

# A better way to care

Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital

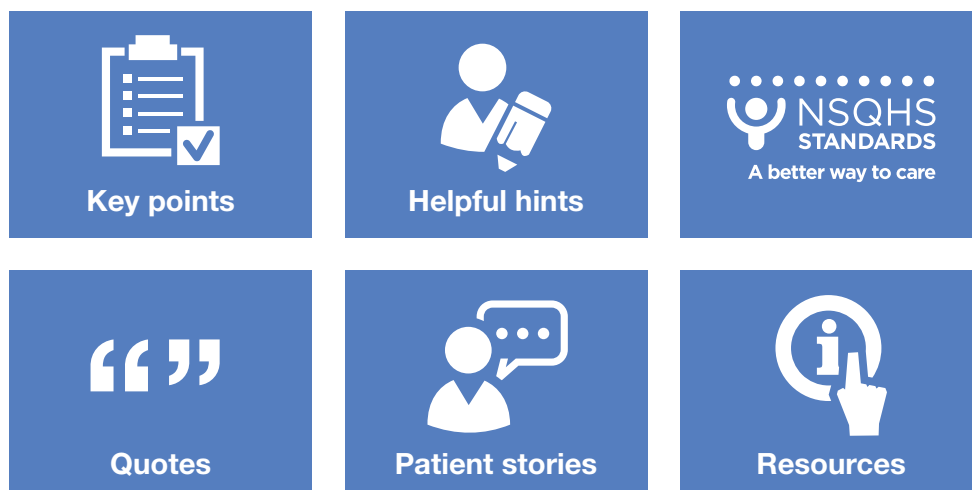


**Actions for clinicians**

**AUSTRALIAN COMMISSION**  
**ON SAFETY AND QUALITY IN HEALTH CARE**

 **NSQHS**  
**STANDARDS**  
A better way to care

## Key icons



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Many individuals and organisations have freely given their time, expertise and documents to aid the development of this resource. In particular, the Commission wishes to thank those who participated in the national consultation process. The involvement and willingness of all concerned to share their experience and expertise is greatly appreciated.

### Disclaimer

This resource has been developed as a general guidance for healthcare professionals and is based on the best evidence available at the time of development. It incorporates or summarises guidance and views and is assembled in good faith, solely for the purpose of improving early recognition of and response to patients with cognitive impairment. Users should independently analyse the completeness and relevance of this resource to their provision of healthcare services, and consider the need to seek further professional advice, before relying on it.

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# Contents

<b>Safety and quality pathway for patients with cognitive impairment (dementia and delirium) in hospital</b>	<b>1</b>
Introduction	1
Purpose	1
How to use this resource	1
The pathway and key steps	1
<b>Step 1 Be alert to delirium and the risk of harm for patients with cognitive impairment</b>	<b>4</b>
Why is this important?	4
Who should I be concerned about?	4
What should I do?	5
What does being alert mean to me?	7
Patient story 1	8
Where do I go for more information?	10
<b>Step 2 Recognise and respond to patients with cognitive impairment</b>	<b>16</b>
Why is this important?	16
Who should I be concerned about?	16
What should I do?	17
What does effective recognition and response mean to me?	20
Patient story 2	22
Where do I go for more information?	24
<b>Step 3 Provide safe and high-quality care tailored to the patient's needs</b>	<b>26</b>
Why is this important?	26
Who should I be concerned about?	26
What should I do?	27
What does providing safe and high-quality care mean to me?	30
Patient story 3	32
Where do I go for more information?	34
<b>References</b>	<b>38</b>
<b>Resource links</b>	<b>40</b>
<b>Appendix 1 An example of a brief cognitive screening tool</b>	<b>44</b>
<b>Appendix 2 An example of a delirium assessment tool</b>	<b>45</b>





# Safety and quality pathway for patients with cognitive impairment (dementia and delirium) in hospital

## Introduction

People with cognitive impairment have problems with memory, communication and/or thinking that can be temporary or long term. Common causes of cognitive impairment for older patients in hospital are dementia and/or delirium.

Patients with dementia and/or delirium are at increased risk of preventable complications and adverse events, such as falls and pressure injuries, and require additional care to prevent harm. However, cognitive impairment is often not identified and/or the risks of harm are often under-recognised or dismissed.

## Purpose

The goal of this resource is to improve the early recognition of, and response to, patients with cognitive impairment so that they receive safe and high-quality care. The resource guides clinicians through the safety and quality pathway for patients with cognitive impairment (dementia and delirium) in hospital (the pathway), which outlines the key steps to be taken. The key steps in the pathway are consistent with the intent of the [National Safety and Quality Health Service \(NSQHS\) Standards<sup>cxix</sup>](#). The implementation of the pathway will contribute to creating a safe and caring culture that is aware of the needs of patients with cognitive impairment.

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

## How to use this resource

The Australian Commission on Safety and Quality in Health Care (the Commission) developed this resource for clinicians, with funding from the Australian Government Department of Social Services. It is complemented by two other resources:

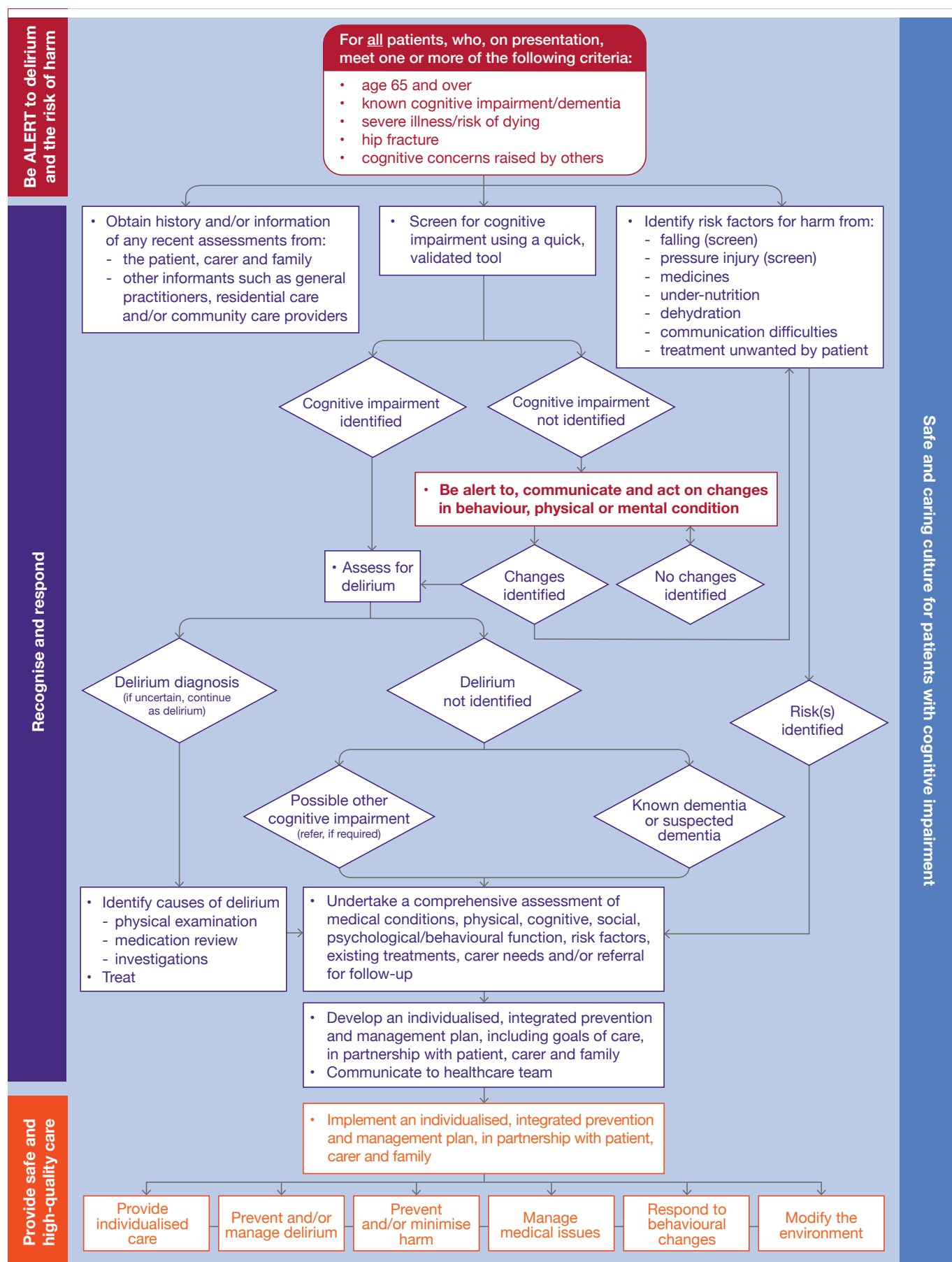
- [A better way to care: Safe and high-quality care for patients with cognitive impairment \(dementia and delirium\) in hospital – Actions for health service managers<sup>cxix</sup>](#), which is a more detailed resource for health service managers that provides further rationale for action, outlines their role in driving change and demonstrates how the key strategies can be linked to the NSQHS Standards.
- [A better way to care: Safe and high-quality care for patients with cognitive impairment \(dementia and delirium\) in hospital – Actions for consumers<sup>cxix</sup>](#), which outlines key actions for patients, carers and families.

This resource has been designed to be viewed electronically. [The electronic resource<sup>cxix</sup>](#) provides links to external web sites and will be updated as required.

## The pathway and key steps

The pathway (Figure 1) and the key steps are presented on the following pages.

**Figure 1:**  
Safety and quality pathway for patients with cognitive impairment (dementia and delirium) in hospital



## Key steps in the pathway

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

- Clinicians are alert to delirium and the risk of harm from cognitive impairment among patients who:
  - are aged 65 and over
  - have a known cognitive impairment or a formal diagnosis of dementia
  - have a severe illness or are at risk of dying
  - have a hip fracture.
- Clinicians are also alert when the patient, carer, family and/or other key informants raise concerns.
- A patient with cognitive impairment is supported to understand and participate in healthcare decisions. Their informed consent is obtained. If the patient is assessed as unable to provide consent, their substitute decision-maker is consulted.

