



A better way to care

Safe and high-quality care for patients with cognitive impairment or at risk of delirium in acute health services
Second edition

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Introduction

The **National Safety and Quality Health Service (NSQHS) Standards**¹ were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of healthcare provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The Commission has worked closely with partners to review the NSQHS Standards and develop the second edition, embedding person-centred care and addressing the needs of people who may be at greater risk of harm. This includes patients with cognitive impairment or who may be at risk of developing delirium.

The new **Comprehensive Care Standard**² includes two specific cognitive impairment actions on preventing delirium and managing cognitive impairment (5.29 and 5.30). The **Recognising and Responding to Acute Deterioration Standard**³ now includes acute deterioration in mental state (8.5).

People with cognitive impairment may have problems with memory, communication or thinking that can be temporary or long term. Although cognitive impairment is not a normal part of ageing, it is common in hospitalised older patients, with dementia and delirium the most frequent causes. Patients with dementia or delirium are at increased risk of preventable complications and adverse events, such as falls and pressure injuries, and require additional care to prevent harm.

Cognitive impairment is not confined to older people and can result from various causes. People might be cognitively impaired due to younger onset dementia, delirium due to a critical illness, an acquired brain

injury, a stroke, a medical condition, a psychiatric condition, intellectual disability or drug use. Any form of cognitive impairment needs to be recognised, the causes of it understood, any risks of harm identified, and action taken to minimise risks.

However, cognitive impairment is often not identified or the risks of harm are often under-recognised or dismissed. Some of the complications and adverse outcomes associated with cognitive impairment are preventable, and harm could be minimised if cognitive impairment is identified early and action taken to address the associated risks.

Purpose

This resource describes a pathway to improve the early recognition of, and response to, patients with cognitive impairment to reduce harm and ensure they receive safe and high-quality care. The resource is for clinicians and for each step of the pathway there are actions clinicians can take to improve care for their patients with cognitive impairment.

Implementation of the pathway will contribute to creating a safe and caring culture where clinicians are aware of the needs of patients with cognitive impairment, and take action to address these needs.

This resource consolidates evidence-based actions from a range of existing guidelines and resources, and reflects good practice already underway in many hospitals across Australia. The links listed under 'Where do I go for more information?' provide clinicians with the opportunity to learn more about each of the steps in the pathway.

This is the second edition of the resource, and it has been updated to align with the second edition of the NSQHS Standards. The key steps in the pathway are consistent with the cognitive impairment actions described in the **NSQHS Standards Guide for Hospitals**.⁴

Clinical governance

While safety and quality outcomes are highly dependent on the skills, knowledge and performance of individual clinicians, they are also an organisational responsibility. Clinicians work within and are supported by well-designed clinical systems. They are supported and supervised to develop the right knowledge, skills and attitudes and to understand their roles, responsibilities and accountabilities to provide safe and high-quality care. These processes form part of the clinical governance requirements of a health service organisation.

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes.⁵ It ensures that the community and health service organisation can be confident that systems are in place to deliver safe and high-quality care, and continuously improve services. Clinical governance ensures that everyone – from frontline clinicians to managers to members of governing bodies – is accountable for their contribution to the safety and quality of care delivered to patients.

Good health outcomes rely on effective governance and management processes and the establishment of safety and quality systems that form the basis of a clinical governance framework. The Commission has developed the National Model Clinical Governance Framework⁵ that is based on the Clinical Governance and Partnering with Consumers Standards from the [NSQHS Standards](#).

How to use this resource

While available to download and print, this resource has been designed to be viewed electronically. It incorporates links to external websites and will be updated as required.

It is complemented by two other resources that are specifically focussed on cognitive impairment:

- [NSQHS Standards User guide for health services providing care for patients with cognitive impairment or at risk of delirium](#)⁶, which is a more detailed resource for health service organisations that outlines the specific cognitive impairment actions in the second edition of the NSQHS Standards, additional actions that are critical to support implementation, and further supporting actions in the NSQHS Standards.
- [Delirium Clinical Care Standard](#)⁷, which provides guidance to consumers, clinicians and health services on delivering appropriate care to people at risk of, or with, delirium.

Other implementation guides for the NSQHS Standards are available on the [Commission's NSQHS Standards microsite](#).⁸

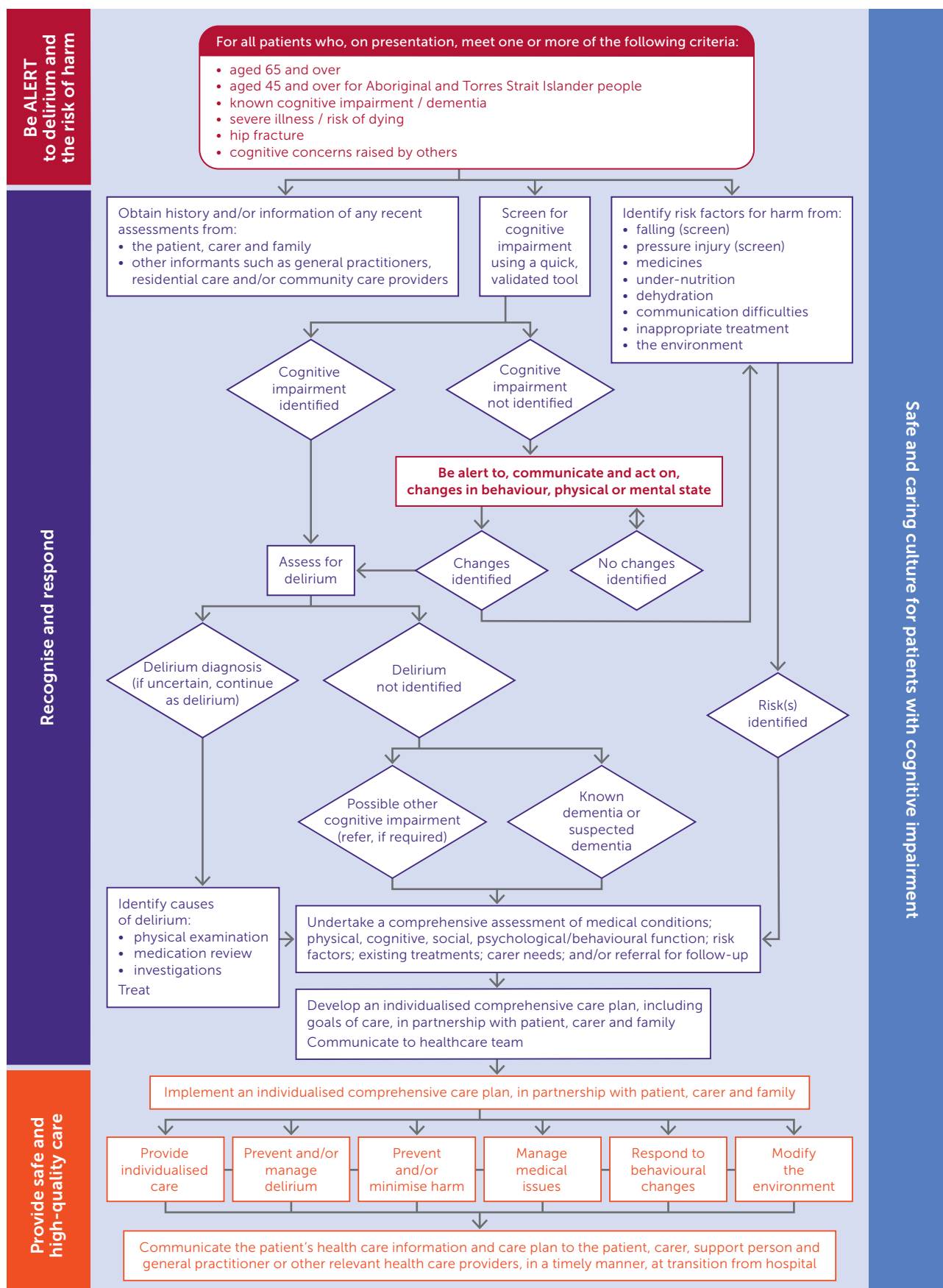
The pathway and key steps

The safety and quality pathway for patients with cognitive impairment (Figure 1) and the key steps within the pathway are summarised on the following pages. It should be noted that the steps may not be linear and some will occur at the same time as others. For example, while investigating the cause of delirium, it is also important to take action to keep a patient safe from harm. The pathway also does not preclude an immediate response to urgent need.

More detail about each step is included in the remainder of this resource. Each step is structured to provide information about:

- Why the step is important to improve outcomes and the safety and quality of care
- Whether there are particular groups of patients who should be the focus of concern
- Strategies and actions that can be applied to improve care and outcomes
- What each step in the pathway means for clinicians and the way they work
- The experiences of patients and carers, highlighting things that went well and what could have been done better
- Resources that provide more information.

Figure 1: Safety and quality pathway for patients with cognitive impairment or at risk of delirium



Key steps in the pathway

1

Be alert to delirium and the risk of harm for patients with cognitive impairment

Clinicians are alert to delirium and the risk of harm from cognitive impairment among patients who:

- Are aged 65 years and over (or aged 45 years and over for Aboriginal and Torres Strait Islander people)
- Have a known cognitive impairment or a formal diagnosis of dementia
- Have a severe illness or are at risk of dying
- Have a hip fracture.

