CONTROLLED DOCUMENT

University Hospitals Birmingham NHS
NHS Foundation Trust

Guidelines for the Assessment and Care Of Patients with Known or Suspected Dementia or Delirium

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Contents

1. Introduction

The Royal College of Nursing (RCN 2013) state that currently around a quarter of hospital beds are occupied by someone living with dementia. With the number of people living with dementia in the UK set to rise from 850,000 in 2015 to just under 1.5 million by 2025 (Alzheimer's Society 2014), it is certain that the number of people with dementia within hospitals will similarly increase.

Delirium is the most common complication of hospital admission for older people. People with pre-existing cognitive problems such as dementia are more likely to develop a delirium (Young and Inouye 2007). The prevalence of delirium in people on medical wards in hospital is about 20% to 30%, and 10% to 50% of people having surgery develop delirium. Reporting of delirium is poor in the UK, indicating poor awareness and reporting procedure (NICE 2010).

Delirium was previously thought to have a benign prognosis but in recent years it has been shown to be associated with poor outcomes. In-hospital mortality ranges from 22-76% depending on the study setting and mortality at one year ranges from 35-40% (Yang et al 2009). It is also associated with an increased length of hospital stay (Siddiqi et al 2006) and cognitive decline (MacLullich et al 2009).

In recent years there have been a number of documents published including the National Institute for Health and Clinical Excellence (NICE) Guidance on both Dementia and Delirium (2006 and 2010), RCN Dementia: Commitment to the Care of People with Dementia in Hospital Settings (2013) and Department of Health Making a Difference in Dementia: Nursing Vision & Strategy (2013), all of which provide guidance and frameworks for the delivery of quality care for patients with delirium or dementia. Within the Department of Health's Living Well with Dementia: A National Dementia Strategy (2009), three key areas are identified; improved outcomes, earlier diagnosis and intervention and higher quality of care. It states that effective intervention and support from diagnosis through the course of their illness can enable the individual to live well with their condition.

The following guidelines are to assist staff within the Trust to deliver safe and appropriate care and support for the patient with a known or suspected dementia and/or delirium.

2. Definitions

2.1 Dementia

Dementia may be caused by a number of conditions which affect the brain in which there is progressive decline in multiple areas of function, including memory, reasoning, communication skills and the skills needed to carry out daily activities (Department of Health 2009, RCN 2013). Alongside this decline, the person with dementia may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering (Department of Health 2009). The sub-groups of dementia are:

- Alzheimer's
- Vascular
- Lewy Body Dementia
- Parkinson's Disease with Dementia
- Reversible Dementias (e.g. caused by drugs, metabolic disturbance, subdural haemorrhage, normal pressure hydrocephalus)
- Mixed aetiology (in particular Alzheimer's and Vascular)

According to the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5) criteria, dementia is characterised by:

- Memory impairment and at least one of the following: aphasia (partial or total inability to produce and understand speech as a result of brain damage caused by injury or disease), apraxia (loss of the ability to perform activities that a person is physically able and willing to do), agnosia (loss of ability to recognise objects, persons, sounds, shapes, or smells while the specific sense is not defective nor is there any significant memory loss), or disturbances in executive functioning.
- Cognitive impairments severe enough to cause impairment in social and occupational functioning.
- Decline representing deterioration from a previously higher level of functioning.

2.2 Delirium

NICE (2010) define delirium as a clinical syndrome characterised by disturbed consciousness, cognitive function or perception; which has an acute onset and fluctuating course. According to the DSM-5 criteria, delirium is characterised by:

- Disturbance of consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain and shift attention.
- Change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a pre-existing or evolving dementia.
- The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
- There is evidence from history, physical examination, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition, substance intoxication or substance withdrawal.

Delirium can be further defined as:

- **Hypoactive:** when the person becomes withdrawn, quiet and/or sleepy
- **Hyperactive:** when the person has heightened arousal, is restless, agitated and aggressive

2.2.1 Prevention of Delirium

Prevention of delirium centres on being able to:

- Identify those patients at risk of developing delirium:-
  - Age > 65
  - Severe illness
  - Dementia
  - Current hip fracture
  - Alcohol Excess
  - Polypharmacy
  - Physical frailty
  - Visual impairment
- Identify the risk factors which put them at increased risk:-
  - Cognitive impairment or disorientation
  - Dehydration or constipation
  - Hypoxia
  - Immobility or limited mobility
  - Infection
  - Multiple medications
  - Pain
  - Poor nutrition
  - Sensory impairment
  - Sleep disturbance
- Correct those risk factors (refer to NICE Guidelines 2010)
- Involve the multidisciplinary team.

