K&L GATES

7 September 2026

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Our ref: 7370394.03524

Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

By email: [redacted]

Dear CPU team

COR 2022 005588 - Coronial investigation into the death of Damien Stone (deceased)

1. Introduction

1.1 We act on behalf of Barwon Health (**the Hospital/our client**) in relation to the abovenamed coronial investigation.

1.2 We refer to the Findings of Coroner Audrey Jamieson dated 16 April 2026 in which recommendations were made pursuant to section 72(2) of the Coroners Act 2008 (**the Act**).

1.3 We write on behalf of our client to provide the following responses to those recommendations pursuant to section 72(3) of the Act.

2. Barwon Health response

Recommendation 1(a)

Accompany the release of their revised Pain Management Policy that includes the assessment of pain in differently abled persons, with training for clinical staff in assessing and managing pain in people with cognitive impairment, especially communication issues.

2.1 Our client's response: The Coroner's recommendation will be implemented.

2.2 The Hospital agrees with this recommendation. The Hospital's Pain Management Guideline is being revised to apply across all areas of the organisation. The guideline currently focuses on the aged care setting and is being revised to incorporate the Abbey Pain Scale for assessing pain in cognitively impaired patients, which will be extended organisation wide. We have enclosed a copy of the Hospital's Delirium and Cognitive Impairment – Assessment and Management Procedure dated 31 August 2026. The Pain Management Guideline is being revised to similarly incorporate the Abbey Pain Scale. Training for clinical staff in the assessment of pain is already included in a number of the Hospital's existing training events (examples listed below);

however, this training is not currently specific to the care of people with cognitive impairment or communication issues. The training curriculum will be reviewed and updated to align with the revised Pain Management Guideline, with a particular focus on assessing and managing pain in patients with a cognitive impairment and communication difficulties.

2.3 The Hospital's current training events which will be reviewed and updated include:

(a) International Clinical Staff Study Day, which addresses patient assessment, sepsis recognition and escalation for clinical staff of all disciplines.

(b) Essentials of Acute Medical Nursing Study Day, which covers effective patient assessment, communication and escalation practices, and recognition of deterioration.

(c) Inclusive Care Study Day (2025 and 2026), which addresses disability, neurodivergence and inclusive care practices and their impact on accessing health services.

(d) AHCEN Complex Case Series - Disability, an interdisciplinary clinical educators' session on complex clinical case management for patients with disability in the inpatient setting.

(e) Recognising and Responding to Acute Deterioration Study Day, which covers recognition of deteriorating patients, structured communication (ISBAR) and escalation.

Recommendation 1(b)

Consider that nursing staff use the existing Barwon Health Health Passport where appropriate and especially when the patient is non-verbal, to guide information collection from people with disability, their families and carers, to inform patient-centred care planning.

2.4 Our client's response: The Coroner's recommendation has been implemented and the Coroner's recommendation will be implemented.

2.5 The development of the Hospital's Health Passport is currently facilitated by the Disability Liaison Officers on referral, when a patient is identified as appropriate for a Health Passport, and it is used by nursing staff and other members of the multidisciplinary team. Face-to-face training on the Health Passport is provided by the Disability Liaison Officers.

2.6 There is not currently a procedure or guideline formally supporting and standardising the use of the Health Passport, including guidance on when nursing staff should proactively seek referral for one, such as when a patient is non-verbal.

2.7 The Hospital are developing a 'Health Passport' procedure to provide staff with clear guidance on the use of the Health Passport, including prompting its use in circumstances such as those encountered in the Deceased's admission. This procedure is currently in its final draft and is awaiting endorsement by the Hospital's Comprehensive Care Committee.

2.8 The Hospital's Delirium and Cognitive Impairment – Assessment and Management procedure: Special Considerations – Consumers with a Disability dated 31 August 2026 notes that consumers who identify as having a disability are referred by clinical staff to the Disability Liaison Office for a "My Health Passport" to be completed and available to the wards before or on admission.

2.9 The Hospital further confirms that it is developing and implementing Disability Champions on each ward, with a trial planned for busier wards. The implementation of Disability Champions is addressed further under the response to recommendation 1(c). The Disability Champions will be supported by the Disability Liaison Office. Their training will include information about My Health Passports, disability awareness and the GROW training module. They will also provide face-to-face education to ward staff, with the aim of improving early identification of patients with disability and referral to the Disability Liaison Office where a referral has not already been made.

Recommendation 1(c)

Consider implementing professional development for nursing staff on providing patient-centred care to patients with a cognitive disability. The 'disability champion/lead' actioned by the Inclusive Victoria State Disability Plan 2022-2026 for each health service partnership would be ideally placed to promote appropriate professional development and capacity-building within the service.

2.10 Our response: The Coroner's recommendation has been implemented and the Coroner's recommendation will be implemented.

2.11 The Hospital confirms that training for staff on the care of patients with a disability, including a disability awareness training package, is already in place. The Hospital intends to implement a pilot of the Hidden Disabilities Sunflower Project within the next 12 months, which will involve establishing and supporting disability champions across the organisation, consistent with the model contemplated by the Inclusive Victoria State Disability Plan 2022 to 2026.

2.12 Training will be further updated based on the outcomes of that pilot. This work will be supported by the Barwon Health Inclusion and Equity Framework for staff and consumers, which is currently in development.

