Indicators of Delirium—Section B5
The Assessment Process
Sharon Warlick, RN, BA—Director MDS/OASIS

Delirium, often referred to in the past as an acute confusion state, is a common indicator or non-specific symptom of a variety of acute, treatable illnesses. Delirium is a medical emergency, with high rates of morbidity and mortality, unless it is recognized and treated appropriately. Delirium is never a part of normal aging. Some of the classic signs of delirium may be difficult to recognize and may be mistaken for the natural progression of dementia, particularly in the late stages of dementia when delirium has high mortality. Thus, careful observation of the resident’s inattentiveness and review of potential causes is essential. Since delirium is a medical emergency, this will be the focus of this newsletter.

MDS Accuracy Quick Check—Section B5

If these MDS Items are: B5a-f = 1 or 2

- Do your staff know delirium is never a part of normal aging and that persistent or new onset of symptoms should be reported for further assessment?
- Do your staff know psychosocial distress may produce signs of delirium? Do staff observe residents who have been isolated from people, objects or situations, as happens frequently while recuperating from an illness or receiving a treatment, for signs of delirium?
- Do staff know the greater the number of medications, the greater the possibility of adverse drug reaction/toxicity? Do staff, along with physician and pharmacist, review medications to compare benefits versus risks?
- Do staff know restraints often aggravate the conditions staff are trying to treat? Reference: RAI Manual Appendix C, page C5-C10.

Indicators of Delirium—Periodic Disordered Thinking/Awareness, Section B5 of the MDS has a 7-day look back period. The INTENT of Section B5 is to record behavioral signs that may indicate delirium is present. Frequently, delirium is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by rambling.

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Delirium—Section B5
The Assessment Process (continued from page 1)

irrelevant, or incoherent speech. Other behaviors are described in the definitions below.

A recent change (deterioration) in cognitive function is indicative of delirium, an acute confusional state, which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a pre-existing cognitive impairment or pre-existing behaviors such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to find his or her way around the unit may begin to get “lost.”

The DEFINITION for behaviors assessed at Section B5 include the following: a) Easily Distracted—this refers to residents with difficulty paying attention or who get easily sidetracked.

b) Periods of Altered Perception or Awareness of Surroundings—refers to residents observed moving lips or talking to someone not present. It also refers to the resident who believes he/she is somewhere else or confused night and day. c) Episodes of Disorganized Speech—refers to the resident whose speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject or loses their train of thought. d) Periods of Restlessness—describes those residents who are fidgeting or picking at their skin, clothing, napkins, etc.; it also refers to those residents who change positions frequently, have repetitive physical movements or call out. e) Periods of Lethargy refers to residents who (Continued on page 3)

Residents with delirium may believe they are somewhere else or confuse night and day

The MDS Connection
Section B5—Indicators of Delirium

If B5a-f = 2
Then review MDS items
• O4a—Antipsychotic
• O4b—Antianxiety
• O4c—Antidepressant
• O4d—Hypnotic

Have you accurately coded the resident’s medication according to the pharmacological classification and not according to reason for medication? Review medications prescribed around the time of the onset of the indicators of delirium and check a reputable drug book for the medications’ classification. Review side-effects and drug/drug, drug/food, and drug/lifestyle interactions.

Psychotropic medications (antipsychotics, antianxiety, hypnotics, and antidepressants) are among a group of medications that cause delirium. Additionally, a rare but often fatal side-effect of most antipsychotic medications and Phenergan is Neuroleptic Malignant Syndrome.

If your residents receive antipsychotic medications or Phenergan, and you do not know the symptoms of this serious side effect, become familiar with its symptoms and educate staff. It could save a life.

Other drugs causing delirium include: Cardiac, Gastrointestinal, Analgesics, Anti-inflammatory, and over-the-counter drugs such as cold remedies (antihistamines, e.g., Phenergan) pseudoephedrine, Sedatives (antihistamines, e.g., Benadryl), Stay-awakes (caffeine), Antinauseants, and Alcohol

Reference: RAI Manual, Appendix C, pages C5-10
are sluggish, stare into space, who are difficult to arouse or have little body movement. f) Mental Function Varies Over the Course of the Day—refers to those residents who sometimes get better, sometimes worse or whose behaviors are sometimes present, and sometimes not.

As you assess your resident for these indicators, you will code for the resident’s behavior in the last seven days regardless of what you believe the cause to be—focusing on when the manifested behavior first occurred. When assessing your resident, you have the following three coding choices:

0—Behavior not present
1—Behavior present, not of recent onset
2—Behavior present over the last 7 days appears different from resident’s usual functioning (e.g., new onset or worsening).

Successful management depends on accurate identification of the clinical picture, correct diagnosis of specific cause(s), and prompt nursing and medical intervention. Delirium is often caused and aggrivated by multiple factors. Thus, if you identify and address one cause, but delirium continues, you should continue to review the other major causes of delirium and treat any that are found.

