AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE







National Safety and Quality Health Service Standards

User guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium

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Level 5, 255 Elizabeth Street, Sydney NSW 2000 Phone: (02) 9126 3600 Fax: (02) 9126 3613

Email: mail@safetyandquality.gov.au Website: www.safetyandquality.gov.au

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Chapter 1 Introduction

The National Safety and Quality Health Service (NSQHS) Standards¹ 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, consumers, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision.

The NSQHS Standards 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 that consumers can expect from their health service organisations.

This second edition of the NSQHS Standards embeds person-centred care and addresses 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.

People with cognitive impairment 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.² Patients with dementia or delirium are at increased risk of preventable complications and adverse events, such as falls and pressure injuries, and require precautions to prevent harm.^{3,4}

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 critical illness⁵, 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 prevent harm occurring. The National Safety and Quality Health Service Standards <u>User guide for acute</u> and community health service organisations that provide care for children⁶ includes information about cognitive impairment. The NSQHS Standards User guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium (the User Guide) outlines critical actions in the second edition of the NSQHS Standards that support safe and highquality care for patients with cognitive impairment or at risk of delirium.

This User Guide is relevant to all health service organisations that provide general or specialised health care to patients with cognitive impairment. The main purpose of the User Guide is to suggest strategies that health service organisations can consider for implementation that are linked to the NSQHS Standards. Links to further resources are also provided to assist with implementation. Examples of good practice demonstrate that these actions are achievable and are being implemented across Australia. <u>Supplementary resources</u> have also been developed for clinicians.

How to use this User Guide

The User Guide first describes clinical governance as the overarching framework in which all the actions that follow take place.

It discusses the three specific cognitive impairment actions listed in the second edition of the NSOHS Standards. The chapters that follow outline additional actions listed in the NSQHS Standards that are particularly critical in supporting implementation of the specific cognitive impairment actions. These are summarised in Table 1 on page 6. These additional critical actions are from the Clinical Governance, Partnering with Consumers, Medication Safety, Comprehensive Care, Communicating for Safety, and Recognising and Responding to Acute Deterioration Standards. The critical actions are supported by further actions or enable further actions to be implemented for the provision of safe and high-quality care for patients with cognitive impairment.

The chapters outlining critical actions each provide information about:

- Why the action is critical for patients with cognitive impairment
- Strategies for improvement
- Additional actions that support the critical actions
- Resources
- Examples of good practice
- Examples of supporting evidence for accreditation.

Four case studies are also provided to illustrate care for patients with cognitive impairment or at risk of delirium that went well, care that did not go well and what could have been done better.

The User Guide builds on <u>A better way to care: Safe</u> and high-quality care for patients with dementia or delirium in hospital – Actions for health services managers.⁷ This resource was developed by the Commission in 2014 to link improvements in the care of patients with dementia or delirium with the first edition of the NSQHS Standards.

While available to download and print, this Use Guide has been designed to be viewed electronically. It incorporates links to external websites and will be updated as required. It is complemented by three other resources that focus on cognitive impairment:

- A better way to care: Safe and high-quality care for patients with cognitive impairment or at risk of delirium in acute care services – Actions for clinicians (second edition)⁸ is a resource for clinicians that 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 highquality care. It outlines actions that clinicians can take to improve care for their patients with cognitive impairment for each step of the pathway. It consolidates evidence-based actions from a range of existing guidelines and resources, and reflects good practice already under way in many hospitals across Australia. Initially produced to align with the first edition of the NSQHS Standards, it has been updated to align with the second edition.
- Clinician fact sheet: Cognitive Impairment: Clinicians can take action to reduce the risk of harm⁹ includes the pathway in a flowchart and a summary of the key steps for clinicians.
- The Delirium Clinical Care Standard¹⁰ outlines the key components of clinical care for patients with suspected delirium and patients at risk of developing delirium in hospital. It is accompanied by a set of indicators to support clinical teams and health services to identify and address areas that require improvement at a local level.

The key tasks, strategies, and use of resources provided in this User Guide are not mandatory. Health service organisations can choose improvement strategies that are specific to their local context.

These strategies should be meaningful, useful and relevant to the organisation's governance, structure, workforce and consumers.

Organisations that are part of a corporate group may need to refer to the implementation strategies required by their governing body or management.

While this User Guide highlights a selected number of actions or parts of actions, other actions and parts of actions in the NSQHS Standards can also be relevant for patients with cognitive impairment.

This guide is designed as a supplement to existing resources to assist health service organisations to implement the NSQHS Standards. These resources are available on the Commission's **NSQHS Standards microsite**.¹¹



Туре	Action number
There are three specific	5.29 Developing a system for caring for patients with cognitive impairment
actions about cognitive impairment in the NSOHS Standards	5.30 Clinicians use the system for caring for patients with cognitive impairment
	8.5 Recognising acute deterioration in mental state
Among the actions that are relevant for all patients, some are particularly critical for patients with cognitive	 1.15 Diversity and high-risk groups 1.20c Safety and quality training 1.27 Evidence-based care 1.29–1.33 Safe environment
impairment or at risk of delirium	2.4 and 2.5 Informed consent and substitute decision making 2.6 and 2.7 Sharing decisions and planning care
	4.10b Medication review
	5.4 Systems for comprehensive care 5.5 Collaboration and teamwork 5.7 Screening and assessment processes and identification of the risks
	of harm 5.9 Advance care planning
	5.33 Predicting, preventing and managing aggression and violence 5.35 Minimising restrictive practices: restraint
	6.4 Effective communication to transfer critical information
	8.6 Escalating care

Table 1: Actions related to cognitive impairment in the NSQHS Standards

Туре	Action number
There are also actions that support or enable safe and high-quality care for patients with cognitive impairment or at risk of delirium	 1.2 Specific health needs of Aboriginal and Torres Strait Islander people 1.4 Safety and quality priorities for Aboriginal and Torres Strait Islander people 1.8 Measurement and quality improvement 1.17 My Health Record system 1.25 and 1.26 Roles and responsibilities
	2.10 Effective communication 2.13 Partnership with Aboriginal and Torres Strait Islander communities
	4.5 and 4.6 Medication reconciliation4.11 Information for patients4.12 Provision of a medicines list
	5.4b Provide care in a setting that best meets their clinical needs 5.4d Clinician with overall accountability
	5.10 and 5.11 Clinicians use screening processes and comprehensively assess 5.12 Clinicians document screening assessment findings
	5.18–5.20 Comprehensive care at the end of life 5.21, 5.24 and 5.27 Other risks of harm
	5.34 Collaboration with families in managing aggression 6.7 and 6.8 Clinical handover
	6.11 Documentation of information
	8.7 Patients, carers or families escalate care 8.10 Responding to deterioration
These criteria are required for effective clinical governance processes	1.1–1.6 Governance, leadership and culture 1.7–1.18 Patient safety and quality improvement systems 1.19–1.28 Clinical performance and effectiveness
	2.1–2.14 Partnering with consumers

Chapter 2 Clinical Governance Framework

Good health outcomes rely on effective governance and management processes and the establishment of safety and quality systems. These processes and systems form the basis of a clinical governance framework. To support the delivery of safe and high-quality care, the Commission developed the <u>National</u> Model Clinical Governance Framework.¹²

The key components of a clinical governance framework as described in the National Model Clinical Governance Framework are reflected in the Clinical Governance Standard and the Partnering with Consumers Standards of the NSQHS Standards. These are summarised in Figure 1.

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.¹² 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.





For cognitive impairment, each group's accountabilities are reflected in the following roles.

Patients and carers

Patients with cognitive impairment, carers, support people and families participate as partners to the extent that they choose, in line with the patient's needs and preferences. These partnerships can be in their own care, and in organisational design and governance.

Clinicians

Clinicians work within, and are supported by, welldesigned clinical systems to deliver safe, highquality clinical care for patients with cognitive impairment. Clinicians are responsible for the safety and guality of their own professional practice, and for following professional codes of conduct including requirements that align with the clinical governance framework. 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 for patients with cognitive impairment. They understand that their responsibilities include working in partnership with patients, carers, support people and families in the delivery of care.

Managers

Managers advise and inform the governing body, and operate the organisation within the strategic and policy parameters endorsed by the governing body. They are primarily responsible for ensuring that the systems to identify and respond to the needs of patients with cognitive impairment are well designed and perform well. Managers support clinicians and ensure systems are in place to effectively partner with patients and carers in the governance of the organisation.

Governing body

The governing body is ultimately responsible for ensuring that the organisation is run well and delivers safe, high-quality care for patients with cognitive impairment. It does this by establishing a strong safety culture that recognises cognitive impairment as a safety and quality issue that is part of the organisation's strategic direction. It ensures that the risks of harm for patients with cognitive impairment are addressed within an effective clinical governance system. It sets a culture for partnering with consumers and ensures resource allocation enables the organisation to partner with patients and carers. It monitors progress in improving the safety and quality of care provided to this high-risk group.

The outcomes of effective clinical governance related to patients with cognitive impairment or at risk of delirium are described in Table 2.

Health service organisations will need to make progressive improvements so that cognitive impairment and delirium risk are part of the organisation's clinical governance framework. While it is recognised that health service organisations will be at different stages of implementation with varying starting points, improvements should be achievable over a planning cycle.

When improvements are successfully implemented, leaders at all levels use clinical governance systems to improve safety and quality for patients with cognitive impairment. Policies and procedures are reviewed; improvement strategies are implemented and monitored. Reports are provided to the governing body, the workforce and consumers. The organisation uses information about patients with cognitive impairment from incident reporting, feedback and complaints to improve safety and quality. Effective safety and quality systems are crucial in enabling health service organisations to actively manage and improve the safety and quality of health care for patients with cognitive impairment.

Resources

The National Model Clinical Governance Framework¹² provides a summary of the roles and responsibilities for clinical governance. The document is a valuable resource when considering how to incorporate safety and quality systems for cognitive impairment into the organisation's clinical governance framework. Implementation of an organisation's clinical governance system involves contributions by individuals and teams at all levels of the organisation.

The National Safety and Quality Health Service Standards Guide for Governing Bodies¹³ provides further advice to governing bodies exercising their governance responsibilities in the implementation of the NSQHS Standards.

Table 2: Outcomes of effective clinical governance related to patientswith cognitive impairment or at risk of delirium

Role	Outcomes of effective clinical governance related to patients with cognitive impairment or at risk of delirium
Patient with cognitive impairment	When I go to hospital, my cognitive impairment or my delirium risk is identified, understood and responded to. My comprehensive care plan is tailored to my needs, goals and preferences and is delivered in a way that protects my dignity
or at high risk	My care is provided in a safe, supportive and culturally appropriate environment
delirium	l am supported to understand and participate in all decisions and discussions about my care to the extent I am capable. My substitute decision-maker is identified and consulted if I am unable to consent to medical treatment
Carer	l am informed and consulted on the development of the comprehensive care plan of the person l care for, in line with the person's preferences and needs
	l am supported when I choose to be involved in the person's care, in line with the person's preferences and needs
	I am encouraged to report changes in the behaviour, or physical or mental condition of the person I care for
Workforce	I am alert to the risk of delirium, I am aware when a patient has cognitive impairment and I can respond to their additional communication, orientation and support needs
	l understand the safety and quality risks for patients with cognitive impairment and l know I can act to make a positive difference to patient outcomes
	The system supports me to provide the right care to patients with cognitive impairment and to seek input from carers and other support people where appropriate
Manager	l work with the workforce and consumers to design and implement a system for cognitive impairment
	I seek regular feedback from patients, carers and families to improve patient outcomes and their experience of care
	I regularly monitor the use of best-practice evidence-based strategies in the care plan, provide feedback and work with the workforce and consumers to implement improvement strategies
	l review and, if necessary, revise the organisation's education and training program to support implementation
	l ensure that the facility is designed to support the needs of patients with cognitive impairment and at high risk of developing delirium
Governing body member	I set the strategic direction for responding to the risks of harm from cognitive impairment. I show leadership and commitment to partnerships with consumers
	I endorse the clinical governance framework that includes cognitive impairment and allocates roles, responsibilities and accountabilities for establishing or maintaining the system for cognitive impairment
	l seek reports to ensure a system for providing high-quality care for patients with cognitive impairment is in place and monitor progress
	l champion the importance of the environment in supporting high-quality care for patients with cognitive impairment and at high risk of developing delirium

Chapter 3 Cognitive impairment in the NSQHS Standards The primary aim of the NSQHS Standards is to protect the public from harm and improve the quality of health care. There are specific actions that relate to cognitive impairment in the NSQHS Standards in recognition of the greater risk of harm for people with cognitive impairment, their prevalence in hospital and the existence of strategies to address these risks.

People with cognitive impairment who are admitted to hospital are at a significantly increased risk of preventable complications such as falls, pressure injuries, delirium and failure to return to premorbid function, as well as adverse outcomes such as unexpected death, or early and unplanned entry into residential care.^{3, 14, 15} People with cognitive impairment may also experience distress in unfamiliar and busy environments. Inappropriate environments may also accelerate functional decline.¹⁶

A Queensland study found that around 20% of people 70 years of age or over 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.² Although cognitive impairment is a common condition experienced by people in health service organisations, it is often not detected, or is dismissed or misdiagnosed.

The Comprehensive Care Standard is an important new development in the second edition of the NSQHS Standards. This new Standard recognises the need for care that is centred on patient goals and wellbeing and also addresses important areas that have potential for significant improvements in care. Cognitive impairment has been included in this Standard in recognition that some of the complications and adverse outcomes associated with cognitive impairment are preventable. Furthermore, harm can be minimised if cognitive impairment is identified early and action is incorporated in the comprehensive care plan to address the associated risks. Delirium, once thought to be benign and transient, can have lasting, serious consequences. Poor outcomes for patients with delirium include increased cognitive and functional decline, hospitalacquired complications, longer length of stay, increased risk of entry into residential care, and death.^{4,17, 18} Mortality rates are high, increasing by 11% for every additional 48 hours of active delirium¹⁹, and failure to detect delirium in the emergency department (ED) is associated with increased mortality following discharge.²⁰

Although delirium is common in hospitalised older patients, the rate of prevalence varies across different populations. For example, rates of delirium in older people after orthopaedic and cardiac surgery are reported to be just over 50%²¹⁻²⁴ and 23% in vascular surgery.²⁵ Within an intensive care environment, approximately one third of patients will develop delirium, and have an increased risk of dying in hospital, longer length of stay and cognitive impairment after discharge.²⁶

A 2015 meta-analysis reported that multicomponent non-pharmacological delirium interventions can halve incident delirium (delirium that develops during a hospital stay) as well as significantly reduce the rate of falls.²⁷ These interventions include reorientation, therapeutic activities, reduction in psychoactive drugs, early mobilisation, adequate hydration and nutrition, and provision of hearing and visual aids.⁴ Cognitive impairment should always be investigated to see whether it may be delirium, as underlying causes may be treatable. Where possible, investigation should include seeking collateral information from carers, family members or other support people.