2.13 Evidence relied upon:

(a) The existing suite of interdisciplinary training addressing disability, bias and inclusive clinical practice, including the AdvICE program (comprising the Core Course and Deep Dive Days such as Effective Communication, Professionalism and Humanism, and Pride and Prejudice in Clinical Practice), the Inclusive Care Study Day (2025 and 2026), and the AHCEN Complex Case Series – Disability, as identified in response to Recommendation 1(a) above.

(b) Barwon Health's planned pilot of the Hidden Disabilities Sunflower Project and the Barwon Health Inclusion and Equity Framework (currently in development), as described above.

2.14 The Hospital confirms that copies of the relevant training materials, flyers and the Health Passport template referred to above are available to the Court on request.

2.15 Barwon Health appreciates the Court's invitation to provide a response to the above recommendations.

2.16 Should the Court require any further information or clarification in relation to this response, please contact me or Steph Ferguson.

Yours faithfully

Emma Dawes
Partner

Table of Contents

Purpose

The purpose of the procedure is to provide guidance for clinical staff in the prevention, identification, assessment and management of delirium within University Hospital Geelong (UHG), the McKellar Centre Inpatient Rehabilitation Unit (IRC) and @Home programs. This procedure also includes principles to guide the care of people with dementia and other forms of cognitive impairment during their admission.

The procedure does not relate to consumers in ICU (refer to Agitation and Delirium Assessment and Management in ICU), or consumers with Post Traumatic Amnesia (See Mild Traumatic Brain Injury Abbreviated Westmead PTA Scale) or Delirium Tremens/Alcohol withdrawal syndrome (See Alcohol Withdrawal - Acute Management).

Link to Policy

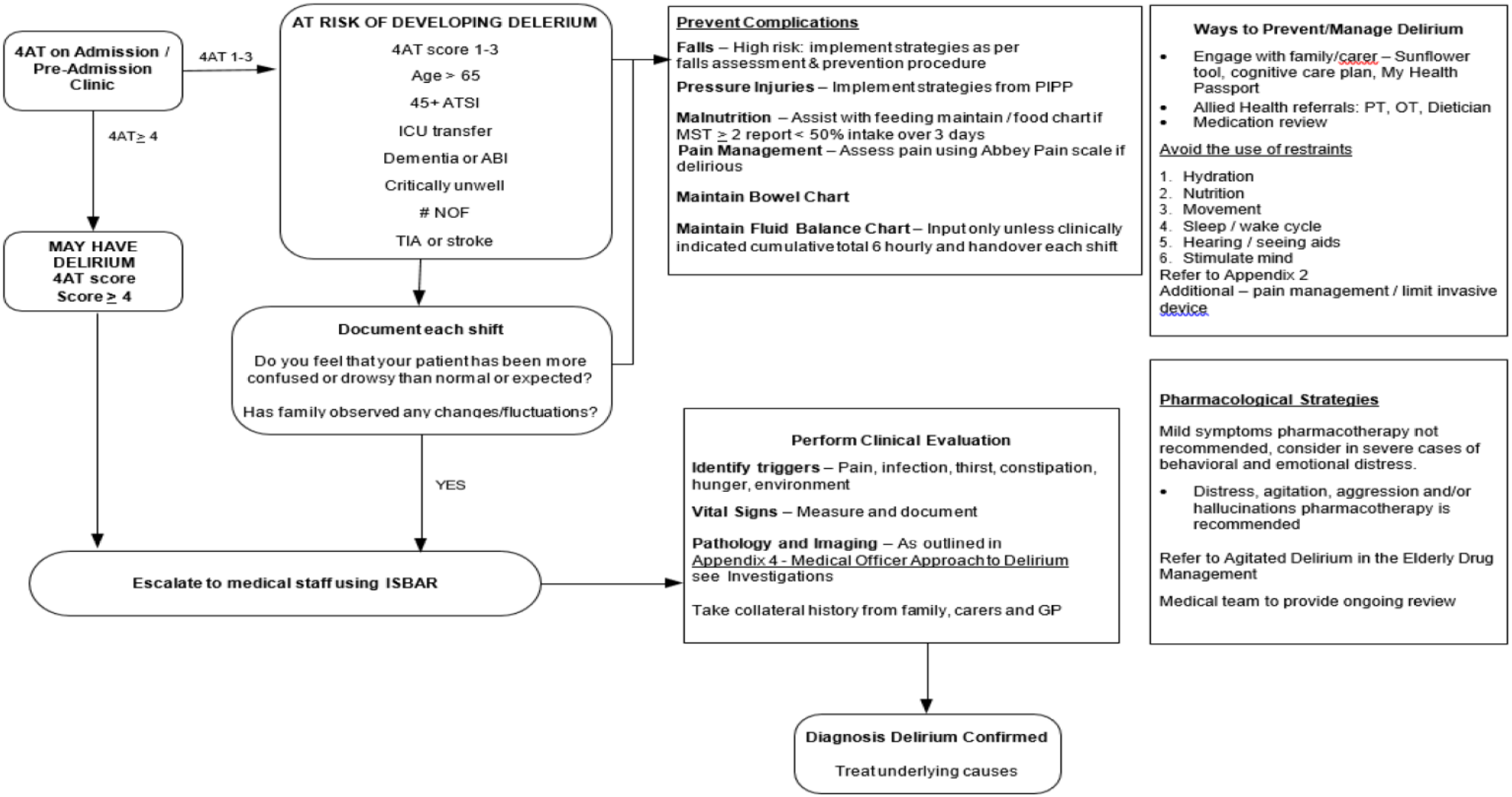
The **Delirium & Cognitive Impairment – Assessment & Management** procedure is linked to the Barwon Health Safety & Quality Policy.

