Cognitive Impairment Clinical Practice Standard

1. Background

The Australian Commission's National Safety and Quality Health Services Standards (NSQHSS) and the Delirium Clinical Care Standards provide a minimum practice standard of care and inform this policy and its associated documents. It directs the clinician in the screening, assessment, support and care of patients with a Cognitive Impairment (CI) throughout WA Country Health Service (WACHS).

For the purpose of this Clinical Practice Standard (CPS), the term Cognitive Impairment will be used to refer to patients with Dementia, Delirium and Depression although the focus will be on screening, assessment and support to patients with Delirium and Dementia. This policy document also includes information on:

- Management and Prevention strategies
- Role of Family/Carer with Assessment and Care planning
- Palliative Care considerations
- Management of Agitation in older Adults with Dementia or Delirium
- Clinical Communication
- Staff Education/ Information/ Resources

Approximately 20 per cent of all patients over 70 years admitted to hospital have Cognitive Impairment (CI) and the proportion increases with age. Around 10 per cent of older patients are admitted with delirium and a further 8 per cent will develop Delirium during their hospital stay due to the impact of surgery, infections, changes to nutrition and/or hydration or side effects of medications. (*Australian Commission on Safety and Quality in Health Care*. Delirium Clinical Care Standard.)

It can be difficult to distinguish between Delirium, Dementia and Depression because symptoms overlap, and some people may have more than one condition. Appendix 1 describes the difference - Dementia, Delirium and Depression – a comparison and Section 22 describes some further definitions.

Delirium is an acute medical condition and must be treated as a medical emergency.

People with Cognitive Impairment who are admitted to hospital, are at a significantly increased risk of preventable complications.

Complications include falls, pressure injuries, failure to return to premorbid function and adverse outcomes such as unexpected death or early and unplanned entry into residential care.

2. Roles and Responsibilities

This policy is applicable to all Medical, Nursing, Midwifery and Allied Health staff working within WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of qualifications, training and responsibility.
Where care requires specific procedures that may vary in practice across sites, staff are to seek senior clinician advice.

This policy is to be used in conjunction with the:

- WACHS Disturbed Behaviour Management Clinical Practice Standard
- WACHS Restraint Minimisation Policy
- WACHS Adults with Impaired decision making Capacity Procedure
- WA Department of Health MP0086/18 Recognising and Responding to Acute Deterioration Policy

3. Screening and Assessment Procedure

This procedure guides clinicians to the processes for screening and assessing at risk patients and those identified as having a Delirium or Dementia within WACHS acute care settings. The procedures could also acts as a guide and adapted in other WACHS care settings. It includes links for all required tools and Medical Records.

3.1 Guiding Principles

Cognitive screening and assessment allow for the detection and appropriate actions to support people with Cognitive Impairment (CI). CI (Dementia and delirium) is common in hospitalised older people, who are at high risk of sub-optimal outcomes and adverse events, especially if their CI is not detected or identified.

Inclusions:
At risk patient criteria:

- Cognitive concerns raised by others
- Age 65 or over (>45 if Aboriginal)
- Known Cognitive Impairment/Dementia
- Severe or acute medical illness/risk of dying
- Current hip fracture

Exclusions:

- Patients with a new Acute Brain Injury requiring Glasgow Coma Scale (GCS) observations

3.2 Procedure

All at risk patients (see above) are to receive an initial Cognitive Impairment screen using the 4-item Abbreviated Mental Test (AMT4):

- During presentation to WACHS Emergency Departments OR as early as possible within the hospital patients' journey.
- When attending a preadmission clinic, or

- Following direct admission to the hospital.

An abnormal AMT4 Score (i.e. less than 4) will prompt:

- Assessing the patient further using the 4AT cognitive test – MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium
- Further screening and assessment as per infographic on the WACHS Cognitive Impairment flowchart (Appendix 5)
- Staff to provide patient, care partner, and/or family with the Delirium Patient / Family Information Brochure.

Staff should **be alert** to any cognitive changes during their shift and concerns raised by the patient or their care partner. If changes are noted they must be referred to the treating team and Occupational Therapist for cognitive assessment (if available) and document these concerns in the patient's notes

3.2.1 Aboriginal Patients

Some Aboriginal patients may not normally know the answers to some of the AMT4 questions due to their cultural background. If this is the case, then the family member/care partner (if and when available) needs to be asked this additional question-"Do you think (name of person) is thinking differently or behaving differently or more drowsy over the past few hours or days". This validated screening question is known as the Single Question in Delirium (SQID).