Whatever form of cognitive impairment a person may have, getting to know each individual, and understanding how each person is affected, how they are interpreting their environment and what they are experiencing are fundamental to highquality care. This approach is built into the second edition of the NSQHS Standards. Cognitive impairment influences medical treatment, health care and discharge arrangements. A patient with cognitive impairment may:

- Not be able to give, or need time and support to provide, informed consent and to actively participate in their own care
- Have difficulties relaying information, including history of symptoms and medical history, pain or discomfort
- Not remember instructions or discussions and need information repeated and provided in writing
- Become disoriented in finding their way around a ward or when trying to find their way to appointments
- Need information provided more slowly and be allowed more time in responding to questions and undertaking activities
- Become dehydrated while waiting in the ED, contributing to the development of delirium if they are unable to communicate thirst and need prompting to drink
- Not be able to manage lids on containers at mealtimes and leave their food untouched
- Not be able to communicate the need to go to the toilet or not be able to locate it, and become increasingly uncomfortable and distressed as a result
- Be disoriented and become anxious in unfamiliar, noisy clinical environments
- Misplace their glasses or hearing aids
- Have communication difficulties that add to their distress; and the combination of these factors can quickly trigger behavioural disturbance
- Experience additional cognitive difficulties following surgery
- Have difficulty understanding changes to their medicines and may not take medicines correctly on discharge.



Chapter 4 Actions in NSQHS Standards that specifically relate to cognitive impairment There are three actions in the second edition of the NSQHS Standards that relate specifically to cognitive impairment. The first two actions focus on developing and using a cognitive impairment system. The third action incorporates the recognition and response to delirium and deteriorating behaviour in the organisation's system for recognising and responding to acute deterioration.

Comprehensive care

The intent of the **Comprehensive Care Standard**²⁸ is to ensure that patients receive appropriate clinical care that is aligned with their expressed goals of care and their healthcare needs. Their risks of harm are identified, prevented where possible and managed as part of their comprehensive care plan.

The Comprehensive Care Standard has two specific actions (5.29 and 5.30) related to patients who have cognitive impairment or are at risk of developing delirium. They require health services to have a system for caring for cognitive impairment and for clinicians to use the system.

Action 5.29

The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to:

- a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the <u>Delirium Clinical Care Standard</u>¹⁰, where relevant
- b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation.

Action 5.30

Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to:

- a. Recognise, prevent, treat and manage cognitive impairment
- b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care.

Recognising and responding to acute deterioration

In the second edition of the NSQHS Standards, the **Recognising and Responding to Acute Deterioration Standard**²⁹ now includes recognition and response to acute deterioration in mental state. This new focus is relevant to cognitive impairment as it highlights the importance of being alert to delirium, assessing patients when changes are observed or reported, and taking action to manage these changes.

Action 8.5

The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to:

- a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium
- b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan
- c. Assess possible causes for acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported
- d. Determine the required level of observation
- e. Document and communicate observed or reported changes in mental state.

What do these actions mean for the health service organisation?

The health service organisation needs to develop a system for caring for cognitive impairment that supports clinicians to identify patients with cognitive impairment or at risk of developing delirium, to minimise their risk of harm and provide safe and high-quality care. The key elements of this system are listed in Table 3.

Processes need to be established that enable clinicians to undertake cognitive screening, and clinical assessment, establish goals of care, assess for delirium, and identify and treat the causes of delirium. Clinicians should also be able to identify additional risks and care needs for inclusion in the comprehensive care plan. Delirium prevention strategies should be introduced for patients at risk of delirium and incorporated into the model of care for units where the majority of patients are at high risk.

A plan alone does not minimise risk or guarantee the provision of safe and high-quality care. Clinicians need to understand their roles, responsibilities and accountabilities and have the knowledge and skills to be able to use the system and implement the actions that are part of the care plan. A crucial component of implementation is to work closely with patients, carers and families to provide person-centred care.

Clinicians need to be supported to implement strategies to reduce a person's distress, in partnership with the patient and carer and in line with the patient's needs and preferences. They need access to training and to understand their roles so that are they can respond appropriately to any behavioural issues that arise, undertake a comprehensive assessment and avoid antipsychotics and other psychoactive medicines as the first line of response. These medicines should only be used when a patient is severely distressed or there is an immediate risk of harm to themselves or others.

Clinicians need to be alert to the possible development of incident delirium. Processes need to be put in place to monitor patients at risk and to assess or re-assess if there is any change or deterioration in the patient's behaviour, mental status or physical condition.

Details about the elements of cognitive impairment systems are included in the following chapters. Table 3 demonstrates how the critical actions that are described in the following chapters link to the key elements. The table also makes the link to the quality statements in the **Delirium Clinical Care Standard.**¹⁰ **Table 3:** Key elements of a system for caring for cognitive impairment to identify
patients with cognitive impairment or at risk of developing delirium

Key elements of a system for cognitive impairment (Actions 5.29, 5.30 and 8.5)		Delirium Clinical Care Standard Quality statements	
A well-designed cognitive impairment system is responsive to the risk profile of the organisation's patient population and the design1.of the environment maximises safety and quality. It supports skilled clinicians to implement evidence-based strategies to:1.		Early screening (cognitive screening is also included in the Quality	
 Routinely screen for cognitive impairment in patients aged 65 years or over using a validated tool 	5.7, 5.10	statement 1 of Hip Fracture Standard)	
 Screen patients of any age at high risk of delirium and when the patient, carer, family or other key informants raise concerns about cognitive impairment 	8.6e		
For all patients with cognitive impairment:			
 Assess for delirium and reassess with any changes to behaviour or thinking using validated delirium tools applicable to the setting 	5.7	Assessing for delirium	
 If delirium is identified, investigate and treat the causes of delirium 	5.14, 8.6	Identifying and	
 Investigate (or refer for investigation) other causes of cognitive impairment if not known 	5.11	treating underlying causes	
 Partner with patients, carers and family members, provide information and set goals of care in line with advance care planning processes 	5.9, 5.13		
 Identify other risks of harm and additional care needs 	5.10	Preventing falls and	
 Comprehensively assess and develop an individualised plan 	5.11-5.13	pressure injuries	
• Support patients to understand and participate in healthcare decisions	2.6, 2.7		
 Obtain informed consent, or if the patient is assessed as unable to provide consent, consult their substitute decision-maker 	2.4, 2.5		
 Effectively manage medical issues 	5.14		
 Communicate effectively and seek information to provide individualised care 	6.4		
 Respond appropriately to behavioural symptoms, including minimising the use of antipsychotics and other psychoactive medicines and minimising restraints 	5.33, 5.35	Minimising use of antipsychotics	
 Provide a supportive environment 	1.29-1.33		
 Manage transitions effectively 	6.4b	Transition from hospital care	
For patients at risk of delirium:			
 Implement multi-component delirium prevention strategies 	5.14	Interventions to prevent delirium	
For all patients:			
 Be alert to, assess for delirium and respond when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported 	8.5, 8.6	Assessing for delirium	

These steps are not linear. Keeping a person safe should happen at the same time as investigating the possible cause of delirium, if detected.

Patient story 1

The following story and Table 4 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. 2011.³⁰

Table 4: Patient story 1 summary – outcomes, links to actions in theNSQHS Standards and suggested improvement strategies

What did not go well?	NSQHS Standards
No falls risk assessment	5.10
Change in condition not acted on	8.10
No subsequent delirium assessment	5.29
Use of bedrails	5.24
Bed not in a low position	
Daughter's (carer's) safety advice ignored	5.10
False reassurance	
Clinicians not understanding care needs	5.13
Patient's bed not easily visible to nursing staff	1.29
Daughter not informed of fall	6.9

What went well?	NSQHS Standards
Daughter informed clinicians that mother had dementia	6.10
Daughter raised concerns about the risk of her mother falling	6.10

What could have been done better?	NSQHS Standards
Clinicians recognising and documenting existing dementia	5.29, 6.11
Clinicians undertaking further assessment and developing a comprehensive care plan to address safety issues	5.13
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	5.14
Engaging carer, and taking carer concerns seriously and acting on them	5.30b, 6.3, 8.6

Chapter 5 Clinical Governance Standard

The <u>Clinical Governance Standard</u>,³¹ together with the Partnering with Consumers Standard provide the basis for a robust clinical governance framework. They set the overarching requirements for the effective implementation of all other standards. The Clinical Governance Standard recognises the importance of governance, leadership, culture, patient safety systems, clinical performance and the patient care environment in delivering high-quality care.

The four criteria are:

- 1. Governance, leadership and culture
- 2. Patient safety and quality systems
- 3. Clinical performance and effectiveness
- 4. Safe environment for the delivery of care.

While all actions are important, a number of actions from the Clinical Governance Standard are discussed in this chapter because of their particular relevance to providing safe and high-quality care for people with cognitive impairment.

Diversity and high-risk groups

Action 1.15

The health service organisation:

- a. Identifies the diversity of the consumers using its services
- b. Identifies groups of patients using its services who are at higher risk of harm
- c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care.

Why is this action critical for patients with cognitive impairment?

Knowing the risk profile of their patient population enables health service organisations to develop strategies to overcome the risks of harm related to cognitive impairment.

Health service organisations are expected to know their patient population profile and the common risks they face. Patients with all forms of cognitive impairment should be included in risk profiles as they are at higher risk of harm and consistently have poor experiences of health care. For example, people with intellectual disability have high healthcare needs, with frequent hospital use but face significant barriers to appropriate diagnosis, treatment and management.³² Patients from diverse backgrounds may experience discrimination and stigma or language difficulties that may create further barriers in accessing health care.

For many health service organisations, the largest group of patients at greatest risk of cognitive impairment will be older patients aged 65 and over; these patients account for 45% of patient-days for all hospital stays.³³ Some organisations may have a relatively younger population who also have a range of cognitive care needs. In the Northern Territory, a point prevalence study confirmed a high proportion of patients under 65 years of age with cognitive care needs, many of whom were from Aboriginal and Torres Strait Islander background. Other examples include rehabilitation units with younger patients with acquired brain injury and services with patients presenting with cognitive impairment related to drug and alcohol use. An important consideration is an understanding of the demographic and health profile of the Aboriginal and Torres Strait Islander population and communities in the organisation's catchment area. Local understanding is important, given the extensive diversity in Aboriginal and Torres Strait Islander communities.

Aboriginal and Torres Strait Islander people remain significantly disadvantaged across a range of social and economic indicators, including access to health services and health outcomes. Their poor health status is reflected in dementia prevalence rates. Studies have shown that remote, rural, regional and urban Aboriginal and Torres Strait Islander people have dramatically higher rates of dementia and at younger ages, most commonly Alzheimer's dementia.^{34, 35}

It is possible that disadvantage and trauma across the life span of Aboriginal and Torres Strait Islander people increases the risk of developing dementia later in life. Important risk factors include head injury, stroke^{36, 37} and epilepsy. Well-designed studies in remote and urban populations found that dementia due to alcohol abuse was relatively uncommon.³⁵

Strategy for improvement

Incorporate information on cognitive impairment into planning and care delivery

Cognitive impairment affects a patient's ability to function in an acute clinical environment, which in turn can increase the risk of harm. Patients with cognitive impairment, as reflected in the organisation's patient population and diversity profile, should be considered a high-risk group in health service planning. Health service organisations can implement alternate models of care including hospital substitution, residential outreach, fast track and transition programs to minimise or avoid unnecessary exposure to the acute care environment and provide appropriate intervention in an appropriate setting for these patients. Evidence suggests that 'hospital in the home' programs may be an effective alternative to inpatient care for a select group of older patients.³⁸ This model of care has been shown to reduce delirium in geriatric rehabilitation patients and behavioural disturbance in patients with advanced dementia.^{39,40} Other programs, such as transition care programs, can provide extra short-term support and assist in the transition back to the community.⁴¹

Another model of care that can assist in coordinating the health care of patients with complex care needs, such as cognitive impairment, is the integration of acute, shared care models and subacute, outpatient and community services under the same clinical leadership.⁴¹

Key agencies providing supported accommodation for people with intellectual disability may be located or operate within the organisation's catchment area. Building a relationship and developing local protocols with disability accommodation services can clarify roles, responsibilities and accountabilities before, during and after transfer of care from hospital.

Through understanding the diversity of its catchment population the health service organisation can develop strategies to reduce barriers to safe and high-quality care. These include:

- Reviewing education and training policies and programs on cognitive impairment to cover key areas such cultural competency
- Including education of care staff in outreach models to encourage more timely responses
- Ensuring interpreters and liaison officers understand cognitive impairment and do not answer on behalf of a patient undergoing cognitive screening and delirium assessment
- Developing partnerships with local disability services
- Developing partnerships with Aboriginal and Torres Strait Islander health service organisations such as local Aboriginal medical services and Aboriginal community controlled health organisations.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **1.2** The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
- 2.13 The health service organisation works in partnership with Aboriginal and Torres Strait islander communities to meet their healthcare needs.

Successful implementation of this strategy will support the following action:

5.4b The health service organisation has systems for comprehensive care that provide care to patients in the setting that best meets their clinical needs.

Resources

Under **resources/information a-z**⁴² 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.

Examples of good practice

Policy

NSW Ministry of Health Policy Statement 2017 **Responding to the needs of people with disability during hospitalisation**⁴³ includes establishing protocols with key local agencies.

Programs and models of care

The Transition Care Programme⁴⁴ provides a shortterm package of services at the end of a hospital stay to restore functioning and provide time to finalise long-term arrangements.

The NSW Aged Care Emergency (ACE) Model of Care⁴⁵ and the Victorian residential in-reach (RIR) service⁴⁶ aim to improve the management of urgent acute health issues for people living in residential aged care.

Aged Care Services in Emergency Teams⁴⁷

rapidly identify and assess patients with cognitive impairment in EDs, facilitating discharge or fasttracking admissions where appropriate. <u>The</u> <u>Geriatric ED Intervention (GEDI)</u>⁴⁸ is a similar initiative.

Collaboration

A project from Melbourne Ageing Research Collaboration's (MARC's) project is <u>Preventing</u> Avoidable Hospital Admissions for People with Dementia (PAHA).⁴⁹

The **New England Dementia Partnership**⁵⁰ in NSW produced a resource, New England North West Dementia Care, that includes a single, standardised referral form and referral pathway for memory assessment services.

The Top End Health Service (TEHS) undertook a comprehensive, evaluated Cognitive and Delirium Care in Hospital Project (CDCP), across the four TEHS hospital sites over three years (2016–19). Following data collection that confirmed high rates of delirium risk and cognitive care needs at younger ages, a multi-component integrated cognitive care pathway is being implemented and evaluated. An important component is a new, culturally relevant cognition screen for use in acute care where 50–80% of inpatients are Aboriginal and Torres Strait Islander people.

