University Hospitals of Leicester NHS
NHS Trust

Policy for the Assessment and Management of Patients with Altered Behaviours

(and symptoms associated with underlying Cognitive Impairment)

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Board Director Lead:	Chief Nurse
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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

- Section 5.4.7 removed
- Sections 5.4.7 – 5.5.1 updated
- Appendix 4 included

KEY WORDS

Dementia, delirium, confusion, agitated behaviours, challenging behaviour, behaviour chart, 1:1 supervision, wandering, and security (restraint)

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester NHS Trust's (UHL) Policy and Procedures for assessing and managing patients who have altered behaviours (behaviours that challenge), as a result of cognitive impairment.

1.2 This policy draws together a number of previously standalone documents into a single, overarching policy which will better support clinical staff in practice, by avoiding duplication and repetition.

2 POLICY SCOPE

2.1 This policy is applicable to all Trust staff, and Bank, Agency and Locum staff who are involved in the direct care of adult patients who meet all of the following criteria:

a) Where the person is an adult inpatient aged 18 years and over, **and**:
b) Where the person is suffering from temporary, fluctuating or permanent cognitive impairment, due to a disturbance in their brain or mind (as per the Mental Capacity Act (MCA) 2005).

2.2 This policy includes patients who may lack 'decision and time specific' mental capacity, for example to consent to their care and treatment. In those cases staff must also refer to the Trust's 'Mental Capacity Act Policy and Procedures', Trust Reference: B23/2007.

2.3 It does not include patients who are displaying violent or aggressive behaviours towards staff or others, where there is no cognitive impairment due to a disturbance in their brain or mind. In those circumstances staff must refer to the Trust's 'Policy for Management of Violence, Aggression and Disruptive Behaviour Policy (including restraint guidance)', Trust Reference: B11/2005.

2.4 This policy does not cover situations where a patient is receiving care and treatment in circumstances where the levels of restriction and restraint could constitute a deprivation of liberty. In those cases staff must refer to the Trust's 'Deprivation of Liberty Safeguards Policy and Procedures', Trust Reference: B15/2009.

2.5 This policy does not cover patients that have absconded, or are missing from the Trust. In those cases staff must refer to the Trust's 'Missing Patient – Adults' Policy, Trust Reference: B15/2005.

2.6 This policy does not cover situations where adult patients require rapid tranquilisation. In those cases staff must refer to the Trust's 'Guidelines for Rapid Tranquilisation of disturbed adult patients', Trust Reference: B11/2016.

2.7 This policy cannot cover every individual scenario, or every possible reason for a person's altered behaviour(s). If staff face a difficult or unusual situation involving a person with altered behaviour(s) then they should escalate their concerns to their line manager / department lead and the Consultant in charge of the person's care and treatment.

3 DEFINITIONS AND ABBREVIATIONS

a) **Altered Behaviours/Behaviour that Challenges** – these are altered behaviours which present risks to patients/ others, and require additional safeguards to be in place. The types of behaviours include agitation, wandering, disorientation and confusion.

b) **Cognitive Impairment –** in the context of this policy, this means a noticeable and measurable decline in cognitive abilities, including memory and thinking skills. The person may have difficulty remembering, learning new things, concentrating, or making decisions that affect their everyday life.

c) **Dementia –** describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. A person with dementia may also experience changes in their mood or behaviour.

d) **Delirium –** sometimes called 'acute confusional state' is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually develops over 1-2 days. It is a serious condition that can be associated with poor outcomes. However, it can be treated if dealt with urgently.

e) **Disturbance in the brain or mind (MCA 2005) –** an impairment of the mind or brain, or some sort of disturbance that affects the way their mind or brain works. Examples of an impairment or disturbance in the functioning of the mind or brain may include the following: • conditions associated with some forms of mental illness • dementia • significant learning disabilities • the long-term effects of brain damage • physical or medical conditions that cause confusion, drowsiness or loss of consciousness • delirium • concussion following a head injury, and the symptoms of alcohol or drug use.

f) **Wandering –** for the purpose of this policy, wandering means a 'locomotion that is non-direct or more simply it is travelling about without any clear destination. It can take the form of pacing, lapping or a random pattern. Wandering cannot always be prevented or even reduced. A balance needs to be found between prevention of actual risk and enabling the person to have freedom of movement' (Algase *et al*, 2001).

4 ROLES AND RESPONSIBILITIES

Responsibilities within the Organisation

4.1 The **Chief Executive and Board of Directors** have overall responsibility for Trust compliance with the Law and Trust Policies and Procedures.