Target Audience

Clinicians within scope of practice.

Definitions

4AT	Delirium Assessment Tool.
AMT	Abbreviated Mental Test.
ATSI	Aboriginal and Torres Strait Islander.
CALD	Culturally and Linguistically Diverse.
Cognitive Impairment	An overarching term referring to deficits in one or more areas of cognition including memory, communication, attention, thinking or problem solving. This term is used in this document to include people with dementia and other forms of cognitive impairment, which may include Mild Cognitive Impairment, Acquired Brain Injury and Intellectual Disability.
Delirium	Is an acute change in mental status that is often triggered by acute illness, surgery, injuries or adverse effect of medicines. Delirium is characterised by disturbances in consciousness, attention, cognitive function and/or perception that develop over a short period of time. The symptoms of delirium may include difficulty with attention/concentration, altered conscious state, altered sleep-wake cycle, hallucinations, delusions, paranoia and impairment of aspects of cognition such as memory or language. Consumers may have a hyperactive subtype (heightened arousal, restlessness, agitation and aggression) or a hypoactive subtype (quiet, lethargic, drowsy, withdrawn, and not interested in activities) or a mixture of both. The hypoactive subtype may go undetected without screening.
Dementia	Dementia describes a collection of symptoms that is caused by different brain diseases. Dementia affects thinking, behaviour and the ability to perform everyday tasks. These symptoms typically emerge gradually and progress in severity over time. Brain function is affected to the degree that it interferes with someone's normal social or working life. The diseases that commonly cause dementia include Alzheimer's disease, dementia with lewy bodies, vascular dementia, and frontotemporal dementia. (See Dementia Information CDAMS).
MMSE	Mini-Mental State Examination.
MOCCA	Montreal Cognitive Assessment.
RUDAS	Rowland Universal Dementia Assessment Scale.


4AT on Admission / Pre-Admission Clinic
4AT 1-3
4AT≥ 4
AT RISK OF DEVELOPING DELERIUM
4AT score 1-3
Age > 65
45+ ATSI
ICU transfer
Dementia or ABI
Critically unwell
NOF
TIA or stroke
MAY HAVE DELIRIUM 4AT score Score ≥ 4
Document each shift
Do you feel that your patient has been more confused or drowsy than normal or expected?
Has family observed any changes/fluctuations?
YES
Escalate to medical staff using ISBAR
Prevent Complications
Falls – High risk: implement strategies as per falls assessment & prevention procedure
Pressure Injuries – Implement strategies from PIPP
Malnutrition – Assist with feeding maintain / food chart if MST ≥ 2 report < 50% intake over 3 days
Pain Management – Assess pain using Abbey Pain scale if delirious
Maintain Bowel Chart
Maintain Fluid Balance Chart – Input only unless clinically indicated cumulative total 6 hourly and handover each shift
Perform Clinical Evaluation
Identify triggers – Pain, infection, thirst, constipation, hunger, environment
Vital Signs – Measure and document
Pathology and Imaging – As outlined in Appendix 4 - Medical Officer Approach to Delirium see Investigations
Take collateral history from family, carers and GP
Diagnosis Delirium Confirmed
Treat underlying causes
Ways to Prevent/Manage Delirium
Engage with family/carer – Sunflower tool, cognitive care plan, My Health Passport
Allied Health referrals: PT, OT, Dietician
Medication review
Avoid the use of restraints
1. Hydration
2. Nutrition
3. Movement
4. Sleep / wake cycle
5. Hearing / seeing aids
6. Stimulate mind
Refer to Appendix 2
Additional – pain management / limit invasive device
Pharmacological Strategies
Mild symptoms pharmacotherapy not recommended, consider in severe cases of behavioral and emotional distress.
Distress, agitation, aggression and/or hallucinations pharmacotherapy is recommended
Refer to Agitated Delirium in the Elderly Drug Management
Medical team to provide ongoing review

Background

Delirium is a common but under-recognised medical emergency for consumers in healthcare settings. Delirium increases the risk of death, the risk of hospital acquired complications including falls, pneumonia, malnutrition and decline in functional ability and the increase the length of stay in hospital. While prevention is the most effective strategy, early intervention can also improve outcomes for consumers with delirium.

The principles of delirium care are:

- Identify consumers at risk of delirium
    - By screening using the 4AT delirium assessment tool
    - By identifying consumers with risk factors for delirium
        - Age >65 or >45 for Aboriginal and Torres Strait Islander People
        - Known cognitive impairment or diagnosis of dementia
        - A previous diagnosis of delirium
        - A severe medical illness (a clinical condition that is deteriorating or is at risk of deterioration)
        - Current hip fracture
- Prevent delirium
- Provide information and support
- Assess and diagnose delirium
- Identify and treat underlying causes
- Prevent complications of delirium
- Avoid use of antipsychotic medications

The principles of delirium care are recommended for consumers with dementia and other forms of cognitive impairment as this consumer group is at high risk of morbidity and mortality during their hospital stay.

