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MDS Alert

Clinical Care ~ Use The MDS To Detect Delirium In Real Time

Don't let this medical emergency get the best of your residents.

Delirium is one condition you definitely want to catch now rather than later. And the MDS can help you flag a resident's change in mental status whether it occurs during an MDS assessment window or in between PPS and OBRA-required assessments.

The clinical bottom line:

Delirium is a "medical emergency with high rates of morbidity and mortality" if staff don't treat it appropriately, warns **Sheila Capitosti, RN, BSN,** a consultant with **LTCQ Inc.** in Lexington, MA. But "if you detect delirium in time by identifying and correcting the cause, if possible, you can reverse the condition," reassures **Christine Twombly, RN,** a consultant with **Reingruber & Company** in St. Petersburg, FL. And the MDS provides "the clues the interdisciplinary team needs to identify" delirium, says **Rena Shephard, RN, MHA, FACDONA,** president of **RRS Healthcare Consulting** in San Diego.

Refer to Section B5

"A big key to identifying delirium is to look for acute onset," says **Ann Marie Monahan, RN, MSN,** clinical nurse educator with the practice resource team for mental health and addictions services at the **Vancouver Island Health Authority,** which has developed extensive training materials on delirium.

And a "2" coded at items B5a-f shows a resident has symptoms that can indicate delirium because they are new or worsening. In fact, one or more of the following items and coding trigger the delirium resident assessment protocol (RAP), which provides a comprehensive template for staff to use in investigating the cause of the person's change in cognitive status, mood and behavior:

B5a = 2 Easily Distracted - Difficulty paying attention; gets sidetracked.

B5b = 2 Periods of Altered Perception or Awareness of Surroundings - Moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day.

B5c = 2 Episodes of Disorganized Speech - Speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought.

B5d = 2 Periods of Restlessness - Fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out.

B5e = 2 Periods of Lethargy - Sluggishness, staring into space; difficult to arouse; little body movement.

B5f = 2 Mental Function Varies Over the Course of the Day - Sometimes better, sometimes worse; behaviors sometimes present, sometimes not.

B6 = 2 Deterioration in cognitive status

E3 = 2 Deterioration in mood

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E5= 2 Deterioration in behavioral symptoms.

Delirium or Dementia?

Perhaps the biggest mistake that Twombly sees staff make is that they attribute a resident's change in mental status to dementia rather than delirium. In such cases, they code a "1" at B5a-f for "behavior present, not of recent onset" rather than a "2" (behavior present, represents a departure from resident's usual functioning). "One of the biggest reasons that delirium is so deadly is that healthcare staff often mistake it for dementia," emphasizes Monahan.

Look for this key difference: Monahan notes that "people with dementia will have disorganized thinking, which you also see in delirium. Yet even when someone has dementia, you will "see a level of consistency in their cognitive functioning that you don't see with delirium," Monahan adds. For example, "in a person with Alzheimer's disease, look for acute onset of cognitive change and a fluctuation over 24 hours." The person's mental status will fluctuate from his baseline or presentation to confusion or agitation or not responding at all.

Example of a missed case: One resident taking Remeron as an appetite enhancer developed acute hallucinations, relays Shephard. But the staff didn't know him very well. And even though the man had been oriented to person, time and place for the three weeks he was in the facility, they "attributed the hallucinations to dementia or a normal part of the aging process," says Shephard. The staff did rule out UTI, "as nursing homes are good at investigating UTI as a cause of delirium or behavioral changes." If the resident continued taking the medication and his body didn't adjust to it, he'd be at risk for functional decline, she notes.

Beware The Non-Squeaky Wheel

Keep in mind that delirium comes in two forms: a hyperactive form in which the person becomes agitated, and a hypoactive version, advises Monahan. People with hypoactive delirium appear "withdrawn, apathetic, lacking in motivation and non-responsive," she says. And "those are the folks who more often get missed because they aren't bothering anyone," she says. Or sometimes the care staff may mistake the hypoactive form of delirium for depression.

Key points: When you admit a new resident, obtain a good baseline description of his behavior from family members. If the resident has been in the facility for a while, the CNAs will often know he has had a change in mental status or behavior. But you have to train them to report that to the nursing staff immediately, emphasizes Shephard.

Work the RAP: When you suspect that a resident has delirium, the delirium RAP walks you through potential causes (see "Resident Showing Signs Of Delirium? Check Out These Meds And MDS Items").

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