2.3 Differential Diagnosis

Table 1 illustrates the differential diagnosis for Delirium and Dementia

FEATURE	DEMENTIA	DELIRIUM
Onset	Chronic, generally insidious, depends on cause	Acute/sub-acute depends on cause, often twilight
Course	Long, no diurnal effects, symptoms progressive yet relatively stable over time	Short, diurnal fluctuations in symptoms; worse at night in the dark and on awakening
Progression	Slow	Abrupt
Duration	Months to years	Hours to less than one month, seldom longer
Awareness	Clear	Reduced
Alertness	Generally normal	Fluctuates; lethargic or hyper-vigilant
Attention	Generally normal	Impaired, fluctuates
Orientation	May be impaired	Fluctuates in severity, generally impaired
FEATURE	**DEMENTIA**	**DELIRIUM**
Memory	Recent and remote impaired	Recent and immediate impaired
Thinking	Difficulty with abstraction, thoughts	Disorganised, distorted,

	impoverished, makes poor judgement, words difficult to find	fragmented, slow or accelerated incoherent
Perception	Misperceptions often absent	Distorted; illusions, delusions and hallucinations, difficulty distinguishing between reality and misperceptions

Table 1: Differential diagnosis: distinguishing between Delirium and Dementia

3. Assessment and Diagnosis

The prompt assessment and diagnosis of both dementia and delirium is important in ensuring the delivery of safe and appropriate care and support for the patient with a known or suspected dementia or delirium.

For patients with dementia it is not uncommon for them to never receive a formal diagnosis or to be diagnosed late following the onset of the condition. A diagnosis will facilitate more appropriate medical and nursing care for the patient while they are in hospital, and in addition may help to relieve carer stress and burden, prevent delirium and reduce associated complications. Obtaining an accurate and full history is the most important part of assessment of the person with dementia and should be taken both from the patient and an informant. Particular attention should be paid to the onset, speed of progression, symptoms, drug and alcohol history. Other aspects to include are:

- Ability to retain new information
- Short and long term memory
- Ability to manage complex tasks (e.g. cook a meal, plan a route)
- Language (word-finding difficulty, conversation, change in vocabulary)
- Behavioural / personality changes (aggression, irritability)
- Sleep disturbance
- Disorientation (getting lost in familiar places)
- Recognition of family
- Ability to perform Activities of Daily Living (e.g. grooming, bathing, feeding)

The diagnosis of dementia should **NOT** be made if the cognitive deficits occur exclusively during the course of a delirium.

Delirium is a common and serious condition often poorly recognised in hospitals but which could be prevented in up to a third of cases (Fong et al 2009). Prompt diagnosis of delirium and of those at risk of developing delirium is essential in order to avoid or lessen its effects. Delirium is a clinical diagnosis ideally made against criteria in the DSM-5. Although it can occur in any hospitalised patient those at greater risk (refer to 2.2.1) should be routinely screened for delirium.

3.1 Screening Tools

In addition to capturing a patient's history the use of a screening tool assists in obtaining an objective evaluation. They also form a benchmark for future assessments. The screening tools available include:

- **Abbreviated Mental Tests (AMT) for Dementia**
  - **AMT 10**

    In accordance with the Dementia CQUIN (NHS England 2015) all patients aged 75 years and over must be screened using the AMT10 accessible on the Prescribing and Information Communication System (PICS) within 72 hours of admission. A score of <7 indicates possible dementia and will automatically prompt a statement to be included on the patient's discharge letter which advises the General Practitioner (GP) to consider referral for further assessment.
  - **AMT 4**

    The four item AMT has recently been found to be as effective as the 10 point AMT screening for cognitive impairment (Schofield et al 2010). A score of three or less would indicate the possible presence of cognitive impairment and could lead to a referral for further assessment. However use of the AMT 4 should be mainly restricted to within the Emergency Department setting due to time constraints.

- **4AT for Delirium**

  The 4AT is a test incorporating the AMT 4 which is used to identify delirium. It was designed to be used at first contact with the patient, and at other times when delirium is suspected and is illustrated in Table 2.

Alertness	AMT 4	Attention	Acute changes
Observe (wake gently if asleep) Ask name and address	Age / DOB Place / Year	Ask the months of the year backwards. One prompt permitted	Evidence of significant change/fluctuation in alertness, cognition or other mental function
Normal-fully alert, not agitated 0 Mild sleepiness for <10 seconds after waking 0 Clearly abnormal 4	No mistakes 0 1 mistake 1 >2 mistakes 2	>7 correct 0 <7 months or refuses to start 1 Un-testable/drowsy or too unwell 2	No 0 Yes 4

Table 2: 4AT Screening Instrument for cognitive impairment and delirium

The scoring used in the test is:

- >4 indicates possible delirium and/or cognitive impairment
- 1-3 indicates possible cognitive impairment
- 0 indicates that delirium or cognitive impairment is unlikely

If a person scores 1-3 and there is no previous history of a diagnosis they must be investigated further to determine if they have dementia. If a person scores >4 their delirium must be managed and the diagnosis of dementia considered once the delirium has settled.

