ACT Government | Canberra Health Services

CHSXX/XXX (number will be allocated by Policy Register Manager after final endorsement

Canberra Health Services Procedure

Cognitive Impairment (Delirium and Dementia) and Deteriorating Mental State - Adult

Contents

Purpose

The purpose of this procedure is to:

- Provide direction to all clinical staff to improve the safety of patients, through early recognition, assessment and management of Cognitive ~~I~~impairment (Delirium and Dementia) and deteriorating mental state.
- Establish a consistent approach to the planning and delivery of care for patients with Cognitive Impairment (Delirium and Dementia) and deteriorating mental state that is in accordance with Australian best practice guidelines.
- Identify the current cognitive and mental state of the patient to the patient's general practitioner and nominated person (advocate, family, and carer) at time of discharge and provide an individualised care plan.
- Minimise occupational violence episodes directed at staff.

A summary is provided at Attachment 1: Pathway for Assessment and Management of Cognitive Impairment and deteriorating mental state. [4]

Back to Table of Contents

Scope

Delirium, Dementia, ~~and~~ Cognitive ~~I~~impairment and mental illness, should be considered for all adults. This procedure applies to patients aged 18 years and over with an inpatient admission to Canberra Health Services (CHS).

Awareness, assessment, and management of Cognitive Impairment (Delirium and Dementia) and deteriorating mental state is the responsibility of all staff.

Back to Table of Contents

Section 1 – Screening for Cognitive Impairment (Delirium and Dementia)

Cognitive Impairment is a decline in cognitive function that can be acute (days to weeks) or chronic (months to years), and/or fluctuating.

Delirium is an acute change in mental status that is common among patients in hospital. Delirium is characterised by a disturbance of consciousness, attention, cognition, and perception that develops over a short period of time (usually hours to a few days). Patients with delirium may be agitated and restless (hyperactive delirium), quiet and withdrawn (hypoactive delirium), or move between these two subtypes (mixed delirium).

Dementia is a syndrome –usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e., the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not affected.

Why screen for Cognitive Impairment (Delirium and Dementia)?
Patients with Cognitive Impairment (Delirium and Dementia) are at a significantly higher risk of adverse events and preventable complications, such as: falls; pressure injuries; accelerated functional decline; infection; prolonged hospital stay; premature entry to residential care; and death. [1, 2] To ensure patients with Cognitive Impairment (Delirium and Dementia) who present to hospital are identified early so that appropriate management and preventative measures can be put in place. [3]

Who needs to be screened for Cognitive Impairment (Delirium and Dementia)?
The following group of adult patients who are an inpatient admission to CHS must be screened by CHS staff for Cognitive impairment (Delirium and Dementia) within 24hours of presentation, as part of the Integrated Patient Risk Screening with time and date recorded.

- Age ≥ 65 years (≥ 45 years for Aboriginal and Torres Strait Islander peoples)
- Severe illness (a clinical condition that is deteriorating or is at risk of deterioration)/risk of dying/people receiving palliative care
- New hip fractures
- Known Cognitive Impairment (Delirium and Dementia) care facility residents
- Disruptive behaviour
- Recent (4weeks) surgery
- Acute intoxication with drugs and other substances
- Cognitive concerns raised by others/ hypoactive state
- Recent onset of confusion, anxiety, or hallucination

Potential causes for Patient's to present with Cognitive Impairment and Delirium
Multifactorial causes for Cognitive Impairment and Delirium include, but are not limited to:

- cardiac events
- constipation
- infections (especially urinary tract infections/respiratory tract infections)
- intracerebral events
- metabolic disturbance
- organ failure
- pain
- seizures and postictal states
- substance withdrawal (prescribed, over the counter, illicit)
- surgical procedures
- unfamiliar environment.

When should screening for Cognitive Impairment (Delirium and/or Dementia) occur?
Screening should occur within 4-hours of presentation to CHS.

Testing may be deferred by the treating team in patients who are:

- Medically unstable
- Unresponsive
- Non-verbal
- Acutely intoxicated
- In the terminal phase of a life-limiting illness
- Visually or physically impaired and unable to complete the screening for Cognitive Impairment (Delirium and/or Dementia).

If deferred, document the plan for assessment completion and handover.

