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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Trust Leads:	Jenny Kay – Senior Nurse, Older People and Dementia Sarah Meadows – Matron, Adult Safeguarding
Board Director Lead:	Julie Smith – Chief Nurse
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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

- Appendix Four removed as the booklet is now Standard Nursing Documentation (SND Number 031) available from UHL Print Rooms and on INsite.
- Minor changes to the 'Policy Monitoring Table' as the antipsychotic medications audits and audit of FOPAL referrals are no longer undertaken

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 **Older People and Dementia Nurses** provide day to day advice and support where concerns are raised about the ongoing management of patients with altered behaviours, as a result of dementia and / or delirium.

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 ICE 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 Dementia Care Pathway

5.2.1 The Dementia Care Pathway (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 Dementia Care Pathway provides details of the 6C's of Dementia Care. The 6C's of Dementia Care should be applied throughout admission.

5.2.3 The 6C's 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 Frail Older People's Advice and Liaison Team (FOPAL) for advice on managing behaviours that carry risks. See INsite for contact details.

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 When it is deemed that a patient requires one to one supervision from a security guard this must be agreed with a Head of Nursing or Deputy in hours and a Duty Manager during the night time period and a 'Security Guard Monitoring Form' completed (found within the Nursing Booklet - Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on INsite).

5.4.8 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).

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	e-UHL records / reports	Bimonthly	Safeguarding Assurance Committee
Improvement in Delirium coding	Older People and Dementia Team	Audit discharge letters	Annual	Through Dementia Implementation Group
Improved recognition of delirium through Documentation Audit	Older People and Dementia Team	Audit the documentation of delirium within the medical notes of those coded with a diagnosis of delirium	Annual	Through Dementia Implementation 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 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) Deprivation of Liberty Safeguards Code of Practice 2008. London: The Stationery Office.

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

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.

Appendix 1

"THINK DELIRIUM" SUPPORT TOOL

Caring at its best

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THINK DELIRIUM

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

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

Yes

① 4AT

1)	Alertness	Normal / fully alert	0
		Agitated / drowsy	4
2)	AMT4	No mistakes	0
		1 mistake	2
		≥ 2 mistakes / untestable	4
3)	Attention	(Months of the year backwards)	
		≥ 7 correct < 7 correct / refuses	0
		Untestable	1
			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 (without evidence of acute cognitive impairment or delirium)

Score

THINK DELIRIUM

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 SIRS 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
smoKer 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
DOES THE PATIENT NEED AN URGENT SENIOR REVIEW?
What is the management plan?
Remember: Delirium is a strong marker for dementia. Ensure follow up is arranged as required.

MANAGE DELIRIUM

GENERAL MANAGEMENT OF DELIRIUM

Hypoxia / electrolytes	Treat hypoxia, electrolyte imbalance and follow **sepsis guidelines if appropriate.**
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*.
FOPAL	for complex and challenging patients only (Frail Older Persons Advice & Liaison), ext 5587; FOPAL@uhl-tr.nhs.uk

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 UHL wandering 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 Supervision of patients with Challenging Behaviour'**
- 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.. **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.