- **Cognitive Testing and Assessment**

The patient dependant on their score against the appropriate test must be considered for further testing alongside the obtaining of a collateral history from family or friends. This includes patients who:

- score <7 on the AMT 10
- score >1 on the 4AT
- score <4 on the AMT4

Further assessment should be conducted using the Geriatric Depression Scale (GDS) and the Montreal Cognitive Assessment (MOCA) or the Mini Mental State Examination (MMSE):

- **GDS** is a screening test used to detect and monitor depression in the elderly. Assessment using the GDS will help exclude a diagnosis of depression. The test is conducted orally with the patient in reference to how they have felt over the preceding week. (Table 3)

1.	Are you basically satisfied with your life?	Yes	**No**
2.	Have you dropped many of your activities and interests?	**Yes**	No
3.	Do you feel that your life is empty?	**Yes**	No
4.	Do you often get bored?	**Yes**	No
5.	Are you in good spirits most of the time?	Yes	**No**
6.	Are you afraid that something bad is going to happen to you?	**Yes**	No
7.	Do you feel happy most of the time?	Yes	**No**
8.	Do you often feel helpless?	**Yes**	No
9.	Do you prefer to stay at home rather than going out and doing new things?	**Yes**	No
10.	Do you think it is wonderful to be alive now?	Yes	**No**
11.	Do you feel you have more problems with your memory than most?	**Yes**	No
12.	Do you feel pretty worthless the way you are now?	**Yes**	No
13.	Do you feel full of energy?	Yes	**No**
14.	Do you feel that your situation is hopeless?	**Yes**	No
15.	Do you think that most people are better off than you are?	**Yes**	No
Scoring: 0-4 No depression, 5-10 Mild depression, 11+ Severe depression			

Table 3: Geriatric Depression Scale

The responses in bold as displayed in table 3 are those which are added together to obtain a score which is then used to denote the extent of the depression if present.

- **MOCA:** A 30 point test which assesses cognitive function over several domains (short term recall, visuo-spatial, executive function, language, attention, concentration and working memory) (Appendix 1)
- **MMSE:** A copyrighted 30 point test of cognitive function which can be conducted at the bedside

For further guidance on the use of the screening tools refer to Appendix 2.

3.2 Investigations

3.2.1 Dementia

NICE (2006) recommend that a basic dementia screen should be performed at the time of presentation. It should include:

- Routine haematology
- Biochemistry tests (electrolytes, calcium, glucose, and renal and liver function)
- Thyroid function tests
- Serum vitamin B12 and folate levels.

A midstream urine test should always be carried out if delirium is a possibility.

Clinical presentation should determine whether investigations such as chest x-ray or electrocardiogram (ECG) are needed.

Do not routinely:

- test for syphilis serology or HIV unless there are risk factors or the clinical picture dictates
- examine cerebrospinal fluid.

3.2.2 Delirium

Given the vast differential of delirium, investigations should be guided by history and physical examination findings. In the absence of these, a preliminary work-up in all patients without definitive historical or physical findings should include the investigations as illustrated in Table 5.

Investigations	Information and rationale for investigation
FBC	To rule out infection or anaemia.
Chemistry panel	To rule out metabolic disturbances, hepatic encephalopathy
Urinalysis	To rule out infection
CXR	To rule out pneumonia, congestive heart failure, or other potential causes of hypoxia
Drug levels	For patients on digoxin, lithium, and quinidine, and alcohol if a history of alcohol abuse is suspected.
ECG	To rule out myocardial infarction. A coronary angiogram may also be performed
Arterial blood gas	To evaluate for hypoxia, hypercarbia, and/or lactate (the latter commonly found in sepsis)
If no aetiology is identified from preliminary testing, further diagnostics should be considered including:	
Neurological imaging	CT and/or MRI
Lumbar puncture	To rule out meningitis and encephalitis
EEG	To rule out seizure activity and encephalopathy

Table 5: Delirium investigations and reasons for (NICE 2010)

Further investigations that may be considered depending on suspected cause include: sputum and blood culture, abdominal ultrasound scan, D-dimer, thyroid function tests, ACTH stimulation test, Venereal Disease Research Laboratory (VDRL) test, and fluorescent treponema antibody test-absorption (FTA-abs).

4 Care of the Patient

For the patient with dementia or delirium the hospital setting can be confusing, challenging and overwhelming (RCN 2013). Wellbeing for the patient can be influenced by a number of factors including neurological impairment, physical health, individual biography, personality and physical and social environment (RCN 2013).