If Delirium is identified, then rescreen as per care plan. Also rescreen if acute changes in presentation and before discharge.

Which screening tools for Cognitive Impairment (Delirium and/or Dementia) can be used?
CHS nursing staff to screen for cognitive impairment in the patients specified above using:

- 4AT Assessment for Delirium and Cognitive Impairment (sharepoint.com)

If 4AT score is ≥1, the medical team will be notified to complete:

- CONFUSION ASSESSMENT METHOD (CAM) DELIRIUM SCREEN (sharepoint.com) within 4 hours, to assess for Delirium.

Reassess according to clinical need.

Document the results in progress notes and ensure the results are part of clinical handover and form part of the Digital Health Record (DHR)

The patients who screen positive for Cognitive Impairment on the initial screening tool (4AT) but who are not delirious when assessed by the Confusion Assessment Method (CAM) will be assessed for other causes of Cognitive Impairment e.g., dementia, mental illness, cerebral pathology by the medical team at appropriate time. [3, 4, 5]

Back to Table of Contents

Section 2 – Use of the Cognitive Impairment Identifier (Cognitive Impairment, Delirium and/or Dementia)

For patients screening positive for Cognitive Impairment, a Cognitive Impairment Identifier (Figure 1) must be placed at the patient's bedside, as shown below, to ensure all staff can implement appropriate strategies and support. Consumer information to be provided by treating team to patient, and their family and/or carer.

Figure 1. Cognitive Impairment Identifier [8]

Consumer information: Cognitive Impairment Identifier – Information for Patients, Families, Support People and Carers

Back to Table of Contents

Section 3 – Care Planning and Management of Patients with Cognitive Impairment, Dementia, and/or Delirium

Non-Pharmacological interventions

An individualised and integrated prevention and management plan should be developed in partnership with the patient, family/carers. It must include the multidisciplinary teams' collaboration.

The following interventions should be considered to manage Cognitive Impairment:

- Assess the need for increase in care and/or supervision
- Bowel and bladder management to minimize complications
- Calm approach while facing the person and use simple factual explanations
- Clock within sight
- Environmental factors, including lighting, day/ night orientation
- Education and support for the patient, family, and carer/s
- Encourage participation in activities of daily living
- Ensure and monitor adequate hydration and nutrition intake
- Ensure continuity of carers (familiar staff), if possible
- Ensure wearing of glasses or hearing aids as needed
- Give only one instruction at a time and give the patient time to respond
- Introduction of staff at every contact and include orientation (time, person, place) if required
- Involvement of family and/or carers
- Maintenance of eye contact while communicating at all times (if culturally appropriate), avoid standing over patient and communicate at eye level
- Normalise sleep patterns
- Request medication review and limit non essential medications, but ensure adequate analgesia
- Remove catheters and cannulas, if not needed
- Reorientation and reassurance strategies
- Speak slowly and clearly and check understanding

- **Avoid** using physical or mechanical restraints, as they can increase agitation, prolong delirium and increase the risk of injury.
- Manage complications associated with cognitive impairment, e.g.: risk of harm from falls and pressure injuries.

See "Restraint of a Person" policy.
https://actgovernment.sharepoint.com/:w:/r/sites/Intranet-CHS/PolicyRegister/Policy%20and%20Plans%20Register/Restraint%20of%20a%20Person.doc?d=wa2ab538e8e9642be98f65882379b9455&csf=1&web=1&e=VU8bUA

Commented [HJ(1]: This will need to be updated when the restrictive practices policy is finalised

Pharmacological Interventions
Medications are prescribed only if non-pharmacological strategies have not addressed the patient's behaviours of concern or eased their symptoms. The use of antipsychotics and other psychoactive medicines should be managed in accordance with best practice and legislation but utilised if the patient with Cognitive Impairment (Delirium and/or Dementia) is severely distressed or there is an immediate risk of harm to the patient or others.

Refer to Therapeutic Guidelines for the short-term management of acute behavioural disturbance, adult bed-based services Delirium | Therapeutic Guidelines (tg.org.au)

Section 4 – Recognising and Responding to Deteriorating Mental State

Formatted: Font: 14 pt

Deterioration in mental state refers to "changes in a person's mental state that indicate the need for closer observation, clinical review or more frequent review and for the introduction, change or increase of therapeutic interventions".

Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including:

- Mental illness
- Psychological or existential stress
- Physiological changes
- Cognitive impairment (including delirium)
- Intoxication, withdrawal from substances
- Environment.

Changes can be gradual or acute; they can be observed by staff, reported by the person themselves, or by their family or carers. When identifying and tracking change for that individual, the assessment should rely on accessing collateral information about the person's baseline mental health.

Five indicators of deterioration in a person's mental state may include:

1. Reported change
2. Distress
3. Loss of touch with reality or consequence of behaviours
4. Loss of function
5. Elevated risk to self, others or property.

See attachment 2 for definition of indicators and signs

When considering a person's baseline mental state, the assessment will consider all aspects of their illness as reported by the person, carer or family member. Assessment of baseline mental state includes the identification of early warning signs that may provide critical information as to when deterioration is occurring.

Cognitive impairment and delirium assessment should occur prior to further escalation of care. See Attachment 1 - Safety and quality pathway for patients with cognitive impairment, delirium, demenetia and deteriorating mental state

Initial assessment of a person's mental state is the responsibility of the current treating team.

Escalation of care

When there are any concerns regarding a person's change of baseline behaviour or any concerns regarding deterioration of their mental state, escalation must occur. Escalation actions are determined by the acuity of deterioration in the person's mental state in collaboration with the treating team. The process for escalation varies dependent on the service and location, however it is recommended that at a minimum the following processes occur:

Canberra Hospital:

- The treating clinician will report the deterioration to the senior clinician, registrar or consultant consistent with the ISBAR clinical handover procedure.
- An action plan is formulated with the clijnical team based on the assessment of the severity of deterioration.
- A determination will be made as to whether to refer the person to Mental Health Consultation Liaison, to Allied Health Services, or both, depending on the type of presentation and acuity of deterioration. (Note: not all cases of mental illness require psychiatric services, in some cases psychology and social work services are more appropriate)
- The person and their family/carer must be involved in care planning and management where possible.
- All treatment must be aligned with the persons consent or instruments of the relevant mental health or guardianship legislation.
- The deteriorating person will continue to be discussed daily at clinical reviews until the decision is made collectively that the person no longer requires idenitifying as a deteriorating patient.

University of Canberra Hospital:

- The treating clinician will report the deterioration to the senior clinician, registrar or consultant consistent with the ISBAR clinical handover procedure.
- An action plan is formulated with the clinical team based on the assessment of the severity of deterioration.
- A determination will be made as to whether to refer the person to Mental Health Team or to Allied Health Services, or both, depending on the type of presentation and acuity of deterioration. (Note: not all cases of mental illness require psychiatric services, in some cases psychology and social work services are more appropriate)
- The person and their family/carer must be involved in care planning and management where possible.

- All treatment must be occupied with the persons consent or instruments of the relevant mental health or guardianship legislation.
- The deteriorating person will continue to be discussed daily at clinical reviews until the decision is made collectively that the person no longer requires idenitifying as a deteriorating patient.

Responding to deterioration in a person's mental state

A shared decision making framework is inclusive of the person, carer, family and support persons to develop a comprehensive and individualised plan which includes recommended follow up and time frames. The response may include consideration of:

- Existing treatment plans for management of deterioration e.g. utilisation of PRN medications or non-pharmacological interventions such as de-escalation
- Assertive intervention by the treating team in collabotarion with Allied Health and/ or Consulation Liaison Psychiatry; including face to face assessment, medical review, and pharmaceutical, practical and psychotherapeutic approaches
- Strategies outlined in the person's Advace Consent Directive, care plan, behavioural management or other care plan
- Enacting emergency detention as per the *Mental Health Act 2015* if criteria is met
- Referral to external experts if required e.g. geriatrician, neurology etc if appropriate
- Community resources and supports such as Non-Government Agencies (NGOs), friends, family that may be able to support the person
- Communication to shared care providers such as the person's general practitioner
- Ongoing assessment of the persons risk for self-harm, suicide, aggression and absconding using the appropriate tools

Back to Table of Contents

Evaluation

Outcome:
Diagnostic related group funding to reflect the recognition of Cognitive Impairment (Delirium and/or Dementia) and deteriorating mental state in patients on admission to Canberra Health Services.