Risk of Hospital Acquired Complications

Consumers with a cognitive impairment including delirium have a higher risk of hospital acquired complications.

Please refer to the following linked procedures to ensure appropriate prevention strategies are implemented;

- Diversional Therapy
- Falls Assessment and Prevention
- Food, Nutrition and Hydration Framework
- Pressure Injury Prevention and Management Manual
- Safe Use of Bed Rails

Procedure Manual

Identify Consumers at Risk of Delirium

Cognitive Screening

- Nursing staff must complete the 4AT within 8 hours of admission to the UHG or IRC McKellar Centre for:
    - Consumers aged > 65 years, or aged >45 years for Aboriginal and Torres Strait Islander people
    - Consumers with a previous diagnosis of delirium

- Consumers with known cognitive impairment including dementia
- Consumers who have had an acute change in behavior or cognitive functioning

See Risk Screen Tool Adult - BHS06534

For CALD consumers use an interpreter (preferably face to face) to complete the 4AT (translated documents available at 4AT Delirium Assessment Tool Translations. Consider medical/occupational therapy to complete RUDAS

- Repeat screening to occur
  - Changes in the consumer's condition – including behavior and cognition
  - A carer or family member report changes in cognition or behaviors
  - A sudden decline in the person's baseline functional capacity
  - Daily for 3 days post a procedure requiring sedation or an anaesthetic if remaining an inpatient
  - Upon ward transfer
- All consumers admitted to GEM@Home are screened with the 6CIT. Further screening may include; AMT, MOCCA or MMSE.

Care for People with Dementia and Other Forms of Cognitive Impairment in Hospital

Prevent Delirium

If 4AT Score is 1-3 (Possible cognitive impairment or consumers at risk of delirium): Identify and address any delirium risk factors

- Implement delirium prevention strategies (See Appendix 2 - Non Pharmacological Prevention and Management Strategies), (See Appendix 1 – If the consumer is unable to communicate their pain, use the Abbey Pain Scale)
- Consider placing cognitive impairment identifier (See Cognitive Impairment Identifier) sticker on consumer's bed card and on the care plan
- Ensure the 4AT score is reflected on the handover tool / Journey Board
- Medical Officer to investigate and manage potential causes of cognitive deterioration (See Appendix 4 – Medical Officer Approach to Delirium)
- Ask the single question each time you interact with a consumer: "Does the consumer present more confused from previous interactions?" if 'Yes', repeat 4AT
- Complete a Cognitive Care Plan (See Cognitive Care Plan) in consultation with the consumer, family and/or carer. Contact Clinical Liaison Nurse (CLN) at UHG for assistance Phone: 0466 939 354

Special Considerations – Elective Surgery

- All preplanned elective surgery consumers complete Adult Elective Surgery Admission Form
- For consumers identified at risk of delirium – CLN advised of pending admission, cognitive care plan provided to the consumer, family and carer for completion prior to admission. Unit will receive Cognitive care plan prior to or at time of admission

Special Considerations – Consumers with a Disability

- Consumers who identify as having a disability are referred by clinical staff to the Disability Liaison Office for a "My health passport" to be completed and available to the wards prior or on admission.

Provide Information and Support

- Clinical staff to provide consumers at risk of delirium and their families with information about delirium and ask them to report any concerns. (See Delirium Consumer Information).

Assess and Diagnose Delirium, Identify and Treat Underlying Causes, Prevent Complications
If 4AT Score is 4 or above due to symptoms of delirium or in a consumer at risk of delirium.

In addition to the 'Prevent Delirium' actions above:

- Placing cognitive impairment identifier sticker on consumer's bed card and on care plan (See Cognitive Impairment Identifier)
- Inform Treating Medical Team and NIC/NUM
- Activate the blue light outside the consumer rooms in units that have Concentric Care Workflow Terminals
- Medical team to assess to confirm presence of delirium
  Take a collateral history from family, carers or contact GP to check for pre-existing established cognitive impairment or diagnosis of dementia
  Delirium is very common for consumers in hospital. Consumers to be assessed as though they have possible delirium until proven otherwise. The main differential diagnoses for delirium such as dementia or mental illness also require exclusion of organic causes. (See Appendix 4 - Medical Officer Approach to Delirium)
- Medical team to treat all possible contributing reversible causes of delirium
- Medical team to inform the consumer and their significant others of the diagnosis of delirium and provide written information (See Delirium Consumer Information)
- Consumer information is available in 15 languages from the Agency for Clinical Innovation 4AT Delirium Assessment Tool Translations
- Delirium diagnosis to be documented in the progress notes including when the delirium arose, likely causes including the presence of any underlining conditions such as dementia, as well as the plan for management. (See Appendix 5)
- If the consumer is unable to communicate their pain, use the Abbey Pain Scale (see Appendix 1)
- Prevent complications of delirium (See Appendix 2 - Non Pharmacological Prevention and Management Strategies
- Complete a Cognitive Care Plan (See Cognitive Care Plan)
- Medical team to continue to monitor the presence of delirium and confirm either ongoing delirium status or indicate that delirium has resolved. This to be reflected in the progress notes