Clinicians are also alert when a patient, carer, family member or other key informant raises concerns about cognitive function.

Clinicians understand the concepts of capacity, informed consent and substitute decision-making.

2

Recognise and respond to patients with cognitive impairment

A patient identified as at-risk is screened for cognitive impairment. The patient's history is obtained from the patient, carer, family member, support person or other key informants.

A patient's risk of harm from surgery, falls, pressure injuries, medicines, under-nutrition, dehydration, communication or comprehension difficulties, inappropriate treatment or the environment is identified. Urgent action is taken for patients at immediate risk of harm.

A patient with cognitive impairment is supported to understand and participate in healthcare decisions. The person they may choose as a support person is identified. Their informed consent is obtained. If the patient is assessed as unable to provide consent, their substitute decision-maker is consulted.

A patient with cognitive impairment is assessed for delirium. If delirium is present, causes are investigated and treated. If uncertain, the patient's condition is treated as delirium. Information is provided to the patient, carer, family member or other support person.

Any change in a patient's behaviour, or physical or mental state is acted on. If changes are observed, the patient is re-assessed for delirium and other risk factors.

A comprehensive assessment of the patient is undertaken. Their values, needs and preferences are taken into consideration.

If undiagnosed dementia or another forms of cognitive impairment is suspected and a comprehensive diagnostic process is not appropriate, the patient is referred for further assessment and follow-up after discharge.

A comprehensive care plan is developed in partnership with the patient, carer, family member, support person or substitute decision-maker, in line with the patient's needs and preferences. The comprehensive care plan is documented and communicated to the healthcare team.

3

Provide safe and high-quality care tailored to the patient's needs

The patient's comprehensive care plan is implemented as follows:

- The patient receives person-centred care in partnership with the patient, carer, family or other support person, in line with the patient's needs and preferences
- A patient's carer, family member or other support person is supported when they choose to be involved in the person's care
- The patient's medical issues are managed, including treating the underlying causes of delirium, presenting condition and any co-morbidities. Medication reconciliation and review are undertaken
- A patient with, or at risk of developing, delirium has strategies implemented to limit its duration and prevent delirium from occurring
- A patient with identified safety risk factors has strategies implemented to prevent and manage the risks
- A patient with behavioural changes is appropriately assessed and strategies are introduced to reduce distress. Antipsychotic or other psychoactive medicines are avoided unless non-pharmacological interventions have been ineffective, the patient is severely distressed or the patient is at immediate risk of harm to themselves or others
- The clinical environment is modified to provide safe and supportive patient care
- The patient's healthcare information and care plan, including medication changes, are documented and communicated to the patient, carer, family member, support person or substitute decision-maker, general practitioner and relevant healthcare providers in a timely manner and in sufficient detail, particularly at transition from hospital care.





Step 1:

Be alert to delirium and the risk of harm for patients with cognitive impairment

Why is this important?

Although cognitive impairment is not a normal part of ageing, it is common in hospitalised older people. Dementia and delirium are common forms of cognitive impairment among older people admitted to hospital. Around 20% of people aged 70 years and older who are admitted to hospital have dementia and the rate increases with increasing age. Another 10% are admitted with delirium and a further 8% will develop delirium during their hospital episode.⁹

Delirium rates are higher in settings such as intensive care units and surgical wards where people are sicker and exposed to more hospital-related interventions. For example, rates of delirium in older people after cardiac and orthopaedic surgery are reported to be just over 50%^{10, 11, 12} and 23% after vascular surgery.¹³

Cognitive impairment is not confined to older people and can result from various causes. People might be cognitively impaired due to younger onset dementia, an acquired brain injury, a stroke, a medical condition, a psychiatric condition, intellectual disability or drug use.

Aboriginal and Torres Strait Islander people living in remote, rural, regional and urban areas have higher rates of dementia and at younger ages; this is most commonly Alzheimer's disease.^{14, 15} Well-designed studies in remote and urban Aboriginal and Torres Strait Islander populations found that dementia due to alcohol abuse was relatively uncommon.¹⁴

Temporary or permanent cognitive impairment can impede a person's ability to provide informed consent, follow instructions, attend to self-care needs and find their way.

Older patients with cognitive impairment are at greater risk of falling, developing a pressure injury, becoming more cognitively impaired, developing functional decline, losing their independence and dying than those who are not cognitively impaired.¹⁶ An older person with dementia has a five-fold increased risk of developing delirium while in hospital compared with those without dementia.¹⁷ Patients of all ages with intellectual disability can also experience poorer outcomes.¹⁸

Delirium can be an indicator of a serious, underlying illness and can have lasting, serious consequences. Delirium may alter the clinical course and trajectory of cognitive decline,^{19, 20} and is associated with poorer long-term outcomes in people who already have both physical and cognitive impairments.^{17, 21, 22}

Some of the risks of harm, complications and adverse outcomes associated with cognitive impairment are preventable, and harm could be minimised if cognitive impairment is identified early and risks acted upon.²¹ Unfortunately, cognitive impairment is under-identified in Australian hospitals.²³ In older patients, delirium can be mistaken for dementia and consequently dismissed.²⁴

Who should I be concerned about?

You need to be concerned about patients who may have cognitive impairment, and who are at risk of harm or developing delirium.

Patients with cognitive impairment will have difficulties with memory, and problems with communication, attention, thinking and judgement. These issues can affect their capacity to function in a hospital environment and consequently place them at increased risk of harm.

Patients who are at greater risk of developing delirium include patients:

- Aged 65 years or older
- With known cognitive impairment or diagnosed dementia
- With a hip fracture
- Who are severely ill or at high risk of dying.²⁵

Be alert to delirium and the risk of harm when concerns are raised through:

- Your own observations. The key signs to look for are that the patient:
 - cannot answer your questions
 - is inattentive or easily distracted
 - has disorganised thinking
 - has an altered level of consciousness
 - is agitated
 - is overly sleepy, which may indicate hypoactive delirium
- A carer, family member or other support person. If an informant, such as a carer, family member or other support person accompanying the patient mentions confusion, ask 'Do you think the person has been more confused lately?'²⁶ Recent onset of confusion is an important indicator of delirium.
- Documentation from the patient's general practitioner or residential or community care provider, or previous records and assessments that mention dementia, delirium or confusion.

What should I do?

Know which patients you should be concerned about

How do I do it?

- Think of cognition as another vital sign.
- As part of a collaborative multidisciplinary team, work out which patients would benefit from ongoing monitoring and who is responsible for this monitoring.
- Understand the importance of identifying delirium, and the difference between delirium, dementia and other forms of cognitive impairment.
- Understand that delirium can be superimposed on dementia or other forms of cognitive impairment and can be persistent, but is still potentially reversible. Monitor patients with cognitive impairment for changes in their mental state.
- Know who is at risk.
- Be alert to, monitor, communicate and act on any changes in behaviour, physical or mental condition.
- Be alert to, and respond to, concerns regarding cognitive function that are raised by any source.
- Know that reduced mobility and movement, slow responses and withdrawal can be hypoactive delirium.
- Listen to carers, family members and other support people. They usually know if a person is cognitively impaired, whether it is an existing, diagnosed dementia, or if the person's cognitive function has recently or suddenly worsened. However, they are often not asked about this, or their concerns are dismissed.

Understand the risks associated with cognitive impairment

How do I do it?

Know that patients with cognitive impairment are at higher risk of harm from:

- Falls
- Pressure injuries
- Medicines
- Under-nutrition
- Dehydration
- Communication difficulties
- A confusing or disturbing environment
- Inappropriate treatment.

Understand the importance of managing these risks appropriately (see Step 3 on page 27).

Understand the concepts of capacity, informed consent and substitute decision-making

How do I do it?

- Always presume a person has capacity. Under common law, adults are presumed to have the capacity to make all their own decisions.
- Find out whether the person has made provision for somebody else to make relevant decisions on their behalf, or if an order of a tribunal or court exists to the same effect.
- Do not make assumptions that a person lacks capacity because of their age, appearance, disability or behaviour. A person's capacity should be assessed on their decision-making abilities.
- Assess a person's decision-making ability – not the decision they make. A person cannot be assessed as lacking capacity just because a decision may appear to others as being unwise, reckless or wrong. However, if a person appears to be making a decision against their own interest, careful consideration to their capacity should be given.
- Understand that capacity is decision specific. Apply the presumption of capacity to every decision. If a person can make some but not all decisions, then they have a right to make those decisions.

- Understand that capacity is fluid. A person's capacity can fluctuate over time or in different situations, so whenever there is doubt about a person's capacity, their capacity should be assessed for each decision.
- Respect a person's privacy. In most cases, individuals must give their prior consent to personal information being collected about them or provided to others. Personal information should only be used for purposes relevant to the capacity assessment.

Use substitute decision-makers as a last resort. Before lack of capacity is determined, everything possible should be done to support individuals to make their own decisions, including identifying any support people a person wants involved in communications and decision-making about their care. When a person is assessed as not having capacity, follow the guardianship legislation in your state or territory to consult their substitute decision-maker.