All patients identified as having Cognitive Impairment (Delirium and/or Dementia) have Cognitive Impairment identifier displayed at bedside to ensure staff awareness. To give better patient centred care and to prevent complications.

Measures:
Training to identify Cognitive Impairment (Delirium and/or Dementia) and deteriorating mental state has been completed with compliance verified via an annual audit of Capabiliti.

All patients identified as having Cognitive Impairment (Delirium and/or Dementia) have cognitive impairment identifier placed at bedside to ensure staff awareness.

All cases of Cognitive Impairment (Delirium and/or Dementia) and mental illness ~~and~~ have an individualised comprehensive care plan recorded on the discharge summary forwarded to the general practitioner.

Reduced length of stay due to early identification and management of Cognitive Impairment (Delirium and/or Dementia).

Identifying all CHS inpatients with Cognitive Impairment (Delirium and/ or Dementia) and deteriorating mental state with adherence to the procedure verified via an annual audit process.

Reviewing Hospital Acquired Complications (HAC) dashboard for rates of Delirium acquired within CHS.

Back to Table of Contents

Related Policies, Procedures, Guidelines and Legislation

Consumer Information

- Cognitive Impairment Identifier - Information for Patients, Families, Support People and Carers
- Delirium (Recent Onset Confusion) - Information for Patients, Families, Support People and Carers

Policies

- Clinical Records Management Policy
- Informed Consent - Clinical
- Occupational Violence Policy
- ~~Restraint of a Person~~

Procedures

- Advance Care Planning
- Falls Prevention and Management
- Increased Nursing Patient Care and or Supervision
- Language Services - Interpreters and Translated materials
- Occupational Violence Procedure
- Vital Signs and Early Warning Scores.docx (sharepoint.com)
- Restrictive practices in non-mental health areas

Guidelines

- Use of Palliative Care Sedation Therapy (Adults).docx (sharepoint.com)
- A better way to care (second edition) | Australian Commission on Safety and Quality in Health Care

- Clinical Guidelines for Dementia - Cognitive Decline Partnership Centre (sydney.edu.au)
- Delirium Clinical Care Standard | Australian Commission on Safety and Quality in Health Care
- NSQHS Standards user guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium | Australian Commission on Safety and Quality in Health Care

Legislation

- *Human Rights Act 2004* (ACT)
- *Health Act 1993* (ACT)
- *Health Records (Privacy and Access) Act 1997* (ACT)
- *Mental Health Act 2015* (ACT)
- *Senior Practitioner Act 2018* (ACT)
- *Work Health and Safety Act 2011* (ACT)

Back to Table of Contents

References

1. Australian Commission on Safety and Quality in Health Care. Comprehensive Care Standard https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard
2. Australian Commission for Safety and Quality in Health Care. Recognising and Responding to Acute Deterioration Standard https://www.safetyandquality.gov.au/standards/nsqhs-standards/recognising-and-responding-acute-deterioration-standard
3. Australian Commission for Safety and Quality in Health Care. Delirium Clinical Care Standard. 2021. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/delirium-clinical-care-standard
4. Australian Commission for Safety and Quality in Health Care. A better way to care (second edition): Safe and high-quality care for patients with cognitive impairment or at risk of delirium in acute health services. . https://www.safetyandquality.gov.au/publications-and-resources/resource-library/better-way-care-second-edition
5. Australian Commission on Safety and Quality in Health Care. Cognitive Impairment https://www.safetyandquality.gov.au/our-work/cognitive-impairment
6. Bellelli G, et al. Validation of the 4AT, a new instrument for rapid delirium screening: a study in 234 hospitalised older people. Age Ageing. 2014 Mar; 43: 496–502. Available from: DOI: 10.1093/ageing/afu021
7. Dementia Care in Hospitals Program, Ballarat Health Service. https://www.bhs.org.au/node/130 2017
~~7.~~8. Gaskin, C & Dagley, G. (2018). Recognising Signs of Deterioration in a Person's Mental State. Sydney: ACSQHC https://www.safetyandquality.gov.au/sites/default/files/migrated/Recognising-Signs-of-Deterioration-in-a-Persons-Mental-State-Gaskin-Research-Final-Report.pdf
~~8.~~9. Inouye S. The Short Confusion Assessment Method (Short CAM): Training Manual and Coding Guide. 2014; Boston: Hospital Elder Life Program