In addition to the above measures for prevention and management of delirium:

- Consider the need to involve Medical Treatment Decision Maker/Support Person for medical decision making if consumer is unable (See Patient Capacity to Consent)
- Commence a Behavior Observation Chart (See Appendix 6) to monitor consumers with challenging behaviours or potential to develop behaviours of concern

For further advice and input, consider referrals to:

- Geriatric Consultation Service @UHG (medical referral via switchboard)
- Occupational Therapy (E-referral through BossNET UHG and blanket referral McKellar Centre IRC)
- Neuropsychology Department – only accessible at McKellar Centre
- Contact Clinical Liaison Nurse at UHG for assistance Phone: 0466 939 354
- Dementia Support Australia (Phone 1800 699 799) for people with Dementia who have Behavioural/Psychological symptoms of dementia/responsive symptoms

Avoid Antipsychotic Medications

- There are no pharmacological measures recommended to prevent or treat delirium or improve prognosis
- A full medication review and reconciliation should be conducted by the medical and pharmacy team – this should include consideration of the type and number of medications taken, including any sudden withdrawal of medications.
- Reducing, ceasing or avoiding the use of psychoactive drugs is recommended as they may worsen the delirium. There is no strong evidence that they effectively improve prognosis. They may prolong duration of delirium and associated cognitive impairment or simply switch patient's delirium from hyperactive to hypoactive delirium.
- Benzodiazepines to be avoided as they can worsen or prolong delirium, except in delirium related to alcohol, other substance withdrawal or seizures (See Alcohol Withdrawal - Acute Management)
- For evidence-based advice and guidance about the use of medications for agitated delirium management, see Agitated Delirium in the Elderly Drug Management)
- If pharmacological management is required, use for shortest period possible, document the indications for using and stopping use of antipsychotic medication in the patient's medical history, review frequently and inform patient's family and carers

Transition from Hospital/Discharge Planning and Follow-up

When planning a discharge for a person with delirium clinicians should ensure consultation with the consumer, family, carers and support services and complete the following:

- Document the episode of delirium in the consumers discharge summary, including precipitants/causes, management and details of any persisting symptoms
- Document any follow up or monitoring to be completed by the GP
- Consider the need for additional support (inpatient or community services)
- Provide written information about delirium to the consumer and their family or carers – Delirium Consumer Information
- Consider referral to Community Geriatrics Clinic, CDAMS (Cognitive, Dementia and Memory Service) or private geriatrician if there is a new undiagnosed cognitive impairment suspected

  Note: Further assessment of cognition requires sufficient time for the consumer to have recovered from the episode of delirium (usually allow 3 -6 months)
- For consumers being discharged to a residential aged care facility, other hospital or ward, a copy of the Cognitive Care Plan must be sent with the consumer

Considerations for Specific Population Groups

Aboriginal and Torres Strait Islander:

- Involve an Aboriginal Liaison Officer to assist with care planning and management. Contact Aboriginal Health Unit on 4215 0768

Culturally and Linguistically Diverse:

- Involve carers and family to assist with cultural and religious considerations whilst receiving care as an inpatient
- All interpreter booking request via Interpreter Management Systems or phone 52344 (Mon-Fri)

Consumers Identifying as Having a Disability:

- Involve the Disability Liaison Office to assist with care planning and management. Contact Disability Liaison Office on 0434 856 014

Consumers at End of Life: (Terminal Delirium or Terminal Restlessness)

- Terminal Delirium (also known as terminal restlessness) occurs in some consumers as they approach the end of their lives
- Careful consideration of the person's overall condition as well as potential alternative causes is required before a diagnosis of terminal delirium is made
- Symptoms to consider include unmet physical and/or psychosocial symptom needs, urinary retention, hypoxia or constipation
- Non-pharmacological management remains crucial to the management of terminal delirium
- For further advice, contact the Palliative Care Consultancy Service at UHG or the Palliative Care Unit at McKellar Centre

Evaluation

The Barwon Health Caring for Consumers with Cognitive Impairment Working Group is responsible for monitoring the Indicators outlined in the Delirium Clinical Care Standard and Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard.

A report is presented to the Consumer Experience and Clinical Governance Committee as per the committee's annual work plan.

Key Aligned Documents

Agitated Delirium in the Elderly Drug Management
Agitation and Delirium Assessment and Management in ICU
Alcohol Withdrawal - Acute Management
Behaviour Observation Chart - BHS04972
Clinical Communication Framework
Code Grey
Cognitive Care Plan
Cognitive Impairment Identifier
Comprehensive Care Procedure Manual
Comprehensive Care Framework
Delirium Assessment Tool 4AT BHS19503
Delirium Consumer Information
Diversional Therapy
Falls Assessment and Prevention
Food, Nutrition and Hydration Framework
Integrated Risk Screening
Mild Traumatic Brain Injury Abbreviated Westmead PTA Scale
Occupational Violence and Aggression
One Point Delirium Expert Advisory Group Site - Resources
Patient Specialling Acute and Sub-Acute Services
Pressure Injury Prevention and Management Manual
Safety & Quality Policy
Safe Use of Bed Rails
Therapeutic Toys Purchase and Maintenance

Key Legislation, Acts & Standards

Australian Charter of Healthcare Rights

Australian Commission on Safety and Quality in HealthCare, Delirium Clinical Care Standard (2021)

Health Services Act 1988

National Safety and Quality Health Services Standards; Standard 5 Comprehensive Care

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Committee/s:	Members	Caring for People with Cognitive Impairment Expert Advisory Group	Date 14th August 2026

	Members	Comprehensive Care Committee	27th August 2026

Appendix 1: Abbey Pain Scale

The measurement of pain for consumers who have a cognitive impairment that are non-verbal.