3.3 Cognitive Assessment Tools and When to Use Them

- The AMT4 and the 4AT are the WACHS recommended CI screening tools and are used as described in the Cognitive Impairment Flowchart (Appendix 5)
- The AMT4 can be completed by any registered health professional.
- The 4AT can be completed by any clinician – Nurse, Allied Health or Medical Officer.
- Refer to WACHS approved CI screening and assessment tools (Appendix 4)
- MMSE, MoCA, RUDAS and KICA represent examples of second line tools for the assessment of Dementia when patients are thought to not have Delirium. These should be undertaken by clinicians trained in its use (e.g. Medical Officers, Nursing staff and Occupational Therapists). (MR66 series- cognitive tools)
- The Geriatric Depression Scale (GDS) identifies if a patient is experiencing signs of Depression and can include symptoms of changed cognition.
- It is important to distinguish between Dementia, Delirium and Depression (Appendix 1) in order to direct care and treatment according to diagnosis.
- Instrument results are affected by the responder's educational and cultural background.
- Instrument results are biased by various communication problems.

3.4 Procedures for Documenting, Notification and Initial Management

3.4.1 Pre-admission and short stay admission screening procedure

All at risk patients are to be screened by the admitting clinician (Nursing or Allied Health) using the 4-item Abbreviated Mental Test (AMT4) to determine if there is a

cognitive impairment. The "Delirium Risk + Cognitive Screen" Sticker (Appendix 3) is obtainable for this use and to be placed in the Health Care Record for appropriate follow up if scores are abnormal.

If abnormal screen is obtained in **pre-admission clinic** then inform the relevant treating medical team or GP for follow up or document if there is a known Cognitive Impairment.

3.4.2 Documenting (admitted patient)

CI scores should be recorded:
- In the observations section of the iSoBAR handover to the admitting ward; and / or
- On inter-ward and inter-hospital transfer forms.

The AMT4 screening tool is located on the following forms to identify at risk patients:
- MR111 WACHS Nursing Admission, Screening and Assessment Tool – Adults
- MR521 WACHS Falls Risk Assessment and Management Plan (FRAMP)

The "Delirium Risk + Cognitive Screen" sticker is obtainable for initial screening in ED and to be placed within ED documentation that supports visibility by all clinicians to ensure screening, assessment and clinical escalation as required.

3.4.3 Notification

When abnormal screening scores are obtained (i.e. AMT 4 < 4) then further assessment is indicated using the MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium.

Depending on the score, the clinician who completes the 4AT will either:

- Inform the Medical Officer and coordinator of potential Delirium **or**
- Inform the Allied Health team or Nursing for further cognitive assessment.

AND commence prevention of Delirium strategies as per "PITCHED" (Appendix 2) on the Cognitive Impairment Flowchart Poster (Appendix 5) and also refer to the strategies within the Prevention and Management of Cognitive Impairment (Appendix 7).

3.4.4 Initial Management

The treating medical team must be informed of all patients identified as having Cognitive Impairment (via abnormal 4AT) and consideration given to further medical assessment to identify Delirium and any causative (reversible) factors. A plan/treatment should be initiated as indicated and documented in patient notes.

The Nursing / Allied Health team will follow up an identified Cognitive Impairment with the preferred tool to provide a baseline cognitive score. Document results in progress notes.

3.5 Ongoing Assessment and Management

Details of further assessment remains a choice for the treating medical team and will be dependent on whether the patient is felt to have Delirium, Dementia or Depression and the various characteristics of the patient.

The patient's treating team should consider if referral to a Geriatrician or Psychiatry service is required to assess further. Nursing response should be initiated to provide a safe low stimulus environment (refer to Management of Cognitive Impairment and Prevention of Delirium Appendix 7)

All clinicians (Nursing, Medical Officers and Allied Health) should continue to be alert to Delirium and observe patients for acute changes in behaviour and thinking. The AMT4 must be repeated on:

1. Change in cognitive state
2. Medical condition change
3. Ward transfer
4. Post fall

All staff will ensure patients and families are given a Delirium Patient / Family Information Brochure if diagnosed or at high risk of Delirium (e.g. post-operative patients and those diagnosed with Dementia).

Following discharge from hospital, the treating team should include in the discharge summary:
- Information related to the identification, investigation and management of cognitive impairment (where appropriate).
- Cognitive assessment scores that are the most current score to describe approximate cognitive baseline.

3.6 Patients Discharged from Emergency Department

If the patient with an AMT4 scores less than 4, is discharged from the Emergency Department, and has no previous diagnosis of Cognitive Impairment, a GP letter recommending follow-up and onward referral (e.g. to a Geriatrician or TeleGeriatrics, if available) should be included in the ED discharge summary.

Consider the WA Health Cognitive Impairment Discharge Instructions for patients known to have a Cognitive Impairment.

ED Medical staff should also consider a patient's pre-existing CI is not due to Delirium before discharge.

Should the patient transfer to another hospital, their cognitive status must be included in the verbal and written iSoBAR handover with recommendations to re-screen cognition on arrival.

See also Section 8.5 Discharge Planning

4. Management and Prevention Strategies

Management of Cognitive Impairment and Prevention of Delirium (Appendix 7) describes non-pharmacological management and prevention strategies.