**2 Recognise and respond to patients with cognitive impairment**

- A patient identified as being at-risk is screened for cognitive impairment. The patient's history is obtained from the patient, carer, family and/or other key informants. A patient's risk of harm from falls, pressure injuries, medicines, under-nutrition, dehydration, communication difficulties or unwanted treatment is identified.
- A patient with cognitive impairment is assessed for delirium. If delirium is present, causes are investigated and treated. If uncertain, the patient's condition is treated as delirium.
- Any change in a patient's behaviour, or physical or mental condition is acted on. If changes are observed, the patient is re-assessed for delirium and other risk factors.
- A comprehensive assessment of the patient is undertaken. If dementia is suspected and a comprehensive diagnostic process is not appropriate, the patient is referred for further assessment and follow-up.
- An individualised, integrated prevention and management plan is developed in partnership with the patient, carer and family, and communicated to the healthcare team.

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

- The patient's individualised, integrated prevention and management plan is implemented as follows:
  - The patient receives individualised care in partnership with the patient, carer and family.
  - The patient's medical issues are managed, including treating the underlying causes of delirium, presenting condition and any co-morbidities.
  - A patient with, or at-risk of developing, delirium has strategies implemented to prevent delirium from occurring or to limit its duration.
  - A patient with identified safety risk factors has strategies implemented to prevent and manage the risks.
  - A patient with behavioural changes is appropriately assessed and strategies are introduced to reduce distress. Antipsychotic medicine is avoided unless non-pharmacological interventions have been ineffective, the patient is severely distressed and/or the patient is at immediate risk of harm to themselves or others.
  - The hospital environment is modified to provide safe and supportive patient care.
  - The patient's healthcare information and management plan are documented and communicated to the patient, carer and all relevant healthcare providers in a timely manner and in sufficient detail, on transition from hospital to the community.

## Step 1

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

### Why is this important?

- Cognitive impairment (dementia and delirium) is common in hospitalised older people. Around 20% of people more than 70 years of age 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.<sup>1</sup> Delirium rates are higher in settings such as intensive care units and surgical wards where people are sicker and exposed to more hospital-related interventions.<sup>2</sup>
- Cognitive impairment can impede a person's ability to provide informed consent, follow instructions, attend to self-care needs and find their way.
- Patients with cognitive impairment are at risk of harm if their cognitive impairment is not detected. They are at greater risk of falling, developing a pressure injury, becoming more cognitively impaired, developing functional decline, losing their independence and dying.<sup>3</sup>
- Delirium can be an indicator of a serious, underlying illness, but is often not detected, and is underdiagnosed or misdiagnosed. Delirium is often mistaken for dementia and consequently dismissed. Patients with existing cognitive impairment (e.g. dementia) have their risk of developing delirium increased up to five-fold.<sup>3</sup>

### Who should I be concerned about?

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

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

Patients who are at risk of developing delirium include patients:

- aged 65 or older
- with known cognitive impairment or diagnosed dementia
- with a hip fracture
- who are severely ill or at high risk of dying.<sup>4</sup>

Be alert when concerns are raised through:

- your own observations; the key signs to look for are that the patient
  - cannot answer your questions
  - is inattentive or easily distracted
  - has disorganised thinking
  - has an altered level of consciousness
  - is agitated
  - is overly sleepy – this may be hypoactive delirium
- a carer, family member or friend. If an informant, such as a carer, family member or friend, accompanying the patient mentions confusion, ask 'Do you think your relative/friend has been more confused lately?'<sup>5</sup> because recent onset of confusion is an important indicator of delirium
- documentation from the patient's general practitioner, residential or community care provider, or previous records and assessments that mention dementia, delirium or confusion.



## What should I do?

### 1. Know which patients you should be concerned about

#### How do I do it?

- Think of cognition as another vital sign that needs to be monitored.<sup>6</sup>
- Understand the importance of identifying delirium, and the difference between delirium and dementia.
- Know who is at risk (see 'Who should I be concerned about?').
- Be alert to, and respond to, concerns raised by any source.
- Know that reduced mobility and movement, slow responses and withdrawal can be hypoactive delirium.
- Understand that delirium can be superimposed on existing dementia, but is still potentially reversible.
- Listen to carers and family members. Carers and family members usually know if a person is cognitively impaired, whether it is an existing, diagnosed dementia, or if their cognitive function has recently or suddenly worsened. However, they are often not asked about this, or their concerns are dismissed.

### 2. Understand the risks associated with cognitive impairment

#### How do I do it?

- Patients with cognitive impairment are at higher risk of harm (complications and adverse events),<sup>3</sup> from:
  - falls
  - pressure injuries
  - medicines
  - under-nutrition
  - dehydration
  - communication difficulties
  - unwanted treatment.
- It is important that these risks are appropriately managed (see Step 3).

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

#### How do I do it?

Understand the following principles:

- Always presume a person has capacity: Under common law, adults are presumed to have the capacity to make all their own decisions.
- Find out whether the person has made provision for somebody else to make the relevant decision on their behalf, or if an order of a tribunal or court exists to the same effect.

## Step 1

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

### What should I do?

### (continued)

- Don't make assumptions that a person lacks capacity because of their age, appearance, disability or behaviour: A person's capacity should be assessed on their decision-making abilities.
- Assess a person's decision-making ability – not the decision they make: A person cannot be assessed as lacking capacity merely because a decision may appear to others as being unwise, reckless or wrong. However, if a person appears to be making a decision against their own interest, careful consideration to their capacity should be given.
- 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.
- 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.
- Substitute decision-making is a last resort: Before lack of capacity is determined, everything possible should be done to support individuals to make their own decisions. When a person is assessed as not having capacity, follow the guardianship legislation in your jurisdiction to consult their substitute decision-maker.<sup>a</sup>

<sup>a</sup> Guardianship and Management of Property Act 1991 (ACT); Guardianship Act 1987 (NSW); Advanced Personal Planning Act 2013 (NT); Guardianship and Administration Act 2000 (Qld); Guardianship and Administration Act 1993 (SA); Guardianship and Administration Act 1995 (Tas); Guardianship and Administration Act 1986 (Vic); Guardianship and Administration Act 1990 (WA).



### Helpful hints

- Be aware that the unfamiliar environment of a hospital will appear strange, noisy, over-stimulating and confusing to a patient with cognitive difficulties.
- A patient with cognitive impairment may feel overwhelmed by different faces and multiple instructions, and may not be able to make sense of what is happening. For example, verbal information such as, 'Mrs B, I'm your nurse and I'm going to take you to the shower. First, I would like to do your vital signs and then I need to give you your medicines, plus get your clothing ready' may be overwhelming and confusing.
- Be aware that a relatively simple task may be difficult – for example, locating the toilet.

### What does being alert mean to me?

- I understand that cognitive impairment is not a normal part of ageing, but is common in older hospitalised patients.
- I am alert to patients at risk of delirium and increased risk of harm because of their cognitive impairment.
- I am aware that patients with cognitive impairment may need additional assistance.
- I understand my responsibilities to obtain informed consent from the patient, and otherwise to consult a substitute decision-maker.

# Patient story 1



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

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

She remembered that she has a 'normal doctor' but could not remember the name. She informed clinicians that the doctor's name was probably in her handbag and gave permission for them to have a look.

The ED doctor discovered that her medicines were in her handbag and included aspirin and amlodipine. The prescribing general practitioner (GP) was contacted and informed clinicians that Mrs A was a widow and appeared well except for some hypertension; however, she hadn't seen her for many months.

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

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

Following suturing of her wound, Mrs A was admitted for overnight head injury and blood pressure observations. A scheduled computerised tomography (CT scan) needed to be delayed to the following evening and, therefore, she was kept in hospital another night. 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.





What did not go well?	What went well?
✗ No cognitive screening.	✓ ED staff alerted to 'confusion' by ambulance officer.
✗ Because cognitive impairment was not recognised, the baseline history may be inaccurate. For example, her self-reported pre-admission activities of daily living (ADL) ability may have been inaccurate.	✓ Prescribing GP contacted.
✗ Previous 'confusion' may have been an indicator of cognitive impairment (acute or longstanding) rather than a possible head injury.	✓ Daughter contacted and informed of mother's hospitalisation.
✗ An underlying delirium may have been missed and consequently the underlying health problem not investigated and treated.	✓ Appropriate management of primary presenting problems.
✗ No response to documented deterioration.	
✗ 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.	

What could have been done better?
✓ 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 were recognition and response triggers in place.
✓ Engaging daughter in providing a history, including medicines.
✓ Providing better nursing supervision of care and patient comfort.

# Resources

Where do I go for more information?



## Understanding of dementia, delirium and risks of harm

- [Evidence for the safety and quality issues associated with the care of patients with cognitive impairment in acute care settings: a rapid review<sup>i</sup>](#), from the Commission, provides a summary of 31 publications relating to the safety and quality issues faced by people with cognitive impairment in acute hospitals.
- [Delirium in elderly people<sup>ii</sup>](#), published in *The Lancet* by Inouye SK, Westendorp RG and Saczynski JS, provides a comprehensive review of delirium, including epidemiology, predisposing and precipitating factors, diagnosis, outcomes, prevention and interventions.
- [Dementia services pathways<sup>iii</sup>](#) provides a framework for jurisdictions in dementia service planning and delivery. [The case studies<sup>iv</sup>](#) illustrate the practical considerations in implementing service provision. The case studies presented are:
  - person with dementia from an Aboriginal or Torres Strait Islander community (particularly in rural or remote areas)
  - person with dementia from a culturally and linguistically diverse (CALD) background
  - person with younger onset dementia – under the age of 65 years
  - person (with undiagnosed dementia) presenting to a hospital ED or other acute setting with other co-morbidities.

## Overview of dementia and delirium

### Online courses

- [Dementia Training Study Centres<sup>v</sup>](#) is the web site for the five dementia training study centres funded by the Australian Government, which provide development opportunities for existing and future dementia care health professionals. It includes links to e-learning, resources, education events including guest lectures, and to the *Australian Journal of Dementia Care*. Online modules are aimed at:
  - undergraduate students completing health-related courses
  - health and care staff wishing to undertake professional development to improve their knowledge and skills in dementia care.

The e-learning page includes links to:

- [e-learning lectures<sup>vi</sup>](#)
- [ten e-learning online modules<sup>vii</sup>](#), each attracting 15 continuing nurse education points.

The web site also includes:

- [Assessment and management of confusion in the acute care setting<sup>viii</sup>](#), a self-directed learning package with a focus on delirium
- [a training package<sup>ix</sup>](#) to support overseas-qualified nurses as they adapt to working in the Australian dementia care setting.
- [Understanding Dementia<sup>x</sup>](#), from the University of Tasmania, is a free nine-week online course divided into three themes:
  - **The brain** provides a background on basic nervous system anatomy and function, followed by a discussion of the diseases that cause dementia, current dementia research and future directions.
  - **The diseases** explores the differences between normal ageing and dementia, risk factors, symptoms of dementia, the issues surrounding diagnosis, as well as medical management.
  - **The person** addresses the difficulties in recognising symptoms, living with dementia, progression and staging, palliation, behaviours, management, and alternative therapies.

