CARE PATH
Symptoms of Acute Mental Status Change

New Mental Status Change Noted
• New symptoms or signs of increased confusion (e.g. disorientation, change in speech)
• Decreased level of consciousness (sleepy/lethargic)
• Inability to perform usual activities (due to mental status change)
• New or worsened physical and/or verbal agitation*
• New or worsened delusions or hallucinations*
• Unresponsiveness
• New or worsened memory loss

Take Vital Signs
• Temperature
• BP, pulse, apical HR (if pulse irregular)
• Respirations
• Oxygen saturation
• Finger stick glucose (diabetics)

Vital Sign Criteria (any met?)
• Temp > 100.5°F
• Apical heart rate > 100 or < 50
• Respiratory rate > 28/min or < 10/min
• BP < 90 or > 200 systolic
• Oxygen saturation < 90%
• Finger stick glucose < 70 or > 300
• Resident unable to eat or drink

Evaluate Symptoms and Signs for Immediate Notification**
• Not eating or drinking
• Acute decline in ADL abilities
• New cough, abnormal lung sounds
• Nausea, vomiting, diarrhea
• Abdominal distension or tenderness
• Edema
• New or worsened incontinence, pain with urination, blood in urine
• New skin condition (e.g. rash, redness suggesting cellulitis, signs of infection around existing wound/pressure ulcer)
• Unrelieved pain
• New irregular pulse

Consider Contacting MD/NP/PA for orders (for further evaluation and management)
• Portable chest X-ray
• Urinalysis and C-s (if indicated)
• Blood work (Complete Blood Count, Basic Metabolic Panel)
• EKG

Tests Ordered

Evaluate Results
• WBC > 14,000 or neutrophils > 90%
• Infiltrate or pneumonia on chest X-ray
• Urine results suggest infection and symptoms or signs present
• EKG results show new changes suggestive of MI or arrhythmia

Notify MD / NP / PA

Monitor Response
• Vital signs criteria met
• Worsening condition and/or immediate notification criteria met

Manage in Facility
• Monitor vital signs, fluid intake/urine output every 4-8 hrs
• Oral, IV or subcutaneous fluids if needed for hydration
• Check results of urinalysis and culture (if ordered)
• Non-pharmacological interventions for delirium *
• Pain management
• Update advance care plan and directives if appropriate

* Refer also to the INTERACT Behavior Change Care Path
** Refer also to other INTERACT Care Paths as indicated by symptoms and signs