

Delirium Clinical Care Standard

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AUSTRALIAN COMMISSION
ON **SAFETY** AND **QUALITY** IN **HEALTH CARE**



**Clinical Care
Standards**

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Disclaimer

The Australian Commission on Safety and Quality in Health Care has produced this Clinical Care Standard to support the delivery of appropriate care for a defined condition. The Clinical Care Standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patients and their carer or guardian, when applying information contained within the Clinical Care Standard. Consumers should use the information in the Clinical Care Standard as a guide to inform discussions with their healthcare professional about the applicability of the Clinical Care Standard to their individual condition.

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Delirium Clinical Care Standard

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1 A patient presenting to hospital with one or more key risk factors for delirium receives cognitive screening using a validated test. In addition, the patient and their carer are asked about any recent changes (within hours or days) in the patient's behaviour or thinking.
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2 A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed for delirium by a clinician trained and competent in delirium diagnosis and in the use of a validated diagnostic tool. The patient and their carer are asked about any recent changes in the patient's behaviour or thinking. The patient's diagnosis is discussed with them and is documented.
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3 A patient at risk of delirium is offered a set of interventions to prevent delirium and regular monitoring for changes in behaviour, cognition and physical condition.
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4 A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment.
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5 A patient with delirium receives care based on their risk of falls and pressure injuries.
- 

6 Treatment with an antipsychotic medicine is only considered if a patient with delirium is distressed and the cause of their distress cannot be addressed and non-drug strategies have failed to ease their symptoms.
- 

7 Before a patient with current or resolved delirium leaves hospital, the patient and their carer are involved in the development of an individualised care plan and are provided with information about delirium. The plan is developed collaboratively with the patient's general practitioner and describes the ongoing care that the patient will require after they leave hospital. It includes a summary of any changes in medicines, strategies to help reduce the risk of delirium and prevent complications from it, and any other ongoing treatments. This plan is provided to the patient and their carer before discharge, and to their general practitioner and other ongoing clinical providers within 48 hours of discharge.

Introduction

Clinical Care Standards aim to support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians.

A Clinical Care Standard is a small number of quality statements that describe the clinical care that a patient should be offered for a specific clinical condition. It differs from a clinical practice guideline: rather than describing all the components of care for managing a clinical condition, a Clinical Care Standard addresses priority areas for quality improvement.

The Clinical Care Standard supports:

- people to know what care should be offered by their healthcare system, and make informed treatment decisions in partnership with their clinician
- clinicians to make decisions about appropriate care
- health services to examine the performance of their organisation and make improvements in the care they provide.

This Clinical Care Standard was developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with consumers, clinicians, researchers and health organisations.^a It complements the Commission's resource, *A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital*¹, and builds on existing state and territory-based initiatives, such as the *Confused hospitalised older persons program* (NSW)², *Older people in hospital resource* (Victoria)³, and the *Delirium model of care* (WA).⁴

For more information about the development of this Clinical Care Standard, visit www.safetyandquality.gov.au/ccs.

Context

Delirium is an acute change in mental status that is common among older patients in hospital.⁵ Despite being a serious condition that is associated with increased mortality⁶⁻⁸, delirium is poorly recognised, both in Australian hospitals^{4,9} and internationally.^{10,11} Prevention is the most effective strategy, but outcomes for patients with delirium can also be improved by early intervention.

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).^{6,12} Patients with delirium may be agitated and restless (hyperactive delirium), quiet and withdrawn (hypoactive delirium), or move between these two subtypes (mixed delirium).^{5,6}

The burden associated with delirium is high. Often a frightening and isolating experience¹³, it is also associated with poor outcomes for patients.⁶ Compared with patients of the same age without delirium, patients with delirium have an increased risk of death, increased length of stay, increased risk of falls, a greater chance of being discharged to a higher dependency of care and a greater chance of developing dementia.⁵⁻⁷

Delirium is sometimes confused with dementia but there are important differences. The onset of delirium is quick (over hours to a few days), disturbed consciousness and impaired attention are common, and symptoms usually fluctuate. In contrast, onset of dementia is gradual, people with dementia are usually alert, and cognition and symptoms are slowly progressive.⁵ Dementia is a risk factor for delirium, which can complicate diagnosis, as some people who present to hospital with delirium may have underlying and undiagnosed dementia.⁵

About 10% to 18% of Australians aged 65 years or older have delirium at the time of admission to hospital, and a further 2% to 8% develop delirium during their hospital stay.^{9,14} Currently there are no data on the prevalence of delirium among Aboriginal

a The evidence base for these statements is available at www.safetyandquality.gov.au/ccs.

and Torres Strait Islander peoples, but high rates of dementia and cognitive impairment in some Indigenous communities¹⁵⁻¹⁸ suggests that delirium prevalence may also be greater than that in the overall Australian population.

Rates of delirium vary according to the healthcare settings, with incidences of 30% or more in patients following cardiac surgery and hip surgery⁵, and incidences of 50% or more in adult intensive care units, regardless of patient age.^{5, 19, 20}

While delirium can occur in patients of any age, older patients with cognitive impairment, dementia, severe medical illness or a hip fracture are considered those at greatest risk during a hospital admission.⁶ Sensory impairment (difficulty in hearing or seeing), infection, the use of certain medicines or multiple medicines, abnormal serum sodium levels, urinary catheterisation and depression also predispose older patients to develop delirium.^{5, 21}

Despite guidelines on managing delirium, early detection is poor and most cases of delirium are missed.^{4, 9, 11} Delirium is potentially preventable in more than a third of older people with risk factors.²² Early identification of patients at risk is important so that effective interventions can be put in place.^{5, 6} Prompt diagnosis and timely treatment of underlying causes are important for reducing the severity and duration of delirium and risk of complications from it.

The Delirium Clinical Care Standard aims to ensure that patients with delirium at the time of presentation to hospital receive optimal treatment to reduce the duration and severity of the condition. It also aims to ensure that patients at risk of delirium during a hospital admission are identified promptly and receive preventive strategies.

Clinicians and health services can use this Clinical Care Standard to support the delivery of high-quality care.