"Cracks in the Pathway", a publication by the Care Quality Commission (CQC 2014) detailing people's experiences of dementia care, concludes that those gathered demonstrated that quality of care for people living with dementia varies greatly. A patient centred care approach delivered by knowledgeable and skilled staff has a significant and positive impact on wellbeing and quality of life, enabling the patient and their families to be treated with respect, dignity and compassion (CQC 2014).

It is generally agreed that the principles of person centred care underpin good practice and are reflected in many of the recommendations made for the care of the patient with a delirium or dementia (NICE 2006). The principles assert:

- the human value of the patient, regardless of age or cognitive impairment, and those who care for them
- the individuality of the patient, with their unique personality and life experiences among the influences on their response to their condition
- the importance of the perspective of the patient
- the importance of relationships and interactions with others to the patient, and their potential for promoting well-being.

Treatment and care must take into account the patient's needs and preferences. Good communication between the healthcare professional and the patient in their care is essential and should be supported by evidence-based written information tailored to the patient's needs (NICE 2010).

Refer to Appendix 3: Management of Patients with Delirium and Appendix 4: Management of Patients with known or suspected Dementia.

4.1 See Me Care Bundle

The Trust has adopted the **See Me Care Bundle** (UHB 2013) as its approach to ensure that all elements of care are in place for patients with dementia and delirium. The See Me Care Bundle incorporates:

- **All About Me**
  The All About Me document can be completed by anyone but it is preferable by someone who knows the patient best. This may be the patient themselves if able or their family / carers. It allows for information to be recorded about the patient which in turn will assist the clinical staff to provide patient centred care. If the patient requires specialling the nursing staff specialling the patient must

complete the document detailing the activities and care provided for the patient. For further information on specialling refer to Trust Controlled document Number 823: Procedure for the care of the patient at increased risk requiring 1-1 care (Specialling) (current version) and see section 4.4.

- **Talk and Listen to Me**
  - 'Make every Encounter Count' - utilise each interaction with the patient to say 'Hello, My name is…….' or remind them who you are and explain why you are there.
  - Always address the patient using their preferred name
  - Ensure Person Centred Compassionate Communication:
    - Respond to how the patient is feeling and say "Lets…."
    - Avoid confrontation and do not argue or confront people with their mistakes (Sheard 2013)
  - Use the Trust's Communication Box to assist and support communication with the patient as necessary. The Hospital Communication Book, part 1 and part 2 is available on the Trust's intranet.
  - Hourly Care Rounds:
    - allow us to be proactive in offering timely essential care
    - particularly important for patients who cannot summon help and do not know where they are
    - important to communicate at least hourly as well as responding to any distress immediately

- **Enable Me to Eat and Drink**
  - Give appropriate support in a social setting. Where possible, encourage patients to eat at the table with other patients to encourage conversation and social stimulation.
  - If eating at the bedside ensure someone is at hand to support or encourage.
  - Welcome the patient's relative(s) or carers to assist at mealtimes.

- **Help me to be Safe & Mobile and Free From harm**
  People with dementia are at particular risk of falls and injury.
  - Ensure all necessary risk assessments are completed and acted upon
  - Encourage activities. Access the patient's **All About Me** to learn about their interests. The Trust has a number of resources including an activities coordinator, volunteers and a large collection of books, DVDs, games, and crafts which may be accessed if required. **Have You Tried** (http://uhbhome/have-you-tried.htm) is a resource available on the Trust's intranet.
  - Ensure the patient has appropriate footwear and if appropriate, their individually labelled walking aid.
  - Maintain the patient's privacy and dignity.

- **Stay with Me: End of Life care**
  - Discussion around supportive care, preferred place of care and particular requests about care and treatment must be undertaken early in the disease process
  - Provide essential care to the patient, including mouth care.
  - Review the patient's medication and prescribe anticipatory drugs.
  - Support family / carers.
  - Offer bereavement pack to family / carers.

4.2 Consent and Capacity

Where possible the patient's consent for any treatment and/or care they require must be obtained and this must be documented in the patient's records. For further information regarding consent and mental capacity please refer to the following documents:

- Department of Health Reference Guide to Consent for Examination or Treatment (2009).
- The Trust's Policy and Procedural document for consent to examination or treatment (current version).
- *Mental Capacity Act (2005).*

If the patient refuses any treatment / care consider whether:

- The patient has capacity to make the decision
- The patient has an advance decision to refuse treatment
- The treatment is necessary and there is not a less restrictive option available
- There is an alternative treatment / care option available
- If medication, is there another route for administration or another suitable medication which the patient would consent to.

If the patient refuses treatment / care follow the Trust's 'What to do if a patient refuses care or treatment' flowchart (Appendix 5).

If the patient lacks capacity, has no advance directive and it is determined they require the treatment / care; a best interest's decision must be made involving next of kin or an Independent Mental Capacity Advocate (IMCA).

