Trust-wide Document

Great Western Hospitals NHS Foundation Trust

Dementia Care Pathway for Adult In-Patients - Trustwide

Document No	UC – 0001	**Version No**	2.0
Approved by	Policy Governance Group	**Date Approved**	30/06/2020
Ratified by	Unscheduled Care Divisional Board	**Date Ratified**	25/06/2020
Date implemented (made live for use)	14/07/2020	**Next Review Date**	25/06/2023
Status	LIVE		
Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: Ensuring any training required is attended and kept up to date. Ensuring any competencies required are maintained. Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees as employees can come in to contact with dementia patients at any stage during their pathway. For simplicity, they are referred to as 'employees' throughout this policy		
Special Cases	Neonatal, Paediatric and Maternity services.		
Accountable Director	Chief Nurse		
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Division and Department	Planned Care – DOME (Department of Medicine for the Elderly)		
Implementation Lead	Clinical Lead for Dementia Matron Lead for Dementia		
If developed in partnership with another agency ratification details of the relevant agency	N/A		
Regulatory Position	Department of Health and Social Care (DHSC) - National Dementia Strategy (2009) (Ref 6) NICE Quality Standards for dementia care in hospitals (Ref 9 and 5) Care Quality Commission (CQC) (Ref 18) The British Geriatric Society (Ref 24) Royal College of Physicians (Ref 20) Society of Acute Medicine (Ref 25) NHS Quality Outcomes Frameworks (Ref 26) The Alzheimer's Society & Dementia Action Alliance (Ref 12)		
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

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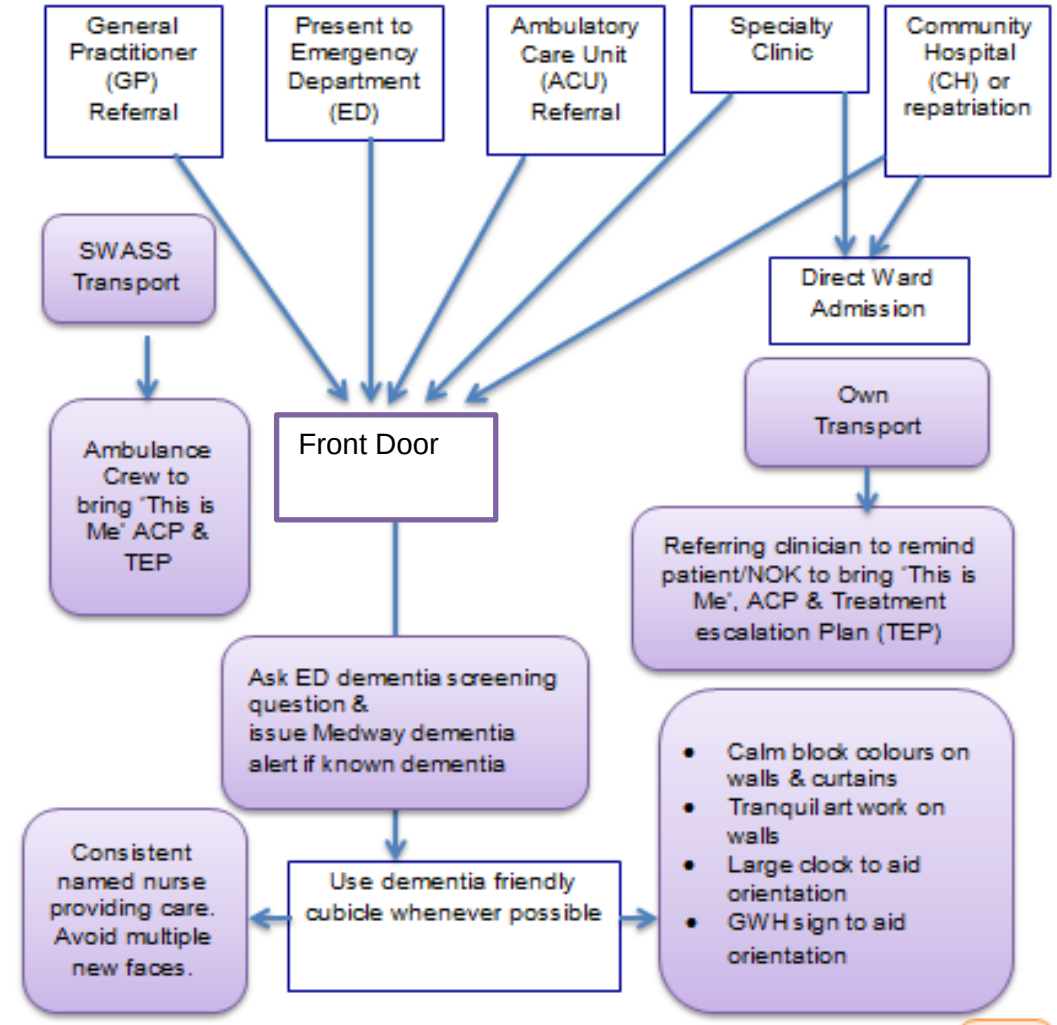


4 Cs of Acute Dementia Care
To be addressed within first 24 hours of admission

Communication: Optimise communication with patient

- Ensure sensory impairments corrected – glasses, hearing aids
- Read/request 'This is Me' document to understand and know patient better
- Provide easy to read written communication where appropriate
- Use Abbey Pain Scale for patients unable to communicate pain adequately

Collateral: Collect a good collateral history

- Contact carers / NOK / GP / care home to obtain the baseline status of the patient regarding usual cognition, usual functional abilities, usual mobility, level of continence, any behavioral challenges, ceilings of treatment/advance care plan decisions previously made.
- Ensure 'This is Me' is completed
- If there has been an acute change in patient's cognition or abilities consider asking the delirium screening question and treating delirium if present

Cognition: Baseline AMTS should be carried out within 24 hours of admission

Capacity: Two Stage Capacity Assessment should be carried out regarding consent to treatment in hospital. If patient found not to have capacity for treatment decisions then complete Best Interest paperwork, consider DOLS and inform Mental Health Liaison Team

