

OASIS Alert

Assessment: 5 FIELD-TESTED TECHNIQUES TO DETECT & ADDRESS DELIRIUM

Use M1700 to catch your patient's decreased cognitive function in time to turn it around.

Your patient was recently discharged into your care, so any cognitive difficulties -- including disorientation, delirium, or dementia -- would be caught by her physician, right?

Not necessarily, experts warn -- and failing to catch those problems can be deadly.

Bad news: Delirium and other cognitive dysfunctions can result in death or ongoing debility if you don't catch it in time to eliminate or treat the underlying cause, notes **Valerie Cotter**, director of the adult health nurse practitioner program at the **University of Pennsylvania** in Philadelphia. Furthermore, delirium can be difficult to detect in its early stages, especially in people with dementia.

Good news: You can spot and detour any patients you think are on a path toward being dangerous to themselves or others. Use this care map to guide your steps.

1. Look for behavioral clues when assessing M1700. OASIS C gives you the tools to assess patients for delirium or dementia, though the actions you observe may not fall directly in line with the available responses.

For instance, you might see "fluctuating states of consciousness, disorientation, decreased environmental awareness, and other behavioral changes," Cotter points out. But the responses ask about patients needing "some direction" or "considerable assistance."

Do this: To accurately respond, consider why your patient needs assistance. If she is distracted because there are many people in the home or she is exhausted from a long day, you might choose response 1 (Requires prompting [cuing, repetition, reminders] only under stressful or unfamiliar conditions).

However, if the patient can't seem to complete even routine tasks without confusion, you might select 3 (Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time).

Bonus: Supplement your clinicians' delirium and dementia detection skills with tools like the Confusion Assessment Method, which walks clinicians through a series of questions that will help root out any cognitive function weak spots.

For a copy of the tool, email the editor at kellyq@eliresearch.com.

2. Don't be fooled by silence. Your greatest mistake when trying to spot cognitive dysfunction is taking a quiet or silent patient at face value, says Cotter.

The hyperactive form of delirium is easy to see and treat because the patient is agitated. 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 tells **Eli**.

Key tip: To decide whether a patient's mental status and behavior represents a departure from her baseline, ask the family or previous caregivers to describe the resident's functional abilities and behavior before she was under your care, advises Cotter.

3. Remember, some patients are more high-risk than others. Any patient can develop delirium or dementia -- and many

medications come with a side effect of disorientation -- but you should observe certain patients more closely because they are highly likely to develop cognitive problems.

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.

Best bet: Flag these patients as soon as they enter your care and then be sure to inquire regularly as to their mental state. Ask family members or other caregivers to alert you to any behaviors that might indicate the patient is struggling with delirium or dementia.

4. Dig deep for the etiology. While disorientation, delirium, and dementia are frequently seen as underlying mental conditions, these cognitive dysfunctions are often caused by more superficial -- and easy to treat -- problems, Cotter notes. Common causes are "sleep deprivation, overstimulation, and undertreated pain," as well as fluid and electrolyte disturbances, she says.

Medications can also cause delirium. Even the most bizarre and frightening hallucinations could be simply the body's reaction to a new drug regimen, points out **Rena Shephard**, president and CEO of **RRS Healthcare Consulting Services** in San Diego.

Once you've figured out why the patient's cognitive function is decreasing, you can work to reverse it.

5. Head off delirium before it starts. You don't have to wait for a patient's cognitive function to take a turn for the worse to implement some routines that will keep delirium in check, Cotter notes.

For example, clinicians can help establish a normal sleep-wake cycle by encouraging the patient to create a calm environment conducive to sleep at night, such as by investing in a white-noise machine to lull her to sleep.

More tips: Patients who have a morning and evening routine are more likely to maintain a sleep cycle that will stave off delirium. Encourage patients to get out of bed and start their days at the same time each morning and to begin preparing for bedtime at the same time each evening.

Remind them that what they do in the afternoons -- such as drinking lots of caffeine or making late-evening plans -- will affect their ability to get much-needed rest.