## Courses developed by jurisdictions

### New South Wales

- [Health Education and Training Institute – dementia/delirium module<sup>xi</sup>](#) is intended for NSW Health clinical workers who are not specialised in aged care or mental health. It is an introductory module with information to assist clinicians to understand, assess and respond to patients, and accept their role in managing the issue.
- [Dementia Care Resource and Training Network<sup>xii</sup>](#) is for NSW Health participants in online dementia courses, facilitated by dementia clinical nurse consultants. There are three courses:
  - **Positive approach to care of the older person** is a 12-week course aimed at registered nurses (RNs), endorsed enrolled nurses (EENs) and allied health. It is suitable for clinicians working in all settings, including in acute care, residential aged care and the community. On successful completion of the course, 30 continuing professional development points are awarded.
  - **Behavioural and psychological symptoms of dementia** is a six-week course also aimed at RNs, EENs and allied health, and is suitable for those working in all settings.
  - **Person-centred care in the community** is a four-week course aimed specifically at assistants in nursing (AINs) and patient care assistants (PCAs) who work in acute care, residential aged care or the community.

The courses include discussion forums, real-time online chats, quizzes and self-directed lessons. Anyone can join to gain access to the resources on the site and to network with members. The site also provides access to dementia care competencies developed for health professionals at essential, enhanced and expert levels.

### Western Australia

- [Western Australia Centre for Healthy Ageing<sup>xiii</sup>](#) has a series of modules that include dementia and delirium. The delirium module is a case study focusing on the recognition of delirium in an older Aboriginal person in hospital.

## Educational resources

### National

- [Alzheimer's Australia<sup>xiv</sup>](#) has a section on understanding dementia and memory loss. It includes:
  - [translated information and resources for CALD groups<sup>xv</sup>](#)
  - [publications and resources for Aboriginal and Torres Strait Islander communities<sup>xvi</sup>](#).
- [Delirium in older people<sup>xvii</sup>](#), from the Australian Government Department of Health, is a booklet for health professionals on delirium.
- [Delirium care pathways poster<sup>xviii</sup>](#) is from the Australian Government Department of Health.

# Resources

Where do I go for more information?



## International

- [The Scottish Dementia Promoting Excellence: dementia informed practice level education framework<sup>xix</sup>](#) outlines the competencies required by different levels of the workforce, and provides videos to support staff and students who require the knowledge and skills of that level.
- [The National Health Service's Education for Scotland \*Dementia care in the emergency department: learning resource\*<sup>xx</sup>](#) provides practical tips and links to further resources, outlining:
  - initial contact
  - assessment
  - intervention
  - resolution.
- [The Social Care Institute for Excellence's Dementia Gateway<sup>xxi</sup>](#) provides information and training resources on dementia.
- [Portal of Geriatrics Online Education<sup>xxii</sup>](#) is a free collection of expert-contributed geriatrics educational materials for educators and learners.
- [International Dementia Hospital Hub<sup>xxiii</sup>](#) has a range of relevant resources and invites contributions to share knowledge about evidence-based practice.

## New South Wales

- [Care of Confused Hospitalised Older Persons \(CHOPS\)<sup>xxiv</sup>](#), developed by the Aged Health Network at the Agency for Clinical Innovation, aims to improve the experiences and outcomes of confused older people in hospital. It includes:
  - [Why doctors need to know about delirium: relevance, implications, screening and diagnosis<sup>xxv</sup>](#) is a video that focuses on the role of doctors in screening, assessment and diagnosis of delirium.
  - [Overview of delirium risk assessment, prevention and management in an acute care nursing environment<sup>xxvi</sup>](#) is a video that focuses on the perspective of patients and nurses, with the emphasis on the principles of person-centred care.

## Queensland

- [Caring for a person with dementia<sup>xxvii</sup>](#) is a guide for hospital nursing staff that provides an overview of dementia and suggestions on how to respond to patients living with dementia.
- [Learn about delirium<sup>xxviii</sup>](#), from the Queensland University of Technology School of Nursing, is an online, independent learning resource about delirium and delirium superimposed on dementia, with vignettes to enhance learning.
- [Confused older person in ED – clinical guide<sup>xxix</sup>](#), from the Clinical Access and Redesign Unit, Queensland Department of Health, is a one-page flow chart and tables on assessment, examination and management.



## Victoria

- [Dementia care in hospitals<sup>xxx</sup>](#) was a Victorian research program that sponsored four projects on dementia-friendly care in hospitals. Project outcomes provided ideas and suggestions for hospitals in:
  - culture, policy and practice change
  - education programs and resources
  - specific dementia care practice
  - engaging families and carers of patients with dementia.

[The Dementia Care in Hospitals Program<sup>xxxi</sup>](#), a dementia awareness and communication project within this program uses a bedside alert called the Cognitive Impairment Identifier (CII).
- [Best care for older people everywhere: the toolkit<sup>xxxii</sup>](#) is a web-based toolkit to assist clinicians to improve care and minimise the functional decline of older patients in hospital. It provides tips, clinical information and resources in a number of areas, including cognition.
- [Victorian Geriatric Medicine Training Program<sup>xxxiii</sup>](#) includes modules on delirium, dementia and the CogCard as an aid to the detection of cognitive impairment.

## Capacity, substitute decision-making and planning ahead

### National

- [Advance Care Planning Australia<sup>xxxiv</sup>](#), from the Respecting Patient Choices Program, is aimed at consumers and health professionals, and includes links to each jurisdiction, training and how to create an advance care plan.
- [Start2talk<sup>xxxv</sup>](#), developed by Alzheimer's Australia and its partners, aims to help all Australians to start the conversations involved in planning ahead. It includes resources for healthcare professionals.

### Australian Capital Territory

- [Guardianship and Management of Property Act 1991 \(ACT\)<sup>xxxvi</sup>](#) is the Australian Capital Territory legislation relevant to substitute decision-making.
- [The Public Advocate of the ACT<sup>xxxvii</sup>](#) provides information on guardianship and the enduring power of attorney.

### New South Wales

- [Capacity toolkit: information for government and community workers, professionals, families and carers in New South Wales<sup>xxxviii</sup>](#), from the NSW Department of Attorney General and Justice, is a guide to assessing a person's capacity to make legal, medical, financial and personal decisions.
- [Get it in black and white: planning ahead tools<sup>xxxix</sup>](#), from the NSW Government, contains information, tools and resources to enable individuals to communicate their wishes and plan for the future by completing wills, powers of attorney, enduring guardianship and advance care plans. It has sections for individuals, families, carers, legal professionals, health professionals and service providers.
- [A plan of care: a book to help people in New South Wales make health and personal care decisions on behalf of a person with dementia<sup>xl</sup>](#) is a booklet for family members and carers who have to make decisions about the medical and personal care of people who have lost capacity.
- [Guardianship Act 1987 \(NSW\)<sup>xli</sup>](#) is the New South Wales legislation relevant to substitute decision-making.

# Resources

Where do I go for more information?



## Northern Territory

- [\*Advance Personal Planning Bill 2013 \(NT\)\*<sup>xliii</sup>](#) is the Northern Territory legislation relevant to substitute decision-making.
- [\*The Northern Territory Department of the Attorney-General and Justice\*<sup>xliii</sup>](#) provides information on advance personal planning, including the Advance Personal Plan and application to register.

## Queensland

- [\*Making health care decisions for others\*<sup>xliv</sup>](#), produced by the Queensland Government, provides information on how and when decisions can be made by healthcare decision-makers.
- [\*Guide to informed decision-making in healthcare\*<sup>xlv</sup>](#), produced by the Patient Safety and Quality Improvement Service, Queensland Health, aims to support practitioners in understanding the ethical and legal requirements of informed decision-making about health care.
- [\*Guardianship and Administration Act 2000 \(Qld\)\*<sup>xlvi</sup>](#) is the Queensland legislation relevant to substitute decision-making.

## South Australia

- [\*Office of the Public Advocate\*<sup>xlvii</sup>](#) has information about planning ahead and making decisions for others.
- [\*Capacity and dementia: a guide for South Australian health care professionals\*<sup>xlviii</sup>](#), produced by the Australian Centre for Capacity and Ethics, aims to prevent exploitation of people with disabilities.
- [\*Guardianship and Administration Act 1993 \(SA\)\*<sup>xlix</sup>](#) is the South Australian legislation relevant to substitute decision-making.

## Tasmania

- [\*Capacity and dementia: a guide for Tasmanian health care professionals\*<sup>i</sup>](#), produced by the Australian Centre for Capacity and Ethics, aims to prevent exploitation of people with disabilities.
- [\*Guardianship and Administration Act 1995 \(Tas\)\*<sup>ii</sup>](#) is the Tasmanian legislation relevant to substitute decision-making.

## Victoria

- [\*Office of the Public Advocate\*<sup>iii</sup>](#) has information about guardianship, medical consent, powers of attorney and supported decision-making.
- [\*Capacity and dementia: a guide for Victorian health care professionals\*<sup>iiii</sup>](#), produced by the Australian Centre for Capacity and Ethics, aims to prevent exploitation of people with disabilities.
- [\*Guardianship and Administration Act 1986 \(Vic\)\*<sup>liv</sup>](#) is the Victorian legislation relevant to substitute decision-making.

## Western Australia

- [Position statement: decisions about treatment<sup>lv</sup>](#) was produced by the Government of Western Australia, Department of the Attorney General, Office of the Public Advocate.
- [Consent to treatment policy for the Western Australian health system<sup>lvi</sup>](#) was produced by the Office of Safety and Quality in Healthcare.
- [Guardianship and Administration Act 1990 \(WA\)<sup>lvii</sup>](#) is the Western Australian legislation relevant to substitute decision-making.