Formatted: No underline, Font color: Auto

Formatted: No Spacing

Formatted: Font: +Body (Calibri)

~~9.~~10. ICD-11 International Classification of Diseases for Mortality and Morbidity Statistics 11th Revision. World Health Organization. 2018. https://www.who.int/standards/classifications/classification-of-diseases

Back to Table of Contents

Definition of Terms

Cognitive Impairment: Difficulty with memory, thinking, concentration, and ability to read and write. People may be cognitively impaired due to an acquired brain injury, a stroke or an intellectual disability.

Delirium: A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours or days) and tends to fluctuate during the course of the day. Recovery is expected to be complete if the underlying cause (e.g. physical illness, drug toxicity) is promptly corrected or self-limited.

Dementia is a syndrome: usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e., the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not affected.

On Presentation: means within 24 hours of presentation at hospital. This includes any time that the patient may have spent in the emergency department.

Mental state: is broadly understood to refer to the person's intellectual capacity, emotional state, and general mental health based on clinical observations and interviewing. Mental state comprises mood, behaviour, orientation, judgement, memory, problem solving ability and contact with reality.

Formatted: Font: Bold

Deterioration in mental state: refers to changes in a person's mental state that indicate the need for closer observation, clinical review or for the introduction, change or up-scaling of therapeutic interventions.

Formatted: Font: Bold

Formatted: Font: Bold

Back to Table of Contents

Search Terms

Cognition, Cognitive Impairment, Delirium, Dementia, Mental Illness, Mental State, Deterioration~~.~~

Back to Table of Contents

Attachments

Attachment 1: Pathway for Assessment and Management of Cognitive Impairment

Disclaimer: *This document has been developed by Canberra Health Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Canberra Health Services assumes no responsibility whatsoever.*

Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*

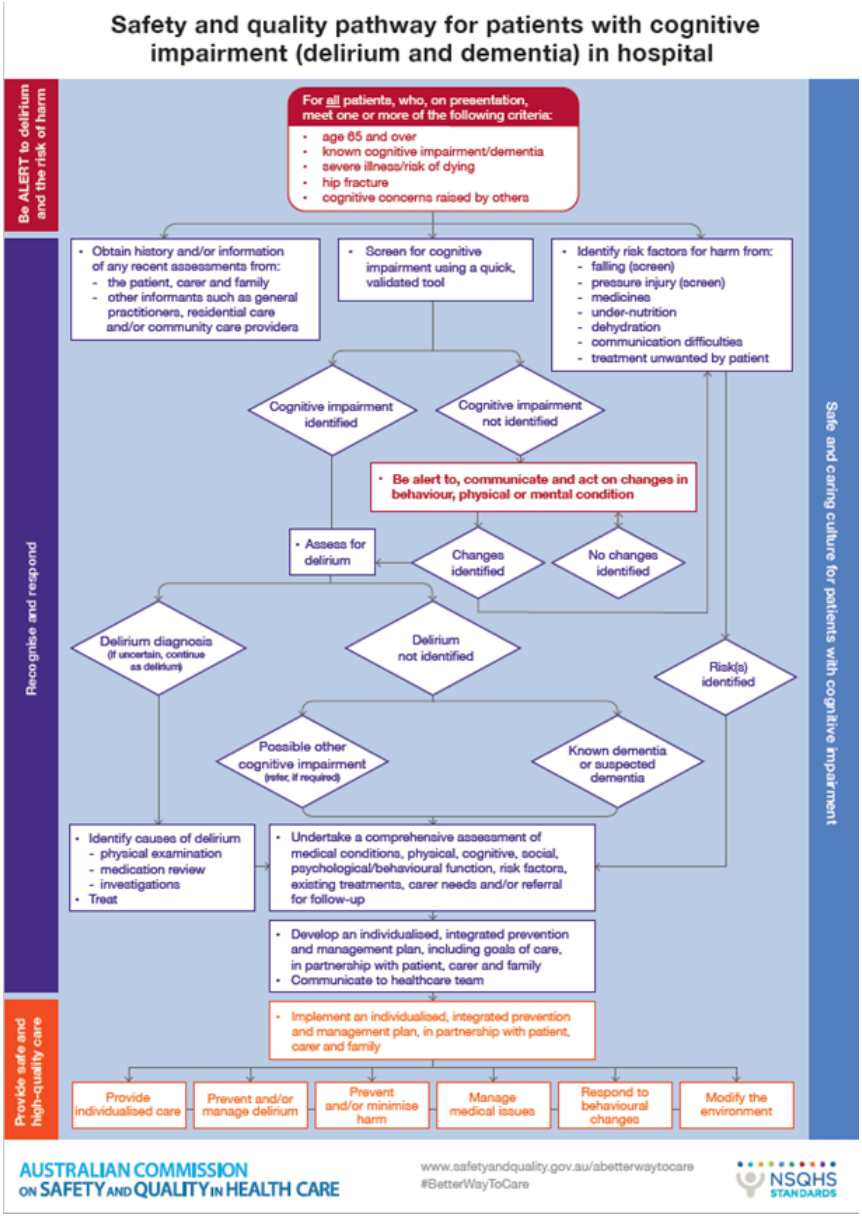
This document supersedes the following:

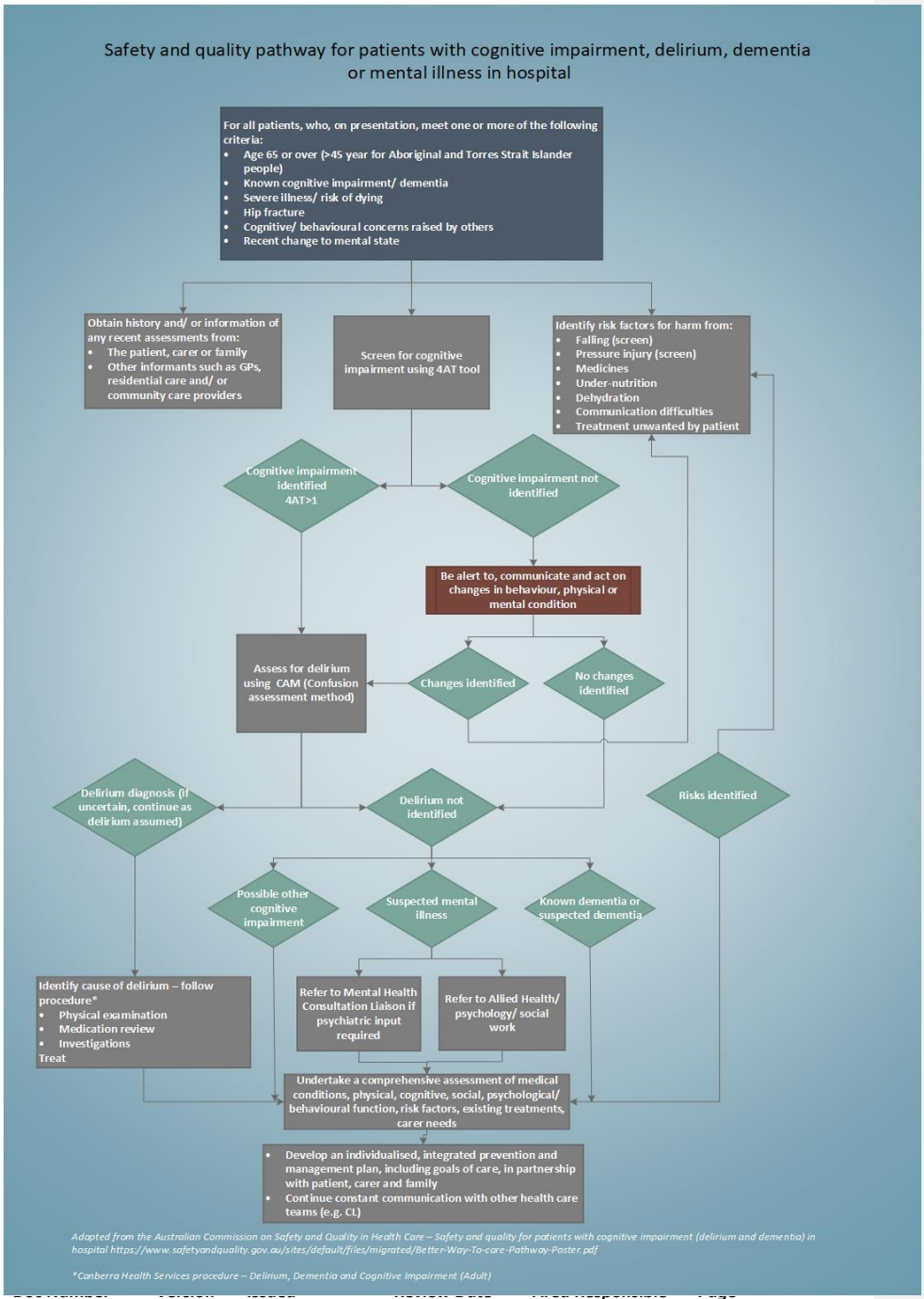
Document Number	*Document Name*

~~**Attachment 1: Pathway for Assessment and Management of Cognitive Impairment**~~

Attachment 1 - Safety and quality pathway for patients with cognitive impairment, delirium, demenetia and deteriorating mental state

Formatted: Font: Bold


Safety and quality pathway for patients with cognitive impairment (delirium and dementia) in hospital
Be ALERT to delirium and the risk of harm
Recognise and respond
Provide safe and high-quality care
Safe and caring culture for patients with cognitive impairment
For all patients, who, on presentation, meet one or more of the following criteria:
age 65 and over
known cognitive impairment/dementia
severe illness/risk of dying
hip fracture
cognitive concerns raised by others
Obtain history and/or information of any recent assessments from:
the patient, carer and family
other informants such as general practitioners, residential care and/or community care providers
Screen for cognitive impairment using a quick, validated tool
Identify risk factors for harm from:
falling (screen)
pressure injury (screen)
medicines
under-nutrition
dehydration
communication difficulties
treatment unwanted by patient
Cognitive impairment identified
Cognitive impairment not identified
Be alert to, communicate and act on changes in behaviour, physical or mental condition
Assess for delirium
Changes identified
No changes identified
Delirium diagnosis (if uncertain, continue as delirium)
Delirium not identified
Risk(s) identified
Possible other cognitive impairment (refer, if required)
Known dementia or suspected dementia
Identify causes of delirium
physical examination
medication review
investigations
Treat
Undertake a comprehensive assessment of medical conditions, physical, cognitive, social, psychological/behavioural function, risk factors, existing treatments, carer needs and/or referral for follow-up
Develop an individualised, integrated prevention and management plan, including goals of care, in partnership with patient, carer and family
Communicate to healthcare team
Implement an individualised, integrated prevention and management plan, in partnership with patient, carer and family
Provide individualised care
Prevent and/or manage delirium
Prevent and/or minimise harm
Manage medical issues
Respond to behavioural changes
Modify the environment