Key evidence sources for the Delirium Clinical Care Standard are the Australian *Clinical practice guidelines for the management of delirium in older people*⁵ and the United Kingdom's National Institute for Health and Clinical Excellence (NICE) guideline, *Delirium: diagnosis, prevention and management*.⁶

Central to the delivery of patient-centred care identified in this Clinical Care Standard is an integrated, systems-based approach supported by health services and networks of services.

Key elements of this approach include:

- an understanding of the capacity and limitations of each component of the health care system across metropolitan, regional and remote settings, including pre-hospital, within and across hospitals, through to community and other support services
- clear lines of communication across components of the health care system
- appropriate coordination so that people receive timely access to optimal care regardless of how or where they enter the system.

Scope

This Clinical Care Standard relates to the care that adult patients (18 years and older) with suspected delirium and adult patients at risk of developing delirium should receive from presentation to hospital through to transition to primary care.

The care of children and young people (under the age of 18 years) with suspected delirium, and the care of patients with delirium tremens (alcohol or substance withdrawal delirium) are outside the scope of this Clinical Care Standard. Specific guidance on the management of delirium tremens exists and should be consulted if appropriate.^{23, 24}

Many quality statements in the Delirium Clinical Care Standard also apply to patients receiving palliative and/or end-of-life care. Specific guidance on the management of delirium in patients receiving palliative care should also be consulted if appropriate.

While this Clinical Care Standard applies to the care received by patients in hospitals, it can also be adapted for use by residential aged care facilities.

Goal

To improve the prevention of delirium in patients at risk and to improve the early diagnosis and treatment of patients with delirium, so as to reduce the severity and duration of delirium.

Local monitoring

The Commission has developed a set of indicators to support clinical teams and health services to identify and address areas that require improvement at a local level (see Appendix).

Monitoring the implementation of the Clinical Care Standards will assist in meeting some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards. Information about the NSQHS Standards is available at www.safetyandquality.gov.au/accreditation.

The *Indicator Specification: Delirium Clinical Care Standard* with full details of the indicators can be found at <http://meteor.aihw.gov.au/content/index.phtml/itemId/613164>

Supporting documents

The following resources supporting this Clinical Care Standard are available from the Commission's website at www.safetyandquality.gov.au/ccs

- a consumer fact sheet
- a clinician fact sheet
- data collection tools
- the *Guide for use and data dictionary for the Delirium Clinical Care Standard indicators*.

Complementing this Clinical Care Standard is the resource, *A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital*.¹ Handbooks for clinicians, consumers and health services managers are available at www.safetyandquality.gov.au/our-work/cognitive-impairment/better-way-to-care/

Patient-centred care

Patient-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.²⁵

Clinical Care Standards support the key principles of patient-centred care, namely:

- treating patients with dignity and respect
- encouraging and supporting patient participation in decision making
- communicating and sharing information with patients about clinical conditions and treatment options
- providing patients with information in a format that they understand so they can participate in decision making.²⁶

Substitute decision-makers

Patients with delirium should have the opportunity to make informed decisions about their care and treatment. If a patient lacks capacity to make a decision about their health care and treatment is not urgent, clinicians must seek consent from a substitute decision-maker. To support clinicians, health services should have systems in place for identifying the capacity of patients to make decisions about their care, and for identifying substitute decision-makers if required. The systems should follow the relevant state or territory legislation that deals with consent to medical treatment and guardianship. More information can be found at www.advancecareplanning.org.au

Carers and family members

Carers and family members have a central role in the prevention, early recognition, assessment and recovery relating to a patient's health conditions. They know the patient very well, and can provide detailed information about the patient's history, routines or symptoms, which may assist in determining treatment and ongoing support.²⁵

Each quality statement in the Clinical Care Standard should be understood to mean that carers and family members are involved in clinicians' discussions with patients about their care, if the patient prefers carer involvement.

Quality statements

Quality statement 1

Early screening

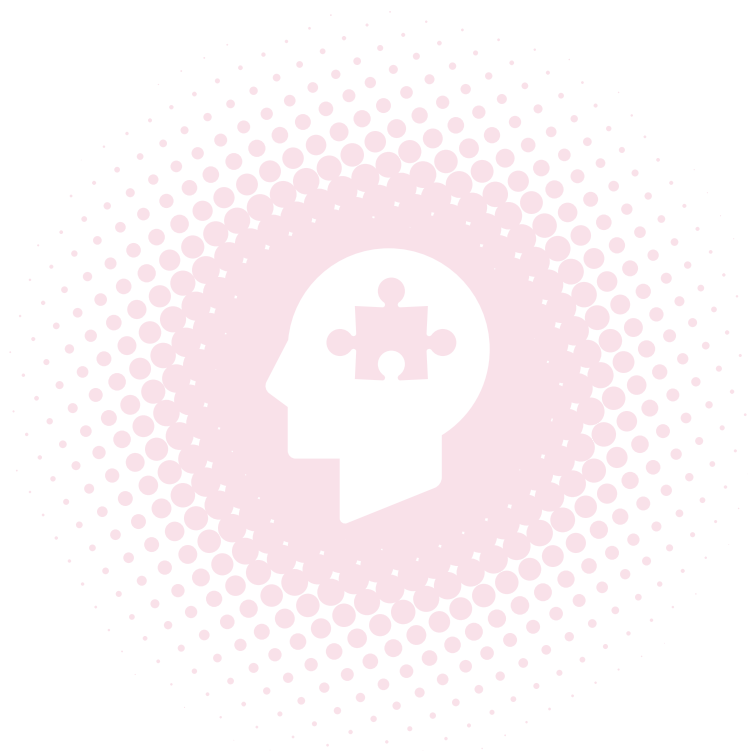
A patient presenting to hospital with one or more key risk factors for delirium receives cognitive screening using a validated test. In addition, the patient and their carer are asked about any recent changes (within hours or days) in the patient's behaviour or thinking.

Purpose

To ensure patients with delirium and those at risk of delirium who present to hospital are identified early so that appropriate management and preventive measures can be put in place.