ED & ACUTE ADMISSION WARDS (LAMU & SAU)

Instant Information 2 – GWH Dementia Care Pathway Step 2 - Transfers

Transfer to a new ward

1. No ward moves between 8pm-8am (unless clinically necessary)
2. Avoid unnecessary ward moves
3. Ensure sensory impairments corrected before transfer – glasses on, hearing aids in & switched on
4. Ensure 'Familiar Face' accompanies patient – carer / NOK / familiar Health Care Assistant (HCA) or nurse
5. Ensure 'This is Me', TEP, Advance Care Plan & Abbey Pain Scale accompany patient
6. Ensure important documents are at the front of the medical notes: Mental Capacity 2 Stage Assessment (Ref 27), Best Interests form (Ref 28), DOLS paperwork (Ref 29) (as applicable)
7. Ensure 'Reasonable Adjustments' Alert is entered on Medway before ward transfer
8. Good verbal handover should be given to the receiving ward regarding patient's needs

Transfer to a different department e.g. for investigations, procedures or

9. Ensure sensory impairments corrected before transfer – glasses on, hearing aids in & switched on
10. Ensure 'Familiar Face' accompanies patient – carer / NOK / familiar HCA or nurse
11. Request same porter for transfer to destination and back to ward whenever possible
12. Ensure 'This is Me', TEP, & Abbey Pain Scale accompany patient on transfers
13. Take distractions in case of delays – sensory bands, items from memory box such as reminiscence books or photos
14. Utilise volunteer support services such as Outpatient & Welcome Liaison Service (OWLs) in Outpatient Departments

NOCTURNAL WARD MOVES & MULTIPLE WARD MOVES

→

- ↑ Disorientation
- ↑ Anxiety & distress
- ↑ Delirium
- ↑ Need for close support / 1 to 1 nursing
- ↑ Length of hospital stay
- ↓ Patient experience & satisfaction

Instant Information 3 – GWH Dementia Care Pathway Step 3 – Care on Wards

ON ADMISSION TO WARD

28. Introduce yourself to the patient and carer using a 'Hello My Name Is' approach
29. Take a comprehensive handover from the transferring nurse
30. Ask dementia & delirium screening questions within 72 hours of admission to hospital and complete further assessments as required
31. Complete swallow assessment if indicated
32. Complete the 'Close support' risk assessment if clinically indicated
33. Refer to Mental Health Liaison if indicated
34. If learning difficulties (LD) and dementia check if person known to LD community team
35. Ensure 'This is Me' & Abbey Pain Scale and included in the patient's end of bed notes
36. Ensure important documents are completed and placed at the front of the medical notes: Mental Capacity 2 Stage Assessment (Ref 27), Best Interests form (Ref 28), DOLS paperwork (Ref 29) (as applicable)
37. Investigate if the ACP for the dying or TEP exists
38. Ensure forget-me-not visible on patient ward board and behind the bed boards and on the electronic white boards where applicable.
39. Check Reasonable Adjustments Alert has been entered on Medway
40. Ensure you have up-to-date NOK/Carer contact details and agree contact/support arrangements

DURING HOSPITAL STAY

15. For patients who lack capacity/invasive procedures/ 'unbefriended'/family objections to treatment consider appointing an independent mental capacity advocate (IMCA)
16. Ensure care is person centred, compassionate and promotes choice
17. At least Hourly Care Rounding if patient unable to use call bell effectively
18. Consider ACP and TEP discussions if appropriate and not completed and the person has capacity. Raise alert on Medway
19. Provide assistance to eat and drink as required/coloured crockery/food and fluid charts
20. Ensure patient has their glasses on, hearing aids in & switched on, mobility aid to hand – report to ward Sister in charge if lost or broken
21. Ensure patient has pain assessed regularly using the Abbey Pain Scale
22. Try to co-ordinate tests to minimise trips off the ward
23. Personalise bed space with familiar objects from home. Engage patient in 'meaningful' activities - discuss with Ward Dementia Champion, Admiral Nurses or Team on Jupiter Ward for ideas & resources
24. Recognise the carer as an 'expert' and involve them in care planning, delivery of care and discharge planning if they wish to be included
25. Facilitate the carer role in hospital by offering: open visiting/overnight stay/parking permits/recliner chair/blankets/hot drinks (consider offering carers passport)
26. Be aware of the increased risk of mortality when in Hospital
27. Refer to the Admiral Nurse Service, if appropriate, via Nerve Centre, online or by phone (see referral criteria on intranet)

Instant Information 4 – GWH Dementia Pathway Step 4 – Timely and Safe Discharge Process

WITHIN 72h OF ADMISSION

41. Involve the patient and relative/carer as much as possible

42. Gather 'baseline' information (Mobility/ Activities of Daily Living (ADL's)/Equipment)

43. Establish level of current and likely future carer involvement

44. If patient is from a care home/nursing home establish lines of communication and if home needs to reassess the patient prior to discharge

45. Refer patient to relevant agencies/support services

46. Issue relevant support leaflets to patient/and/or Carer – Dementia Support (Swindon)/Dementia Advice Service (Wiltshire)

    Refer early to Integrated Discharge Service (IDS) team

DURING HOSPITAL STAY

48. Ensure capacity has been established in relation to discharge planning at clinically appropriate time

49. Facilitate 'Best Interest' Meeting as soon as clinically appropriate, if required

50. Regularly update the patient/relative/carer about discharge plans and respond to concerns

51. If patient lives 'out of area' discuss discharge plans daily with patient flow team

52. Assess for the need for a medication DOSETT box

    Ensure appropriate referrals to community services are made on discharge e.g. District Nurse (DN), Community Psychiatric Nurse (CPN) etc.

