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Caring for People with Dementia in Acute Care Settings
A Resource Pack for Staff

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With Thanks to University Hospitals of Leicester for producing this Resource Pack
Reference Guide

This guide is intended to be used as a reference to support you to care for people with dementia. Please add your own local policies/information as needed.

Name of Trust: ________________________________

Name of Clinical Leads and contact details:

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Name of Specialist Dementia Nurse and contact details:

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Training and Education department for dementia and contact details:

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Signed by: __________________________________________

Chief Executive

With Thanks to University Hospitals of Leicester for producing this Resource Pack.
INTRODUCTION

About 700,000 people in the UK currently have dementia, and this is likely to increase to 1.7 million by 2051 (DH, 2009). The term ‘dementia’ is used to describe a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning and communication skills and the ability to carry out daily activities.

Two thirds of NHS beds are occupied by older people and it is estimated that up to 60 per cent have or will develop a mental disorder during their admission and up to 40 per cent will have dementia (Royal College of Psychiatrists, 2005). Being a patient in hospital can be a very difficult experience for a person with dementia, hospital environments can be disorientating and make the person with dementia appear more confused than normal, but there are things we can do to make the person’s experience in hospital less stressful.

The aim of this resource folder is to provide practical information for staff caring for people with dementia to help understand some of the particular needs of people with dementia and their carers.

Further reading and signposting to further information is included at the back of the resource folder.

References


SECTION 1

10 Point Guide: Caring for People with Dementia in Acute Hospitals

Introduction

Being admitted into hospital and the time spent there as a patient can be a very challenging experience for a person with dementia. There are times when caring for people with dementia on acute hospital wards can be challenging for staff also.

60-70% of beds in acute hospitals are typically occupied by people aged 65 and over, and of these approximately 30% suffer from dementia. With the numbers of people with dementia in hospitals as high as they are it is important staff have some understanding of the particular needs of people with dementia and their carers.

This brief guide aims to help with this understanding by focusing on a few key aspects of care. Further reading is given at the end of the booklet.

1. What is dementia?

- Dementia is caused by a disease of the brain, usually chronic (at least six months duration) and progressive.

- There is a decline in memory and other higher cortical functions such as judgement, thinking, orientation, comprehension and language, and learning capacity

- Consciousness is not clouded

- A deterioration in emotional control, social behaviour and motivation is also common.

- ‘There are over 100 causes of dementia, however approximately 95% of cases are caused by the commonest conditions, these include Alzheimer’s disease, Vascular dementia and Dementia with Lewy Bodies.

Alzheimer’s disease

This is the most common condition causing dementia accounting for around 55% of all cases of dementia. It is a progressive disease in which the neurones (brain cells) and communication pathways of the brain are destroyed. Plaques and tangles develop in the structure of the brain, and the chemical messengers in the brain are affected. Possible features include:

- Memory loss – initially affecting short term memory whilst long term memory remains intact although this too is affected over time
- Loss of sense of time and place
Loss of everyday skills
Word-finding difficulties
Impaired reasoning
Recognition problems – objects and people
disinhibitory behaviour
Movement problems
Mood swings
Incontinence (later stages)
Hallucinations (Be aware that certain misunderstandings can be misleadingly labelled as “hallucinations” e.g. a person mistaking their reflection in the mirror to be an intruder in their room)

Vascular dementia

Vascular Dementia (sometimes referred to as “multi-infarct dementia”) is the second most common cause, and occurs as a distinct condition in about 20% of people with dementia. It can be caused by a stroke, or series of strokes where blood supply to areas of the brain is blocked by a blood clot. Deprived of blood supply, brain cells in affected areas can die causing impairments related to the function of that particular area of the brain.

Symptoms can be similar to Alzheimer’s Disease but the following differences are often apparent:

- Onset is often abrupt
- There may be periods where symptoms do not progress followed by an episode of acute confusion often associated with a new “mini-stroke” – a step-like progression
- People can sometimes have a greater degree of self-awareness
- There is an increased likelihood of problems with unpredictable behaviour or changeable moods
- Some abilities may remain largely unaffected depending on which areas of the brain are undamaged

As with all types of dementia vascular dementia can co-exist with Alzheimer’s and other forms of dementia.
Dementia with Lewy Bodies / Lewy Body Dementia

DLB accounts for approximately 15% of cases of dementia (some studies put this figure higher). Lewy bodies are tiny spherical protein deposits found in nerve cells and their presence in the brain disrupts its' normal functioning. Lewy bodies are also found in the brains of people with Parkinson's Disease. Again, the symptoms can be similar to Alzheimer's Disease but the following differences are often apparent:

- Symptoms are more likely to fluctuate, episodes of more severe confusion can be followed by lucid intervals over minutes, hours or days
- People are more likely to experience visual or auditory hallucinations
- Parkinsonian symptoms – e.g. tremor, muscle stiffness, slowness, changes to voice tone and strength may be present
- People are more prone to falls
- People may have restless and disturbed nights with nightmares and hallucinations
- People with Lewy Body Dementia have a potentially life-threatening sensitivity to neuroleptic medication which can cause parkinsonism.

The Alzheimer's Society provides the following advice:

If a person with DLB must be prescribed a neuroleptic it should be done with the utmost care, under constant supervision, and it should be monitored regularly. The following list includes the names of many of the major neuroleptics available. New drugs are appearing from time to time. The generic name is given first, followed by some of the common proprietary (drug company) names for that particular compound.

Chlorpromazine (Largactil)
Clopenthixol (Clopixol)
Haloperidol (Haldol, Serenace)
Olanzapine (Zyprexa)
Promazine
Quetiapine (Seroquel)
Risperidone (Risperdal)
Sulpiride (Dolmatil, Sulparex, Sulpitil)
Trifluoperazine (Stelazine)

1 Alzheimer's Disease Information Sheet 403 August 2003
2. Be aware of the differences between dementia and other causes of confusion

Delirium (or acute confusion) is characterised by altered consciousness and cognitive decline, and often has a rapid onset. WARNING: It is often rather “quiet” and easy to miss in elderly patients.

Delirium may be brought on by any physical illness (e.g. infections, diabetes, side effect of drugs) and may be the presenting sign in an elderly patient with dementia.

A person may also be confused and disorientated due other reasons such as a reaction to medications, sensory impairment, depression, pain, bereavement, sudden change to surroundings/routine.

Delirium is a particularly high risk in patients with the following:

Old age, severe illness, dementia, physical frailty, admission with infection or dehydration, visual impairment, polypharmacy, surgery, alcohol excess and renal impairment

Key messages:

- Be aware that changes in behaviour from the norm for the person (e.g. increased agitation, or increased withdrawal) may indicate an underlying health problem that may need urgent attention.
- Any acute illness can precipitate delirium.
- Dementia can become a “label”. Do not assume that a person’s behaviour and confusion is necessarily a direct consequence of their dementia. Always consider other causes of confusion.

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3. Focus on communication

People with dementia often experience increasing difficulty with verbal language. This can be a problem of both expressing and interpreting language.