Rationale

Delirium is often missed in patients who present to hospital.^{4,9} A structured approach can help improve detection rates.⁵ Age \geq 65 years, known cognitive impairment/dementia, severe medical illness and current hip fracture are key risk factors for delirium; additional risk factors may be included. Patients with any one key risk factor should undergo cognitive screening, be asked about any recent changes in behaviour and thinking, and receive interventions to prevent delirium.⁶ Cognitive screening on presentation helps identify patients who should be assessed for delirium and is useful for monitoring delirium onset during a hospital stay.^{5, 27, 28} Patients who have cognitive impairment or who have had a recent change in behaviour or thinking may have delirium and need to be assessed for it.⁶



What the quality statement means

- **For patients.** After arriving at hospital, if you are at risk of getting delirium, you are offered a short test to see if you have problems with your memory, in putting your thoughts together and in communicating with others. In the test, a doctor, nurse or other clinician asks you a series of questions. You and your carer are also asked about any recent changes in your behaviour.
- **For clinicians.** Identify patients at risk of delirium and offer cognitive screening using a validated cognitive function test that is culturally appropriate.^b Patients with one or more of the following key risk factors should receive cognitive screening:⁶
 - age \geq 65 years (\geq 45 years for Aboriginal and Torres Strait Islander peoples²)
 - known cognitive impairment/dementia
 - severe medical illness
 - current hip fracture.In addition, ask the patient and their carer, family member or other informant about any recent changes (within hours or days) in the patient's behaviour or thinking.
- **For health services.** Ensure systems are in place to support routine screening of cognitive function for patients at risk of delirium who present to a health service. This includes ensuring that locally-agreed validated cognitive function tests, appropriate to the cultural backgrounds of relevant communities, are available, and that they are used by staff trained and competent in their use.

b A range of validated cognitive function tests is available for use in hospitals. Some examples are:

- i. The Abbreviated Mental Test Score (AMTS)²⁹
<http://www.racgp.org.au/your-practice/guidelines/silverbook/tools/abbreviated-mental-test-score/>
- ii. The Standardised Mini-Mental State Examination (SMMSE)³⁰
<https://www.ihsa.gov.au/what-we-do/standardised-mini-mental-state-examination-smmse>
- iii. The 4AT test: screening instrument for cognitive impairment and delirium³¹
www.the4AT.com
- iv. Rowland Universal Dementia Assessment Scale (RUDAS).³²
<http://www.dementia-assessment.com.au/cognitive/index.html>
- v. Kimberly Indigenous Cognitive Assessment tools (KICA)³³
<https://www.perkins.org.au/wacha/our-research/indigenous/kica/>

Refer to *A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital*¹ for more examples.

Quality statement 2

Assessing for delirium

A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed for delirium by a clinician trained and competent in delirium diagnosis and in the use of a validated diagnostic tool.

The patient and their carer are asked about any recent changes in the patient's behaviour or thinking. The patient's diagnosis is discussed with them and is documented.

Purpose

To improve the early diagnosis and timely treatment of patients with delirium.

Rationale

Early diagnosis and prompt treatment offers patients with delirium the best chance of recovery.⁵ A range of clinicians can accurately diagnose delirium with the aid of a validated tool, but training in the tool is essential.³⁴ Carers or family members are often the best source of information about acute changes in a patient's mental status or behaviour.³⁵



What the quality statement means

- **For patients.** If you are in hospital and your symptoms suggest that you may have delirium, a doctor, nurse or other qualified clinician carries out an assessment to confirm if you have delirium. Part of the assessment includes asking if you or your carer have noticed any recent changes in your thinking or behaviour, such as being confused, agitated, quieter, sleepier, or less communicative than usual. The doctor or nurse discusses your diagnosis with you and your carer, and documents your diagnosis in your health record.
- **For clinicians.** Assess for delirium, with the aid of a validated diagnostic tool:^{c, d}
 - patients with cognitive impairment on presentation to hospital, and
 - patients who have a sudden decline in cognitive function or change in behaviour during their hospital admission.^{2, 5, 6}

Seek information about the patient's usual mental status from the patient and their carer, general practitioner, other primary care provider or informant. Ask about behavioural changes such as, confusion, worsened concentration, agitation, restlessness, sleepiness (including altered levels of consciousness), whether the patient has been less communicative or less responsive than usual, or has had difficulty cooperating with reasonable requests or has had other alterations in mood.⁶

Discuss the diagnosis with the patient and their carer and document the diagnosis in the patient's health record.⁶

- **For health services.** Ensure systems are in place to support clinicians assess patients with suspected delirium. This includes ensuring that a validated locally-agreed diagnostic tool for delirium is available and that clinicians are trained and competent in its use.

c Some examples of validated diagnostic tools:

- i. Confusion Assessment Method (CAM)^{35,36}
- ii. Confusion Assessment Method (CAM-ICU)³⁷
- iii. 3D-CAM.³⁸

d The current diagnostic standard for delirium is described in the Diagnostic Statistical Manual of Mental Disorders (DSM-5)³⁹

Quality statement 3

Interventions to prevent delirium

A patient at risk of delirium is offered a set of interventions to prevent delirium and regular monitoring for changes in behaviour, cognition and physical condition.

Purpose

To reduce the incidence of delirium among patients who are at risk.

Rationale

Delirium can be prevented in more than a third of older patients at risk.²² Multicomponent interventions reduce the incidence of delirium and may prevent complications, such as falls.²² Regular monitoring of patients at risk of delirium for changes in behaviour, cognition and physical condition can assist the prompt detection of delirium.⁵



What the quality statement means

- **For patients.** If you are at risk of developing delirium, a doctor, nurse or other clinician offers care to reduce your risk. Care may include a combination of things, such as reviewing your medicines, giving you more fluids, or helping you stay as mobile as possible.^{5,6} Your family and carers are encouraged to be involved in your care and are given information about delirium and how to prevent it. You also receive regular checks on your physical condition and cognition (ability to put your thoughts together and to communicate).
- **For clinicians.** Offer patients a set of interventions to prevent delirium, taking into account clinical risk factors and the setting.^{5,6} Discuss with the patient and their carer the interventions being put in place and encourage family and carers to be involved (e.g. providing orientation and reassurance to the patient). Monitor patients regularly for changes in cognition and behaviour, and for clinical deterioration.⁵ Provide carers with information about delirium and how to prevent it.^e

Interventions for preventing delirium include:^{5,6}

- medication review
- correction of dehydration, malnutrition and constipation
- mobility activities
- oxygen therapy
- pain assessment and management
- regular reorientation and reassurance
- activities for stimulating cognition
- non-drug measures to help promote sleep
- assistance for patients who usually wear hearing and visual aids.