All patients at risk of Delirium or a diagnosis of a Cognitive Impairment should be provided, at a minimum, with the prevention of Delirium strategies as identified on the **P.I.T.C.H.E.D** poster (Appendix 2). These need to be incorporated into the patients' care plan. Refer to WACHS Cognitive Impairment Flowchart (Appendix 5).

See also WACHS Cognitive Impairment intranet site for more resources in Education, Information and Management Strategies.

4.1 Relevant Resources (Note: if Internet Explorer does not open, copy the links into Chrome)

- Australian Commission on Safety and Quality in Healthcare
  - Cognitive impairment resources
  - NSQHS- Comprehensive Care standard
- Caring for Cognitive Impairment Campaign
- Delirium Clinical Care Standards
- Clinical Practice Guidelines for Dementia in Australia
- SIGN 157:Risk Reduction and Management of Delirium- UK publication April 2019
- WA Health: Dementia Model of Care, 2011 (Obsolete- for reference only)

4.2 Supporting people who are Aboriginal with dementia or delirium

There is a higher incidence of dementia amongst Aboriginal people.
The needs of the Aboriginal person with dementia and their families may require extra considerations and resources. WACHS have developed some useful Aboriginal resources for families and people living with dementia that can be found on the Cognitive Impairment intranet page. They include:

- Delirium brochure for patient and families
- What is delirium
- What is dementia
- Agitation in Dementia
- What is Depression
- My Life Tree (which is a substitute to the Sunflower tool)

4.2.1 Assessment of Dementia

There are many complex needs of older Aboriginal people with dementia and therefore utilising an assessment tool that is appropriate to their culture is important. There are four WACHS endorsed assessment tools to assist in assessing someone for cognitive related changes:

- MR66.11 WACHS Kimberley Indigenous Cognitive Assessment (KICA) – Remote living
- KICA – short cognitive screen MR66.12
- KICA- Regional - Urban MR66.13
- KICA – Depression Scale MR 66.14

4.2.2 Other Useful Resources

- CareSearch- Aboriginal and Torres Strait Islander Care
- Dementia Australia – Indigenous resources

5. Role of Family/Care Partner with Assessment and Care Planning

Where possible, family members and care partners of people at risk of Delirium or diagnosed with a Cognitive Impairment should be involved in identifying any changes in behaviour and thinking. This is especially essential when screening an Aboriginal patient who does not usually know some of the answers to the AMT4 questions. Establishing this will trigger the question, “Do you think (name of person) is thinking or behaving differently or more drowsy over the past few hours or days”. This could indicate a potential delirium.

Care partners’ information is essential to ascertain if there has been an acute decline (characteristic of Delirium) but also to establish if there has been a much longer decline (characteristic of Dementia). Care partners can also clarify if fluctuations in level of alertness or of cognitive functions are different from baseline fluctuations. The clinician should:

- acknowledge the carer partner’s expertise and contributions
- work with the care partner and patient to identify the individual’s preferences to support a person centred care plan tailored to the individual’s care needs
- acknowledge the individual needs of the patient including being sensitive to culture, spiritual, language and gender factors.
- offer the care partner the opportunity to speak with the social worker or a Cognitive Care / Aged Care Champion (if available) for support while the patient is in hospital and refer to discharge planning processes
- provide a Delirium Patient / Family Information Brochure to the patient / family member/ care partner and encourage them to inform the clinician if they note any signs of Delirium during the hospital stay. Also point out the helpful care strategies within this brochure to support the patient during their stay.

5.1 Development of an individualised person-centred care plan

To identify a patient’s unique care and communication needs it is important to obtain information from the care partner. This information must be documented within the care plan to avoid the care partner having to repeat this information and to prevent any responsive behaviours caused by unknown triggers. Useful information to gather includes:

- Support required around communication
- Sleep and personal care preferences
- Meal support required
- Mobility needs to prevent falls
- Vision and hearing aids
- Indicators of pain and how to relieve it
- Understanding changes in mood and how to support

This information could also be captured in the WACHS endorsed “Focus on the Person” form which could be completed by care partner and / or with the patient on

admission. Photocopy and leave care partner with original for future hospital admissions.

5.2 Cognitive Impairment and Supported Decision-Making

Supported decision-making is a practice that enables people to make decisions about their own life and enabling the person to be involved in decisions that affect their care.

To enable inclusion of the patient with Delirium or Dementia in decision-making, timing of the conversations around more lucid moments will be paramount while still including the care partner. People are presumed to have decision-making ability, unless proven otherwise. The person has decision making ability if they have:

- the ability to understand the information relevant to the decision
- the ability to use this information to weigh up options
- the ability to retain information long enough to make a decision
- the ability to communicate their wishes in some way (not necessarily verbal).