4.2 The **Chief Nurse** is the Board Director with lead responsibility for this policy.

4.3 The **Deputy Chief Nurse** is the Nominated Deputy for the Chief Nurse.

4.4 **Clinical Directors, General Managers and Heads of Nursing** are the leads for disseminating the policy to staff within their Clinical Management Groups.

4.5 The **Admiral Nurse** is a dementia specialist nurse that provides life-changing care for families affected by all forms of dementia.

4.6 The **Adult Safeguarding Nurse Specialists** provide day to day advice and support to UHL staff where concerns are raised about a person's mental capacity to consent to / decline care and treatment.

4.7 The **Director of Estates and Facilities** is responsible for ensuring that Security Personnel are aware of and comply with the relevant aspects of this Policy.

4.8 **All Staff** who work with patients who have behaviours that challenge must comply with this policy. All staff are responsible for identifying which policies are applicable to their area of work and for following Trust policy documents. All staff must attend relevant training, as appropriate for individual role. If staff require further guidance they should consult their department or line manager, or the person in charge at the time.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

This policy is supported by the associated documents as detailed below, which must be used in conjunction with this policy.

5.1 Managing Patients with Delirium

5.1.1 Delirium is a common problem which occurs in many people who are admitted to hospital.

5.1.2 It is associated with increased morbidity and mortality, with increased risk of institutionalisation on discharge.

5.1.3 Patients who develop delirium also have a longer length of stay and are more likely to develop hospital acquired complications such as falls and pressure sores. They are also more likely to develop dementia. Despite this, reporting of delirium is poor in the UK, indicating that awareness and reporting procedures need to be improved (NICE CG 103).

5.1.4 It is the responsibility of the attending nurse or doctor to screen for a delirium by identifying whether the patient is more confused or withdrawn than their usual baseline.

5.1.5 If the initial screen is positive then the nurse and doctor should refer to the THINK DELIRIUM Support Tool (Appendix 1) and follow advice regarding investigations for a potential cause of delirium.

5.1.6 Once a cause of the delirium has been identified then this must be managed appropriately. Where there is difficulty in managing the delirium then reference should be made to the General Management section of the THINK DELIRIUM Support Tool.

5.1.7 Any antipsychotic or sedative medication use should only be used when all other (non chemical) management plans have been exhausted and be restricted to those with dangerous symptoms. This must be used under supervision of a senior member of the medical team and reference to the THINK DELIRIUM Support Tool to ensure that the delirium has been managed appropriately.

5.1.8 The episode of delirium including date of onset, type of delirium, identified causes and treatment plan must be clearly documented by the doctor in the patient's medical notes. By documenting an episode of delirium this prompts early recognition of future delirium episodes.

5.1.9 Patients with a diagnosis of delirium must be given the UHL information leaflet on delirium for information and advice.

5.1.10 Prior to discharge the THINK DELIRIUM Support Tool should be referred to, to ensure that the community teams are aware that the patient has had an episode of delirium and if any follow up is required. The episode must be clearly documented on the discharge letter.

5.1.11 The 'Prone to Delirium' (PTD) code on the special register of patient centre should be added to the patient's record, to alert professionals if the patient is admitted to UHL in future.

5.2 UHL Well Pathway for Dementia

5.2.1 The UHL Well Pathway for Dementia (Appendix 2) is to be used on all adult inpatients with a known or suspected diagnosis of dementia within 4 hours of admission.

5.2.2 The Well Pathway for Dementia provides details to support a person with a known or suspected diagnosis of dementia from admission through to discharge.

5.2.3 The Pathway provide guidance and prompts for staff to consider when supporting a patient with dementia or suspected dementia.

5.3 Managing Patients at Risk of Wandering

5.3.1 Many people with cognitive impairment are compelled to walk about, a symptom often described as wandering. For example, up to 60 percent of people with dementia may wander. Walking can provide significant benefits for people with dementia, and should not be discouraged from doing so as this can make agitation and distress worse. However, at times wandering can present some risks, particularly in the acute hospital setting.

5.3.2 Patients with altered behaviours, who are also mobile, are at risk of wandering.

5.3.3 Nursing staff should inform the patient's significant others, and have proactive discussions about risk, supervision and helpful interventions including completing the 'Know Me better' Patient Summary (see appendix 3).

5.3.4 A patient who is wandering must have a 24hr Behaviour Chart and a Patient Observation Care Plan commenced (found within the Nursing Booklet – Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on Insite).

5.3.5 A patient who is wandering must be observed as a minimum every 30 minutes and this should be documented.

5.3.6 It is the responsibility of the nurse in charge (NIC) of the patient to assess the level of supervision required for the patient with wandering behaviours (see section 5.4).