As a consequence, we have to pay greater attention to trying to interpret a person’s needs and feelings and when we wish to express something to a person with dementia we need to adapt our usual style of communication to compensate for their difficulties.

Consider the following:

- Slow down (do not out-pace) and reduce the length of your sentences.
- Concentrate on your non-verbal communication (your words might not make sense to the person but your tone of voice and body language will)
- Make use of objects/cues/pictures to back up what you are saying
- Concentrate on the feeling/need behind what a person is saying (if a person is asking for their mother, think why this might be and try to clarify: Are they feeling anxious, lost, trapped, are they in pain, do they need the loo?)
- Try to provide opportunities for reassuring human contact. Stop and share a few moments when you can. Encourage flexible visiting where possible (see below)
- Talk through procedures as you do them to try to allay fear. Repeat information such as who you are, what you are doing and why.

4. Aim for the familiar

Put yourself in the shoes of a person with dementia, if you were in a strange and disturbing place and your short-term memory was so poor you couldn’t retain information what or who might help you feel more safe and secure?

Being in hospital can be disorientating and frightening for a person with dementia. Familiar people and familiar things can provide support, comfort and reassurance.

- Encourage rather than discourage the presence of close family/friends.
- Encourage the person to have possessions from home (preferably not things of value in-case they go astray!) e.g. photo, bed throw, clock, cuddly toy etc
5. See behaviour as communicating a need

A person’s behaviour may at times be challenging for staff and other patients. A person with dementia may for example be creating a difficulty on the ward by for example: Repetitive shouting, wandering off the ward, interfering with other people’s possessions or equipment...

What we need to recognise first and foremost is that all behaviour has meaning and we should “read” the behaviour as communicating a need or a feeling.

Behaviour may indicate many things; here are just a few possibilities:
Being in pain
Being afraid
Feeling Lost
Being overwhelmed by too much noise or activity on the ward
Not having enough activity to simulate
Trying to express a need – hunger, thirst, the need for the toilet
Effects of medication
Trying to find someone or something familiar

- Remember, a sedative used to control behaviour will not meet any of these underlying needs.

6. Make the most of the expertise of family members and friends

Knowing as much as possible about a person with dementia can assist greatly in their care. Your most valuable supply for this information will be the person themselves and/or their relative/carer.

Relatives may have precious information on what actions/responses are likely to make a person more distressed, and what can help a person feel more secure.

Relatives might be able to provide insight and explanations of behaviours you find puzzling (for example it would be imperative to know that if a person with dementia was refusing fluids on the ward, whether they had any particular needs around drinking at home. It might be for example, that when at home they only ever drank from a particular mug or cup. Bringing this in might just be an answer).

Make sure such vital information is shared across the care team.
7. Ensure the person eats and drinks well

A person with dementia may look like they should be able to eat and drink without assistance, but may in fact need help.

In addition to problems anyone might have when it comes to eating well in hospital such as physical discomfort, loss of appetite, sensory impairment etc. A person with dementia may have specific problems such as:

- Difficulty initiating an action (picking up a fork or spoon to eat)
- Difficulty recognising food, drinks, implements for what they are (agnosia)
- Difficulty with visual-spatial awareness, making seeing the food more difficult
- Difficulties with memory – remembering to eat and drink
- Experiencing anxiety and other emotions that may effect appetite

Consider:

- Appropriate prompting
- The presentation of the food
- Stress-free environments in which to eat main meals (too much noise and distraction are not conducive to this)
- Being able to eat little and often rather than just at the set mealtimes

8. Try to make the environment as stress-free as possible

People with dementia are likely to benefit from continuity and familiarity.

Try to avoid repeated moves within the hospital wherever possible.

Try to make a person’s surroundings as calm and familiar as possible.

Make use of signage for toilets and other rooms to improve the chances of a person finding their way around. Good signage will use a picture (e.g. of a toilet) rather than a word.

9. Encourage the person to be meaningfully occupied

Like everyone else, people with dementia have a need to be occupied, purposeful and active. All too often in hospitals there is very little to occupy people. For a person with dementia this lack of occupation may lead to them behaving in ways that cause difficulties for themselves and others, or conversely, it may lead to a person withdrawing more and more into themselves and losing all motivation.

- Ideas for encouraging meaningful activity:
- Encourage families to visit and to bring in anything that may help keep a person occupied.
- Find out from families what interests the person has
- Books, photos, bags with items to rummage through may all help.
- Provide opportunities for exercise
10. Providing adequate pain relief

There is evidence to suggest that people with dementia are likely to experience less pain relief in hospital than people who do not have dementia and this becomes a greater problem the more severe the cognitive impairment\(^3\). Hence, the more confused and disorientated, a person is the less likely they are to receive effective pain control.

Behaviour such as shouting, aggression, agitation and wandering may be triggered by pain. All too often anti-psychotic medication is prescribed for people with these behaviours rather than pain relief.

Nurses play a vital role in assessing pain and administering pain relief in people with dementia and should consider the following:

- Asking patients with dementia regularly if they are in pain
- Use of pain assessment scales particularly where verbal communication skills are reduced
- Observe for behavioural, physiological and body language changes in individuals to guide assessment of pain
- Consider requesting “by the clock” medication for some people rather than “as required”\(^4\)


Support for family carers

Relatives may be an invaluable support to the person with dementia and to the ward team. However, caring is very stressful and being in hospital may in itself be the opportunity for a much needed break from caring. The following organisations may be able to provide support and advice to carers (and to people with dementia directly)

Alzheimer’s Society (National)
National helpline and helpful web resource for information and support for people with dementia, relatives and professionals:

Telephone: 020 7306 0606 Email: enquiries@alzheimers.org.uk
Helpline: 0845 300 0336 (8.30am to 6.30pm Monday to Friday)
www.alzheimers.org.uk

Picks Disease Support Group (PDSG)
For carers of frontotemporal dementia: Pick’s Disease, Frontal Lobe Degeneration, Dementia with Lewy Bodies, Corticobasal Degeneration and Alcohol Related Dementia.

Contact: Carol Jennings, Adviser
Tel: 0845 458 3208 carol@pdsg.org.uk
www.pdsg.org.uk

Further Reading

Books:


Archibald, C (1999) Food and Nutrition in the Care of People with Dementia. The Dementia Services Development Centre. Stirling.


Journal Articles

Nursing Standard series on dementia care in acute hospitals:


Journals:

The Journal of Dementia Care: Hawker Publications

Useful websites:

www.alzheimers.org.uk
The UK’s leading care and research charity for people with dementia, their families and carers

www.brad.ac.uk/health/dementia
Bradford Dementia Group. Provide teaching, education and research in dementia care and home to Dementia Care Mapping

www.dementia.stir.ac.uk
The DSDC works to spread research and good practice about home and hospital care for people with any type of dementia including Alzheimer’s disease, multi-infarct dementia, Lewy body dementia, vascular dementia and alcohol-related dementia throughout the world.