4.3 Medications for Alzheimer's disease

There are currently no drug treatments available that can cure Alzheimer's disease or any other common type of dementia. However, medicines have been developed for Alzheimer's disease that can temporarily alleviate symptoms, or slow down their progression, in some people.

If medications are considered as part of the patient's treatment, the patient must first be reviewed by a specialist consultant and if determined their use is warranted NICE guidance recommends:

- Donepezil, Galantamine and Rivastigmine for mild and moderate Alzheimer's disease
- Memantine for moderate Alzheimer's disease for patients who cannot take acetylcholinesterase inhibitors (AChE) inhibitors; and for managing severe Alzheimer's disease

It is imperative to remember that non-drug treatments, activities and support are as important in helping the patient to live well with Alzheimer's disease as medication.

4.4 Person Centred Care for Patients who become agitated and confused, resulting in behaviours that may be seen as challenging.

The primary purpose is not to control the behaviour but to modify the processes leading to that behaviour.

- Treat underlying illness
- Modify environment
- Manage behaviour
- Occasionally medication may reduce distress and may allow further assessment.

4.4.1 Assessment and Care

- **Why is My Patient Shouting/ Distressed?**
  - Ask yourself the question whether you would be shouting/distressed if you were in the same situation
  - Deliver appropriate and safe care to the patient and their carers by using the See Me Care Bundle approach.
  - Use Antecedent, Behaviour and Consequence behaviour (ABC) chart to understand behaviour and establish aggravating and relieving factors
  - Listen and respond to what the patient is actually saying or experiencing:
    - I can't get to the toilet
    - I'm in pain
    - I'm trapped (in bed by bed rail or I'm in a chair that I can't get out of)
    - I can't move
    - I'm frightened or lonely
    - I'm shut away in a side room
    - I'm receiving minimal sensory stimulation
    - People are treating me in a rough manner
    - No-one takes any notice of me
    - I'm angry
    - I'm hungry or thirsty
    - I don't know where I am or what has happened to me**.**
- **What about medical conditions?**
  - Observe the patient , get evidence from case notes and PICS
  - Obtain corroborative history from family, GP, carers

- Think about:
  - Existing cognitive impairment or mental illness
  - Infection
  - Drug side effects and withdrawal
  - Alcohol intake
  - Full bladder – do they have retention of urine?
  - Dehydration
  - Constipation
  - Metabolic causes
  - Primary neurological causes: acute or chronic head injury
  - Don't forget rarer problems e.g. acute glaucoma, painless myocardial infarction

- **What about the environment?**

  Provide
  - Optimal lighting
  - Orientation
  - Familiar objects
  - Familiar routines

  Consider
  - Enrolling the help of the family
  - Engage in Activities (Distraction)
  - Be aware that allowing the patient a degree of wandering may be less harmful than constantly trying to restrict their mobility.

- **What about communication?**
  - Communicate face to face - be quiet and reassuring
  - Be empathetic and non-confrontational
  - Use non-threatening body language.

4.5 Make Specialling Special

Make specialling special (MSS) involves ensuring therapeutic interventions are provided for the patient who requires enhanced observation due to concerns about the patient's risk of hurting them self or others.

Each clinical area within the Trust has a MSS activity box which should be used to support patient care when the patient requires enhanced observation. In use with other resources such as the 'All About Me' document, it supports the carer to engage their patient in a therapeutic activity.

For patients requiring one to one care refer to Trust Controlled document Number 823: Procedure for the care of the patient at increased risk requiring 1-1 care (Specialling) (current version).

4.6 Pharmacological Management of Behavioural and Psychological Symptoms

Pharmacological measures in the management of the patient's dementia or delirium MUST NOT be considered unless the patient's behaviour has been assessed as being dangerous to themselves or others and if non-pharmacological interventions have been tried and failed to be effective.

The effectiveness of pharmacological interventions is doubtful and can be counterproductive, and therefore this should be used as the last resort following examination and assessment of the patient. It is important that the patient's existing medication be reviewed, including any antipsychotics which where possible should be reduced. Some medications are implicated in contributing to a patient's confusion.
Examples of medications which are commonly implicated are included in Table 6.

Anti-cholinergics	Alcohol (and withdrawal)
Anti-histamines	Sedatives e.g. Benzodiazepines (and withdrawal)
Antidepressants	Cardiac drugs (e.g. digoxin)
Analgesics (opiates, tramadol)	Respiratory drugs (e.g. aminophylline)
Anti-convulsants	Steroids
Antipsychotics	

Table 6: Medications commonly implicated in worsening cognitive impairment

The Banerjee report commissioned by the Department of Health in 2009 called for urgent action to reduce the inappropriate use of antipsychotic drugs in dementia. This was followed in 2011 by The Right Prescription: A Call to Action Reducing the inappropriate use of antipsychotic drugs for people with dementia.