54. Agree discharge plans/times/mode of transport with relative/carer

55. Ensure patient is dressed in weather/season appropriate clothing on discharge including appropriate footwear

56. Avoid discharge after 6 pm

57. If patient discharged and carers are waiting at home ensure carers are informed patient is on their way and make sure they have the ACP/TEP with them

58. Ensure dementia/delirium follow up plan is clearly documented on the Electronic Discharge Summary (EDS) and patient has received any additional written information (i.e. delirium leaflet/dementia support information)

PROLONGED STAY IN HOSPITAL

- ↑ Disorientation
- ↑ Anxiety & distress
- ↑ Delirium
- ↑ Need for close support / 1 to 1 nursing
- ↑ Risk of Infection
- ↑ Risk of falls
- ↓ Patient/Carer experience & satisfaction

Instant Information 5 – GWH Dementia Pathway Step 5 – Dying in Hospital

1. RECOGNISE

Understand triggers for dying with Dementia:

1. Recurrent infections
2. Developing pressure sores/poor skin integrity
3. On-going agitation/delirium
4. Progressive eating difficulties/poor swallow
5. Increasing immobility
6. Three or more admissions in the last year
7. Decision made to no longer accept treatment to reverse condition

2. COMMUNICATE

1. Establish who the responsible clinician and nurse are in care
2. Communicate sensitively and clearly and at a pace that is right for the person and family
3. Be aware of any ACP and TEP
4. Understand the content of 'This is Me'
5. Use Best Interests framework to inform care
6. Check any established preferences about organ donation
7. Provide 'Easy read' written communication where appropriate
8. Ensure sensory impairments corrected

3. INVOLVE

Patient & family in all decisions and care to the extent that they wish * IMCA

4. SUPPORT

1. Explain what to expect in the last few days
2. Explore the needs of those important to the patient – emotional, cultural, practical, and spiritual
3. Check the carers need for external organisational support
4. Provide regular updates to the patient those important to them and offer opportunities for questions

5. PLAN & DO

1. Understand any cultural, spiritual, religious needs of the patient and family
2. Check preferred place of care and preferred place of death
3. Ensure anticipatory medications for dying patients are prescribed
4. Agree a plan for assessment of symptoms
5. Explain the rationale for syringe drivers
6. Agree a plan for the provision of food and fluid
7. Agree a plan for medications and investigations, use abbey pain score
8. Decide the ceilings of treatment, check a TEP is in place
9. Formulate a nursing plan to meet agreed decisions around care, allow relative involvement if desired
10. Provide practical information about the ward and hospital environment, parking, open visiting, refreshments, toilet facilities for relatives.
11. Consider referral to Palliative Care Team for specialist support as appropriate.
12. Avoid unnecessary ward moves, but consider patient and family wishes for a side room

6. AT DEATH & POST DEATH

1. Follow any specific cultural/religious/cultural practices where possible
2. Allow the family the time they need.
3. Ensure the NOK are aware of the next steps
4. Provide the bereavement booklet
5. Establish a plan regarding property
6. Inform professionals involved in care of the death
7. Perform personal care after death
8. Check any wishes regarding organ and tissue donation are being addressed
9. Inform Bereavement services if patient is under DOLS

1 Introduction & Purpose

1.1 Introduction & Purpose

Dementia is a term used to describe a syndrome that may be caused by a number of illnesses in which there is progressive decline in multiple areas of cognitive function. These include a decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside the decline, individuals may develop behavioural and psychological symptoms of dementia, such as agitation, aggression, wandering, shouting, repeated questioning, sleep disturbance, depression and psychosis. The delivery of high standards of care in all settings for people living with dementia and their carers is a Department of Health and Social Care (DHSC) priority (Ref 6).

It is well recognised that the United Kingdom (UK) population is ageing. The incidence of dementia increases with age with one in 14 people over the age of 65 being affected and one in six people over the age of 80 being affected. Demographic trends therefore predict that hospital beds are increasingly likely to be occupied by older adults with dementia (Ref 10).

Outcomes are worse for hospital inpatients with dementia, compared to age equivalent patients without dementia, being treated for the same problem. Inpatients with dementia have longer length of stay in hospital, higher hospital mortality rates, are more likely to be prescribed anti-psychotics and have a greater likelihood of being discharged to institutional care. It is currently estimated the annual cost of caring for patients with dementia in hospital is £1.2 billion (Ref 10).

The purpose of this document is to combine recommendations from a wide range of sources to provide guidance on what constitutes ‘gold standard’ dementia care for hospitalised individuals. These comprehensive guidelines on dementia care are designed to be accessible to all employees to facilitate the delivery of excellent dementia care, which is standardised throughout all areas of the Great Western Hospitals NHS Foundation Trust (the Trust).

1. Glossary/Definitions

The following terms and acronyms are used within the document:

%	Per cent
<	Under/Lower Than
>	Over/Higher than
ACP	Advanced Care Plan
ACU	Ambulatory Care Unit
ADL	Activities of Daily Living
AM TS	Abbreviated Mental Test Score
APS	Abbey Pain Scale
BPSD	behavioral and psychological symptoms of dementia
CH	Community Hospital
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
DART	Discharge Assessment and Referral Team
DN	District Nurse
DOG	Dementia Operational Group
DHSC	Department of Health & Social Care
DOLS	The Deprivation of Liberty Safeguards
DSG	Dementia Strategy Group
DSOG	Dementia Strategy Operational Group
ED	Emergency Department
EDS	Electronic Discharge Summary

EIA	Equality Impact Assessment
FMN	Forget-me-not
GP	General Practitioner
GWH	Great Western Hospital
HCA	Health Care Assistant
IMCA	independent mental capacity advocate
IP&C	Infection Prevention and Control
LD	Learning Difficulties
NEWS	National Early Warning Score
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NOK	Next of Kin
OWLs	Outpatient & Welcome Liaison Service
PCP	Personalised Care Plan (for the dying)
SWAST	South West Ambulance Service Trust
TEP	Treatment Escalation Plan
TIM	This is Me
UK	United Kingdom

2 Main Document Requirements

2.1 The Admiral Nurse Service

The specialist Admiral Nursing service was established in October 2018. The service fulfils a unique role in the dementia pathway, supporting families affected by dementia with complex needs through specialist assessment, bio-psychosocial interventions, education and consultancy. It meets the needs of the hospital for patients, their families and staff to have access to dementia expertise, which is also a recommendation for the National Audit of Dementia Care in General Hospitals (Royal College of Psychiatrists).

