Management of Patients with Cognitive Impairment F/2010/2867 [V5]		
Policy Owner:	Quality & Risk Manager	No. of pages: 8

Policy Statement

This policy aims to provide clinical staff with the information and tools to assist in the early assessment, identification and treatment of cognitively impaired patients. The objective of this Procedure is to outline a standardised approach that promotes:

- Awareness of cognitive impairment (delirium and dementia) in the acute hospital setting
- Early assessment, identification and treatment of delirium in patients
- Management of risks associated with cognitively impaired patients
- Communication with patients, carers and staff

Scope of Policy

This policy pertains to all clinicians caring for patients who present with known cognitive impairment or who, on presentation, **meet <u>one</u> or more** of the following

- age 65 or over
- patients with a known cognitive impairment or a formal diagnosis of dementia
- have a severe illness
- hip fracture
- cognitive concerns raised by others
- at risk of drug or alcohol withdrawal (more than 6 standard drinks a day-commence Alcohol Withdrawal Scale).

Definitions

Dementia: is a syndrome characterized by disturbance of multiple brain functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.

Delirium: An altered state of consciousness accompanied by a change in cognition that develops over a few hours or days, with a tendency to fluctuate during the course of the day. It is characterized by a change in cognition which may include memory impairment, the development of perceptual disturbance, disorientation, language disturbance and a reduced clarity of awareness of the environment which may affect or impair their ability to focus, sustain, or shift attention. Delirium may manifest in hyperactive or/and hypoactive states.

TOP 5: is an initiative that acknowledges the value of carer information about patients with dementia and other types of cognitive impairment in hospital settings. TOP 5 uses the recording of tips gathered from the carer for effective communication and supportive care to promote personalised care.

Roles & Responsibilities

Visiting Medical Officers / Career Medical Officers/ Interns will be responsible for:

- Identifying patients at risk of developing delirium and those patients with delirium and to initiate a treatment plan appropriate for the stage of the patient's illness and contributing

factors and response to treatment
- Identifying the Person Responsible for medical decision making.
- Working in partnership with patients, carers and hospital staff to develop an individualised plan when required.

Nurse Managers will be responsible for:
- Ensuring nurses are trained in the use of the recommended screening and assessment tools
- Identifying the Person Responsible for medical decision making
- Ensuring Nursing staff implement non-pharmaceutical strategies to manage delirium and/or dementia and reduce risks associated with delirium and/or dementia e.g. reduce risk of falls, effective verbal and non-verbal communication (Top 5 program), staff and carer safety.
- Monitor compliance with this procedure

Educators will be responsible for:
- Educating nurses in the use of the screening and assessment tools and interventions required for patients
- Provide ongoing training and support to nursing staff implementing this procedure

Nursing staff will be responsible for:
- Ensure all patients are screened for cognitive impairment risk.
- Ensure all patient at risk of cognitive impairment are assessed for cognitive impairment
- Reassess a patient's cognitive state if there is a change in the patient's condition or they are concerned regarding a patient.
- Identifying the Person Responsible for medical decision making
- Escalate any concerns to the medical officers, Manager/Nurse Educator
- Implement non-pharmaceutical strategies to manage delirium and/or dementia and reduce risks associated with delirium and/or dementia e.g. reduce risk of falls, effective verbal and non-verbal communication (Top 5 program), staff and carer safety.
- Documentation of the screening score and management plan in the patients' health care record
- Working in partnership with patients, carers and hospital staff to develop an individualised plan when required
- Current knowledge and training in the use of tools included in this document

Occupational Therapist will be responsible for:
- Ensure all patient referred for cognitive assessment receive timely are assessment.
- Escalate any concerns to the medical officers, Manager/Nurse Educators
- Work in partnership with patients, carers and hospital staff to develop individualised plans when required.

General Guidelines/Procedure

The prevention of delirium maybe possible when early assessment is undertaken for those patients suspected of cognitive impairment.

The Australian Commission on Safety and Quality in Health Care has developed a pathway

for patients with cognitive impairment (dementia and delirium) in an acute hospital. Three (3) steps have been identified when assessing a patient

Screening for Cognitive Impairment Risk

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

All patients (excluding maternity & paediatric patients) are screened for their cognitive impairment risk factors on admission. This maybe completed at the pre admission clinic or on admission dependent on where they are admitted. The Mater utilises the Cognitive Impairment Screening Risk Tool (found on the Initial Nursing Risk Assessment Tool).