Q1 **Vocalising** **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 Changes** **Q4** ☐
Eg. Increased confusion, refusing to eat, alteration in usual patterns
Absent - 0 Mild - 1 Moderate - 2 Severe - 3

Q5 **Physiological Changes** **Q5** ☐
Eg. temperature, pulse or blood pressure outside normal limits
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 Q1 – Q6 **Total pain score:** ☐

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

Update the observation chart as required

Appendix 2: Non Pharmacological Prevention and Management Strategies

Domain	Strategy
Hydration and Nutrition	• Encourage and assist with oral intake (S/C or IVT if necessary) • Pour water and ensure it is accessible to consumer • Open all food packets and setup food tray • Food chart and fluid balance chart • Minimise interruptions during mealtimes • Involve carer/family in meal times • High colour contrast cutlery, crockery, tray **Consider referral: Dietetics**
Orientation	• Orientation aids (clock, whiteboard, photos) • Regular verbal reorientation and reassurance • Avoid room changes • Get family to bring in personal belongings or items that are familiar or important to consumer such as photographs, toiletries, pillows or clothing **Consider referral: Occupational Therapy**
Immobility & Falls Reduction	• Falls minimisation strategies as per risk assessment (gait aids, footwear, eye wear, call bell, reduce clutter, bed brakes) • Encourage movement a minimum of 3 times a day including range of movement exercises, mobilisation, foot stomping, marching on the spot • Consider use of assistive aids (RN +, bed alarm, low- low bed) • Avoid immobilising equipment (physical restraints, IDC, • NGT and IV lines) • Consider need for one-to-one supervision **Consider referral: Physiotherapy and Occupational Therapy**
Bowel and Bladder	• Fluid Balance Chart and Bowel Chart • Monitor for constipation and urinary retention • Toileting regime – to manage incontinence and monitor output • Minimise IDC usage
Sleep	• Maintain normal sleep/wake cycles – close curtains when dark, open curtains when daytime • Limit daytime napping to 1 hour early afternoon • Promote sleep through non-drug measures (warm milk before bed, limited or no caffeine and limit night time interruptions e.g. meds/obs) • Limit noise and bright light on ward at night
Sensory	• Ensure use and accessibility of sensory aids (hearing aids, spectacles, dentures) **Consider referral; Audiology and Speech Pathology**

Domain	Strategy
Environment	• Ask carer to bring consumer belongings • Lighting appropriate to time of day • Avoid clutter • Avoid room changes • Try to have consistent staff • Ensure adequate signage to toilet facilities • Avoid bed rails • Space to engage in activities **Consider referral: Occupational Therapist**
Pain	• Assess and manage pain • Look for non-verbal cues such as facial expression, increased agitation and decreased functioning
Communication	• Always introduce yourself, your role and what you will be doing at every contact • Involve family/carers where possible • Remain calm and modify your volume and tone accordingly • Keep sentences short and simple • Focus on one instruction at a time • Allow more time for response • Repeat information if required • If non English speaking background consider necessity for interpreter, use of written commonly used words or picture cards, family involvement with care **If ATSI consider referral to Aboriginal Liaison Office**
Supervision	• Appropriate supervision for consumers with at risk behaviours as per Patient Specialling procedure
Pressure Care	• Pressure injury prevention strategies as per risk • Assessment (pressure area care, moisture, reduce friction, air mattress) • Think – friction and sheering risk factors for agitated and restless consumer (e.g., rubbing of heels in bed) • Encourage movement **Consider referral: Occupational Therapy**
Activity and diversional therapy	• Access to usual activities, if appropriate (eg. Newspaper, TV, hobbies) • Provide activities for stimulating cognition such as reminiscence, sorting and matching activities (nuts and bolts, coins, shells, socks), games (bingo, cards), repetitive activities (winding, stacking, folding), music, aromatherapy • Social Morning tea – family, sunroom, chairs brought together in shared rooms

Domain	Strategy
	• Encourage independence in basic ADLs • Diversional therapy has been evidenced to significantly decrease the incidents of behaviours of concerns for people experiencing a cognitive impairment • Any equipment utilised for diversional therapies must follow – Therapeutic Toys Purchase and Maintenance **Consider referral:** Occupational Therapy for Activity Boxes