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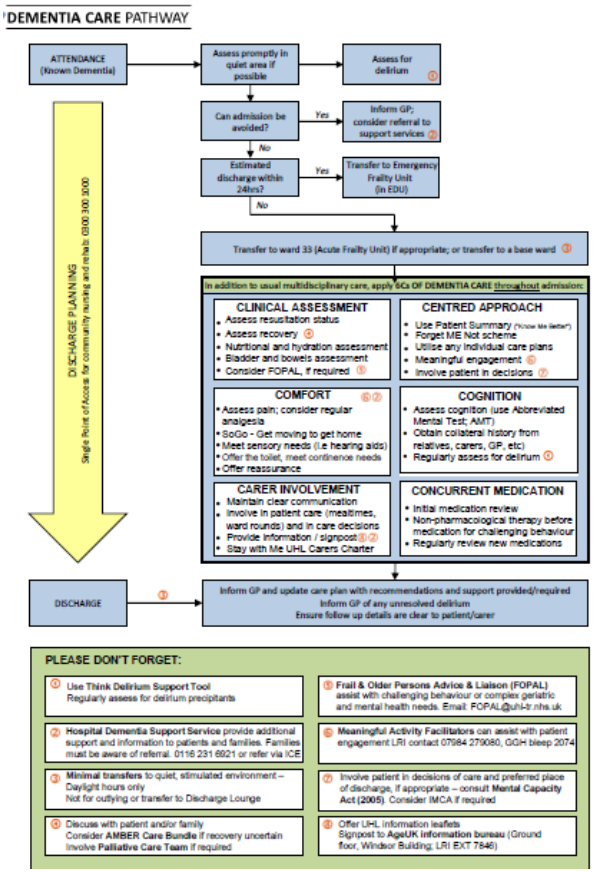
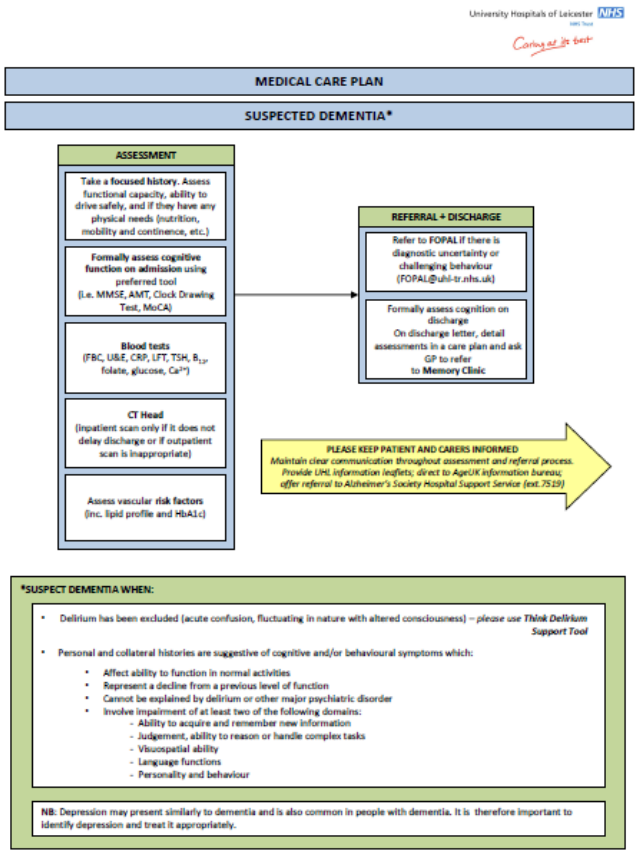
Appendix 2