## Step 2

# Recognise and respond to patients with cognitive impairment

### Why is this important?

- Sometimes, it is hard to detect cognitive impairment. Delirium is often missed.<sup>7-9</sup> Many people with dementia have not been formally diagnosed and may not say that they are having cognitive difficulties, because it is unlikely to be the reason for their admission.
- Patients with existing cognitive impairment are at greater risk of harm from falling, pressure injuries, medicine, under-nutrition, dehydration, communication difficulties and unwanted treatment. They may become more cognitively impaired and decline functionally.
- If you recognise cognitive impairment, you are able to assess and provide for a patient's additional care needs, which will then minimise their risk of harm.
- Patients with an existing cognitive impairment, such as dementia, are at the greatest risk of developing delirium during their hospital stay. Changes in their behaviour, physical condition or mental state can be mistakenly attributed to their dementia and not investigated, leading to poor outcomes.
- If you identify patients at risk of delirium, you can introduce strategies to prevent delirium from developing.<sup>10</sup> Delirium prevention is effective.<sup>6</sup>
- Delirium is very common in patients with a hip fracture but, again, it can be prevented.<sup>11</sup>
- If you diagnose delirium early, you can investigate and treat the underlying cause. You may decrease its severity and reduce its long-term impact.
- The experience of delirium can be distressing for patients, carers, families and clinicians.<sup>12</sup>

### Who should I be concerned about?

You need to be concerned about patients who:

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



## What should I do?

### 1. Screen identified patients for cognitive impairment

#### How do I do it?

- Be familiar with the cognitive screening tool/s used in your facility, their strengths and limitations, and how to interpret results (e.g. abbreviated mental test score – AMTS; see Appendix 1).
- Administer a quick validated screening tool that tests orientation, recall and attention, and record the score.
- Be aware that a poor score is not a diagnosis, but a trigger for further assessment.
- If there is concern about the patient's medical decision-making capacity, conduct or arrange a capacity assessment.

### 2. Obtain a history from the patient, carer and other key informants

#### How do I do it?

- Always talk to carers, family and friends of the patient.
- Contact their GP, residential care facility, and/or community aged care provider for background information.
- Determine if the cognitive impairment is recent (past few hours or days), because acute onset is an important indicator for delirium diagnosis.
- Use an interpreter when required.
- If a person is cognitively impaired and is unable to consent to medical treatment, identify any existing advance care plan and/or substitute decision-maker.
- Document information and communicate to other staff members so that the patient, their carer and their primary healthcare provider are not asked the same questions multiple times.

### 3. Identify if the patient has risk factors for harm

#### How do I do it?

- Be familiar with the screening tools used in your facility for falls, pressure injuries and nutrition.
- Be familiar with risks of certain medicines.
- Screen the patient for risk of pressure injury.
- Screen the patient for risk of falls.
- Undertake a nutrition risk screen.
- Undertake medicine review.
- Identify any communication difficulties.
- Be familiar with your jurisdiction's legislation regarding consent to medical treatment.
- Be familiar with the processes of advance care planning in your facility.

## Step 2

# Recognise and respond to patients with cognitive impairment

### What should I do?

(continued)

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

##### How do I do it?

- Be familiar with the delirium assessment tool used in your facility, its strengths and limitations and how to interpret results (e.g. Confusion Assessment Method – CAM; CAM for the intensive care unit – ICU; Single Question in Delirium – SQID; the 4 A's test – 4AT; see Appendix 2).
- Assess the patient for delirium and record result.
- If delirium is diagnosed, identify and treat possible causes, understanding that the causes are often multifactorial.
- If uncertain, manage as delirium.
- Note that delirium can be a trigger or flag for a medical emergency.
- Collate history with the patient, carer and/or family, and review medicines as a priority.
- Consider ceasing medicines that may cause delirium; be aware of anticholinergic load.
- Undertake a physical examination, measure vital signs such as temperature, oxygen saturation and blood glucose concentration.
- Undertake targeted diagnostic tests based on history and examination.
- Re-assess with any change to the patient's behaviour, mental state or physical condition.
- Provide the patient, carers and family with information on delirium that is easy to understand.
- Involve the patient, carers and family in clinical handover, and encourage them to report any changes.

#### 5. Undertake a comprehensive assessment of the patient

##### How do I do it?

- Assess the patient's medical conditions, including presenting problems, co-morbidities and existing treatments, medicines, and presence of pain.
- Assess physical, cognitive, social, psychological and behavioural function.
- Assess identified risk factors, such as falls, pressure injuries, under-nutrition and communication difficulties.
- Be aware of signs of abuse of older people, and your jurisdictional policies and protocols regarding intervention.
- Assess carer needs and their preferred level of involvement during the hospital stay.
- If dementia is suspected and a comprehensive diagnostic process is not appropriate in hospital, refer for further assessment and follow-up. Record assessment results and communicate these to the patient, carer and family.



## 6. Develop an individualised, integrated patient prevention and management plan

### How do I do it?

- Based on the comprehensive assessment, develop an individualised prevention and management plan.
- Prioritise needs, and set short- and long-term goals in collaboration with the patient, carer and family.
- Document goals of care.

### Helpful hints

- ✓ The cognitive screening score provides a baseline that can be recorded and compared when any further testing is undertaken during the hospital stay.
  - ✓ Remember that a person may not score well for reasons other than dementia or delirium – for example, pain, medicines, depression, and not understanding questions due to language, or hearing or learning difficulties.
  - ✓ When taking a patient's history and performing assessments, make sure the patient has their spectacles and hearing aids in place (if appropriate). Use a headphone amplification device if the patient is not able to hear you speaking.
  - ✓ Introduce yourself clearly and explain the purpose of your visit.
  - ✓ Seat yourself at the level of the patient, and speak slowly and clearly.
  - ✓ Ask the patient what is troubling them.
  - ✓ Inform the patient, carer and family of [\*A better way to care: Safe and high-quality care for people with cognitive impairment \(dementia and delirium\) in hospital – Actions for consumers\*<sup>CXXX</sup>](#).
- 
- ✗ Do not dismiss any patient as 'pleasantly confused', or assume they have existing dementia and do nothing.
  - ✗ Do not ignore lethargy and withdrawal, because hypoactive delirium is easily missed.
  - ✗ Do not miss the opportunity to talk to carers and family.
  - ✗ Do not dismiss a carer's or family's concerns. Claims of 'She/he is not usually like this!' should be taken seriously.

## Step 2

# Recognise and respond to patients with cognitive impairment

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

- I have the knowledge and skills to obtain timely and sufficient information from the patient and/or key informants, including advance care plans.
- I am trained in risk assessment, cognitive screening and interpretation of results.
- I understand the contribution carers can make to my understanding of the patient and I seek their input.
- I know which patients in my care have dementia and/or delirium, and I understand their risks of harm. I also know which patients are at risk of developing delirium.
- I provide the patient, carers and family with health information that is easy to understand.
- I am now in a position to provide care in a way that will minimise their risks of harm.







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 she had an internal fixation of her right femur performed. She subsequently suffered a slight heart attack 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*. Sydney. University of Technology, 2011.

What did not go well?	What went well?
✗ No falls risk assessment.	✓ Daughter informed clinicians that mother had dementia.
✗ Change in condition not acted on.	✓ Daughter raised concerns about the risk of her mother falling.
✗ No subsequent delirium assessment.	
✗ Use of bedrails.	
✗ Bed not in a low position.	
✗ Daughter's (carer's) safety advice ignored.	
✗ False reassurance.	
✗ Clinicians not understanding care needs.	
✗ Patient's bed not easily visible to nursing staff.	
✗ Daughter not informed of fall.	

What could have been done better?
✓ Clinicians recognising and documenting existing dementia.
✓ Clinicians undertaking further assessment and developing an individualised prevention and management plan to address safety issues.
✓ Implementing an individualised prevention and management plan, including regular assisted toileting and environmental modification – low bed, closer to nurses' station.
✓ Engaging carer, and taking carer concerns seriously and acting on them.

# Resources

Where do I go for more information?



The courses and many of the resources outlined under Step 1 are also useful to this section.

## Screening for cognitive impairment

### Screening tools

- [Abbreviated Mental Test Score for dementia<sup>lviii</sup>](#) (Appendix 1), from the National Ageing Research Institute, is an example of a brief screening tool and an evaluation.
- [Time and Change Test<sup>lix,13</sup>](#) is a screening tool based on time and money calculations.
- [Digit Span Test<sup>lx,14</sup>](#), reviewed in [International Psychogeriatrics<sup>cxviii</sup>](#), assesses verbal working memory by seeing how many numbers the patient can remember.
- [Short Portable Mental Status Questionnaire<sup>lxi,15</sup>](#) is a brief questionnaire about current events and knowledge.
- [4AT<sup>lxii</sup>](#) (Appendix 2) is a screening tool for both delirium and cognitive impairment that is free to download and use. [The months of the year backward test<sup>lxiii</sup>](#) and [the 4-item Abbreviated Mental Test<sup>lxiv</sup>](#), which are brief tests for cognitive impairment, are also incorporated.
- [National Institute on Aging<sup>lxv</sup>](#) (United States) lists 116 tools to detect cognitive impairment in older adults.

## Delirium

### Guidelines

- [Delirium in older people: Australian and New Zealand Society for Geriatric Medicine position statement 13<sup>lxvi</sup>](#) provides evidence-based recommendations on the prevention, assessment, treatment and management of delirium.
- [Clinical practice guidelines for the management of delirium in older people<sup>lxvii</sup>](#), from the Australian Health Ministers' Advisory Council (AHMAC), are guidelines for the management of delirium, designed specifically for the Australian healthcare environment.
- [Management of delirium in older people: quick reference guide<sup>lxviii</sup>](#) is a quick reference of information from the AHMAC guidelines.
- [Delirium care pathways<sup>lxix</sup>](#) summarises the AHMAC guidelines and provides examples of the patient journey in the community, acute care and residential care.
- [Delirium: diagnosis, prevention and management<sup>lxx</sup>](#), from the United Kingdom (UK) National Institute for Health and Care Excellence, is a clinical guideline that describes methods of preventing, identifying, diagnosing and treating delirium. It focuses on preventing delirium in patients identified to be at risk, using targeted, multicomponent, non-pharmacological interventions.
- [Guidelines for the prevention, diagnosis and management of delirium in older people in hospital<sup>lxxi</sup>](#) is part of the 2006 National Guidelines from the British Geriatrics Society.

### Assessment tools

- [Confusion Assessment Method<sup>lxxii</sup>](#) provides access to the CAM training manual.
- [CAM-ICU: the complete training manual<sup>lxxiii</sup>](#) provides information about a modified version of the CAM intended for use when the patient is only able to provide nonverbal responses.
- [Assessing and managing delirium in older adults with dementia<sup>lxxiv</sup>](#) provides information on assessing delirium superimposed on dementia.
- [Delirium superimposed on dementia<sup>lxxv</sup>](#) provides information on detecting and managing delirium superimposed on dementia, and also has links to videos and other sources of information.