Booklet written by:

Trent Dementia Services Development Centre
Part of a network of centres offering advice, training, and service development for all service providers. Registered Charity no 1109855

Telephone: 0116 257 5017
www.trentdsdc.org.uk
info@trentdsdc.org.uk

With Thanks to University Hospitals of Leicester for producing this Resource Pack
This is me

This leaflet will help you support me in an unfamiliar place

Please place a photograph of yourself in the space provided.

My name

With Thanks to University Hospitals of Leicester for producing this Resource Pack
This is me is about the person at the time the document is completed and will need to be updated as necessary.

This is me should be completed by the person or persons who know the patient best and wherever possible with the person themselves.

Please refer to the back page for guidance notes to help you complete This is me.

My name: full name and the name I prefer to be known by

I currently live

Carer/the person who knows me best

I would like you to know

My home and family, things that are important to me

My life so far

My hobbies and interests

Things which may worry or upset me

With Thanks to University Hospitals of Leicester for producing this Resource Pack
I like to relax by

My hearing and eyesight

My communication

My mobility

My sleep

My personal care

My eating and drinking

My medication

Date completed: ___________________________  By whom: ___________________________

Relationship to patient: ___________________________

In signing this document, I agree that the information in this leaflet may be shared with health and care workers.  

With Thanks to University Hospitals of Leicester for producing this Resource Pack
Guidance notes to help you to complete This is me

This is me is intended to provide professionals with information about the person with dementia as an individual. This will enhance the care and support given while the person is in an unfamiliar environment. It is not a medical document.

This is me is about the person at the time the document is completed and will need to be updated as necessary. This form can be completed by the person with dementia or their carer with help from the person with dementia where possible.

My name: Full name and the name I prefer to be known by.

Where I currently live: The area (not the address) where I live. Include details about how long I have lived there, and where I lived before.

Carer/the person who knows me best: It may be a spouse, relative, friend or carer.

I would like you to know: Include anything I feel is important and will help staff to get to know and care for me, eg I have dementia, I have never been in hospital before, I prefer female carers, I don’t like the dark, I am left handed, I am allergic to... etc.

My home and family, things that are important to me: Include marital status, children, grandchildren, friends, pets, any possessions, things of comfort. Any religious or cultural considerations.

My life so far: Place of birth, education, work history, travel, etc.

My hobbies and interests: Past or present – eg reading, music, television or radio, crafts, cars.

Things which may worry or upset me: Anything that may upset me or cause anxiety such as personal worries, eg money, family concerns, or being apart from a loved one, or physical needs, eg being in pain, constipated, thirsty or hungry.

I like to relax by: Things which may help if I become unhappy or distressed. What usually relaxes me, eg comforting words, music or TV? Do I like company and someone sitting and talking with me or prefer quiet time alone? Who could be contacted to help and if so when?

My hearing and eyesight: Can I hear well or do I need a hearing aid? How is it best to approach me? Is the use of touch appropriate? Do I need eye contact to establish communication? Do I wear glasses or need any other vision aids?

My communication: How do I usually communicate, eg verbally, using gestures, pointing or a mixture of both? Can I read and write and does writing things down help? How do I indicate pain, discomfort, thirst or hunger? Include anything that may help staff identify my needs.

My mobility: Am I fully mobile or do I need help? Do I need a walking aid? Is my mobility affected by surfaces? Can I use stairs? Can I stand unaided from sitting position? Do I need handrails? Do I need a special chair or cushion, or do my feet need raising to make me comfortable?

My sleep: Usual sleep patterns and bedtime routines. Do I like a light left on and do I find it difficult to find the toilet at night? Position in bed, any special mattress, pillow, do I need a regular change of position?

My personal care: Normal routines, preferences and usual level of assistance required in the bath or, shower or other. Do I prefer a male or female carer? What are my preferences for continence aids used, soaps, cosmetics, shaving, teeth cleaning and dentures?

My eating and drinking: Do I need assistance to eat or drink? Can I use cutlery or do I prefer finger foods? Do I need adapted aids such as cutlery or crockery to eat and drink? Does food need to be cut into pieces? Do I wear dentures to eat or do I have swallowing difficulties? What texture of food is required to help, soft or liquidised? Do I require thickened fluids? List likes, dislikes and any special dietary requirements including vegetarianism, religious or cultural needs. Include information about my appetite and whether I need help to choose food off a menu.

My medication: Do I need help to take medication? Do I prefer to take liquid medication?

Dedicated to the memory of Ken Ridley, a much valued member of the Northumberland Acute Care and Dementia Group.

The Royal College of Nursing is pleased to support This is me.

To order extra copies call Xcalibre on 01753 535751. For general dementia queries call our Helpline on 0845 300 0336.

alzheimers.org.uk

With Thanks to University Hospitals of Leicester for producing this Resource Pack.
SECTION 3

Cognitive Assessment

A cognitive assessment is an examination conducted to determine someone's level of cognitive function. Cognitive function refers to a person's ability to process thoughts. Cognition primarily refers to things like memory, the ability to learn new information, speech, and reading comprehension.

There are a number of reasons to perform a cognitive assessment and these assessments can be administered by a doctor, nurse or allied health professional. Several standardised cognitive assessments have been published which are outlined in the Cognitive Assessment Tools guideline within this section including a cognitive screening algorithm.

The algorithm recommends the use of four cognitive tests:

1. MMSE – Mini Mental State Examination
2. CLOX1 – An executive clock drawing task
3. CAM (short version) – Confusion Assessment Method
4. IQCODE (short version) – Informant questionnaire on cognitive decline in the elderly

It is important to note that if a person with dementia is physically unwell, any results of the cognitive assessment can be considerably affected. Cognitive impairment that presents as dementia may also be associated with delirium or depression. It is therefore essential to speak to family and carers to establish a good baseline history.
1. Introduction

Dementia is common in older people. It affects 5% of people over age of 65 and 25% of people over age of 80. Yet diagnosis of dementia is frequently missed by health care professionals. It is well recognised that people living with dementia have reduced survival, increased risk of wandering and falls, increased risk of developing dehydration and malnourishment, poor outcome following surgery for hip fracture and significantly increased risk of developing delirium (acute confusional state). Evidence suggests that failure to recognise dementia results in the following:

- unnecessary hospital admission
- increased incidence of delirium
- delayed discharge
- unnecessary re-admissions
- unnecessary institutionalisation
- increased morbidity and mortality

The aim of this guideline is

- To offer cognitive assessment tools to health care professionals working with older people
- To provide overview and limitations of each cognitive assessment tool
- To raise the profile of the condition and allow clinicians to confidently diagnose and manage the condition.
- To encourage cognitive testing on adults over the age of 65
- To develop appropriate care planning and referral of people with established condition

2. Legal Liability Guideline Statement

Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional it is fully appropriate and justifiable - such decision to be fully recorded in the patient’s notes

3. Scope

The guideline applies to all healthcare staff working within UHL including Bank and Agency staff and those on honorary contracts.