- age 65 or over
- patients with a known cognitive impairment or a formal diagnosis of dementia
- have a severe illness
- hip fracture
- cognitive concerns raised by others
- Risk of drug or alcohol withdrawal (more than 6 standard drinks a day).

Any patient with 1 or more of the risk factors above is considered at risk of cognitive impairment and requires cognitive impairment assessment using the 4AT Assessment test for delirium & cognitive impairment.

Assessment for Delirium & Cognitive Impairment

2 Recognise and respond to patients with cognitive impairment

4AT Score	
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.

If the 4AT identifies a **score of 4** (suggestion of Delirium) escalate via clinical review or Rapid Response call. Repeat daily assessment or when there is a change in the patients clinical condition.

If the 4AT identifies a **score of 1-3** (suggestion of Cognitive Impairment) refer the patient to Occupational Therapist for a comprehensive cognitive assessment. Repeat daily assessment or when there is a change in the patients clinical condition.

A score of 0 does not definitively exclude delirium or cognitive impairment. Delirium is still possible if assessment point 4 has not been answered. More detailed testing may be required. Reassess if there is any recent cognitive, functional or behavioural identified.

NB: For patients assessed in Day of Surgery Admissions please refer to Appendix 2: Screening and Assessment Flowchart for Day of Surgery Admissions (DOSA)

Clinical Review

Medical officer will review and comprehensive assessment of the patient, in consultation with the patient and their carer, to identify possible causes for delirium, this should include;

- physical examination
- medication review
- investigations and treatments

Whilst the underlying cause of delirium is often multifactorial, and can be due to such conditions as urinary tract infections, pneumonia, electrolyte imbalance and pain, a rigorous assessment is required to identify the cause of each individual case so that appropriate treatment can be commenced within the model of patient centred care.

NB: Refer to Appendix 4: DELIRIUM: Reversible causes and investigations checklist for ward/ICU registrars

Diagnosis

The clinical diagnosis of delirium is based on a detailed history, examination and relevant investigations. Other conditions which may mimic delirium include:

- Dementia
- Depression/mania
- Effects of and withdrawal from drugs and alcohol

Investigations

Investigations need to be tailored to the individual patient circumstance and the medical staff responsible for the care of the patient.

Additional tests that may be considered include:

- blood gases
- thyroid function
- B12 and folate
- CT brain
- lumbar puncture
- CSF examination.

Medications

Some medications decrease cognitive function and worsen confusion including:

- Drugs with anticholinergic effects
- Anticonvulsants
- Anti-Parkinson drugs
- Alcohol
- Antipsychotics
- Opioids
- Benzodiazepines
- Corticosteroids (high dose)
- Cardiovascular medications (e.g. digoxin, metoprolol)

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

Delirium can be a fluctuating condition. Potential risks should be identified and an individualised integrated prevention and management plan formulated in partnership with the patient, carer and family. This plan needs to be consistently revised if the patient's condition changes throughout the admission.

The patients' management plan should be documented and communicated to the patient, carer and all relevant healthcare providers in a timely manner and in sufficient detail.

Key points to consider when providing individualised care should include:

- Modify the environment (Nurse close to nurses' station, remove objects which may cause harm)
- Review of medications by medical staff
- Respond to behavioural changes (effective communication/body language)
- Encourage family members/carers to stay with patients to assist with regular reorientation and reassurance from a familiar face.
- Educate family members/carers to engage patients in activities to stimulate cognition
- Non-drug measures to help promote sleep (i.e. Lighting, bed time routine)
- Ensure patients who usually wear hearing and visual aids are using them.
- For those patients who have identified they consume more than 6 standard drinks a day the Alcohol withdrawal Scale form should be implemented and followed.

Discharge from Hospital
Before the patient is discharged from hospital, the patient and their carer will be provided with written and verbal information about delirium, a current list of medications, a comprehensive discharge summary that includes plan for any follow up needed and contact details of ongoing support services available in the community.

Education and Training

All clinical staff will receive mandatory training in dementia / delirium upon commencement of employment. Education will cover the following areas:

- Screening patients for Risk factors for Delirium and cognitive impairment
- 4AT Assessment test for delirium & cognitive impairment
- Flagging Dementia and / or Delirium in patients
- Delirium treatment strategies
- Referral processes
- Documentation requirements

TOP 5

For patients who have been flagged or admitted with known cognitive Impairment, the TOP5 program should be implemented throughout the patient's admission. This is achieved by contacting a carer or family member in person, or by phone and discussing the following:

1. Ask if they have heard of TOP 5. Provide a brochure or discuss the concept
2. Acknowledge their expertise and knowledge of the patient
3. Ask for information about the patients capabilities, likes, dislikes and idiosyncrasies
4. Identify strategies to help settle and comfort the patient
5. Invite carer to bring small inexpensive items that have special meaning to the patient e.g. photo, rug, music, bags.