5.3.7 Patients at risk of wandering must be nursed in a high observation area within the ward area, where possible, away from main thoroughfares and exits. Ward doors should be closed as such a physical barrier can simply prevent wandering out of a clinical area.

5.3.8 If the patient is sensitive to over stimulation from noise and light levels, then consider a quieter area on the ward.

5.3.9 Ensure the patient is wearing a pre-printed identity band and ensure the person is appropriately dressed to promote dignity.

5.3.10 Provide appropriate signs and cues (words and/or pictures) for orientation purposes including personal photographs/clocks to identify personal bed space and the toilets.

5.3.11 Assess the patient for evidence of physical discomfort such as hunger, thirst, pain and desire to go to the toilet. Refer to the Know Me Better Patient Summary for guidance.

5.3.12 Ensure carers have flexible visiting should they wish to contribute to supporting patients whilst they are in hospital.

5.3.13 Ensure the patient is supervised for all tests and procedures outside of the main care setting and where possible re-orientate the person on their return.

5.3.14 Where possible accompany the patient whilst they wander/walk. This may help reassure the patient making them feel more secure in hospital. It may be beneficial to accompany the patient for a longer walk away from the clinical area if this is safe to do so.

5.3.15 Consider referring the patient to specialist groups such as the Mental Health Liaison Service for advice on managing behaviours that carry risks. All mental health referrals from the UHL hospital wards must be emailed on the new MHLS referral form to: lpt.mentalhealthliaison@nhs.net available via Insite.

5.3.16 If a patient who is assessed as at risk of wandering goes missing from the clinical area, please refer to the UHL Missing Patients Policy – Adults (Trust Reference Number: B15/2005).

5.3.17 Staff must complete a Datix incident form where unsafe, and potentially unsafe, wandering has occurred.

5.4 Managing the One to One Supervision of Patients with Altered Behaviours

5.4.1 In the hospital environment, some patients may require more than general level of observation when they present with altered behaviours that challenge due to an impairment in their brain or mind.

5.4.2 These patients may present a risk to themselves or others. Heightened levels of observation may need to be employed as a management strategy to minimise such risks. For the purpose of this guideline this is referred to as one to one supervision.

5.4.3 It is the responsibility of the attending nurse to use the 'Managing Adult Agitated Patient Flowchart' for all patients exhibiting behaviour that challenges (found within the Nursing Booklet – Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on Insite).

5.4.4 Relative/Carers must be informed of decision and rationale for one to one supervision by the responsible nurse or Nurse in Charge (NIC) and this should be documented in patient's notes.

5.4.5 When it is deemed that a patient requires one to one supervision then the 'Standards for the Provision of One to One Supervision' must be applied (found within the Nursing Booklet – Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on Insite). All one to one supervision must be reviewed every 24 hours by the Nurse in Charge/Ward Manager with consultation of the Multi-disciplinary team to ascertain if one to one supervision is still required and the rationale for terminating one to one supervision must be clearly documented in patient's notes.

5.4.6 All patients receiving one to one Supervision from a nurse must have a Know me Better Patient Summary commenced, a 'Patient Observation Care Plan' and '24 Hour Behaviour Chart' completed (found within the Nursing Booklet – Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on Insite).

5.4.7 To reduce the challenging behaviour the reason for escalation should be identified as soon as possible. The THINK Delirium support tool, Alcohol withdrawal Policy or Multi-Disciplinary team assistance maybe used to assist with identifying the cause of the initial challenging behaviour to reduce risk and risk of escalation.

5.4.8 Wards who require immediate support with patients who require an increased level of supervision and who are at immediate risk of harm to themselves or others must call the security department via 2222. If the patient requires restraint, please refer to Trust Reference B11/2005 and the 'Requesting Security for Ward Areas' document (appendix 4).

5.4.9 UHL Security must remain with the patient until the level of risk is reduced. While UHL security supports the patient and the department, the registered nurse in charge must provide clinical leadership

5.5.0 The Security Team leader will allocate and co-ordinate the security staff members to support the ward/area/patient. In the circumstance where UHL Security requires temporary security staff, due to unexpected leave or an increase in patient activity, the security team leader will arrange for temporary staffing via UHL Security Bank staff.

5.5.1 In an exceptional circumstance where UHL Security are unable to support temporary staffing via the Security Bank, the Security Team Leader will inform the Nurse in Charge of the ward/area that security are unable to support the long term provision of security. The available duty may then be offered to an agency provider by the Matron of the Day or the Duty Manager. The level of Enhanced Support can be discussed with the Enhanced Patient Observation Team 07483 167652 Monday-Sunday 08:30-20:30 or the duty management team outside of hours.