## Comprehensive assessment

- [Dementia Outcomes Measurement Suite<sup>bxxvi</sup>](#) provides access to a variety of cognitive identification and assessment methods, including their purpose, validation, administration time and recommended administration personnel. It provides downloads of the tools in a usable format, including:
  - Modified Mini Mental Exam (3MS)
  - Alzheimer's Disease Assessment Scale: Cognition (ADAS-Cog)
  - General Practitioner Assessment of Cognition (GPCOG)
  - Psychogeriatric Assessment Scale (PAS)
  - Rowland Universal Dementia Assessment Scale (RUDAS)
  - Kimberley Indigenous Cognitive Assessment (KICA) tool
  - Montreal Cognitive Assessment (MoCA).
- [Alzheimer's Australia<sup>bxxvii</sup>](#) provides access to RUDAS, which was developed to minimise the influence of language and cultural education. It provides a link to a video, a guide to administration and scoring, as well as a scoring sheet and copies of journal articles. [Best care for older people everywhere: the toolkit<sup>bxxviii</sup>](#) provides a summary and evaluation of RUDAS<sup>bxxix</sup>.
- [Diagnostic and statistical manual of mental disorders \(5th ed\)<sup>bxxx</sup>](#), produced by the American Psychiatric Association, is a resource for clinicians, researchers, insurers and patients. It includes information on implementation of the manual and answers frequently asked questions.
- [Advancing practice in the care of people with dementia<sup>bxxxi</sup>](#), produced by the Dementia Training Study Centres, is a resource for aged care assessment clinicians. It contains the following topics:
  - Evident cognitive impairment but no formal diagnosis
  - Capacity
  - Behaviour or psychological symptoms of dementia
  - Fitness to drive
  - Hoarding and squalor
  - Major neurocognitive disorder
  - Comparison of the clinical features of delirium, dementia and depression.
- [Sharing clinical information across care settings: the birth of an integrated assessment system<sup>bxxxii</sup>](#), developed by the InterRAI research collaborative, describes a suite of assessment tools to support assessment and care planning.

## Elder abuse

- [NSW Elder Abuse Helpline<sup>bxxxiii</sup>](#) is a confidential helpline offering information, advice and referrals for people who experience, witness or suspect the abuse of older people living in their homes in NSW.
- [Elder Abuse Prevention Unit<sup>bxxxiv</sup>](#) is a statewide service to response to the abuse of older people in Queensland.
- [Responding to elder abuse: Tasmanian Government practice guidelines for government and non-government employees<sup>bxxxv</sup>](#) were developed by the Tasmanian Department of Health and Human Services.
- [Elder abuse prevention and response guidelines for action 2012-14<sup>bxxxvi</sup>](#) were developed by the Victorian Department of Health as part of the Health priorities framework 2012-22.
- [Elder abuse protocol: guidelines for action<sup>bxxxvii</sup>](#), developed by the Alliance for the Prevention of Elder Abuse, aim to assist organisations in Western Australia working with older people to respond to elder abuse.

## Step 3

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

### Why is this important?

- Patients with cognitive impairment (dementia and delirium) may be recognised but not provided with the extra assistance or support they need to be safe from harm – for example, prompts to drink regularly.
- Carers and families often report that they are not consulted or kept informed during the hospital stay, and that their relative has declined significantly in their capacity to look after themselves after a hospital stay.
- Delirium can be prevented if you identify patients who are at risk and provide the right care.
- Behavioural disturbance can be mistakenly thought to be part of a patient's dementia when the patient may have an underlying physical condition, be in pain or be expressing an unmet need.<sup>16</sup>
- Antipsychotics such as haloperidol are overused as the first-line response to agitation and aggression. They only have modest benefit, and increase the risk of adverse events such as death, stroke, falls and further cognitive decline.<sup>17</sup>
- It is possible to prevent escalation of behavioural issues by assessing and treating the underlying cause, and by the way you communicate.
- Carers are often experts who can tell you how to reduce the patient's distress.

### Who should I be concerned about?

You need to be concerned about patients with existing cognitive impairment and/or identified delirium, and patients at risk of developing delirium (see Step 1).

## What should I do?

### 1. Provide individualised patient care, in partnership with the patient, carer and family

#### How do I do it?

- Put the principles of patient-centred care into practice:
  - treat patients, carers and families with dignity and respect
  - communicate and share information
  - encourage and support participation in decision-making.
- Get to know the individual person, their abilities, specific needs and preferences, and how their cognitive impairment affects their ability to communicate.
- If the patient does not have a carer, offer to contact a nominated person who can be informed of their hospital admission, if the patient wishes.
- Provide additional care when required, such as regular toileting, prompts for fluid intake, encouragement with ADLs and mobilising when appropriate.
- Encourage and support carers when they choose to be involved in a patient's care.
- Implement the individualised, integrated prevention and management plan, in consultation with the patient, carer and family.
- Consult the patient, carer and family in planning for transitions of care.
- Provide access to hospital substitution, fast-track and transition programs to maximise recovery and restoration of function.
- Refer for ongoing community and carer support.

### 2. Manage the patient's medical issues

#### How do I do it?

- Discuss wishes with the patient or substitute decision-maker, and agree to and document goals of care.
- Obtain informed consent and treat the presenting condition.
- Be familiar with your jurisdiction's legislation regarding consent to medical treatment.
- Continue to treat any identified underlying cause/s of delirium.
- Review medicines with a view to reducing delirium and falls risks.
- Manage pain.
- Optimally manage co-morbidities.
- Document delirium and/or diagnosed or suspected dementia in transfer information.
- Arrange follow-up medical review.



## Step 3

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

### What should I do?

(continued)

#### 3. Prevent delirium and/or manage the patient's delirium<sup>18</sup>

##### How do I do it?

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

#### 4. Prevent and/or minimise patient harm from identified safety risk factors

##### How do I do it?

- Consider close observation.

- Implement multicomponent falls prevention strategies. Examples include:
  - Make sure the patient has their usual spectacles and visual aids at hand (this will also assist in preventing delirium).
  - Avoid using bedside rails.
  - Check that the patient understands how to use assistive devices.
  - Organise a physiotherapy review for patients with mobility issues.
  - Place high-risk patients within view of, and close to, the nursing station.
  - Be aware of the high risk of falls in the bathroom.
- For identified patients at risk of pressure injuries, undertake regular skin inspections and implement a pressure injury prevention plan.
- For patients with pressure injuries, implement a comprehensive wound management plan, including pain management.
- Implement a nutrition care plan that may include encouraging and assisting with food intake.
- Avoid dehydration (see 'Prevent delirium and/or manage the patient's delirium').
- Encourage effective communication to reduce distress and anxiety.
- Discuss wishes with the patient or substitute decision-maker, adhere to advance care planning, and agree to and document goals of care to avoid unwanted treatment.
- Avoid functional decline by mobilising and encouraging self-care.

## 5. Respond appropriately to behavioural changes

### How do I do it?

- Always assess the underlying causes of behaviour such as physical illness or pain. Understand that the patient may only be able to communicate through behaviour.<sup>16</sup>
- Reassure the patient, talk in a gentle tone, stay calm and use simple language. Delirium can be frightening and people with dementia can feel increasingly anxious in an unfamiliar environment.
- Learn from the carer or family how to reduce a person's distress, agitation or aggression.
- Engage the patient in purposeful and individual-targeted activities.
- Only consider use of antipsychotics if non-pharmacological interventions have failed, and the person is severely distressed and is at immediate risk of harm to themselves or others. Over-sedation can lead to pneumonia, pressure injuries, falls and fractures.
- Seek advice and support from clinical experts when presentation is complex or beyond the skill level of receiving staff. Experts may include geriatricians, psycho-geriatricians, nurse practitioners, clinical nurse consultants and staff from [Dementia Behaviour Management Advisory Services<sup>CXX</sup>](#).

## Step 3

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

### What should I do?

(continued)

#### 6. Modify the environment to provide safe and supportive patient care

##### How do I do it?<sup>19,20</sup>

- Provide a calm, safe and secure environment.
- Provide meaningful activities.
- Enable safe walking and self-care.
- Minimise noise; try to provide a quiet environment, especially at rest times.
- Provide opportunities for both privacy and community.
- Promote continence (visual signage and access to toilets).
- Provide a way-finding orientation design.
- Provide lighting that is appropriate for the time of day.

#### 7. Document and communicate the patient's healthcare information and management plan on transition

##### How do I do it?

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

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

- I have the knowledge and skills to provide all the components of safe and high-quality care, or I know when to seek advice and support from clinical experts.
- I make decisions in partnership with carers and family.
- I am alert to changes in my patient that trigger review or changes in the management plan.
- I communicate patient and treatment changes to my team.
- I have the skills and knowledge to recognise when a person is approaching end of life and to discuss goals of care.
- I understand the importance and applicability of transition programs.
- I assist with the patient's continuity of care.





Mr C is an 83 year-old man who resides in a low-level residential aged care facility. His wife had 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 directive (ACD) saying that he does not wish to be admitted to the Intensive Care Unit (ICU) or have 'extraordinary treatment' such as assisted ventilation or intubation.

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

His condition continued to deteriorate 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 ACD. However, the ICU clinicians were not aware that there was one in existence, although staff at the residential aged care facility were aware that Mr C had completed one. Because of Mr C's confusion on admission, he was not asked about this.

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



What did not go well?	What went well?
✗ Clinicians in the ED did not ask the residential aged care facility if there was an ACD in existence.	✓ Clinicians agreed to family's request once the existence of an ACD was known.
✗ The residential aged care facility did not provide information about the ACD.	
✗ Clinicians in the ED did not contact family despite Mr C's obvious confusion.	

What could have been done better?
✓ Contacting family to participate in information exchange and healthcare decision-making at presentation.
✓ Contacting the residential aged care facility at presentation to participate in information exchange regarding an ACD.