Anti-psychotic and sedative medication has serious side-effects, which may actually increase the patient's risk of falling and may worsen agitation and disorientation and for people with dementia include increased risk of stroke and premature death.

If required, dosage of the medication should start low and increase slowly, with the dose titrated against response. The emphasis should be on regular rather than PRN medication. Table 7 illustrates some of the medications which may be considered.

Drug	Dose	Route	Indications	Cautions
Haloperidol	0.5-1mg PRN to a maximum of 10mg in 24 hours. Give in 0.5mg aliquots up to	Oral IM	Agitation/ aggression when patient is at risk of harming self or staff	Avoid in patients with cardiovascular disease, cerebrovascular disease, Parkinson's Disease or Lewy Body Dementia

	10mg.			Risk of over sedation.
Lorazepam	0.5 – 1mg PRN	Oral IM or IV	2nd line for short term management of agitation e.g. if urgent scans needed	Can cause or worsen respiratory depression
Midazolam	(if Lorazepam unavailable) 1.25 – 5mg	Oral or IV	Same as other benzodiazepines	very quick-acting but short-lived
Quetiepine	25mg PRN / BD	Ora;	Is an alternative to haloperidol in patients with LBD / Parkinson's.	Use cautiously in patients with cardiovascular disease
Risperidone	0.5mg PRN Maximum of 1mg in 24 hours.	Oral	Should be used with specialist guidance for certain patients with psychosis, short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological interventions and when there is a risk of harm to self or others	Dementia with Lewy bodies

Table 7: Medications used in the pharmacological management of delirium and dementia

In addition to those medications listed in table 7:

- Neuroleptics mustbe used with caution and avoided in patients with Lewy Body Dementia (LBD), Parkinson's disease and Head Injury. Ensure Procyclidine is readily available in case of extra-pyramidal side-effects.
- Benzodiazepines, although particularly useful for patients in alcohol withdrawal, must be used with caution as they can cause profound sedation and respiratory depression.

For further information in relation to safe and correct medicines management refer to the Trust's Medicines Code (current versions).

5 Supporting the Family / Relatives / Carers

The patient's family / relatives /carers are an essential and integral part of the care, health and wellbeing of a patient. (Refer to Trust Principles for Carers, current version).

The Dementia Action Alliance 'Carers Call To Action' (2013) supports the needs of and rights for family carers of people with dementia through their shared vision.

Carers of people with dementia:

- Should have recognition of the unique experience of caring for someone with dementia
- are recognised as essential partners in care - valuing their knowledge and the support they provide to enable the person with dementia to live well
- have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the person with dementia
- have assessments and support to identify the on-going and changing needs to maintain their own health and well-being
- have confidence that they are able to access good quality care, support and respite services that are flexible, culturally appropriate, timely and provided by skilled staff for both the carer and the person for whom they care

The patient's family, relatives or carer should be offered an assessment of their emotional, psychological and social needs and receive interventions to meet these needs.

6 Discharge

The National Dementia Strategy has 4 key objectives relevant to hospital discharge support:

- Good quality information for those with diagnosed dementia and their carers
- Implementing the Carers Strategy
- Improved quality of care for people with dementia in hospitals
- Improved intermediate care for people with dementia

Where possible it is good practice to return people living with dementia back to their home as soon as possible, as familiar surroundings and routines are important.

Some people with dementia may not be able to make a decision about where they go on discharge from hospital because they lack the capacity to decide about the best place for them to live. If this is the case, someone else will need to decide for them.
See complex discharge http://uhbpolicies/assets/DischargeProcedure.pdf

When a patient with dementia or delirium is to be discharged from the Trust then the following must be undertaken:

- Record diagnosis on KMR1 if confirmed by psychiatrist or geriatrician
- If antipsychotics have been commenced during the patient's hospital admission there must be a clear documented plan for review and follow up in the discharge letter
- Document any psychiatry reviews and plans for follow-up on discharge letter
- Document significant conversations / information on where to obtain information / support.

Careful consideration needs to be given re ongoing support once home.

- If ongoing symptoms or if dementia diagnosis not confirmed during admission, then inform GP regarding referral to the Memory Service if appropriate
- In relation to the use of medication.
    - Any new medication started must be in the GP letter, giving the indication for starting it and the need for review.
    - Consider if blister packs or supervision of medication required?

7 National Dementia Training Mandate

The Dementia Training Mandate is to provide the minimum of dementia awareness training for **all** NHS staff who look after patients with dementia. The level of recommended training is divided into 3 tiers:

- Tier 1 – awareness raising, in terms of knowledge, skills and attitudes of all those working in health care;
- Tier 2 – developing knowledge, skills and attitudes of roles that have regular contact with people living with dementia;
- Tier 3 – enhancing the knowledge, skills and attitudes of key staff (experts) working with people living with dementia designed to support them to play leadership roles.