5.5.2 All patients receiving supervision from a security guard must have a 'Checklist when using Security Officers for one to one Supervision of Patients' completed initially after 30 minutes of requiring a security guard and then every 24 hours (found within the Nursing Booklet – Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on Insite).

5.5.3 As the patient's risk level reduces, the enhanced support level should also reduce with immediate effect.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 All staff in UHL must complete the Trust Dementia Awareness Category A training e-learning module which is accessed on HELM.

6.2 All clinical staff that has direct clinical contact with patients must complete the Trusts Dementia Category B training. This is a face to face workshop for all staff excluding medical staff who can complete a combined e-learning module for category A and B dementia awareness training

6.3 Delirium training is incorporated into the Dementia Awareness Category B training for all clinical staff.

6.4 All clinical staff that have direct clinical contact with patients must complete the Trust's e-learning modules titled 'Basic Consent/Mental Capacity Act/Deprivation of Liberty Safeguards'.

6.5 For staff providing one to one supervision, training in 'Holding skills for Patients with Dementia training' is recommended. This training is provided by the UHL Health and Safety Team and can be booked via HELM.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 Policy Monitoring Table

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Essential to job role training in Consent / MCA and DoLS	Head of Safeguarding	HELM records / reports	Bimonthly	Safeguarding Assurance Committee
Improvement in Delirium coding	Admiral Nurses	Audit discharge letters National Audit for Dementia	Annual	Through Dementia Strategy Action Group
Improved recognition of delirium through Documentation Audit	Admiral Nurses	Audit the documentation of delirium within the medical notes of those coded with a diagnosis of delirium	Annual	Through Dementia Strategy Action Group
Patients with a known diagnosis of dementia will have a patient profile or Patient Summary completed as part of an admission	Patient Experience Team	Ward spot check audit. Audit of patient profile	Annually	Through Dementia Strategy Implementation Group

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Evidence Base

a) Mental Capacity Act Code of Practice 2007. London: The Stationery Office.

b) https://www.cqc.org.uk/sites/default/files/Deprivation%20of%20liberty%20safeguards%20code%20of%20practice.pdf

c) Delirium: prevention, diagnosis and Management. Nice Guideline CG 103

d) Algase, D et al (2001) Impact of cognitive impairment on wandering behaviour. Western Journal of Nursing Research. 23 (3), pp: 283-295. https://www.ncbi.nlm.nih.gov/pubmed/11291432

e) Leicester, Leicestershire and Rutland's Living well with Dementia Strategy 2019-2022.https://www.leicester.gov.uk/media/185998/living-well-with-dementia-strategy-2019-2022-accessible-version.pdf

Policies Available on Insite

a) UHL Mental Capacity Act Policy (Trust Ref: B23/2007)

b) UHL Deprivation of Liberty Safeguards Policy and Procedures (Trust Ref: B15/2009)

c) UHL Management of Violence, Aggression and Disruptive behaviour Policy – Including Restraint Guidance (Trust Ref: B11/2005)

d) Missing Patient Policy – Adults (Trust Ref: B15/2005)

e) Guideline for the Rapid Tranquilisation of disturbed adult patients (Trust Ref: B11/2016)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 The latest version of the Policy will be uploaded and available through Insite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system.

10.2 This policy and procedures contained within it will be reviewed after 3 years by the Policy Authors.

"THINK DELIRIUM" SUPPORT TOOL

THINK DELIRIUM

Consider high risk for delirium if:
The patient is over 65
The AMT score is <4?
(Age, D.O.B., Place, Year - point for each)

Is the patient more confused or more withdrawn than usual
OR
is the 4AT >4? www.the4at.com

Yes

4AT

1) Alertness	Normal / fully alert	0
	Agitated / drowsy	4
2) AMT4	No mistakes	0
	1 mistake	1
	≥2 mistakes / untestable	2
3) Attention	(Months of the year backwards)	
	≥7 correct	0
	<7 correct / refuses	1
	Untestable	2
4) Acute / fluctuant	(from collateral history)	
	Yes	4
	No	0

Is delirium possible?
- ☐ YES, as 4AT >4
- ☐ NO, 4AT = 1-3 (possible cognitive impairment)
- 4AT = 0 (delirium & severe cognitive impairment unlikely)