### Individualised care

- [Patient and consumer-centred care](#)<sup>bxxxviii</sup>, by the Commission, provides access to:
  - [Partnering with Consumers Newsletter](#)<sup>bxxxix</sup>, which highlights some of the national and international work being done in this area
  - [Patient-centered care: Improving quality and safety through partnerships with patients and consumers](#)<sup>xc</sup>
  - [Health literacy: taking action to improve safety and quality](#)<sup>xc</sup>
  - [National Statement on Health Literacy](#)<sup>xcii</sup>.
- [Make SPACE for good dementia care](#)<sup>xciii</sup>, from the UK Royal College of Nursing, details the five ingredients needed to support good dementia care, and includes resources and good-practice examples. The ingredients are:
  - Staff who are skilled and have time to care
  - Partnership working with carers
  - Assessment and early identification of dementia
  - Care plans that are person centred and individualised
  - Environments that are dementia friendly.
- [Improving quality of care for people with dementia in general hospitals](#)<sup>xciv</sup> is a UK evidence-based guide that provides a whole-of-hospital approach to care of patients with cognitive impairment.
- [Dignity in care: the dignity factors](#)<sup>xcv</sup>, from the UK Social Care Institute for Excellence, details eight research-informed factors that contribute to a person's sense of self-respect. These are:
  - choice and control
  - eating and nutritional care
  - communication
  - pain management
  - personal hygiene
  - practical assistance
  - privacy
  - pain management.
- [Improving quality of care for people with dementia in general hospitals](#)<sup>xcvi</sup>, from the Victorian Government, aims to assist clinicians to minimise the functional decline of older patients in hospital. It provides information and resources in cognition (which includes delirium, dementia and depression); mobility, vigour and self-care; continence; nutrition; skin integrity; assessment; and person-centred practice and medicine.
- [Dementia: Osborne Park Hospital guide for occupational therapists in clinical practice](#)<sup>xcvii</sup> provides an overview of dementia, occupational therapy assessment processes and evidence-based strategies to address common issues related to the environment and activities of daily living.
- [Acute hospitalization and Alzheimer's disease: a special kind of care](#)<sup>xcviii</sup>, from the National Institute on Aging, provides communication and environmental tips to meet the needs of a patient with dementia.



## Management and prevention of delirium

See also Step 2.

- [Hospital Elder Life Program \(HELP\)<sup>xcix</sup>](#), developed by the Yale University School of Medicine, is an evidence-based delirium prevention and management strategy.
- [Delirium model of care<sup>c</sup>](#), developed by the Western Australian Department of Health, is a comprehensive resource for clinicians.

## Prevention and minimisation of harm

- [National Safety and Quality Health Service Standards \(NSQHS Standards\)<sup>ci</sup>](#) detail the standards that are required in Australian health care. The NSQHS Standards were developed by the Commission, and their primary aims are to protect the public from harm and to improve the quality of health service provision. The NSQHS Standards relevant to safe and high-quality care for patients with cognitive impairment are:
  - Standard 8 – Pressure injury
  - Standard 10 – Falls guidelines.

## Medicines

- [American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults<sup>cii</sup>](#) is a special article published in the *Journal of the American Geriatrics Society* in 2012.
- [Drugs, delirium and older people<sup>ciii</sup>](#) reviews medicines that precipitate delirium, and those used for treatment and prevention of delirium.
- [Antipsychotic overuse in dementia – is there a problem?<sup>civ</sup>](#) is an article from NPS MedicineWise that provides practice points and a summary of recommendations in the use of antipsychotics with behavioural and psychological symptoms of dementia.
- [Anticholinergics and sedatives in older people – managing the risks<sup>cv</sup>](#) is an article from NPS MedicineWise that highlights the risks for older people of cumulative use of anticholinergic and sedative medicines.

## Nutrition

- [Position Statement No 6, Under Nutrition and the Older Person<sup>cv</sup>](#), from the Australian and New Zealand Society of General Medicine, recommends screening in all settings, including acute care, to identify older people at risk of under-nutrition and the employment of a range of non-pharmacological management strategies.
- [Best care for older people everywhere: the toolkit – Nutrition<sup>cvi</sup>](#) is part of the Victorian Government Health Information web site.
- [Nutrition and dementia: A review of available research<sup>cvi</sup>](#), published by Alzheimer's Disease International, summarises existing research, including under-nutrition in dementia and interventions to improve the nutrition of people living with dementia.

## Pain

- [Pain assessment in the nonverbal patient: position statement with clinical practice recommendations<sup>cix</sup>](#) was developed by a task force approved by the American Society for Pain Management Nursing.
- [Pain and dementia<sup>cx</sup>](#) is a fact sheet developed by Alzheimer's Australia.

# Resources

Where do I go for more information?



## Communicating with patients and carers

- [Talk to me brochure](#)<sup>cxix</sup>, developed by the Alzheimer's Australia Dementia Advisory Committee, provides tips on communicating with people living with dementia.
- [Dementia care](#)<sup>cxii</sup>, by the Centre for Cultural Diversity in Ageing, provides information on appropriate cultural communication.
- [Eastern Health](#)<sup>cxiii</sup> provides downloadable cue cards in community languages to aid in communication.
- [This is me tool](#)<sup>cxiv</sup>, developed by the UK Alzheimer's Society, aims to allow people with dementia to let health and social care professionals know about their needs, interests, preferences, likes and dislikes.
- [The triangle of care: carers included – a guide to best practice for dementia care](#)<sup>cxv</sup>, by the Carers Trust and the UK Royal College of Nursing, has been taken from mental health services and adapted for people with dementia in acute hospitals.
- [Top 5](#)<sup>cxvi</sup>, developed by the NSW Central Coast Local Health District, is a program that promotes communication between clinicians and the carer of a patient with cognitive impairment. [The Clinical Excellence Commission's Partnering with Patients program](#)<sup>cxvii</sup> in NSW trialled and evaluated the program.

## Unwanted treatment

See also Step 1.

- [National Consensus Statement: essential elements for safe and high-quality end-of-life care in acute hospitals](#)<sup>cxviii</sup>, released by the Commission, guides health services in the delivery of high-quality end-of-life care.
- [Feeding tubes in advanced dementia position statement](#)<sup>cxix</sup>, from the American Geriatrics Society, discusses the use of feeding tubes in advanced dementia.

## Response to behavioural issues

### National

- [Dementia Behaviour Management Advisory Services \(DBMAS\)](#)<sup>cxix</sup> provide clinical support for clinicians and family members caring for persons living with dementia, who present with behavioural and psychological symptoms of dementia.
- [Behaviour management: a guide to good practice](#)<sup>cxix</sup> was designed for clinicians of DBMAS. It outlines psychological, environmental and biological management strategies, backed by supporting evidence and an assessment of the quality of evidence. It also includes a comprehensive description of cultural competency and cultural consideration in working with Aboriginal and Torres Strait Islander people and people from CALD backgrounds. The guide has been condensed into a mobile 'app', *A Clinician's Field Guide to Good Practice* and *A Guide for Family Carers*.

## New South Wales

- [\*Assessment and management of people with behavioural and psychological symptoms of dementia \(BPSD\): a handbook for NSW health clinicians\*<sup>cxxii</sup>](#) was developed by the NSW Ministry of Health, and the Royal Australian and New Zealand College of Psychiatrists, for clinicians in EDs, inpatient units and community settings. It promotes three key principles of care:
  - Ensure person-centred care.
  - Have a multidisciplinary and multiteam approach.
  - Meet legal and ethical responsibilities.
- [\*Poole's algorithm: nursing management of disturbed behaviour in older people\*<sup>cxxiii</sup>](#) provides a decision and action tree for delirium care pathways.

## South Australia

- [\*The SA Health Recognition and Management of Challenging Behaviour Program\*<sup>cxxiv</sup>](#) is designed to identify priorities relevant to the prevention and management of challenging behaviours during health care, to minimise harm to workers and patients.

## Victoria

- [\*Regional Dementia Management Strategy\*<sup>cxxv</sup>](#), developed by Bendigo Health, includes an ABC of behaviour management.

## Environmental design

- [\*Adapting the ward for people with dementia\*<sup>cxxvi</sup>](#) is a NSW Health resource to guide small hospitals in improving the environment, and includes design principles and an audit tool.
- [\*Developing supportive design for people with dementia\*<sup>cxxvii</sup>](#) provides access to resources developed by the King's Fund in the UK to enable care environments to become more dementia friendly.

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# Resource links

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

### Understanding of dementia, delirium and risks of harm

- i. [www.safetyandquality.gov.au/wp-content/uploads/2013/10/Rapid-Review\\_Evidence-for-the-safety-and-care-of-patients-with-cognitive-impairment-in-acute-care-settings.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2013/10/Rapid-Review_Evidence-for-the-safety-and-care-of-patients-with-cognitive-impairment-in-acute-care-settings.pdf)
- ii. [www.ncbi.nlm.nih.gov/pubmed/23992774](http://www.ncbi.nlm.nih.gov/pubmed/23992774)
- iii. [www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-dementia-services-pathways-2011-toc.htm~ageing-dementia-services-pathways-2011-framework.htm](http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-dementia-services-pathways-2011-toc.htm~ageing-dementia-services-pathways-2011-framework.htm)
- iv. [www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-dementia-services-pathways-2011-toc.htm~ageing-dementia-services-pathways-2011-case.htm#Case%20scenario%202](http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-dementia-services-pathways-2011-toc.htm~ageing-dementia-services-pathways-2011-case.htm#Case%20scenario%202)

### Overview of dementia and delirium

- v. [www.dtsc.com.au](http://www.dtsc.com.au)
- vi. [www.dtsc.com.au/category/elearning-lectures](http://www.dtsc.com.au/category/elearning-lectures)
- vii. [www.dtsc.com.au/dementia-training-study-centres/elearning/elearning-online-modules](http://www.dtsc.com.au/dementia-training-study-centres/elearning/elearning-online-modules)
- viii. [www.dtsc.com.au/dementia-training-study-centres/elearning/assessment-and-management-of-confusion-in-the-acute-care-setting/](http://www.dtsc.com.au/dementia-training-study-centres/elearning/assessment-and-management-of-confusion-in-the-acute-care-setting/)
- ix. <http://oqn.dtsc.com.au>
- x. [www.utas.edu.au/wicking/wca/mooc](http://www.utas.edu.au/wicking/wca/mooc)
- xi. <http://nswhealth.moodle.com.au/login/index.php>
- xii. <http://dementiacare.health.nsw.gov.au>
- xiii. <http://e-ageing.wacha.org.au/index.php?id=828>
- xiv. [www.fightdementia.org.au](http://www.fightdementia.org.au)
- xv. <https://vic.fightdementia.org.au/vic/support-and-services/services-and-programs-we-provide/multicultural-services>
- xvi. <https://fightdementia.org.au/about-dementia-and-memory-loss/aboriginal-and-torres-strait-islander-groups/aboriginal-and-torres-strait-islander-resources-and-publications>
- xvii. [www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-dementia-delirium.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-dementia-delirium.htm)
- xviii. [www.health.gov.au/internet/main/publishing.nsf/Content/FA0452A24AED6A91CA257BF0001C976C/\\$File/Delirium%20poster%20A3.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/FA0452A24AED6A91CA257BF0001C976C/$File/Delirium%20poster%20A3.pdf)
- xix. [www.knowledge.scot.nhs.uk/home/portals-and-topics/dementia-promoting-excellence/framework/informed-level/learning-resources.aspx](http://www.knowledge.scot.nhs.uk/home/portals-and-topics/dementia-promoting-excellence/framework/informed-level/learning-resources.aspx)
- xx. [www.nes.scot.nhs.uk/media/350995/dementia\\_emergency\\_dept\\_interactive\\_2011.pdf](http://www.nes.scot.nhs.uk/media/350995/dementia_emergency_dept_interactive_2011.pdf)
- xxi. [www.scie.org.uk/publications/dementia/index.asp](http://www.scie.org.uk/publications/dementia/index.asp)
- xxii. [www.pogoe.org](http://www.pogoe.org)