These interventions should be implemented for patients at risk of delirium as well as for those with delirium.

- **For health services.** Ensure systems are in place to support clinicians in providing patients at risk of delirium with a set of preventive strategies and regular monitoring.

e An example of patient information about delirium can be found at:

http://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0018/181701/Delirium-Brochure.pdf

Quality statement 4

Identifying and treating underlying causes

A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment.

Purpose

To ensure patients with delirium receive timely treatment of the underlying cause(s) of delirium.

Rationale

Identifying and treating the causes of delirium early is likely to reduce the duration and severity of delirium.^{5, 6} There are many potential causes of delirium, so a comprehensive assessment is required.





What the quality statement means

- **For patients.** If you are diagnosed with delirium, in consultation with you and your carer, a doctor or nurse carries out a medical check to identify what is causing the delirium and how best to treat it. You receive a physical examination and tests (e.g. blood test, urine test, chest X-ray), and also a check of the medicines you are taking and any recent changes to them and a check on whether you are in pain. You receive treatments based on the causes identified (e.g. a change to your medicines, more fluids, a course of antibiotics if you have an infection).
- **For clinicians.** Carry out a comprehensive assessment of the patient, in consultation with the patient and their carer, to identify possible causes for delirium.^{5, 6} Seek a patient summary from the patient's general practitioner to help inform the investigation. A comprehensive assessment involves:
 - a medical and social history, paying close attention to the patient's medication history, their pain management needs, and their nutritional status
 - a physical examination
 - investigations, informed by the medical history and physical examination.Start treatment based on the causes identified, ensuring that interventions for preventing delirium, such as involving carers and modifying the environment, are also in place. Monitor patients regularly for changes in cognition and behaviour, including clinical deterioration.
- **For health services.** Ensure systems are in place to support clinicians in identifying and treating the causes of delirium.

Quality statement 5

Preventing falls and pressure injuries

A patient with delirium receives care based on their risk of falls and pressure injuries.

Purpose

To minimise the risk of hospital-acquired complications for patients with delirium.

Rationale

Patients with delirium have a higher incidence of hospital-acquired complications, such as falls and pressure injuries, compared with patients of the same age without delirium.^{7, 40}





What the quality statement means

- **For patients.** If you have delirium, you are offered care to reduce your risk of falling over and having an injury from a fall, and care to reduce your risk of developing a pressure sore. Your family and carers are encouraged to be involved in your care.
- **For clinicians.** If a patient has delirium, assess, monitor and document their risk of having a fall and harm from a fall, and their risk of developing a pressure injury. Put in place interventions tailored to these assessments in consultation with the patient and their carer.
- **For health services.** Ensure systems are in place to support clinicians in identifying and managing the risk of falls and pressure injuries for patients with delirium. This includes implementation of the related NSQHS Standards.

Quality statement 6

Minimising use of antipsychotic medicines

Treatment with an antipsychotic medicine is only considered if a patient with delirium is distressed and the cause of their distress cannot be addressed and non-drug strategies have failed to ease their symptoms.^f

Purpose

To ensure that patients with delirium are not routinely prescribed an antipsychotic medicine, and that those who are distressed receive an assessment for possible causes as well as non-drug strategies before an antipsychotic medicine is considered.^{5, 41} Other psychotropic medicines (e.g. benzodiazepines) are not an appropriate alternative to an antipsychotic medicine.^{5, 41}

Rationale

Antipsychotic medicines have a number of serious adverse effects for older people and can worsen delirium.²³ Reserving antipsychotic medicines for patients who are distressed and in whom non-drug strategies are ineffective, may help reduce the incidence of adverse drug events.^{5, 6}



^f Antipsychotic medicines do not have Australian marketing approval for treating delirium.

What the quality statement means

- **For patients.** If you have delirium and you are distressed, you receive emotional support, noise is minimised (if possible), and the cause of your distress is investigated. Your family and carers are encouraged to be involved in your care. If you remain distressed, a doctor or nurse discusses with you and your carer if an antipsychotic medicine at a low dose for a short time may help ease your symptoms. They also discuss with you the choice of antipsychotic medicine, its side effects and benefits, dose, and how long you need to take it for. Use of materials or equipment that restrict movement is avoided if possible.
- **For clinicians.** If a patient with delirium is distressed:
 - investigate possible causes by conducting a comprehensive assessment including a medication review
 - offer the patient emotional support and other non-drug strategies, involving carers if possible to calm the patient and de-escalate the situation^{5, 6, 42}
 - ensure the environment is safe for the patient, noise is minimised, and the patient is closely observed^{5, 43}
 - avoid the use of physical restraints if possible as they can increase agitation, prolong delirium and increase the risk of injury^{44, 45}
 - reserve antipsychotic medicines for patients who are distressed despite non-drug strategies^{4, 40}, such as patients whose behavioural or emotional disturbance is a threat to themselves or others.^{5, 41}

If non-drug strategies are ineffective and an antipsychotic medicine is being considered for a patient with delirium who is distressed:

- before prescribing, refer to guidelines, such as *The AMH aged care companion*⁴¹ or the *Therapeutic guidelines: psychotropic*²³
 - discuss with the patient and carer the choice of antipsychotic medicine, the risks and benefits, dosage, and duration²³
 - use a low dose, closely monitor response before considering any dose increases, and limit use for as short a period as possible²³
 - use antipsychotic medicines with caution or not at all for people with Parkinson's disease or dementia with Lewy Bodies.⁶
- **For health services.** Ensure systems are in place to guide the treatment of patients with delirium and that these systems support use of non-drug strategies as first-line therapy. Systems may require one-on-one nursing or a trained support person (that is, specialising), and involvement of family members.^{5, 43} Ensure there are systems to support the appropriate use of antipsychotics, such as guidance for clinicians on dosage, duration of therapy, and the need for regular review. Ensure that systems are also in place to minimise the use of physical restraints.

