Confusion care pathway

To improve care for anyone with dementia, delirium or cognitive impairment

			Initial	Date
Within 24h (doctor/nurse)	**IDENTIFY CONFUSION**	• Check clerking 'dementia / delirium assessment' completed • Apply sticker to clerking booklet • Put identifier above bed • Record on 'Confusion Care Pathway' in medical notes • Ask carer to complete & return 'Important Things About Me'		
Within 72 h (doctor)	**MEDICAL ASSESSENT** (Document in EDN)	• Collateral history: describe nature & severity of cognitive impairment • What is overall impression: dementia/delirium/both/unclear? • Investigate the causes		
Throughout (MDT)	**DON'T MOVE**	• Unless better for patient • Avoid overnight moves • Justify any moves in the medical notes and liaise with family		
Throughout (MDT/family)	**CAREPLAN**	• Assess ADLs, mobility & falls risk • Assess for pain • Support with eating / drinking • Flexible carer visiting • Assess bowel care/continence • Management of behaviours that challenge ▪ Consider legal status		
Throughout (MDT/family)	**DISCHARGE PLAN**	• Family involvement is key • Allow time for recovery - consider non-permanent discharge options if delirium • Consider need for diagnostic assessment after hospital • Complete discharge summary accurately		

http://lnwhintranet/departments/dementia-delirium-and-cognitive-impairment/trust-confusion-care-pathway/

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DELIRIUM OR DEMENTIA

Delirium is extremely common. **If the syndrome is unclear manage initially as if delirium**. Use CAM (Confusion Assessment Method) to help identify delirium. **Dementia is best diagnosed post-admission**.

BEHAVIOURS THAT CHALLENGE

In many cases the acute environment and illness exacerbate distress and agitation.

- gather **background information** from family to set in context (essential)
- setup behavioural charting to help identify triggers and approaches that help
- **look for unmet needs**
- identify and have low threshold for treating pain
- identify and correct sensory impairment if possible
- avoid antipsychotics unless on specialist advice
- avoid transitions in care
- do not nurse patients with security guards
- follow LNWH Enhanced Supportive Observational Guideline

IF FURTHER ADVICE IS NEEDED

- distress / behaviour that challenges / complex needs: first liaise with Ward Manager
- diagnostic complexity / risk management and treatment / additional mental health problems: refer Liaison Psychiatry (ICE referral – NPH / White card – CMH / bleep 456 – Ealing)

MDT CAREPLANNING

Ensure the following are considered;

- assessment of functional abilities
- assess for pain
- help with orientation aids, consider communication strategies
- consider ways to improve sleep
- optimise mobility and falls risk
- correct sensory impairments
- consider support needed with eating and drinking
- consider legal status– Mental Capacity Act, DOLS, Mental Health Act, Advance Directives
- consider the need for palliative care input / anticipatory care planning / end of life care

FOLLOW UP

Known dementia: usual follow up

Possibility of undiagnosed dementia:

-Ealing; Refer direct to memory service if delirium excluded

-NPH/CMH: Request GP review at 4 weeks, and refer to memory service if indicated

In all cases the following is <u>essential</u>

- a thorough discharge summary outlining history of functional / cognitive change and diagnostic impression
- any cognitive tests
- all inpatient medical tests results (incl. TFT, B12, Folate & neuroimaging)
- **Discussion with the family about any suspicion of dementia and advice on follow-up.**