- xxiii. [www.internationaldementiahospitalhub.com/](http://www.internationaldementiahospitalhub.com/)
- xxiv. [www.aci.health.nsw.gov.au/chops](http://www.aci.health.nsw.gov.au/chops)
- xxv. [www.aci.health.nsw.gov.au/chops/education/delirium-videos/why-doctors-need-to-know-about-delirium](http://www.aci.health.nsw.gov.au/chops/education/delirium-videos/why-doctors-need-to-know-about-delirium)
- xxvi. [www.aci.health.nsw.gov.au/chops/education/delirium-videos/overview\\_of\\_delirium\\_risk\\_assessment\\_prevention\\_and\\_management\\_in\\_an\\_acute\\_care\\_nursing\\_environment](http://www.aci.health.nsw.gov.au/chops/education/delirium-videos/overview_of_delirium_risk_assessment_prevention_and_management_in_an_acute_care_nursing_environment)
- xxvii. [www.health.qld.gov.au/mentalhealth/docs/dementia.pdf](http://www.health.qld.gov.au/mentalhealth/docs/dementia.pdf)
- xxviii. <http://www.delirium.health.qut.edu.au/>
- xxix. [www.health.qld.gov.au/caru/networks/docs/coped-guide.pdf](http://www.health.qld.gov.au/caru/networks/docs/coped-guide.pdf)
- xxx. [www.health.vic.gov.au/agedcare/publications/dementia.htm](http://www.health.vic.gov.au/agedcare/publications/dementia.htm)
- xxxi. [www.bhs.org.au/node/130](http://www.bhs.org.au/node/130)
- xxxii. [www.health.vic.gov.au/older/toolkit/index.htm](http://www.health.vic.gov.au/older/toolkit/index.htm)
- xxxiii. [www.anzsgm.org/vgmtp](http://www.anzsgm.org/vgmtp)

### Capacity, substitute decision-making and planning ahead

- xxxiv. [www.respectingpatientchoices.org.au](http://www.respectingpatientchoices.org.au)
- xxxv. [www.start2talk.org.au](http://www.start2talk.org.au)
- xxxvi. [www.austlii.edu.au/au/legis/act/consol\\_act/gamopa1991379/](http://www.austlii.edu.au/au/legis/act/consol_act/gamopa1991379/)
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- xl. [www.advancecaredirectives.org.au/AdvanceCareDirectives-a-plan-of-care.html](http://www.advancecaredirectives.org.au/AdvanceCareDirectives-a-plan-of-care.html)
- xli. [www.legislation.nsw.gov.au/maintop/view/inforce/act+257+1987+cd+0+N](http://www.legislation.nsw.gov.au/maintop/view/inforce/act+257+1987+cd+0+N)
- xlii. [www.nt.gov.au/justice/policycoord/lawmake/documents/Issues\\_Paper\\_Advance\\_Personal\\_Planning\\_Bill.pdf](http://www.nt.gov.au/justice/policycoord/lawmake/documents/Issues_Paper_Advance_Personal_Planning_Bill.pdf)
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- xliv. [www.publicguardian.qld.gov.au/adult-guardian/health-care-decisions/making-health-care-decisions-for-others](http://www.publicguardian.qld.gov.au/adult-guardian/health-care-decisions/making-health-care-decisions-for-others)
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- l. <http://capacityaustralia.org.au/wp-content/uploads/2013/10/Tas-legal-mini-kit-v1.4-final-20164-ACCEPD.pdf>

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- liv. [www.austlii.edu.au/au/legis/vic/consol\\_act/gaaa1986304/](http://www.austlii.edu.au/au/legis/vic/consol_act/gaaa1986304/)
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- lvi. [www.health.wa.gov.au/CircularsNew/attachments/404.pdf](http://www.health.wa.gov.au/CircularsNew/attachments/404.pdf)
- lvii. [www.slp.wa.gov.au/legislation/statutes.nsf/main\\_mrtile\\_406\\_homepage.html](http://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtile_406_homepage.html)
- lxxiv. [http://consultgerirn.org/uploads/File/trythis/try\\_this\\_d8.pdf](http://consultgerirn.org/uploads/File/trythis/try_this_d8.pdf)
- lxxv. [www.mainehealth.org/workfiles/mmc\\_services/geriatrics/Improving\\_Detection.How\\_to\\_try\\_this\\_DSD.Fick.pdf](http://www.mainehealth.org/workfiles/mmc_services/geriatrics/Improving_Detection.How_to_try_this_DSD.Fick.pdf)

## Step 2 Recognise and respond to patients with cognitive impairment

### Screening for cognitive impairment

- lviii. [www.health.vic.gov.au/older/toolkit/07Cognition/02Dementia/docs/Abbreviated%20Mental%20Test%20Score%20\(AMTS\).pdf](http://www.health.vic.gov.au/older/toolkit/07Cognition/02Dementia/docs/Abbreviated%20Mental%20Test%20Score%20(AMTS).pdf)
- lix. [www.healthcare.uiowa.edu/igec/tools/cognitive/timeAndChange.pdf](http://www.healthcare.uiowa.edu/igec/tools/cognitive/timeAndChange.pdf)
- lx. <http://alzheimers.about.com/od/testsandprocedures/a/What-Is-The-Digit-Span-Test.htm>
- cxxxi. [www.ncbi.nlm.nih.gov/pubmed/21729426](http://www.ncbi.nlm.nih.gov/pubmed/21729426)
- lxi. [www.healthcare.uiowa.edu/igec/tools/cognitive/SPMSQ.pdf](http://www.healthcare.uiowa.edu/igec/tools/cognitive/SPMSQ.pdf)
- lxii. [www.the4at.com](http://www.the4at.com)
- lxiii. <http://jnnp.bmj.com/content/early/2014/02/25/jnnp-2013-307053.full.pdf+html>
- lxiv. [www.ncbi.nlm.nih.gov/pubmed/20164778](http://www.ncbi.nlm.nih.gov/pubmed/20164778)
- lxv. [www.nia.nih.gov/research/cognitive-instrument/search](http://www.nia.nih.gov/research/cognitive-instrument/search)

### Delirium

- lxvi. [www.anzsgm.org/documents/PS13DeliriumstatementRevision2012.pdf](http://www.anzsgm.org/documents/PS13DeliriumstatementRevision2012.pdf)
- lxvii. [http://docs.health.vic.gov.au/docs/doc/A9F4D074829CD75ACA25785200120044/\\$FILE/delirium-cpg.pdf](http://docs.health.vic.gov.au/docs/doc/A9F4D074829CD75ACA25785200120044/$FILE/delirium-cpg.pdf)
- lxviii. [http://docs.health.vic.gov.au/docs/doc/83E191191D4E1AE0CA2578520012390D/\\$FILE/delirium-qrf.pdf](http://docs.health.vic.gov.au/docs/doc/83E191191D4E1AE0CA2578520012390D/$FILE/delirium-qrf.pdf)
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- lxx. [www.nice.org.uk/guidance/cg103/resources/cg103-delirium-full-guideline3](http://www.nice.org.uk/guidance/cg103/resources/cg103-delirium-full-guideline3)
- lxxi. [www.bgs.org.uk/index.php/clinicalguides/170-clinguidedeliriumtreatment](http://www.bgs.org.uk/index.php/clinicalguides/170-clinguidedeliriumtreatment)
- lxxii. [www.hospitalelderlifeprogram.org/delirium-instruments/short-cam/the-short-confusion-assessment-method-short-cam/](http://www.hospitalelderlifeprogram.org/delirium-instruments/short-cam/the-short-confusion-assessment-method-short-cam/)
- lxxiii. [www.icudelirium.org/docs/CAM\\_ICU\\_training.pdf](http://www.icudelirium.org/docs/CAM_ICU_training.pdf)

### Comprehensive assessment

- lxxvi. [www.dementia-assessment.com.au](http://www.dementia-assessment.com.au)
- lxxvii. [www.fightdementia.org.au/understanding-dementia/rowland-universal-dementia-assessment-scale.aspx](http://www.fightdementia.org.au/understanding-dementia/rowland-universal-dementia-assessment-scale.aspx)
- lxxviii. [www.health.vic.gov.au/older/toolkit/](http://www.health.vic.gov.au/older/toolkit/)
- lxxix. [www.health.vic.gov.au/older/toolkit/07Cognition/02Dementia/docs/RUDAS%20resource%20review.pdf](http://www.health.vic.gov.au/older/toolkit/07Cognition/02Dementia/docs/RUDAS%20resource%20review.pdf)
- lxxx. [www.dsm5.org](http://www.dsm5.org)
- lxxxii. [www.biomedcentral.com/1472-6963/9/71](http://www.biomedcentral.com/1472-6963/9/71)
- lxxxiii. [www.dtsc.com.au/wp-content/uploads/Final-Dementia-sheets-for-web.pdf](http://www.dtsc.com.au/wp-content/uploads/Final-Dementia-sheets-for-web.pdf)

### Elder abuse

- lxxxiii. [www.elderabusehelpline.com.au](http://www.elderabusehelpline.com.au)
- lxxxiv. [www.eapu.com.au](http://www.eapu.com.au)
- lxxxv. [www.dhhs.tas.gov.au/\\_data/assets/pdf\\_file/0013/112450/120600\\_Elder\\_Abuse\\_Practice\\_Guidelines\\_FINAL\\_0708.pdf](http://www.dhhs.tas.gov.au/_data/assets/pdf_file/0013/112450/120600_Elder_Abuse_Practice_Guidelines_FINAL_0708.pdf)
- lxxxvi. [www.health.vic.gov.au/agedcare/downloads/pdf/eap\\_guidelines.pdf](http://www.health.vic.gov.au/agedcare/downloads/pdf/eap_guidelines.pdf)
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## Step 3 Provide safe and high-quality care tailored to the patient's needs