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE
www.safetyandquality.gov.au/abetterwaytocare
#BetterWayToCare
NSQHS STANDARDS


Safety and quality pathway for patients with cognitive impairment, delirium, dementia or mental illness in hospital
For all patients, who, on presentation, meet one or more of the following criteria:
Age 65 or over (>45 year for Aboriginal and Torres Strait Islander people)
Known cognitive impairment/ dementia
Severe illness/ risk of dying
Hip fracture
Cognitive/ behavioural concerns raised by others
Recent change to mental state
Obtain history and/ or information of any recent assessments from:
The patient, carer or family
Other informants such as GPs, residential care and/ or community care providers
Screen for cognitive impairment using 4AT tool
Identify risk factors for harm from:
Falling (screen)
Pressure injury (screen)
Medicines
Under-nutrition
Dehydration
Communication difficulties
Treatment unwanted by patient
Cognitive impairment identified 4AT>1
Cognitive impairment not identified
Be alert to, communicate and act on changes in behaviour, physical or mental condition
Assess for delirium using CAM (Confusion assessment method)
Changes identified
No changes identified
Delirium diagnosis (if uncertain, continue as delirium assumed)
Delirium not identified
Risks identified
Possible other cognitive impairment
Suspected mental illness
Known dementia or suspected dementia
Identify cause of delirium – follow procedure*
Physical examination
Medication review
Investigations
Treat
Refer to Mental Health Consultation Liaison if psychiatric input required
Refer to Allied Health/ psychology/ social work
Undertake a comprehensive assessment of medical conditions, physical, cognitive, social, psychological/ behavioural function, risk factors, existing treatments, carer needs
Develop an individualised, integrated prevention and management plan, including goals of care, in partnership with patient, carer and family
Continue constant communication with other health care teams (e.g. CL)
Adapted from the Australian Commission on Safety and Quality in Health Care – Safety and quality for patients with cognitive impairment (delirium and dementia) in hospital https://www.safetyandquality.gov.au/sites/default/files/migrated/Better-Way-To-care-Pathway-Poster.pdf
*Canberra Health Services procedure – Delirium, Dementia and Cognitive Impairment (Adult)