Refer to the Trust Training and Development intranet page for details on available courses.

8 Monitoring of the Guidelines

The Lead Nurse Older Adult will lead the review of the guidelines. The review will be undertaken in accordance with the review date and may include examination of:

- Any untoward incidents or complaints
- Data in relation to staff training
- Patient Experience Feedback
- National Dementia Audit Data

All audits must be logged with the Risk and Compliance Unit.

9 References and Bibliography

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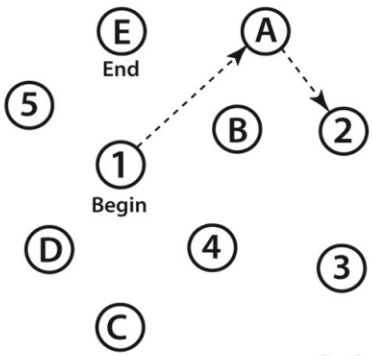
MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

NAME :
Education : **Date of birth :**
Sex : **DATE :**

VISUOSPATIAL / EXECUTIVE



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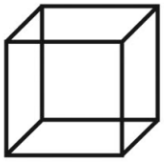


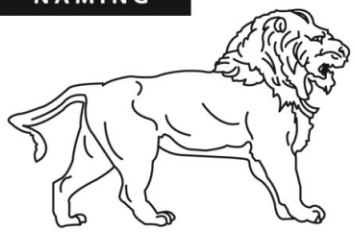
[ ] [ ]

Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS ___/5

NAMING



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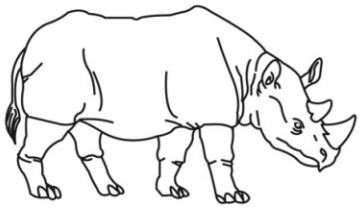

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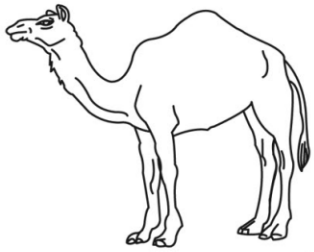

[ ]

___/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION Read list of digits (1 digit/ sec.).
Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2
___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B
___/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**
___/3

LANGUAGE Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ]
___/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)
___/1

ABSTRACTION Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler
___/2

DELAYED RECALL

	FACE	VELVET	CHURCH	DAISY	RED	
Has to recall words **WITH NO CUE**	[ ]	[ ]	[ ]	[ ]	[ ]	Points for UNCUED recall only
Optional Category cue						
Optional Multiple choice cue						

___/5

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City
___/6

© Z.Nasreddine MD **www.mocatest.org** Normal ≥ 26 / 30

TOTAL ___/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

Appendix 2: Screening Tools Summary

Screening Tool:	Screen for:	Information:	Scoring:	Actions:
4AT	Delirium	Used at first contact with the patient	>4 indicates possible and/or cognitive impairment. 1-3 possible cognitive impairment. 0 unlikely to have cognitive impairment	Manage and consider diagnosis of dementia once delirium settles If the patient scores >1 triggers the need for more detailed cognitive testing.
AMT 4	Dementia		Score of three or less would indicate the possible presence of cognitive impairment.	<4 on the AMT4 will need further assessment using GDS
AMT 10	Dementia		<7 indicates possible Dementia	Further testing alongside the obtaining of a collateral history from family or friends If >1 patient will need further assessment.
MMSE (copyrighted)	Dementia	A 30 point test of cognitive function which can be conducted at the bedside	>/=27 is normal 20-26 is mild 10-20 is moderate <10 is severe	Refer to specialist
MOCA	Dementia	A 30 point test which assesses cognitive function over several domains (short term recall, visuo-spatial, executive function, language, attention, concentration and working memory)	>/=26 is normal	Refer to specialist if score less than 26
GDS	Depression	With MMSE or MOCA detects and monitors depression in the elderly. A 15 item questionnaire	0-4 normal 5-9 Mild depression 10-15 Severe depression	Refer to specialist

Appendix 3: Management of Patients with Delirium Summary

Does your patient show signs of delirium?

- Disturbance of consciousness (alertness and/or sleepiness)
- Change in cognition/attention over short period of time (hours to days)
- Fluctuating course
- Increased confusion at night

THINK DELIRIUM

Is your patient at high risk of delirium?

