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MDS Alert

QUALITY OF CARE: Ready, Set: Detect, Address, Prevent Delirium

This care map can help keep residents off a dangerous clinical path.

Delirium is definitely one of those good news, bad news clinical issues. The bad news: Delirium can result in death or ongoing debility if you don't catch it in time to eliminate or treat the underlying cause. Furthermore, delirium can be difficult to detect in its early stages, especially in people with dementia.

The good news: A few keystrategies can help you stay on top of this tricky condition in order to improve resident outcomes and help prevent rehospitalization.

1. Develop an admission delirium assessment protocol. "If the protocol becomes part of an initial assessment, it will eventually become second nature," says **Valerie Cotter, DrNP, CRNP,** director of the adult health nurse practitioner program at the University of Pennsylvania in Philadelphia. "Then you have a baseline to evaluate for change during the person's nursing home stay or if they go back to the hospital and are readmitted" to the nursing facility.

Look for: "Fluctuating states of consciousness, disorientation,decreased environmental awareness, and behavioral changes," directs the RAI User's Manual, Appendix C (Resident Assessment Protocols). Delirium, the manual notes, "usually develops rapidly, over a few days or even hours."

Consider using the Confusion Assessment Method (CAM) as part of the protocol. According to the CAM, a person likely has delirium if he shows an acute change in mental status, a fluctuating course, signs of inattention, and either disorganized thinking or an altered level of consciousness. (For further information and to view the CAM and training manual, go to http://hospitalelderlifeprogram.org/pdf/The_Confusion_Assessment_Method.pdf.)

Better assessment ahead: The MDS 3.0 incorporates the CAM in its delirium assessment (see p. 102 of this newsletter), which should help improve delirium detection once the instrument rolls out on Oct. 1, 2010.

2. Don't be fooled by silence. Nursing homes almost never miss the hyperactive form of delirium because the patient is agitated and may very often experience visual hallucinations, says Cotter. By contrast, someone with the hypoactive form may simply appear tired or depressed and more quiet than usual, she adds. "Yet that type of delirium is just as serious as the hyperactive kind," she cautions.

Key tip: To decide whether a newly admitted resident's mental status and behavior represents a departure from his baseline, ask the family or previous caregivers to describe the resident's functional abilities and behavior before he went to the hospital, advises Cotter.

3. Focus more on high-risk residents. Use the admission assessment protocol to flag residents who are more likely to develop delirium so the team can monitor them more closely. High-risk patients include those "with a pre-existing dementia diagnosis, a neurological condition, such as brain injury or a brain tumor,or anyone who has had delirium before," advises Cotter.

4. Dig deep for the etiology. In many cases, the cause of delirium turns out to be "multi-factorial," cautions Cotter. For starters, look for underlying conditions, such as heart attack, infection (UTI, pneumonia, sepsis, etc.), and fluid and electrolyte disturbances. "Sleep deprivation and overstimulation can also cause delirium," Cotter adds.

In addition, "under-treated pain can be a source of delirium," reminds Cotter. "Perhaps the person used to be on a chronic pain medication that was stopped when he went to the hospital for another problem."

Check the meds: Medications can also cause delirium. For example, one nursing home resident who had been alert and

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oriented started experiencing visual hallucinations of colorful murals on the walls, which terrified him, relays **Rena Shephard, MHA, RN, RAC-MT, C-NE,** president and CEO of RRS Healthcare Consulting Services in San Diego. "The staff explained away his symptoms as being due to the move to the nursing home. It turns out, however, that he was on Remeron [mirtazapine] as an appetite stimulant, which the doctor had increased in dose, and that was what was causing his symptoms," Shephard relays.

Lesson learned: Take a close look at the patient's drug regimen anytime he experiences delirium or a change in condition.

End-of-life tip: "About 70 to 80 percent of people are delirious when near death," says **Mary Lynn McPherson, PharmD, BCPS,** at the University of Maryland in Baltimore. And "sometimes we can reverse or diminish the delirium but other times not," she says.

"The delirium could be reversible if it's triggered by a medication,dehydration or electrolyte imbalance -- for example, hypercalcemia is common in end-stage cancer," says **Azza Ezzat, RN, FNP,** president of Aging WELL family health for palliative and pain consulting services in Staten Island, N.Y.

5. Take steps to prevent delirium. Helping residents develop a normal sleep-wake cycle can head off delirium, advises Cotter. For example, "make an effort not to wake people during the night to give them medications, if possible, and turn down the lights so they can rest." A resident might like a white-noise machine to lull him to sleep.

More tips: Bring familiar objects into the resident's environment, advises Cotter. In fact, surveyors will be focusing on whether the facility does this for all residents, including short-stay ones, based on new quality-of-life survey guidance. Also encourage family members or people whom the resident knows well to visit at the bedside to ease his transition to the nursing home.

And implement a proactive approach to avoid prescribing medications known to cause delirium (see page 104 for details).

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