Helpful hints

- Be aware that the unfamiliar environment of a hospital will appear strange, noisy, over-stimulating and confusing to a patient with cognitive impairment. Anxiety and depression can also impact on a person's experience of the environment.
- A patient with cognitive impairment may feel overwhelmed by different faces and multiple instructions, and may not be able to make sense of what is happening. For example, verbal information such as, 'Mrs B, I'm your nurse and I'm going to take you to the shower. First, I would like to take your vital signs and then I need to give you your medicines, plus get your clothing ready' may be overwhelming and confusing. This kind of information should be broken down and conveyed step by step as needed.
- Be aware that a relatively simple task such as locating the toilet may be difficult.

■ Step 1: Be alert to delirium and the risk of harm for patients with cognitive impairment

What does 'being alert' mean to me?

- I understand that cognitive impairment is not a normal part of ageing, but is common in older hospitalised patients, with dementia and delirium being the most frequent causes.
- I also understand that cognitive impairment is not confined to older people and can have a variety of causes.
- I am alert to increased risk of harm for all patients with cognitive impairment.
- I am aware that patients with cognitive impairment may need additional assistance.
- I understand my responsibilities to obtain informed consent from patients and to support them to make their own decisions. I understand that if this is not possible I should consult a substitute decision-maker.



Patient story 1

The following story and Table 1 illustrate how the care of a patient with cognitive impairment can be improved.

Mrs A is aged 80 years and presented unaccompanied via ambulance to the emergency department (ED) after being found in a garden with a large laceration to her forehead. Handover from the ambulance officer suggested that she had some 'confusion'.

She informed the clinicians that she couldn't remember the fall. She told them that she lived alone and did her own cooking, shopping and personal care. She appeared somewhat unkempt in appearance but clinicians put that down to her working in the garden. She was unable to provide clinicians with contact details of her daughter, whom she said 'lives a long way away'.

She remembered that she has a 'normal doctor' but could not remember the name. She informed clinicians that the doctor's name was probably in her handbag and gave permission for them to have a look. The ED doctor discovered that her medicines were in her handbag and included aspirin and amlodipine. The prescribing general practitioner (GP) was contacted and informed clinicians that Mrs A was a widow and appeared well except for some hypertension; however, she hadn't seen her for many months.

The GP stated that because of Mrs A's age, she was offered a 75-plus assessment, with a view to potentially providing her with some home-care assistance, but Mrs A refused because she didn't want other people in her home. Mrs A's daughter's contact details were obtained from the GP.

On examination, Mrs A had a significant symptomatic postural hypotension and dehydration, which responded to intravenous fluids. The doctor documented that she had 'no confusion now'. Her daughter was advised by the ED doctor that she was being admitted to the hospital to 'keep an eye on her suspected head injury and blood pressure'.

Following suturing of her wound, Mrs A was admitted for overnight head injury and blood pressure observations. A scheduled computerised tomography scan (CT) needed to be delayed to the following evening and, therefore she was kept in hospital another night and moved wards. No cognitive assessments were undertaken. During the following day, nurses documented that she was 'not quite right' and displayed some 'confusion'. Consequently, her head injury observations were continued. On the second night, she kept calling out and couldn't remember how to use the buzzer.

She continued to get 'distressed'. She climbed out of bed to go to the toilet but fell over and sustained a hip fracture.

Step 1: Be alert to delirium and the risk of harm for patients with cognitive impairment

Table 1: Patient story 1 summary – outcomes and suggested improvement strategies

What did not go well?	What went well?
No cognitive screening	ED staff alerted to 'confusion' by ambulance officer
Because cognitive impairment was not recognised, the baseline history may be inaccurate. For example, her self-reported pre-admission ability regarding activities of daily living may have been inaccurate	Prescribing GP contacted
Previous 'confusion' may have been an indicator of cognitive impairment (acute or long-standing) rather than a possible head injury	Daughter contacted and informed of mother's hospitalisation
An underlying delirium may have been missed and consequently the underlying health problem not investigated and treated	Appropriate management of primary presenting problems
Changing of wards increased confusion and disorientation	What could have been done better?
No response to documented deterioration	Recognising cognitive impairment earlier because policies and procedures for cognitive impairment recognition were in place and clinicians were trained and informed of their use
No response to Mrs A's increasing distress, or 'calling out' due to 'not remembering how to use the buzzer'. Mrs A may have been becoming more distressed because she wanted to go to the toilet	Investigating cognitive impairment further because clinicians were alert to the risk of delirium, and there were recognition and response triggers in place
	Engaging daughter in providing a history, including medicines
	Providing better nursing supervision of care and patient comfort
	Avoiding as many ward moves as possible

Where do I go for more information?

Understanding of cognitive impairment and risks of harm

Commission resources

- [NSQHS Standards microsite](#)²⁷
- [Delirium Clinical Care Standard](#)⁷
- [Caring for Cognitive Impairment campaign](#)²⁸
- [Dementia infographic](#)²⁹
- [Delirium infographic](#)³⁰
- [Be Alert to Delirium: webinar](#)³¹

Other resources

Under [resources/information a-z](#)³², on the ACSQHC cognitive care website go to:

- Aboriginal and Torres Strait Islander resources
- Brain injury resources
- Culturally and linguistically diverse resources
- Intellectual disability resources
- Lesbian, gay, bisexual, transgender and intersex (LGBTI) resources.

Programs

Go to [programs](#)³³ under resources/programs and policies on the ACSQHC cognitive care website.

Online courses

Go to [online learning](#)³⁴ under resources / online learning on the ACSQHC cognitive care website.

Clinical networks

Go to clinical networks under [resources/information a-z](#)³² on the ACSQHC cognitive care website.

Resources for consumers

Go to consumer information under [resources/information a-z](#)³² on the ACSQHC cognitive care website.





Step 2:

Recognise and respond to patients with cognitive impairment

Why is this important?

Sometimes it is hard to detect cognitive impairment. Delirium is often missed.^{35–37} Many patients with cognitive impairment have not been formally diagnosed and may not say that they are having cognitive difficulties, because it is unlikely to be the reason for their admission.

Patients with cognitive impairment are at greater risk of harm from falling, pressure injuries, medication-related problems, under-nutrition, dehydration, communication difficulties and inappropriate treatment. They may decline cognitively and functionally.

If you recognise cognitive impairment, you are able to assess and provide for a patient's additional care needs, which will then minimise their risk of harm.

Patients with cognitive impairment, such as dementia, are at the greatest risk of developing delirium during their hospital stay. Changes in their behaviour, physical condition or mental state can be mistakenly attributed to their dementia and not investigated, leading to poor outcomes. Depression, dementia and delirium do have some common features and need to be differentiated. Hypodelirium, where a patient may be quiet, withdrawn and slow to respond is common and is often overlooked. If you diagnose delirium early, you can investigate and treat the underlying cause. You may decrease its severity and reduce its long-term impact.

If you identify patients at risk of delirium, you can introduce strategies to prevent delirium from developing.³⁸ Delirium is preventable in 30–40% of cases. Successful multi-component interventions to prevent delirium include reorientation, therapeutic activities, reduction in psychoactive drugs, early mobilisation, adequate hydration and nutrition, and provision of hearing and visual aids.²²

The experience of delirium can be distressing for patients, carers, families, other support people and clinicians.³⁹

Who should I be concerned about?

You need to be concerned about patients who:

- Have been identified as being at risk, and require screening for cognitive impairment and assessment for delirium
- Are at risk of harm and of developing delirium.

What should I do?

Screen all identified at-risk patients for cognitive impairment

How do I do it?

- Be familiar with the cognitive screening tools used in your facility, their strengths and limitations, and how to interpret results. One example of a screening tool is the Abbreviated Mental Test Score (AMTS). Understand how these tools are integrated with other screening processes.
- Administer a quick validated screening tool that tests orientation, recall and attention, and record the score in the patient's healthcare record.
- Be aware that a poor score is not a diagnosis, but a trigger for further assessment.
- If there is concern about the patient's medical decision-making capacity, refer to the concepts of 'capacity' in Step 1, on page 11.

Undertake a clinical assessment

How do I do it?

- Assess the patient's medical conditions, including presenting problems, provisional or final diagnosis, co-morbidities and existing treatments, medicines, and presence of pain. Be familiar with pain assessment tools used by your organisation.
- Assess physical, cognitive, social, psychological and behavioural function. Include functional assessment of self-care such as bathing and independent living such as administering own medication.
- If the patient agrees, always talk to carers, family and other support people of the patient.
- Contact the patient's GP, residential care facility, or community aged care provider for background information.
- Determine if the cognitive impairment is recent (past few hours or days), because acute onset is an important indicator for delirium diagnosis.
- Use an interpreter when required.

- Refer the patient for more comprehensive specialist cognitive or neuropsychological assessment if the presentation is complex and diagnosis difficult or uncertain.
- If dementia or another form of cognitive impairment is suspected and a comprehensive diagnostic process is not appropriate in hospital, refer the patient for further assessment and follow-up. Record the results of the assessment in the patient's healthcare record and communicate these to the patient, carer, family member or substitute decision-maker.
- If a person is cognitively impaired and is unable to consent to medical treatment, identify any existing advance care plan or substitute decision-maker.
- Make a diagnosis or note the medical team's diagnosis with regard to cognitive impairment.
- Document information and communicate to other members of the multidisciplinary team so that the patient, their carer, family member or other support person and their primary healthcare provider are not asked the same questions multiple times.