This document provides detailed evidence based clinical guidance for assessing cognition of patients with dementia. The guidance is primarily aimed at older people (defined as aged 65 and above) although it may be of some relevance to younger patients who have cognitive impairment.
COGNITIVE ASSESSMENT TOOLS
University Hospitals of Leicester NHS Trust

GUIDELINE FOR COGNITIVE ASSESSMENT OF THE OLDER PERSON ADMITTED TO HOSPITAL

Adopted from British Geriatrics Society & Faculty of Old Age Psychiatry Consensus, Royal College of Physicians and National Institute for Health and Clinical Excellence (NICE) guideline on delirium and dementia 2006
Cognitive Assessment Tools

Why do we need cognition assessment tools?

- These tools are crucial for the diagnosis of dementia and delirium
- Delirium and dementia are common
  - Delirium – up to 30% of older medical admissions
  - Dementia – affects 5% of people over age of 65 and 25% of people over age of 80 over 2/3 of patients in hospital are over 65 years and up to 60% have impaired cognition
- Yet delirium and dementia are frequently missed by health care professionals

Importance of recognising delirium and dementia

- People with delirium have
  - High mortality – twice compared to matched control
  - Increased length of stay
  - Increased rate of institutional placement
  - Three times risk of developing dementia
- People living with dementia have
  - Reduced survival
  - Increased risk of wandering and falls (those who are independently mobile)
  - Three times the likelihood of developing dehydration and malnourishment
  - Poor outcome following surgery for hip fracture
  - Significantly increased risk of developing delirium
- Failure to recognise dementia and plan for the needs of both the dementia sufferer and their carer(s) can result in the following:
  - unnecessary hospital admission
  - increased incidence of delirium
  - delayed discharge
  - unnecessary re-admissions
  - unnecessary institutionalization
  - increased morbidity and mortality.
Why improve the assessment of cognition in older people?

- Dementia is prevalent in the acute hospital setting.
- It is currently under detected and often remains undiagnosed.

National Service Framework (NSF) - Standard 7 aims

- to promote good mental health in older people
- to treat and support older people with dementia and depression

What is dementia?

- A generic term indicating a slowly progressive loss of intellectual functions including memory, significant deterioration in the ability to carry out day-to-day activities, and often, change in social behaviour, **lasting more than 6 months**
- Diagnosis of a subtype of dementia – Alzheimer’s, vascular, dementia with Lewy bodies, fronto-temporal and other dementia – should be made by health care professionals with expertise in differential diagnosis using standard criteria.
Cognitive testing should be carried out on all people over age 65 admitted to hospital. A diagnosis of dementia should be made only after a comprehensive assessment, which should include:

- history taking
- cognitive and mental state examination
- physical examination and other appropriate investigations (basic dementia screen includes – FBC, U+E, LFT, Glucose, Calcium, TFT, B12, Folate, imaging – imaging helps to exclude other cerebral pathology and help establish subtype, MRI brain preferred)
- a review of medication in order to identify and minimise use of drugs that affect cognition adversely
- Tests for delirium are different and include screening for sepsis, excluding metabolic disturbance and reviewing the drug history – more detail is given in (see delirium guideline)

The consensus statement of British Geriatrics Society (BGS) recommends a cognitive screening algorithm (Figure:1, Table:1) that will help to provide a standard, reliable initial diagnosis of dementia.

The algorithm recommends the use of four cognitive tests:

1. MMSE – Mini Mental State Examination
2. CLOX1 – An Executive Clock Drawing Task
3. CAM (short version) – Confusion Assessment Method
4. IQCODE (short version) – Informant Questionnaire on Cognitive decline in the Elderly.
COGNITIVE ASSESSMENT PATHWAY

In emergency department (ED)

Four point test

Age
DOB
Place
Year

On Admission to AMU/ Ward

Abbreviated Mental Test (AMT) score:
1. Age
2. Time (to the nearest hour)
3. Address for recall at the end of test (42 West St)
4. Year
5. Name of hospital
6. Recognition of two people (e.g. doctor, nurse)
7. Date of birth
8. Dates of WW2 (1939-1945)
9. Name of present monarch
10. Count backwards from 20-1 (also tests attention)

AMT < 8/10, ED four point test ≤ 3/4
Abnormal

Mini Mental State Examination (MMSE)
An Executive Clock Drawing Task (CLOX1)

Follow cognitive screening algorithm

NB: Paper copies of guideline may not be most recent version. The definitive version is held on the Document Management System.
Figure: 1 Cognitive screening algorithm to be used by any medical professional

LGH – Leicester General Hospital; CMHT – Community Mental Health Team

A guideline for cognitive assessment of older person admitted to hospital
Author: Nainal Shah
Approved by: SEA committee
Insite Document Number: 

NB: Paper copies of guideline may not be most recent version. The definitive version is held on the Document Management System
### Further cognitive assessment

<table>
<thead>
<tr>
<th>TEST</th>
<th>MMSE</th>
<th>CLOX 1</th>
<th>CAM</th>
<th>IQCODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject of the test</td>
<td>The patient</td>
<td>The patient</td>
<td>The patient plus their carer, family member and/or staff</td>
<td>The patient’s carer, family member or friend</td>
</tr>
<tr>
<td>Overview</td>
<td>It tests – 1. Orientation 2. Registration 3. Attention &amp; calculation 4. Recall 5. Language 6. Construction</td>
<td>A test that asks the patient to draw a clock with hands pointing to the time of ‘1:45’. Specific elements of the drawing are then rated</td>
<td>The carer is asked if there is any acute change in mental state. The patient is then observed and asked a list of questions to gauge: 1. Inattention 2. Disorganised thinking 3. Level of consciousness</td>
<td>A list of 16 questions about the patient’s ability to carry out a range of everyday tasks</td>
</tr>
<tr>
<td>What it assesses</td>
<td>Cognitive function</td>
<td>Executive function</td>
<td>Presence or absence of delirium</td>
<td>Degree of decline in ability for a range of everyday tasks</td>
</tr>
<tr>
<td>Abnormal Test score</td>
<td>&lt; 24/30</td>
<td>&lt; 11/16</td>
<td>Presence of 1+2, and either 3 or 4</td>
<td>&gt; 3.44</td>
</tr>
<tr>
<td>Limitations</td>
<td>Not easily performed on bed-ridden patients for whom the test may give false positive results</td>
<td>Most reliable outcomes in elderly populations</td>
<td>Relies on people who know the patient and being able to monitor their daily activities</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Summary of cognitive screening tools
### An Executive Clock Drawing Task (CLOX1)

**Instruction:** ‘draw me a clock that says 1:45. Set the hands and numbers on the face so that a child could read them.’ All positive answers are scored.