Examples of supporting evidence

- Organisational risk profile that details safety and quality risks for patients with cognitive impairment
- Administrative, clinical and indicator data on health outcomes for patients with cognitive impairment and examples of actions to reduce poor outcomes
- Committee and meeting records that demonstrate the health service organisation's involvement in dementia pathway initiatives to integrate primary, community and acute care
- Consumer information about cognitive impairment available in different formats and languages.

Safety and quality training

Action 1.20

The health service organisation uses its training systems to:

- a. Assess the competency and training needs of its workforce
- b. Provide access to training to meet its safety and quality training needs
- c. Monitor the workforce's participation in training.

Why is this action critical for patients with cognitive impairment?

Safety and quality outcomes are highly dependent on the knowledge, skills and performance of the whole workforce. This requires continual targeted education, training and performance management, and the allocation and understanding of roles, responsibilities and accountabilities.

The hospital workforce needs to associate cognitive impairment with increased risks of harm and to understand the importance of screening, monitoring and further action. Access to education and training can dispel the belief that 'nothing can be done' for patients with cognitive impairment and increase the workforce's delirium prevention efforts.

Despite increasing prevalence rates, cognitive impairment is often poorly recognised or thought not to be clinically relevant. Without appropriate education, cognitive impairment may be wrongly dismissed as a normal part of ageing, or delirium ruled out if a patient is orientated at only one time point.⁵¹ Deteriorating cognition or behaviour may be assumed to be a person's usual state, dismissed as dementia, or not properly assessed, and potentially treatable causes of delirium or cognitive impairment left untreated. Patients with cognitive impairment may also face negative or ageist attitudes. They may be perceived as being too complex, interfering with measured priorities or that nothing medically can be done for them; this is reflected in unprofessional labels such as 'acopia', 'social admission', and 'bed-blocker'.⁵² Additional barriers may be experienced because of the patient's social, economic or geographic circumstances; cultural background, religion or preferred language; or sexuality.

The workforce needs to know which patients need additional care, how to deliver that care and their role in communicating critical information. Awareness training needs to be accessible to both the clinical and relevant non-clinical workforce, including hotel services, paramedics and ambulance staff.⁵³ For example, members of the food service workforce need training about their role in managing risks associated with malnutrition and dehydration for patients with cognitive impairment.

The hospital workforce may not know how to communicate with a patient who is cognitively impaired, or may lack confidence in how to engage with carers and family members who often know the best ways to reduce a patient's distress in their absence.

Clinicians frequently encounter agitation and sometimes aggression from people with cognitive impairment and need skills to manage behavioural disturbances other than through the use of medicines such as antipsychotics or other psychoactive medication, or through physical restraint. Without training, those responsible for one-to-one supervision can take a custodial approach rather than introducing behaviour management or delirium prevention techniques.

Patients can quickly lose functional ability and independence. If pressured to save time with additional care needs, members of the workforce may take control of a patient's decision-making and tasks of daily living to save time, leading to further functional decline.

Increased knowledge can improve confidence and job satisfaction and improve communication with patients and family members. Multifaceted education programs that include enabling and reinforcing techniques can result in changes in staff behaviour and positive outcomes for patients.⁵⁴

Strategies for improvement

Review and, if necessary, revise the organisation's education and training program to support implementation

One way of reviewing the organisation's education and training program is to seek feedback from the workforce regarding their training needs, perceived gaps and preferred formats. Another way is to analyse incident management and feedback from patients' experiences to identify gaps.

Provide education, training and orientation for the workforce to understand their individual roles, responsibilities and accountabilities in working with patients, carers and families to prevent and reduce the risk of harm for people with cognitive impairment or at risk of developing delirium. Topics for training and education might include:

- Different forms of cognitive impairment, possibly including co-morbid mental health issues
- Risks of harm to patients with cognitive impairment
- That cognitive impairment is not a normal part of ageing
- Policies, procedures and tools for cognitive impairment (this may include the screening tools used by the organisation)
- Person-centred care
- Non-pharmacological interventions to reduce distress in patients with cognitive impairment
- Communicating with a patient who is cognitively impaired
- Engaging with patients, carers and families of patients with cognitive impairment
- Cultural awareness and competence
- Teamwork in providing high-quality care for patients with cognitive impairment or at risk of delirium
- Legislative responsibilities for informed consent and substitute decision-making.

Recruit cognitive champions who can reinforce education, offer peer support to help clinicians improve their skills and confidence, and organise relevant resources for their wards.⁵⁵ Successful implementation of this strategy will be supported by, or rely on, the following additional action:

1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients.

Allocate role and responsibilities

Clinicians from multiple disciplines and care and support staff all have a role in delivering safe and high-quality care for patients with cognitive impairment. To work together effectively as teams, the workforce needs to understand and be trained in their roles, responsibilities and accountabilities for safety and quality.

Workforce position descriptions can be reviewed to check that safety and quality roles, responsibilities and accountabilities are clearly defined for important activities such as for screening for cognitive impairment, delirium assessment, responding to acute deterioration, behaviour management and carer engagement.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **1.25** The health service organisation has processes to:
 - a. Support the workforce to understand and perform their roles and responsibilities for safety and quality
 - b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff.

Resources

Go to **online learning**⁵⁶ under resources / online learning on the ACSQHC cognitive care website.

Example of good practice

Cognition champions

Princess Alexandra Hospital introduced and evaluated its knowledge translation program, Cognition Champions (**CogChamps**).⁵⁵ The program demonstrated that nurses can be effectively empowered to educate other nurses about dementia and delirium and increase the rate of cognitive screening.⁵⁵

Awareness

The **Confused Hospitalised Older Person's Program**⁵⁷ (CHOPS) sites arranged multiple screenings of the film **Barbara's Story**⁵⁸ to raise awareness of the hospital experience of patients with dementia with the whole workforce.

Examples of supporting evidence

- Feedback from the workforce regarding their training needs for cognitive impairment and delirium risk
- Attendance records for orientation and induction training by clinicians and other members of the workforce related to cognitive impairment
- Skills appraisals and records of competencies for the workforce, including the locum and agency workforce
- Employment documents that describe the safety and quality roles, responsibilities and accountabilities for tasks related to the system for cognitive impairment
- Analyses of incident data and patient feedback to identify training needs and provide access to evidence-based training programs.

Evidence-based care

Action 1.27

The health service organisation has processes that:

- a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice
- b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care.

Why is this action critical for patients with cognitive impairment?

Good clinical governance promotes clinical practice that is based on evidence and best practice. There is increasing evidence of the effectiveness of strategies that can reduce the risks of harm for patients with cognitive impairment, reduce the risk of developing delirium, and increase safety during an acute care episode.

The current evidence and priority actions for patients with or at risk of delirium are incorporated in the **Delirium Clinical Care Standard**,¹⁰ developed by the Commission.

Delirium prevention is particularly relevant for health service organisations as delirium has been included in the list of hospital-acquired complications (HAC). A HAC refers to a patient complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.⁵⁹ The Independent Hospital Pricing Authority (IHPA) has outlined a pricing and funding model for HACs, which came in to effect from 1 July 2018.⁶⁰ Delirium is a multifactorial condition that results from a complex interplay between underlying risk factors and hospital-related events. Precipitating factors for delirium include:

- Polypharmacy, and adding more than three medications during the hospital stay
- Use of psychoactive medication
- Use of physical restraint
- Presence of in-dwelling catheters
- Recent surgery
- Under-nutrition and dehydration.

Delirium is easier to prevent than to treat. International research from a diverse range of settings shows that delirium is preventable in 50% of cases when multi-component nonpharmacological interventions are successfully implemented.²⁷ In the Intensive Care Unit (ICU), a bundle approach has decreased the likelihood of delirium.⁶¹ The evidence is mounting against the use of antipsychotics such as haloperidol for the treatment of delirium in different settings, such as intensive care and palliative care.^{62–65}

This action is also relevant to caring for people with all forms of cognitive impairment. Evidence confirms that antipsychotics have only modest benefit and are not effective in treating most behavioural and psychological symptoms of dementia (BPSD). BPSD include aggression, apathy, anxiety, agitation, psychotic symptoms, depression, disinhibited behaviours, wandering, nocturnal disruption and vocally disruptive behaviours.⁶⁶ There are a number of alternative terms used to describe behavioural and psychological symptoms, including responsive behaviours, changed behaviours, and expression of unmet needs. Behaviours of concern and challenging behaviours are not preferred terms.⁶⁷

Antipsychotics are known to further increase the risk of adverse events; for example, they are associated with increased morbidity such as stroke, pneumonia, falls and fractures and mortality.⁶⁸⁻⁷⁰ They are also associated with accelerated cognitive decline, increased confusion, parkinsonism and urinary incontinence. Many atypical antipsychotics are also anticholinergic, reducing the effectiveness of anticholinesterase dementia medicines.⁷¹

Recent dementia guidelines outline the steps in appropriately responding to behavioural and psychological symptoms.⁷² There is emerging evidence regarding the benefit of nonpharmacological or psychosocial interventions as effective alternatives to antipsychotic medicines.⁷³ Behavioural interventions that explore the purpose of behaviour have been found to be as effective as pharmacological treatment without possible adverse side effects.⁷⁴ Effective pain management can also reduce agitation and reduce the use of psychoactive medicines.⁷⁵

There have been positive evaluations of programs that can help reduce anxiety and distress for patients with cognitive impairment and assist in delirium prevention such as the TOP 5 program and well-structured volunteer program.⁷⁶⁻⁷⁸ In addition, there are programs that improve communication processes from admission to discharge such as the **A2D folder**.⁷⁹

Strategies for improvement

Adopt the cognitive impairment pathway

A better way to care: actions for clinicians has been updated to reflect the second edition of the NSQHS Standards and expanded to be applicable to all forms of cognitive impairment. It 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 highquality care. This pathway is summarised in Figure 2. The resource consolidates evidence-based actions from a range of existing guidelines and resources, and reflects good practice already under way in many health service organisations across Australia.

Health service organisations can adapt the pathway to fit with their local context and allocate roles, responsibilities and accountabilities for implementing the key steps and identify local referral arrangements to specialist support. It can be used as an educational as well as a monitoring tool. Its use will promote consistent practice across multidisciplinary teams.





Include the Delirium Clinical Care Standard in policies and process

The **Delirium Clinical Care Standard**¹⁰ aims to ensure that patients with delirium at the time of presentation to hospital receive optimal treatment to reduce the duration and severity of the condition. It also aims to ensure that patients at risk of delirium during a hospital admission are identified promptly and receive preventive strategies.

The Hip Fracture Clinical Care Standard⁸⁰ also includes cognitive screening for patients presenting to hospital with a suspected hip fracture.

Monitor delirium as a hospital-acquired complication

Hospital-acquired delirium should be monitored at multiple levels, including by clinicians, managers and governing bodies. Monitoring HACs enables the identification of opportunities to improve the systems in place for the identification, treatment and prevention of delirium.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **1.8** The health service organisation uses organisation-wide quality improvement systems that:
 - a. Identify safety and quality measures, and monitor and report performance and outcomes
 - b. Identify areas for improvement in safety and quality
 - c. Implement and monitor safety and quality improvement strategies
 - d. Involve consumers and the workforce in the review of safety and quality performance and systems.

Support clinicians to minimise the use of antipsychotics and other psychoactive medicines

Guidelines recommend that antipsychotic medicines are only appropriate if a person is severely distressed or there is an immediate risk of harm to themselves or others, and not as a first-line, routine response.⁷² There is a risk that any behavioural disturbance exhibited by a person with cognitive impairment is attributed to the person's cognitive impairment, response to the unfamiliar environment, or communication difficulties. It is essential that the underlying cause is sought as it may be related to delirium, pain, hunger, thirst or other unmet needs. The essential steps are to investigate and treat the possible causes of behavioural changes and use targeted non-pharmacological strategies through a personcentred approach to care.

If antipsychotics are used, key steps in prescribing antipsychotics include:

- Discussing risks and benefits with patients and carers and obtaining informed consent
- Targeting symptoms that will potentially respond
- Starting low, increasing slowly, monitoring and reviewing
- Limiting the time the patient is on the medicine.⁶⁶

Support clinicians at an organisational level to reduce the use of antipsychotics and other psychoactive medicines by:

- Adding requirements to policies and procedures for obtaining informed consent and considering alternatives before prescribing and administrating antipsychotics and other psychoactive medicines, including those prescribed 'as required' (prn)
- Working with pharmacists to monitor use of antipsychotics and other psychoactive medicines and obtain feedback on clinical effectiveness
- Providing education on the risks and benefits of antipsychotics, alternative options and individual strategies (Figure 3)
- Using medication reviews for patients with cognitive impairment.

Figure 3: Infographic outlining rationale and strategies for reducing inappropriate use of antipsychotics⁸¹

REDUCING INAPPROPRIATE USE OF ANTIPSYCHOTICS in people with behavioural and psychological symptoms of dementia (BPSD)

Antipsychotics are medicines that can reduce symptoms of psychosis but have limited benefit for BPSD

....

Use of antipsychotics in Australia is **high** for BPSD in all settings



Antipsychotics are overused for BPSD

Around **1 in 5** residents in Australian aged care homes are prescribed at least one antipsychotic medicine



Guidelines recommend that antipsychotics **should not be used** as first-line treatment for BPSD

Inappropriate use of antipsychotics is a problem



Only one antipsychotic (risperidone) is approved for BPSD

on the PBS, and only to be used:

- on authority script for 12 weeksfor dementia of Alzheimer's type
- with psychosis and aggression, and • after non-pharmacological
- interventions have failed.



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Resources

Commission resources

- A better way to care: Safe and high-quality care for patients with cognitive impairment or at risk of delirium in acute care services – Actions for clinicians (second edition)⁸
- Delirium Clinical Care Standard¹⁰
- HACs information kit fact sheet: Delirium⁸²
- Infographic outlining rationale and strategies for reducing inappropriate use of antipsychotics.⁸¹

Guidelines and handbook

- Clinical practice guidelines and principles of care for people with dementia⁷², and Consumer companion guide⁸³
- Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD): a handbook for NSW Health clinicians.⁶⁶

Examples of good practice

Queensland Older Person's State-wide Clinical Network⁸⁴ has conducted an audit on the use of antipsychotics, benzodiazepines and medicines with significant anticholinergic action in Queensland public hospitals.

The Australian and New Zealand Society for Geriatric Medicine's (ANZSGM) first of **TOP 5 low-value practices and interventions**⁸⁵ is to not use antipsychotics as the first choice to treat behavioural and psychological symptoms of dementia.

Examples of supporting evidence

- Audit results of healthcare records for adherence to the cognitive impairment pathway and the Delirium Clinical Care Standard¹⁰
- Education and training records on risk of administering antipsychotic and other psychoactive medicines and need for informed consent in line with guardianship legislation
- Reports on delirium as a hospital-acquired complication
- Examples of quality improvement activities that have been implemented and evaluated to increase use of non-pharmacological behavioural strategies.

Safe environment for the delivery of care

Most of the actions in this criterion are critical, reflecting the importance of the environment for providing high-quality care to patients with cognitive impairment.