The Service consists of two Band 7 specialist mental health nurses, known as Admiral Nurses, who work closely together across the acute-community pathway (one AN is based at GWH in the acute hospital and one is based in the community). They bring to the role extensive knowledge and experience in dementia care, which is enhanced by regular professional and practice development. They bring added value as mental health nurses, role modelling complex therapeutic practice which addresses both physical and mental health needs of both the person with dementia and the carer.

There are four main objectives of the Admiral Nurse Service:

1. Deliver direct clinical interventions with families in the acute and community settings, which help to prevent carer breakdown, improve outcomes for the person with dementia and carer, minimise social admissions and support effective and timely discharge.

2. Support best practice in relationship-centred dementia care by building confidence and competence, and improving the skills and knowledge, of health and social care professionals.

3. Provide education and consultancy, acting as a catalyst for positive change and enabling improved quality of dementia care in hospitals.

4. Work closely with existing services with the aim of supporting reduced fragmentation of service provision across the health and social care pathway, particularly around transitions of care.

The Admiral Nurse Service is available Monday to Friday between 8am-4pm (excluding bank holidays).

2.1.1 Referral to the Admiral Nurse Service

The individual (person with dementia) MUST be in receipt of care/treatment and/or support across the Great Western Hospital's pathway either as an inpatient or be accessing day/outpatient services.

*NB. To access support of the Admiral Nurse (Community Outreach), the person with dementia **must** be registered with a Swindon GP as below;*

Abbey Meads Medical Practice	Moredon Medical Centre
Ashington House Surgery	North Swindon Practice
Carfax NHS Medical Centre	Old Town Surgery
Cornerstone Practice	Park Lane Practice
Eldene Health Centre	Phoenix Surgery
Eldene Surgery	Priory Road Medical Centre
Elm Tree Surgery	Ridge Green Medical Centre
Great Western Surgery	Ridgeway View Family Practice
Hawthorn Medical Practice	Sparcells Surgery
Hermitage Surgery	Taw Hill Medical Practice
Kingswood Surgery	Victoria Cross Surgery
Lawn Medical Centre	Westrop Surgery
Merchiston Surgery	Whalebridge Practice

Referral Criteria

The person being supported/cared for has a diagnosis of dementia.
The carer must agree to a referral to the Admiral Nurse.
The carer should have one or more of the following identified needs and/or concerns:

High levels of distress/change in presentation of the person with dementia	Carer neglecting or unable to address their own needs
Presence of carer stress/anxiety and/or depression	Misuse, abuse and/or non compliance with medications for person with dementia and/or carers
Carer and/or person with dementia have difficulty adjusting to diagnosis of dementia	Need for support with developing news skills to care for person with dementia
Difficulty in adjusting to transitions between care environment	Carer neglecting or unable to address person with dementia's needs
Poor communication with professionals	Carer requiring support with end of life issues
Carer/family need support with managing risk	Need for information (about dementia/services/benefits)
Presence of complex family dynamics	Complex discharge planning from hospital

Exclusion Criteria

Do not refer the following to the Admiral Nurse Service if:

- Delirium in the absence of a diagnosis of dementia
- Acute confusion due to alcohol or drug withdrawal in the absence of a diagnosis of dementia
- A primary diagnosis of cognitive impairment due to head injury
- Crisis management requiring an immediate response
- Carer's primary need is not related to the dementia (e.g. significant MH problem which requires intervention in own right)
- Needs can be/are being met by existing services
- Carer declines to engage

Best Practice referrals

In addition to caseload or individual referrals, the Admiral Team will accept referrals and enquiries from health care professionals in regards to dementia advice, education or training for staff. Health care professionals are also able to seek advice from the Admiral Nurses with dementia related enquiries of which may relate to a specific patient; including advice and support with the patients assessment, treatment, management, provision care and future planning. The team will also undertake activity in order to raise and promote the profile of the Admiral Service.

Referral Process

The Admiral Nurse Service can accept referrals from any of the following:

- Acute inpatient hospital service
- Community/District nursing team (GWH NHS Trust)
- Memory Service (AWP)
- Mental Health Liason Service (AWP)*
- Complex Intervention Team (AWP)*
- Voluntary Sector (Alzheimer's Society/Alzheimer's Support)
- Social Services
- Swindon Carer's Centre
- Hospice/Pallative care team
- Self referral from Carer's family member/friend

*Avon and Wiltshire Mental Health Partnership NHS Trust.

Referrals can be accepted from any Health and Social Care Professional within any of these organisations.

All health care professionals are able to refer to the Admiral Nurse service in the following ways:

Email a referral form:

Emailing a **referral form** to the designated Admiral Nurse Referrals inbox at;
gwh.admiralnursereferrals@nhs.net

If working for Great Western Hospitals NHS Foundation Trust, a referral form is able to be obtained from the intranet, along with the referral criteria. Please search the intranet under 'A' (Admiral Nurse Service) or 'D' (Dementia) pages for this information.

If a health care professional works outside of Great Western Hospitals NHS Foundation Trust, they are able to request a referral form to be sent to them through emailing the above Admiral Nurse direct email address.

Contact an Admiral Nurse via phone:

All health care professionals working within the acute, community or third party sector are able to make a referral to the Admiral Nurse Service via the telephone. Self-referrals are also able to be received via telephone.

Call DECT phone: 01793 60(7214) in the first instance.

07825 716933 (Tim Allen – Admiral Nurse) or
07788 362348 (Hannah Rogers – Admiral Nurse)

2.2 'This is Me' (TIM) Document

In order to improve care and outcomes for individuals with dementia, a 'person centred' approach is essential. Person centred dementia care is emphasised in the National Dementia Strategy (Ref 6) and National Institute for Health and Care Excellence (NICE) Dementia Quality Standards (Ref 5). It is often difficult for patients with dementia to communicate their preferences, choices and needs to hospital employees, therefore person centre care can only be provided following detailed discussion with individuals who are well acquainted with the person living with dementia.