<table>
<thead>
<tr>
<th>Organisational elements</th>
<th>Point value</th>
<th>CLOX1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does figure resemble a clock?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Outer circle present?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Diameter &gt;2.5 cm?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>All numbers inside the circle?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>12, 6, 3 and 9 placed first?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Spacing intact? (symmetry on either side of the 12–6 axis)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>If spacing errors are present, are there signs of correction or erasure?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Only Arabic numerals?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Only numbers 1–12 among the Arabic numerals?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sequence 1–12 intact? No omissions or intrusions.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Only two hands present?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>All hands represented as arrows?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hour hand between 1 and 2 o’clock?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Minute hand longer than hour?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>None of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) hand pointing to 4 or 5 o’clock?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) ‘1:45’ present?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) intrusions from ‘hand’ or ‘face’ present?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) any letters, words or pictures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) any intrusion from circle below?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score:  16

---

**Use the Confusion Assessment Method (CAM) if delirium is suspected:**

**To have a positive CAM result the patient must display:**

1. Presence of acute onset and fluctuating course  
   and  
   2. Inattention (e.g. 20-1 test with reduced ability to maintain attention or shift attention)  
   and either  
   3. Disorganized thinking (disorganized or incoherent speech)  
   or  
   4. Altered level of consciousness (usually lethargic or stuporous)
# Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

<p>| | | | | |</p>
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<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Remembering things about family and friends, eg occupations, birthdays, addresses</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>2</td>
<td>Remembering things that have happened recently</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>3</td>
<td>Recalling conversations a few days later</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>4</td>
<td>Remembering her/his address and telephone number</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>5</td>
<td>Remembering what day and month it is</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>6</td>
<td>Remembering where things are usually kept</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>7</td>
<td>Remembering where to find things which have been put in a different place from usual</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>8</td>
<td>Knowing how to work familiar machines around the house</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>9</td>
<td>Learning to use a new gadget or machine around the house</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>10</td>
<td>Learning new things in general</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>11</td>
<td>Following a story in a book or on TV</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>12</td>
<td>Making decisions on everyday matters</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>13</td>
<td>Handling money for shopping</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>14</td>
<td>Handling financial matters, eg the pension, dealing with the bank</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>15</td>
<td>Handling other everyday arithmetic problems, eg knowing how much food to buy, knowing how long between visits from family or friends</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
<tr>
<td>16</td>
<td>Using his/her intelligence to understand what's going on and to reason things through</td>
<td>Much improved</td>
<td>A bit improved</td>
<td>Not much change</td>
</tr>
</tbody>
</table>
The assessment

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now.

On the previous page are situations where this person has to use his/her memory or intelligence and we want you to indicate whether this has improved, stayed the same or got worse than in that situation over the past 10 years.

Note the importance of comparing his/her present performance with 10 years ago. So if 10 years ago this person always forgot where he/she had left things and he/she still does this, then this would be considered ‘Not much change’.

Please indicate the changes you have observed by circling the appropriate answer.

Scoring the test

1 = Much improved
2 = A bit improved
3 = Not much change
4 = A bit worse
5 = Much worse

<table>
<thead>
<tr>
<th>Score for this question</th>
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<tbody>
<tr>
<td>1</td>
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<td>10</td>
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<td>11</td>
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<tr>
<td>12</td>
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<tr>
<td>13</td>
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<tr>
<td>14</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>16</td>
</tr>
</tbody>
</table>

Total score

\[
\text{Sum of the results of all of the questions} = \frac{\text{Total number of questions}}{16} = \frac{16}{16} = 1
\]
MMSE

It covers 5 domains:
- Orientation
- Registration
- Attention & calculation
- Recall
- Language

Total score is 30

- Does not assess executive function.
- For any section a patient is unable to complete due to a disability, it should be assumed that full points were obtained.
- Questionable validity in assessing cognition in ethnically diverse population

References
- NICE guideline: http://www.nice.org.uk/CG042
- Royal College of Physicians guideline: http://www.rcplondon.ac.uk
SECTION 4

Caring for people with dementia who wander in the acute care setting

The key to good management of wandering behaviour is to allow the person to walk freely. Use of technology may contribute to this, but only in conjunction with good design of the environment, meaningful activity and appropriately trained care-givers.

The Dewing Tool for Wandering Screening is a screening tool to help practitioners to identify patients who are at risk of wandering and likely to leave a safe area.

The wandering assessment and therapeutic plan can also be used in conjunction with the Patient Profile to help identify potential triggers that can cause the patient to wander such as noise, pain, boredom, anxiety etc.

References

© Jan Dewing 2005 Methods for preventing/responding to wandering in acute care settings www.wanderingnetwork.co.uk

© Jan Dewing 2005 The Dewing Tool for Wandering Screening
Guidance for Assessment and Care Management of Patients who are at risk of Wandering in the Acute Care Setting

Section | Content | Page number
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2.0 | Definition | 3
3.0 | Guideline Intention | 3
4.0 | Roles & Responsibilities | 3
5.0 | Screening | 4
6.0 | Assessment | 4
7.0 | Care planning | 4-5
8.0 | Use of assistive technology | 5
9.0 | Audit & review | 6
10.0 | References | 6-7
11.0 | Acknowledgements | 7

With Thanks to University Hospitals of Leicester for producing this Resource Pack
1. Introduction

1.1 Any person of any age who has a confusional state whether acute or chronic may be at risk of wandering. This could be related to a dementia type illness, but not exclusively. (UK Wandering Network, 2005) However the literature that supports this policy is limited to patients with dementia who wander, nonetheless the principles of assessment and care management can be applied to any patient who may wander.

1.2 People wander for a variety of reasons, seeking a safe place, exit seeking, wanting to take some exercise and to familiarise themselves with where they are. They may also wander when they are in a strange or unfamiliar place such as a hospital.

1.3 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.

2. Definitions

2.1 There is no agreed definition of wandering; Algase et al (2001) propose that wandering is 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.

3. Guideline Intention

3.1 This policy sets out the screening, assessment and care planning processes for adult patients, who after initial assessment have been identified as at risk of wandering.

3.2 This policy will also detail good practice standards for promoting ‘safer’ wandering as part of the fundamental care needs of the person.

3.3 This policy does not cover patients that have absconded, please refer to a Missing Patients Policy

4. Roles & Responsibilities

4.1 The senior team including, General Managers, Heads of Nursing, Clinical directors & Heads of Departments are responsible for ensuring that all clinical staff are made aware of this policy, screening tool and factors to be considered as part of the patient’s treatment and care.

4.2 Individual Clinical Directorates are responsible for agreeing the criteria and risk factors that trigger the use of the Dewing Tool for Wandering.
5. **Screening**

5.1 The Healthcare Professional who identifies concern at initial patient assessment that wandering may be possible must then complete the Dewing Tool for Wandering Screening ideally in partnership with the patient and their carers and take appropriate action. (© Dewing, J. 2005 - Appendix 1)

5.2 The Dewing tool for wandering screening will help practitioners to identify patients who are at risk of wandering and particularly those who are likely to try to leave a safe setting, in this instance the Ward or department.

5.3 It enables staff to care plan measures for responding to safer or unsafe wandering.

5.4 It also prompts practitioners to recognise the need to talk with families and have proactive discussions about risk, supervision and helpful interventions to respond to wandering activity and document helpful information.

6. **Assessment**

6.1 If a patient has been screened and identified as ‘at risk of wandering’ then the Wandering Assessment and therapeutic plan (Appendix 2) should be completed. This tool can be used to help identify triggers to wandering and should be used to plan interventions and care accordingly.

6.2 The Wandering Assessment & therapeutic plan (Appendix 2) can also be used in conjunction with the dementia patient profile.