SCORE

THINK DELIRIUM

COMPLETE MDT DELIRIUM MANAGEMENT AND ASSESSMENT BUNDLE

IMMEDIATE ACTION

- Focused history and examination
- **Collateral history** and gather information from GP, relatives/ carers (new or worsening confusion, falls, mobility, continence, hallucinations)
- **Identify and treat underlying causes →**
- **Does the patient fit the Red flag sepsis criteria? Refer to UHL sepsis pathway**
- Complete **'Know Me Better'** profile with carers
- Cognitive assessment with AMT 10 / MMSE
- Perform medication review (refer to STOPP/START)
- Heighten level of supervision and position patient in a high visibility bed if available
- **Update and involve relatives with care and provide 'UHL delirium' leaflet**

POTENTIAL UNDERLYING CAUSES

Trauma (head injury, intracranial event)
Hypoxia (PE, CCF, MI,COPD, Pneumonia)
Increasing age/ Frailty
Neck of femur fracture
smo**K**er or alcohol withdrawal
Drugs (new stopped/started, side effects, drug interactions)
Environment – especially ward moves
Lack of sleep, reversal of sleep-wake cycle
Imbalanced electrolytes **(Renal failure, Na+, Ca^{2+} glucose, liver function)**
Retention (urinary or constipation)
Infection/**Sepsis**
Uncontrolled pain
Medical conditions (Dementia, Parkinson's Disease)

THINK TYPE OF DELIRIUM

What is the type of delirium?	**Hyperactive:**	Agitated, hallucinations, restless and/or aggressive.
	Hypoactive:	Sleepy, drowsy and/or withdrawn.
	Mixed:	Features of both.

Identify the potential underlying causes – Refer to list above

MANAGE DELIRIUM

GENERAL MANAGEMENT OF DELIRIUM

Hypoxia / electrolytes	Treat hypoxia, electrolyte imbalance and follow **sepsis guidelines.**
Constipation	PR to exclude impaction, ensure good hydration, laxatives and enemas if required and encourage to sit out onto the toilet or commode if appropriate.
Retention	Treat the underlying cause; only catheterise if absolutely necessary
Pain	Non-verbal pain scores, utilise other routes e.g. patches
Observe and Reassess	Heighten level of supervision/ Repeat Cognitive Assessment to monitor progress
Avoid moves	Avoid multiple ward and bed moves
'Know Me Better'	Complete a profile with the help of the family/ carers
Vision / Hearing	Ensure patient has their glasses and hearing aids if appropriate.
Avoid distress	Avoid constraints, unnecessary or repeated interventions that can cause distress
SoGo	Sit out, Get out; encourage mobilisation, Refer to 'Get moving to get home'
Sleep	Engage in activities during day, classical music; avoid excess noise
DOLS	Complete DoLS assessment if patient at risk of Deprivation of Liberty
Orientation	Use calendars/ clocks, photos (family/ familiar objects); signpost to toilets
Staff	Aim for continuity with ward staff
Nutrition	Promote nutrition – offer regular drinks, snacks and "finger foods".
Mental Health Liaison Service	for complex and challenging patients please refer to the **Mental Health Liaison Service via ICE**

MANAGING BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS

WANDERING

- Provide close observation within a safe and reasonably closed environment (refer to DOLs)
- Act in patient's best interests; allow wandering if in a safe environment
- Ask relatives to help offering meaningful distractions
- **Refer to 'Altered Behaviours in Patients UHL Policy'.**

FALSE IDEAS

Try the following:

- Avoid contradicting patients and challenging ideas.
- Change the subject or use distraction techniques.
- Concentrate on the feeling / need behind what the patient is saying.

MANAGEMENT – For ICU patients please refer to 'ICU delirium guidelines'

- Aim to use verbal and non-verbal de-escalation measures prior to prescribing any medications.
- Use the tips above with challenging behaviours and refer to the **'UHL guidelines for the Assessment and Management of Patients with Altered Behaviours'**
- Think about utilising nursing 1-1 supervision.
- Regularly update carers / family members with progress/ treatment plan.