Quality statement 7

Transition from hospital care

Before a patient with current or resolved delirium leaves hospital, the patient and their carer are involved in the development of an individualised care plan and are provided with information about delirium. The plan is developed collaboratively with the patient's general practitioner and describes the ongoing care that the patient will require after they leave hospital. It includes a summary of any changes in medicines, strategies to help reduce the risk of delirium and prevent complications from it, and any other ongoing treatments. This plan is provided to the patient and their carer before discharge, and to their general practitioner and other ongoing clinical providers within 48 hours of discharge.

Purpose

To ensure patients with current or resolved delirium, their carer, and their general practitioner or ongoing clinical provider are informed about the diagnosis of delirium and of the treatment the patient will require after they leave hospital.

Rationale

Effective communication between hospital clinicians and ongoing clinical providers is essential for the ongoing care and recovery of patients with delirium²³, many of whom may have unresolved symptoms at the time of discharge.⁷ Providing patients and carers with information about delirium and involving them in the development of the care plan allows treatment goals to be tailored to the patient's needs and circumstances.



What the quality statement means

- **For patients.** Before you leave hospital, a doctor, nurse or other clinician discusses with you and your carer your episode of delirium and the ongoing care you will need when you leave hospital. They provide you with information about delirium and help develop a plan with you and your carer in a format that you understand. The plan sets out your goals of care and ways that you can reduce your risk of delirium and prevent complications from it, such as eating a nutritious diet and drinking enough water. It describes the ongoing treatments you may need, such as the medicines you need to take and why medicines may have stopped. It also includes the community support services you are referred to. You get a copy of this plan before you leave hospital. Your general practitioner and other ongoing clinical providers get a copy within two days of you leaving hospital.
- **For clinicians.** Before the patient leaves hospital, develop an individualised care plan with the patient and their carer and provide them with information about delirium.^g In the plan, include strategies for managing persistent delirium and for preventing delirium recurrence. Describe all ongoing treatments and any follow up needed for any comorbidities. List all medicines that the patient needs to take, specifying for each one: the generic drug name, dose, reason for use, and duration. Explain why any medicines have been stopped or changed. If an antipsychotic medicine is prescribed, include a plan for ongoing review and withdrawal. Include contact details of ongoing support services available in the community, as appropriate. Provide the care plan to the patient and their carer before they leave hospital and to their general practitioner and other ongoing clinical providers within 48 hours of the patient leaving hospital.
- **For health services.** Ensure systems are in place so clinicians can provide information about delirium to patients and their carer, and so they can develop an individualised care plan with the patient and carer prior to discharge. Ensure systems support clinicians in providing the plan to the patient's general practitioner and other ongoing clinical providers within 48 hours of discharge.

g An example of patient information about delirium can be found at:

http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/181701/Delirium-Brochure.pdf

Glossary

Abbreviated Mental Test Score (AMTS): A quick and easy to use screening test to detect cognitive impairment.⁶

Antipsychotic medicine: A medicine used to treat psychosis and other mental illnesses and conditions.⁴⁶

Assessment: A clinician's evaluation of the disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition and the clinician's objective findings, including data obtained through laboratory test, physical examination, medical history, and information reported by family members and other healthcare team members.⁴⁷

Benzodiazepine medicine: A class of medicines that has a hypnotic and sedative action, used mainly as a tranquiliser to control symptoms of anxiety.⁴⁸

Care plan (individualised): A written agreement between a consumer and health professional (and/or social services) to help manage day-to-day health.⁴⁹ This information is identified in a health record.

Carers: People who provide care and support to family members and friends who have a disease, disability, mental illness, chronic condition, terminal illness or general frailty.⁵⁰

Clinician: A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners and teams of health professionals, who provide direct clinical care. They can be doctors, nurses, allied health professionals, nurses' assistants, Aboriginal health workers and other people who provide direct clinical care.^{50, 51}

Cognition: The mental activities associated with thinking, learning and memory.⁵²

Cognitive function test: A tool developed to aid clinicians conduct a cognitive assessment. Cognitive assessments are commonly used for the following reasons: (i) screening for cognitive impairment; (ii) differential diagnosis of cause; (iii) rating of severity of a disorder, or monitoring disease progression.⁵³

Cognitive impairment: Difficulty with memory, thinking, concentration and ability to read and write.⁶

Cognitive screening: Using a simple test (see cognitive function test) to identify patients with cognitive impairment. It can also be used to establish baseline cognitive function for ongoing monitoring during a hospital stay.

Comorbidities: Coexisting diseases (other than that being studied or treated) in an individual.⁶

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.⁵⁴

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or another lower level.⁵⁵

Health record: Information about a patient held in paper or electronic copy. The health record may comprise clinical records (such as medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records, medication charts), administrative records (such as contact and demographic information, legal and occupational health and safety records) and financial records (such as invoices, payments and insurance information).⁵⁵

Health service: A service responsible for the clinical governance, administration and financial management of unit(s) providing health care. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients and can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.⁵⁰

Hospital: A licensed facility providing healthcare services to patients for short periods of acute illness, injury or recovery.⁵⁶

Hospital-acquired complications: Diagnoses that have an onset during the episode of admitted patient care.⁵⁷

Individualised care plan: See Care plan.

Informant: A person who gives information, such as a carer, family member or friend accompanying the patient. It may also be an ambulance officer, general practitioner or other primary care provider.

Intervention: Healthcare action intended to benefit the patient, for example, drug treatment, surgical procedure, psychological therapy.

Medication review: A critical review of all prescribed, over-the-counter and complementary medications undertaken to optimise therapy and minimise medication-related problems.⁵⁸

Medical check: See assessment.

Medicine: A chemical substance given with the intention of preventing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included.⁵⁰

Multicomponent intervention: A combination of different strategies or treatments aimed at preventing or treating a medical condition.