7. **Care planning**

The following factors must be considered as part of a patient's therapeutic care plan;

7.1 Wandering should only be prevented where there are high level safety risks and the person does not respond to diversion or distraction and regularly or constantly seeks to leave the designated clinical area.

7.2 Delirium should be ruled out or treated – a delirium can be diagnosed using the ‘Confusional Assessment Method’ (CAM) (Appendix 3)

7.3 Ensure a baseline cognitive assessment has been recorded, in most instances this will be the ‘Abbreviated Mental Test Score (AMTS)’. A detailed ‘Mini-Mental State Examination (MMSE); is recommended – (Appendix 4)

7.4 A patient ‘Falls Assessment Tool’ should be completed on risk admission, repeated and regularly reviewed to identify the patient's risk of falling.

7.5 Patients at risk of wandering should be nursed in a high observation area within the Ward area where possible & ensure they are placed away from main thoroughfares and exits and that ward door security alarms or locks are used where fitted.
7.6 If the patient is sensitive to over stimulation from noise and light levels, then consider a quieter area but ensure 7.8 is actioned.

7.7 Ensure Ward doors are always closed, such a physical barrier can simply prevent wandering out of a clinical area.

7.8 Check the person is there on a regular basis, the nurse in charge must assess the level of supervision, the patient must be checked at least every 30 minutes as a minimum level of supervision, however following risk assessment there maybe times when the patient requires continuous supervision. The nurse in charge is responsible for delegating team member/s to be responsible for this duty during a shift.

7.9 Ensure the person is wearing a correct identity band and appropriately dressed to ensure dignity.

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

7.11 Check for causes of physical discomfort such as hunger, thirst, pain and desire to go to the toilet.

7.12 Negotiate with family or volunteers to provide ‘sitter’ companionship services during busy periods for staff or at the times when the wandering usually occurs.

7.13 Ensure the person has an escort for all tests outside of the main care setting and where possible re-orientate the person on their return.

7.14 Where possible accompany the person whilst they wander/walk, this will reassure the person making them feel more at home in our environment and less likely to leave. If you can accompany the person for a longer walk so they can leave the ward or department for a short time this can be beneficial.

7.15 If a patient goes missing from the clinical area please refer to a Missing patient policy for guidelines and actions (Document number 19918).

8. Use of Assistive technology

8.1 If the patient has been identified through the Screening tool to have the potential to undertake a more risky type of wandering and or has made an attempt to leave/wander from the ward, then staff can consider the use of assistive technology such as pressure pad alarm sensors or electronic location devices. Assistive technology where available for use, should only be used in a therapeutic manner, in circumstances in order to maintain patient safety and promote safer wandering.

8.2 Where possible the patient’s consent should be sought for the use of these devices. If a person lacks capacity to make this decision the practitioner must take into account the views of anyone named by the person as someone to be consulted and/or anyone engaged in caring for the person interested in their welfare. The practitioner should also consider the use of an Independent Mental Capacity Advocate (IMCA) please refer the MCA Policy

8.3 Prior to using any equipment the following check list (Appendix 5) must be completed and filed in the patients notes and reviewed daily.
9. Audit & Review

9.1 This policy has been created to allow a simple audit process to be reviewed through Datix and Clinical Governance Teams. When auditing the following outcomes should be measured:

- Reduction in the number of incidents of patients attempting to leave an area of safety
- Reduction in the number of incidents of patients with dementia, who are wandering, that abscond from the Ward/Department.
- Reduction in the number of falls related incidents
- Use of assistive technology as a therapeutic intervention
- The number of patients with a baseline cognitive assessment – Abbreviated Mental Test (AMT) completed
- The number of patients with a delirium diagnosis using the Confusion Assessment Method (CAM)

9.2 It is encouraged that if any audit is undertaken using this policy, the author and or the Directorate of Services for Older People should be informed to advise and implement audit results into subsequent policy and practice reviews.

10. References


Clarifying confusion: the confusion assessment method. Annals of Internal Medicine, 113(12), 941-948.

© Jan Dewing 2005 Methods for preventing/responding to wandering in acute care settings Internet source accessed 31/1/2008 www.wanderingnetwork.co.uk

© Jan Dewing 2005 The Dewing Tool for Wandering Screening – permission to use tool given by the author.

11. Acknowledgements

Claire Agnew
Jan Dewing
Nicolette Morgan
Lara Wealthall
Appendix 1

The Dewing Tool for Wandering Screening
(Dewing 2000)

Part A (pre-dementia)

**Please circle as appropriate:**

- Does the patient have a history of being a regular walker, whether as a hobby or as part of their daily life? **YES** **NO**
- Has the patient regularly used walking as a means of thinking things through, cooling, dealing with stress or cooling off? **YES** **NO**
- Does the person have a history of being extremely sociable or known to have an outgoing personality? **YES** **NO**

Part B (currently)

**Please circle as appropriate:**

In the last year, has the person:

- Moved home (or been moved between or within a care setting)? **YES** **NO**
- Shadowed or closely followed a relative or carer around for prolonged periods? **YES** **NO**
- Moved around more frequently and had difficulty in sitting still for more than a few minutes? **YES** **NO**
- Entered into others personal areas to investigate their belongings to rummage? **YES** **NO**
- Made attempts to leave a safe place? (Note: the place must be well known to the person) **YES** **NO**
- Left a safe place and got lost? (Note: the place does not have to be known to the person) **YES** **NO**

If the answer to any question in Part A is YES and there is a diagnosis of dementia (especially Alzheimer's) then the person is at risk of wandering; has the potential to wander if they become excessively under or over cognitively stimulated.

If the answer to any question in Part B is YES, the person is highly likely to be engaging in one type of wandering and may be at risk/have the potential to undertake a more risky type of wandering.
Wandering Assessment and Therapeutic Plan

Should be used in conjunction with the personal profile

Please ensure family members, carers, next-of-kin are involved in assessment where possible

Please circle as appropriate:

<table>
<thead>
<tr>
<th>Does the patient usually wander at home?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient tried to leave their home or an area of safety?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does the wandering usually occur at:</td>
<td>Night</td>
<td>Day</td>
</tr>
<tr>
<td>Does the wandering have a pattern/typology?</td>
<td>Pacing</td>
<td>Trailing</td>
</tr>
</tbody>
</table>

Please tick as appropriate:

- **Darkness**: If YES, ensure adequate lighting
- **Noise**: If YES, consider side-room
- **Crowding**: If YES, consider side-room
- **High level activity**: If YES, consider side-room
- **Desire to go to the toilet**: If YES, offer regular toileting. Ensure pictorial signs are in place.
- **Hunger**: If YES, offer regular snacks
- **Thirst**: If YES, ensure drinks are available
- **Tiredness**: If YES, encourage rest periods
- **Pain**: If YES, observe for verbal and non-verbal clues
- **Boredom**: If YES, consider planned activities or rummage bags
- **Over-stimulation**: If YES, encourage rest periods
- **Loneliness**: If YES, consider planned activities, outside visitors, volunteers
- **Anxiety**: If YES, encourage the use of familiar objects, photos, clocks etc
- **Being upset**: If YES, reassure and establish normal comfort mechanisms
- **Anger**: If YES, reassure and establish if in pain or normal comfort mechanisms
- **Extreme temperatures**: If YES, use of fans, blankets