5.3 Further resources/links:

- Supported Decision-Making in Aged Care (2nd edition)
- Helpsheet- Supported decision making –for decision makers and supporters
- Advance Care Planning and Dementia – Dementia Australia website link.
- WACHS Advanced Directive And Enduring Power Of Guardianship –Guideline
- WACHS Adults With Impaired Decision Making Capacity Procedure
- Capacity Australia- About Decision making Capacity

6. Palliative Care

Care for patients with advanced Dementia should be based on a palliative approach and involve a palliative care service if indicated. Treatment and care should be provided as per the person's Advanced Care Plan.

6.1 Delirium in Palliative care patients

- Despite its prevalence in palliative care, Delirium is underdiagnosed, especially hypoactive Delirium. A high index of clinical suspicion is needed. Diagnosis is important for management, prognostication, and in order to counsel families.
- Delirium in palliative care patients can have a number of potential reversible conditions.
- Regular presentations of Delirium may be associated with a worsening prognosis.
- Delirium is more common in patients with previous Cognitive Impairment or Dementia, which makes identification and assessment more difficult.
- Delirium is a condition which causes significant distress to patients, families and staff. The presence of delirium makes it much harder to assess and treat other problems such as pain or depression.
- Since Delirium symptoms fluctuate, assessment should be part of routine care. Like pain, Delirium is most accurately assessed if it is monitored regularly rather than being screened for intermittently.
- Assess patient using the MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium for when there is a change in usual behaviour which could include

hyperactivity or hypo activity. Treating medical teams may also find the Confusion Assessment Method (CAM) useful to aid diagnosis.
- There is often more than one predisposing and precipitating factor

Criteria for referral to Specialist Palliative Care Service

6.2 Goals of Patient Care

The clinical indicators for completion of the MR00H.1 State Goals of Patient Care for patients who are frail and/ or have dementia (source: https://www.spict.org.uk/) include:
- Unable to dress, walk or eat without help
- Eating and drinking less; difficulty with swallowing
- Urinary and faecal incontinence
- Not able to communicate by speaking; little social interaction
- Frequent falls; factored femur
- Recurrent febrile episodes or infections; aspiration pneumonia
- Progressive deterioration in physical and/ or cognitive function

Refer to WACHS Goals of Patient Care (Adults) Guideline for further directions in supporting a patient (or responsible person) to complete this process.

6.3 Resources and Links

- Palliative Care for end stage Dementia – Prognostication and Dementia Specific Treatment
- Delirium in Palliative Care – General Information, Management and Pharmacological guidelines
- Clinical Assessment and Management of Delirium in the Palliative Care Setting
- Evidence Based Clinical guidelines for Adults in the Terminal Phase
- Palliative Care and Dementia – Discussion Paper from Dementia Australia (2017)
- CareSearch – Palliative care knowledge network – Advanced Dementia
- CareSearch- Aboriginal and Torres Strait Islander Care
- End-of-Life and Palliative Care for People with Dementia Framework

7. Management of Agitation in Older Adults with Dementia or Delirium

The Management of Agitation in Older Adults with Dementia or Delirium Poster provides clinicians with steps / strategies when supporting patients with persistent responsive behaviours due to Delirium or Dementia such as:

- restlessness, fidgeting, jumpiness
- continually trying to get out of bed
- trying to leave ward or hospital
- shouting, swearing, arguing, insulting staff, threatening or trying to hit, kick, bite or scratch
- talking to self, pacing.

It includes pharmacological management guidelines although non-pharmacological interventions are **first line** management. See also Management of Cognitive Impairment and Prevention of Delirium

7.1 Further Resources/links

Understanding Responsive Behaviours and Prevention of Restraints:

- Responsive Behaviours is a term, preferred by persons with dementia, representing how their actions, words and gestures are a response, often intentional, that express something important about their personal, social or physical environment
- A WACHS Understanding Responsive Behaviours and Prevention of Restraints Information Sheet (Appendix 6) covers recognition and assessment; interventions; and alternative strategies to restraint (communication, physical environmental; social and emotional).
- Referrals to Dementia Support Australia on 1800 699 799 24/7 to support staff to problem solve and understand a patient/ resident's responsive behaviours.

Relevant Clinical Practice Standards:

- WACHS Restraint Minimisation Policy

8. Clinical Communication

8.1 Clinical Handover / Documentation

- Be specific to any changes in behaviour or thinking you have observed/encountered in your patients and include strategies that have assisted in delivering positive care.
- Include cognitive scores in written iSoBAR handovers and transfer documents
- Ensure the AMT4 assessment is completed and is within the patient health record upon arrival to ward
- Appropriate care interventions are documented in patient nursing care plan and FRAMP

Information exchange is to adhere to the WA Health MP0095/18 Clinical Handover Policy using the iSoBAR framework.

Failure to accurately and legibly record, and understand what is recorded, in patient health records contribute to a decrease in the quality and safety of patient care. Refer to WACHS Documentation Clinical Practice Standard.