### Individualised care

- lxxxviii. [www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care](http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care)
- lxxxix. [www.safetyandquality.gov.au/publications-resources/newsletters/patient-and-consumer-centred-care-newsletters](http://www.safetyandquality.gov.au/publications-resources/newsletters/patient-and-consumer-centred-care-newsletters)
- xc. [www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC\\_Paper\\_August.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC_Paper_August.pdf)
- xc. [www.safetyandquality.gov.au/wp-content/uploads/2014/08/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2014/08/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf)
- xcii. [www.safetyandquality.gov.au/wp-content/uploads/2014/08/Health-Literacy-National-Statement.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2014/08/Health-Literacy-National-Statement.pdf)
- xciii. [www.rcn.org.uk/development/practice/dementia/commitment\\_to\\_the\\_care\\_of\\_people\\_with\\_dementia\\_in\\_general\\_hospitals](http://www.rcn.org.uk/development/practice/dementia/commitment_to_the_care_of_people_with_dementia_in_general_hospitals)
- xciv. <http://rcnpublishing.com/userimages/ContentEditor/1373367875414/Improving-dementia-care-quality.pdf>
- xcv. [www.scie.org.uk/publications/guides/guide15/factors/index.asp](http://www.scie.org.uk/publications/guides/guide15/factors/index.asp)



# Resource links

XCvi. [www.health.vic.gov.au/older/toolkit/index.htm](http://www.health.vic.gov.au/older/toolkit/index.htm)

XCvii. [www.dtsc.com.au/dementia-guide-for-occupational-therapists-in-clinical-practice/](http://www.dtsc.com.au/dementia-guide-for-occupational-therapists-in-clinical-practice/)

XCviii. [www.nia.nih.gov/alzheimers/publication/acute-hospitalization-and-alzheimers-disease](http://www.nia.nih.gov/alzheimers/publication/acute-hospitalization-and-alzheimers-disease)

## Management and prevention of delirium

XCix. [www.hospitalelderlifeprogram.org/](http://www.hospitalelderlifeprogram.org/)

C. [www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Delirium\\_Model\\_of\\_Care.pdf](http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Delirium_Model_of_Care.pdf)

## Prevention and minimisation of harm

ci. [www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf)

## Medicines

cii. [www.americangeriatrics.org/files/documents/beers/2012BeersCriteria\\_JAGS.pdf](http://www.americangeriatrics.org/files/documents/beers/2012BeersCriteria_JAGS.pdf)

ciiii. [http://jprr.shpa.org.au/lib/pdf/2011\\_09/Mary\\_Britton\\_GT.pdf](http://jprr.shpa.org.au/lib/pdf/2011_09/Mary_Britton_GT.pdf)

civ. [www.nps.org.au/health-professionals/health-news-evidence/2013/antipsychotic-dementia](http://www.nps.org.au/health-professionals/health-news-evidence/2013/antipsychotic-dementia)

cv. <http://www.nps.org.au/publications/health-professional/health-news-evidence/2014/anticholinergics-older-people>

## Nutrition

cv. [www.anzsgm.org/documents/positionstatementno6under-nutritionintheelderly.pdf](http://www.anzsgm.org/documents/positionstatementno6under-nutritionintheelderly.pdf)

cvii. [www.health.vic.gov.au/older/toolkit/06Nutrition/index.htm](http://www.health.vic.gov.au/older/toolkit/06Nutrition/index.htm)

cviii. [www.alz.co.uk/nutrition-report](http://www.alz.co.uk/nutrition-report)

## Pain

ciX. [www.aacn.org/WD/Practice/Docs/NonverbalJournalFINAL.pdf](http://www.aacn.org/WD/Practice/Docs/NonverbalJournalFINAL.pdf)

CX. [www.fightdementia.org.au/common/files/NAT/20121211\\_NAT\\_UpdateSheet\\_DementiaQA16\\_Pain.pdf](http://www.fightdementia.org.au/common/files/NAT/20121211_NAT_UpdateSheet_DementiaQA16_Pain.pdf)

## Communicating with patients and carers

CXi. [www.fightdementia.org.au/research-publications/talk-to-me.aspx](http://www.fightdementia.org.au/research-publications/talk-to-me.aspx)

CXii. [www.culturaldiversity.com.au/practice-guides/dementia-care](http://www.culturaldiversity.com.au/practice-guides/dementia-care)

CXiii. [www.easternhealth.org.au/services/cuecards/cards.aspx](http://www.easternhealth.org.au/services/cuecards/cards.aspx)

CXiv. [www.alzheimers.org.uk/site/scripts/download\\_info.php?fileID=1604](http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1604)

CXv. [www.rcn.org.uk/\\_data/assets/pdf\\_file/0009/549063/Triangle\\_of\\_Care\\_-\\_Carers\\_Included\\_Sept\\_2013.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0009/549063/Triangle_of_Care_-_Carers_Included_Sept_2013.pdf)

CXvi. [www.cclhd.health.nsw.gov.au/Services/Carer-Support/TOP5.html](http://www.cclhd.health.nsw.gov.au/Services/Carer-Support/TOP5.html)

CXvii. [www.cec.health.nsw.gov.au/\\_documents/programs/falls-prevention/one-page-flyers/top5-one-page-flyer-v1.pdf](http://www.cec.health.nsw.gov.au/_documents/programs/falls-prevention/one-page-flyers/top5-one-page-flyer-v1.pdf)

## Unwanted treatment

CXviii. [www.safetyandquality.gov.au/wp-content/uploads/2014/01/Draft-National-Consensus-Statement-Essential-Elements-for-Safe-and-High-Quality-End-of-Life-Care-in-Acute-Hospitals.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2014/01/Draft-National-Consensus-Statement-Essential-Elements-for-Safe-and-High-Quality-End-of-Life-Care-in-Acute-Hospitals.pdf)

CXix. [www.americangeriatrics.org/files/documents/feeding\\_tubes.advanced.dementia.pdf](http://www.americangeriatrics.org/files/documents/feeding_tubes.advanced.dementia.pdf)

## Response to behavioural issues

CXX. <http://dbmas.org.au>

CXXi. [www.dementiaresearch.org.au/images/dcrc/output-files/328-2012\\_dbmas\\_bpsd\\_guidelines\\_guide.pdf](http://www.dementiaresearch.org.au/images/dcrc/output-files/328-2012_dbmas_bpsd_guidelines_guide.pdf)

CXXii. [www.health.nsw.gov.au/dementia/Pages/assessment-mgmt-people-bpsd.aspx](http://www.health.nsw.gov.au/dementia/Pages/assessment-mgmt-people-bpsd.aspx)

CXXiii. [www.health.gov.au/internet/publications/publishing.nsf/Content/delirium-care-pathways-toc~delirium-care-pathways-pooles](http://www.health.gov.au/internet/publications/publishing.nsf/Content/delirium-care-pathways-toc~delirium-care-pathways-pooles)

CXXiv. <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/recognition+and+management+of+challenging+behaviour+program>

CXXv. [www.dementiamanagementstrategy.com](http://www.dementiamanagementstrategy.com)

## Environmental design

CXXvi. [www0.health.nsw.gov.au/pubs/2003/pdf/adapting\\_the\\_ward.pdf](http://www0.health.nsw.gov.au/pubs/2003/pdf/adapting_the_ward.pdf)

CXXvii. [www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia](http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia)

## Additional resources

CXXix. [www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/](http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/)

CXXX. [www.safetyandquality.gov.au/our-work/cognitive-impairment/cognitive-impairment-resources](http://www.safetyandquality.gov.au/our-work/cognitive-impairment/cognitive-impairment-resources)



## Appendix 1 An example of a brief cognitive screening tool

The Abbreviated Mental Test Score (AMTS) was introduced by Hodkinson in 1972 to quickly assess elderly patients for the possibility of dementia. The test is useful across a range of acute and outpatient settings. It takes five minutes to administer and must include all 10 questions. A score of less than 7 or 8 suggests cognitive impairment.

	Question	Score 0 or 1
1	How old are you?	
2	What is the time (nearest hour)?	
3	Address for recall at the end of test - this should be repeated by the patient (e.g. 42 West Street).	
4	What year is it?	
5	What is the name of this place?	
6	Can you recognise this person? (Choose two relevant people in the room – for example, the carer, nurse or doctor.)	
7	What was the date of your birth?	
8	When was the Second World War?	
9	Who is the present prime minister?	
10	Count down from 20 to 1 (no errors, no cues)	
	<b>TOTAL CORRECT</b>	

Source: Hodkinson HM. Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age Ageing* 1972;1(4):233–238.

Note: This resource does not recommend a specific tool. Appendix 1 and 2 are provided as examples for illustration purposes only. Clinicians should be familiar with the tools used in their facility, their strengths and limitations, and how to interpret results.

## Appendix 2

## An example of a delirium assessment tool



Patient name: \_\_\_\_\_ Tester: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Patient number: \_\_\_\_\_  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_

**[1] ALERTNESS****CIRCLE**

*This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.*

Normal (fully alert, but not agitated, throughout assessment)	0
Mild sleepiness for <10 seconds after waking, then normal	0
Clearly abnormal	4

**[2] AMT4**

*Age, date of birth, place (name of the hospital or building), current year.*

No mistakes	0
1 mistake	1
2 or more mistakes/untestable	2

**[3] ATTENTION**

*Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.*

Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores <7 months / refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2

**[4] ACUTE CHANGE OR FLUCTUATING COURSE**

*Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs*

No	0
Yes	4

**4 or above:** possible delirium +/- cognitive impairment

**1-3:** possible cognitive impairment

**0:** delirium or severe cognitive impairment unlikely

(but delirium still possible if [4] information incomplete)

**4AT SCORE**

**GUIDANCE NOTES**

Version 1.1. Information and download: [www.the4AT.com](http://www.the4AT.com)

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more suggests delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated solely on observation of the patient at the time of assessment. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

**Alertness:** Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

Disclaimer: responsibility for the interpretation of scores and any actions rests with the clinical team using the 4AT.

Please refer to: [www.the4at.com](http://www.the4at.com)



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