Appendix 3: The 3 D's

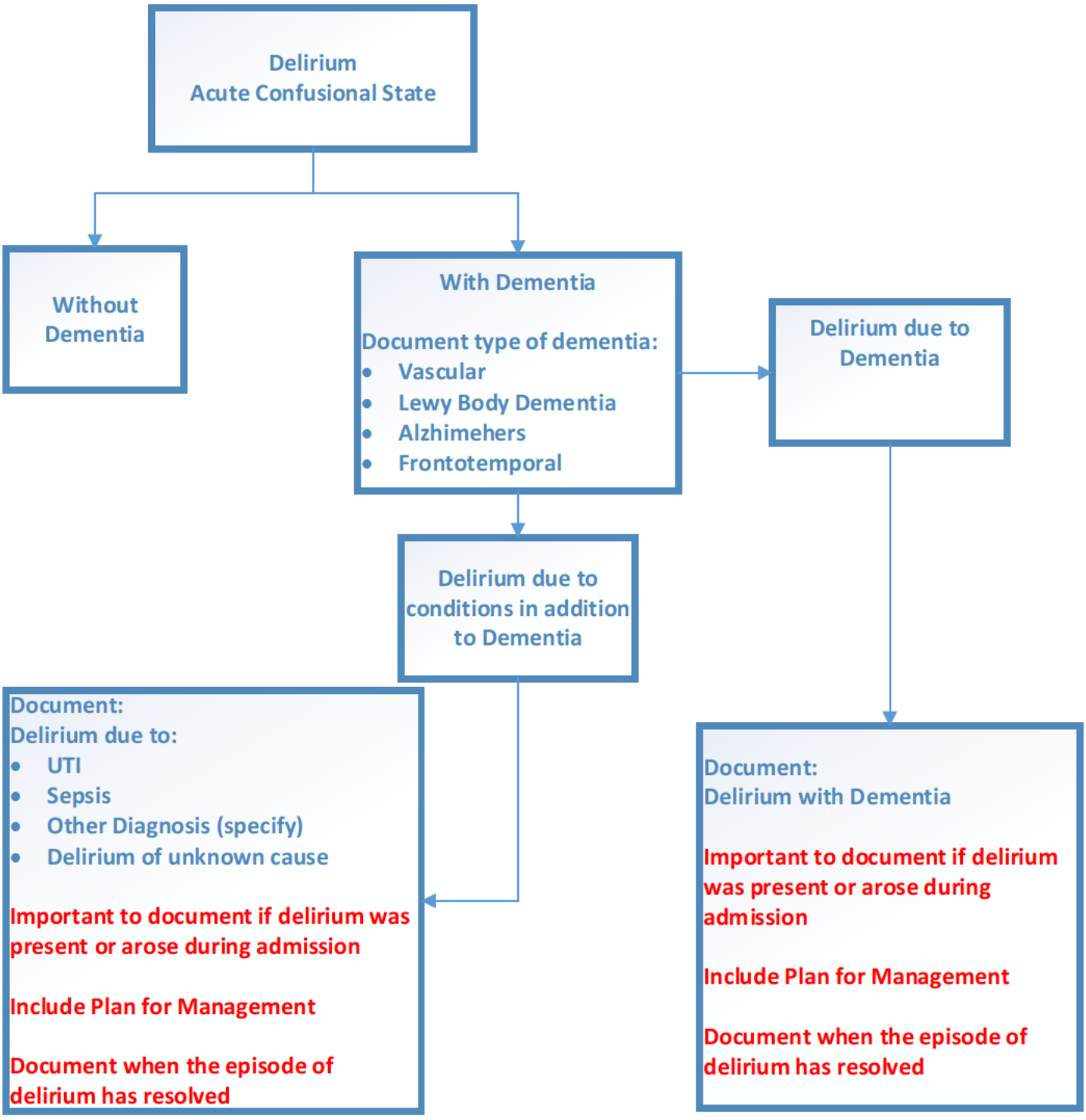
	Delirium	Dementia	Depression
Onset	Acute or subacute	Insidious	Gradual
Duration	Hours/days/Weeks	Months/years	Weeks/months
Course	Fluctuates – worse at night Lucid periods, usually during day	Stable and progressive (unless vascular dementia – usually stepwise	Usually worse in morning, improves as day goes on
Activities of daily living (ADL's)	Sudden deterioration in ability to do ADLs	Gradual decline in ability to do ADLs	Normal
Alertness	Fluctuates	Usually normal, clear until later stages	Normal
Orientation	Fluctuates, but will always be impaired in some aspect: time, place, and person?	May be normal – usually impaired for time and place	Usually normal
Memory	Recent impaired	Poor short term memory, attention less affected until severe	Recent may be impaired Remote intact
Thoughts	Often paranoid and grandiose ? bizarre ideas and topics ? paranoid	Slowed Reduced interests Perseverant Delusions are common	Usually slowed, and preoccupied by sad and hopeless themes
Perception	Visual and auditory hallucinations common, Delusions common	? normal – hallucinations and delusions often absent	About 20% have mood congruent auditory hallucinations
Emotions	Irritable Aggressive Fearful	Shallow, apathetic, labile?, irritable, careless	Flat, unresponsive or sad and fearful May be irritable
Sleep	Nocturnal confusion and/or "sundowning" common	Often disturbed Nocturnal wandering common Nocturnal confusion	Early morning wakening
Other features	Physical causes may not be obvious		? past history of mood disorder