8.2 Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

Inform ward coordinator/ medical team of any acute changes that could indicate signs of Delirium.

8.3 Related Documents / Forms

MR184 WACHS Inter-hospital Clinical Handover Form

8.4 Patient / Carer information

- WACHS Delirium Patient / Family Information Brochure. (For information on printing of this brochure see the Cognitive Impairment intranet site).
- Supported Decision Making: A guide for people living with dementia, family members and carers
- Focus on the Person form

8.5 Discharge Planning

- Assess for services required on discharge
- Liaise with Multi-disciplinary team
- Involve social worker as appropriate
- Involve and inform patient and care partners in discharge plan
- Provide relevant individualised information to patient/ facilities/ services
- Provide patient/family/care partners with the Delirium Patient / Family Information Brochure
- Complete discharge plan in patient health record and follow site specific discharge processes
- Medical Officer to complete discharge summary, including cognitive scores for monitoring or follow up
- Ensure medication safety prompts are in place if required, such as dose administration devices e.g. Webster packs

9. Staff Education / Information / Resources

Clinicians and direct care staff working in relevant clinical areas and Residential Aged Care Facilities at Multi-purpose sites are to be oriented to Cognitive Impairment resources by senior clinical nursing staff from that area. Resources will vary for each WACHS Health Service, and may include:

- Cognitive Impairment Flowchart (Appendix 5) and Management of Cognitive Impairment and Prevention of Delirium
- Delirium Risk + Cognitive Screen AMT4 Sticker (Appendix 3)
- MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium
- Management of Agitation in Older Adults with Dementia or Delirium Poster
- Definitions
- List of Screening and Assessment tools (Appendix 4) MR66 series
- Chart for Dementia, Delirium and Depression (Appendix 1)
- Education Resources link on WACHS Cognitive Impairment Intranet site Includes:
  - WACHS My Learning Quality Dementia Support in Hospitals (QDSH EL2)– Dementia, Delirium and Geriatric Assessments

10. Compliance

All staff are accountable and responsible for the delivery of safe and effective, high quality care and continuously improving the health service.

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

11. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

12. Evaluation

Evaluation, audit and feedback processes are to be in place by all WACHS regions to monitor compliance within this Clinical Practice Standard. The CoBRA Country audit tool includes a number of questions to check for compliance of the screening and assessment procedures within this policy.

13. Relevant Legislation

Accessible via: Government of Western Australia (State Law Publisher or ComLaw)
Carers Recognition Act 2004
Disability Services Act 1993
Guardianship and Administration Act 1990
Health Practitioner Regulation National Law (WA) Act 2010
Mental Health Act 2014
Occupational Safety and Health (OSH) Act, 1984 (Amended 2011)
OSH Regulations, 1996
Public Sector Management Act, 1994
State Records Act 2000
Aged Care Act 1997
WA Health Services Act 2016

14. Relevant Standards

National Safety and Quality Healthcare Standards
- Comprehensive Care Standard - 5.29; 5.30
- Recognising and Responding to Acute Deterioration Standard – 8.5
- Cognitive Impairment Key Actions for Health Service organisations (PDF)

Australian Aged Care Quality Agency Accreditation Standards

- Standard 1 – all requirements
- Standard 2- all requirements
- Standard 3- requirements (a) to (f)
- Standard 4- requirements (a) to (e)
- Standard 5- requirements (a) and (b)

National Standards for Mental Health Services

- Standard 1- 1.1;1.7;1.9
- Standard 2- 2.1; 2.2
- Standard 5- 5.6
- Standard 6- 6.1;6.5
- Standard9- 9.3
- Standard 10- 10.1.2; 10.1.3;

National Standards for Disability Services

- Standard 1- All Indicators
- Standard 2- All indicators
- Standard 3- All indicators
- Standard6- 6.2;

15. Related Strategies

WACHS Strategic Plan 2019-24
ACSQHC Strategic Intent 2020-2025
WA End of Life and Palliative Care Strategy 2018-2028

16. Related Forms

MR00H.1 State Goals of Patient Care
MR111 WACHS Nursing Admission, Screening and Assessment Tool – Adults
MR184 WACHS Inter-hospital Clinical Handover Form
MR521 WACHS Falls Risk Assessment and Management Plan (FRAMP)
MR66. 1-10 series (Cognitive tools)
MR66.11 WACHS Kimberley Indigenous Cognitive Assessment – Remote living
MR66.12 WACHS Kimberley Indigenous Cognitive Assessment - Short Cognitive Screen
MR66.13 WACHS Kimberley Indigenous Cognitive Assessment - Regional - Urban
KMR66.14 WACHS Kimberley Indigenous Cognitive Assessment – Depression Scale
MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium

17. Other Related Policy Documents

WACHS Adults With Impaired Decision Making Capacity Procedure
WACHS Advanced Directive And Enduring Power Of Guardianship –Guideline
WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy
WACHS Documentation Clinical Practice Standard
WACHS Falls Prevention and Management Clinical Practice Standard
WACHS Goals of Patient Care (Adults) Guideline

WACHS Restraint Minimisation Policy

18. Related WA Health System Policies

MP0095/18 Clinical Handover Policy
MP0122/19 Clinical Incident Management Policy 2019
MP0086/18 Recognising and Responding to Acute Deterioration Policy
MP0053/17 WA Clinical Alert (MedAlert) Policy
OD0657/16 WA Health Consent to Treatment Policy
MP0051/17 WA Health Language Services Policy

19. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework
Clinical Services Planning and Programs Policy Framework

20. Acknowledgements

Acknowledgment to:

- Royal Perth Bentley Group, SMHS and WACHS site endorsed work used to compile this Cognitive Impairment Clinical Practice Standard.
- Top End Health, Northern Territory, in reference to their Delirium screening resources and the work and consultation provided
- Prince Charles Hospital, Queensland for permission to adapt their “PITCHED” delirium prevention and management work and in particular Jake (Javier) Reynolds (R/N) who developed and openly shared this concept.

21. References

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WA Country Health Service. What you need to know about delirium. Perth: Western Australian Department of Health; 2011

22. Definitions

Definitions	
Aboriginal	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community. The term Aboriginal is used within this document to represent both.
CI	Cognitive Impairment
Care partner	Care partners provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged.
Cognitive impairment	It is acknowledged that the term cognitive impairment is inclusive of a broader range of genetic, medical and acquired conditions and that it can affect people from any age. For the purpose of this policy cognitive impairment will be used to refer to patients with dementia, delirium and depression.
Dementia	A syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is a disturbance of multiple higher cortical function, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Consciousness is not clouded. There are a number of different types of dementia with the most common being Alzheimer's type dementia.
Delirium	Characterised by a disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days). Types of Delirium • **Hyperactive** – (easily recognized) the patient can be loud resistive, have heightened arousal and can be restless, agitated and aggressive. • **Hypoactive** – (not easily recognized but most common) is often mistaken for depression, patient becomes withdrawn, quiet and sleepy. • **Mixed (hyperactive/hypoactive)** – mixed delirium can be more difficult to recognise as patients present with both hyperactive and hypoactive symptoms with fluctuating levels of activity and lucidity.
Depression	An illness of emotional dysregulation which involves a disturbance of mood, movement and cognition. Cognitive changes associated with depression likely contribute to the disabilities experienced by persons with this disorder. Many individuals with major depressive disorder respond to treatment which can be effective in diminishing the cognitive deficits of depression.
Patient	A person who is receiving care in a health service organisation

23. Appendices

This document can be made available in alternative formats on request for a person with a disability

Contact:	Project Coordinator Aged Care		
Directorate:	Health Programs	**TRIM Record #**	ED-CO-15-91368
Version:	3.01	**Date Published:**	22 September 2023

Appendix 1: Chart for Delirium, Dementia and Depression

Feature	Dementia	Delirium	Depression
Onset	Gradual	Abrupt (hours to days)	Either
Prognosis	Irreversible	Reversible	Variable
Course	Progressive	Fluctuating (Worse in p.m.)	Fluctuating (Worse in a.m.)
Attention	Normal	Impaired	Variable
Memory	Impaired recent and remote	Impaired recent and immediate	Selective impairment
Perception	Normal	Impaired	Normal
Psychomotor Behaviour	Normal/ Loss of Coordination	Very active/ Unusually quiet and still	Retardation/Agitation

Adapted from Resnick B (ed). Restorative Care nursing for older Adults: A Guide for all Care. New York: Springer Publishing Company. 2004

Appendix 2: Cognitive Impairment – Prevention and Management Strategies 'PITCHED'

The pseudonym, PITCHED acts as a prompt to support non-pharmacological interventions and to prevent delirium in patients identified as "at risk" to delirium. Below is a brief description of the pseudonym. Further details can be found in the Management of CI and Prevention of Delirium guidelines

PAIN

- Regular assessment and management of pain
- Use appropriate pain assessment tool (especially if non-verbal)
- Agitated behaviour may indicate pain. Consider trial of prophylactic analgesia

INFECTION

- Monitor for signs and source of infection
- Monitor skin integrity; ensure pressure injury prevention
- Ensure regular oral care
- Avoid use of catheters

THIRST

- Encourage fluids and maintain a fluid balance to ensure adequate intake
- Identify preferred fluids and offer each time you enter their room (if appropriate)
- Avoid caffeine at night

CONSTIPATION

- Monitor bowels and avoid constipation by considering regular aperients
- Promote high fibre diet and identify food types which supports regularity for the patient
- Encourage regular exercise