Action 1.29a

The health service organisation maximises safety and quality of care through the design of the environment.

Action 1.30

The health service organisation:

- a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce
- b. Provides access to a calm and quiet environment when it is clinically required.

Action 1.31

The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose.

Action 1.32

The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so.

Action 1.33

The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.

Why are these actions critical for patients with cognitive impairment?

The physical environment can hinder or enhance the provision of safe and high-quality care. Cognitive impairment can affect a person's orientation, and ability to recognise objects and to filter unwanted stimulation.⁸⁶ Patients with cognitive impairment are likely to find a busy, noisy clinical environment, with unfamiliar faces and different routines overwhelming, disorienting and distressing. They may not be able to locate the bathroom if it is not clearly marked or visible, or be able find their way to their bed. The design and layout of the clinical area, especially where there is limited access or clutter may make it difficult to walk around safely. Alternatively, good design can reduce distress, support independence and social interaction, and promote safety.

Carers are often stressed about having to leave their family member in an acute care environment where care may not be targeted to their additional care needs. Flexible visiting hours, strategies to consult carers, and providing a safe environment for patients with cognitive impairment can assist in allaying their concerns.⁸⁷

Going to hospital can be traumatic for Aboriginal and Torres Strait Islander people. This is particularly the case if the setting is far from Country or family, remembered as a place to die, or where children were historically removed. Past traumas may resurface, disrupting their spiritual well-being.⁸⁸ Aboriginal and Torres Strait Islander people may still face institutional racism, disrespect and unwelcoming environments. These additional factors may compound the distress experienced by an Aboriginal or Torres Strait Islander person as a result of cognitive impairment and require further efforts in creating a welcoming place that feels safe and accepting.

Strategies for improvement

Environment audits

Environment audits should be regularly conducted against evidence-based principles to see whether the environment supports high-quality care for patients with cognitive impairment.

There are well developed audit tools available to evaluate the safety of clinical environments to identify opportunities for environmental modifications.⁸⁶ The inclusion of signage in environment audits can highlight the lack of simple signage, including symbols for critical areas such as bathrooms.

Implement evidence-based design principles

Design principles⁸⁶ include reducing unhelpful stimuli such as clutter and noise, avoiding glare and patterns on flooring, and highlighting useful stimuli, such as the use of contrasting colours between floor and walls, or for toilet seats, and use natural lighting during the day. Access to safe outside areas can assist in reducing agitation and promoting mobility.

Design principles can be implemented at all levels. They can be included in scheduled major capital works or refurbishments, as well as through simple, small-scale changes at the clinical area and waiting areas. For example, clocks that display the correct time and date can aid in orientation.

Calm and quiet treatment environment

Consider creating quiet, decluttered rooms for patients with cognitive impairment so that unhelpful stimuli are reduced. Some hospitals have created specific units where an appropriate physical environment is combined with skilled and increased staffing levels for patients with cognitive impairment and behavioural disturbances. It is predicted that presentations of older people to EDs will increase. Many of these presentations will involve people who are frail with cognitive impairment, highlighting the importance of providing more appropriate design in this environment.^{89, 90}

Environmental noise leading to poor sleep may play a role in the development of delirium. Simple measures such as the use of ear plugs in ICU may reduce this risk.⁹¹
Provide flexible visiting arrangements

By facilitating unrestricted access for carers, family members or chosen support people, patients with cognitive impairment can be provided with emotional and social support. Flexible visiting arrangements can increase satisfaction and reduce anxiety for patients, carers and families. They can promote communication with the team and enable participation in care in line with the patient's references and needs.

The design of clinical areas (Action 1.29) can also promote the involvement of a support person, carer or family members through practical strategies such as providing beds or chairs for overnight stays and access to refreshment areas. Providing space where a large family gathering can wait when visiting can also help to respond to the cultural needs of visitors and carers.⁹²

Create a welcoming environment for Aboriginal and Torres Strait Islander people

Work in partnership with local Aboriginal and Torres Strait Islander peoples to review and implement the suggested strategies in the <u>User guide for</u> Aboriginal and Torres Strait Islander health.⁹²

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- 1.4 The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
- 2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
- **1.21** The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients.

Resources

- National Safety and Quality Health Service
 Standards User guide for Aboriginal and Torres
 Strait Islander health⁹²
- Dementia Training Australia environmental design resources⁸⁷
- Go to environment under resources/ information a-z⁴² on the ACSQHC cognitive care website.

Examples of good practice

Carer zones⁹³ commissioned at Blacktown Hospital, Sydney enable the conversion of a visitor's seat near the window to an overnight bed for carers to stay overnight.

Environmental improvements were included in sites implementing the Confused Hospital Older Persons (CHOPS) Program in NSW as described in these videos about <u>Hornsby Hospital</u>⁹⁴ and <u>Lismore</u> <u>Hospital.</u>⁹⁵

Clinicians provide suggestions for creating a supportive environment in hospital in this video **Dementia and delirium: Providing a safe and supportive environment in hospital.**⁹⁶

A Victorian resource, **Improving the environment for older people in Victorian EDs**⁹⁷ provides examples of good practice where the physical environment of EDs is improved to meet the needs of older patients.

- Observation that the physical environment is safe for patients with cognitive impairment
- Documents or evidence of environmental improvements in response to environmental audit results
- Room design that allows carers to stay overnight
- Records of collaboration with Aboriginal and Torres Strait Islander communities to design inclusive healthcare environments.

Chapter 6 Partnering with Consumers Standard

The intention of the <u>Partnering with Consumers Standard</u>⁹⁸ is to create an organisation in which there are mutually valuable outcomes.

This can be achieved by having:

- Consumers who are partners in planning, design, delivery, measurement and evaluation of systems and services
- Patients as partners in their own care, to the extent that they choose.

The second edition of the NSQHS Standards expands this Standard to include partnering with patients in the delivery of care.

The four criteria are:

- 1. Clinical governance and quality improvement systems to support partnering with consumers
- 2. Partnering with patients in their own care
- 3. Health literacy
- 4. Partnering with consumers in organisational design and governance.

While all actions are important, a number of actions from the Partnering with Consumers Standard are discussed in this action because of their particular relevance to providing safe and high-quality care for people with cognitive impairment.

Healthcare rights and informed consent

There are two actions under this item and they are critical for patients with cognitive impairment.

Action 2.4

The health service organisation ensures that its informed consent processes comply with legislation and best practice.

Action 2.5

The health service organisation has processes to identify:

- a. The capacity of a patient to make decisions about their own care
- b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves.

Why are these actions critical for patients with cognitive impairment?

It is a basic legal presumption that every adult can make their own healthcare decisions and consent to treatment.

However, some patients with cognitive impairment may not have that capacity or may need some level of support to make decisions. Clinicians have a legal and professional responsibility to obtain informed consent before treating any person and should satisfy themselves of their patient's capacity to provide this consent and make healthcare decisions. This includes informed financial consent.

Broadly speaking, when a person has capacity to make a particular decision, they are able to do all of the following:

- Understand the facts involved
- Understand the choices
- Weigh up the consequences of the choices
- Understand how the consequences affect them
- Communicate their decision.

If patients have difficulty in demonstrating this level of capacity to understanding and making decisions about their medical treatment, this warrants further exploration by clinicians. Clinicians must ascertain if the difficulty is due to cognitive impairment or due to other reasons such as health literacy, cultural differences, education levels or physical issues, such as hearing impairment. Clinicians need to present health information in ways that overcome these barriers.⁹⁹

Where a clinician believes that a patient's capacity is in question, it is the clinician's responsibility to give careful and detailed consideration of whether their patient has capacity, commensurate with the gravity of the decision to be made, to make a decision to accept or refuse treatment. Correctly identifying whether an individual has such capacity is fundamental to the protection of their human rights. All healthcare needs to be consistent with current legislation, regulations and jurisdictional requirements. When a person is assessed as not having capacity, clinicians need to be able to follow the guardianship legislation in their state or territory and to consult the person's substitute decision-maker or the relevant authority.

The hierarchy of substitute decision-makers varies under the different state and territory laws. Health administrators and practitioners should familiarise themselves with the relevant hierarchy in their state or territory. Generally, the hierarchy for seeking consent is:

- The substitute decision-maker appointed by the person in writing, or by a court or tribunal
- The spouse of the person
- A person who has the unpaid care of the person
- A close friend or relative of the person
- An appropriate court or tribunal.

Applications to courts or tribunals should be pursued as a last resort when all other options have been explored. Situations in which this may be necessary include when:

- There is no-one available to make substitute decisions informally
- The person has not put legal arrangements in place to appoint someone to make decisions for them when they lack capacity
- There is a disagreement or problem preventing a decision from being made.

If a court or a tribunal finds that a person does not have the capacity to make particular decisions and appoints a substitute decision-maker for some decisions, this does not automatically mean that the person does not have the capacity to make other types of decisions. Where the patient has not made provision for somebody else to make the health decisions on their behalf, or there is no order of a tribunal or court to the same effect, then the following principles should be followed whenever a patient's capacity is being considered:¹⁰⁰

- Always presume a person has capacity: Under common law, adults are presumed to have the capacity to make all their own decisions.
- Don't make assumptions that a person lacks capacity because of their age, appearance, disability, education level 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 merely because a decision may appear to others as being unwise, reckless or wrong. However, a decision that appears to be inconsistent with the person's best interests may indicate that further consideration needs to be given to their capacity to make that decision.
- 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 as many decisions as possible.
- 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.

Strategies for improvement

Review current informed consent processes

Informed consent processes must comply with state or territory legislation and best practice. Use the best practice principles for informed consent systems outlined in the **NSQHS Standards Guide for Hospitals**¹⁰¹ as a checklist. Key areas include maintaining the integrity of the consent system, patient information, documentation, education and training, protocols for complaints about consent processes and links to the organisation's open disclosure policy.

Review processes for determining patients' capacity to make decisions and for identifying substitute decision-makers

Ensure that effective processes are in place to identify:

- Patients who do not have the capacity to make decisions about their own health care
- Appropriate substitute decision-makers who can make decisions on behalf of the patient.

If effective processes are not in place, the **NSQHS Standards Guide for Hospitals**¹⁰¹ provides a list of strategies to develop them. These include developing an organisational policy incorporating relevant legislation, educating the workforce, and providing the resources and tools for capacity assessment.

Periodically evaluate informed consent and substitute decision-making

Health service organisations should periodically review the processes for informed consent and substitute decision-making to ensure they continue to meet the needs of patients and reflect best practice.

Resource

NSQHS Standards healthcare rights and informed consent¹⁰² web page on the NSQHS Standards microsite.

Examples of supporting evidence

- Patient information packages or resources about treatment and consent processes that are available for consumers in different formats and languages, consistent with the patient profile
- Feedback about the consent process from patients and carers after treatment
- Observation of admissions processes or clinical interactions where capacity should be assessed.

Shared decisions and planning care

Patients with cognitive impairment receive safe and high-quality care when they, their support person and, when required, their substitute decisionmaker are involved in decisions and planning about current and future care.

Action 2.6

The health service organisation has processes for clinicians to partner with patients and/or their substitute decisionmaker to plan, communicate, set goals and make decisions about their current and future care.

Action 2.7

The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care.

Why are these actions critical for patients with cognitive impairment?

Person-centred care is widely recognised as a foundation to safe, high-quality healthcare.

It is respectful of, and responsive to, a patient's preferences, needs and values.¹⁰³ Each individual and their unique experience and presentation of cognitive impairment needs to be understood and care provided in a respectful manner that maintains a person's dignity.

Person-centred care is a well-known concept in residential dementia care where efforts are made to support a person's identity and meet their psychosocial needs.¹⁰⁴ Person-centred care is an effective strategy in reducing agitation.¹⁰⁵

Partnering with patients in their own care is an important pillar of person-centred care. Clinicians need to apply the capacity principles outlined in the previous section so as not to assume that a patient with cognitive impairment is incapable of being involved in decisions. Patients should be included. supported and where possible, make their own decisions. They should be given the opportunity to choose a support person such as a carer to be part of discussions (Action 5.13c). Supported decisionmaking enables a person with cognitive impairment to remain involved in decisions about their health care rather than having their decision-making capacity removed. Supported decision-making is a key principle of the United Nations Convention on the Rights of Persons with Disabilities. Substitute decision-making should be a last resort, not be a substitute to appropriate support, should be for the shortest possible time, and be reviewed.¹⁰⁶

Where a person is unable to communicate their needs and preferences, clinicians should partner with substitute decision-makers and be guided by any advance care planning processes that have been undertaken. Relevant clinicians need to be able to discuss the patient's wishes and agree to goals of care, particularly if the condition of the patient with cognitive impairment deteriorates. Effective communication (Action 6.4) is an important component of partnering with consumers. Members of the workforce may lack confidence in communicating with a person with cognitive impairment or may not have the skills or necessary understanding to partner with patients and carers. For example, clinicians need to understand that Aboriginal and Torres Strait Islander people and some people from culturally diverse or refugee backgrounds may have a collective approach to carer responsibilities. Confirming who is responsible for different aspects of care is important for ensuring that carer engagement is effective.

Skilled clinicians are able to find the right balance between enabling a patient with cognitive impairment to contribute to their own care within their capabilities, and providing the assistance the patient needs in a way that maintains their dignity. The clinician does not assume that someone with cognitive impairment cannot make decisions and, therefore, involves the person in all decisions that they are capable of making and in discussions about their care.

Strategies for improvement

Encourage effective communication between clinicians and patients

Opportunities for clinicians to develop their communication skills with patients who are cognitively impaired, their carers, support people and substitute decision-makers can be included in the organisation's education and training program.

Information about the person, their needs, usual routines and preferences is a powerful tool in providing person-centred care and reducing distress a patient with cognitive impairment may experience. When a person is unable to provide the information themselves, structured tools such as 'TOP 5', 'Focus on the Person', 'This is me' and the 'Sunflower' can be introduced to support clinicians to engage with carers.

Make use of technology such as telehealth, especially as a strategy for facilitating clinician and patient communication across long distances.

Clinicians can be encouraged to view patients, carers (with patient's consent) and substitute decision-makers as valuable team members and develop processes for their involvement in clinical handover. Carers, support people and substitute decisionmakers cannot be part of a patient's healthcare decision-making if they are not present. Review the organisation's visiting policies to identify opportunities to allow a patient's carer, support person or substitute decision-makers to be present throughout care. One strategy to support this is patient-directed visiting, which removes restrictions on visiting times, allowing carers and family to decide on the visiting times that best suit them.

There is growing understanding that delirium may be a frightening, distressing and traumatic experience for patients.^{107, 108} Carer stress is also high in delirium and continues after discharge.¹⁰⁹ Health service organisations should provide relevant delirium information to patients, carers and families in an easy-to-understand format. Include information on what family members can do to reduce risk and help manage delirium when it occurs.