MEDICATIONS

Sedatives may also cause delirium – please use carefully

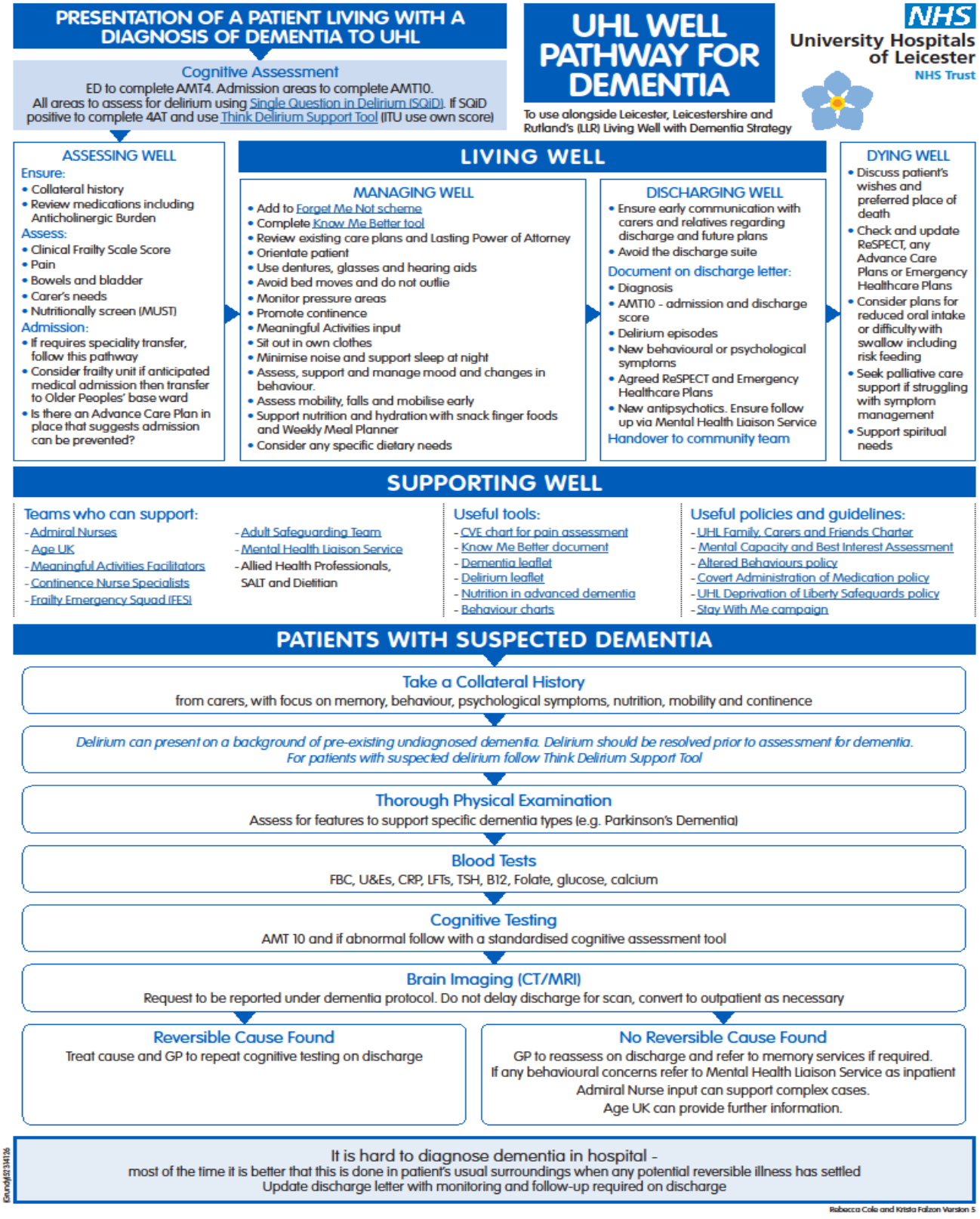
- **ONLY to be used to manage dangerous or distressing symptoms; allows tests or treatment to be given:**
- **Haloperidol** is the preferred option:
  Dosage: 0.5mg PO – up to 2 hrly. Max dose: 5mg / 24hrs.
- **AVOID HALOPERIDOL IN LEWY BODY DEMENTIA AND PARKINSON'S DISEASE***

**Lorazepam is an alternative (less evidence base but limit to withdrawal states or if haloperidol is contraindicated).*

*Lorazepam Dose: 0.5-1mg orally stat may be given. If agitation continues, consider adding in either regular Sulpiride, Olanzapine or Risperidone as alternatives. **However, should only be started after senior review.***

DISCHARGE

- Document delirium as a diagnosis on the discharge letter and if still current or resolved.
- Review anti-psychotics prior to discharge (discontinue or instruct GP with review date)
- Follow-up: GP/ CMHT (via FOPAL)/ Memory Clinic/ Geriatric Medicine clinic – **document on ICE letter**
- Consider advance care planning, if appropriate
- Provide patient and/ or relatives with delirium information/ leaflet.


