journal of Emergency Nursing*, 26:430–435.
- Henry, M. (2002). Descending into delirium. *American Journal of Nursing*, vol. 102(3), 49–55.
- Laplante, J., & Cole, M. (2001). Detection of delirium using the Confusion Assessment Method. *Journal of Gerontological Nursing*, vol. 27(2), 16–23.
- Meagher, D. (2001). Delirium: optimizing management. *Behavioral Management Journal*, vol. 332(20) 144–149.
- McElhaney, J. (2002). Delirium in elderly patients: How you can help. *Consultant*, 42(4), 488–490.
- Naylor, M. (2003). Delirium, Depression Often Overlooked. *American Journal of Nursing*, vol. 103(5), 116.

- O'Brien, D. (2002). Acute postoperative delirium: Definitions, incidence, recognition, and interventions. *Journal of Perianesthesia Nursing*, vol.17 (6), 384–392.
- Rabinowitz, T. (2002). Delirium: An important (but often unrecognized) clinical syndrome. *Current Psychiatry Report*, 4(3), 202–208.
- Ranjan, A. (2001). Recognizing delirium in the hospitalized elderly. *Family Practice Recertification*, vol. 23(7), 11–18.
- Rapp, C. G., (2001). Acute confusion/delirium protocol. *Journal of Gerontological Nursing*, vol. 27(4), 21–33.
- Richardson, S. (2003). Delirium: Assessment and treatment of the elderly patient. *The American Journal for Nurse Practitioners*, vol. 7(1). 9–15.
- Roberts, B. L. (2001). Managing delirium in adult intensive care patients. *Critical Care Nurse*, 21(1), 48–55.
- Rockwood, K., Lindsay, J. (2002). The concept of Delirium: Historical antecedents and present meaning. In J. Lindsay, K. Rockwood, & A. Macdonald, (Eds.), *Delirium in Old Age* (pp.1–8). Oxford: Oxford Press.
- Samuels, S., Evers, M. (2002). Delirium: Pragmatic guidance for managing a common confounding and sometimes lethal condition. *Geriatrics*, 57(6),33–40.
- Sanders, A. B. (2002). Missed delirium in older emergency department patients: A quality-of-care problem. *Annals of Emergency Medicine*, 39:338–341.
- Schofield, I. (2002). Assessing for delirium. *Nursing Older People*, vol. 14(7), 31–33.
- Schofield, I. & Dewing, J. (2001). The nursing contribution to the care of older people with a delirium in acute care settings. *Nursing Older People*, 13(1), 21–35.

78 *References*

- Schuurmans, M., Duursma, S., & Shortridge-Baggett, L. (2001). Early recognition of delirium: Review of the literature. *Journal of Clinical Nursing*, 10:721–729.
- Stein-Parbury, J. & McKinley, S. (2000). Patients' experience of being in an intensive care unit: a select literature review. *American Journal of Critical Care*, 9(1), 20–27.
- Truman, B, & Wesley, E. (2003). Using the Confusion Assessment Method for the intensive care unit. *Critical Care Nurse*, 23(2),25–38.
- Trzepacz, P., van der Mast, R. (2002). The neuropathophysiology of delirium. In J. Lindesay, K. Rockwood, & A. Macdonald, (Eds.), *Delirium in Old Age* (pp.51–90). Oxford: Oxford Press.
- Wakefield, B & Johnson, J. (2001). Acute confusion in terminally hospitalized patients. *Journal of Gerontological Nursing*, vol. 27(4), 49–55.
- Weindel, I. (2002). A case study of postoperative delirium. *AORN Journal*, vol. 75(3), 595–599.
- Wright, S. (2000). Delirium in the elderly. *Advance for Nurse Practitioners*, vol. 8(4), 71–74.
- <http://www.luphealth.com>
- <http://www.psych.org>
- http://www.merk.com/pubs/mm_geriatrics/sec5/ch39.htm

THE CONFUSION ASSESSMENT METHOD (CAM)*

Feature 1: ACUTE ONSET AND FLUCTUATING COURSE

This feature is obtained from a family member or nurse and is shown by positive responses to the following questions:

- Is there evidence of an acute change in mental status from the patient's baseline?
- Did the (abnormal) behavior fluctuate during the day—that is, tend to come and go, or increase and decrease in severity?

Feature 2: INATTENTION

This feature is shown by a positive response to the following question:

- Did the patient have difficulty focusing attention—for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: DISORGANIZED THINKING

This feature is shown by a positive response to the following question:

- 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?

Feature 4: ALTERED LEVEL OF CONSCIOUSNESS

This feature is shown if any other than "alert" is given to the following question:

- Overall how would you rate this patient's level of consciousness? Alert (normal), vigilant (hyper alert), lethargic (drowsy, easily aroused), stupor (difficult to arouse), or coma (unrousable)?

THE DIAGNOSIS OF DELIRIUM BY CAM REQUIRES THE PRESENCE OF FEATURES 1 & 2 AND EITHER 3 OR 4