Information should be culturally appropriate and accessible to people with additional sensory difficulties and who do not speak or read English. There is also a wealth of consumer information on different forms of cognitive impairment and services available.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **1.32** The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
- **2.10** The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:
 - a. Information is provided in a way that meets the needs of patients, carers, families and consumers
 - b. Information provided is easy to understand and use
 - c. The clinical needs of patients are addressed while they are in the health service organisation
 - d. Information needs for ongoing care are provided on discharge.

Train the workforce in effective communication at the end of life

Relevant clinicians need to be able to discuss the patient's wishes and agree to goals of care, particularly if the patient's condition deteriorates. They need to be familiar with the organisation's processes for identifying patients who are at the end of life, and to have the skills to be able to discuss any concerns about recovery or risk of dying with the patient, carers and families. Carers, support people and families should be informed about what to expect and treatment options for conditions such as advanced dementia.¹¹⁰ Clinicians need to understand their responsibilities with regard to respecting patients' wishes and adhering to advance care plans so that inappropriate treatment can be avoided.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **5.18** The health service organisation provides access to supervision and support for the workforce providing end-of-life care
- **5.19** The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
- **5.20** Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.

Resources

Commission resources

- Person-centred healthcare organisations and supporting resources¹¹¹
- National Consensus Statement: Essential elements for safe and high-quality end-of-life care¹¹²
- End-of-life care: Tools and resources for health services¹¹³
- Caring for Cognitive Impairment Campaign consumer stories¹¹⁴
- Communicating with patients and colleagues¹¹⁵

Palliative care

Dementia and Palliative Care.¹¹⁶

Person-centred care

Dignity in Care Australia.¹¹⁷

Resources for consumers

Go to consumer information under <u>resources/</u> <u>information a-z</u>⁴² on the ACSQHC cognitive care website.

Examples of good practice

The **TOP 5 initiative**⁷⁶ in NSW encourages clinicians to engage with carers to gain valuable non-clinical information to help personalise care for patients with cognitive impairment. This information is made available to every member of the healthcare team to improve communication between the patient, the carer and the team, and information is documented on a TOP 5 form:

- **T** Talk to the carer
- **O** Obtain the information
- P Personalise the care
- **5** Strategies developed.

The University of Queensland's Centre for Online Health is working with Aboriginal and Torres Strait Islander health services to provide specialist geriatric consultations from Brisbane's Princess Alexandra Hospital and Cairns Hospital through <u>telehealth</u>¹¹⁸ for people with dementia and their carers living in rural and remote areas of Queensland.

- Surveys, interviews or discussions with patients, carers, support people, substitute decisionmakers and consumers about their experiences of being involved in decision-making, which could include collection of information about patient-reported outcomes
- Schedule of mortality and morbidity meetings, and death reviews where the safety and quality of end-of-life care provided to patients with cognitive impairment was compared with the planned goals of care and best practice
- Patient and carer information packages or resources about end-of-life care options.



Chapter 7 Medication Safety Standard

The <u>Medication Safety Standard</u>¹²⁰ aims to ensure that clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. It also aims to ensure that consumers are informed about medicines, and understand their own medicine needs and risks.

The four criteria are:

- 1. Clinical governance and quality improvement to support medication management
- 2. Documentation of patient information
- 3. Continuity of medication management
- 4. Medication management processes.

An important change in the second edition of the NSQHS Standards is that health service organisations are now required to identify patients at risk of experiencing medicine-related problems, and undertake a medication review for these patients. This action has been selected for its particular relevance to cognitive impairment.

Medication review

Action 4.10b

The health service organisation has processes to prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems.

Why is this action critical for patients with cognitive impairment?

Patients with cognitive impairment are at higher risk of experiencing medicine-related adverse events. Medicine-related problems can occur when patients are on multiple medicines, have not been adequately monitored for their adherence to medicine-related treatment, do not know their medications, or do not recognise the alternative brands of medicines used in health service organisations as being the same as their usual medicines.

Twenty to thirty per cent of all admissions to hospital in the population aged 65 years and over are estimated to be medicine-related and most aged care residents have medicine-related problems.⁶⁸ Older people presenting to hospital may be on a combination of anticholinergic and psychoactive medicines that increase the risk of confusion.^{66, 67} As mentioned earlier, psychoactive medicines are associated with serious adverse events.⁶⁸⁻⁷⁰

Strategy for improvement

Undertake medicine review for patients with cognitive impairment

Admission to hospital provides an opportunity to review and possibly cease (or deprescribe) ineffective, duplicate or potentially inappropriate medicines for patients with cognitive impairment. For example, evidence suggests that long-term antipsychotics can be withdrawn for many people with dementia and behavioural and psychological symptoms of dementia (BPSD).⁶⁹

A review of medicines is also important because they are the most frequent precipitating factor for delirium.⁷⁰ Clinicians need to be alert to the role of medicines in causing delirium directly through toxicity or indirectly through interactions, or by inducing abnormalities that precipitate delirium such as electrolyte imbalance. As with all high-risk medicines, reasons for any changes, including the discontinuation of psychoactive medicines, should be documented in the medicines lists and communicated to receiving clinicians at transitions of care and to patients and carers at discharge. If the medicine is intended for short-term use, clear documentation at transfer regarding the duration of treatment will also ensure the risk of inadvertent continuation or recommencement is avoided.

The involvement of patients, carers, families and general practitioners (GPs) is also crucial in decisionmaking and discussing medicine-related treatment options. Their involvement is also important to ensure timely communication and understanding about any changes to the person's medicines and the rationale especially at discharge.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **4.5** Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care
- **4.6** Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
- **4.11** The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risk
- **4.12** The health service organisation has processes to:
 - a. Generate a current medicines list and the reasons for any changes
 - b. Distribute the current medicines list to receiving clinicians at transitions of care
 - c. Provide patients on discharge with a current medicines list and the reasons for any changes.

Resources

Medicines

- Go to medicines under <u>resources/information</u> <u>a-z</u>⁴² on the ACSQHC cognitive care website
- Go to consumer information under <u>resources/</u> <u>information a-z</u>⁴² on the ACSQHC cognitive care website.

Example of good practice

Education on polypharmacy and deprescribing

The Royal Australian College of Physicians (RACP) encourages its Advanced Trainees and Fellows to develop and conduct research on the Evolve recommendations as part of specialty training. One advanced trainee demonstration project is focusing on reducing inappropriate polypharmacy in older inpatients in line with **ANZSGM Evolve Recommendations 2 and 4**:¹¹⁹

- Do not prescribe benzodiazepines or other sedative-hypnotics to older adults as first choice for insomnia, agitation or delirium
- Do not prescribe medication without conducting a drug regimen review.

The demonstration project includes the development of a module on polypharmacy and deprescribing by Health Education and Training Institute NSW (HETI) and a questionnaire to test its effectiveness in improving awareness and selfefficacy of deprescribing.

- Policy documents about undertaking, prioritising and documenting medication reviews
- Documented examples of actions taken as a result of medication review
- Orientation or training documents about medication review
- Employment documents that outline the roles, responsibilities and accountabilities for medication review
- Reports of monitoring of antipsychotics and other psychoactive medicines
- Examples of resources that can be provided to support discussion about patients' medicines needs and risks
- Examples of quality improvement activities that have been implemented and evaluated to reduce prescribing of antipsychotics and other psychoactive medicines to patients with cognitive impairment.



Chapter 8 Comprehensive Care Standard

The <u>Comprehensive Care Standard</u>²⁸ aims to ensure that patients receive comprehensive health care that meets their individual needs and considers the impact of their health issues on their life and wellbeing. It also aims to ensure that risks of harm for patients during health care are prevented and managed through targeted strategies. It includes actions related to falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care.

The four criteria are:

- 1. Clinical governance and quality improvement to support comprehensive care
- 2. Developing the comprehensive care plan
- 3. Delivering comprehensive care
- 4. Minimising patient harm.

There are two specific actions relating to cognitive impairment in the Comprehensive Care Standard. Action 5.29 relates to the establishment of a system for caring for cognitive impairment and Action 5.30 relates to clinicians' use of an existing system. These actions are described on page 17. While all remaining actions are important, a number of actions from the Comprehensive Care Standard have been selected for their particular relevance to cognitive impairment.

Systems for comprehensive care

Action 5.4

The health service organisation has systems for comprehensive care that:

- a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment
- b. Ensure timely referral of patients with specialist healthcare needs to relevant services.

Why is this action critical for patients with cognitive impairment?

A well-developed comprehensive care plan can be a powerful tool for patients with cognitive impairment as they may have complex health issues and multiple risks of harm. The plan brings together screening, assessment and shared decisions and guides the multi-disciplinary team to implement safe and high-quality care. It reflects a collaborative, person-centred approach to care that is different to traditional, siloed, discipline-specific actions.

Strategy for improvement

Design processes to develop, document and communicate comprehensive care plans

Work with clinicians and consumers to reach consensus about:

- The key elements of a comprehensive care plan relevant for patients with cognitive impairment
- Roles and responsibilities for implementing, monitoring and updating the actions in the comprehensive care plan
- Processes for documenting and communicating the contents of the comprehensive care plan.

Special consideration should be given to establishing appropriate and timely referral processes to specialised services such as older people's mental health or to guardianship tribunals, when required.

Resources

- Guardianship application process for adult inpatients of NSW Health facilities¹²¹
- <u>Guardianship and least restrictive practice</u> in Victoria¹²²
- Guardianship and administration applications in hospital: Important information for carers of older people in Victoria.¹²³

Example of good practice

NSW Health, the Premier's Implementation Unit, NSW Civil and Administrative Tribunal, the Office of the Public Guardian, NSW Treasury and NSW Trustee and Guardian partnered to review and identify options for reducing processing times for hospital patients requiring guardianship decisions under the **Guardianship project**.¹²⁴

Examples of supporting evidence

- Standardised tools and templates for developing, documenting and communicating comprehensive care plans
- Records of interviews with clinicians that demonstrate that they understand the health service organisation's processes for comprehensive care
- Feedback from patients and carers about whether they can identify the clinician with overall responsibility for the patient.

Collaboration and teamwork

Action 5.5

The health service organisation has processes to:

- a. Support multidisciplinary collaboration and teamwork
- b. Define the roles and responsibilities of each clinician working in a team.

Why is this action critical for patients with cognitive impairment?

Multidisciplinary collaboration and teamwork are essential for the delivery of comprehensive care. Patients with cognitive impairment often have multiple complex health problems requiring coordination and liaison across specialties and disciplines. A team approach where team members know and respect the roles and skills of others and work in partnership with the patient, carer and family can assist in providing safe and high-quality care for patients with cognitive impairment.⁶⁶

Comprehensive geriatric assessment of frail, older patients with input from specialised medical, allied health and nursing personnel is effective in reducing the risks of harm. Collaborative models of care such as orthogeriatrics have been shown to reduce mortality for patients with hip fracture and increase the likelihood of a person returning home.¹²⁵

With behavioural difficulties, advice may be sought from experts in older people's mental health or aged care, such as geriatricians, psychogeriatricians, nurse practitioners, or clinical nurse consultants. A more comprehensive specialist cognitive or neuropsychological assessment may be required if the person's presentation is complex and diagnosis is uncertain or difficult. Clinicians need to be able to work together in effective teams to meet the healthcare needs of patients with cognitive impairment.

Strategy for improvement

Support clinicians to work in collaborative multidisciplinary teams

Implement strategies that support collaboration and teamwork. Examples include:

- Interdisciplinary education and training
- Clinical practice improvement programs
- Processes to improve communication access to contact numbers and structured tools such as iSoBAR¹²⁶ are examples.

Define the roles, responsibilities and accountabilities for the multiple clinicians from a range of disciplines that are likely to be involved in delivering care to patients with cognitive impairment. Include the roles, responsibilities and accountabilities for care and support staff.

Clarify and communicate who will undertake cognitive screening, monitor and assess for delirium, and communicate with carers and family members.

As multiple clinicians are likely to be involved in the care of a patient with cognitive impairment, it is important to have processes in place to identify the clinician who has overall responsibility for coordinating the patient's care.

Successful implementation of this strategy will be supported by, or rely on, the following additional action:

5.4d The health service organisation has systems for comprehensive care that identify, at all times, the clinician with overall accountability for a patient's care.

Resources

- A Handbook for NSW Health Clinicians: Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD).⁶⁶ Refer to chapter titled 'Accept: Roles in care of differing professional disciplines, teams and settings'
- Allies in Dementia Health Care project.¹²⁷

Example of good practice

Orthogeriatric model of care

The Australian and New Zealand guideline for hip fracture care: Improving outcomes in hip fracture management of adults, produced by the Australian and New Zealand Hip Fracture Registry (ANZHFR) Steering Group, defines the orthogeriatric model of care that involves a shared care arrangement of hip fracture patients between the specialties of orthopaedics and geriatric medicine. Monitoring cognition is an important component of the model of care. This model of care is included in the <u>Hip</u> **Fracture Care Clinical Care Standard**.⁸⁰

- Relevant documentation from multidisciplinary meetings or case conferences about patients with complex needs
- Evidence of roles and responsibilities for delivering care to patients with cognitive impairment defined for clinicians and care and support staff.

Screening and assessment processes

Action 5.7

The health service organisation has processes relevant to the patients using the service and the services provided:

- a. For integrated and timely screening and assessment
- b. That identify the risks of harm in the 'Minimising patient harm' criterion.

Why is this action critical for patients with cognitive impairment?

One of the key tasks for developing a system for cognitive impairment is establishing processes to screen for cognitive impairment. This action is integral to Actions 5.29 and 5.30 that relate specifically to cognitive impairment.

Screening for cognitive impairment and identifying risks of harm should be undertaken as soon as possible after presentation, given that adverse events such as falls and pressure injuries can happen quickly. The results of screening prompt further assessment to rule out delirium and implementation of strategies to keep the patient safe.

Clinical assessment includes assessment of the medical issues arising from the presenting problem and reason for admission, co-morbidities, as well as a person's physical, cognitive, social and psychological and behavioural function so that underlying clinical issues are identified and the best outcomes are achieved. It includes investigation of the underlying causes of delirium or new onset cognitive impairment, if it is identified. Many older people presenting to EDs are likely to have multiple functional and medical problems including cognitive difficulties and recent falls.⁹⁰ Once admitted, older patients with cognitive impairment are at increased risk of harm from complications and adverse events, including medicine incidents, pressure injuries, falls, further functional decline, dehydration and under-nutrition. The identification of these risks through screening enables further assessment and the development of an individualised comprehensive care plan to manage these risks.

Strategies for improvement

Implement processes for cognitive screening

Introduce routine cognitive screening for patients aged 65 and over, Aboriginal and Torres Strait Islander patients who are aged 45 and over, patients at high risk of delirium at any age, and when the patient, carer, family or other key informants raise concerns about cognition. Concerns may be raised by:

- The clinician's own observations of a patient who cannot answer questions, or is easily distracted, agitated or overly sleepy
- An informant, such as a carer, family member or friend accompanying the patient, or the ambulance officer
- Documentation from the GP, or residential or community care provider
- Previous records that mention dementia, delirium or confusion, or previous assessments for these conditions.