HUNGER

- Monitor nutrition: ensure meal support as required
- Provide dentures and oral care
- Monitor weight, consider dietitian referral

ENVIRONMENT

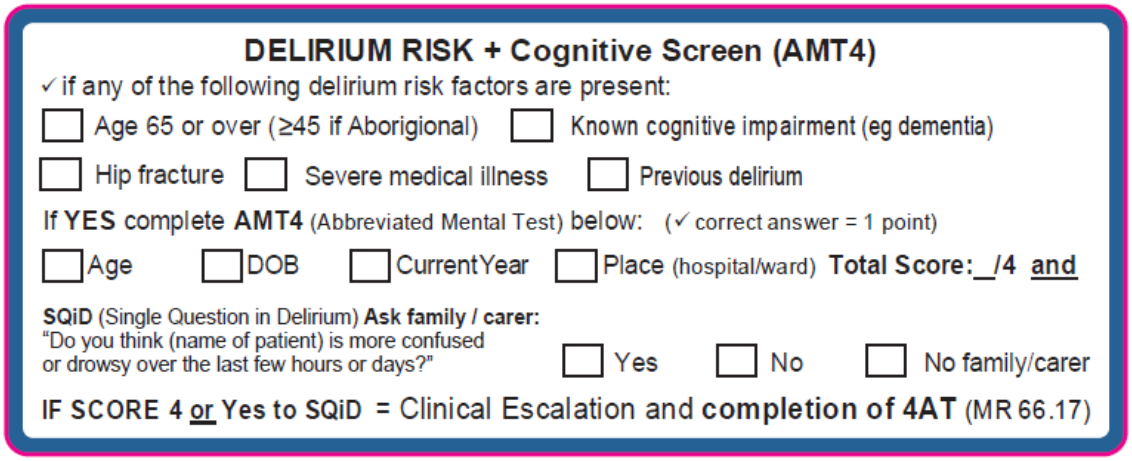
- Maintain normal sleep/wake pattern
- Personalise environment and reduce clutter
- Avoid unnecessary stimuli
- Communication: orientate; speak clearly; short sentences
- Ensure consumer has access to glasses and hearing aids if required

DRUGS

- Regular medication review: Avoid polypharmacy;
- Avoid use of psychotropic and sedative drugs. These medications to be used as a last resort only

Available in poster format for printing here.

Appendix 3: Delirium Risk Screen AMT4 Sticker



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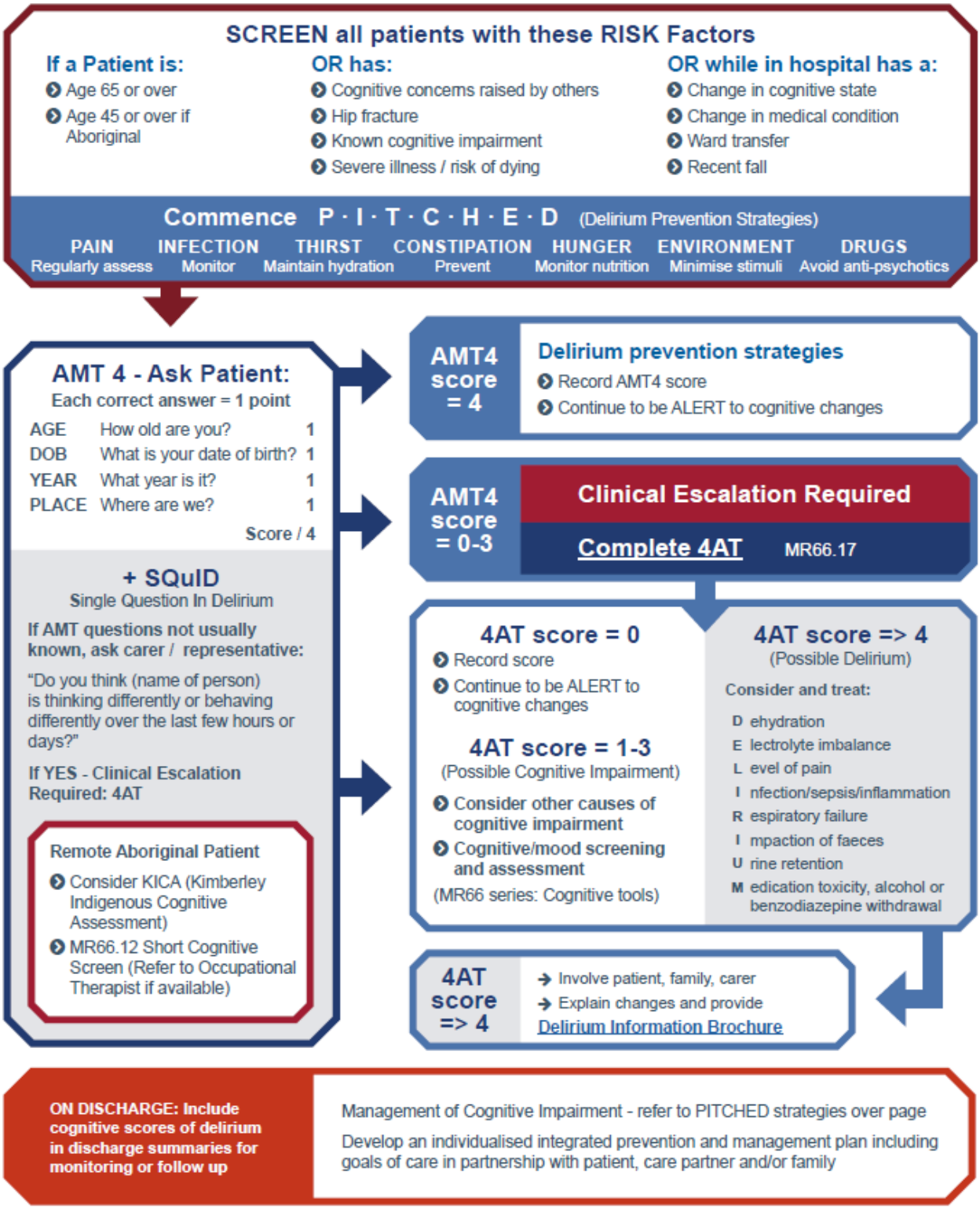
Contact details for ordering