Attachment 2 – Signs of mental state deterioration : definitions, indicators abd cluster signs of mental state deterioration (Gaskin, Dagley, 2019, p.6)

Formatted: Font: Bold

Signs of Mental State Deterioration	
Definition: A change for the worse in a person's mental state, compared to the most recent information available for that person, which may indicate a need for additional care.	
Assessing Change **Identifying and tracking change relies on the availability of individual baseline information to which a person's current mental state can be compared.** **Baseline information** ⟷ **Current mental state**	
Indicators of deterioration	**Cluster of signs of deterioration**
Reported Change **A person, or someone who knows the person well, reports that her or his mental state is changing for the worse.**	- Self-initiated requests for assistance - Requests for treatment from healthcare professionals or those close to the person - Self-reported negative or inflated sense of self - Self-reported uncontrollable thought processes - Self-reported negative emotions
Distress **A person, or someone involved in her or his care, shows signs of distress, which are evident through observation and conversation.**	- Uncharacteristic facial expressions - Physiological/ medical deterioration - Negative themes in conversation - Apparent distress of self or others
Loss of touch with reality or consequence of behaviour **A person is losing touch with reality or consequences of her or his behaviour/s.**	- Experiencing delusions - Experiencing hallucinations - Unusual self-presentation - Unusual ways of behaving - Appearing confused during conversations
Loss of function **A person is losing her or his ability to think clearly, communicate, or engage in regular activities.**	- Unusual movement patterns - Loss of skills - Poor daily self-care - Reduction in regular activities - Difficulty participating in conversations - Unusual speech during conversations - Seemingly impaired memory - Apparent difficulty with thinking about things in different ways
Elevated risk to self, others or property **A person's actions indicate an increased risk to self, others, or property.**	- Increases in the use of restrictive practices - Reduced safety of self - Reduced safety of others - Reduced safety of property - Disengaging from treatment - Unresponsive to treatment

Attachment 3 – Recognising and responding to acute deterioration in a person's mental state tool for medical wards

Formatted: Font: Bold

Formatted: Font: Bold

Recognising deterioration in a persons mental state

- **Deterioration** refers to a change in a person's mental state that indicates the need for closer observation, clinical review or more frequent review and for the introduction, change or up-scaling of therapuetic interventions.
- **Five indicators of deterioration in a persons mental state may include:**
  - Reported change in bhevaiour or cognition
  - Distress
  - Loss of touch with reality or consequences of behaviours
  - Loss of function
  - Elevated risk to self or others or property

Escalating care

- Treating clinician will conduct baseline cognitive function screen including the 4AT and CAM (if indicated) to exclude delirium, and baseline mental state examination; and report deterioration to a clinical senior using the ISBAR format
- An identificationmechanism for deteriorating patient will exist for each team
- A thorough organic work up will be conducted to eliminate physiological causes for the deterioration
- The deterioration will be discussed at clinical handover, MDT and clinical rounds
- Senior medical officer will determine suitability for referral to Allied Health/ Consultation Liaison Psychiatry
- Urgent referrals to Allied Health or Consultation Liaison must be accompanied by a phone call

Responding to deterioration in mental state

- Consultation advice and assessment may be provided by Allied Health or by the Consultation Liaison Psychiatry Team, and the assessment and plan documented and utilised to inform a proactive management approach, in consultation with the treating doctor.
- Where necessary, an interhospital transfer may be required to a more suitable environment, based on the patient's presentation
- Releapse prevention plans, Advanced Care Directives and other existing plans should be incorporated into the management plan