Reference: RAI Manual Chapter 3, pages 47-48 and Appendix C, pages C-5—C-10

Nursing Home Goal—
High Practicable Level of Functioning
Stay Informed—Section B5—Indicators of Delirium

Detecting signs and symptoms of delirium requires careful observation. Knowledge of a person’s baseline cognitive abilities facilitates evaluation.

Staff should become familiar with the resident’s cognitive function by regularly observing the resident in a variety of situations so that even subtle but important changes can be recognized.

When observed in this manner, the presence of any trigger signs/symptoms may be seen as a potential marker for acute, treatable illness.

An approach to detection and treatment of the problem can be selected by reviewing items that follow in the order presented in the MDS Section B5. Also refer to the RAP Guidelines in Appendix C of the Resident Assessment Instrument (RAI) Manual for guidance on the relevant MDS items.

Reference: RAI Manual Appendix C, pages 5-10

SCENARIO QUIZ—Section B5—Indicators of Delirium

Mr. D has a history of Alzheimer’s disease. His skills for decision making have been poor for a long time. He often has difficulty paying attention to tasks and activities, more so in late afternoon, when he usually wanders away from tasks. He rarely speaks to others and, when he does, his speech is garbled and the contents are nonsensical. He is often observed mumbling and moving his lips as if he’s talking to someone.

Although Mr. D is often restless and fidgety, this behavior is not new for him and it rarely interferes with a good nights sleep.

How will you code Section B5—Indicators of Delirium—Items a-f?
MDS Automation Tips
Bob Bischoff  Program Manager, MDS/OASIS Automation

Are you delirious for reports?  Try the One Stop Shop.

These reports are automatically placed with your validation reports monthly between the 5th and the 7th day of each month. These reports are a definite “must review” if you are new with your facility, or if you have never reviewed these reports. The following are the report codes, names, and a brief overview:

<table>
<thead>
<tr>
<th>Report Code</th>
<th>Name</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR122006.txt</td>
<td>Activity report</td>
<td>Assessments/Tracking records received 12-2006.</td>
</tr>
<tr>
<td>DR122006.txt</td>
<td>Discharged without return</td>
<td>Lists all discharge records received with discharge dates of 12-2006.</td>
</tr>
<tr>
<td>MR122006.txt</td>
<td>Missing assessment report has</td>
<td>All residents whose last assessment date is greater than 138 days.</td>
</tr>
<tr>
<td>QR122006.txt</td>
<td>Questionable new resident</td>
<td>The residents first record received is not an admission assessment.</td>
</tr>
<tr>
<td>RR122006.txt</td>
<td>Roster report</td>
<td>Lists all residents appearing as active in the state database.</td>
</tr>
<tr>
<td>CR122006.txt</td>
<td>Changes to resident identifiers</td>
<td>Lists all residents that have different resident identifiers from last assessment/ tracking record received.</td>
</tr>
<tr>
<td>AD122006.txt</td>
<td>New admission report</td>
<td>Lists all admission assessments received for 12-2006.</td>
</tr>
</tbody>
</table>

The report codes will change monthly. The next reporting month will be reflected as AR012007.txt (i.e. January 2007).

Test vs. Production Final Validation Report

<table>
<thead>
<tr>
<th>CMS State Report</th>
<th>MDS Final Validation Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Report Date/Time]</td>
<td>12/30/2006 08:59:32</td>
</tr>
<tr>
<td>[Batch Status]</td>
<td>RECEIVED</td>
</tr>
<tr>
<td>[Submission Date/Time]</td>
<td>12/30/2006 08:59:20</td>
</tr>
<tr>
<td>[Submission Batch ID]</td>
<td>999999</td>
</tr>
<tr>
<td>[Batch Submission Type]</td>
<td>Test</td>
</tr>
<tr>
<td>[Facility ID]</td>
<td>NH9999</td>
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<tr>
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<td>Fair Care NH</td>
</tr>
<tr>
<td>[# records Processed]</td>
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<tr>
<td>[Duplicate Records]</td>
<td>5</td>
</tr>
<tr>
<td>[# 0_0 Records]</td>
<td>2</td>
</tr>
<tr>
<td>[# Records with Messages]</td>
<td>65</td>
</tr>
<tr>
<td>[Total # of Messages]</td>
<td>110</td>
</tr>
</tbody>
</table>

Reminder: Ensure that all your records are transmitted in Production mode. Records submitted in Test mode do not upload to the State database. Contact the Helpdesk with questions related to this.

Automation Tip: Security & Safeguards

When selling, donating, or disposing of your MDS computer, ensure that the hard drive and any software have been totally cleared of all resident identifiable information.

Answer: Scenario—Section B5

B5a—Easily Distracted 1
B5b—Periods of altered perception or awareness of surroundings = 1
B5c—Episodes of disorganized speech 1
B5d—Periods of restlessness = 1
B5e—Periods of lethargy = 0
B5f—Mental function varies over the course of the day = 1

Rationale:
Mr. D. has had difficulty paying attention to tasks & activities for a long time. He mumbles to himself, moves his lips as if talking to someone and is often restless and fidgety. These behaviors are not new which the code 1 represents.

No lethargy was described in the scenario and, therefore is (0) (behavior not present).

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