Completions by:

Name __________________________ Signature __________________________

With Thanks to University Hospitals of Leicester for producing this Resource Pack.
<table>
<thead>
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<th>Date</th>
<th>Time</th>
<th>Comment</th>
<th>Signature</th>
<th>Print name</th>
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Appendix 3

The Confusion Assessment Method (CAM)

The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1  Acute Onset or Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions:

Is there evidence of an acute change in mental status from the patient’s baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2  Inattention

This feature is shown by a positive response to the following question:

Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3  Disorganised Thinking

This feature is shown by a positive response to the following question:

Was the patient’s thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4  Altered Levels of Consciousness

This feature is shown by any answer other than “alert” to the following question:

Overall, how would you rate this patient’s level of consciousness?:
alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], comatose [unarousable]

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.
University Hospitals of Leicester NHS

Appendix 4

Mini Mental State Examination

Orientation (1 point for each correct answer)
What is the: year ☐ season ☐ day ☐ date ☐ month ☐
Where are we: country ☐ county ☐ town ☐ hospital ☐ floor ☐

Registration (2 points for each correct answer)
Ask patient to name three unrelated objects. ☐ ☐ ☐ = ☐
Allow one second to say each.
Then ask the patient to repeat all three after you have said them.
Repeat them until he or she learns all three. Count trials and record
Number of trials: ☐ ☐

Attention and Calculation (1 point for each correct answer)
Ask patient to count backwards from one hundred by sevens.
(93, 86, 79, 72, 65, 58, 51; 44, 37, 30, 23, 16, 9, 2) Stop after five answers. ☐ ☐ ☐ ☐ ☐ = ☐
(Alternatively), spell world backwards! (5 points)

Recall (1 point for each correct answer)
Ask patient to recall the three objects previously stated ☐ ☐ ☐ = ☐

Language
Show patient a wrist watch; ask patient what it is
Repeat a poem. (1 point for each correct answer)
Ask patient to repeat the following: “No ifs, ands, or buts” (1 point)
Ask patient to follow a three-stage command: “Take a piece of paper in your right hand, fold it in half, and place it on the floor” (3 points)
Ask patient to read and obey the following sentence, which you have written on a piece of paper: “Close your eyes” (1 point)
Ask patient to write a sentence (1 point)
Ask patient to copy a design (1 point)

TOTAL SCORE: ☐ ☐ ☐ ☐ ☐ ☐

Assess level of consciousness along a continuum
Alert ☐ Drowsy ☐ Stupor ☐ Coma ☐

With Thanks to University Hospitals of Leicester for producing this Resource Pack.
# Appendix 5

**Checklist for the Use of Assistive Technology**

1. Using the screening tool, has the patient been identified as very high risk for leaving an area of safety?  
   - YES □  NO □

2. Has the patient tried to leave the current area of safety?  
   - YES □  NO □

   If the answer to both questions is **no**, then please refer back to therapeutic plan, if the answer to either question 1 or 2 is **yes** then continue.

3. Is the patient able to consent to the use of assistive technology?  
   - YES □  NO □

   **If yes** record in notes. **If no** continue

4. Has consent been sought and recorded from the person(s) interested in the patient's welfare?  
   - □  □

5. Has the decision been supported by the Consultant & Nurse in Charge?  
   - YES □  NO □

**Consultant**

Name: ........................................

Signature: ........................................

Designation: ........................................

**Nurse in Charge**

Name: ........................................

Signature: ........................................

Designation: ........................................

---

With Thanks to University Hospitals of Leicester for producing this Resource Pack.
A guideline to help all clinical staff identify, diagnose and manage delirium in hospitalised older people

Adapted from the Royal College of Physicians and British Geriatrics Society National Guideline on: The Prevention, Diagnosis and Management of Delirium in Older People, June 2006.

R. Parikh | N. Morgan
August 2008
Delirium

Why does delirium matter?
- Common – up to 30% of all older medical patients
- Patients with delirium have:
  - Higher mortality – twice that of matched controls
  - An increased length of stay and chance of institutional placement
  - Three times the likelihood of developing dementia

The following guidelines aim to improve recognition of this complex and challenging condition

What is delirium?
Delirium is characterised by a disturbance of consciousness and a change in cognition that develop over a short period of time. The disorder has a tendency to fluctuate during the course of the day, and there is evidence from the history, examination or investigations that the delirium is a direct consequence of a general medical condition, drug withdrawal or intoxication (DSM-IV)

What factors increase the likelihood of developing delirium?
- Frailty
- Severe illness
- Dementia – increases the risk fivefold
- Previous episode of delirium
- Infection or dehydration at admission
- Visual impairment
- Polypharmacy
- Surgery e.g. fractured neck of femur
- Alcohol excess
- Renal impairment

Identifying those at risk is the first step in trying to prevent or curtail episodes of delirium

Where can I get more information on delirium?
Our guidelines are based on the Royal College of Physicians and British Geriatric Society guidance published in 2006:

“The prevention, diagnosis and management of delirium in older people” - www.rcplondon.ac.uk/pubs/contents/e8b55299-11c0-4953-994b-e56f137a2215.pdf
Identify older patients (over 65 years) with cognitive impairment using the Abbreviated Mental Test (AMT) score:

1. Age
2. Time (to the nearest hour)
3. Address for recall at the end of test (42 West St)
4. Year
5. Name of hospital
6. Recognition of two people (e.g. doctor, nurse)
7. Date of birth
   1. Dates of WW2 (1939-1945)
   2. Name of present monarch
   3. Count backwards from 20-1 (also tests attention)

Obtain collateral history

**Step 2: Consider delirium in patients with cognitive impairment**

Use the Confusion Assessment Method (CAM):

**To have a positive CAM result the patient must display:**

1. Presence of acute onset and fluctuating course and
2. Inattention (e.g. 20-1 test with reduced ability to maintain attention or shift attention) and either
3. Disorganized thinking (disorganized or incoherent speech) or
4. Altered level of consciousness (usually lethargic or stuporous)

**Delirium can be subdivided into three subtypes:**

- Hyperactive – increased motor activity with agitation, hallucinations and inappropriate behaviour
- Hypoactive – reduced motor activity and lethargy
- Mixed

Be alert when talking to patients – delirium is frequently missed!
Step 3: Clinical assessment and investigation

Identify potential causes of delirium using collateral history and clinical examination.