PRESENTATION OF A PATIENT LIVING WITH A DIAGNOSIS OF DEMENTIA TO UHL
Cognitive Assessment
ED to complete AMT4. Admission areas to complete AMT10.
All areas to assess for delirium using Single Question in Delirium (SQiD). If SQiD positive to complete 4AT and use Think Delirium Support Tool (ITU use own score)
UHL WELL PATHWAY FOR DEMENTIA
To use alongside Leicester, Leicestershire and Rutland's (LLR) Living Well with Dementia Strategy
NHS
University Hospitals of Leicester
NHS Trust
ASSESSING WELL
Ensure:
• Collateral history
• Review medications including Anticholinergic Burden
Assess:
• Clinical Frailty Scale Score
• Pain
• Bowels and bladder
• Carer's needs
• Nutritionally screen (MUST)
Admission:
• If requires speciality transfer, follow this pathway
• Consider frailty unit if anticipated medical admission then transfer to Older Peoples' base ward
• Is there an Advance Care Plan in place that suggests admission can be prevented?
LIVING WELL
MANAGING WELL
• Add to Forget Me Not scheme
• Complete Know Me Better tool
• Review existing care plans and Lasting Power of Attorney
• Orientate patient
• Use dentures, glasses and hearing aids
• Avoid bed moves and do not outlie
• Monitor pressure areas
• Promote continence
• Meaningful Activities input
• Sit out in own clothes
• Minimise noise and support sleep at night
• Assess, support and manage mood and changes in behaviour.
• Assess mobility, falls and mobilise early
• Support nutrition and hydration with snack finger foods and Weekly Meal Planner
• Consider any specific dietary needs
DISCHARGING WELL
• Ensure early communication with carers and relatives regarding discharge and future plans
• Avoid the discharge suite
Document on discharge letter:
• Diagnosis
• AMT10 - admission and discharge score
• Delirium episodes
• New behavioural or psychological symptoms
• Agreed ReSPECT and Emergency Healthcare Plans
• New antipsychotics. Ensure follow up via Mental Health Liaison Service
Handover to community team
DYING WELL
• Discuss patient's wishes and preferred place of death
• Check and update ReSPECT, any Advance Care Plans or Emergency Healthcare Plans
• Consider plans for reduced oral intake or difficulty with swallow including risk feeding
• Seek palliative care support if struggling with symptom management
• Support spiritual needs
SUPPORTING WELL
Teams who can support:
- Admiral Nurses
- Age UK
- Meaningful Activities Facilitators
- Continence Nurse Specialists
- Frailty Emergency Squad (FES)
- Adult Safeguarding Team
- Mental Health Liaison Service
- Allied Health Professionals, SALT and Dietitian
Useful tools:
- CVE chart for pain assessment
- Know Me Better document
- Dementia leaflet
- Delirium leaflet
- Nutrition in advanced dementia
- Behaviour charts
Useful policies and guidelines:
- UHL Family, Carers and Friends Charter
- Mental Capacity and Best Interest Assessment
- Altered Behaviours policy
- Covert Administration of Medication policy
- UHL Deprivation of Liberty Safeguards policy
- Stay With Me campaign
PATIENTS WITH SUSPECTED DEMENTIA
Take a Collateral History
from carers, with focus on memory, behaviour, psychological symptoms, nutrition, mobility and continence
Delirium can present on a background of pre-existing undiagnosed dementia. Delirium should be resolved prior to assessment for dementia.
For patients with suspected delirium follow Think Delirium Support Tool
Thorough Physical Examination
Assess for features to support specific dementia types (e.g. Parkinson's Dementia)
Blood Tests
FBC, U&Es, CRP, LFTs, TSH, B12, Folate, glucose, calcium
Cognitive Testing
AMT 10 and if abnormal follow with a standardised cognitive assessment tool
Brain Imaging (CT/MRI)
Request to be reported under dementia protocol. Do not delay discharge for scan, convert to outpatient as necessary
Reversible Cause Found
Treat cause and GP to repeat cognitive testing on discharge
No Reversible Cause Found
GP to reassess on discharge and refer to memory services if required.
If any behavioural concerns refer to Mental Health Liaison Service as inpatient
Admiral Nurse input can support complex cases.
Age UK can provide further information.
It is hard to diagnose dementia in hospital -
most of the time it is better that this is done in patient's usual surroundings when any potential reversible illness has settled
Update discharge letter with monitoring and follow-up required on discharge
Rebecca Cole and Krista Falzon Version 5

Know me better Patient Summary

NHS
University Hospitals of Leicester
NHS Trust

Patient details

This document is to be completed by / for people who cannot consistently communicate their own needs. Please be as thorough and descriptive as you like - the more information you provide, the more we can adapt the care we provide to suit you. If you need more space please ask staff for a 'Know Me Better Patient Profile'

Name: ..... I like to be called: ..... Date: .....

