The Critical Vital Sign of Cognitive Health and Delirium
Whose Responsibility Is It?

A few years ago, I was giving a lecture in a local retirement community on cognitive aging and delirium, and in the audience that day were long-term care staff and residents of the facility. I was speaking about delirium recognition, prevention, and management, and my colleague was illustrating exercises and activities for cognitive stimulation and brain health. As we spoke, I noticed what looked like an older woman in a wheelchair and a younger woman sitting in the front row listening attentively. When we finished the presentation, the two women were in line behind several people, waiting patiently to talk to me as staff members asked questions.

When it was their turn, the daughter looked at me with serious eyes and said with emotion and relief in her voice:

I am so glad that we came here today and I want to thank you because this is the first time I've ever heard someone talk about delirium and delirium superimposed on dementia, and now I realize that this is what my mother had when she was in the hospital.

She went on to tell me that her mother had been in the local hospital after a fall at the assisted living facility, and she was diagnosed with pneumonia and dehydration. The daughter stated that her mother was different than her usual self during her time in the hospital: she was very confused, could not remember things, did not even recognize her daughter at times, was restless, was trying to get out of bed, and appeared frightened much of the time. The daughter said that this was not her mother’s usual behavior and she was upset to see her this way.

The daughter ended by telling me that her mother had gotten much better and less confused after being discharged from the hospital and began doing even better in the following days and weeks, which is important knowledge in understanding whether her mother was experiencing acute confusion (i.e., delirium versus something else). Although her mother was not completely back to normal yet, she was almost herself again. What was most important and telling about this encounter was that her mother, Teresa (pseudonym), then began to speak with tears in her eyes, telling me about an incident during the hospitalization in which she was being transported to physical therapy in a wheelchair and a piece of paper was in her lap regarding physical therapy instructions with the words “patient has dementia” written at the top. Teresa and her daughter said no one had talked to them about the confusion or told Teresa she had dementia. Of course, this is just one side of the story and perspective—but a very important side. It is possible Teresa may have had some cognitive impairment,
as we do not know her full medical history or cognitive baseline (which, by the way, are things that most of those reading this probably do not have documented). However, based on the daughter’s description of Teresa acting differently from her baseline mental status and then getting better, Teresa most likely had delirium. So, whose responsibility is it to assess for, prevent, and manage delirium, and how can we help?

Health professionals and caregivers may not report delirium, as they may be unsure they can do anything about it, think it might go away on its own without harm occurring, or not have enough time (Yevchak et al., 2012). Evidence shows that delirium and delirium superimposed on dementia lead to poor patient outcomes and patient suffering, and thus should not be ignored with the mindset that it, think it might go away on its own without harm occurring, or not have enough time (Yevchak et al., 2012). Evidence shows that delirium and delirium superimposed on dementia lead to poor patient outcomes and patient suffering, and thus should not be ignored with the mindset that they will go away (Fick & Foreman, 2000; Fick, Steis, Waller, & Inouye, 2013; Oh, Fong, Hshieh, & Inouye, 2017). A study by Morandi et al. (2012) analyzed the delirium experience in 30 older adults and found that even older adults with moderate and severe dementia were able to describe the episode of delirium; recalled being restrained; and reported feeling anxiety, fear, anger, and shame. More than one half of individuals with dementia in the study by Morandi et al. (2012) recalled being confused.

These studies provide evidence that delirium leads to human suffering, and, importantly, a 2015 report by the Institute of Medicine recommended prevention of delirium as important for improving overall cognitive health (Fick, 2016). Yet, when asked, many providers say they do not routinely assess for delirium in their health system (Morandi et al., 2012). Many assessment tools are available to assess for delirium and delirium superimposed on dementia. Currently, I am part of a team that is pilot testing a 36-second screen for delirium that has more than 90% sensitivity to detect delirium and delirium superimposed on dementia and can be performed easily by nursing assistants, RNs, and physicians (Fick et al., 2015; Fick et al., 2018). The Hospital Elder Life Program website also has resources for screening and diagnosing delirium and for family members and patients (access https://www.hospitalelderlifeprogram.org).

Although nurses are at patients’ bedsides and play a key role in assessment and prevention of delirium, assessment and prevention also require a team approach, organizational and administrative support for taking changes in mentation seriously, and cooperation—rather than competition—between disciplines. As nurses, we already routinely assess many organs at the bedside with vital sign measurements (e.g., blood pressure, lung function), so do not be afraid to say the word delirium and do not apologize for assessing the brain using cognitive screens and assessments when needed.

Finally, nurses also know that we can take steps to better prevent and manage delirium, so ignoring it or allowing it to occur untreated in our health systems can no longer be the norm. Evidence strongly suggests that prevention of delirium is better than management after it occurs, so if health systems decide to assess for delirium, assessment should be paired with delirium prevention bundles on topics such as daily mobility, hydration, avoidance of central nervous system–active medications, and caregiver support (Hshieh et al., 2015; Oh et al., 2017). The good news is that several resources and initiatives exist to assist health systems in providing delirium prevention and quality care for older adults (Table 1 and Table 2).

The Age-Friendly Health Systems (AFHS) model focuses on the “4Ms” of (1) What Matters, (2) Mobility, (3) Medications, and (4) Mentation (i.e., delirium, dementia, and depression). This model is both evidence-based and practical for putting in place across settings of care. All of

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**TABLE 1**

**TIPS FOR BEDSIDE DELIRIUM CARE**

- Ask about older adults’ preferences and goals when addressing delirium prevention and care
- Document cognitive strengths and abilities (not just deficits) in health record
- Remember delirium is common in older adults with dementia and leads to poorer outcomes if not recognized
- Always have a prevention plan in place when screening for delirium
- Assess for common causes of delirium (e.g., infection, dehydration, medications, acute illness, pre-existing cognitive impairment)
- Consider highlighting World Delirium Day every March 14 with delirium awareness activities
- Delirium care is good care, so consider working with health system administrators to illustrate the evidence for cost savings and quality for prevention of delirium

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**TABLE 2**

**WEBSITE RESOURCES FOR DELIRIUM EDUCATION, CARE, AND RESEARCH**

- iDelirium.org
- ICUdelirium.org
- americandeliriumsociety.org
- ihi.org
- hospitalelderlifeprogram.org
- deliriumnetwork.org
- deprescribing.org
the Ms interact to improve care; for instance, mobility and decreasing inappropriate medications are critical in preventing delirium (Pelton, Fulmer, Hendrich, & Mate, 2017). Understanding and acting on what matters to older adults provides guidance for the care of individuals with or at risk for delirium. The AFHS currently has a call for health systems to join their Action Community. Information on the AFHS and the Action Community can be found online (access http://www.ihi.org).

To conclude, let us use a team approach, consider brain health a vital sign, and make it everyone’s responsibility to care about delirium and support prevention and management of delirium in older adults. Good delirium care is good care.

REFERENCES


Donna M. Fick, PhD, RN, FGSA, FAAN
Editor

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