Non-drug strategy: A treatment or other intervention that does not involve a medicine. Examples of non-drug strategies for managing delirium include: a support person with training in delirium care, modification of the environment (e.g. dim lights at night time, bright light during the day, calendar, clock), support and reassurance from carers and family, regular mobilisation and relaxation strategies.⁵

Palliative Care: An approach to treatment that improves the quality of life of patients and their families facing life-limiting illness, through the prevention and relief of suffering. It involves early identification, and impeccable assessment and treatment of pain and other problems (physical, psychosocial and spiritual).⁵⁹

Physical restraints: A mechanism used to control or modify a person's behaviour. Examples include lap belts, bed rails, table tops, meal trays and backwards-leaning chairs or 'stroke chairs' that are difficult to get out of, and possibly bed alarm devices. Tucking bed clothes in too tight, wedging cupboards against beds or locking doors are also considered physical restraints.⁴⁵

Presentation to hospital: Care received by patients on entry to the hospital system, including the emergency department, preadmission clinic, acute assessment unit, ward, or day surgery. For some remote areas, this may include primary health clinics.

Pressure injuries: These are localised to the skin and/or underlying tissues, usually over a bony prominence and caused by unrelieved pressure, friction or shearing. Pressure injuries occur most commonly on the sacrum and heel but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.⁵⁵

Primary care: The first level of care or entry point to the health care system for consumers. It is multidisciplinary and incorporates: office based practices (e.g. general practice clinics), community health practice (e.g. clinics, outreach or home visiting services, emergency services (e.g. ambulance services), community-based allied health services (e.g. pharmacists), services for specific populations (e.g. health services for Aboriginal and Torres Strait Islander peoples, refugee health services, or school health clinics).⁶⁰

Psychotropic medicines: Medicines that exert an effect on the mind or modify mental activity.⁶¹

Risk factor: Any variable (e.g. smoking, abnormal blood lipids, elevated blood pressure, diabetes) that is associated with a greater risk of a health disorder or other unwanted condition or event.⁶²

Screening: Screening is a process of identifying people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.⁶³

Specialling: Special and constant observation of a patient deemed to be at risk to themselves and others.⁶⁴

Standardised Mini-Mental State Examination (SMMSE): A test for evaluating cognitive impairment in older adults. The SMMSE was developed to provide scoring instructions and clear unambiguous guidelines for administration of the Mini-Mental State Examination.⁶⁵

Substitute decision-maker. A person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a person whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the person, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation that varies from state to state.⁶⁶

System: The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish the objectives of the Standard. The system:

- interfaces risk management, governance, operational processes and procedures, including education, training, and orientation
- deploys an active implementation plan and feedback mechanisms
- includes agreed protocols and guidelines, decision support tools and other resource materials, and
- employs a range of incentives and sanctions to influence behaviours and encourage compliance with policy, protocol, regulation and procedures.⁵⁵

Appendix

The Commission has developed a set of indicators to support clinical teams and health services at a local level to identify and address areas that require improvement.

Monitoring the implementation of the Clinical Care Standards will assist in meeting some of the requirements of the National Safety and Quality Health Service Standards.

Full details of these indicators can be found in the *Indicator Specification: Delirium Clinical Care Standard* available at

<http://meteor.aihw.gov.au/content/index.phtml/itemId/613164>

The *Guide for use and data dictionary for the Delirium Clinical Care Standard indicators* and data collection tools are available at

www.safetyandquality.gov.au/ccs

Quality statement 1 – Early screening

- **1a:** Evidence of local arrangements for cognitive screening of patients presenting to hospital with one or more risk factors for delirium.
- **1b:** Proportion of older patients undergoing cognitive screening within 24 hours of admission to hospital using a validated test.

Quality statement 2 – Assessing for delirium

- **2a:** Evidence of training sessions undertaken by staff in the use of a validated diagnostic tool for delirium.
- **2b:** Proportion of patients who screen positive for cognitive impairment at admission who are assessed for delirium using a validated diagnostic tool.
- **2c:** Rate of delirium among acute admitted patients.
- **2d:** Rate of delirium among acute admitted patients with onset during the hospital stay.

Quality statement 3 – Interventions to prevent delirium

- **3a:** Evidence of local arrangement for implementing interventions to prevent delirium for at-risk patients.



Quality statement 4 – Identifying and treating underlying causes

- **4a:** Proportion of patients with delirium who have a comprehensive assessment to investigate cause(s) of delirium.
- **4b:** Proportion of patients with delirium who receive a set of interventions to treat the causes of delirium, based on a comprehensive assessment.

Quality statement 5 – Preventing falls and pressure injuries

- **5a:** Evidence of local arrangements for patients with delirium to be assessed for risk of falls and pressure injuries.
- **5b:** Proportion of patients with delirium assessed for risk of falls and pressure injuries.
- **5c:** Proportion of patients with delirium who have had a fall or a pressure injury during their hospital stay.

Quality statement 6 – Minimising use of antipsychotic medicines

- **6a:** Evidence of local arrangements to ensure that patients with delirium are not routinely prescribed antipsychotic medicines.
- **6b:** Proportion of patients with delirium prescribed antipsychotic medicines in hospital.

Quality statement 7 – Transition from hospital care

- **7a:** Proportion of patients with current or resolved delirium who have an individualised care plan.
- **7b:** Proportion of older patients with current or resolved delirium who are readmitted for delirium within 28 days.