The use of a cognitive screening tool is important because:

- Cognitive impairment is under-recognised
- Tools can be a more accurate indication of cognitive impairment than clinical judgement¹²⁸
- People will present with cognitive impairment who have not been formally diagnosed and who may not raise their difficulties with clinicians as it is unlikely to be the reason for their admission
- The score provides a baseline that can be recorded and compared when any further testing is undertaken during the current and any subsequent hospital stays. Often a person's cognition prior to admission is unknown and cognitive baseline score is part of delirium risk and assessment.¹²⁹

A range of cognitive tools have been developed with different purposes, ranging from screening for cognitive impairment, to obtaining a differential diagnosis, rating severity or monitoring disease progression.¹³⁰ At a minimum, an initial screen should test orientation, recall and attention. Other cognitive tests that may be used at the comprehensive assessment stage will test other domains such as language and executive function.

The screening tool needs to be short, validated in a hospital setting, reliable and acceptable, with good sensitivity and specificity.¹³¹ The screening tool is not expected to diagnose, but to detect cognitive impairment and to trigger risk mitigation and further investigation.

A systemic review of screening for dementia identified the following tools that had been validated in a hospital setting¹³²:

- Abbreviated Mental Test Score (AMTS)
- Digit Span Backwards Test
- Time and Change Test
- Informant Questionnaire on Cognitive Decline in the Elderly short form (IQCODE)
- Short Portable Mental Status Questionnaire (SPMSQ)
- Ten-Item Test
- Mini Mental State Examination (MMSE).

Other relevant brief screening tools include:

- 6-Item Cognitive Impairment Test (6-CIT)
- General Practitioner Assessment of Cognition (GPCOG)
- 7-Minute-Screen
- Montreal Cognitive Assessment (MoCA)
- Mini-COG
- Clock Drawing Test
- Abbreviated Mental Test 4 (AMT4).

However, not all these tests have been validated in a hospital setting or for cross-cultural use.

A new rapid screening test for delirium, the 4 'A's Test (4AT) has been validated for use with older people in the ED, acute geriatrics, orthogeriatrics, general medical, rehabilitation and stroke units.¹³³⁻¹³⁶ It incorporates two simple cognitive screening items that may mean that a cognitive screen followed by a delirium test may not be necessary. The 4AT is also applicable to patients with probable dementia or who do not speak English.^{133, 135}

Cognitive screening tools have been criticised for not addressing educational levels, literacy levels and English proficiency. More culturally sensitive tools have been developed such as the Rowland Universal Dementia Assessment Scale (RUDAS)¹³⁷ and the Kimberley Indigenous Cognitive Assessment (KICA) tool for Indigenous Australians.¹³⁸

The Commission does not recommend specific tools because some health service organisations already have screening tools in place. It is an evolving field, with increased research interest that will lead to further validated tools.

The location for screening could be in an ED, a pre-admission clinic at ED or acute assessment unit or on the ward.

Screening for cognitive impairment should be integrated with other screening processes. These processes should be streamlined to reduce duplication and the burden on clinicians and patients and be shared effectively across disciplines.¹³⁹ Health service organisations need to take an organisation-wide approach to screening that could include:

- Using local data to identify common risks of harm
- Adopting models of care that mitigate against those common risks
- Establishing an agreed approach to screening and the core tools to use
- Defining roles, responsibilities and accountabilities and providing training and education to the workforce
- Monitoring and reviewing implementation and impact and acting on opportunities for improvement.¹⁴⁰

Implement processes for identifying delirium

Currently, the Confusion Assessment Method (CAM) is the most widely used tool for assessing delirium, although there is concern that it requires training for its use, and its application may be variable.^{141, 142}

The 3D-CAM, which is the 3-Minute Diagnostic Assessment for Delirium using the CAM algorithm assists in operationalising the CAM algorithm.¹⁴² The confusion assessment method – intensive care unit (CAM-ICU) has been developed for nonverbal, mechanically ventilated patients. Both instruments have been validated in a variety of inpatient settings, with some concern that their relatively low sensitivity may result in delirium being underestimated.¹⁴³

One approach suggested for improving delirium identification in settings where delirium is common is to choose a two-step process: a rapid, easy to use, highly sensitive screen that is not reliant on corroborative information for monitoring to detect possible cases, followed by a highly specific tool to make a definitive diagnosis.¹⁴⁴

The choice of screening tools will differ according to patient type and clinical settings. For example, the Nurses' Delirium Screening Checklist (NuDESC) has been judged to be best suited to the surgical and recovery room setting.¹⁴¹ Detection of cognitive impairment and of delirium can be quite complex in some settings (such as acute stroke units) where a person may have undiagnosed dementia, delirium or language and sensory disturbances.¹³⁴

The 4AT and the 6-item cognitive impairment test (6-CIT) have been shown to accurately exclude both dementia and delirium in the ED.¹³³ The 6-CIT is not reliant on corroborative information but generates more false positives, and an algorithm for scoring 4AT in the absence of corroborative information in ED shows promise.¹³³

If delirium is identified, it is essential to try to find and treat the causes. It can be difficult to distinguish between dementia and delirium, and some people will have both conditions. If clinical uncertainty exists over the diagnosis, the person should be managed initially for delirium.¹⁴⁵ Assessing the underlying causes of delirium involves collating relevant history, undertaking physical examination and undertaking targeted investigations. A review of medicines is important, because they are the most frequent precipitating factor for delirium.¹⁴⁶

It is important to assess patients with dementia who have an acute change in their mental status or behaviour, because they may have delirium superimposed on their pre-existing dementia. This assessment will be best undertaken with family members and carers.

Clinicians also need to be aware that that reduced mobility and movement, and slow responses and withdrawal can be an indicator of hypoactive delirium and that the signs and symptoms of delirium can fluctuate.

Implement processes for assessing safety risks and care needs for patients with cognitive impairment

Older patients with cognitive impairment have a greater risk of falls and pressure injuries compared to patients without cognitive impairment. Additional care needs include assisting with oral healthcare, nutrition and hydration,¹⁴⁷ reorienting, safe mobilising, maintaining or restoring functioning, and providing meaningful activities. Assessing and addressing these needs can assist in prevention

of delirium and other geriatric syndromes. A multi-component intervention such as Eat, Walk and Engage¹⁴⁸ or a well-structured supported volunteer program may successfully address risks and additional care needs.^{77, 149} People with cognitive impairment may not be able to verbally report pain, requiring clinicians to undertake suitable pain assessment that includes non-verbal indicators such as facial expressions.

Older patients with dementia are at a greater risk of forms of abuse such as neglect, and physical and financial abuse. These issues may arise during the assessment process so clinicians need to be aware of their state or territory policies and protocols to identify and address issues related to elder abuse and implement these when relevant.

Routine use of simple trigger tools and questions can prompt clinicians to assess whether a patient with cognitive impairment has end-of-life care needs. A patient may be identified as approaching the end of life where access to palliative care can maximise comfort and quality of life.

Define roles and provide training and education to the workforce

Health service organisations need to clarify who is responsible for screening, how positive scores are documented and reliably communicated, and who is responsible for mitigating risks and undertaking further assessment.¹²⁹

Cognitive screening needs to be undertaken respectfully by trained clinicians who know that a test score is not a diagnosis, but a trigger for further action. They need to understand that a poor score may be due to cognitive impairment, or a range of other reasons such as pain, medicines, depression or sleep disturbance. In addition, a poor score could simply reflect not being able to understand questions due to language, health literacy or cultural barriers, hearing impairment or learning difficulties.¹³¹

Whichever cognitive screening tool is chosen, clinicians need to be aware of its strengths and limitations. For example, patients may have impairment in areas of cognition not targeted in the chosen screening tool. Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **5.10** Clinicians use relevant screening processes:
 - a. On presentation, during clinical examination and history taking, and when required during care
 - b. To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm
 - c. To identify social and other circumstances that may compound these risks
- **5.11** Clinicians comprehensively assess the conditions and risks identified through the screening process
- **5.12** Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
- **5.21** The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
- **5.24** The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for:
 - a. Falls prevention
 - b. Minimising harm from falls
 - c. Post-fall management
- **5.27** The health service organisation that admits patients overnight has systems for preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice.

Resources

Cognitive screening

Go to screening under resources/information $a-z^{42}$ on the ACSQHC cognitive care website.

Delirium assessment

Go to delirium assessment under **resources/ information a-z**⁴² on the ACSQHC cognitive care website.

Elder abuse

Go to elder abuse under resources/information $a-z^{42}$ on the ACSQHC cognitive care website.

Pain

PainChek® – a point of care App.¹⁵⁰

End-of-life

End-of-Life Essentials – education for acute hospitals.¹⁵¹

Volunteer program

Volunteer dementia and delirium care implementation and training resource.¹⁵²

Examples of good practice

<u>Confused Hospitalised Older Persons (CHOPS)</u> <u>Program⁵⁷ was initially piloted in five NSW rural and</u> metropolitan sites with subsequent roll out and evaluation in another 13 NSW hospitals.

The Dementia Care in Hospitals Program (DCHP)¹⁵³ originated in Ballarat but was also trialled in four hospitals in other states.

Eat Walk Engage¹⁵⁴ is an evidence-based multidisciplinary delirium prevention program developed at Queensland's Royal Brisbane and Women's Hospital.

- Policy documents that outline processes for conducting screening and identify:
 - when routine screening will occur in an episode of patient care
 - the roles, responsibilities and accountabilities of members of the workforce who screen patients
 - the process for taking action when risks are identified
 - indications for repeating the screening process
- Observation of clinicians' practice that shows use of cognitive screening processes
- Audit results of healthcare records for cognitive screening and delirium identification
- Observation of clinicians screening patients according to the health service organisation's policies, procedures or protocols
- Feedback from patients and carers about cognitive screening, delirium identification and other assessment
- Discussion that confirms that the question 'How many people on this ward have cognitive impairment?' can be answered
- Audit results of healthcare records for assessment of safety risks and care needs for patients with cognitive impairment.



Patient story 2

The following story and Table 5 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 (GCSused 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 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 5:** Patient story 2 summary – outcomes, links to actions in theNSQHS Standards and suggested improvement strategies

What did not go well?	NSQHS Standards	What could have been done better?	NSQHS Standards
During the admission process the doctor did not ask about cognitive function or conduct any cognitive	5.10, 5.30	Conduct baseline cognitive screening as part of the admission process and neurological examination	5.10, 5.29, 5.30
Details of surgery, risks and possible complications were discussed but with Mr S's capacity to understand and provide informed consent not clearly established	2.5	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	2.4, 2.5, 2.10
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	5.10c, 5.13d		
	NSQHS	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	6.4b
What went well? Medical and allied health staff raised concerns regarding Mr S's cognitive issues and arranged cognitive screening by an occupational therapist	Standards 5.29, 5.10		
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)	5.11		
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	5.13		
GP was informed of the comprehensive care plan and the arrangements that had been put in place	e 6.8		

Advance care planning

Action 5.9

Patients are supported to document clear advance care plans.

Why is this action critical for patients with cognitive impairment?

It is important that patients, carers and clinicians have a shared understanding of a person's prognosis, goals of care and preferences for care. Conditions such as dementia cause progressive deterioration in a person's condition and cognition, and may limit their ability to participate in future decision-making about their treatment. Ideally, the process of advance care planning should begin as soon as possible after a person is diagnosed with a progressive disease that causes cognitive impairment. Discussions need to occur regularly so that any advance care plans that are developed can be updated.

Advance care planning should include talking with patients about their values, goals of care and treatment preferences to enable future care to be provided in accordance with their wishes. In the absence of effective advance care planning, patients with cognitive impairment may receive unwarranted and burdensome treatments.

Strategies for improvement

Develop policies and procedures for advance care planning

Policies and procedures for advance care planning should include:

- Relevant state or territory legislation
- The roles and responsibilities of patients, carers, support people, substitute decision-makers and clinicians in advance care planning
- The process for documenting, communicating and updating advance care plans
- Information, forms and tools for participants.

Resources

- Advance Care Planning Australia website¹⁵⁵
- Advance care planning for dementia.¹⁵⁶

- Policies and procedures for advance care planning
- Audit results of healthcare records that contain advance care plans
- Staff survey results demonstrating knowledge about where to locate advance care plans in the healthcare record
- Consumer and carer information packages or resources about advance care planning.



Patient story 3

The following story and Table 6 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 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, 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 6: Patient story 3 summary – outcomes, links to actions in theNSQHS Standards and suggested improvement strategies

What did not go well?	NSQHS Standards	What could have been done better?	NSQHS Standards
The residential aged care facility did not provide information about the advance care plan	6.4b	Contacting family to participate in information exchange and healthcare decision-making at presentation	2.6
Clinicians did not ask the residential aged care facility or Mr C's GP if there was an advance care plan in existence	5.17	Contacting the residential aged care facility or Mr C's GP at presentation to participate in information exchange	6.4
Clinicians did not contact family despite Mr C's obvious confusion	5.30, 6.3		
What went well?	NSQHS Standards		
Clinicians agreed to family's request once the existence of an advance care plan was known	5.14		

Predicting, preventing and managing aggression and violence

Action 5.33

The health service organisation has processes to identify and mitigate situations that may precipitate aggression.

Why is this action critical for patients with cognitive impairment?

Patients with cognitive impairment are likely to find the hospital environment disorientating and distressing. Their behaviour may deteriorate further to aggressive outbursts that can include shouting, screaming, hitting out, pushing or throwing objects.¹⁵⁷ Aggression may be a response to the environment but also triggered by interaction with others, often during personal care, as a response to a perceived threat. It may also relate to their physical condition or underlying depression or psychotic symptoms.¹⁵⁷ It is crucial that a comprehensive assessment is undertaken to understand the reason for the behaviour and appropriate language used to reduce stigma associated with behavioural expressions of distress.

Carers and families can play an important role in reducing a person's distress and de-escalating situations by providing a familiar and reassuring presence and informing clinicians of effective deescalation strategies.

There are very small numbers of people with cognitive impairment who demonstrate very severe aggressive behaviour. They may be in hospital as a result of an unsuccessful residential care placement or because they cannot be cared for in the community. They require urgent review from psychiatric or older person's mental health services or other relevant specialist services and may require specific accommodation.

Strategies for improvement

Involve carers and families

Carers and others who know the person well are able to provide valuable information on strategies that help calm the person, what can trigger distress and what behaviours may be indicators of need or a form of communication.⁶⁶ TOP 5 is an example of a strategy that can be introduced to provide a structured way for clinicians to communicate with carers and capture this information.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- 5.34 The health service organisation has processes to support collaboration with patients, carers and families to:
 - a. Identify patients at risk of becoming aggressive or violent
 - b. Implement de-escalation strategies
 - c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce.