DEMENTIA CARE PATHWAY
ATTENDANCE (Known Dementia)
Assess promptly in quiet area if possible
Assess for delirium
Can admission be avoided?
Yes
Inform GP; consider referral to support services
No
Estimated discharge within 24hrs?
Yes
Transfer to Emergency Frailty Unit (in EDU)
No
Transfer to ward 33 (Acute Frailty Unit) if appropriate; or transfer to a base ward
DISCHARGE PLANNING
Single Point of Access for community nursing and rehab 0300 300 3000
In addition to usual multidisciplinary care, apply 6Cs OF DEMENTIA CARE throughout admission:
CLINICAL ASSESSMENT
Assess resuscitation status
Assess recovery
Nutritional and hydration assessment
Bladder and bowels assessment
Consider FOPAL, if required
CENTRED APPROACH
Use Patient Summary ("Know Me Better")
Forget ME Not scheme
Utilise any individual care plans
Meaningful engagement
Involve patient in decisions
COMFORT
Assess pain; consider regular analgesia
SoGo - Get moving to get home
Meet sensory needs (i.e hearing aids)
Offer the toilet, meet continence needs
Offer reassurance
COGNITION
Assess cognition (use Abbreviated Mental Test; AMT)
Obtain collateral history from relatives, carers, GP, etc)
Regularly assess for delirium
CARER INVOLVEMENT
Maintain clear communication
Involve in patient care (mealtimes, ward rounds) and in care decisions
Provide information / signpost
Stay with Me UHL Carers Charter
CONCURRENT MEDICATION
Initial medication review
Non-pharmacological therapy before medication for challenging behaviour
Regularly review new medications
DISCHARGE
Inform GP and update care plan with recommendations and support provided/required
Inform GP of any unresolved delirium
Ensure follow up details are clear to patient/carer
PLEASE DON'T FORGET:
Use Think Delirium Support Tool
Regularly assess for delirium precipitants
Hospital Dementia Support Service provide additional support and information to patients and families. Families must be aware of referral. 0116 231 6921 or refer via ICE
Minimal transfers to quiet, stimulated environment – Daylight hours only
Not for outlying or transfer to Discharge Lounge
Discuss with patient and/or family
Consider AMBER Care Bundle if recovery uncertain
Involve Palliative Care Team if required
Frail & Older Persons Advice & Liaison (FOPAL) assist with challenging behaviour or complex geriatric and mental health needs. Email: FOPAL@uhl-tr.nhs.uk
Meaningful Activity Facilitators can assist with patient engagement LRI contact 07984 279080, GGH bleep 2074
Involve patient in decisions of care and preferred place of discharge, if appropriate – consult Mental Capacity Act (2005). Consider IMCA if required
Offer UHL information leaflets
Signpost to AgeUK information bureau (Ground floor, Windsor Building, LRI EXT 7846)


University Hospitals of Leicester NHS
Caring at its best
MEDICAL CARE PLAN
SUSPECTED DEMENTIA*
ASSESSMENT
Take a focused history. Assess functional capacity, ability to drive safely, and if they have any physical needs (nutrition, mobility and continence, etc.)
Formally assess cognitive function on admission using preferred tool (i.e. MMSE, AMT, Clock Drawing Test, MoCA)
Blood tests (FBC, U&E, CRP, LFT, TSH, B12, folate, glucose, Ca2+)
CT Head (inpatient scan only if it does not delay discharge or if outpatient scan is inappropriate)
Assess vascular risk factors (inc. lipid profile and HbA1c)
REFERRAL + DISCHARGE
Refer to FOPAL if there is diagnostic uncertainty or challenging behaviour (FOPAL@uhl-tr.nhs.uk)
Formally assess cognition on discharge
On discharge letter, detail assessments in a care plan and ask GP to refer to Memory Clinic
PLEASE KEEP PATIENT AND CARERS INFORMED
Maintain clear communication throughout assessment and referral process.
Provide UHL information leaflets; direct to AgeUK information bureau; offer referral to Alzheimer's Society Hospital Support Service (ext. 7519)
*SUSPECT DEMENTIA WHEN:
Delirium has been excluded (acute confusion, fluctuating in nature with altered consciousness) – please use Think Delirium Support Tool
Personal and collateral histories are suggestive of cognitive and/or behavioural symptoms which:
Affect ability to function in normal activities
Represent a decline from a previous level of function
Cannot be explained by delirium or other major psychiatric disorder
Involve impairment of at least two of the following domains:
- Ability to acquire and remember new information
- Judgement, ability to reason or handle complex tasks
- Visuospatial ability
- Language functions
- Personality and behaviour
NB: Depression may present similarly to dementia and is also common in people with dementia. It is therefore important to identify depression and treat it appropriately.

Know me better Patient Summary

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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	☐	I eat independently	☐
Poor appetite	☐	I require some assistance at mealtimes	☐
Small portions	☐	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: ☐