S. Number: ..... Completed by: ..... The language I speak is: .....

Communication

Do you have any difficulty communicating?
Yes ☐ No ☐

Do you have impairment of:
Vision ☐ Hearing ☐ Other .....

Do you use:
Glasses ☐ Hearing aid(s) ☐ Details .....

Do you mind wearing your glasses / hearing aid? Yes ☐ No ☐

Getting About

How do you normally get about:

Walk independently	☐	Need assistance	☐
Walk with a stick	☐	Walk with a frame	☐
Walk with a trolley	☐	Use a wheelchair	☐
Stay in the chair or bed	☐	Other	

I am: Prone to wandering ☐ At risk of falls ☐

My usual routine and care

I can:

Wash myself	☐	Feed myself	☐
Dress myself	☐	Cook for myself	☐
Toilet myself	☐	Shop for myself	☐
Clean myself after toileting	☐	Clean for myself	☐

Need help with all of the above: ☐

I am incontinent of:
Urine ☐ Faeces ☐ I wear pads ☐ I have a catheter ☐

I live:

Alone	☐
With my spouse	☐
With family	☐
In a residential home	☐
In a nursing home	☐

I require help at home from: .....

I have carers:
Yes ☐ No ☐
How many carers visit?
1 ☐ 2 ☐
Number of visits / day: ☐ per day

Relaxation and Sleep

How do you like to relax:

Talk	☐	Be quiet	☐
Read	☐	Watch television	☐
Listen to music	☐		

Details: .....

How do you sleep:

Well	☐
With difficulty	☐
Awake most of the night	☐

What helps you to sleep? .....

Eating and drinking

This section, in part relates to any advice you have been given by the dietician / speech and language therapist regarding food and / or drink

I have not been given any advice regarding food / drink ☐

I eat:

Soft diet	☐
Fork mashable	☐
Pre-mashed	☐
Pureed	☐

I drink:

Thickened fluids	☐
If thickened, what stage:	
I use a spouted beaker	☐

I have a:

Good appetite	☐
Poor appetite	☐
Small portions	☐

I eat independently	☐
I require some assistance at mealtimes	☐
I cannot feed myself	☐

Do you wear dentures or dental plates? Yes ☐ No ☐ **If yes,** do you wear them: all the time ☐ only when eating ☐

Do you have a special diet? .....
What are your food / drink likes? .....
Do you have any food allergies? .....
What are your food / drink dislikes? .....

Memory

I am sometimes forgetful, but I don't have dementia	☐	I am currently more confused than my normal self	☐
I am often forgetful, but I don't have dementia	☐	I am currently more drowsy/withdrawn than my normal self	☐
I have dementia	☐	I have had an episode of delirium previously	☐

Taking medication:

I am able to take medication ☐
I struggle to take medication ☐
I often won't take medication ☐

I prefer to take my medications as:

Tablets ☐ Liquids/dispersibles ☐ Non-oral routes ☐

Do you have any preferences for taking your medications?
(eg type of drink, time of day) .....

Important things in my life

These will help staff understand who or what are important to you. This helps us to understand you more and can assist in providing you with individualised care

Family that are important to me:

.....

.....

Pets that are important to me:

.....

.....

Routines that are important to me:

.....

.....

Hobbies and interests I have:

.....

.....

Places that are important to me:

.....

.....

Jobs and life events important to me:

.....

.....

Emotional support:

Things that upset or distress me:

.....

.....

How you can help me if I am upset or distressed:

.....

.....

How I may react to upsetting or distressing things:

.....

.....

How will you notice if I am in pain:

.....

.....

Spiritual and Cultural needs:

I am religious? Yes ☐ No ☐
If yes, which religion?

.....

I have the following spiritual or religious beliefs:

.....

Is there any way we can help you to follow your spiritual or religious beliefs?

.....

.....

Are there any aspects of your care that your family would like to be involved in?

.....

.....

.....

.....

.....

If you wish for someone close to you to be involved in your care please provide their details here:

Contact Name:..... Contact Details:.....

If you feel there is more in depth or additional information that would be useful for us to know about you please ask staff for a 'Know Me Better Patient Profile' to complete. If a full 'Know Me Better Patient Profile' has been completed please tick here: ☐

Requesting Security for Ward Areas

Security may be required to support patients in ward areas in specific circumstances where there is the potential for:

- Significant immediate harm to the patient, others, or the environment, including the risk of absconding.
- Restraint is necessary to manage a patient's behaviours safely and to support with essential and time-critical assessments/interventions (where sufficient ward staff does not have the appropriate level of skill and knowledge to manage restraint).

Appropriate de-escalation techniques and a dynamic risk assessment should be completed by clinical staff before contacting Security.

Flowchart