References

1. Australian Commission on Safety and Quality in Health Care. A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital - Actions for health service managers. Sydney: ACSQHC; 2014; Available from: <http://www.safetyandquality.gov.au/publications/a-better-way-to-care-actions-for-health-service-managers/>
2. ACI Aged Health Network. Key principles for care of confused hospitalised older persons. Agency for Clinical Innovation; 2014; Available from: http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0006/249171/CHOPS-key-principles1-2-web.pdf
3. Department of Health & Human Services Victoria, The Clinical Leadership Group on care of older people in hospital, The National Ageing Research Institute. Older people in hospital. 2015; Available from: <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people>
4. Department of Health WA. Delirium model of care. Perth: Aged Care Network, Department of Health, Western Australia; 2008; Available from: http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Delirium_Model_of_Care.pdf
5. Clinical Epidemiology and Health Service Evaluation Unit. Clinical practice guidelines for the management of delirium in older people. Melbourne: Victorian Government Department of Human Services on behalf of AHMAC; 2006; Available from: [http://docs.health.vic.gov.au/docs/doc/A9F4D074829CD75ACA25785200120044/\\$FILE/delirium-cpg.pdf](http://docs.health.vic.gov.au/docs/doc/A9F4D074829CD75ACA25785200120044/$FILE/delirium-cpg.pdf)
6. National Institute for Health and Clinical Excellence. Delirium: diagnosis, prevention and management; Clinical Guideline 103. London: NICE, 2010.
7. Travers C, Byrne G, Pachana N, Klein K, Gray L. Delirium in Australian hospitals: a prospective study. *Curr Gerontol Geriatr Res* 2013;ID284780.
8. Siddiqi N, House AO, Holmes JD. Occurrence and outcome of delirium in medical in-patients: a systematic literature review. *Age Ageing* 2006;35(4):350-64. Epub 2006/05/02.
9. Iseli RK, Brand C, Telford M, LoGuidice D. Delirium in elderly general medical inpatients: a prospective study. *Intern Med J* 2007;37:806-11.
10. Collins N, Blanchard MR, Tookman A, Sampson EL. Detection of delirium in the acute hospital. *Age Ageing* 2010;39(1):131-5. Epub 2009/11/18.
11. Han JH, Zimmerman EE, Cutler N, Schnelle J, Morandi A, Dittus RS, et al. Delirium in older emergency department patients: recognition, risk factors, and psychomotor subtypes. *Acad Emerg Med* 2009;16(3):193-200. Epub 2009/01/22.
12. Inouye S, Westendorp R, Saczynski J. Delirium in elderly people. *Lancet* 2014;383:911-22.
13. Belanger L, Ducharme F. Patients' and nurses' experiences of delirium: a review of qualitative studies. *Nurs Crit Care* 2011;16(6):303-15. Epub 2011/10/18.
14. Travers C, Byrne G, Pachana N, Klein K, Gray L. Prospective observational study of dementia and delirium in the acute hospital setting. *Intern Med J* 2012;43(3):262-9.
15. Smith K, Flicker L, Lautenschlager NT, Almeida OP, Atkinson D, Dwyer A, et al. High prevalence of dementia and cognitive impairment in Indigenous Australians. *Neurology* 2008;71(19):1470-3. Epub 2008/09/19.

16. Li SQ, Guthridge SL, Eswara Aratchige P, Lowe MP, Wang Z, Zhao Y, et al. Dementia prevalence and incidence among the Indigenous and non-Indigenous populations of the Northern Territory. *Med J Aust* 2014;200(8):465-9. Epub 2014/05/06.
17. Radford K, Mack HA, Draper B, Chalkley S, Daylight G, Cumming R, et al. Prevalence of dementia in urban and regional Aboriginal Australians. *Alzheimers Dement* 2015;11(3):271-9. Epub 2014/07/06.
18. Lo Giudice D, Smith K, Fenner S, Hyde Z, Atkinson D, Skeaf L, et al. Incidence and predictors of cognitive impairment and dementia in Aboriginal Australians: A follow-up study of 5 years. *Alzheimers Dement* 2015. Epub 2015/05/23.
19. Reade MC, Eastwood GM, Peck L, Bellomo R, Baldwin I. Routine use of the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) by bedside nurses may underdiagnose delirium. *Crit Care Resusc* 2011;13(4):217-24. Epub 2011/12/02.
20. Salluh JI, Wang H, Schneider EB, Nagaraja N, Yenokyan G, Damluji A, et al. Outcome of delirium in critically ill patients: systematic review and meta-analysis. *BMJ* 2015;350:h2538. Epub 2015/06/05.
21. Ahmed S, Leurent B, Sampson EL. Risk factors for incident delirium among older people in acute hospital medical units: a systematic review and meta-analysis. *Age Ageing* 2014;43(3):326-33. Epub 2014/03/13.
22. Hshieh TT, Yue J, Oh E, Puelle M, Dowal S, Trivison T, et al. Effectiveness of multicomponent nonpharmacological delirium interventions: a meta-analysis. *JAMA Intern Med* 2015. Epub 2015/02/03.
23. Psychotropic Expert Group. *Therapeutic Guidelines: Psychotropic*. Melbourne: Therapeutic Guidelines Limited, 2013.
24. National Institute for Health and Clinical Excellence. *Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications*. London: NICE, 2010.
25. Australian Commission on Safety and Quality in Health Care. *Patient-centred care: improving quality and safety through partnerships with patients and consumers*. A discussion paper: ACSQHC; 2011; Available from: http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC_Paper_August.pdf
26. Australian Commission on Safety and Quality in Health Care. *Windows into safety and quality*. ACSQHC; 2011; Available from: <http://www.safetyandquality.gov.au/wp-content/uploads/2011/11/Windows-into-Safety-and-Quality-in-Health-Care-2011.pdf>
27. O'Keeffe ST, Mulkerrin EC, Nayeem K, Varughese M, Pillay I. Use of serial Mini-Mental State Examinations to diagnose and monitor delirium in elderly hospital patients. *J Am Geriatr Soc* 2005;53(5):867-70. Epub 2005/05/10.
28. Jitapunkul S, Pillay I, Ebrahim S. Delirium in newly admitted elderly patients: a prospective study. *Q J Med* 1992;83(300):307-14. Epub 1992/04/01.
29. Hodkinson HM. Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age Ageing* 1972;1(4):233-8. Epub 1972/11/01.
30. Molloy DW, Standish TI. A guide to the standardized Mini-Mental State Examination. *Int Psychogeriatr* 1997;9 Suppl 1:87-94; discussion 143-50. Epub 1997/01/01.