In addition to standard questioning, the following information should be sought:

### History
- Onset and course of confusion
- Drug history including recent changes
- Bladder and bowel function
- Dietary intake including fluids
- Symptoms suggestive of an underlying cause e.g. infection
- Previous intellectual function and functional status
- Sensory deficits and use of hearing aids/ glasses

Communicate with staff from other disciplines to avoid unnecessary repetition

A full physical examination should be conducted and particularly consider:

### Examination
- Conscious level
- Nutritional status
- Evidence of pyrexia
- Signs of infection: lungs, urine, abdomen
- Evidence of alcohol abuse or withdrawal
- Neurological examination
- Signs of urinary retention or faecal impaction

The following investigations are almost always indicated to help identify the cause:

### Investigations
- FBC, U&E, LFT, Bone, CRP
- Glucose
- ECG
- CXR
- Pulse oximetry
- Urinalysis (+/- culture)
- Blood cultures

Consider also depending on history and examination findings:
- ABG
- CT head
- Lumbar Puncture
- B12, folate and TFTs – if pre-existing dementia suspected

Drugs (particularly tricyclic antidepressants, opiates, analgesics, steroids and anti-Parkinsonian medications) are common contributory causes.

Don’t forget alcohol and benzodiazepine withdrawal as a potential cause.

Urinary retention and faecal impaction are often overlooked as potential causes!

When is CT scanning indicated?

**Indications are:**
- Focal neurology
- Confusion post head injury
- Confusion after a fall
- Evidence of raised ICP
**Step 4: Management**

Identify and treat the underlying cause:

**Treatment of Underlying Cause**
- Withdraw incriminated drugs
- Correct biochemical derangements
- If there is a high likelihood of infection commence antibiotics promptly. Use the antimicrobial web pages to help select an appropriate agent.
- Administer parenteral thiamine when alcohol abuse or under-nutrition is apparent

Management should also focus on symptomatic improvement:

**Environmental**
- Appropriate lighting for the time of day
- Cues to improve orientation
- Familiar objects from home
- Glasses and hearing aids in working order
- Medication review including adequate analgesia
- Encourage mobility
- Promote nutrition
- Avoid dehydration and constipation
- Involve relatives and carers

**Wandering**
- Provide close observation within a safe and reasonably closed environment
- Act in patient’s best interests to keep them safe
- Ask relatives to help offering meaningful distractions
- Use drug treatment only as the final option

**Dealing with false ideas**
Try the following:
- Tactfully disagree (if the topic is not sensitive)
- Change the subject
- Acknowledge the expressed feelings – ignore the content

**Avoid**
- Catheters (where possible)
- Constipation
- Inter ward transfers
- Irritating and intrusive noise e.g. pump alarms
- Restraint

Remember, there may be an easily remedied cause of wandering – pain, thirst or need for the toilet.

Confused and rambling speech is common in delirium. It is usually preferable not to agree but respond to the feelings expressed.

Repeating the AMT will help you gauge improvement!!
Medication

The main aim of drug treatment is to calm or manage dangerous or distressing behavioural disturbance e.g. agitation and hallucinations:

Pharmacological options may be necessary in the following circumstances:
- To allow essential investigations or treatment to take place
- To prevent the patient endangering themselves or others
- To relieve distress in a highly agitated or hallucinating patient.

Which drug should I choose?

Haloperidol is the preferred option:
- Dosage: 0.5mg orally – can be given up to two hourly
  - Maximum dose: 5mg in 24 hours
- If the oral route is unavailable and symptoms necessitate:
  - Try: 1-2mg IM (maximum of 5mg in 24 hours)

Lorazepam is an alternative:
- Dosage: 0.5-1mg orally – can be given up to two hourly
  - Maximum dose: 3mg in 24 hours
- If the oral route is unavailable and symptoms necessitate:
  - Try: 0.5-1.0mg IV or IM (dilute to 2ml with normal saline) up to a maximum of 3mg in 24 hours

Sedation is only a small part of management and should be kept to a minimum!!

If psychotropic drugs are prescribed, the prescription should be reviewed regularly and discontinued as soon as possible. Aim to tail off sedation after 24-48 hours.

One-to-one care of the patient is often required and should be provided while the dose of psychotropic medication is titrated upward in a controlled and safe manner.
How long does delirium last?

Delirium can persist after treatment of the underlying cause:

- The duration of the illness may range from a few days to several months
- It is important to explain to the patient and carers that resolution may take time

Summary

Delirium is
- Common
- Associated with an increased morbidity and mortality
- Characterised by acute changes and fluctuation in cognition

At admission
- Use the AMT and CAM to help make the diagnosis
- Remember:
  o Collateral history is vital
  o Hypoactive delirium is really easy to miss!!

Clinical Assessment and Investigation
- Try to identify potential causes using collateral history and clinical examination
- Specifically consider:
  o Dehydration, infection, drugs, urinary retention and faecal impaction

Management
- Treat the underlying cause
- Attend to the ward environment
- Closely supervise those who wander within a safe and reasonably closed environment
- Drugs to calm patients should be kept to a minimum

Want to know more?
Our guidelines are based on the Royal College of Physicians and British Geriatric Society guidance published in 2006:

“The prevention, diagnosis and management of delirium in older people” - [www.rcplondon.ac.uk/pubs/contents/e8b55299-31c0-49c1-923b-e56f137a2215.pdf](www.rcplondon.ac.uk/pubs/contents/e8b55299-31c0-49c1-923b-e56f137a2215.pdf)

Do you want more information on how to manage the problems experienced by older patients?
If you do, why not visit the British Geriatric Society website – [www.bgs.org.uk](www.bgs.org.uk)
SECTION 6

Further information and advice

The following organisations may be able to provide support and advice to carers and people with dementia;

Alzheimer’s Society
- Support and advice for people with dementia and their carers, services include;
- Befriending
- Carer Support
- Carer Support Groups
- Information & Advice
- Training
- Advocacy

Local Information
Alzheimer’s Society (National)
National helpline and helpful web resource for information and support for people with dementia, relatives and professionals:

Telephone: 02074233500   Email: enquiries@alzheimers.org.uk
Helpline: 0845 300 0336 (8.30am to 6.30pm Monday to Friday)
www.alzheimers.org.uk

Trent Dementia Services Development Centre
Part of a network of centres offering advice, training, and service development for all service providers. Registered Charity no 1109855
Telephone: 0116 257 5017
info@trentdsdc.org.uk or www.trentdsdc.org.uk

Useful websites

www.alzheimers.org.uk
The UK’s leading care and research charity for people with dementia, their families and carers.

www.brad.ac.uk/health/dementia
Bradford Dementia Group. Provide teaching, education and research in dementia care and home to Dementia Care Mapping

www.dementia.stir.ac.uk
The DSDC works to spread research and good practice about home and hospital care for people with any type of dementia including Alzheimer’s disease, multi-infarct dementia, Lewy body dementia, vascular dementia and alcohol-related dementia throughout the world.
Further reading

Books

Bryden, C (2005) Dancing with Dementia: My story living positively with dementia

Reports


Dementia quality standard (NICE) Guidelines

1. People with dementia receive care from staff appropriately trained in dementia care.

2. People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.

3. People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.

4. People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care coordinator and addresses their individual needs.

5. People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of: advance statements, advance decisions to refuse treatment, Lasting Power of Attorney, Preferred Priorities of Care.

6. Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.

7. People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.

8. People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people’s mental health.

9. People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.

10. Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.