Age > 65	Alcohol Excess
Severe illness	Polypharmacy
Current hip fracture	Dementia
Visual impairment	Physical frailty

THINK DELIRIUM

Delirium – Medical Causes

- Infection (Pneumonia, UTI)
- Drugs (especially anticholingergics)
- Drug or alcohol withdrawal
- Cardiological (MI, CCF)
- Respiratory (Hypoxia, PE)
- Urinary retention (check bladder)
- Neurological (Stroke, subdural haemorrhage, post-ictal state)
- Faecal impaction
- Electrolyte imbalance
- Pain
- Endocrine (thyroid dysfunction, thiamine deficiency)

Management of Delirium
Non-Pharmacological Measures

- Review and rationalise medication
- Ensure analgesia adequate
- Avoid sedation
- Avoid constipation
- Avoid catheters
- Ensure sensory aids in place
- Use communication book/box
- Ensure person centred care (Use 'All About Me')
- Use ABC chart to understand behaviour
- Ensure natural light
- Re-orientate the patient (clocks, photos)
- Eliminate distracting noise
- Encourage familiar faces/routines
- Consider 1:1 nursing (see MSS guidelines)
- Consider relaxation techniques (hand massage)
- Avoid restraint/confrontation
- Avoid ward transfers
- Ensure good sleep routine
- Optimise nutrition and hydration
- Involve relatives and carers
- Encourage mobility, allow supervised wandering
- Refer to activities coordinator
- Promote good sleep routine
- See Patients who refuse care and treatment flowchart

4AT: Screening Instrument for cognitive impairment and delirium

Alertness	AMT 4	Attention	Acute changes
Observe (wake gently if asleep) Ask name and address	Age / DOB Place / Year	Ask the months of the year backwards. One prompt permitted	Evidence of significant change/fluctuation in alertness, cognition or other mental function
Normal-fully alert, not agitated 0 Mild sleepiness for <10 seconds after waking 0 Clearly abnormal 4	No mistakes 0 1 mistake 1 >2 mistakes 2	>7 correct 0 <7 months or refuses to start 1 Un-testable/drowsy or too unwell 2	No 0 Yes 4

>4 : possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or cognitive impairment unlikely, but delirium still possible if information incomplete

MONITOR DAILY If not improving seek expert medical advice
Record symptoms and AMTS/MMSE

Appendix 4: Management of Patients with known or suspected Dementia

All patients aged >75 who screen +ve to the screening question asked within 72 hours of admission "*Have you (your relative) been more forgetful over the past 12 months to the extent that it has significantly affected daily life?"*

Known dementia

Assessment

AMT 10

<7

Possible delirium / dementia

>7

Delirium / dementia unlikely

Collateral History

Delirium is more likely if this is an acute change from normal and if conscious level is fluctuating. Dementia is likely if changes have been more gradual. Confirm the patient's baseline. Consider using IQCODE (see full guidelines). The two often co-exist.

Investigations

FBC, U+E, LFT, TFT, Ca, Vit B12, Folate
Consider CT head, LP / syphilis serology if not known to have dementia

Bedside cognitive tests

MOCA / MMSE
+-GDS (Geriatric Depression Scale)

Monitor for co-existing or emerging delirium and correct underlying contributing factors –

- Infection
- Electrolyte disturbance
- Drugs
- Drug / alcohol withdrawal
- Pain
- Sensory deprivation
- Constipation
- Dehydration
- Hypoxia
- Sleep disturbance
- Change of environment
- Restraint (including bed rails)
- Reduced mobility

Review needs of patient

Medication review and ensure PRN analgesia + laxative
Offer information (verbal + written)
MDT assessment
Social worker if indicated
Referral to Dignity Team
Referral via PICS to Rapid Assessment, Interface and Discharge (RAID) Team for psychiatric assessment or advice

Review needs of carer

Offer information (verbal +written) and support
Consider offering respite care

Alzheimer's Society

Information and support for carers, patients and professionals. Useful range of factsheets on website.
0121 442 65565 / 0845 300 0336 www.alzheimer's.org.uk 149-153 Alcester Road, Moseley, B13 8JP

Challenges you may encounter

On Discharge

- Record diagnosis on KMR1 if confirmed by psychiatrist or geriatrician.
- If antipsychotics were started in hospital, document plans to review ongoing need.
- Document any psychiatry reviews and plans for follow-up on discharge letter.
- Document significant conversations / information on where to obtain information / support .

Challenges you may encounter

Patient agitation / aggression / Behavioural and Psychological Symptoms of Dementia (BPSD)

- Ask yourself what the person is trying to communicate (pain, hunger, thirst)
- Ask relatives to help interpret behaviour
- Aid communication with communication book and communication box (on all wards)
- Use the ABC chart to help establish aggravating and relieving factors
- Consider referral to Dignity Team
- Consider referral via PICS to Rapid Assessment, Interface and Discharge (RAID) Team for psychiatric assessment or advice.
- Obtain letters from old age psychiatry if already known to the service

What to do if a patient is refusing care or treatment

Queen Elizabeth Hospital Birmingham NHS
Part of University Hospitals Birmingham NHS Foundation Trust

Further information is available in the Trust Violence and Aggression and Management of Agitation and Confusion Guidelines.

Regular reassessment must take place.