Appendix 4: Cognitive Impairment Screening and Assessment Tools

Cognitive Impairment Screening Tools	
AMT4 – 4-item Abbreviated Mental test Questions asked: 1. How old are you? (Age) 2. What is your date of birth? (DOB) 3. What year is it? (Year) 4. Where are we? (Place) – hospital or ward	AMT4 is a practical screening tool for cognitive impairment for older patients within a busy clinical environment. It provides a brief assessment of cognitive function. Score less than 4 indicate abnormality and the 4AT should be completed. The AMT4 questions can be located in the MR111, and FRAMP. AMT4 stickers are also available.
AMTS - Abbreviated Mentals Test Score	AMTS is more accurate than the AMT4. It includes the AMT4. It is not recommended for people from Culturally and Linguistically Diverse (CALD) or Aboriginal or Torres Strait Islander (ATSI) backgrounds due to cultural issues around the test and an AMT4 will be more appropriate. A score of less than 8/10 suggests cognitive impairment. MR66.4
Delirium Assessment Tools	
4AT- Rapid assessment of delirium and cognitive impairment	The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment and should be completed when AMT4 is less than 4. A score of 4 or more suggests delirium but is not diagnostic: more detailed assessment may be A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history- taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required. MR66.17 WACHS 4A TEST Rapid Assessment Test for Delirium
CAM - Confusion Assessment Method	The CAM is a validated delirium diagnostic tool. It comprises a screen for overall cognitive impairment, and a diagnostic algorithm based on the four features of delirium; 1) acute onset and fluctuating course, 2) inattention, 3) disorganised thinking and 4) altered level of consciousness. A positive diagnosis of delirium is made if the person has feature 1 and 2 plus either 3 or 4.

Cognitive Impairment Assessment tools	
Mini Mental State Examination (MMSE)	The MMSE is a screening test for evaluating cognitive impairment in older adults. It is usually used for assessing dementia. It tests personal information, orientation, short-term memory, attention, naming, visuospatial and language domains. A score of less than 24/30 suggests possible CI. MR66.3
Montreal Cognitive Assessment (MoCA)	The MoCA is a Cognitive assessment tool used to evaluate cognitive abilities, initially validated in the setting of mild cognitive impairment. The MoCA assesses the following cognitive domains; Attention and concentration, executive functions, memory, language, visuo-constructional skills, conceptual thinking, calculations, and orientation. A score less than 26 suggest possible CI. It is available in other languages. MR66.6
Rowland Universal Dementia Assessment Scale (RUDAS)	The RUDAS is designed to enable the translation of the assessment into other languages and to be culturally fair. It is recommended for use with those from culturally and linguistically diverse backgrounds communicating in their first language with the use of an interpreter. A score of 22 or less suggests possible CI. MR66.8
Kimberley Indigenous Cognitive Assessment (KICA)	The KICA is the preferred cognitive screen for older indigenous Australians (Aboriginal and Inter Torres State population), particularly for those living in remote and rural areas, aged 45 and older. A score of 21 or below suggests possible CI. MR66.12 (short screen)
Depression Assessment Tool	
GDS – Geriatric Depression Scale **(15 item version)**	The GDS is used to identify depression in older people in all settings. 5-10 minutes to complete. Scores greater than 5 suggest the presence of depression and warrant follow up. Scores >10 are almost always depression. MR66.1

Appendix 5: Cognitive Impairment Flowchart



Printable poster available: here.