Acute Mental Status Change Cheat Sheet

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New Mental Status Change Noted

New symptoms or signs of increased confusion

(e.g. disorientation, change in speech)

- ☐ Decreased level of consciousness
- ☐ Inability to perform usual activities (due to mental status change)
- ☐ New or worsened physical and/or verbal agitation*
- ☐ New or worsened delusions or hallucinations*

Take Vital Signs

- ☐ Temperature
- ☐ BP, pulse, apical HR (if pulse irregular)
- ☐ Respirations
- ☐ Oxygen saturation
- ☐ Finger stick glucose (diabetics)

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Vital Sign Criteria (any met?)

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- ☐ Apical heart rate > 100 or < 50
- ☐ Respiratory rate > 28/min or < 10/min
- ☐ BP < 90 or > 200 systolic
- ☐ Oxygen saturation < 90%

Further Nursing Evaluation

- ☐ Mental Status
- ☐ Functional Status
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Gastrointestinal/abdomen
- ☐ Genitourinary
- ☐ Skin
- ☐ Consider IV or subcutaneous fluids
- ☐ Update advance care plan and directives if appropriate

Evaluate Symptoms and Signs**

- ☐ Not eating or drinking
- ☐ Acute decline in ADL abilities
- ☐ New cough, abnormal lung sounds
- ☐ Nausea, vomiting, diarrhea
- ☐ Abdominal distension or tenderness
- ☐ New or worsened incontinence, pain with urination, blood in urine

Manage in Facility

- ☐ Monitor vital signs, fluid intake/urine output every 4-8 hrs for 24-72 hrs
- ☐ If on diuretic, consider holding
- ☐ Offer frequent small fluids (2-4 oz q 2h)
- ☐ If on tube feeding, give more water with flushes