The 'This is me' booklet (See Appendix B of this document for a copy) is a booklet completed by patients with dementia, their relatives or carers which records the patient's preferences, dislikes, habits, behaviours and routines. It enables healthcare professionals in all settings to understand each individual with dementia and facilitates the delivery of care specifically tailored to that person. In acute care settings the use of 'This is me' may reduce anxiety and distress, prevent delirium, improve hydration and increase nutritional intake. 'This is me booklets' are available in paper copy on all wards and patients are encouraged to have a copy at home that can be brought in with them should they need to be admitted to the acute Trust.

2.3 Medway Reasonable Adjustment Alert

The Medway alert system can be used to highlight to employees that a person has dementia and may require a more individualised approach to their care. Employees can view Medway alerts by clicking on the 'Alerts' button on the Medway system. Employees can request that an alert be put on the system as soon as they become aware a patient has a confirmed diagnosis of dementia. This can be done through e-mailing the PAS/EPR_System_Team details of the alert. The alert will then appear every time subsequent employees log into a patient's electronic records.

2.4 Forget-me-not Symbols

Forget-Me-Not flowers have become a nationally recognised symbol for dementia following their introduction by the Alzheimer's Society as part of their Dementia Friends Campaign in 2012 (Ref 14). The Trust uses the 'Forget-Me-Not' flower on electronic ward boards, medical records and above patient beds as a discrete reminder to all employees that a patient has dementia and may require a more personalised approach. Forget-Me-Nots have been used throughout the Trust since 2013 and are available as plastic icons for standard ward white boards, as well as electronic icons for newer electronic ward boards since 2016. Icons can be purchased by the wards through NHS Supplies.

There is a section on the Nerve Centre to allow patient's cognitive status to be electronically documented and readily available to share this information between clinical staff.

2.5 Abbey Pain Scale (APS)

The APS (See Appendix C) is an observational tool which has been designed to assist in the assessment of pain in patients unable to communicate their needs, including levels of pain they may be experiencing. It was specifically designed for use in people with advanced dementia. The tool includes assessment of physiological and behavioural indicators of pain including vocalisations, facial expressions, body language, changes in behaviour and changes in physiological observations such as heart rate and blood pressure. A simple score is assigned by an experienced observer (usually a healthcare professional) in each of these domains with an overall score generated which may suggest the presence of mild, moderate or severe pain. If appropriate, analgesia should be given and then the patient's pain score re-assessed after a suitable time.

The preferred pain assessment is self-reporting often utilising tools such as visual analogue scales, numeric rating scales and verbal rating scales. However, such tools are not suitable for use in people with cognitive impairment. Behavioural and physiological measures can also be used to aid assessment of pain and may be more useful in those with cognitive impairment, learning difficulties or speech disorders.

It is important to note that the Abbey Pain Scale is unable to differentiate between pain and other causes of distress in people with dementia. Despite this the tool can be a valuable alternative aid in the assessment of pain in hospitalised individuals with dementia.

Guidance for use of the Abbey pain scoring tool (Appendix D) is included in the following documents

Acute Pain Assessment and Management in Adults (Including the Abbey Pain Scale) for use with Patients who are Cognitively Impaired or unable to Communicate or Verbalise Clinical Guideline (Ref 23)

2.6 Dementia Friendly Environments

Hospitals can be confusing, challenging and overwhelming for people with dementia. People with dementia find it difficult to orientate themselves in unfamiliar environments and have reduced physical and mental reserves to cope with the environmental challenges found in acute hospital settings. Increased length of stay, complications arising from prolonged hospitalisation, higher rates of institutionalisation and higher death rates are seen in hospitalised adults with dementia compared to equivalent hospitalised individuals without dementia (Ref 5, 6, 11, 12, and 14).

In 2003 the DHSC commissioned the King's Fund to develop specific programs to enhance the environment in which care is provided to patients as a means of improving patient experience. The King's Fund project 'Enhancing the Healing Environment' (Ref 17) focused on improving hospital environments for individuals with dementia.

Since the inception of Enhancing the Healing Environment, the King's Fund have worked with over 250 healthcare providers on numerous projects to improve environments in which dementia care is provided. Through this work they have compiled an extensive body of evidence which demonstrates that relatively inexpensive interventions, such as changes to lighting, floor coverings and improved way-finding, can have a significant impact.

Evaluation has shown that simple environmental improvements can have a positive effect on reducing falls, violent and aggressive behaviors, and improving employee recruitment and retention.

The Enhancing the Healing Environment project has shown that it is possible to improve the quality and outcomes of care for people with dementia as well as improve employee morale and reduce overall costs by making inexpensive changes to the environment of care.

The Trust has been involved in making dementia friendly changes to care environments since 2013 including the refurbishment of the first dementia friendly ward (Jupiter Ward) according to the principles of the Enhancing the Healing Environment program; creation of a dementia friendly cubicle in the Emergency Department; introduction of a program of meaningful activities on Jupiter, Woodpecker and Teal Wards; Enhanced Care Practitioners have been employed on a close support basis to dementia patients; as well as smaller environmental changes to fixtures and fittings throughout both acute and community sites through annual PLACE audits. The most recent change has been to replace the flooring in the hospital main corridor with appropriate dementia friendly flooring. The use of these dementia appropriate environments and meaningful activities are encouraged through Dementia Link Nurses and Dementia Master Classes provided by the academy.

2.7 Dementia & Delirium Screening on Admission

Early diagnosis of dementia enables earlier interventions including treatment with cognitive enhancing medications; initiation of support services for carers and commencement of advanced care planning for the future (Ref 5, 6, 10, 14). This is why the Trust screen patients on admission to the Great Western Hospital.

Delirium in hospital has been found to be associated with reduced functional recovery as well as increased mortality and institutionalization 12 months after discharge Individuals who suffer with delirium are also three times more likely to develop future dementia, even in the absence of cognitive impairment prior to the episode of delirium (Ref 20).

There are well recognized risk factors associated with the development of delirium including advanced age; inter-current illness; pre-existing cognitive impairment or dementia and hip fracture. These particular features provide clinicians with the means to easily identify ‘at risk’ individuals.