Provide guidance on responding to aggression for patients with cognitive impairment

Ensure that general policies for preventing and responding to aggression include specific and age-appropriate guidance on responding to acute behavioural disturbance for patients with cognitive impairment. The workforce can be trained in using de-escalation techniques and non-pharmacological approaches in the first instance. Antipsychotic medicines are only appropriate if a person is severely distressed or there is an immediate risk of harm to themselves or others; not as a first-line, routine response.

If medicines are used, ensure that any medicine use is evidence-based, including ageappropriate dosage. Over-sedation can have serious consequences, such as dehydration, falls, respiratory depression, pneumonia and death.¹⁵⁸ Psychiatric services have expertise in the judicious use of psychotropic medicines.

The strategies related to providing a safe environment under Actions 1.29–1.33 are also relevant to minimising the risk of aggression.

Develop referral pathways and models of care to respond to patients with cognitive impairment with severe aggression

There are specialist services that provide expertise in responding to severe aggression. For example, older persons' mental health services provide psychiatric expertise in responding to severe behavioural and psychological symptoms associated with dementia or mental illness. Referral pathways can be put in place and the workforce educated about the referral process for severe aggression for all forms of cognitive impairment.

The health service organisation can include the development of shared partnership models between specialist mental health services and aged care providers in service planning and provision to provide for the long term care needs of people with cognitive impairment. The Australian Government is currently working to develop specialist dementia care units to support people who experience very severe behavioural and psychological symptoms of dementia.

Resource

Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD).⁶⁶

Examples of good practice

Policies and procedures

South Australia has developed a <u>challenging</u> <u>behaviour policy framework</u>¹⁵⁹ that includes a risk management guideline and accompanying resources for preventing and responding to challenging behaviour, violence and aggression.

Royal Perth Bentley Group in Western Australia has developed a policy for the management of agitation in older patients and created a behavioural observation form to assist with monitoring cognitive deterioration and recommending action. Ellie Newman, coordinator for cognitive impairment, outlines the policies and procedures in an **interview**¹⁶⁰ on the ACSQHC cognitive care website.

Service models

NSW Specialist mental health services for older people – Mental Health Aged Care Partnership Initiative model¹⁶¹ is a specialist unit within residential aged care facilities that includes increased staffing; a multidisciplinary approach (including nursing, medical and allied health input), enhanced staff psychiatric knowledge and skills in behavioural management, access to specialist psychogeriatric and geriatric medical support, and prosthetic design.

State-wide project

The Queensland State-wide Older Person's Health Clinical Network has undertaken a project, Hospital Avoidance Model for Persons with Dementia who have refractory aggression project¹⁶², with the aim of establishing a dedicated pathway for assessing and managing extreme behaviours within an appropriate environment. It was implemented in all Queensland public hospitals and completed between December 2016 and December 2017.

- Policy documents that outline the processes for identifying and mitigating situations that may precipitate aggression
- Training documents about identifying and mitigating situations that may precipitate aggression
- Audit results of healthcare records for documented use of resources and tools to prevent violence and aggression if necessary
- Observation of design and use of the environment to minimise sources of potential conflict
- Observation of ward routines that minimise additional stresses for patients. Examples of quality improvement activities that have been implemented and evaluated to increase use of de-escalation strategies and to minimise, and where possible, eliminate the use of restraint.

Minimising restrictive practices: restraint

Action 5.35

Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:

- a. Minimise and, where possible, eliminate the use of restraint
- b. Govern the use of restraint in accordance with legislation
- c. Report use of restraint to the governing body.

Why is this action critical for patients with cognitive impairment?

Cognitive impairment increases the risk of being restrained when in hospital. People with cognitive impairment may have difficulty understanding procedures and interventions or following instructions, may try to walk unassisted when their mobility is restricted, or be fearful and try to leave or resist care. Without education and policy guidance, clinicians may believe physical restraints prevent falls or injuries or assist with medical treatment.¹⁶³

As described in Action 5.33, it is crucial to find out the cause of increasing agitation. At the same time, providing meaningful activities and safe walking areas, and engaging families may be useful to reduce the use of restraint.

The **NSQHS Standards Guide for Hospitals**¹⁰¹ notes the lack of consensus on chemical restraint and limits the requirements of this action to physical restraint. The use of physical restraint can have negative consequences, including decreased mobility and further functional decline, increased length of stay, and an increase in pressure injuries, incontinence and serious injuries.¹⁶³ Physical restraint is a risk factor for delirium and is likely to increase the person's distress and agitation. Any changes in behaviour should trigger further assessment of the causes of the behaviour rather than the use of restraint (see Action 8.5).

Strategies for improvement

Develop policies to report and review the use of physical restraint

The NSQHS Standards User guide for health services providing care for people with mental health issues¹⁶⁴ acknowledges that restraint used in other health settings has not been subject to the same level of scrutiny as mental health services despite the known adverse outcomes. Services can consider adapting the strategies for benchmarking, reporting and reviewing the use of restraints that are already in place in mental health services.

In ICU, chemical and physical restraints are used to minimise harm to the patient or others, such unplanned removal of an endotracheal tube. However, this can occur even though a patient is restrained and the evidence for the use of restraints in ICU is unclear.^{165, 166}

Safe and high-quality care without the use of physical restraint is possible. Strategies include:

- Person-centred care consultation with carers and families to understand the person, their routines, and behaviours that can be anticipated
- Systematic measurement of observations and review of behaviour
- Early discontinuation of invasive treatments
- Education and training for the workforce
- Development of an organisational culture and structure that supports minimising restraint.¹⁶⁷
- Development of policies so that the health service organisation can understand where and when restraint is used, how well it is documented and monitored, and that use of restraint is reported to the governing body.

Provide access to education on the use of physical restraint

Topics can include legal and ethical issues, current organisational policies that emphasise the use of restraint for emergencies only, documentation and reporting, current evidence of risks, effectiveness and consequences of restraint, and possible alternatives.

Recruit leaders to help change practice

Cognitive champions and other clinical leaders such as nurse educators or specialist nursing positions can provide effective role models and help change practice through education.

Engage carers and families

If the person with cognitive impairment is having difficulty communicating their needs, carers and family members may be able to provide important information about the person, their routines, and behaviours that can be anticipated. Some families may be able to arrange a roster so that they are present to assist in calming and reassuring the person.

Resource

Australia and New Zealand Society for Geriatric Medicine (ANZSGM) Position Statement Physical Restraint in Older People¹⁶⁸ recommends that physical restraints are not used except in an emergency situation. The decision to use restraints should be a collaborative decision involving the individual or their substitute decision-maker, nursing staff, medical practitioner, and other relevant healthcare providers. The decision to use physical restraints should include a review by a medical practitioner and documentation of the rationale, its intended duration and the alternatives considered.

- Policy documents that outline processes to treat patients without using restraint, and processes regarding the use of restraint in line with legislation
- Training documents about the use of restraint and strategies for minimising and, if possible, eliminating the use of restraint
- Data about the use of restraint
- Reports provided to the governing body that document the use of restraint
- Communication with patients, carers and families about the use of restraint.

Chapter 9 Communicating for Safety Standard

The aim of the <u>Communicating for Safety Standard</u>¹⁶⁹ is to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients. Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

The five criteria are:

- 1. Clinical governance and quality improvement to support effective communication
- 2. Correct identification and procedure matching
- 3. Communication at clinical handover
- 4. Communication of critical information
- **5.** Documentation of information.

While all actions are important, a number of actions have been selected for their particular relevance to cognitive impairment.

Effective communication

Action 6.4

The health service organisation has clinical communications processes to support effective communication when:

- a. Identification and procedure matching should occur
- b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge
- c. Critical information about a patient's care, including information on risks, emerges or changes.

Why is this action critical for patients with cognitive impairment?

Effective communication processes are crucial for patients with cognitive impairment to obtain critical information for diagnosis, understand a person's needs, decide on appropriate treatment decisions, deliver comprehensive care and make arrangements for discharge. During a hospital stay, early recognition of incident delirium is reliant on effective processes to communicate changes in cognition and behaviour.

There will be many times when information about a patient with cognitive impairment will need to be communicated or transferred; these processes will include communication with the patient, and carer (when appropriate), and between clinicians. For example, when a patient with cognitive impairment is unable to provide adequate information about their care needs, obtaining additional or corroborative information from a carer or support person,family, GP, and residential and community care providers becomes a priority.

Carers and family can be a vital resource. If the patient is unable to do so, carers can provide a patient's history, current care needs and possible safety risks to guide diagnosis, treatment and care. They can alert clinicians to changes to the patient's condition and their involvement in care delivery can help to reduce patient distress.

Care of a patient with cognitive impairment is likely to involve multiple clinicians to deliver comprehensive care. Effective communication is crucial for safe and high-quality care, reflecting the close links between the Communicating for Safety Standard and the Comprehensive Care Standard.

Strategies for improvement

Identify situations when safe communication is required for a person with cognitive impairment or at risk of delirium

Consider all the situations when identification, procedure matching and information about a patient's care need to be communicated or transferred. For example, when a patient with cognitive impairment is undergoing a procedure they may not be able to communicate all the information to confirm their identity, such as correct date of birth. Consider the role of carers and family members in identification and procedure processes or alternatively, include a clinician who knows the patient in the process.

Transitions of care are also examples of high-risk situations, when a person with cognitive impairment is admitted to hospital from home or residential care, moves within the hospital, leaves hospital, and when responsibility is transferred to the person's GP.

Provide tools and resources to support effective communication

As mentioned in Action 2.7, tools such as 'TOP 5', 'Focus on the Person', 'This is me' and the 'Sunflower' can be useful structured communication tools with carers when a patient is unable to provide the information themselves that can be also be used across settings.

Communication tools such as the **Cognitive** Impairment Identifier¹⁵³ are used in some hospitals to communicate to clinicians and care and support staff that a patient has cognitive care needs.

Consider communication tools that are effective in the transfer of information between organisations, such as 'Yellow envelopes' with residential care. The <u>A2D folder</u>⁷⁹ is an effective communication tool for admission and discharge of people with intellectual disabilities.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **1.17a** The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that are designed to optimise the safety and quality of health care for patients
- **6.7** The health service organisation, in collaboration with clinicians, defines the:
 - a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines
 - b. Risks relevant to the service context and the particular needs of patients, carers and families
 - c. Clinicians who are involved in the clinical handover
- **6.8** Clinicians use structured clinical handover processes that include:
 - a. Preparing and scheduling clinical handover
 - b. Having the relevant information at clinical handover
 - c. Organising relevant clinicians and others to participate in clinical handover
 - d. Being aware of the patient's goals and preferences
 - e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient
 - f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care.

Resource

Communication tools

Go to communication tools under **resources/ information a-z**⁴² on the ACSQHC cognitive care website.

Examples of good practice

Transfer from residential care

The transfer of information for residents from residential aged care facilities can be an area of high risk. The use of **transfer-to-hospital envelopes**¹⁷⁰, or 'yellow' envelopes can assist in ensuring the transfer of critical information.

This **South Australian guideline**¹⁷¹ outlines transfer of individuals between public health services and residential aged care services.

The Admission 2 discharge (A2D) website⁷⁹ demonstrates how the Admission 2 Discharge Together Folder can improve the hospital experience for people with an intellectual disability.

Model of care

The Dementia Care in Hospitals Program¹⁵³, is a cognitive impairment/dementia awareness and communication program for hospital based clinical and non-clinical staff that uses a bedside alert called the Cognitive Impairment Identifier (CII).

- Activities to manage identified risks with patient identification, transfer and handover of patient care, and receipt and distribution of critical information for patients with cognitive impairment
- Reports, investigations and feedback from the incident management and investigation system that identifies adverse events, incidents and near misses relating to patient identification, transfer and handover of patient care, or receipt and distribution of critical information
- Documentation about structured processes for communicating critical information to the responsible clinicians when all or part of care is transferred (for example, between hospitals, allied health and GP)
- Audit of the proportion of patients with cognitive impairment or substitute decision-maker and relevant healthcare providers receiving a discharge summary within the specified time frame.

Communication of critical information

Action 6.9

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

- a. Clinicians who can make decisions about care
- b. Patients, carers and families, in accordance with the wishes of the patient.

Action 6.10

The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians.

Why are these actions critical for patients with cognitive impairment?

Critical information such as a patient's medical history and co-morbidities, medicines list, recent cognitive changes, functional status and living arrangements, advance care plans and goals of care need to be communicated in a timely way to clinicians responsible for diagnosis, medication reconciliation, appropriate treatment and care decisions and effective discharge. Such information will inform the goals of care within the comprehensive care plan. Patients with cognitive impairment are at greater risk of complications such as incident delirium and adverse events such as falls. When critical information emerges, such as changes in a patient's cognitive function or behaviour, the workforce needs to follow processes to alert the responsible clinician, agree on action, document the information and inform the patient, carer and families.

Carers and families are often the first to notice change or deterioration in a person's cognition, functioning or behaviour. These concerns should never be ignored or dismissed as a person may have developed delirium or some other underlying condition requiring treatment, such as a stroke. Processes need to be in place to enable patients, carers and families to directly communicate critical information.

Strategy for improvement

Policies for communicating critical information

Policies for communicating critical information should be developed or reviewed to address the specific information needs of clinicians to provide safe and high-quality care for patients with cognitive impairment.

When a patient is unable to provide critical information, clinicians need timely access to information from a patient's healthcare record, carer or support person, GP or residential or community care provider.

Policies should enable patients, carers and support people to know what critical information they should communicate, such as deterioration in a person's cognition, functioning or behaviour and the processes to enable them to communicate, such as clinical handover.

Processes should be in place so that critical information such as the care plan and medication changes are documented in a patient's healthcare record and communicated to the patient, carer, support person or substitute decision-maker and relevant healthcare provider in a timely manner and in sufficient detail at transitions.
A person's cognitive state and request for review is critical information that should be communicated to a person's GP. It is important that clinical follow-up and review is arranged for patients with continuing or newly-diagnosed delirium, or with suspected dementia or other forms of cognitive impairment not previously diagnosed. Many people are admitted to hospital with cognitive impairment (such as dementia) that has not been formally diagnosed, and it may not be possible to undertake a diagnostic process in hospital. Any diagnosis or concern should be discussed with the patient and support person and communicated to the GP.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **6.11** The health service organisation has processes to contemporaneously document information in the healthcare record, including:
 - a. Critical information, alerts and risks
 - b. Reassessment processes and outcomes
 - c. Changes to the care plan
- 8.6e The health service organisation has protocols that specify criteria for escalating care, including worry or concern in members of the workforce, patients, carers and families about acute deterioration.

Resource

ACSQHC Communicating for Safety resource portal.¹⁷²

Examples of good practice

Quality Statement 7 of the **Delirium Clinical Care Standard**¹⁰ emphasises the importance of a care plan that describes the ongoing care required, and provides a summary of any change in medicines and strategies to help reduce the risk of delirium and prevent complications. The plan is developed in partnership with the patient and their carer and is provided to the patient and carer before discharge, and to their GP and other ongoing clinical providers within 48 hours of discharge. The care plan is included in the **My Health Record**.¹⁷³

See examples of patient and family escalation systems under Action 8.6 on page 73.