The table below simplifies the process for writing the TOP 5 strategies – Talk, obtain, personalise and finally strategies developed. Once written, the strategies stay on the bedside chart to be included in each bedside handover.

Appendices

Appendix 1: Screening and Assessment Flowchart
Appendix 2: Screening and Assessment Flowchart for Day of Surgery Admissions (DOSA)
Appendix 3: Delirium pathway
Appendix 4: DELIRIUM: Reversible causes and investigations checklist for ward/ICU registrars

Evaluation

This policy will be reviewed every 3 years in consultation with the Cognitive Impairment

working party.

Monthly audits for compliance with delirium and cognitive impairment risk screening and assessment will be undertaken as part of the NSQHS bedside Audit. .

National Safety & Quality Healthcare Standards (NSQHS)

Standard 1 Clinical Governance
Standard 2 Partnering with Consumers
Standard 5 Comprehensive care
Standard 8 Recognising & Responding to Acute Deterioration

References

http://www.safetyandquality.gov.au/our-work/clinical-care-standards/delirium-clinical-care-standard/

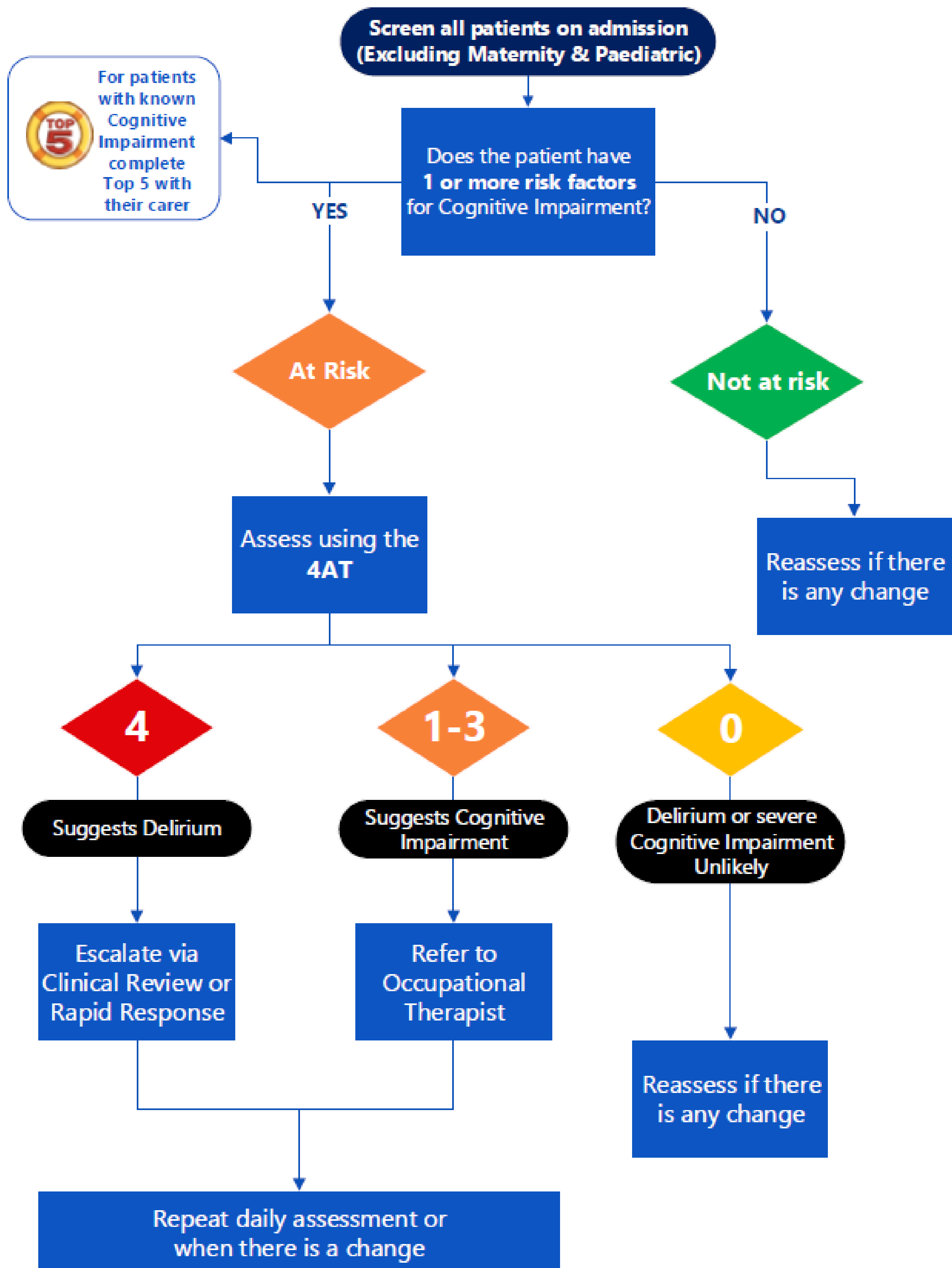
http://www.safetyandquality.gov.au/our-work/cognitive-impairment/better-way-to-care/