Appendix 4: Medical Officer Approach to Delirium

History	Examination	Investigations

• Review medical history, especially premorbid cognition.
• Obtain collateral history – cognitive or behavioural changes.
• Medication review
• Consider possible precipitants:
  ○ Medications
  ○ Drug/Alcohol withdrawal
  ○ Neurological conditions
  ○ Inter-current illness
  ○ Surgery / anaesthetics
  ○ Environmental factors
  ○ Nutritional state
  ○ Pain
  ○ Head trauma (differential diagnosis Post Traumatic Amnesia)
  ○ Terminal illness (Differential diagnosis terminal delirium
• Differential diagnosis between delirium, dementia and depression – (See Appendix 3 – The 3D's)
	• Perform a thorough physical examination, which should include:
	  ○ Vital signs
	  ○ Oxygen saturation
	  ○ Cardiovascular examination including volume status
	  ○ Respiratory system
	  ○ Abdominal examination including the presence of palpable bladder and faeces
	  ○ Neurological examination, especially for new signs
	  ○ Skin - including rashes, such as Herpes Zoster, infections, wounds and pressure injuries
	  ○ Pain assessment
	  ○ Bowel chart, Fluid and food chart (if available)
		• Organise for baseline investigations including:
		  ○ Pathology: FBE, UEC, LFT, Calcium, CRP
		  ○ FWTU +/- MSU
		  ○ BGL
		  ○ ECG +/- cardiac enzymes if indicated
		  ○ Post void residual bladder volume
		• Other investigations should be considered based on clinical scenario. These may include:
		  ○ CXR, AXR (for constipation), CT brain especially if neurological signs or history (or suspicion) of falls or head injury, blood cultures, drug levels, TSHs, serum ammonia level, ABG, lumbar puncture and EEG.
		  ○ MRI if specific indication
		NB: Investigations such as vitamin B12, folate, iron studies and Vitamin D levels are not useful in the work-up for a delirium.

Appendix 5: How to Document Delirium



Appendix 6: Behaviour Observation Chart

The Behaviour Observation Chart should be commenced by a clinician when any altered patter on behaviour has been noted in the consumer by either a clinician or by their family/carer.

The Behaviour Observation charting can be ceased when consumer has no episodes of behaviours of concern for the previous 24 hours.

Each of the Agitation scores listed above is described with the intent to guide a corresponding level of action to be taken in response to the agitation score.

See Agitation Score and Action on the Table Below

Action Score	Action or Intervention
4	**Code GREY**
3	**Urgent Clinical Review:** Non-pharmacological management. Consider Planned Code Grey and possible pharmacological management
2	**Routine team review:** Non-pharmacological management
1	**Non-pharmacological management**
0	**Non-pharmacological management**
-1	**Request team review:** Record observations on the Observation and Response chart
-2	**Urgent Clinical Review:** Review of Pharmacological Management
-3	**Initiate BLS/Code BLUE**

For actions requiring non-pharmacological management – see intervention list below. The corresponding initial/s to be recorded on the Behaviour Observation Chart.

- **A** engage patient in an **Activity** meaningful to them
- **C** engage in **Conversation** – complete ‘Forget Me Nots and Top 5”
- **CPO** **Constant Patient Observer** / Health Care Worker / Assistant in Nursing
- **E** **Environmenta**l changes
- **F** **Family** involvement
- **FD** offer **Food** and **Drink**
- **H** **Hearing aids**
- **M** **Mobilize**
- **N** reduce **Napping**
- **OR** **Orientation** and **Redirection**
- **P** address **Pain**
- **RS** **Reduce stimulus**
- **T** **Toileting**
- **V** **Visual** aids
- **O** **O**ther - _____

Instructions on how to complete the Behaviour Observation Chart:

1. Consumers need to be scored every hour or more frequently if an escalation in behaviour. Place "" in the area the patient is scoring OR **'S'** if the consumer is asleep but rousable. Show the Trend: Plot the dot – Join the lines.
2. Consumers do not need to exhibit all the listed behaviours as applicable to a particular score in the definition of agitation above.
3. Enter the intervention/s in the pink bar **(Int.)** which best represents non-pharmacological management strategies implemented.
4. Record in the progress notes a summary of the actual behavior/s, action/s taken, interventions implemented and outcome.

   It is helpful to title the record with **Behaviour Observation Chart**.
   Examples of what to include in the Progress Notes include:

   a. Consumers actual behaviour i.e. calm, agitated, crying, distressed, asleep, inappropriate sexual behavior,
   b. Make documentation in the progress notes very specific, i.e. consumer is picking at clothing, asking for their mother, wants to catch a bus etc.
   c. Describe wandering or intrusive behaviour.
   d. Resistance to care or refusal of medication.
   e. Food and fluid intake, and any resistance to eating or drinking.
   f. Non – Pharmacological Management of behaviour including which interventions were successful or not.
5. Start a new chart each day.
6. Consumers identified with a cognitive impairment should have a cognitive impairment identifier (See Cognitive Impairment Identifier)located on the care plan
7. Paper based copies of the Cognitive Impairment Identifier can be accessed from the One Point Delirium Expert Advisory Group Site - Resources

8. Units with the Concentric Care Workflow terminals must activate the *General Alert* for consumers with a cognitive impairment. A blue light will be displayed outside the consumers room.

Health Record Form

Behaviour Observation Chart - BHS04972