In the development of Nerve Centre, a Dementia and Delirium assessment has now added to the system to prompt clinicians to screen both conditions.

Once delirium has been diagnosed or ‘at risk’ individuals identified, there are numerous simple, yet effective, interventions which may be implemented in both the treatment and prevention of delirium (Ref 19, 20)

The Trust has well established processes in place to screen for both dementia and delirium in all patients over the age of 75 who are admitted to hospital as an emergency. Patients and/or relatives must be asked the national dementia screening question *‘has the person been more forgetful in the last 12 months to the extent that it has significantly affected their quality of life?’*.

Relatives must be asked a validated delirium screening question ‘*is the person more confused than normal today?’* Both screening questions must be asked within 72 hours of admission and the appropriate guidance followed according to the Dementia & Delirium Assessment Tool (Appendix E). The assessment can be undertaken by any member of the ward team including doctors, nurses, healthcare assistants and other allied health professionals.

If either of the screening questions are answered positively then a clinical work up for either dementia or delirium or both should occur during the admission according to the protocols outlined on Nerve Centre. The results of both screening questions, the clinical actions taken as a result and any on-going follow up arrangements (referral for further assessment in formal memory clinic versus GP follow up to be decided by the clinical team) must then be communicated to primary care via the dedicated dementia and delirium sections on the electronic discharge summary (Appendix F). Anyone who receives a diagnosis of delirium should also receive a delirium patient information leaflet (Ref 8).

2.8 Dying in Hospital with Dementia

A diagnosis of dementia is that of a progressive terminal illness; with numbers increasing as the population lives longer and diagnosis improves.

Ensuring that every person with a dementia diagnosis has a dignified, individualised death with everyone working together confidently and consistently is central to the guidance developed by NICE (Ref 15, 16, 19)

The key elements to high quality care of the dying adult are as follows:

1. Recognising that the person is dying
2. Communicating that decision sensitively and appropriately
3. Involving the dying person and those important to them to the degree they wish to be involved
4. Supporting the dying person and those important to them
5. Supporting the person to develop an individualised plan to manage the dying process.

The plan must incorporate a negotiated plan for nutrition and hydration, monitoring and investigations, ceilings of treatment, symptom control, location of care, spirituality and the physical care they may need. Providing truly individualised care for people dying with dementia has unique challenges, as communication and loss of capacity in late stage dementia are common place. Including those important to the person and working with any Advance Care Plan are fundamental to providing the personalised care expected for all patients dying with Dementia. These principles underpin the Care Quality Commission standards for monitoring, inspection and regulation of Acute NHS Trusts

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
Use of dementia tools (This is Me documents & Forget-me-not symbols) 100% of the time	Internal Audit	GWH Dementia Strategy Group (DSG)	Annual	GWH DSG GWH DOG GWH Patient Quality Committee	Appropriate action depending on nature of gap identified
Use of the Abbey Pain Scale in relevant patients with dementia 100% of the time	Internal Audit	GWH DSG	Annual	GWH DSG GWH DOG GWH Patient Quality Committee	Appropriate action depending on nature of gap identified
Number of ward moves for adults with dementia – Review of monthly trend data	Internal Audit	GWH DSG	Annual	GWH DSG GWH DOG GWH Patient Quality Committee	Appropriate action depending on nature of gap identified
Evidence of compliance with overarching principles of good dementia care – positive trends in relation to multiple elements of care	National Dementia Audit	GWH DSG	3 yearly	GWH DSG GWH DOG GWH Patient Quality Committee	Appropriate action depending on nature of gap identified
Compliance with overarching principles of good dementia care	Regional peer review	Southwest Regional Dementia Action Alliance	3-5 yearly	GWH DSG GWH DOG GWH Patient Quality Committee	Appropriate action depending on nature of gap identified
Trend data suggesting improved Carer experience through completion of	Six monthly report	GWH Carers Committee	six monthly	GWH DSG GWH DOG GWH Patient Quality Committee GWH Carers	Appropriate action depending on nature of gap identified

web-based on-line Trust Carer Feedback Surveys				Committee	

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Ward Managers, Matrons and Managers for Non Clinical Services

All Ward Managers, Matrons and Managers for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

4.4 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.5 The GWH Dementia Strategy Group & Dementia Operational Group

The GWH Dementia Strategy Group (DSG) will be responsible for monitoring the use and effectiveness of the dementia care pathway and will advise on changes to the guideline with respect to changes in National priorities and practises. The GWH Dementia Strategy Operational Group (DSOG) will be responsible for helping to embed any such changes into GWH practises.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Mental Capacity Act 2005	T:\Trust-wide Documents
2	Mental Health Act Policy (Policy under review 2016)	T:\Trust-wide Documents
3	Deprivation of Liberty Safeguards Policy (Policy under review 2016)	T:\Trust-wide Documents
4	Safeguarding Adults at Risk Policy	T:\Trust-wide Documents
5	NICE Quality Standards for dementia care	https://www.nice.org.uk
6	DHSC National Dementia Strategy	www.gov.uk
7	This Is Me Document	T:\Trust-wide Documents