Australian Commission on Safety and Quality in Health Care. 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. Sydney; ACSQHC, 2014

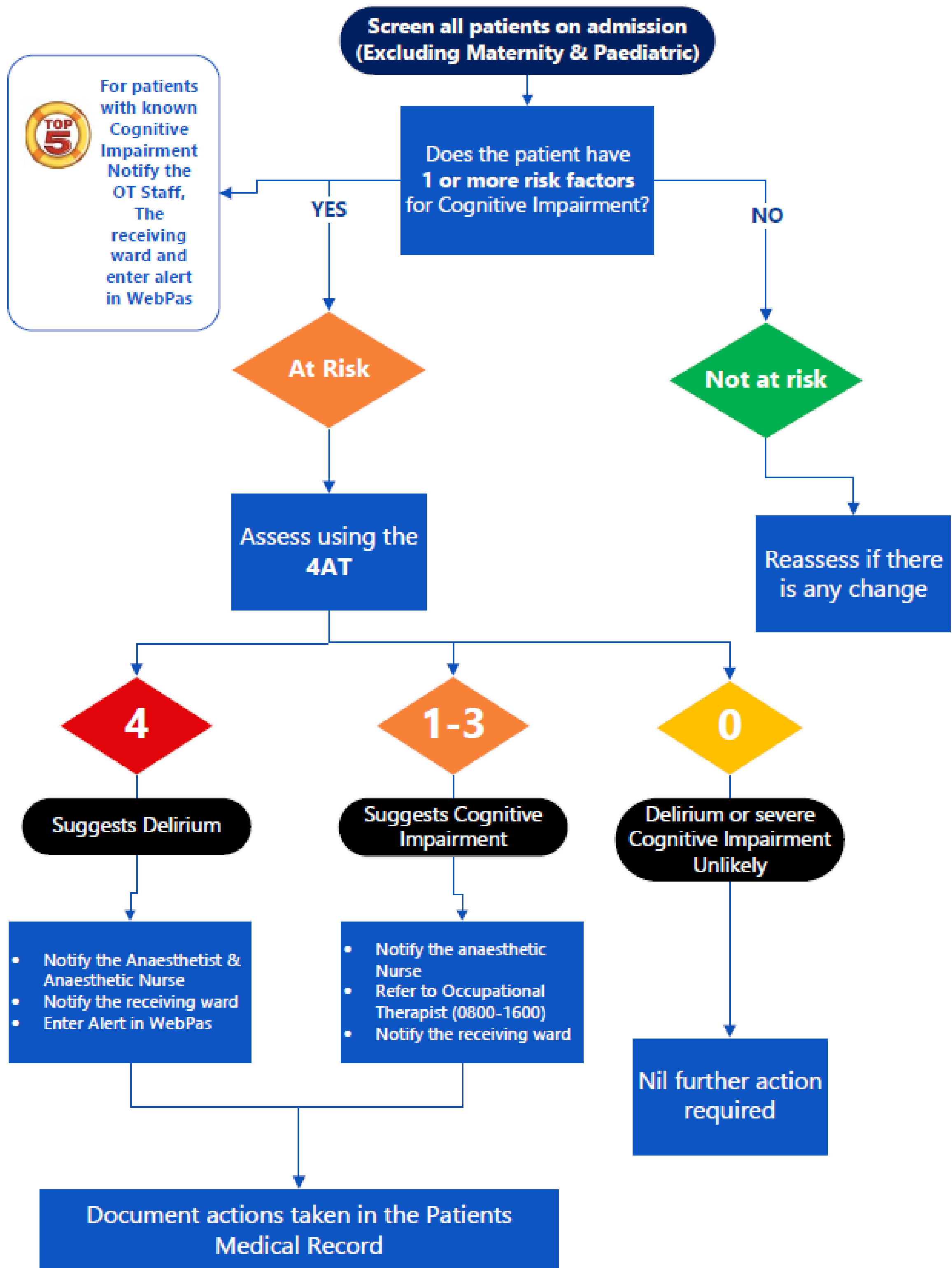
Revision History

Date Written:	26/05/2016
Date of Last Review:	12/04/2021
Date of Next Review:	April, 2024
Reviewed By:	Quality & Risk Manager
Committee Approval:	Comprehensive Care Committee
Date	
Approved by:	Quality & Risk Manager
Date	12/04/2021