Set goals of care

How do I do it?

- Discuss the patient's relevant diagnoses, healthcare goals and preferences with the patient.
- Identify the support people a patient may want involved in communications and decision-making.
- Discuss the risks and benefits of clinically appropriate options for tests, treatment and care.
- Be aware of signs of abuse of older people, and the policies and protocols in your state or territory regarding intervention.
- Assess carer needs and their preferred level of involvement during the hospital stay.
- Identify and document agreed goals of care, including any agreed limitations on medical treatment.

Identify if the patient has risk factors for harm

How do I do it?

- Be familiar with the screening tools used in your facility for falls, pressure injuries and nutrition.
- Be familiar with risks of certain medicines.
- Screen the patient for additional risks of harm.
- Undertake medicine reconciliation and review.
- Identify any communication difficulties.
- Be familiar with the legislation in your state or territory regarding consent to medical treatment.
- Be familiar with the processes of advance care planning in your facility.

Assess the patient for delirium, identify and treat causes, re-assess with any change

How do I do it?

- Be familiar with the delirium assessment tool used in your facility, its strengths and limitations and how to interpret results. Examples of possible tools include the Confusion Assessment Method (CAM), CAM-intensive care unit (CAM-ICU), 3-minute diagnostic interview for CAM-defined delirium (3D-CAM), the Nurses Delirium Screening Checklist (NUDESC) and the 4AT.
- Assess the patient for delirium and record result in the patient's healthcare record.
- If delirium is diagnosed, identify and treat possible causes, understanding that the causes are often multifactorial.
- If uncertain, manage identified cognitive impairment as delirium.
- Note that delirium can be a trigger or flag for a medical emergency.
- Collate the patient's history with the patient, carer, family member or other support person, and review medicines as a priority.
- Consider ceasing medicines that may cause delirium, and be aware of anticholinergic load, where medicines can increase confusion and cognitive decline.
- Undertake a physical examination, and measure vital signs such as temperature, oxygen saturation and blood glucose concentration.
- Undertake targeted diagnostic tests based on the patient's history and examination.

- Re-assess with any change to the patient's behaviour, mental state or physical condition.
- Provide the patient, carer, family member or other support person with information on delirium that is easy to understand.
- Involve the patient, carer, family member or other support person in clinical handover, and encourage them to report any changes.

Develop a comprehensive care plan

How do I do it?

- Based on the clinical assessment, agreed goals of care and identified risks of harm, develop a comprehensive care plan in partnership with the patient, carer, family member, other support person or substitute decision-maker. Prioritise the needs and set short- and long-term goals in collaboration with the patient, carer and family.

Helpful hints

- The cognitive screening score provides a baseline that can be recorded and compared when any further testing is undertaken during the hospital stay.
- Remember that a person may not score well on a cognitive screening test for reasons other than cognitive impairment. Levels of pain, medicines, depression, and not understanding questions due to language, or hearing or learning difficulties may all have an impact on cognition.
- When taking a patient's history and performing assessments, make sure the patient has their glasses and hearing aids in place (if appropriate). Use a headphone amplification device if the patient is not able to hear you speaking. Take time and allow the person time to respond.
- Introduce yourself clearly and explain the purpose of your visit.
- Seat yourself at the level of the patient and speak slowly and clearly.
- Ask the patient if anything is troubling them.
- Inform the patient, carer and family of resources that provide them with information about cognitive impairment and what they can do to support safer care when in hospital.
- Do not dismiss any patient as 'pleasantly confused', or assume they have dementia and do nothing.
- Do not ignore lethargy and withdrawal, because hypoactive delirium is easily missed.
- Take any opportunity to talk to carers and family.
- Do not dismiss a carer's or family's concerns. Statements that she or he is not usually like this should be taken seriously.
- Be aware that the signs and symptoms of delirium can fluctuate.

What does 'effective recognition and response' mean to me?

- I have the knowledge and skills to obtain timely and sufficient information from the patient or key informants, including advance care plans.
- I am aware and trained if I am responsible for clinical assessment, risk assessment, cognitive screening and interpretation of results.
- I understand the contribution carers can make to my understanding of the patient and I seek their input, in line with the patient's needs and preferences.
- I know which patients in my care have cognitive impairment, and I understand their risks of harm. I also know which patients are at risk of developing delirium.
- I provide the patient, carer, family member or other support person with health information that is easy to understand.
- I am now in a position to provide care in a way that will minimise their risks of harm.



Patient story 2

The following story and Table 2 illustrate how the care of a patient with cognitive impairment can be improved.

Mr S is a 22 year-old homeless man with a 5-month history of worsening headaches. A GP requested a brain CT scan which showed a large right frontal lobe meningioma. He was admitted to hospital and underwent craniotomy and resection of the tumour. During admission, a neurological examination was conducted including testing of coordination and sensation, and on the Glasgow Coma Scale (GCS: used to assess level of consciousness) a score of 15/15 was obtained, indicating normal functioning. Mr S's homelessness was noted. Mr S consented to surgery with risks and possible complications explained.

In the postoperative period on the ward, Mr S obtained GCS scores of 15/15 and was noted to be alert and orientated. Given his homelessness, a social work review was requested to assist in discharge planning, with the social worker identifying a number of psychosocial issues (including lack of family and social supports, and that he was unemployed and homeless). Following initial discussions with Mr S, the social worker expressed concerns regarding his cognitive ability, with him having difficulty following and recalling information and appearing easily overwhelmed with information. Cognitive screening was requested and conducted by an occupational therapist. As he performed poorly on cognitive screening the occupational therapist suggested referral for neuropsychological assessment to enable comprehensive assessment of his cognitive function. Neuropsychological assessment was conducted a week after the surgery, when Mr S was deemed medically stable.

Further psychosocial issues were noted during the neuropsychological assessment, including living on the streets, vulnerability with need for help from other homeless people, and having lost identification papers. Mr S referred to long-term learning difficulties with limited reading and writing abilities. Neuropsychological assessment revealed significant impairments in various areas of cognitive function (including slowed thinking, poor attention, very limited learning and recall of new information, limited reasoning, reduced initiative, passivity and need for prompting) and reading and writing were at a second grade equivalent. These impairments were considered to reflect the impact of the meningioma and surgery as well as his longer-term cognitive and learning difficulties.

Given the significant cognitive difficulties identified on assessment, his psychosocial situation and the anticipated demands for activities such as managing medications, medical appointments, monitoring of his health, need for accommodation, and seeking benefits, applications for guardianship and financial management were made. Mr S was referred to Homeless Health Services during the hospital admission and appointed a case manager to help manage appointments and medications. Temporary supported accommodation was arranged until longer-term issues were addressed. Mr S's GP was provided with information about the comprehensive care plan and discharge arrangements.

Table 2: Patient story 2 summary – outcomes and suggested improvement strategies

What did not go well?	What could have been done better?
<p>During the admission process the doctor did not ask about cognitive function or conduct any cognitive screening</p>	<p>Conduct baseline cognitive screening as part of the admission process and neurological examination</p>
<p>Details of surgery, risks and possible complications were discussed but with Mr S's capacity to understand and provide informed consent not clearly established</p>	<p>If cognitive screening indicated impairment then consideration could have been given to Mr S's capacity to provide informed consent for surgery and whether or not there was a need for a substitute decision-maker. Efforts to support decision making could also have been considered. This could have included allowing him plenty of time to respond, providing information in a slow paced manner, providing information in small amounts and in clear simple terms, checking his understanding and providing further explanation where necessary</p>
<p>Psychosocial issues were not considered until later in the admission. The complicated psychosocial situation required significant social work input and discharge plans were delayed while psychosocial issues, guardianship, financial management, accommodation options and the need for a case manager were addressed</p>	<p>Additional information could have been sought from the referring GP and from Mr S during the admission process to help determine possible needs regarding post-operative care and in discharge planning to enable early involvement of relevant teams</p>
What went well?	
<p>Medical and allied health staff raised concerns regarding Mr S's cognitive issues and arranged cognitive screening by an occupational therapist</p>	
<p>Comprehensive assessment of cognitive function (by neuropsychological assessment) was arranged when cognitive screening revealed low scores. Other aspects of comprehensive assessment had also been undertaken in the course of his admission and surgery (including neurological examination, and blood tests)</p>	
<p>Information from the various team members was integrated for short and long-term goals to ensure Mr S's medical, cognitive and psychosocial needs were addressed</p>	
<p>GP was informed of the comprehensive care plan and arrangements that had been put in place</p>	

Patient story 3

The following story and Table 3 illustrate how the care of a patient with cognitive impairment can be improved.

Mrs B is an 87 year-old woman with dementia, who has been a resident in an aged care facility for the past eight years. Mrs B had a fall and fractured her right femur, and was transferred to the local hospital where an internal fixation of her right femur was performed. She suffered a minor myocardial infarction about 36 hours after surgery.