Ref. No.	Document Title	Document Location
8	GWH Delirium Patient Information leaflet	T:\Trust-wide Documents
9	Alzheimer's research UK (2014) Dementia Statistics	http://www.alzheimersresearchuk.org
10	Department of Health (2013) – Dementia. A state of the nation report on dementia care and support in England.	https://www.gov.uk
11	Alzheimer's Society (2009), Counting the cost: Caring for people with dementia on hospital wards, Alzheimer's Society, London	http://alzheimers.org.uk
12	Alzheimer's society (2013). Dementia 2013: The hidden voice of loneliness	http://www.alzheimers.org.uk
13	Department of Health (2009) – Living Well with Dementia: a National Dementia Strategy	https://www.gov.uk
14	Department of Health (2012) The Prime Ministers Challenge on Dementia. Delivering major improvements in dementia care and research by 2015. London. Department of Health	https://www.gov.uk
15	NICE (2006) Dementia: Supporting people with dementia and their carers in health and social care. Manchester.	https://www.nice.org.uk
16	NICE Quality Standards for Dementia (QS1 & QS30) (2010)	https://www.nice.org.uk
17	King's Fund Enhancing the Healing Environments Project	http://www.kingsfund.org.uk
18	Care Quality Commission (2014)– Cracks in the Pathway: people's experience of dementia	http://www.cqc.org.uk/
19	National Institute for Health and Clinical Excellence (2010), Guideline 103, Delirium: diagnosis, prevention and management	https://www.nice.org.uk
20	Royal College of Physicians (2006), Concise Guidance to Good Practice Number 6, The prevention, diagnosis and management of delirium in older people	https://www.rcplondon.ac.uk
21	Hand Hygiene and Skin Care Policy (including scrubbing gowning and gloving)	T:\Trust-wide Documents
22	Standard Infection Control Precautions Policy	T:\Trust-wide Documents
23	Acute Pain Assessment and Management in Adults (Including the Abbey Pain Scale for use With Patients who are Cognitively Impaired or Unable to Communicate or Verbalise) Clinical Guideline	T:\Trust-wide Documents
24	The British Geriatric Society	https://www.bgs.org.uk/

Ref. No.	Document Title	Document Location
25	Society of Acute Medicine	https://www.acutemedicine.org.uk/
26	NHS Quality Outcomes Frameworks	https://digital.nhs.uk
27	Mental Capacity 2 Stage Assessment	GWH Intranet - http://gwh-intranet/trust-wide/mental-health,-mental-capacity-and-learning-disability.aspx
28	Best Interests Forms	GWH Intranet - http://gwh-intranet/trust-wide/mental-health,-mental-capacity-and-learning-disability.aspx
29	DOLS paperwork	GWH Intranet - http://gwh-intranet/trust-wide/mental-health,-mental-capacity-and-learning-disability.aspx

5.2 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Divisional Director UC	25/06/2020
Divisional Director of Nursing UC	25/06/2020
Associate Medical Director - UC	25/06/2020
End User	25/06/2020
Clinical Lead - ED	25/06/2020
Matron, ED	25/06/2020

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A.

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? Dementia Care Pathway		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? The purpose of this document is to combine recommendations from a wide range of sources to provide guidance on what constitutes 'gold standard' dementia care for hospitalised individuals.		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Sarah White
Date completed	10/06/2020
Job Title	Consultant Geriatrician & Clinical Lead for Dementia

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

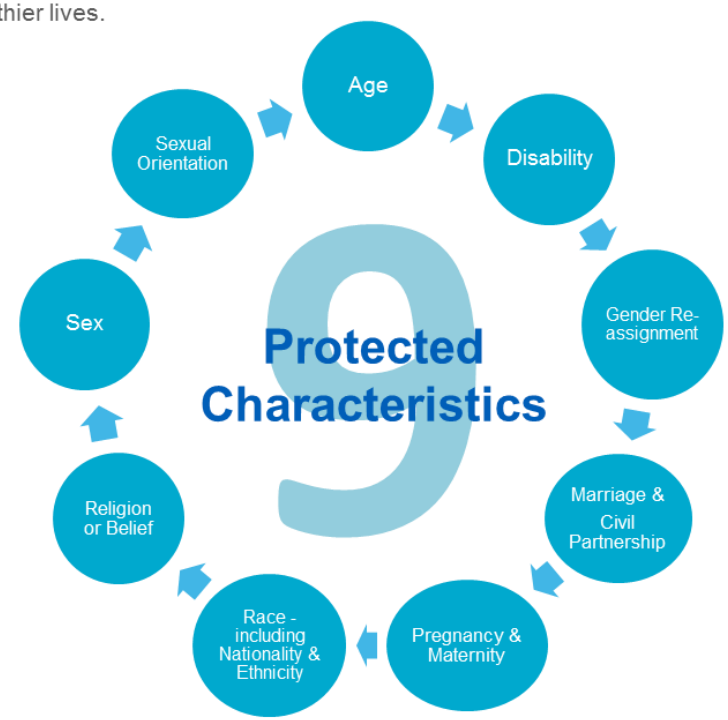
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



Appendix B – This is Me Document

Royal College of Nursing

Leading the fight against dementia
Alzheimer's Society

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

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 reassures 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 01628 529240. For general dementia queries call our Helpline on 0845 300 0336.

alzheimers.org.uk

photo

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

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.

Appendix C - Abbey Pain Scale

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale : While observing the resident, score questions 1 to 6.

Name of resident : .....

Name and designation of person completing the scale : .....

Date : ..... **Time :** .....

Latest pain relief given was.....**at**.....**hrs.**

Q1. Vocalisation — **Q1** ☐
eg whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression — **Q2** ☐
eg looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language — **Q3** ☐
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behavioural Change — **Q4** ☐
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological change — **Q5** ☐
eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes — **Q6** ☐
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 - 6 and record here ⇨ **Total Pain Score** ☐

Now tick the box that matches the Total Pain Score ⇨

0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe

Finally, tick the box which matches the type of pain ⇨

Chronic	Acute	Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002
(This document may be reproduced with this acknowledgement retained)

Appendix D - Abbey Pain Scale, GWH Instructions for Use

WHO?

Who is it for?

It must be used for anyone who is unable to tell you if they are in pain.

Ask yourself this question. **Are you confident this person could tell you if they were in pain?** If No use the APS.

Common situations include:

1. **Cognitive impairment (dementia/delirium)**
2. **Communication difficulties (Stroke)**
3. **Severe depression or psychosis**
4. **Learning difficulties**

Who should use it?

Anyone caring for the patient can initiate or use the APS including:

1. **ED employees**
2. **Junior doctor clerking new patient**
3. **Post take ward round**
4. **Nursing employees**

HOW?

1. Print the APS off the intranet and put it in the patients end of bed notes so all the other information relating the APS is still correct.
2. Convert the APS score calculated into a standard pain score
3. Document the standard pain score on the front of the observation chart
4. If moderate or severe pain documented then issue appropriate analgesia and repeat APS in 30 minutes
5. **Watch GWH junior doctors give an online demonstration on how to use the APS available at GWH intranet dementia pages**

WHEN?