31. Bellelli G, Morandi A, Davis DH, Mazzola P, Turco R, Gentile S, et al. Validation of the 4AT, a new instrument for rapid delirium screening: a study in 234 hospitalised older people. *Age Ageing* 2014;43(4):496-502. Epub 2014/03/05.
32. Storey JE, Rowland JT, Basic D, Conforti DA, Dickson HG. The Rowland Universal Dementia Assessment Scale (RUDAS): a multicultural cognitive assessment scale. *Int Psychogeriatr* 2004;16(1):13-31. Epub 2004/06/12.
33. LoGiudice D, Smith K, Thomas J, Lautenschlager NT, Almeida OP, Atkinson D, et al. Kimberley Indigenous Cognitive Assessment tool (KICA): development of a cognitive assessment tool for older indigenous Australians. *Int Psychogeriatr* 2006;18(2):269-80. Epub 2006/01/13.
34. Wei LA, Fearing MA, Sternberg EJ, Inouye SK. The Confusion Assessment Method: a systematic review of current usage. *J Am Geriatr Soc* 2008;56(5):823-30. Epub 2008/04/04.
35. Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegel AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med* 1990;113(12):941-8. Epub 1990/12/15.
36. Shi Q, Warren L, Saposnik G, Macdermid JC. Confusion assessment method: a systematic review and meta-analysis of diagnostic accuracy. *Neuropsychiatr Dis Treat* 2013;9:1359-70. Epub 2013/10/05.
37. Ely EW, Margolin R, Francis J, May L, Truman B, Dittus R, et al. Evaluation of delirium in critically ill patients: validation of the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU). *Crit Care Med* 2001;29(7):1370-9. Epub 2001/07/11.
38. Marcantonio ER, Ngo LH, O'Connor M, Jones RN, Crane PK, Metzger ED, et al. 3D-CAM: derivation and validation of a 3-minute diagnostic interview for CAM-defined delirium: a cross-sectional diagnostic test study. *Ann Intern Med* 2014;161(8):554-61. Epub 2014/10/21.
39. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association; 2013.
40. O'Keefe S, Lavan J. The prognostic significance of delirium in older hospital patients. *J Am Geriatr Soc* 1997;45(2):174-8. Epub 1997/02/01.
41. AMH Aged Care Companion. Adelaide: Australian Medicines Handbook Pty Ltd; 2014.
42. NSW Department of Health. *Guidelines for working with people with challenging behaviours in residential aged care facilities - using appropriate interventions and minimising restraint*. Sydney: NSW Department of Health; 2006 [cited December 2015]. Available from http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf.
43. Peisah C, Chan DK, McKay R, Kurrle SE, Reutens SG. Practical guidelines for the acute emergency sedation of the severely agitated older patient. *Intern Med J*. 2011;41(9):651-7. Epub 2011/09/09.
44. Australian and New Zealand Society for Geriatric Medicine. *Delirium in older people: position statement 13*. 2012 [cited December 2015]; Available from: www.anzsgm.org/documents/PS13DeliriumstatementRevision2012.pdf

45. Australian Commission on Safety and Quality in Health Care. Preventing falls and harm from falls in older people. Best practice guidelines for Australian hospitals. Sydney: ACSQHC, 2009.
46. The Free Dictionary. Farlex; 2015 [cited December 2015]; Available from: <http://medical-dictionary.thefreedictionary.com/Antipsychotic+Drugs>
47. The Free Dictionary. Farlex; 2015 [cited December 2015]; Available from: <http://medical-dictionary.thefreedictionary.com/assessment>
48. The Free Dictionary. Farlex; 2015 [cited December 2015]; Available from: <http://medical-dictionary.thefreedictionary.com/benzodiazepine>
49. National Health Service. What is a care plan. NHS; 2012 [cited December 2015]; Available from: www.nhs.uk/Planners/Yourhealth/Pages/Careplan.aspx
50. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: ACSQHC, 2011.
51. Australian Commission on Safety and Quality in Health Care. Health literacy: Taking action to improve safety and quality. Sydney: ACSQHC; 2014; Available from: <http://www.safetyandquality.gov.au/wp-content/uploads/2014/08/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf>
52. The Free Dictionary. Farlex; 2015 [cited September 2015]; Available from: <http://medical-dictionary.thefreedictionary.com/cognition>
53. Woodford HJ, George J. Cognitive assessment in the elderly: a review of clinical methods. QJM 2007;100(8):469-84. Epub 2007/06/15.
54. Australian Health Ministers' Advisory Council. Delirium care pathways. Canberra: AHMAC, 2011.
55. Australian Commission on Safety and Quality in Health Care. Hospital accreditation workbook. Sydney: ACSQHC, 2012.
56. Australian Commission on Safety and Quality in Health Care. National consensus statement: essential elements for recognising and responding to clinical deterioration. Sydney: ACSQHC, 2010.
57. Health Policy Analysis. Analysis of hospital-acquired diagnoses and their effect on case complexity and resource use - Final report: Australian Commission on Safety and Quality in Health Care; 2013.
58. Australian Commission on Safety and Quality in Health Care. Safety and quality improvement guide standard 4: medication safety. Sydney: ACSQHC; 2012.
59. World Health Organization. WHO definition of palliative care [cited September 2015]; Available from: www.who.int/cancer/palliative/definition/en
60. Australian Commission on Safety and Quality in Health Care. Guidebook for primary care settings. A companion to the OSSIE toolkit for implementation of the Australian Guidelines for the Prevention of Infection in Health Care. Consultation edition. Sydney: ACSQHC, 2010.
61. The Free Dictionary. Farlex; 2015 [cited May 2015]; Available from: <http://medical-dictionary.thefreedictionary.com/psychotropic>

- 
62. Australian Institute of Health and Welfare. Monitoring acute coronary syndrome using national hospital data: an information paper on trends and issues. Canberra: AIHW, 2011.
 63. UK National Screening Committee. UK Screening Portal [cited December 2015]; Available from: <http://www.screening.nhs.uk/screening>
 64. Dewing J. Special observation and older persons with dementia/delirium: a disappointing literature review. Intern J Older People Nurs 2013;8(1):19-28. Epub 2012/01/18.
 65. Independent Hospitals Pricing Authority. Standardised Mini-Mental State Examination (SMMSE) Sydney:IHPA; 2014; Available from: <http://www.ihoa.gov.au/publications/standardised-mini-mental-state-examination-smmse>
 66. The Clinical Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Council (AHMAC). A national framework for advance care directives. Canberra: AHMAC; 2011.



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