Mrs B's daughter had raised concerns postoperatively about her mother's bed height.

I'd been in there to attend to my mother – they had the bed up really high, which is normal nursing practice, and I had said to them before I left, 'Will I put the bed down low because it's up high and the cot rails are up?' and they said, 'No, no, no. We have to go in and attend to her', and I said, 'Well I'm a bit worried', because her room was not in view of the nurses' station. The door was just down a little bit. And they said, 'Oh just leave her call bell over her shoulder'. I said, 'Well that won't do any good because she's got dementia and she won't remember what the call bell's for'. Besides, she had a morphine infusion running and I said, 'Well she's a bit off her face', and they said, 'No, no, no. She'll be fine'.

During the night, Mrs B had apparently climbed over the bed rails and fell to the floor, fracturing her left leg femur and damaging her right leg. Mrs B then required a hip replacement the following day. Mrs B's daughter was not informed about the fall until the anaesthetist contacted her the next morning to sign the consent form for the surgery.

The next morning the anaesthetist rang me at home and said, 'When are you coming to sign the consent form for theatre?' and I said, 'Well I've already done that. My mum's been to theatre', and the anaesthetist said, 'Well that was for the pin and plate. I'm talking about the hip replacement'. I said, 'Well, what's gone wrong overnight?' and he said, 'Didn't the staff phone you and tell you your mum fell out of bed?' and I said, 'No, they didn't'.

Source: Australian Commission on Safety and Quality in Health Care. Independent research into patient and provider views and experiences with open disclosure. University of Technology Sydney. 2011.⁴⁰

Table 3: Patient story 3 summary – outcomes and suggested improvement strategies

What did not go well?	What went well?
No falls risk assessment	Daughter informed clinicians that mother had dementia
Change in condition not acted on	Daughter raised concerns about the risk of her mother falling
No subsequent delirium assessment	
Use of bedrails	
Bed not in a low position	
Daughter's (carer's) safety advice ignored	
False reassurance	
Clinicians not understanding care needs	
Patient's bed not easily visible to nursing staff	
Daughter not informed of fall	
	What could have been done better?
	Clinicians recognising and documenting existing dementia
	Clinicians undertaking further assessment and developing a comprehensive care plan to address safety issues
	Implementing a comprehensive care plan, including regular assisted toileting and environmental modification, such as a low bed, and a location closer to the nurses station
	Engaging carer, and taking carer concerns seriously and acting on them

Where do I go for more information?

Screening tools

Go to screening under [resources/information a-z](#)³² on the ACSQHC cognitive care website.

Delirium assessment

Go to delirium assessment under [resources/information a-z](#)³² on the ACSQHC cognitive care website.

Delirium guidelines

- [Delirium Clinical Care Standard](#)⁷
- [HACs information kit fact sheet: Delirium](#)⁴¹
- [Delirium in older people: Australian and New Zealand Society for Geriatric Medicine position statement 13](#)⁴²
- National Institute for Health and Clinical Excellence's [Delirium: diagnosis, prevention and management clinical guideline](#).²⁶

Dementia guidelines

[Clinical practice guidelines and principles of care for people with dementia](#).⁴³

Advance care planning

- [Advance Care Planning Australian website](#)⁴⁴
- [Advance care planning for dementia](#).⁴⁵

Elder abuse

Go to elder abuse under [resources/information a-z](#)³² on the ACSQHC cognitive care website.



Step 3:

Provide safe and high-quality care tailored to the patient's needs

Why is this important?

Once you have recognised cognitive impairment and delirium risk and developed an individualised comprehensive care plan, you can now take action to provide safe and high-quality care tailored to the patient's needs.

The agreed goals and actions outlined in the comprehensive care plan are crucial to reduce the risk of harm but are sometimes not implemented. For example, a patient who is at risk of delirium may be identified but no prevention strategies are put into place. A patient with cognitive impairment may be identified but not provided with the extra assistance or support needed to be safe from harm, such as prompts to drink regularly. A patient with cognitive impairment may not be recognised to be at the end of life and therefore not receive appropriate or timely end-of-life care.

Patients with cognitive impairment may have difficulty communicating their needs. They may not be able to ask for help, communicate if they are feeling worse or find their way around. The person may not understand instructions, be frightened or appear uncooperative. Carers and families can be a valuable resource in understanding the patient's capabilities, how to communicate and how to reduce distress but often report that they are not consulted or kept informed during the hospital stay, and that their relative has declined significantly in their capacity to look after themselves after a hospital stay.

It is possible to prevent escalation of behavioural issues by assessing and treating the underlying cause. A busy, noisy hospital environment, with unfamiliar faces and different routines can be overwhelming and can exacerbate disorientation and cause distress and agitation. Agitation is also associated with hyperactive delirium. However, increasing distress or agitation can occur for a variety of reasons with all forms of cognitive impairment. It is essential that the underlying cause is sought as it may be related to pain, hunger, thirst or other unmet needs.⁴⁶

Antipsychotics such as haloperidol are overused as the first line of response to agitation and aggression. They only have modest benefit, and increase the risk of adverse events such as death, stroke, falls and further cognitive decline.⁴⁷

Who should I be concerned about?

You need to be concerned about patients with cognitive impairment, and patients at risk of developing delirium (see Step 1 on page 10).

What should I do?

Provide person-centred care, in partnership with the patient, carer and family

How do I do it?

- Put the principles of person-centred care into practice:
 - Treat the patient, carer and family with dignity and respect
 - Communicate (tips at Table 4) and share easy-to-understand information
 - Encourage and support participation in decision-making.
- Get to know each individual person, their abilities, routines, specific needs and preferences, and how their cognitive impairment affects their ability to communicate.
- With the patient's agreement, involve the patient's carer or other support person as much as possible.
- If the patient does not have a carer or other support person, offer to contact a nominated person who can be informed of their hospital admission, if the patient wishes.
- Provide additional care to the patient when required, such as regular toileting, prompts for fluid intake, encouragement with activities of daily living and mobilisation when appropriate. Encourage and support carers when they choose to be involved in a patient's care.
- Implement the comprehensive care plan in consultation with the patient, carer, other support person or substitute decision-maker.
- Consult the patient, carer, family member or other support person in planning for transitions of care.
- Provide access to hospital substitution, fast-track and transition programs to maximise the patient's recovery and restoration of function.
- Refer the patient for ongoing community and carer support.

Helpful hints

Non-verbal actions

- Minimise background noise
- Stay calm and still while talking, in the person's line of sight
- Use a portable hearing amplifier if no hearing aids available
- Ensure hearing aids are functioning and turned on
- Break down tasks into smaller steps
- Communicate at eye level
- Use simple, calm hand gestures and facial expressions. Allow plenty of time for the person to reply
- Verbal actions.

Talk in a gentle tone

- Use short sentences and simple words
- Explain all procedures and activities in simple terms
- Allow time for what you say to be understood
- Clarify what they have said – repeat or reword
- Use personal references where available, such as your son Bill, your green jumper, this photograph of your granddaughter.

Source: [A Handbook for NSW Health Clinicians: Assessment and management of people with behavioural and psychological symptoms of dementia \(BPSD\)](#).⁴⁶

Prevent or minimise patient harm from identified safety risks

How do I do it?

- For patients identified at risk of falls, implement multi-component falls prevention strategies. Examples include:
 - Making sure the patient has their usual spectacles and visual aids at hand (this will also assist in preventing delirium)
 - Avoiding use of bedside rails
 - Implementing a toileting regime

- Checking that the patient understands how to use assistive devices
- Organising a physiotherapy review for patients with mobility issues
- Placing high-risk patients within view of, and close to, the nursing station
- Being aware of the high risk of falls in the bathroom.
- For identified patients at risk of pressure injuries, undertake regular skin inspections and implement a pressure injury prevention plan.
- For patients with pressure injuries, implement a comprehensive wound management plan, including pain management.
- Implement a nutrition care plan that may include encouraging and assisting with food intake. Assess oral health and provide oral health care.
- Avoid dehydration (see 'Prevent delirium and manage delirium when it occurs' on this page).
- Encourage effective communication to reduce distress and anxiety.
- Avoid functional decline by mobilising and encouraging self-care.

Helpful hints

People with dementia may have changes in taste and can experience particular challenges in maintaining adequate hydration and nutrition.

Memory problems: the person may forget when they last had something to eat or drink.

Agnosia: the person may not be able to recognise a cup, plate, cutlery or food.

Dysphasia: the person may be unable to understand what staff are saying or to express that they are hungry or thirsty.

Dysphagia: the person may develop problems with chewing or swallowing.

Source: UK Royal College of Nursing. Commitment to the care of people with dementia in hospital settings, 2012.⁴⁸

Prevent delirium and manage delirium when it occurs

How do I do it?

- Be familiar with evidence-based delirium prevention and management strategies, such as the [Hospital Elder Life Program \(HELP\)](#).⁴⁹
- Find and treat the causes of delirium.
- If the diagnosis is uncertain, manage as if for delirium.
- Know that you can prevent delirium or shorten its duration by the way you provide care. Be part of a coordinated, multidisciplinary approach to prevention and management.
- Manage the patient's discomfort and pain.
- Be alert to and assess any changes in the patient's cognition, behaviour and physical condition.
- Encourage and assist eating and drinking to ensure adequate intake, provide patients with their dentures and monitor fluid intake. Assess swallowing if there is any indication of difficulties, for example, where a patient has had a stroke or is coughing excessively.
- Minimise bed moves.
- Minimise the use of indwelling catheters and intravenous lines to reduce risk of infection.
- Avoid the use of physical restraints as they make delirium worse and increase the risk of falls.
- Orientate patients using familiar objects and make the clock visible.
- Place glasses, dentures and hearing aids so they are accessible and used.
- Normalise sleep patterns with appropriate lighting and activities in the day.
- Encourage carer, family member or other support person involvement in orientation and reassurance.
- Use interpreters and other communication aids for culturally and linguistically diverse patients and carers, and Aboriginal and Torres Strait Islander patients and carers, if required. Work with Aboriginal and Torres Strait Islander liaison officers.
- Use supportive volunteer programs.
- Provide access to transition care programs, if appropriate.

Respond appropriately to behavioural changes

How do I do it?

- Always assess the underlying causes of behaviour such as physical illness or pain.
- Understand that the patient may only be able to communicate through behaviour.⁴⁶
- Reassure the patient, talk in a gentle tone, stay calm and use simple language.
- Understand that delirium can be frightening and people with dementia can feel increasingly anxious in an unfamiliar environment.
- Learn from the carer, family member or other support person how to reduce a person's distress, agitation or aggression.
- Engage the patient in purposeful and individual-targeted activities.
- Only consider use of antipsychotics and other psychoactive medicines if non-pharmacological interventions have failed, and the person is severely distressed and is at immediate risk of harm to themselves or others. Over-sedation can lead to pneumonia, pressure injuries, falls and fractures. If antipsychotics are used:
 - Discuss risks and benefits with patients, carers, families or other support people and obtain informed consent
 - Target symptoms that will potentially respond
 - Start low, increase slowly, monitor and review
 - Limit the time the patient is on the medicine.
- Seek advice and support from clinical experts when presentation is complex or beyond your skill level. Experts may include geriatricians, psycho-geriatricians, neuropsychologists, nurse practitioners, clinical nurse consultants and staff from [Dementia Support Australia](#).⁵⁰

Manage the patient's medical issues

How do I do it?

- Diagnose and treat the presenting problem and reason for admission. Optimally manage co-morbidities and any chronic health issues, communicating effectively with all health providers.
- Continue to treat any identified underlying causes of delirium.
- Obtain informed consent. Be familiar with the legislation regarding consent to medical treatment in your state or territory.
- Discuss any concerns about recovery or risk of dying with the patient, carer, family member or other support person.
- Discuss what to expect in advanced dementia and treatment options with the patient, carer family member or support person.⁵¹
- Adhere to advance care plans and agreed goals of care to avoid inappropriate treatment.
- Be familiar with your facility's processes for identifying patients who are at the end of life.
- When appropriate, provide access to palliative care to maximise comfort and quality of life.
- Review medicines with a view to reducing delirium and falls risks.
- Manage pain.
- Document delirium, diagnosed or suspected dementia, and other forms of cognitive impairment in transfer information.
- Arrange follow-up medical review.

Modify the environment to provide safe and supportive patient care

How do I do it?

- Provide a calm, safe and secure environment.
- Provide meaningful activities or access to trained and supported volunteers.
- Enable safe walking and self-care.
- Minimise noise and try to provide a quiet environment, especially at rest times.
- Provide opportunities for both privacy and community.
- Promote continence, such as through visual signage and access to toilets.
- Provide a way-finding orientation design.
- Provide lighting that is appropriate for the time of day.
- Provide flexible visiting arrangements and space for carers, families or support people.

Document and communicate the patient's healthcare information and care plan on transition

How do I do it?

- Provide the patient's healthcare information and care plan to their GP and all relevant healthcare providers.
- Provide the patient's healthcare information in a timely manner with sufficient detail, and include agreed goals of care and arrangements for medical follow-up and ongoing carer support.
- Provide copies of the patient's care plan information to the patient, carer and family.

What does 'providing safe and high-quality care' mean to me?

- I have the knowledge and skills to provide all the components of safe and high-quality care, or I know when to seek advice and support from clinical experts.
- I make decisions in partnership with patients, carers, families, support people or substitute decision-makers.
- I am alert to changes in my patient that trigger review or changes in the comprehensive care plan.
- I communicate patient and treatment changes to my team.
- I understand my role in advance care planning.
- I understand the importance and applicability of transition programs.
- I assist with the patient's continuity of care.



Patient story 4

The following story and Table 4 illustrate how the care of a patient with cognitive impairment can be improved.

Mr C is an 83 year-old man who resides in a residential aged care facility. His wife died several years previously. He has moderate cardiac failure, which is well controlled, non-insulin-dependent diabetes mellitus and severe osteoarthritis of his knees, leading to very impaired mobility. He has an advance care plan saying that he does not wish to be admitted to the intensive care unit (ICU) or have 'extraordinary treatment' such as assisted ventilation or intubation.

One evening he developed increasing shortness of breath in his residential aged care facility, became quite confused and was calling out. The residential aged care facility staff called an ambulance and he was taken to the emergency department (ED) of his local hospital. Here, pneumonia and an exacerbation of his cardiac failure were diagnosed, and he was started on diuretics and antibiotics.

Two days after he was admitted, his condition deteriorated overnight and he was transferred to the ICU early the next morning. His family was not notified until later in the morning that he had been admitted to hospital and transferred to the ICU. His daughter was upset that clinicians did not observe her father's advance care plan. However, the ICU clinicians were not aware that there was one in existence, although staff at the residential aged care facility were aware that Mr C had completed one. Because of Mr C's confusion on admission, he was not asked about this.

Mr C's condition continued to deteriorate. His condition was discussed with his family, who requested that he be returned to the ward and receive supportive management, with a view to palliative care if he continued to deteriorate. His family felt that was what he would have wanted.

Table 4: Patient story 4 summary – outcomes and suggested improvement strategies

What did not go well?	What could have been done better?
The residential aged care facility did not provide information about the advance care plan	Contacting family to participate in information exchange and healthcare decision-making at presentation
Clinicians did not ask the residential aged care facility or Mr C's GP if there was an advance care plan in existence	Contacting the residential aged care facility or Mr C's GP at presentation to participate in information exchange regarding an advance care plan
Clinicians did not contact family despite Mr C's obvious confusion	
What went well?	
Clinicians agreed to family's request once the existence of an advance care plan was known	

Where do I go for more information?

Commission resources

- [Partnering with Consumers Standard](#)⁵²
- [Comprehensive Care Standard](#)²
- [End-of-life tools and resources for health services](#)⁵³
- [National Consensus Statement: Essential elements for safe and high-quality end-of-life care](#)⁵⁴
- [Dementia and delirium – communication at transitions of care video](#)⁵⁵
- [Infographic outlining rationale and strategies for reducing inappropriate use of antipsychotics](#)⁵⁶ (Figure 2)
- [Safer use of medicines for cognitive impairment: Webinar](#)⁵⁷
- [Responding to distress: Webinar](#)⁵⁸

Person-centred care

[South Australian Dignity in Care Program](#).⁵⁹

Palliative care

[Palliative Care Australia](#).⁶⁰

Communication

Go to communication on the [resources/information a-z](#)³² on the ACSQHC cognitive care website.

Delirium management and prevention

- Go to delirium prevention on the [resources/information a-z](#)³² on the ACSQHC cognitive care website
- Go to volunteers on the [resources/information a-z](#)³² on the ACSQHC cognitive care website.

Oral health care

[Oral health advice for people with special needs](#).⁶¹

Response to behavioural issues

National

[Dementia Support Australia](#).⁵⁰

New South Wales

- [The NSW Handbook – Assessment and management of people with behavioural and psychological symptoms of dementia \(BPSD\) handbook](#)⁴⁶
- [TOP 5 initiative](#).⁶²

South Australia

[Challenging behaviour policy framework](#).⁶³



■ Step 3: Provide safe and high-quality care tailored to the patient's needs

Managing medical issues

Commission resources

- Infographic outlining rationale and strategies for reducing inappropriate use of antipsychotics⁵⁶ (Figure 2)
- [Safer use of medicines for cognitive impairment: Webinar.](#)⁵⁷

Medicines

Go to medicines on the [resources/information a-z](#)³² on the ACSQHC cognitive care website.

Pain

- [Palliative care aged care evidence – cognitive issues](#)⁶⁴
- The Pain Puzzle [Dementia Training Australia](#) online course.⁶⁵

Environmental design

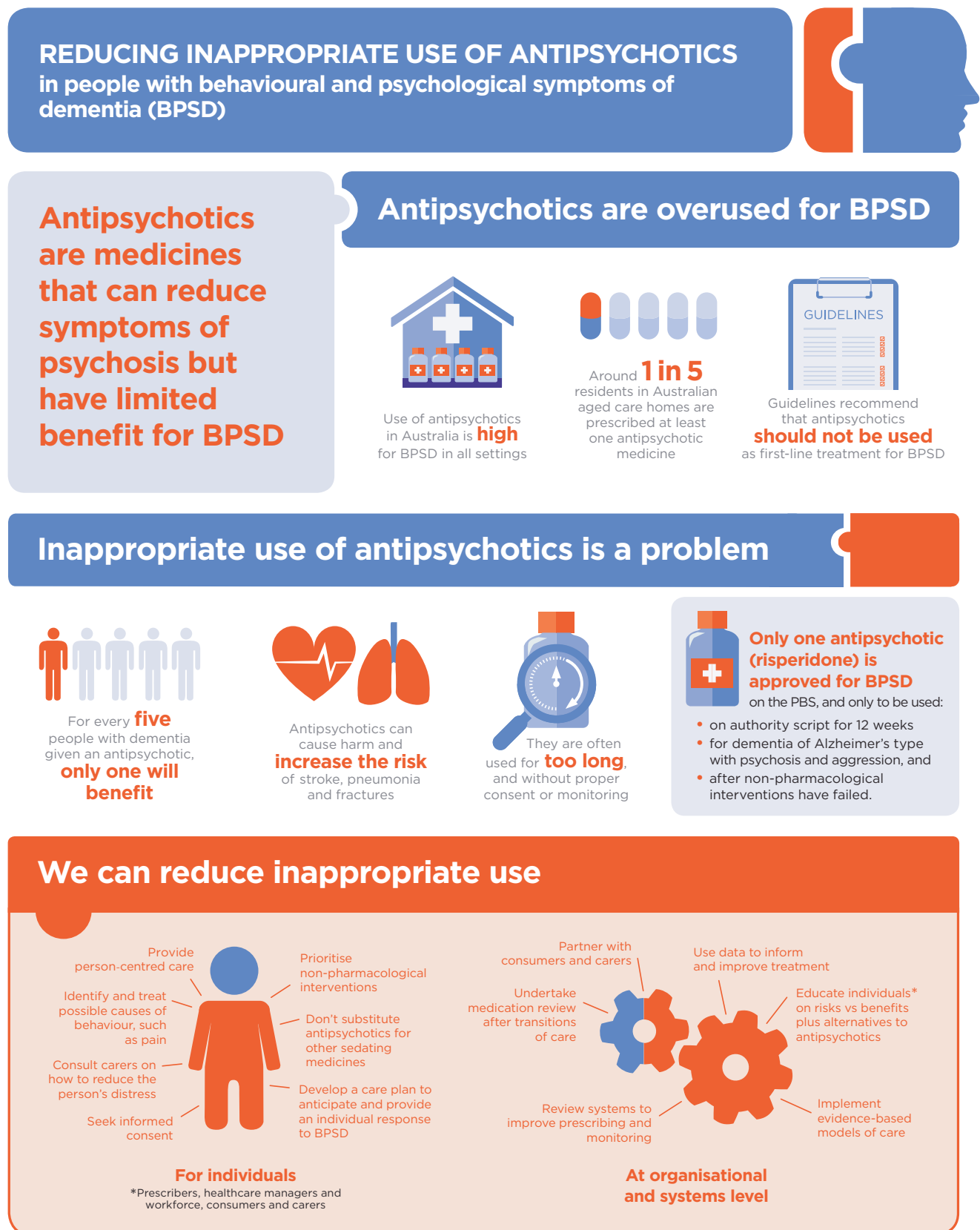
Go to environment on the [resources/information a-z](#)³² on the ACSQHC cognitive care website.

Fast-track and transitions

- [The Transition Care Program](#)⁶⁶
- [The NSW Aged Care Emergency \(ACE\) Model of Care](#)⁶⁷
- [Victorian residential in-reach \(RIR\) program](#)⁶⁸
- [Aged Care Services in Emergency Teams](#)⁶⁹
- [Geriatric Emergency Department Intervention \(GEDI\).](#)⁷⁰



Figure 2: Infographic outlining rationale and strategies for reducing inappropriate use of antipsychotics⁵⁶



References

1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2017.
2. Australian Commission on Safety and Quality in Health Care. Standard 5. Comprehensive Care [Internet]: Sydney: ACSQHC; 2017 [cited 2 January 2019] Available from: <https://nationalstandards.safetyandquality.gov.au/5.-comprehensive-care>.
3. Australian Commission on Safety and Quality in Health Care. 8. Recognising and Responding to Acute Deterioration Standard. [Internet]: Sydney: ACSQHC; 2018 [cited 9 January 2019] Available from: <https://nationalstandards.safetyandquality.gov.au/8.-recognising-and-responding-acute-deterioration>.
4. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards Guide for Hospitals. Sydney: ACSQHC; 2017.
5. Australian Commission on Safety and Quality in Health Care. National Model Clinical Governance Framework. Sydney: ACSQHC; 2017.
6. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards User guide for health services providing care for patients with cognitive impairment or at risk of delirium In press. Sydney: ACSQHC; 2019 Available from <https://www.safetyandquality.gov.au/our-work/cognitive-impairment/better-way-to-care/>
7. Australian Commission on Safety and Quality in Health Care. Delirium Clinical Care Standard [Internet]: Sydney: ACSQHC; 2016 [cited 7 January 2019] Available from: <https://www.safetyandquality.gov.au/our-work/clinical-care-standards/delirium-clinical-care-standard/>.
8. Australian Commission on Safety and Quality in Health Care. NSQHS Standards Resources. [Internet]: Sydney: ACSQHC; 2017 [cited 08 January 2019] Available from: <https://nationalstandards.safetyandquality.gov.au/resources>.
9. Travers C, Byrne G, Pachana N, Klein K, Gray L. Prospective observational study of dementia and delirium in the acute hospital setting. Internal Medicine Journals. 2013 Mar;43(3): 262–9.
10. Bruce A, Ritchie C, Blizzard R, Lai R, Raven P. The incidence of delirium associated with orthopedic surgery: A meta-analytic review. International Psychogeriatrics. 2007 Apr;19(2):197–214.
11. Zywiell MG, Hurley RT, Perruccio AV, Hancock-Howard RL, Coyte PC, Rampersaud YR. Health economic implications of perioperative delirium in older patients after surgery for a fragility hip fracture. J Bone Joint Surg Am. 2015;97(10): 829–36.
12. Koster S, Hensens A, Schuurmans M, Palen J. Risk factors of delirium after cardiac surgery: A systematic review. European Journal of Cardiovascular Nursing. 2011;10(4):197–204.
13. Oldroyd C, Scholz AFM, Hinchliffe R, McCarthy K, Hewitt J, Quinn T. A systematic review and meta-analysis of factors for delirium in vascular surgical patients. Journal of Vascular Surgery. 2017;66(4):1269–1279.
14. Radford K, Mack HA, Draper B, Chalkley S, Daylight G, Cumming R, et al. Prevalence of dementia in urban and regional Aboriginal Australians. Alzheimers Dement. 2015 Mar;11(3):271–9.
15. Smith K, Flicker L, Lautenschlager N, Almeida O, Atkinson D, Dwyer A, et al. High prevalence of dementia and cognitive impairment in Indigenous Australians. Neurology. 2008;71(19):1470–3.

16. Australian Commission on Safety and Quality in Health Care. Evidence for the safety and quality issues associated with the care of patients with cognitive impairment in acute care settings: A rapid review. Sydney: ACSQHC; 2013.
17. Fick D, Agostini J, Inouye S. Delirium superimposed on dementia: A systematic review. *Journal of the American Geriatrics Society*. 2002;50(10):1723–32.
18. Iacono T, Bigby C, Unsworth C, Douglas J, Fitzpatrick P. A systematic review of hospital experiences of people with intellectual disability. *BMC Health Services Research*. 2014;14(1):1–8.
19. Saczynski J, Marcantonio E, Quach L, Fong T, Gross A, Inouye S, et al. Cognitive trajectories after postoperative delirium. *New England Journal of Medicine*. 2012 Jul 5;367(1):30–9.
20. Pandharipande PP, Girard TD, Jackson JC, Morandi A, Thompson JL, Pun BT, et al. Long-term cognitive impairment after critical illness. *N Engl J Med*. 2013;369(14):1306–16.
21. Inouye S. Delirium in older persons. *New England Journal of Medicine*. 2006 Mar 16;354(11):1157–65.
22. Inouye S, Westendorp R, Saczynski J. Delirium in elderly people. *The Lancet*. 2014;383(9920):911–22.
23. Australian Institute of Health and Welfare. Dementia care in hospitals: Costs and strategies. Cat. no. AGE 72. Canberra: AIHW; 2013.
24. Han JH, Wilson, A. & Ely, E. W., Delirium in the Older Emergency Department Patient – A Quiet Epidemic. *Emergency Medicine Clinics of North America*. 2010;28(3):611–31.
25. National Institute for Health and Clinical Excellence. Delirium: Diagnosis, prevention and management; Clinical Guideline 103. London: NICE, 2010.
26. Sands M, Dantoc B, Hartshorn A, Ryan C, Lujic S. Single Question in Delirium (SQiD): Testing its efficacy against psychiatrist interview, the Confusion Assessment Method and the Memorial Delirium Assessment Scale. *Palliative Medicine*. 2010 September 1, 2010;24(6):561–5.
27. Australian Commission on Safety and Quality in Health Care. NSQHS Standards microsite [Internet]: Sydney: ACSQHC; 2017 [cited 10 January 2019] Available from: <https://nationalstandards.safetyandquality.gov.au/>.
28. Australian Commission on Safety and Quality in Health Care. Caring for cognitive campaign website. [Internet]: Sydney: ACSQHC; 2017 [cited 14 January 2019] Available from: <https://cognitivecare.gov.au/>.
29. Australian Commission on Safety and Quality in Health Care. Dementia infographic. Sydney: ACSQHC; 2015.
30. Australian Commission on Safety and Quality in Health Care. Delirium infographic. Sydney: ACSQHC; 2015.
31. Australian Commission on Safety and Quality in Health Care. Be alert to delirium: Webinar [Internet]: Sydney: ACSQHC; [cited 10 January 2019] Available from: <https://cognitivecare.gov.au/videos/be-alert-to-delirium-webinar/>.
32. Australian Commission on Safety and Quality in Health Care. Caring for Cognitive Impairment/ Resources/Information a–z. [Internet]: Sydney: ACSQHC; 2017 Available from: <https://cognitivecare.gov.au/resources/information-a-z/>.
33. Australian Commission on Safety and Quality in Health Care. Caring for Cognitive impairment/ Resources/programs and policies [Internet]: Sydney: ACSQHC; 2017 [cited 10 January 2019] Available from: <https://cognitivecare.gov.au/resources/programs-policies/>.
34. Australian Commission on Safety and Quality in Health Care. Online learning [Internet]: Sydney: ACSQHC; 2018 [cited 14 January 2019] Available from: <https://cognitivecare.gov.au/resources/online-learning/>.
35. Rice K, Gomez M, Theall K, Knight M, Foreman M. Nurses' recognition of delirium in the hospitalized older adult. *Clinical Nurse Specialist*. 2011;25(6):299–311.
36. Suffoletto B, Miller T, Frisch A, Callaway C. Emergency physician recognition of delirium. *Postgraduate Medical Journal*. 2013;29(1057):621–5.
37. Barron E, Holmes J. Delirium within the emergency care setting, occurrence and detection: A systematic review. *Emergency Medicine Journal*. 2013 Apr;30(4):263–8.
38. Marcantonio ER. Delirium in Hospitalized Older Adults. *New England Journal of Medicine*. 2017;377(15):1456–66.

References

39. Partridge J, Martin F, Harari D, Dhesi J. The delirium experience: What is the effect on patients, relatives and staff and what can be done to modify this? *International Journal of Geriatric Psychiatry*. 2013;28(8):804–12.
40. Australian Commission on Safety and Quality in Health Care. Independent research into patient and provider views and experiences with open disclosure. Sydney: University of Technology; 2011.
41. Australian Commission on Safety and Quality in Health Care. HACs information kit fact sheet: Delirium. [Internet]: Sydney: ACSQHC; 2018 [cited 7 January] Available from: <https://www.safetyandquality.gov.au/publications/hacs-information-kit-fact-sheet-delirium/>.
42. Australian and New Zealand Society for Geriatric Medicine. Position statement 13: Delirium in older people. Sydney: Australian and New Zealand Society for Geriatric Medicine, 2012.
43. Guideline Adaptation Committee. Clinical Practice Guidelines and Principles of Care for People with Dementia. Sydney: NHMRC Partnership Centre for Dealing with Cognitive and Related Functional Decline in Older People; 2016.
44. Advance Care Planning Australia. Advance Care Planning Australia Website [Internet]: Austin Health; 2018 [cited 8 January 2019] Available from: <https://www.advancecareplanning.org.au/>.
45. Cognitive Decline Partnership Centre. Advance care planning [Internet]: University of Sydney; [cited 8 January 2019] Available from: <http://sydney.edu.au/medicine/cdpc/resources/advance-planning.php>.
46. Royal Australian & New Zealand College of Psychiatrists. Assessment and management of people with Behavioural and Psychological Symptoms of Dementia (BPSD): A handbook for NSW Clinicians. Sydney: NSW Ministry of Health; 2013.
47. Pratt N, Roughead EE, Salter A, Ryan P. Choice of observational study design impacts on measurement of antipsychotic risks in the elderly: a systematic review. *BMC medical research methodology*. 2012 Jun 8;12:72.
48. Royal College of Nursing. Commitment to the care of people with dementia in hospital settings. London Royal School of Nursing; 2013.
49. The Hospital Elder Life Program. Hospital Elder Life Program. [Internet]: The Hospital Elder Life Program; 2019 [cited 10 January 2019] Available from: <https://www.hospitalelderlifeprogram.org/>.
50. Dementia Support Australia. Dementia Support Australia. [Internet]: Dementia Support Australia; 2019 [cited 10 January 2019] Available from: <https://www.dementia.com.au/>.
51. Koppitz A, Waldbroth V, Dreizler J, Imhof L, et al. Dying with dementia: most frequent symptoms. A review of the literature. *International Journal of Health Professions*. 2015;2(1):49–63.
52. Australian Commission on Safety and Quality in Health Care. Standard 2: Partnering with consumers [Internet]: Sydney: ACSQHC; 2018 [cited 9 January 2019] Available from: <https://nationalstandards.safetyandquality.gov.au/2.-partnering-consumers>.
53. Australian Commission on Safety and Quality in Health Care. End-of-Life Care: Tools and resources for health services. [Internet]: Sydney: ACSQHC; 2016 [cited 8 January 2019] Available from: <https://www.safetyandquality.gov.au/our-work/end-of-life-care-in-acute-hospitals/tools-and-resources-for-health-services/>.
54. Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC; 2015.
55. Australian Commission on Safety and Quality in Health Care. Dementia and Delirium Communications at Transitions video. [Internet]: Sydney: ACSQHC; 2017 [cited 10 January 2019] Available from: <https://cognitivecare.gov.au/videos/dementia-and-delirium-communications-at-transitions-of-care/>.
56. Australian Commission on Safety and Quality in Health Care. Infographic outlining rationale and strategies for reducing inappropriate use of antipsychotics. Sydney: ACSQHC; 2018.
57. Australian Commission on Safety and Quality in Health Care. Safer use of medicines for cognitive impairment: Webinar. [Internet]: Sydney: ACSQHC; 2018 [cited 10 January 2019] Available from: <https://cognitivecare.gov.au/videos/safer-use-medicines-cognitive-impairment-webinar/>.

58. Australian Commission on Safety and Quality in Health Care. Responding to distress: Webinar. [Internet]: Sydney: ACSQHC; 2017 [cited 10 January 2019] Available from: <https://cognitivecare.gov.au/videos/caring-for-cognitive-impairment-responding-to-distress/>.
59. Dignity in Care Australia. Dignity in Care Australia. [Internet]: Dignity in Care Australia; [cited 8 January 2019] Available from: <http://www.dignityincare.com.au/>.
60. Palliative Care Australia. Palliative Care Australia Website [Internet]: Palliative Care Australia [cited 8 January 2019] Available from: <https://palliativecare.org.au/>.
61. Queensland Government. Oral health for people with special needs [Internet]: Queensland Government; 2017 [cited 10 January 2019] Available from: <http://conditions.health.qld.gov.au/HealthCondition/condition/18/156/103/Oral-health-for-people-with-special-needs>.
62. Clinical Excellence Commission. TOP 5 Initiative – Engaging Carers. [Internet]: Clinical Excellence Commission [cited 8 January 2019] Available from: <http://www.cec.health.nsw.gov.au/quality-improvement/people-and-culture/person-centred-care/top5>.
63. SA Health. Challenging behaviour policy framework. [Internet]: Government of South Australia; 2015 [cited 8 January 2019] Available from: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/challenging+behaviour+strategy/challenging+behaviour+policy+framework>.
64. CareSearch. Pain in dementia and other neurological diseases. [Internet]: CareSearch; 2017 [cited 16 January 2019] Available from: <https://www.caresearch.com.au/caresearch/tabid/2394/Default.aspx>.
65. Dementia Training Australia. The Pain Puzzle Dementia Training Australia online course. [Internet]: Dementia Training Australia; [cited 10 January 2019] Available from: <https://www.dta.com.au/>.
66. Department of Health and Ageing. Transition Care Program Guidelines – 2011. Canberra: Department of Health and Ageing, 2011.
67. Agency for Clinical Innovation. Aged Care Emergency [Internet]: Agency for Clinical Innovation 2017 [cited 7 January 2019] Available from: <https://www.aci.health.nsw.gov.au/networks/eci/clinical/ace>.
68. Eastern Health. Residential Inreach (RIR). [Internet]: Eastern Health [cited 7 January 2019] Available from: <https://www.easternhealth.org.au/services/item/685-residential-inreach-rir>.
69. NSW Ministry of Health. NSW Aged Care Services in Emergency Teams Practice Guideline. Sydney: NSW Government 2014.
70. Clinical Excellence Queensland. Geriatric Emergency Department Intervention (GEDI). [Internet]: Queensland Government; 2018 [cited 7 January 2019] Available from: <https://clinicalexcellence.qld.gov.au/improvement-exchange/gedi>.



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