Appendix 1



Appendix 2: DOSA patient ONLY



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Appendix 3: Delirium pathway

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MHS Delirium Pathway

All adult patients are screened for their cognitive impairment risk on admission to hospital

Recognised risk factors for cognitive impairment:

- age 65 or over
- patients with a known cognitive impairment or a formal diagnosis of dementia
- have a severe illness
- hip fracture
- cognitive concerns raised by others
- at risk of drug or alcohol withdrawal (more than 6 standard drinks a day- commence Alcohol Withdrawal Scale).

All patient with known CI or one or more risk factors are assessed on the 4AT delirium assessment tool.

The 4AT is a validated tool for delirium assessment, it incorporates the Months Backwards test and the Abbreviated Mental Test provides basic cognitive testing, aimed at detecting moderate-severe cognitive impairment, alongside assessment for delirium.

4AT Delirium Risk Assessment

Patient score 1-3 (*suggestion of some level cognitive impairment*)

Referred to Occupational Therapist for comprehensive cognitive assessment

Patient score 4 or more (*suggestion of Delirium*)

Escalate to Clinical review or RR calls
+
Referred to Occupational Therapist for comprehensive cognitive assessment

CMO review - comprehensive assessment of the patient, in consultation with the patient and their carer, to identify possible causes for delirium – checklist utilised.

DELIRIUM: Reversible causes and investigations checklist for ward/ICU registrars

Consultant to consultant referral to accredited Neurologists when indicated

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Appendix 4: DELIRIUM: Reversible causes and investigations checklist for ward/ICU registrars

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DELIRIUM: Reversible causes and investigations checklist for ward/ICU registrars

Surname	MRN
Given name	
DOB ..../........../..................	☐ Male ☐ Female
Ward:	
Complete all patient details or affix patient label here	

CMO review: Name.................................... Date.................... Time....................

Admitting Officer informed: Name.................................... Date.................... Time....................

Physician contacted: Name.................................... Date.................... Time....................

Consider referral to Delirium Specialist

CONSIDER INFECTION

UTI
Pneumonia
Wound
Skin/IV access site
Meningitis/encephalitis

Consider: *Dates or NA*
- MSU ☐ ____________
- Chest xray ☐ ____________
- ABG ☐ ____________
- Wound swab ☐ ____________
- Blood cultures ☐ ____________
- LP ☐ ____________

CONSIDER MEDICATIONS

MAOI/Tricyclic antidepressants/anticholinergics
Steroids
Diabetic meds
Missed usual meds (ie benzodiazepines)
Alcohol intake
Post analgesia (opiates and pregabalin/gabapentin)

Consider: *Dates or NA*
- AWS and thiamine 100mg IV ☐ ______
- Diazepam for alcohol/benzo withdrawal ☐ ______
- Reducing opiates ☐ ______

CONSIDER VASCULAR

ACS
Stroke/subdural haematoma (after fall)
Seizure
Ischaemic limb/bowel

Consider: *Dates or NA*
- ECG ☐ ____________
- MRI/CT brain ☐ ____________
- CT abdo ☐ ____________

CONSIDER METABOLIC/ENDOCRINE

Electrolyte disturbances (ie Na, Ca+, ARF, liver failure, dehydration)
Hyper/hypoglycaemia
Anaemia
Hypo/hyperthyroidism
Hypoxia/hypercapnia

Consider: *Dates or NA*
- ABG/VBG ☐ ______
- Formal pathology ☐ ______
  (inc FBC/UEC/LFT/TFTs/B12/folate/trop/ESR)

CONSIDER PAIN

Constipation, Urinary retention

Consider: *Dates or NA*
- Abdo xray ☐ ____________
- Bladder scan ☐ ____________

CONSIDER OTHER

Hearing loss, Vision loss

Consider: *Dates or NA*
- Missing hearing aids/glasses ☐ ______

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