Examples of supporting evidence

- Evidence of communication methods or systems for alerting clinicians who can make decisions about care when there is a change in a patient's condition or new critical information is received
- Patient notes that identify critical information provided by the patient with cognitive impairment, carers and support people and how this information was acted on
- Evidence of referral for follow-up for undiagnosed cognitive impairment
- Results of a patient experience survey or patient, carer and family feedback about their communication with clinicians and the timeliness of a response.

Chapter 10 Recognising and Responding to Acute Deterioration Standard The <u>Recognising and Responding to Acute Deterioration Standard²⁹ aims to</u> ensure that an acute deterioration in a person's physical, mental or cognitive condition is recognised promptly and appropriate action is taken.

The three criteria are:

- 1. Clinical governance and quality improvement to support recognition and response systems
- 2. Detecting and recognising acute deterioration, and escalating care
- **3.** Responding to acute deterioration.

Recognising acute deterioration in a person's mental state, Action 8.5 is one of the new actions in the NSQHS Standards specific to cognitive impairment. In that action, health service organisations have processes that require clinicians to assess for delirium when behaviour, cognitive function perception, physical function or emotional state are observed or reported.

Escalating care

Action 8.6

The health service organisation has protocols that specify criteria for escalating care, including:

- a. Agreed vital sign parameters and other indicators of physiological deterioration
- b. Agreed indicators of deterioration in mental state
- c. Agreed parameters and other indicators for calling emergency assistance
- d. Patient pain or distress that is not able to be managed using available treatment
- e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration.



Why is this action critical for patients with cognitive impairment?

Any unexpected deterioration in the condition of a patient with cognitive impairment or at risk of delirium needs a response so that appropriate and timely assessment, treatment and care can be provided. The patient may have developed delirium or another urgent, serious underlying medical condition.

Another example for escalating care is when the behaviour of a patient with cognitive impairment is deteriorating to the point where they are putting themselves or others in danger. Clear processes need to be in place so that everyone, including clinical and non-clinical workforce, patients, carers and families, know what to do next.

Strategy for improvement

Develop and implement protocols for escalating care when acute deterioration occurs

Use a graded response system within the escalation protocol that includes:

- An emergency response to agreed criteria that indicate severe acute deterioration
- At least one other level of response for criteria that indicate less severe deterioration.

Work with clinical groups to agree on criteria that indicate acute deterioration and possible delirium. Consider local clinical capacity and access to specialist expertise such as older people's mental health services for serious behavioural deterioration. Consider in the protocol:

- Shared decisions with patient, carer, support person or substitute decision-maker
- Pain and distress as a criterion for escalation
- Worry or concern of members of the workforce, patients, carers, support people and families.

Successful implementation of this strategy will be supported by, or rely on, the following additional actions:

- **8.7** The health service organisation has processes for patients, carers or families to directly escalate care
- 8.10 The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration.

Examples of good practice

Ryan's Rule¹⁷⁴ is a three-step process in place in Queensland public hospitals to support patients, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected.

Call and Respond Early (CARE) (WA and ACT)¹⁷⁵ is another example of allowing patients, or their families and carers to call for rapid assistance when they feel that the healthcare team has not fully recognised the patient's changing health condition.

REACH (Recognise, Engage, Act, Call, Help is on <u>its way) (NSW)</u>¹⁷⁶ is a patient and family escalation system developed by the NSW Clinical Excellence Commission for NSW hospitals.

Example of supporting evidence

Policy documents that identify agreed criteria that indicate acute deterioration in physical, mental or cognitive condition that trigger escalation of care, and the expected responses.

Patient story 4

The following story and Table 7 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 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 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.

Table 7: Patient story 4 summary – outcomes, links to actions in the NSQHS Standards and suggested improvement strategies

What did not go well?	NSQHS Standards	What went well?	NSQHS Standards
No cognitive screening	5.10, 5,29 and 5.30	ED staff alerted to 'confusion' by ambulance officer	6.7
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	5.10	Prescribing GP contacted	4.6
		Daughter contacted and informed mother's hospitalisation	l of 6.4
		Appropriate management of primary presenting problems	5.14
Previous 'confusion' may have been an indicator of cognitive impairment (acute or long-standing) rather than a possible head injury	5.11		
		What could have been done better?	NSQHS Standards
An underlying delirium may have been missed and consequently the underlying health problem not investigated and treated	5.11	Recognising cognitive impairment earlier because policies and procedures for cognitive impairment recognition were in place and clinicians were trained and informed of their use Investigating cognitive impairment further because clinicians were alert to the risk of delirium, and there	5.29 1.25 ent
Changing of wards increased confusion and disorientation	5.29		са + г 11
No response to documented deterioration	8.6		ert and 8.5
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	8.6	were recognition and response triggers in place	
		Engaging daughter in providing a history, including medicines	4.3 and 6.8
		Providing better nursing supervisi of care and patient comfort	on 5.14

Acronyms and abbreviations

ACE: Aged Care Emergency

ACSQHC: The Commission

AIHW: Australian Institute of Health and Welfare

AMTS: Abbreviated Mental Test Score

AMT4: Abbreviated Mental Test 4

ANZHFR: Australia and New Zealand Hip Fracture Registry

ANZSGM: Australia and New Zealand Society for Geriatric Medicine

BPSD: behavioural and psychological symptoms of dementia

CAM: confusion assessment method

CARE: Call and Respond Early

CDCP: Cognitive and Delirium Care in Hospital Project

CHOPS: Confused Hospitalised Older Person's Program

CogChamps: Cognition Champions

CT Scan: computerised tomography scan

CII: Cognitive Impairment Identifier

DCHP: Dementia Care in Hospitals Program

ED: emergency department

GEDI: Geriatric Emergency Department Intervention

GP: general practitioner

GPCOG: General Practitioner Assessment of Cognition

HAC: Hospital Acquired Complication

HETI: Health Education and Training Institute NSW

HIV: human immunodeficiency virus

ICU: intensive care unit

IQCODE: Informant Questionnaire on Cognitive Decline in the Elderly short form

IHPA: Independent Hospital Pricing Authority

KICA: Kimberley Indigenous Cognitive Assessment tool for Indigenous Australians

LGBTI: Lesbian, gay, bisexual, transgender and intersex

MARC: Melbourne Ageing Research Collaboration

MDT: multi-disciplinary team

MMSE: Mini Mental State Examination

MoCA: Montreal Cognitive Assessment

NSQHS: National Safety and Quality Health Service

NuDESC: Nurses' Delirium Screening Checklist

PAHA: Preventing Avoidable Hospital Admissions for People With Dementia

PBS: Pharmaceutical Benefits Scheme

RACP: Royal Australian College of Physicians

RUDAS: Rowland Universal Dementia Assessment Scale

REACH: Recognise, Engage, Act, Call, Help is on its way

SPMSQ: Short Portable Mental Status Questionnaire

TEHS: Top End Health Service

The Commission: the Australian Commission on Safety and Quality in Health Care

TOP 5: T – Talk to the carer; O – Obtain the information; P – Personalise the care; 5 – Strategies developed

3D-CAM: 3-Minute Diagnostic Assessment for Delirium using the CAM algorithm

6-CIT: 6-Item Cognitive Impairment Test

Glossary

A2D folder: The Admission2Discharge (A2D) Together folder was created to facilitate timely transfer of relevant and current information to enable hospital staff to meet the needs of people with intellectual disability and assist in the provision of person-centred care. It was developed in partnership by Family and Community Services (Disability) at South East Sydney District, South Eastern Sydney Local Health District, Carer Program, and Metro-Regional Intellectual Disability Network (MRID).

advance care plan: a plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans may be made on the person's behalf, and should be prepared from the person's perspective to guide decisions about care.¹⁷⁷

anticholinergic : medicines that are anticholinergic block the action of the neurotransmitter, acetylcholine in the nervous system. Acetylcholine is involved in transmitting messages that affect the involuntary movements of muscles or balance the production of various chemicals within the body.¹⁷⁸ Some medicines are prescribed for their anticholinergic properties while other are prescribed for other purposes but also have anticholinergic effects. Anticholinergic load is the term used for the cumulative effect of taking one or more medicines with anticholinergic properties. Older people with dementia may be particularly susceptible to cognitive impairment associated with anticholinergic and sedative medicines. This impairment may be misattributed to the disease process itself. Even medicines with minor anticholinergic properties may contribute to unwanted central and peripheral adverse events if used in combination with other agents with anticholinergic effects. Clinically significant adverse events range from mild cognitive impairment to delirium.179

assessment: a clinician's evaluation of the disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition and the clinician's objective findings, including data obtained through laboratory tests, physical examination, medical history, and information reported by carers, family members and other healthcare team members.¹⁸⁰ The assessment is an essential element of a comprehensive care plan.

BPSD: behavioural and psychological symptoms of dementia, which may include aggression, apathy, anxiety, agitation, psychotic symptoms, depression, disinhibited behaviours, wandering, nocturnal disruption and vocally disruptive behaviours.⁶⁶

carer: a person who provides personal care, support or assistance to another individual who needs it because they have a disability, mental illness, a medical condition [including a terminal or chronic illness, or who are frail and/or aged]. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.

clinician: a healthcare provider, trained as a health professional, including registered and nonregistered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision. clinical governance: an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and healthcare organisation that systems are in place to deliver safe and high-quality care.

cognitive impairment: deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. As each individual's experience is different, understanding each individual is important in order to communicate effectively and provide the right care.

While dementia and delirium are common causes of cognitive impairment, cognitive impairment can result from many other conditions and in patients of any age. Cognitive impairment might be related to the patient's presenting problem to hospital, such as a stroke or a traumatic brain injury, or be pre-existing, for example as a result of intellectual impairment, psychiatric disorder, drug and alcohol issues, or past acquired brain injury. Various neurological and medical conditions can result in cognitive impairment, for example multiple sclerosis, epilepsy, HIV, autoimmune disorders, and brain tumours.

competency-based training: an approach to training that places emphasis on what a person can do in the workplace as a result of training completion.¹

comprehensive care: health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate. **comprehensive care plan**: a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, carers and families about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.

cultural competency: a set of congruent behaviours, attitudes and policies that come together in a system or agency or among professionals that enables effective work in crosscultural situations. 'Culture' refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organisation within the context of the cultural beliefs, behaviours and needs presented by consumers and their communities.¹⁸¹

delirium: an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the course of the day. It is potentially preventable and reversible. It is common in older patients exposed to hospital-related events and the prevalence increases with age. Hypoactive or 'quiet' delirium is much more common than hyperactive or agitated delirium and is often missed.^{182, 183}

dementia: the progressive decline in cognitive function that affects memory, judgement, attention, language and problem solving.¹⁸⁴ It is usually gradual, progressive and irreversible, leading to impaired functioning. The most common types are Alzheimer's disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia or a combination of these.¹⁸⁵ The number of people with dementia is growing rapidly as the Australian population ages. People with dementia have a higher rate of hospital admissions than people without dementia.⁴¹ AIHW estimates 376,000 people had dementia in 2018 (8.7% of people aged 65 and over), projected to increase to 550,000 by 2030.¹⁸⁶ For people aged 75 and over, dementia was the second leading cause of burden of disease and the second leading cause of death.

Although dementia is predominantly a disorder related to age, it can affect people younger than 65 years old – this is known as younger onset dementia. People with Down's syndrome have a higher prevalence of Alzheimer's disease, which occurs at a much younger age than in the general population. Dementia may also be more common in people with developmental disabilities who do not have Down's syndrome.¹⁸⁷

There is a complex interplay between dementia and delirium. People with dementia are at fivefold increased risk of developing delirium and, conversely, delirium increases the risk of developing dementia. Delirium is often dismissed and misdiagnosed as dementia. Both conditions are important and both carry increased risk of harm.

deterioration in mental state: a negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.

diversity: the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities (diversity in sexualities is currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI). **environment**: the physical surroundings where health care is being delivered, including the building, fixtures, fittings and services such as air and water supply. Environment can also include other patients, visitors and the workforce.¹

evidence-based practice: care where experience, judgement and expertise are integrated with knowledge about effectiveness gained from a systematic overview of all relevant high-quality research evidence.¹⁸⁸

functional decline: functional decline is when people lose their physical, social and/or thinking capacity. Functional decline is commonly associated with getting older but it is not inevitable.¹⁸⁹

goals of care: clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

health service organisation: a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

informed consent: a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.^{190, 191}

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals. **medicine-related problem**: any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to diseasespecific, laboratory test-specific and patient-specific information. Medicine-related problems include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine-medicine, medicine-disease, medicine-nutrient, medicine-laboratory test)
- Noncompliance.¹

multi-disciplinary team (MDT): a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.¹⁹² Multidisciplinary care includes inter-disciplinary care.

palliative care: an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment, and treatment of pain and other problems – physical, psychosocial and spiritual.

Palliative care:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient's illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness

- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
- Palliative care interventions may be provided by a patient's treating team or by specialist palliative care clinicians. All clinicians should be able to provide care consistent with a palliative approach, but specialist palliative care from providers with advanced training and expertise may be required for patients and families with complex care needs at the end of life.¹⁹³

patient: a person who is receiving care in a health service organisation.

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients. Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care. Also known as patient-centred care or consumer-centred care.¹

policy: a set of principles that reflects the organisation's mission and direction. All procedures and protocols are linked to a policy statement.¹

procedure: the set of instructions to make policies and protocols operational, which are specific to an organisation.¹

protocol: an established set of rules used for the completion of tasks or a set of tasks.¹

psychoactive: psychoactive substances are substances that, when taken in or administered into one's system, affect mental processes, such as cognition or affect. This term and its equivalent, psychotropic drug, are the most neutral and descriptive term for the whole class of substances, licit and illicit, of interest to drug policy. Psychoactive agents include antipsychotics, benzodiazepines, anxiolytics, hypnotics, anticonvulsants, mood stabilisers, opiates, antidepressants and stimulants. **quality improvement**: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.¹⁹⁴ Quality improvement activities may be undertaken in sequence, intermittently or on a continuous basis.

recognition: the confirmation or acknowledgement of the existence of a condition.

risk: the chance of something happening that will have a negative impact. It is measured by consequences and likelihood.¹

risk assessment: assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.¹

safety culture: a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.

screening: a process of identifying patients who are at risk or already have a disease or injury. Screening requires sufficient knowledge to make a clinical judgement.

shared decision making: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.¹

substitute decision-maker: a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies across states and territories.¹⁹⁵ **system**: the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal.

A system:

- Brings together risk management, governance, and operational processes and procedures, including education, training and orientation
- Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials
- Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.

The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.

transitions of care: situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.

workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation see also **clinician**.

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Level 5, 255 Elizabeth Street, Sydney NSW 2000 GPO Box 5480, Sydney NSW 2001

PHONE: (02) 9126 3600 FAX: (02) 9126 3613

@ACSQHC
 safetyandquality.gov.au