1. During routine observations
2. Pre & post any intervention which may cause that particular patient pain e.g. taking blood, washing someone with pressure sores, mobilising someone with severe arthritis
3. If there is a change in observations without an apparent cause (especially raised heart rate, raised respiratory rate or raised blood pressure)
4. If there is a change in behaviour (wandering, aggressive, withdrawn)

Appendix E – Dementia & Delirium Screening Tool

Patient details:
Name:
DOB:
Hospital No:
NHS No:
(Use patient label)

Great Western Hospitals NHS

Complete within 72h of admission for all NON ELECTIVE patients >75.

WARD: _____

Admission Date_____

DATE QUESTIONS ASKED

DEMENTIA + DELERIUM ASSESSMENT (CQUIN)
This is a 3 part process: Part 1: Question. Part 2: Assess Part 3: Investigate and refer

THE DEMENTIA QUESTION **The patient is ≥75 from date of admission**	**Yes** ☐
Does the patient already have a formal diagnosis of dementia? If the patients' medical condition means you cannot ask the questions they can be posed to anyone who knows the patient well (i.e. partner/carer). **If 'yes' do not continue with assessments. Place form in medical notes. If 'No' continue with the process. If the patient is too unwell to have the questions asked log this also on the EDS.**	Yes ☐ No ☐
Does the patient consent to having the questions asked? If 'No' do not ask the question. Doctor to log on the EDS summary that consent was declined	Yes ☐ No ☐

QUESTION: Dementia: 'Has the person been more forgetful in the past 12 months to the extent that it has significantly affected their quality of life?' Yes ⬭ No ⬭

QUESTION:
Delirium: Is the person more confused than normal today? Yes ⬭ No ⬭

PART 2 **FOR THE QUESTIONS ASKED**	**ACTION**
DEMENTIA **If the answer is 'yes'**	**Complete the Dementia diagnostic assessment and document the result below** →
DELERIUM **If the answer is 'yes'**	**Complete the Delirium 'CAM' diagnostic assessment and document the result below** →

PART 3 **FOR THE ASSESSMENT RESULT** **DEMENTIA**	**ACTION**
If the assessment score is ≤ 8? SCORE: ☐	Doctor to exclude other medical conditions. If dementia still suspected request GP to re-assess and refer as appropriate on discharge from hospital via the EDS summary
Results inconclusive **or** clinical condition prevents assessment **or** discharged within 72h of admission?	Request GP to re-assess and refer as appropriate on discharge from hospital via EDS summary

FOR THE ASSESSMENT RESULT: **DELERIUM – Is the patient CAM positive?**	**ACTION** **Yes** ⬭ **No** ⬭
If the answer is 'yes'	**Inform the doctor who will assess and investigate as per delirium guidelines**
If the answer is 'yes'	**Diagnosis information (Delirium leaflet) given to patient/Carer** **Yes** ⬭

Our Values
Service Teamwork Ambition Respect

Patient details:
Name:
DOB:
Hospital No:
NHS No:
(Use patient label)

Great Western Hospitals NHS
NHS Foundation Trust

Complete at any appropriate time during in-patient stay

WARD: _____

Assessment date: _____

THE DEMENTIA DIAGNOSTIC ASSESSMENT

QUESTIONS FOR PATIENT — Registered nurse to complete	SCORE '1' IF CORRECT
Age	
Date of birth	
Repeat '42 West street	Do not score here – see Q 11
What year is it?	
What time is it? (Nearest hour)	
What is the name of this hospital?	
Recognise 2 people (i.e. Dr, Nurse)	
What year did World war 2 end (Answer 1945)	
Name of the Queen of England (Answer : Elizabeth)	
Count backwards from 20	
Ask patient to recall the address from Q 3 (Answer: 42 West Street)	
If patient scores ≤8 suspect undiagnosed dementia. Record score overleaf	TOTAL:

THE DELERIUM ASSESSMENT 'Confusion assessment method' – 'CAM'

Acute change in mental state with a fluctuating course (confusion that varies through the day) **1**

+

'Inattention'
Unable to count back from 20 – 1
OR
Can't Spell 'world' backwards **2**

PLUS

EITHER ONE OR *BOTH* OF THE FOLLOWING

'Disorganised thinking' **3**
Rambling/inappropriate conversation

Altered level of consciousness
Hyperactive = Agitated/Restless
OR
Hypoactive = Sleepy/very drowsy **4**

'CAM' TEST Positive = 1 + 2 *plus* 3 and/or 4 — **Record result overleaf**

DESIGNATION	Signed	PRINT NAME	Date
NURSE (RN1)			

*Once investigations completed please refer back to **Part 3** for practice guidance

Our Values
Service Teamwork Ambition Respect

Appendix F – Dementia & Delirium Sections on Electronic Discharge Summary

DEMENTIA ASSESSMENT DETAILS

Dementia Assessment Completed? ○ Yes ○ No

DEMENTIA QUESTION ASKED DETAILS

Dementia Question Asked? ○ Yes ○ No

Reason Question Not Asked: Select a Reason

Date and time Question Asked:

Patient said they have memory problems: ○ Yes ○ No ○ Unknown

Reason for Answer Delay: Select A reason

Dementia Reason Not Completed: Select a Reason

Date Assessment Completed:

Assessment Score: Select Score out of 10

Follow Up By GP Required? ○ Yes ○ No

DIAGNOSIS OF DELIRIUM?

Delirium Question Asked? ○ Yes ○ No

Delirium Reason Question Not Asked: Select a reason

Diagnosis Of Delirium? ○ Yes ○ No

Diagnosed within 72 hours of admission? ○ Yes ○ No

Has patient been given a leaflet? ○ Yes ○ No
Click here for leaflet

Plan Of Care completed? ☐

GP FOLLOWUP - Future investigations and recommendations

Review Antipsychotic Medications? ○ Yes ○ No ○ N/A

Review In: By GP

Comments:

HOSPITAL Followup - Future investigations and recommendations

Review Antipsychotic Medications?	○ Yes	○ No	○ N/A

Review In _____ By _____

Comments: