Grampians Health

Tuesday, 24 June 2025

Dear Registrar, Werkmeister

I am writing on behalf of Grampians Health in response to the recommendations made by Coroner Olle in relation to case reference COR 2022 007086.

Recommendation 1

The coroner's first recommendation has been implemented.

The circumstances surrounding Mr Dimsey's death contributed to an existing Grampians Health internal review of our processes regarding the assessment of cognitive function at the point of admission. As a result, an updated Clinical Practice Protocol was published in January 2023. This protocol has been integrated into routine clinical care and handover procedures.

We appreciate that the coroner's recommendation aligns with the conclusions we reached at that time and supports our continued focus on improving patient assessment practices.

A copy of the relevant Clinical Practice Protocol is attached for your reference.

Recommendation 2

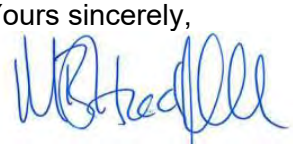
An alternative approach to the coroner's second recommendation has been implemented.

Grampians Health fully support the coroner's decision that clinical decision-making should be based on the most current evidence. However, we recognise that the pace at which clinical research evolves across specialties makes it challenging to rely solely on individual static reviews, which can quickly become outdated.

To address this, since August 2006, Grampians Health subscribes to a recognised, continuously updated commercial database of clinical evidence and guidelines. This resource covers the full spectrum of healthcare topics, including prosthetic joint infection, hip fracture in adults, aspiration pneumonia, and cognitive impairment—topics relevant to this case.

All clinical staff are always provided with access to this resource. It is also a core component of orientation for all new medical staff, ensuring that up-to-date, evidence-based information consistently informs diagnosis and clinical decisions.

Yours sincerely,



Matthew Hadfield FRCS FRACS AFRACMA
Chief Medical Officer Grampians Health

CC: Dale Fraser CEO Grampians Health
ATT: Documents

Grampians Health Ballarat

CLINICAL PRACTICE PROTOCOL

Cognitive Assessment - Cognitive Screening Using Validated Tools (SMMSE Moca)
SCOPE (Area): Acute, Sub Acute
SCOPE (Staff): Medical, Nursing

Rationale

Cognitive screening aims to determine the presence or absence of cognitive impairment on admission; for the identification and mitigation of cognitive impairment as a risk factor for delirium and other adverse events. Identification of cognitive impairment and specific cognitive deficits is vital when planning, delivering and evaluating care for inpatients and when considering the need for further follow up of cognitive issues following discharge.

Expected Objectives / Outcome

Routine cognitive screening using the Standardised Mini Mental State Examination (SMMSE) and clock drawing test (MR/160.0), Montreal Cognitive Assessment (MoCA) (MR/271.5) or alternative validated culturally appropriate tool such as the *Rowland Universal Dementia Assessment Scale (RUDAS) or The Kimberley Indigenous Cognitive Assessment (KICA)* will occur within 24 hours of admission to the acute and sub-acute facilities.

The Montreal Cognitive Assessment (MoCA) is indicated for patients admitted under the stroke unit.

A score of 24 or less on the SMMSE +/- an abnormal clock drawing test; or a score of less than 26/30 on the MoCA is suggestive of cognitive impairment (such as delirium or neurocognitive or mood disorder) and should be investigated further.

SMMSE is not required for patients under Hospital In The Home (HITH) unless clinically indicated. If a patient exhibits acute change in mental status (in comparison to baseline), difficulty focusing attention, disorganised thinking or illogical flow of ideas, altered level of consciousness please complete baseline cognitive assessment and refer to treating team for review.

Referral to the Cognition Clinical Nurse Consultant (CNC) via a Bossnet allied health referral will assist in facilitation of assessment as an inpatient and clarification of any further follow up required.

Definitions

Cognitive impairment is a broad term to describe a wide variety of impaired brain function relating to a persons ability to think, concentrate, react to emotions, formulate ideas, problem solve, reason and remember. There can be a wide range of severity in impairments from mild through to severe.

Within BHS Cognitive Impairment includes

- Delirium
- Dementia
- Any other difficulty with memory and thinking

Delirium: The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) lists five key features that characterise delirium:

A. Disturbance in *attention* (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced *orientation to the environment*).
B. The disturbance develops over a short period of time (usually hours to a few days), *represents an acute change from baseline attention and awareness*, and tends to fluctuate in severity during the course of a day.
C. An additional disturbance in cognition (e.g.memory deficit, disorientation, language, visuospatial ability, or perception).
D. The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and *do not occur in the context of a severely reduced level of arousal such as coma.*
E. There is evidence from the history, physical examination or laboratory findings that the disturbance is *a direct* physiological consequence of another medical condition, *substance intoxication or withdrawal (i.e. due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies*.

Dementia: The umbrella term for a number of neurological conditions, of which the major symptom is the decline in brain function due to physical changes in the brain. It is distinct from mental illness.

Dementia is categorised as a Neurocognitive Disorder (NCD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The NCD category is then further subdivided into Mild NCD such as *Prodromal Disease or Mild Cognitive Disorder ,Mild Cognitive Impairment* and Major NCD. The term "cognitive" refers to thinking and related processes, and the term "neurocognitive" has been applied to these disorders to emphasise that brain disease and disrupted brain function lead to symptoms of NCD.

The NCD category encompasses disorders where the primary clinical deficit is in cognitive function, and these deficits are acquired rather than developmental. Impairments may occur in attention, planning, inhibition, learning, memory, language, visual perception, spatial skills, social skills or other cognitive functions.

Indications

Cognitive screening using a validated tool is indicated in the following circumstances (for patients with an intended stay of 24 hours or more)-

- All patients admitted to BHS Acute/Subacute facilities aged 65 and above
- All Aboriginal and Torres Strait Islander (ATSI) patients admitted to BHS Acute/Subacute facilities aged 45 and above

In addition, All patients who meet the following criteria will have cognitive assessment performed regardless of age:

- Admitted under the Stroke Unit (Montreal Cognitive Assessment to be used)
- Admitted with fractured Neck of Femur (#NOF)
- Admitted with pre-morbid cognitive impairment/ dementia
- When otherwise clinically indicated;for example when admitted with severe medical illness;if staff or family members report change in behaviour, attention or functional state.

Contraindications

Not required for Hospital in the home (HITH) patients unless clinically indicated.

Issues To Consider

An established diagnosis of dementia does not exclude this patient group from cognitive assessment. A reasonable attempt at performing cognitive assessment should be made as per the assessment criteria. An inability to complete or partial completion of the assessment should be documented in the progress notes. Assessment can provide vital information in relation to early detection of delirium and monitoring of cognitive change (whilst an inpatient and in the longer term).

There is an inverse relationship between cognitive screening scores and age. Scores also relate directly to levels of education and formal schooling. Sensory, language, motor and speech impairments may exempt people from certain tasks . These impairments should be clearly noted on the assessment form and the score adjusted accordingly.See the relevant assessment tool guideline for further information.

A patients performance on cognitive screening is insufficient to support a diagnosis of dementia and instead should act as an indicator of current functional status and the need for further investigation.

The use of interpreters and other communication aids are essential for accurate cognitive screening assessments within CALD, Indigenous and ATSI patient populations. Engagement with Aboriginal and Torres Strait Islander liaison officers for this patient group is also recommended.

Diagnosis of a NCD should only be made by specialist clinicians who can diagnose the syndromes of dementia (major neurocognitive disorder) and mild cognitive impairment (mild neurocognitive disorder) based on history, examination, and appropriate objective assessments, using standard criteria such as DSM-5. Further, the cognitive deficits must not occur exclusively in the context of a delirium or be better explained by another mental disorder such as depression.

Equipment

SMMSE and CDT MR form (MR/160.0) or MoCA (MR/271.5) MR form

Watch, pencil, appropriate writing surface, stopwatch or timer for MoCA

RUDAS or KICA validated tools (and appropriate items)

For repeat SMMSE assessment use the same MR form but use alternative words for the recall task (Question 3).

For repeat MoCA assessment use the Review version MR/ 271.6

Detailed Steps, Procedures and Actions

PROCESS STANDARDS:	KEYPOINTS:
All patients meeting the cognitive screening criteria with an intended stay of greater than 24 hours will have cognitive assessment (with a validated tool) performed as part of the admission/pre-admission procedure	• The assessment will ideally be attended within (24) hours of admission to a ward or facility.
Complete the cognitive screening assessment as per the relevant guideline or instructions (see appendices).	• Staff members must be familiar and proficient in use of the validated assessment tool before performing assessment • Guidelines and instructions provide clear unequivocal guidelines for scoring and administration ensuring improved inter-rater reliability
Patients will have Cognitive screening repeated with each admission	• Fluctuations in cognitive state occur quickly and are often not picked up in general conversation • Changes in cognitive function can manifest as changes in physical health and functional status
Patients who attend pre-admission clinic (PAC) should have their assessment repeated on admission if the admission date is 12 months or greater from time of pre-admission clinic or if they have been medically unwell since that time	• If the time lapse between PAC and admission date is <u>less than 12 months</u> duration <u>and</u> the patient has not been ill or required admission for other treatment since that time, the previous SMMSE score is acceptable as a baseline
Patients who are unable to maintain attention for the duration of the assessment may have a delirium	• Document your attempted assessment along with any relevant behaviour / information and refer to the Cognition CNC (acute site) • There may be an underlying medical aetiology for the associated presentation, ensure vital signs including BP, BGL and oxygen saturations are within normal parameters, complete urine FWT • Notify treating team and request review if clinically indicated • Further assessment using the Confusion Assessment Method (MR/200.0) is indicated where delirium is suspected or confirmed • A diagnosis of dementia or other cognitive impairment does not exempt staff from completing or attempting to complete the SMMSE on admission
Patients with an established diagnosis of dementia will have cognitive assessment completed on each admission	• Patients with dementia or other cognitive impairment are at an increased risk of developing delirium during their hospitalisation • Routine cognitive assessment can be useful in monitoring change over time and detecting progressive cognitive decline

An abnormal score (24 or less on SMMSE +/- an abnormal clock drawing test or less than 26/30 on the MoCA) indicates the need for use of the Cognitive Impairment Identifier (See Appendix 2- CII Indications for use) and its associated communication strategies	• Abnormal cognitive screens may indicate an acute change in cognitive state (delirium) or an underlying/evolving dementia and should be investigated further • Notify the treating team, document on the MR/410.23 Comprehensive Care Plan or Progress Notes • Communicate abnormal assessment results to members of the multidisciplinary team and as part of regular handover • Referral of BHS-Acute Site (Base Hospital) patients to the Cognition CNC via Bossnet, will assist in investigation and coordination of care and further follow up required including post discharge (See appendix 3- Cog flow chart of assessment and referral process) • The CII alerts all staff both clinical and non-clinical to needs of this patient group in order to better target additional support for families and better communication with the patient

Related Documents

- CPP0024 - Cognitive Impairment Identifier (CII) Indications For Use
- CPP0456 - Bed Signage
- SOP0001 - Principles Of Clinical Care

References

- Alzheimers Australia (2012). What is dementia?
- American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders DSM-5 (5th ed.). Washington: American Psychiatric Association.
- Capezuti, E., Zwicker, D., Fulmer, T. T. & Boltz, M (Eds.). (2012). Evidence-based geriatric nursing protocols for best practice (4th ed.). New York: Springer Publishing Company.
- Folstein, M. F., Folstein, S. E., McHugh, P. R. (1975). Mini-mental state a practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 12(3), 189-198.
- Kimberley Indigenous Cognitive Assessment
- Molloy, D. W., Alemayehu, E., Roberts, R. (1991). Reliability of a standardized mini-mental state examination compared with the traditional mini-mental state examination. American Journal of Psychiatry, 148(1), 102-105.

Appendix

- BHS DCHP Cognitive Impairment Pathway
- IHPA (2014). Standardised Mini-Mental State Examination (SMMSE): guidelines for administration and scoring instructions.
- KICA Instructions booklet
- KICA Urban/Regional
- MOCA Administration and Scoring Instructions
- MR 160.0 SMMSE
- MR 271.5 MoCA

- MB 271.6 MoCA Review
- RUDAS Administration and Scoring Guide
- RUDAS Scoring Sheet
- Working with the CII

Reg Authority: Clinical Online Ratification Group	**Date Effective:** 23/01/2023
Review Responsibility: Cognition Clinical Nurse Specialist	**Date for Review:** 23/01/2026

Ballarat Health Services
Dementia Care in Hospitals Program (DCHP)
Cognitive Impairment Pathway

Ballarat Health Services
Putting your health first

Cognitive Impairment Identified

- ✓ Patient admitted with or develops delirium
- ✓ Patient has a known diagnosis of dementia or cognitive impairment (CI)
- ✓ Patient scored 24 or less on SMMSE *(MR/160.0) or drew abnormal clock face*
- ✓ Patient scored less than 26 on MoCA *(MR/271.5) or drew abnormal clock face*
- ✓ Staff or family members report change in cognitive state

- Provide patient, carer, family with Cognitive Impairment Identifier (CII) information brochure
- Place the CII at the bedside and use the DCHP communication and carer engagement strategies
- Referral to the cognition service

Obtain History and /or information including recent assessments via – Electronic Medical Record, the patient, carer and family, other informants (CDAMS, ACAS, residential facility, community organisations or service providers)

Patient assessment conducted to determine whether presentation and assessment is consistent with delirium or other cognitive impairment. Assessment supported by Confusion Assessment Method *(CAM MR/200.0)* and SMMSE / MoCA screening tools.

Does the patient have a delirium? *(Using CAM MR/200.0)*

Consider the diagnosis of delirium if features 1 and 2 plus either feature 3 or 4 are present.

1. Acute Onset
2. Inattention
3. Disorganised thinking
4. Altered level of consciousness

YES

- Physical exam, medication review, investigations
- Treat causes

Comprehensive assessment of medical conditions, physical, cognitive, social, psychological/behavioural function, risk factors, existing treatments, carer needs and/or referral for follow up

NO

Does the patient have a pre-existing CI or diagnosed dementia?

NO

Comprehensive assessment of medical conditions, physical, cognitive, social, psychological/behavioural function, risk factors, existing treatments, carer needs and/or referral for follow up

YES

Speak with pt., family, carer and other informants to ensure current presentation and assessment is consistent with baseline cognitive function and or diagnosis

Develop and implement an individualised, integrated prevention and management plan, including goals of care, in partnership with patient, carer and family. Communicate with the patient, family and healthcare team
Consider all factors below:

Provide individualised care ↔ Manage medical issues ↔ Prevent and/or minimize harm ↔ Prevent and/or manage delirium ↔ Respond to changes in behaviour ↔ Modify the environment

On discharge does the patient continue to meet the criteria suggestive of delirium?

YES

- Telephone support to family/carers within 48hrs of discharge
- Home visit to monitor resolution of delirium
- Letter to G.P. for continued monitoring +/- referral to Cognitive Dementia & Memory Service (CDAMS) 3/12 post discharge

NO

- Letter to G.P, detailing hospitalisation, events and need for future monitoring of cognitive state
- Consider referral to CDAMS or provide GP with advice re same

On discharge does the patient continue to meet the criteria suggestive of Cognitive Impairment (not delirium)?

YES

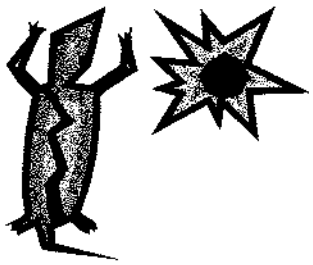
- Letter to G.P. for monitoring and referral to CDAMS
- Request CT brain and dementia screen pathology if not already attended

NO

- Letter to G.P. for monitoring as required

BHS Dementia Care in Hospitals Program; Cognitive Impairment Pathway: Updated March 2015.
References and acknowledgements: Australian Commission on Safety and Quality in Healthcare document "A better way to care". Figure 1.Safety and Quality pathway for patients with cognitive impairment (dementia and delirium) in hospital. http://www.safetyandquality.gov.au/e-pubs/abetterwaytocare-managers/
Clinical Epidemiology and Health Services Evaluation Unit, the Australian Health Ministers' Health Care of Older Australians Standing Committee. Clinical practice guidelines for the management of delirium in older people, 2006. http://www.health.vic.gov.au/acute-agedcare/
Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care setting. Victorian Govt. Depart. of Human Services. Melbourne Victoria 2004.

Kimberley Indigenous Cognitive Assessment (KICA)



Instruction booklet

Background

The Kimberley Indigenous Cognitive Assessment (KICA) is the only valid dementia assessment tool for older Indigenous Australians.

The KICA was developed and validated in the Kimberley region of Western Australia and further validated in the Northern Territory. The participants were rural and remote Indigenous Australians. A short version (KICA-Screen) has been validated in Far North Queensland.

It was developed with the assistance of Kimberley Indigenous community members and councils, the language resource centre, interpreting service and a range of health professionals.

It is recommended for use with rural and remote Indigenous Australians aged 45 years and above for whom other dementia assessments are not suitable.

Tools required

Objects: 5 common items are required for the tool.

- Comb
- Pannikin / cup
- Box of matches
- Plastic bottle with top.
- Watch/ timer for verbal fluency question.

Pictures: found at www.wacha.org.au

- The boomerang, boy, emu, billy/fire, crocodile and bicycle pictures are for the visual naming and free recall questions and should be presented in that order.
- The pictures with 3 options to a page are for the cued recall question.
- If the client is not able to name a crocodile or an emu for their own cultural reasons these pictures can be replaced on an individual basis with the dog and horse pictures found on the website.

Interpreter

Since language skills are being assessed a trained interpreter is recommended. Contact your local Indigenous interpreting service for assistance.

KICA-Cog (Cognitive assessment section)

Orientation: Check with interpreter or family member if answers are correct.

Recognition and naming: If unable to identify the items, name each item for them before hiding them to assess registration and object recall.

Verbal comprehension:

- Ask question 7 and 8 separately.
- For question 8 ask both commands at once and score one point for each correct response (sky / ground). Don't prompt.

Verbal fluency: Tell the client that they will be timed for one minute. An interpreter may be required so animals can be said in language. Can prompt with e.g. 'any more? In the water?'. Note prompts made.

Visual naming:

- Point to the boomerang picture first using it as an example, but don't count it in the score. Tell them that they have to say what the picture is and remember all of the pictures for later on. Once they understand this continue with the rest of the pictures.
- Points are still given when what they say is generally correct.

  eg. 'bird' for emu picture

  'fire, bag or sticks' for billy boiling picture.

Free recall: Show the boomerang picture as a prompt, don't count in score.

Cued recall:

- If they get all of the free recall questions correct (5/5), automatically give a cued recall score of 5/5.
- Use the 'boomerang/ bush tomahawk/ clapping sticks' page as an example only (don't count in score). Continue when they understand to point to only one object out of the three shown on the page.

Poor vision

Recognition and naming: Place each object in the persons hand and ask them what it is and what it is used for. Ask them to remember the objects for later on.

Recall: Ask them 'tell me those 3 things I showed you'.

Visual naming: Name pictures for them to remember.

Cued recall: Tell them the 3 options that they can choose from. For example "Which one did I tell you to remember: boomerang... bush tomahawk... clapping sticks."

Frontal executive function: Write XOXOXOXO in larger letters for them to copy. If they have significant visual impairment omit the question.

Interpreting results

The KICA-Cog is out of 39. A score of 33/39 and below indicates possible dementia. A person scoring 33 or less should be referred to a doctor for dementia medical screens to rule out other causes of cognitive impairment.

The other sections of the tool eg. medical history and activities of daily living are for gathering information to assist with

- identifying risk factors
- diagnosis
- service provision.

Each section can be used independently.

The question under *Family emotional well-being* regarding the onset and progression of the condition is important for diagnosis. With Alzheimer's disease the person has a slow gradual decline in cognition. With delirium and vascular dementia the person tends to have a sudden onset of cognitive impairment.

Individual tasks in the KICA-Cog should also be analysed to assist in determining the type and severity of the dementia.
For example

- A score of 1/5 for free recall followed by a score of 5/5 for cued recall suggests a diagnosis of vascular or frontotemporal dementia (cues help) rather than Alzheimer's type.

The KICA results and dementia checklist is available on www.wacha.org.au . It outlines how KICA results may be presented and includes a checklist for health professionals to review prior to dementia diagnosis.

Refer to the Alzheimer's Australia website www.alzheimers.org.au for further dementia information.
Another useful link is *Dementia: Update for the practitioner* http://ci.columbia.edu/c1182/web/sect_1/c1182_s1_1.html

KICA-Screen (sKICA)

The KICA-Screen contains 10 client questions with a total score of 25. It is to be used as a cognitive screen only. The KICA-Screen and the KICA-Carer should be used together. It is recommended that the full KICA is used for the most optimum results.

KICA Journal articles, reports and abstracts

Smith, K, Flicker, L, Dwyer, A, Marsh G, Mahajani S, Almeida, O, Lautenschlager, N, Atkinson, D, LoGiudice, D. 'Assessing cognitive impairment in Indigenous Australians - Re-evaluation of the Kimberley Indigenous Cognitive Assessment (KICA) in Western Australia and the Northern Territory', Australian Psychologist, 44:1, 54-61, 2009.

Smith K 2008, *Assessment and prevalence of dementia in Indigenous Australians (thesis),* University of Western Australia. Available from http://catalogue.library.uwa.edu.au/

Smith K, LoGiudice D, Dwyer A, Thomas J, Flicker L, Lautenschlager N, Almeida O, Atkinson D. 'Ngana minyarti? What is this?' Development of cognitive questions for the Kimberley Indigenous Cognitive Assessment. Australasian Journal on Ageing 26:3, 115-119, 2007.

LoGiudice D, Smith K, Thomas J, Lautenschlager NT, Almeida OP, Atkinson D, Flicker L. Kimberley Indigenous Cognitive Assessment tool (KICA): Development of a cognitive assessment tool for older Indigenous Australians. International Psychogeriatrics 18:2, 269-280, 2006.

Marsh G, Inglis M, Smith K & LoGiudice D 2006, 'Validation of the Kimberley Indigenous Cognitive Assessment tool (KICA) in rural and remote Indigenous communities of the Northern Territory.' A joint collaboration between Alzheimer's Australia NT, University of Western Australia and National Ageing Research Institute, Alzheimer's Australia, Canberra. Available from http://www.alzheimers.org.au/content.cfm?categoryid=28

Stevenson M, Smith K, Strivens E 2008, Indigenous Cognitive Assessment-Validation of the sKICA-Cog in Far North Queensland, Queensland Health.

Smith K, Dwyer A, Flicker L, Lautenschlager N, Almeida O, Atkinson D, LoGiudice D. Investigating cognitive impairment and other health conditions in older Indigenous

Australians. Australasian Journal on Ageing. 24 (Supplement): A54-A55, November 2005.

LoGiudice D, Smith K, Dwyer A, Thomas J, Lautenschlager N, Almeida O, Atkinson D, Flicker L. Kimberley Indigenous Cognitive Assessment tool: Current status of the validity of the cognitive and informant questions. Australasian Journal on Ageing. 24 Supplement:A43, November 2005.

Smith K, Flicker L, Almeida O, Lautenschlager N, Thomas J, Waters S, LoGiudice D. The Kimberley Indigenous Cognitive Assessment (KICA): Results of reliability and validity testing in an Indigenous population. Internal Medical Journal. 35(50): A48, May 2005.

Contact Information

Questions regarding the KICA can be directed to:

Kate Smith: kate.smith@uwa.edu.au

Dr. Dina LoGiudice: dina.logiudice@mh.org.au

KICA-Screen Urban/Regional

I'd like to see if you can remember things. I'll ask you some questions.

Incorrect answer enter ...0 Correct answer enter...1

Orientation

1. What month is it? 0 1 ( )

(Dates on the cusp may also be scored correct. eg. score correct if the date is 1 April and the person answers March, or if the date is 30 April and the person answers May)

2. What season is it now? 0 1 ( )

(Language specific seasons e.g. Birak; Season description e.g. fire season; may all be acceptable based on region. 'It is hot today' is incorrect)

3. What is the name of this place? 0 1 ( )

Verbal comprehension

4. *(if indoors)* First point to the ceiling, and then point to the floor

OR

(if outdoors) First point to the sky, and then point to the ground

(in order pointing up = 1 point. pointing down = 1 point)

0 1 2 ( )

(pointing with finger or mouth is appropriate)

Verbal fluency

5. Tell me the names of as many different animals as you can. We'll see how many animals you can name in one minute. Ready?

(Time for one minute)

Total No._____

(0 animals)	0	
(1-4 animals)	1	
(5 –8 animals)	2	
(9 animals or more)	3	( )

Visual naming

6. I'll show you some pictures and you tell me what they are. Remember all these pictures for later on, because I'll ask you one more time.

Point to each picture and ask What's this? *Show guitar as example only, don't include in the score*
Remember these pictures for later on.

boy, emu/bird, billy/fire/bag, crocodile, bicycle 0 1 2 3 4 5 ( )

☐ *Couldn't do due to poor vision. Name pictures for them to remember.*

Frontal/ executive function

7. Look at this. Now you copy it here.
Show alternating crosses and circles (XOXO...)

0 1 ( )

Free Recall

8. You remember those pictures I showed you before? What were those pictures?
(Show boomerang/guitar picture as example)

0 1 2 3 4 5 ( )

Cued Recall

(If scored all five correct in Q8, score 5 correct in this question and skip to Q10)

9. Which one did I show you before?
(one of three pictures, use boomerang/guitar page as example)
If poor vision name the three options for them

0 1 2 3 4 5 ( )

Praxis

10. Show me how to use this comb

0 1 ( )

Cut off score 21/25 **Total Score** _____/25

(Score of 21 or below indicates possible dementia, refer for further investigations)

Montreal Cognitive Assessment
(MoCA)

Administration and Scoring Instructions

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. Time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

1. Alternating Trail Making:

Administration: The examiner instructs the subject: *"Please draw a line, going from a number to a letter in ascending order. Begin here* [point to (1)] *and draw a line from 1 then to A then to 2 and so on. End here* [point to (E)]."

Scoring: Allocate one point if the subject successfully draws the following pattern:
1 –A- 2- B- 3- C- 4- D- 5- E, without drawing any lines that cross. Any error that is not immediately self-corrected earns a score of 0.

2. Visuoconstructional Skills (Cube):

Administration: The examiner gives the following instructions, pointing to the **cube**: "*Copy this drawing as accurately as you can, in the space below*".

Scoring: One point is allocated for a correctly executed drawing.
- Drawing must be three-dimensional
- All lines are drawn
- No line is added
- Lines are relatively parallel and their length is similar (rectangular prisms are accepted)

A point is not assigned if any of the above-criteria are not met.

3. Visuoconstructional Skills (Clock):

Administration: Indicate the right third of the space and give the following instructions: *"Draw a **clock**. Put in all the numbers and set the time to 10 past 11".*

Scoring: One point is allocated for each of the following three criteria:
- Contour (1 pt.): the clock face must be a circle with only minor distortion acceptable (e.g., slight imperfection on closing the circle);
- Numbers (1 pt.): all clock numbers must be present with no additional numbers; numbers must be in the correct order and placed in the approximate quadrants on the clock face; Roman numerals are acceptable; numbers can be placed outside the circle contour;
- Hands (1 pt.): there must be two hands jointly indicating the correct time; the hour hand must be clearly shorter than the minute hand; hands must be centred within the clock face with their junction close to the clock centre.

A point is not assigned for a given element if any of the above-criteria are not met.

4. Naming:

Administration: Beginning on the left, point to each figure and say: *"Tell me the name of this animal".*

Scoring: One point each is given for the following responses: (1) lion (2) rhinoceros or rhino (3) camel or dromedary.

5. Memory:

Administration: The examiner reads a list of 5 words at a rate of one per second, giving the following instructions: *"This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn't matter in what order you say them".* Mark a check in the allocated space for each word the subject produces on this first trial. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, read the list a second time with the following instructions: *"I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time."* Put a check in the allocated space for each word the subject recalls after the second trial.
At the end of the second trial, inform the subject that (s)he will be asked to recall these words again by saying, *"I will ask you to recall those words again at the end of the test."*

Scoring: No points are given for Trials One and Two.

6. Attention:

Forward Digit Span: Administration: Give the following instruction: "*I am going to say some numbers and when I am through, repeat them to me exactly as I said them*". Read the five number sequence at a rate of one digit per second.

Backward Digit Span: Administration: Give the following instruction: "*Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order.*" Read the three number sequence at a rate of one digit per second.

Scoring: Allocate one point for each sequence correctly repeated, (*N.B.*: the correct response for the backwards trial is 2-4-7).

Vigilance: Administration: The examiner reads the list of letters at a rate of one per second, after giving the following instruction: "*I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand*".

Scoring: Give one point if there is zero to one errors (an error is a tap on a wrong letter or a failure to tap on letter A).

Serial 7s: Administration: The examiner gives the following instruction: *"Now, I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop."* Give this instruction twice if necessary.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correction subtraction, 2 points for two-to-three correct subtractions, and 3 points if the participant successfully makes four or five correct subtractions. Count each correct subtraction of 7 beginning at 100. Each subtraction is evaluated independently; that is, if the participant responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction. For example, a participant may respond "92 – 85 – 78 – 71 – 64" where the "92" is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the item would be given a score of 3.

7. Sentence repetition:

Administration: The examiner gives the following instructions: *"I am going to read you a sentence. Repeat it after me, exactly as I say it* [pause]: ***I only know that John is the one to help today."*** Following the response, say: *"Now I am going to read you another sentence. Repeat it after me, exactly as I say it* [pause]: ***The cat always hid under the couch when dogs were in the room."***

Scoring: Allocate 1 point for each sentence correctly repeated. Repetition must be exact. Be alert for errors that are omissions (e.g., omitting "only", "always") and substitutions/additions (e.g., "John is the one who helped today;" substituting "hides" for "hid", altering plurals, etc.).

8. Verbal fluency:

Administration: The examiner gives the following instruction: *"Tell me as many words as you can think of that begin with a certain letter of the alphabet that I will tell you in a moment. You can say any kind of word you want, except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix, for example, love, lover, loving. I will tell you to stop after one minute. Are you ready?* [Pause] *Now, tell me as many words as you can think of that begin with the letter F.* [time for 60 sec]. *Stop."*

Scoring: Allocate one point if the subject generates 11 words or more in 60 sec. Record the subject's response in the bottom or side margins.

9. Abstraction:

Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example: *"Tell me how an orange and a banana are alike"*. If the subject answers in a concrete manner, then say only one additional time: *"Tell me another way in which those items are alike"*. If the subject does not give the appropriate response *(fruit)*, say, *"Yes, and they are also both fruit."* Do not give any additional instructions or clarification. After the practice trial, say: *"Now, tell me how a train and a bicycle are alike"*. Following the response, administer the second trial, saying: *"Now tell me how a ruler and a watch are alike"*. Do not give any additional instructions or prompts.

Scoring: Only the last two item pairs are scored. Give 1 point to each item pair correctly answered. The following responses are acceptable:
Train-bicycle = means of transportation, means of travelling, you take trips in both;
Ruler-watch = measuring instruments, used to measure.
The following responses are **not** acceptable: Train-bicycle = they have wheels; Ruler-watch = they have numbers.

10. Delayed recall:

Administration: The examiner gives the following instruction: *"I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember."* Make a check mark (√) for each of the words correctly recalled spontaneously without any cues, in the allocated space.

Scoring: **Allocate 1 point for each word recalled freely without any cues.**

Optional:
Following the delayed free recall trial, prompt the subject with the semantic category cue provided below for any word not recalled. Make a check mark (√) in the allocated space if the subject remembered the word with the help of a category or multiple-choice cue. Prompt all non-recalled words in this manner. If the subject does not recall the word after the category cue, give him/her a multiple choice trial, using the following example instruction, *"Which of the following words do you think it was, NOSE, FACE, or HAND?"*
Use the following category and/or multiple-choice cues for each word, when appropriate:

FACE:	category cue: part of the body	multiple choice: nose, face, hand
VELVET:	category cue: type of fabric	multiple choice: denim, cotton, velvet
CHURCH:	category cue: type of building	multiple choice: church, school, hospital
DAISY:	category cue: type of flower	multiple choice: rose, daisy, tulip
RED:	category cue: a colour	multiple choice: red, blue, green

Scoring: **No points are allocated for words recalled with a cue.** A cue is used for clinical information purposes only and can give the test interpreter additional information about the type of memory disorder. For memory deficits due to retrieval failures, performance can be improved with a cue. For memory deficits due to encoding failures, performance does not improve with a cue.

11. Orientation:

Administration: The examiner gives the following instructions: "Tell me the date today". If the subject does not give a complete answer, then prompt accordingly by saying: *"Tell me the [year, month, exact date, and day of the week]."* Then say: *"Now, tell me the name of this place, and which city it is in."*

Scoring: Give one point for each item correctly answered. The subject must tell the exact date and the exact place (name of hospital, clinic, office). No points are allocated if subject makes an error of one day for the day and date.

TOTAL SCORE: Sum all subscores listed on the right-hand side. Add one point for an individual who has 12 years or fewer of formal education, for a possible maximum of 30 points. A final total score of 26 and above is considered normal.

R U D A S

R owland
U niversal
D ementia
A ssessment
S cale

A Multicultural Cognitive Assessment Scale

Administration and Scoring Guide

Funded under the NSW Dementia Action Plan, 1996-2001, a joint initiative of the NSW Health Department and the Department of Ageing, Disability and Home Care.

NSW HEALTH
Working as a Team

Table of Contents

Introduction

The Rowland Universal Dementia Assessment Scale (RUDAS): A Multicultural Cognitive Assessment Scale – (Storey J, Rowland J, Basic D, Conforti D & Dickson H [2004] *International Psychogeriatrics*, 16(1) 13-31) is a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance.

When administering the RUDAS it is important that the respondent is encouraged to communicate in the language with which they are most competent and comfortable.

Test administrators should read the following instructions carefully before using the RUDAS.

The Assessment Context – General Guidelines:

Test Anxiety

- Make sure the test taker is as relaxed as possible, as test anxiety can interfere with performance on cognitive tests.

Hearing

- Conduct the RUDAS in a quiet area and make sure the test taker can hear clearly. It is important to identify at the beginning of the assessment if the test taker has impaired hearing and accommodate for this as much as possible by speaking slowly and clearly. Encourage the test taker to wear any hearing aids. Be careful not to speak too loudly as this may result in distortion. (There is a large print version of the RUDAS for test takers with severe hearing impairment).

Vision

- Ensure that the test taker is using reading glasses where necessary and that there is sufficient light in the room.

Seating

- Sit opposite the test taker. This is important for communication reasons as well as controlling for the difficulty of some items on the RUDAS. Do not sit behind a desk, as this will inhibit the giving of instructions for some items on the RUDAS and may also be intimidating for the test taker.

Recording Responses

- It is important to record the test taker's full response to each item.

Physical Disability

- For test takers who have a physical disability (e.g. vision, hearing, hemiparesis, amputee, stroke, aphasia) which may affect their ability to perform certain items on the RUDAS, it is important to complete the RUDAS as fully as possible but to interpret any total score less then 22 with caution (further research is necessary to assess validity of the RUDAS in this sub-group of patients)

The Language/ Cultural Context:

Using a Professional Interpreter

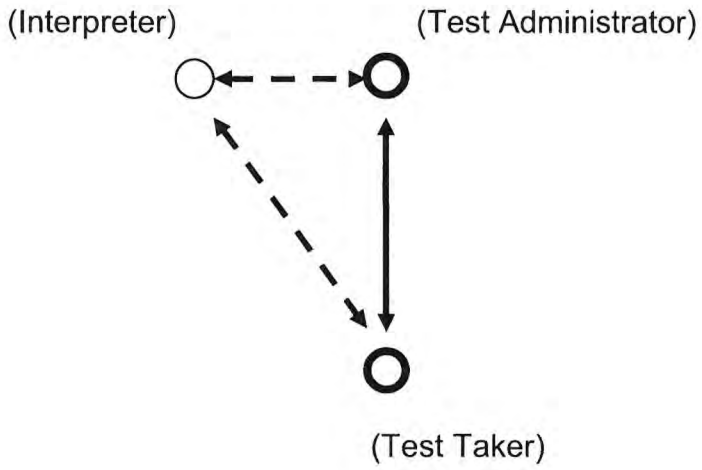
If you are utilising a professional interpreter to administer the RUDAS it is important to consider the following:

1. Interpreters should be used in all situations where the test taker's preferred language is not spoken fluently by the test administrator.

2. Make sure that the language spoken by the interpreter (including the dialect) is the same one with which the test taker is familiar.

3. It is important to explain to the test taker that the interpreter is the facilitator and that you will be asking the questions. This may help to avoid confusion during the assessment.

4. It is better for the interpreter to sit next to the test administrator while the test taker sits opposite. This will reinforce the adjunctive role of the interpreter and make it easier for the test taker to synthesise the non-verbal cues from the test administrator and the verbal cues from the interpreter.



5. It is important to brief the interpreter before starting the assessment:

- The interpreter should be aware of the general nature of the interaction i.e. that it is a cognitive assessment

- Remind the interpreter of the importance of concurrent and precise interpreting. Explain that your instructions and the test taker's responses should be interpreted as exactly as possible.

- Ask the interpreter to take note of any instances during the assessment where the test taker's performance may have been affected by subtle or unintended changes to the meaning of the test instructions due to language or cultural factors

- Inform the interpreter that it may be necessary at the end of the test for you to clarify a concept covered in the assessment to further make the distinction between the test taker's actual cognitive capacity and potential cultural bias which may arise as a result of the translation process.

Multilingual Test Administrators

If, as the test administrator, you are multilingual it is important to consider all of the same issues which are relevant to the use of a professional interpreter, as well as the following:

- You may need to be careful when translating the RUDAS questions as you might find it more difficult when you have to read in one language and speak in another.

- It is important that you translate the RUDAS questions precisely. Be aware of the differences between formal and informal word usage when translating the RUDAS instructions and recording the test taker's responses.

Item 1 – Memory

Grocery List

1. I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 minutes time I will ask you what it is that we have to buy. You must remember the list for me.

   Tea
   Cooking Oil
   Eggs
   Soap

   Please repeat this list for me (Ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of five times.)

Notes:

- Important to give enough learning trials so that test taker registers and retains the list as well as they can (max. of 5 learning trials)

- Ask the test taker to repeat the list back to you at least three times until they can repeat it correctly or as well as they are going to

- Use realistic nature of the scenario and a little humour (if appropriate) to build rapport and make the task less confrontational i.e. WE are going shopping; I am relying on YOU to remember the list FOR ME, so don't forget. When WE get to the shop . . .

- To facilitate learning of the list, use your fingers to list off items on the list when teaching it to the test taker to make the task as concrete as possible e.g. thumb = tea, index finger = cooking oil etc.

Scoring:

This is the learning part of the memory question. There are no points for this part of the question but the memory recall component later in the test has a maximum score of 8 points.

Item 2 - Body Orientation

Body Orientation

2. I am going to ask you to identify/show me different parts of the body. *(Correct = 1, Incorrect = 0).*

Once the person correctly answers 5 parts of this question, do not continue as the maximum score is 5.

(1) show me your right foot	1
(2) show me your left hand	1
(3) with your right hand touch your left shoulder	1
(4) with your left hand touch your right ear	1
(5) which is (point to/indicate) my left knee	1
(6) which is (point to/indicate) my right elbow	1
(7) with your right hand point to/indicate my left eye	1
(8) with your left hand point to/indicate my left foot	1

..../5

Notes:

- Important to sit opposite the test taker (controls for difficulty of the tasks)

- There doesn't need to be a lot of explanation before starting, just say "I am going to ask you to indicate various parts of the body . . ." - the task is explicit as it evolves

Scoring:

- Although there are 8 parts, this item has a maximum score of 5 points. Once the test taker has 5 correct answers there is no need to continue.

- Be careful with scoring - remember you are sitting opposite the test taker - it is easy to make mistakes so concentrate to make sure you score the person accurately

- There are no half marks, the test taker must get each task 100% correct to be marked correct (e.g. if test taker is asked "with your right hand indicate my left eye" and they use their left hand but still point to your left eye - mark as incorrect)

Item 3 - Praxis

Fist / Palm

3. **I am going to show you an action/exercise with my hands. I want you to watch me and copy what I do. Copy me when I do this . . .** (i.e. demonstrate - put one hand in a fist, and the other hand palm down on the table or your knees and then alternate simultaneously**.) Now do it with me. I would like you to keep doing this action at this pace until I tell you to stop** - approximately 10 seconds or 5 – 6 sequences. (Demonstrate at moderate walking pace).

Score as:

Normal	= 2	*(very few if any errors; self-corrected; progressively better; good maintenance; only very slight lack of synchrony between hands)*
Partially Adequate	= 1	***(noticeable errors with some attempt to self-correct; some attempt at** maintenance; poor synchrony)*
Failed	= 0	*(cannot do the task; no maintenance; no attempt whatsoever)*

..../2

Notes:

- It is important to sit opposite the test taker (controls for difficulty of the task)

- When teaching the task use the following steps:

Step 1: I want you to put your hands on your knees like this (i.e. put both your hands palm down on your knees (i.e. if no table surface)

Step 2: Now watch carefully as I do this (put one hand in a fist in the vertical position and leave the other hand palm down) - I want you to do this just like I did.

Step 3: Watch me again now as I am doing this (alternate hands simultaneously - one in a fist and the other palm down and keep alternating for 5 - 6 trials).

Step 4: Ask test taker to copy exactly what you are doing. If test taker is confused and has not learned the task successfully then repeat Steps 1, 2 and 3

Step 5: Once test taker has learned the task (i.e. understands as well as possible what they are meant to do - regardless of whether or not they can do it 100%), ask them to repeat the exercise at the pace you demonstrate until you tell them to stop (now demonstrate task - intervals between change of hands should reflect moderate walking pace). Do not allow the test taker to copy you when scoring – must demonstrate the task independently

Scoring:

This question has a maximum score of 2 points.

In order to help distinguish between the three levels of competence, refer to the following:

Score	Fist / Palm Integrity	No. of Errors	Fluency	Ability to Self-Correct	Progressive Improvement	Synchrony
Normal	Good adherence to 'palm down' and 'fist' actions with few intrusions or incorrect variations	Minimal	Good	Good	Clearly evident	Only very slight lack of synchrony
Partially Adequate	Obvious intrusions and incorrect variations in 'palm down' and 'fist' actions	Noticeable	Some attempt to maintain	Some attempt	Some indication	May be noticeable lack of synchrony
Failed	Barely able to identify correct 'palm down' and 'fist' actions because of many intrusions and incorrect variations	Many	Poor or none	None	Very little or none	Little or no synchrony

Normal

A person who performs normally on this task should exhibit signs of intact learning and should be able to replicate clearly, the 'fist in the vertical position' and 'palm down' actions. Their performance on the task should improve with progressive learning trials to a point where they can do the task fluently with minimal errors. The test taker should demonstrate the ability to self- correct, show progressive improvement over the course of the task and have only very slight lack of synchrony between the hands.

Partially Adequate

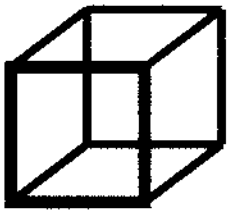
A person whose response is partially adequate will make noticeable errors e.g. occasionally places palm up instead of palm down or may place palm up instead of converting to the fist or may form the fist in the horizontal position. They may have to stop occasionally in order to self-correct but even if they are unable to perform the task perfectly there should be some evidence that they have learned the task, some attempt to self-correct and some indication of an attempt to maintain the fluency of the alternating hands. There may be a noticeable lack of synchrony between the hands.

Failed

A person who fails this task shows very little if no ability to understand and execute the task. There are many errors, very little or no evidence of improvement, inability to self-correct, poor maintenance, and obvious inability to emulate correct hand positions and to perform the simultaneous changing of hands with any synchrony. A person who fails may not be able to form a fist or distinguish between palm up and palm down, may not alternate the actions across hands and may not be able to use both hands together at all.

Item 4 - Drawing

Visuo-Constructional Cube Drawing



4. Please draw this picture exactly as it looks to you (Show cube on back of page).
(Yes = 1; No = 0)

Score as:

(1) Has person drawn a picture based on a square? 1

(2) Do all internal lines appear in person's drawing? 1

(3) Do all external lines appear in person's drawing? 1

..../3

Notes:

This question has a maximum of 3 points.

- Show test taker cue card of cube drawing
- If there is no cue card, the test administrator can draw the cube onto plain (not lined) paper.
- Make sure that test taker can see the drawing clearly (check that they are wearing prescription glasses if applicable)
- Ask test taker to draw the picture of the cube as well as they can

Scoring:

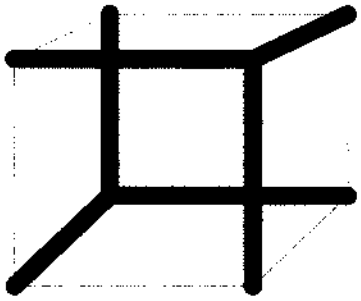
Has test taker drawn a picture based on a square? (i.e. There is a square somewhere in the drawing)

YES / NO

Do all internal lines (i.e. dark lines) appear in test taker's drawing?

YES / NO

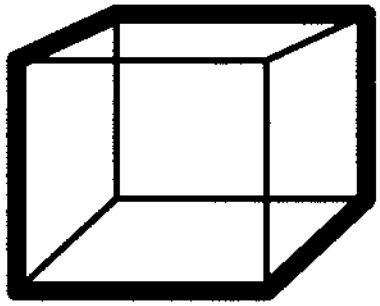
i.e.



Do all external lines (i.e. dark lines) appear in test taker's drawing?

YES / NO

i.e.



Item 5 - Judgement

Judgement - Crossing the Street

5. You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the street **safely**. (If person gives incomplete answer use prompt: "Is there anything else you would do?") Record exactly what patient says and circle all parts of response which were prompted.

.....

.....

Score as:

Did person indicate that they would look for traffic? 2
(YES = 2; YES PROMPTED = 1; NO = 0)

Did person make any additional safety proposals? 2
(YES = 2; YES PROMPTED = 1; NO = 0)

..../4

Notes:

- If the test taker gives no response to the question or says "I don't know", then repeat the question once only.

- Except where the test taker answers both parts of the question on the first attempt, use the prompt 'Is there anything else you would do' in all situations. This is to gain as complete a response as possible from the test taker.

- Use only the general prompt 'Is there anything else you would do' – do not prompt the person in any other way

- Record test taker's response to this question.

- Circle any part of test taker's response which was prompted and score accordingly.

- If the test taker says that they never cross the road by themselves (e.g. they are in a wheelchair or their eyesight is poor), then ask them the question again but modify as follows:

"What would anyone who wanted to cross the road have to do to get across safely?"

Scoring:

This item has a maximum score of 4 points. Each of the two parts:

1. look for traffic, and
2. additional safety proposal

has a total score of 2 points i.e. Yes = 2; Yes Prompted = 1; No = Zero

i.e.

- *Did test taker indicate that they would look for traffic?*

YES / YES PROMPTED / NO
2 1 0

Examples of Correct Responses	Examples of Incorrect Responses
I would look for traffic.	Just go across.
Look left and right.	Put my hand up so the traffic knows I want to cross.
Check the cars.	Go to the corner and cross.
Check that it's clear.	Wave at the cars so they can see me.
Go across when there is nothing coming.	I wouldn't go across.

- *Did test taker make any additional safety proposals in road crossing scenario?*

YES / YES PROMPTED / NO
2 1 0

Examples of Correct Responses	Examples of Incorrect Responses
Cross to the middle of the road and then look again to make sure there was no traffic before going right across.	Run as fast as I can.
Keep looking for traffic while crossing.	Cross when the walk sign is green.
Go across quickly but without running.	Cross at the crossing.
Be careful.	Just put my head down and go.
Wait till I could cross with some other people.	
Ask for help.	

Scoring Examples:

Example 1

"I don't know. (Repeat the question).

"I'd look for the cars. (I can't think of anything else except be careful.)"

This response would score 3 points out of a total of 4 because the person said that they would look for the cars (2/2) and when prompted (i.e. circle indicates that it was prompted) said that they would be careful (1/2) i.e. 2/2 + 1/2 = 3/4

Example 2

"Just go across. (Check for the cars.")

This response would score 1 point only out of a total of 4 because the first part of the answer 'just go across' was incorrect (0/2), and the second part of the answer 'check for the cars' while correct, was prompted (i.e. because it was circled to indicate that it was prompted) (1/2) i.e. 0/2 + 1/2 = 1/4

Example 3

"Put my hand up so the traffic knows I want to cross and then walk to the middle of the road before going right across."

This response would score 2 points out of a total of 4 because the first part of the answer is incorrect (0/2) and the second part of the answer 'then walk to the middle of the road before going right across' is correct (2/2) i.e. 0/2 + 2/2 = 2/4

Item 1 – Memory

Memory Recall (Item 1 Revisited - 4 Grocery Items)

1.® We have just arrived at the shop. (Can you remember the list of groceries we need to buy? (Prompt: If person cannot recall any of the list, say "The first one was 'tea'."

(Score 2 points each for any item recalled which was not prompted.)

Circle 'Tea' if used as a prompt and score as 0 out of 2)

Tea	2
Cooking Oil	2
Eggs	2
Soap	2

..../8

Notes:

- Ask test taker to repeat the 4 items on the grocery list
- If after 20 - 30 seconds the test taker cannot remember learning the list OR any of the items on the list then use the prompt - i.e. the first one was 'tea' and then circle 'tea' or write a 'P' in parentheses after it to indicate that it was prompted and score as zero
- Use the prompt 'the first one was 'tea', only if the person cannot remember any of the grocery items
- Do not use any other prompts in this task (e.g. if the person says 'cooking oil' but cannot remember any of the other grocery items on the list do not use the 'tea' prompt or any other prompt)

Scoring:

The recall component of the memory item has a maximum score of 8 points.

- There are no part marks, the person scores either zero or 2 points for each item on the grocery list
- If 'tea' was used as a prompt then the maximum score the person can get on this task is 6/8
- mark as correct if the person says 'cooking oil' or ' oil'

Item 6 - Language

Language Generativity – Animal Naming

6. I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute. (Repeat instructions if necessary). Maximum score for this item is 8. If person names 8 new animals in less than one minute there is no need to continue.

1.	5. .....
2.	6. .....
3.	7. .....
4.	8. .....

..../8

Notes:

This item has a maximum score of 8 points.

- Time the test taker for one minute ONLY - make sure that it is clear to the test taker when to start i.e. "When I say 'Go' you should start listing animals. Don't worry about me writing them down, say the animals as quickly as you can."

- If test taker does not speak English make sure that interpreter also understands the instructions and the importance of simultaneous interpreting.

Scoring:

- If test taker says for example – 'big horse' and 'little horse', then record these as two separate animal names. Then at the end of the assessment, if the person is from an NESB country, check with the interpreter that these two names actually represent different concepts in the relevant language (e.g. in English – 'big horse' and 'little horse' are not separate animal names therefore an ESB person would score only one point (BUT, if the ESB person had said 'horse' and 'foal' then these are two separate concepts and the person would score two points). An NESB person depending on the language spoken may score two points if they used the correct two words for 'big horse' and 'little horse'. It is important here to distinguish between perseveration (i.e. repetition of the same animal name) and linguistic peculiarities of different languages which conceptualise/describe animals differently.

TOTAL SCORE

Add up the scores for each item to get a **total score out of 30**.

Any score of 22 or less should be considered as possible cognitive impairment and referred on for further investigation by the relevant physician.

R U D A S

The Rowland Universal Dementia Assessment Scale: A Multicultural Cognitive Assessment Scale. (Storey, Rowland, Basic, Conforti & Dickson, 2004). International Psychogeriatrics, 16 (1), 13-31

Date: ____/____/____ Patient **Name:** _____

Item		Max Score
Memory 1. (Instructions) I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 mins. time I will ask you what it is that we have to buy. You must remember the list for me. **Tea, Cooking Oil, Eggs, Soap** Please repeat this list for me (ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of five times.)		
Visuospatial Orientation 2. I am going to ask you to identify/show me different parts of the body. *(Correct = 1)*. Once the person correctly answers 5 parts of this question, do not continue as the maximum score is 5.		
(1) show me your right foot (2) show me your left hand (3) with your right hand touch your left shoulder (4) with your left hand touch your right ear (5) which is (indicate/point to) my left knee (6) which is (indicate/point to) my right elbow (7) with your right hand indicate/point to my left eye (8) with your left hand indicate/point to my left foot	.....1 .....1 .....1 .....1 .....1 .....1 .....1 1	..../5
Praxis 3. I am going to show you an action/exercise with my hands. I want you to watch me and copy what I do. Copy me when I do this . . . (One hand in fist, the other palm down on table - alternate simultaneously.) Now do it with me: Now I would like you to keep doing this action at this pace until I tell you to stop - approximately 10 seconds. (Demonstrate at moderate walking pace). Score as: *Normal* = 2 *(very few if any errors; self-corrected, progressively better; good maintenance; only very slight lack of synchrony between hands)* *Partially Adequate* = 1 *(noticeable errors with some attempt to self-correct; some attempt at maintenance; poor synchrony)* *Failed* = 0 *(cannot do the task; no maintenance; no attempt whatsoever)*		..../2
Visuoconstructional Drawing 4. Please draw this picture exactly as it looks to you (Show cube on back of page). *(Yes = 1)* Score as: (1) Has person drawn a picture based on a square? (2) Do all internal lines appear in person's drawing?  (3) Do all external lines appear in person's drawing? 	.....1 .....1 1	..../3
Judgment 5. You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the road **safely**. (If person gives incomplete response that does not address both parts of answer, use prompt: "Is there anything else you would do?") Record exactly what patient says and circle all parts of response which were prompted. .... Score as: Did person indicate that they would look for traffic? *(YES = 2; YES PROMPTED = 1; NO = 0)* Did person make any additional safety proposals? *(YES = 2; YES PROMPTED = 1; NO = 0)*	 .....2 2	..../4

Memory Recall

1. (Recall) We have just arrived at the shop. Can you remember the list of groceries we need to buy? (Prompt: If person cannot recall any of the list, say "The first one was 'tea'." *(Score 2 points each for any item recalled which was not prompted – use only 'tea' as a prompt.)*

Tea	2	
Cooking Oil	2	
Eggs	2	
Soap	2	
		..../8

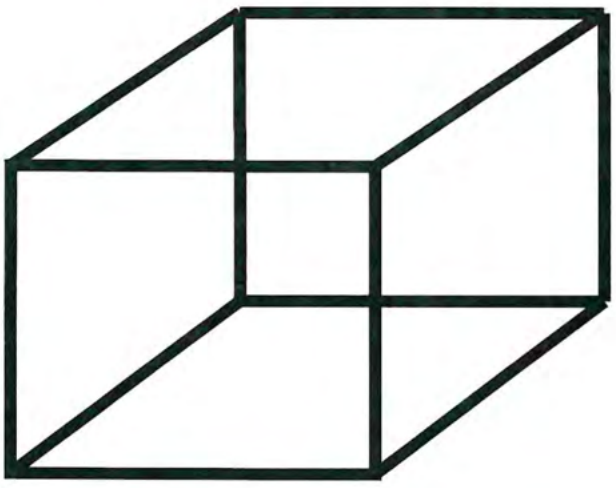
Language

6. I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute. (Repeat instructions if necessary). Maximum score for this item is 8. If person names 8 new animals in less than one minute there is no need to continue.

1.	5. .....
2.	6. .....
3.	7. .....
4.	8. .....

..../8

TOTAL SCORE = **/30**



Cognitive
Impairment
Identifier

Working with the **Cognitive Impairment Identifier (CII)**

Cognitive Impairment is common in the hospital setting; it varies from patient to patient and is often hard to identify on casual contact.

When should the Cognitive Impairment Identifier; Bed Based or Stickers be used?

- **There is a known diagnosis of dementia**
- **There is a confirmed delirium/Acute Confusional State (Established by CAM MR/200.0)**
- **Cognitive impairment has been established using a validated screening tool (for example the SMMSE or MoCA)**

- **The Cognitive Impairment Identifier aims to alert staff to patients with memory and thinking difficulties**
- **In the ward setting a bed based Cognitive Impairment Identifier is used. This slides into the bedside area where the nil orally, diet or diabetic signs are also displayed**
- **Cognitive Impairment Identifier stickers may be utilised on appropriate paperwork when patients are pre-operative, pre-procedural or do not have an allocated bed-space. This includes the Peri-operative Day Procedure Unit (PDPU) and Theatre areas**

When a patient is pre-operative and identified as meeting the criteria for cognitive impairment the CII stickers are to be placed on the top left hand corner of the:

- **Pre-of checklist (MR/362.0)**
- **Anaesthetic record (MR/375.0)**
- **Frequent observations chart (MR/585.0) or (MR/590.0)**

The CII alerts all staff to the patient's needs particularly in relation to communication. It should also alert staff to not expect more of the patient than he or she is capable of.

Please refer to the CII Clinical Practice Protocol and related communication bullet points for best practice approaches to communication with people with cognitive impairment.

For more information contact:
Cognition Clinical Nurse Consultant
Ext. 93652

Grampians Health

Clinical Procedure

Adult Comprehensive Care Plan

Location

All Grampians Health campuses

Scope (Staff)

All staff involved in the adult acute inpatient admission process.

Excludes neonates, obstetrics, paediatrics, day procedure units, care communities, and mental health.

Purpose

Grampians Health has systems and process in place:

- To ensure patients receive coordinated delivery of all healthcare required or requested by clinicians and healthcare consumers, carers, family and other support people.
- To document every patient's individualised daily plan. While other documents may supplement the Comprehensive Care Plan for specific care needs that are identified through ongoing risk screening and assessment, the Comprehensive Care Plan forms the core document for holistic planning and recording of care across each shift or episode of care.

Definitions

Bariatric Risk Assessment Tool (BRAT) – A tool used to assess occupational health and safety risk for staff and equipment needs for patients who weigh over 100kg.

Braden- An internationally validated risk screening tool used to identify adult persons at risk of sustaining a pressure injury.

Consumers- Includes patients, clients, consumers, participants in care.

Care plan - A written document which outlines the care needs and preferences of a consumer receiving care.

Clinicians - Members of the health care team who are qualified as health professionals.

Falls Risk Assessment Tool (FRAT) – A short, validated screening tool to assess the risk of a patient sustaining a fall.

Support person / Carer – Adult person designated to support a person receiving care to make their own decisions and to help ensure these decisions are enacted.

Malnutrition Screening Tool (MST) -- A short, validated screening tool to determine a person's risk of malnutrition.

Adult Comprehensive Care Plan

Multidisciplinary Team - A team of health care professionals which includes two or more of medical, nursing or allied health disciplines.

Personal care – Involves assistance and supervision with activities of daily living such as hygiene, dressing and/or toileting.

Person-centred care – The collaboration between health workers, the consumer and their carer/s which focuses on the consumer, their wishes and needs.

Episode of Care (EoC) - Period where a consumer is receiving care from the health service.

Visual Infusion Phlebitis Score (VIPS) – A widely accepted and validated tool to assess and manage Peripheral Vascular Cannulae.

Procedure

It is essential the Comprehensive Care Plan is relevant to the shift or episode of care to which it refers. Each clinician is to document care based on current assessments; copying from previous episodes of care without reference to a patient's current health status is not acceptable. The Comprehensive Care Plan is a legal document of care given at every point in a patient's journey.

The Comprehensive Care Standard (2019) defines nine (9) umbrella elements under which all care components can be grouped. These elements are:

- Personal Identifiers and preferences
- Clinical assessment and diagnosis
- Goals of care
- Risk screening and assessment
- Planned interventions
- Activities of daily living
- Monitoring plans
- People involved in care
- Discharge planning

General Instructions

These instructions relate to all twenty sections listed below; these sections form the content of the Comprehensive Care Plan.

- The clinician will indicate or add a written comment in the boxed areas, as appropriate.

- Starting at the top of the page, the clinician will work down the front and back of the page, completing the information as required to guide the consumer's treatment and care. This is required on admission and each shift thereafter or at each episode of care.

Adult Comprehensive Care Plan

- Shifts or episodes of care are identified at the top of each column. Where a patient is not an inpatient and care is episodic, the clinician is to strike out AM, PM, ND and write the appropriate date at the top of each column on both sides of the page.
- All sections provide a range tick boxes to indicate care being given. Where care is not required the *not applicable* (N/A) box is to be marked.
- Clinicians are to refer to specific clinical Grampians Health Clinical Guidelines and/or Procedures within GrH Prompt for instructions regarding clinical practice for all areas covered within the Comprehensive Care Plan. Where there is no Grampians Health documentation, refer to '*interim – pre GrH*' governance documentation for local sites.

Special Precautions

Special precautions provide a lens for all care being provided by any clinician.

- All precautions relevant for safe and effective care of a patient are to be documented here.
- As a minimum, all patients will be cared for using Standard Precautions. Standard Precautions are the primary strategy for minimising the transmission of healthcare-associated infections and must be used when providing care to all patients.
- "Pt adrenaline autoinjector available?" This is the place where the clinician confirms each shift at handover time, that there has been a check ensuring the adrenaline autoinjector is within reach of the patient in the agreed location [as per the in-hospital checklist for patient's own use of adrenaline (epinephrine) autoinjectors GR/662], within expiry date and viable
- For Clinical Guidelines or Procedures related to any Special Precautions, refer to Related Documents numbers 1 to 7.

Considerations

The clinician is to document all further Considerations not accounted for in Special Precautions which impact the safe and effective delivery of care.

- Where a consideration is relevant for a patient, the clinician is to circle as indicated or use free text to note any considerations not already on the Comprehensive Care Plan.
- Considerations include, but not limited to:
    - Vision or hearing difficulties. Use tick boxes to indicate if a hearing aid or glasses are normally used by the patient and that these are in use wherever possible and appropriate for care.
    - Communication difficulties. Note these under 'Other Considerations' including any communication aids used by the patient.

- Culturally and linguistically diverse (CALD). Use tick box to note if an interpreter is required. For Interpreter Services consult the SharePoint page relevant to your campus by typing *Interpreter* into the search box.

- Aboriginal and Torres Strait Islander Australian (ATSI). Use tick box to indicate if patient has requested the support of an Aboriginal health liaison officer (AHLO).

- Disability support. Use free text to note nature of disability. Contact the Disability Liaison Office (DLO) via dlo@gh.org.au for support for staff and/or patient. For further information about support for people with a disability at Grampians Health, consult the Disability Liaison Office SharePoint page.

- For Clinical Guidelines or Procedures related to any Considerations, refer to Related Documents numbers 8 to 15.

Cognition

This section alerts clinicians to care needs of patients with:

- Cognitive impairment
- Delirium
- Substance use impacting care needs
- Behaviours of concern including aggression and violence.

- Where any Cognitive Impairment is identified, clinicians are to involve family, carer and/or designated support person in planning and delivery of care.

- The Cognitive Impairment identifier (CII) triggers a package of care actions. Please refer to Grampians Health Cognitive Impairment Identifier Consumer Information Document (CID): Cognitive Impairment Identifier. The Cognitive Impairment Identifier sign is to be utilised at the patient's bedside as a prompt to staff and visitors to utilise communication techniques and strategies to assist the patient in understanding information/ instructions provided. The strategies also assist in reducing anxiety and confusion for the patient with cognitive impairment.

- The ABC Behaviour Observation Diary (or locally approved Behaviour Chart) is to be utilised for any patients displaying behaviours of concern. This allows staff to identify the potential triggers or trends in the patient's behaviour and possible effective de-escalation techniques.

- For Clinical Guidelines or Procedures related to Cognition, refer to Related Documents numbers 16-34.

Observations

- The clinician is to note all observations being made during a shift or EoC, together with required frequency and duration.

Adult Comprehensive Care Plan

- A vertical line is to be made by the clinician to create columns where differing frequency and duration of types of observations are needed.

- For Clinical Guidelines or Procedures related to Observations, refer to Related Documents numbers 35-42.

Oxygen/Suction

- Abbreviations:
  - H/M = Hudson Mask
  - INC = Intranasal Cannula
  - HiFlow = High Flow Oxygen Therapy
  - L/min = Litres per Minute

- A safety check of Oxygen, Suction and any other equipment in use is required once in every 24-hour period. This check is to be completed by the assigned primary nurse and tick box marked.

- For Clinical Guidelines or Procedures related to Oxygen/Suction, refer to Related Documents numbers 43-46.

Vascular Access

- Abbreviations:
  - PIVC = Peripheral Intravenous Cannula
  - Subcut = Subcutaneous Cannula
  - CVC = Central Venous Cannula
  - PORT = A Central Venous Access Device

- A VIP score is to be documented for each shift and when there is clinician or patient concern.

- All types of vascular access are subject to governance documentation for insertion, maintenance, access and removal. Clinicians are to refer to Related Documents numbers 47-68.

Diabetes

- Abbreviations:
  - BGL = Blood Glucose Level

- Ketones monitoring is to be indicated within this section; ketone monitoring may be indicated without the presence of elevated blood glucose levels.

- For Clinical Guidelines or Procedures related to Diabetes, refer to Related Documents numbers 69-88.

Mobility

- Clinicians are to record all equipment and resources (including staff) needed for transfer of a patient in and off the bed.

- Safety and prevention of injury to clinician and patient are dependent on accurate and sufficient documentation concerning mobility needs.
- For a patient with a BRAT score = medium or high, strategies for safe transfer, including staffing needs, are to be documented.
- For Clinical Guidelines or Procedures related to Mobility, refer to Related Documents numbers 89-96.

Falls Risk

- A FRAT must be completed and documented on the Comprehensive Care Plan **every 24 hours**, when a patient's condition changes, after a fall and in the presence of any new risk such as cognition or ability change.
- All equipment and strategies needed to mitigate the risk of a patient falling are to be documented on the Comprehensive Care Plan and these are to be reviewed by the clinician each shift and updated as needed.
- Clinical concern is to escalate evaluation of falls risk regardless of FRAT score and individualised strategies and alerts must be implemented.
- After any fall, the clinician is to consult and comply with Grampians Health Post Falls Management Clinical Procedure.
- A VHIMS is to be completed after any fall.
- For Clinical Guidelines or Procedures related to Falls, refer to Related Documents numbers 97-105.

Nutrition and Hydration

- The clinician is to document every patient's diet and fluid requirements. Where supplements and/or enteral nutrition is required, these are also to be documented.
- The level of assistance required for a patient to ingest food and fluid is to be documented. Where adequate assistance is not provided, the risk of malnutrition increases.
- An MST assessment is required weekly to mitigate risk of malnutrition. The MST is to be documented on the Comprehensive Care Plan.
- Frequency of weight measurement together with when this is due, is to be documented in this section.
- For Clinical Guidelines or Procedures related to Nutrition and Hydration, refer to Related Documents numbers 106-115.

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Other Access

This section is for recording any device which enters the body of a patient and is not otherwise recorded on the Comprehensive Care Plan. The format is primarily adapted for documenting the care of a tube entering the intestinal tract but may be used for any other device.

- Tick N/A if this section is not applicable.

- Abbreviations
  - N/G = Nasogastric
  - PEG = Percutaneous Endoscopic Gastrostomy

- The length of a nasogastric tube from the insertion point at the nose to the distal end is to be recorded. This length needs to be confirmed as correct before any access and escalated to senior nursing staff on duty if incorrect.

- For relevant Clinical Guidelines or Procedures related to Other Access, refer to Related Documents numbers 116-125.

Hygiene

- All patients are to be enabled to perform body hygiene daily and as required throughout the day.

- As a minimum, hygiene includes a full body wash and mouthcare with cleaning of teeth.

- Patients with dentures who are unable to adequately clean these themselves, are to have care that aligns with Oral and Dental Care Clinical Procedure.

- The clinician is to document equipment, resources and staff needed to perform adequate hygiene using the tick boxes provided.

- For relevant Clinical Guidelines or Procedures related to Hygiene, refer to Related Documents numbers 126-127.

Elimination

- Abbreviations:
  - IDC = Indwelling Urinary Catheter
  - FWT = Full Ward Urine Test

- The clinician is to document equipment, processes and assistance needed for patient micturition and bowel evacuation using tick boxes and free text where necessary.

- For patients who suffer from conditions such as urinary frequency and who may be at risk of falls, a toileting regime may mitigate the risk of both falls and incontinence. Typically, a toileting regime will consist of offering the opportunity to void and/or open bowels before each meal and before settling to sleep at night. This is to be documented on the Comprehensive Care Plan.

- If indicated, a Full Ward Test will be documented on the Observation and Response Chart and if this is to be repeated, the due date is to be documented on the Comprehensive Care Plan.

- The clinician is to document the size, date of insertion, type and due date for catheter change for all urinary catheters.
- For relevant Clinical Guidelines or Procedures related to Elimination, refer to Related Documents numbers 128-139.

Pressure Injury

- Abbreviations:
  - PIPM = Pressure Injury and Prevention Management Form/Plan

- The clinician is to complete and document a head to toe and bony prominences skin check each shift or EoC. A full skin check includes inspection under and around any medical devices, i.e.: indwelling or suprapubic catheters, gastrostomy tubes, oxygen tubing etc.

- Where a pressure injury is present:

  - a VHIMS is to be completed when first detected

  - Occupational Therapy contacted for specialised equipment

  - a wound chart is to be commenced to monitor and treat the pressure injury.

  - If more than one pressure injury is present, this is to be noted on the Comprehensive Care Plan and a separate wound chart to be created for each pressure injury together.

  - A VIHMS is also to be submitted that reports every pressure injury. One VIHMS may report more than one pressure injury within the same report. Further VIHMS reporting is required when any new pressure injury is detected.

- Pressure injuries are to be assessed for staging and monitoring of healing. See Appendix B for pressure injury staging tool.

- All equipment needed to prevent and manage pressure injury is to be noted on the Comprehensive Care Plan.

- Required frequency of patient repositioning or turning is to be noted on the Comprehensive Care Plan.

  - Reference to the Mobility section on the Comprehensive Care Plan, will guide the clinician as to equipment and staff resources needed to implement repositioning.

  - Some patients may only need to be prompted to turn/reposition. Other patients will need partial or full assistance.

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- A Braden assessment is to be completed each shift or EoC.
  - Refer to the patient's *Risk Screening Tool* for the *Braden Risk Screening Tool* to complete this assessment.
  - For any risk of mild or above, a Pressure Injury Prevention and Management form is to be commenced.
  - The complete legend for understanding the *Braden Screening Tool* can be found in Appendix C.
- For relevant Clinical Guidelines or Procedures related to Pressure Injury, refer to Related Documents numbers 140-148.

Wounds

- All aspects of wound care are to be indicated in this section where no wound chart is in use. This includes at a minimum:
  - Wound location
  - Dressing type
  - Dressing frequency
  - Review date
- When the dressing has been attended, the clinician is to tick the box marked *'completed'*.
- Where a drain tube/s is present, the clinician is to note type and location.
- Tick the N/A box in the left hand column where there is no wound and no drain tube.
- For relevant Clinical Guidelines or Procedures related to Wounds, refer to Related Documents numbers 149-157.

Venous Thromboembolism – VTE

- Abbreviations:
  - VTE stockings = Venous Thromboembolism Deterrent stockings
  - SCuDs = Sequential Compression Device

This section is to ensure individualised care strategies are in place to mitigate risk of venous thromboembolism (VTE) Implementation guide: Venous Thromboembolism Prevention Clinical Care Standard.

- If any form of stockings or sequential compression device is in use, the clinician is to note this, indicating the type. Tick N/A if stockings or a sequential compression device is not in use.
- Where anti-embolism stockings are in use, the clinician is to ensure they are in situ unless a patient is attending to hygiene, or the stockings have been removed while attending to other care or activity where their use is contraindicated.
- Other prevention strategies include prophylactic anticoagulant medication, scheduled mobilisation and positioning strategies to offload pressure.

- For relevant Clinical Guidelines or Procedures related to Venous Thromboembolism (VTE), refer to Related Document number 158.

Communication Board

- The patient beside communication board is to be reviewed and updated:
  - On admission
  - During clinical handover at every change of shift
  - When there is any change in patient circumstances
  - At patient/family/carer request.

- The clinician is to involve the patient and/or their representative in updates and reviews of the Communication Board.

Other

- This section is designed to record any item of care not otherwise covered in the Comprehensive Care Plan.

- Typically, this section is used for items such as radiology appointments or scheduled surgery time, to allow care to be planned around these events and highlight any preparation required.

Patient Concerns/Goals/Questions/Plans

The Partnering with Consumers Standard 2 requires all admitted patients to be involved in the co-creation of their care. Partnering with Consumers Standard | Australian Commission on Safety and Quality in Health Care

- The free-text questions within this section are designed to involve consumers in the planning of their care in an ongoing manner.

- The questions continue the process commenced within the Risk Screening Tool, of planning for discharge in consultation with the consumer.

- The clinician is to confirm that the care plan has been discussed with the consumer or their representative by ticking the boxes within this section.

Staff Signature

- The primary clinician for a patient each shift or EoC is to sign the Comprehensive Care Plan to confirm it is an accurate record of care planning and delivery.

Related Documents

Special Precautions

1. Standard Precautions
2. Transmission based precautions
3. Ballarat MR410.2 Transmission Based Precautions Care Plan
4. Edenhope MR230.1 Transmission Based Precautions Plan

Adult Comprehensive Care Plan

5. Standardised Care Process (SCP) Infection Prevention and Control (Horsham/Dimboola only - interim - pre GrH)
6. Influenza: Additional Droplet & Contact Precautions
7. Prevention of and Management of Personnel following Cytotoxic Contamination Guideline (Horsham/Dimboola only - interim - pre GrH)

Considerations

8. Aboriginal and Torres Strait Islander Policy (Stawell only - Interim - pre GrH)
9. Cultural Safety For Aboriginal and or Torres Strait Islander People Policy (Ballarat Only – Interim - pre -GrH)
10. Disability Liaison Office
11. Culturally Appropriate Care (Edenhope only - interim - pre GrH)
12. Cultural Awareness (Stawell Only - Interim - Pre GrH)
13. Communication Access – Interpreting Services
14. Communication Access - Deaf And Hard Of Hearing (Ballarat only - interim - pre GrH)
15. Care of Client With an Intellectual Disability (Edenhope only - interim - pre GrH)

Cognition

16. Cognitive Impairment Identifier
17. Delirium (Stawell only - interim - pre GrH)
18. Delirium Clinical Guidelines (Horsham/Dimboola only - interim - pre GrH)
19. Delirium Management in Adults (Edenhope only - interim - pre GrH)
20. Delirium Management (Ballarat only – Interim – preGH)
21. Delirium Prevention Strategies (Edenhope only - interim - pre GrH)
22. Standardised Care Process (SCP) Delirium (Horsham/Dimboola only - interim - pre GrH)
23. Dementia
24. Alcohol Withdrawal - Management (Ballarat only – Interim – preGH)
25. Co-occurring Substance Abuse Alcohol, Drug And Dual Diagnosis
26. Alcohol Withdrawal Syndrome (Stawell only - Interim - Pre GrH)
27. Blood Alcohol Collection (Edenhope only - interim - pre GrH)
28. Cannabis Withdrawal Procedure (Horsham/Dimboola only - interim - pre GrH)
29. Workplace Violence and Aggression (Edenhope Only - Interim - Pre GrH)
30. Prevention And Management Of Clinical Aggression (Ballarat only - interim - pre GrH)
31. Management Of Violence and Aggression - Warning Notice (Ballarat only - interim - pre GrH)
32. Management of OVA Procedure (Horsham/Dimboola only – interim – pre GrH)
33. FHR044 Is it a Planned or Unplanned Code Grey Flow Chart (Stawell only – Interim – pre GrH)
34. Emergency Code Grey - Personal Threat Unarmed (Stawell Only - Interim - Pre GrH)

Observations

35. Adult Observation And Response Chart - ORC (Ballarat only – Interim – pre GrH)
36. Adult Physiological Observations - Vital Signs (Ballarat Only – Interim – pre GrH)
37. Vital Signs - Observation and Monitoring - Adult (Stawell only - interim - pre GrH)
38. Neurological Observations Using the Glascow Coma Scale (GCS) Procedure (Horsham/Dimboola only - interim - pre GrH)
39. Adult Observation Charts (Acute) and Vital Signs (Edenhope Only - Interim - Pre GrH)
40. Neurological Observation & Head Injury (Stawell only - interim - pre GrH)

Adult Comprehensive Care Plan

41. Adult Patient Physiological Observations Vital Signs Clinical Guidelines (Horsham/Dimboola only - interim - pre GrH)
42. Minimum Frequency For Physiological Observations - (Ballarat only - Interim - pre GH)

Oxygen/Suction

43. Oxygen Therapy (Ballarat only - Interim - pre GH)
44. High Flow Oxygen Therapy And Humidification (Ballarat only – Interim – preGH)
45. Airway Suctioning(Oropharyngeal And Nasopharyngeal Suctioning) (Ballarat Only – Interim – pre GrH)
46. High Flow Nasal Cannula (AirVO3) CPG (Stawell only - interim - pre GrH)

Vascular Access

47. Peripheral Intravenous Cannulation - Adult
48. CVAD Troubleshooting (Edenhope only - interim - pre GrH)
49. CVAD General Care & Management (Edenhope only - interim - pre GrH)
50. CVAD Bung Change (Edenhope only - interim - pre GrH)
51. CVAD Flushing and Heparinised Locking (Edenhope only - interim - pre GrH)
52. CVAD Positive Locking Technique (Edenhope only - interim - pre GrH)
53. CVAD Dressing Change (Edenhope only - interim - pre GrH)
54. CVAD - Implantable Venous Port - De-cannulation (Edenhope only - interim - pre GrH)
55. Central Venous Access Devices (CVAD) Policy (Edenhope only - interim - pre GrH)
56. Baxter Infusion (Edenhope only - interim - pre GrH)
57. PICC - Removal of (Edenhope only - interim - pre GrH)
58. PICC - Repair of a Groshong Line (Edenhope only - interim - pre GrH)
59. Accessing and Deaccessing an Implanted Venous Port - Stawell Only - Interim - Pre GrH
60. Principles of Central Venous Access Device (CVAD) Management (Stawell only - interim - pre GrH)
61. Peripherally Inserted Central Catheter (PICC) Dressing Securement & Cap Change (Stawell only - interim - pre GrH)
62. Baxter Infusion Procedure (Horsham/Dimboola only - interim - pre GrH)
63. Hickmans Catheter Procedure (Horsham/Dimboola only - interim - pre GrH)
64. Implanted Venous Port Infusa-port Procedure (Horsham/Dimboola only - interim - pre GrH)
65. Central Venous Catheter (CVC) Procedure (Horsham/Dimboola only - interim - pre GrH)
66. Peripherally Inserted Central Venous Catheter (PICC) Procedure (Horsham/Dimboola only - interim - pre GrH)
67. Principles Of Central Venous Access Device (CVAD) Management - In Adults (Ballarat only – Interim – pre GrH)
68. Central Venous Catheter - Insertion And Management

Diabetes

69. Glucocorticoid Induced Diabetes (Stawell only - interim - pre GrH)
70. Peri-procedural Diabetes Management Guidelines (Ballarat Only – Interim - pre -GrH)
71. Diabetes Mellitus - Hypoglycaemia Management (Ballarat only - interim - pre GrH)
72. Diabetes Mellitus Type 1 Sick Day Management (Ballarat only – Interim – pre GrH)
73. Diabetes Mellitus Type 2 - Sick Day Management (Ballarat Only – Interim – pre GrH¬)
74. Diabetes - Mini-Dose Glucagon Rescue (Ballarat Only – Interim - pre -GrH)
75. Inpatient Blood Glucose Level Management In Adult Diabetes Patients (Ballarat only - Interim - pre GH)

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76. Management Of Adult Diabetic Ketoacidosis - (Ballarat only - Interim - pre GH)
77. Hyperglycaemia & Diabetic Ketoacidosis (DKA) (Stawell only - interim - pre GrH)
78. Capillary Blood Glucose & Ketone Monitoring (Stawell only - interim - pre GrH)
79. Hypoglycaemia Management (Stawell only - interim - pre GrH)
80. Insulin Intravenous Infusion (Stawell only – Interim – pre GrH)
81. Diabetic Ketoacidosis (DKA) for Adults Clinical Guidelines (Horsham/Dimboola only - interim - pre GrH)
82. Insulin (Actrapid®) Intravenous Infusion for Adults Drug Protocol (Horsham/Dimboola only - interim - pre GrH)
83. Insulin Pump Therapy ADULT Clinical Guidelines (Horsham/Dimboola only - interim - pre GrH)
84. MR 484 - Continuous Subcutaneous Insulin Infusion (Insulin Pump Therapy) Chart - HOW TO GUIDE (Horsham/Dimboola only - interim - pre GrH)
85. Insulin Pump Therapy (IPT) for ADULT Inpatients Flowchart (Horsham/Dimboola only - interim - pre GrH)
86. Glucocorticoid-induced Diabetes (Edenhope only - interim - pre GrH)
87. Capillary Blood Glucose & Ketone Testing (Edenhope only - interim - pre GrH)
88. Insulin Pump Therapy - Adult (Edenhope only - interim - pre GrH)

Mobility

89. Bariatric Patient Management Procedure (Horsham/Dimboola only – interim – pre GrH)
90. Manual Handling Policy (Horsham/Dimboola only – interim – pre GrH)
91. Bariatric Management Policy (Stawell Only - Interim - Pre GrH)
92. Manual Handling (Stawell only – Interim – pre GrH)
93. Hovermatt Equipment Manual (Stawell only – Interim – pre GrH)
94. Assessment and Management of Clinically Severe Obese Patients (Edenhope only - interim - pre GrH)
95. Manual Handling – Clinical Staff (Edenhope Only - Interim - Pre GrH)
96. Safe Handling And Transfer Of The Bariatric Patient (Ballarat only - interim - pre GrH)

Falls Risk

97. Post Falls Management
98. Preventing Falls And Harm From Falls Policy (Ballarat Only – Interim - pre -GrH)
99. Falls Prevention & Management Policy (Stawell only - interim - pre GrH)
100. Falls Prevention & Management (Stawell only - interim - pre GrH)
101. MR198A Falls Risk Assessment Tool and Falls Prevention Plan (Stawell only - interim - pre GrH)
102. Equipment & Device Register - Falls & Falls Prevention (Stawell only - interim - pre GrH)
103. Preventing Falls and Harm from Falls Policy (Edenhope only - interim - pre GrH)
104. Preventing Falls and Harm from Falls Procedure (Horsham/Dimboola only - interim - pre GrH)
105. Preventing Falls And Harm From Falls - Acute Subacute (Ballarat only - interim - pre GrH)

Nutrition and Hydration

106. Enteral Nutrition (Stawell only - interim - pre GrH)
107. Nutrition (Stawell only - interim - pre GrH)
108. Enteral Nutrition (Edenhope only - interim - pre GrH)
109. Nutrition & Hydration (Edenhope only - interim - pre GrH)
110. Nutrition And Hydration Management (Ballarat Only – Interim - pre -GrH)
111. Nutrition and Hydration Procedure (Horsham/Dimboola only - interim - pre GrH)

112. Fluid Balance Documentation Guideline (Ballarat only – Interim – pre GrH)
113. Fluid Balance Recording & Management (Stawell only - interim - pre GrH)
114. Identification and Management of Malnutrition Procedure (Horsham/ Dimboola only – Interim- pre GrH)
115. Malnutrition Screening and Diagnosis (Edenhope only - interim - pre GrH)

Other Access

116. Nasogastric Tube (Stawell only - interim - pre GrH)
117. Nasogastric Tube - Insertion In Adults - (Ballarat only - Interim - pre GH)
118. Insertion, Management and Gravity Feeding of Nasogastric Tubes - Adults Procedure (Horsham/Dimboola only - interim - pre GrH)
119. Enteral Feeding - Continuous And Intermittent (Ballarat only - interim - pre GrH)
120. Insertion of PEG
121. Education For Patients Following PEG Insertion (Ballarat only – Interim – preGH)
122. Percutaneous Endoscopic Gastrostomy (PEG) Tube Care (Stawell only - interim - pre GrH)
123. Percutaneous Endoscopic Gastrostomy Tube Procedure (Horsham/Dimboola only - interim - pre GrH)
124. Enteral Feeding - Continuous And Intermittent (Ballarat only - interim - pre GrH)
125. Gastrostomy Tube -Basic Skin Care Guide for Patients

Hygiene

126. Safe Use of Bath Trolley Procedure (Horsham/Dimboola only - interim - pre GrH)
127. Oral and Dental Care

Elimination

128. Bowel Elimination - Assessment & Management
129. Urinary Elimination - Assessment and Management
130. External urinary drainage system
131. Pans And Urinals - Disposable
132. Caring for your urinary catheter
133. Supra Pubic Urinary Catheter Care, Change And Removal
134. Urethral Urinary Catheter Insertion, Care Of And Removal
135. Intermittent Catheterisation (Male & Female)
136. Stoma Management (Ballarat only - interim - pre GrH)
137. Management Of High Output Stomas (Ballarat only - Interim - pre GrH)
138. Stoma Care - Changing One Piece Bag Procedure (Horsham/Dimboola only - interim - pre GrH)
139. Colorectal Stoma Management and Non Functioning (Ballarat Only – Interim - pre -GrH)

Pressure Injury

140. Pressure Injury
141. Pressure Injury Prevention and Management (Stawell only - interim - pre GrH)
142. Pressure Injury Risk Assessment (Ballarat only – Interim – pre GrH)
143. Pressure Injury Prevention Management (Edenhope only - interim - pre GrH)
144. Pressure Injury - Prevention And Management (Ballarat only - interim - pre GrH)
145. Pressure Injury Prevention And Management Policy (Ballarat Only – Interim - pre -GrH)

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146. Pressure Injury Prevention and Management Procedure (Stawell only - interim - pre GrH)
147. Pressure Injury Prevention and Management Procedure (Horsham/Dimboola only - interim - pre GrH)
148. Standardised Care Process (SCP) Pressure Injuries (Horsham/Dimboola only - interim - pre GrH)

Wounds

149. Wound Management (Edenhope only - interim - pre GrH)
150. Negative Pressure Wound Therapy Dressings - (Ballarat only - Interim - pre GH)
151. Negative Pressure Wound Therapy (NPWT) (Stawell only - interim - pre GrH)
152. Wound Management Clinical Practice Guideline (Stawell only - interim - pre GrH)
153. Skin Care - Wound Care (Ballarat only – Interim – pre GrH)
154. Wound Management 2 (Edenhope Only - Interim - Pre GrH)
155. Negative Pressure Wound Therapy Procedure (Horsham/Dimboola only - interim - pre GrH)
156. How to use the PICO® for Negative Pressure Wound Therapy (Edenhope only - interim - pre GrH)
157. Wound Assessment and Management Procedure (Horsham/Dimboola only - interim - pre GrH)

Venous Thromboembolism – VTE

158. Anti embolism stockings

Key Legislation, Accreditation & Standards

Australian Commission on Safety and Quality in Health Care. (2020). Advisory AS18/14: Comprehensive Care Standard: Screening and assessment for risk of harm.

Australian Commission on Safety and Quality in Health Care. (2020). Advisory AS18/15: Comprehensive Care Standard: Developing the comprehensive care plan.

Australian Commission on Safety and Quality in Health Care. (2020). Implementation guide: Venous Thromboembolism Prevention Clinical Care Standard

Partnering with Consumers Standard | Australian Commission on Safety and Quality in Health Care

Australian Commission on Safety and Quality in Health Care. (2019).Implementing the Comprehensive Care Standard: Deliver comprehensive care

Australian Commission on Safety and Quality in Health Care. (2021). National Safety and Quality Health Service Standards (2nd ed.).

References

Appendix A Visual Intravenous Phlebitis Score (VIPs)

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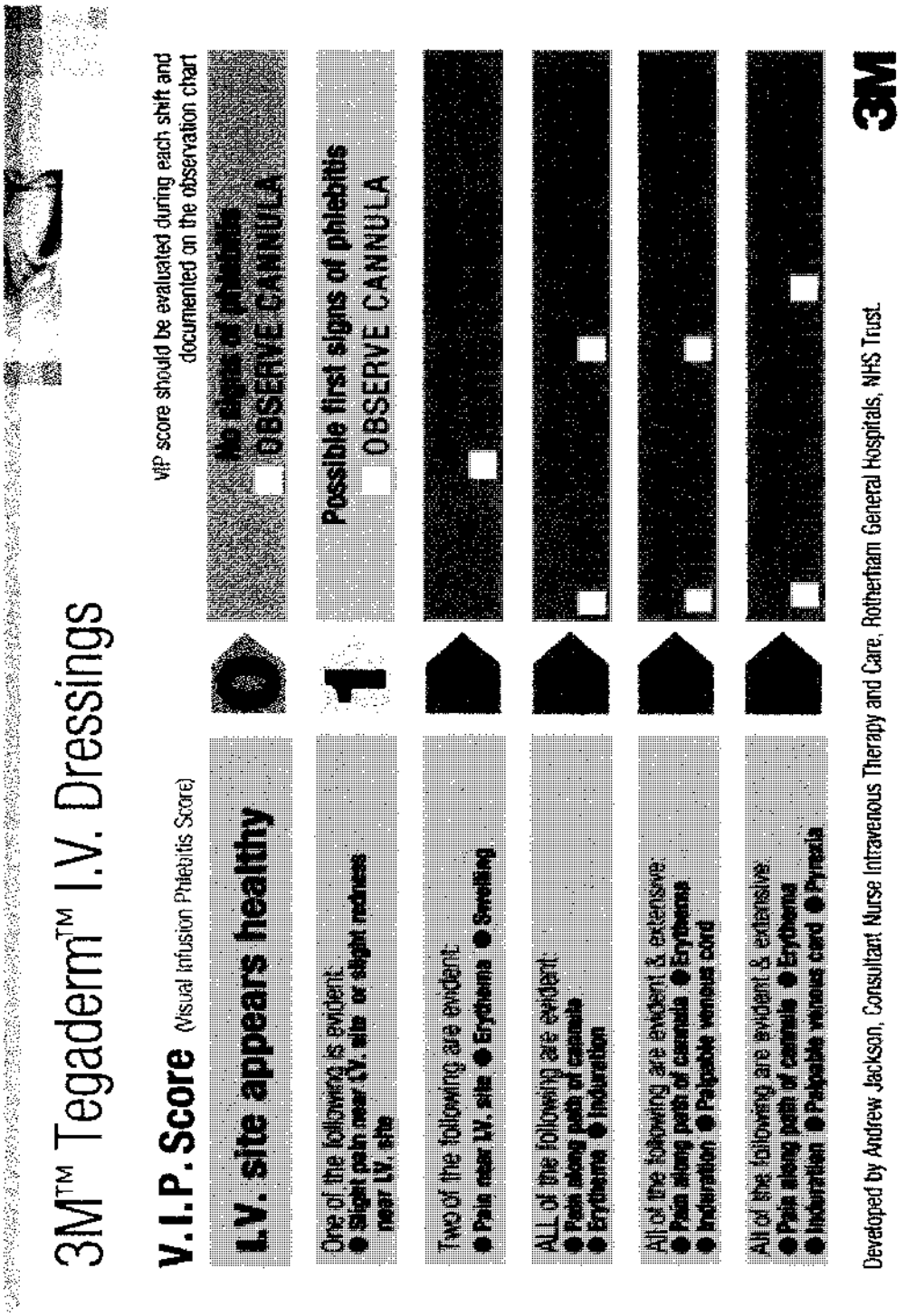

Appendix B- Pressure Injury Staging Tool

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Pressure INJURY (PI) - PREVENTION AND MANAGAEMENT		
Complete comprehensive skin assessment on admission noting existing Pressure Injuries Follow up assessments to be completed TDS for all inpatients Patients with Pressure Injuries, risk automatically defaults to Very High and Wound Chart to be commenced	Pressure Injury (PI) Identification guide	
	Stage 1	Intact skin with non-blanchable redness of localised area
	Stage 2	Partial thickness skin loss, shallow wound or blister, no slough
	Stage 3	Full thickness skin loss, subcutaneous fat may be visible
	Stage 4	Full thickness damage with exposed bone, tendon, or muscle
	Mucosal Membrane PI	Pressure Injuries of the moist membranes that line the respiratory, gastrointestinal and genitourinary tracts
	Unstageable	Stage cannot be determined due to slough +/- eschar
	Suspected deep tissue injury sDTI	Purple/maroon localised area or blood-filled blister, skin intact

Appendix C - Braden Pressure Injury Risk Scale

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SENSORY PERCEPTION Ability to respond to pressure related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR Limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**3. Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or the need to be turned. OR Has some sensory impairment which limits ability to fell pain or discomfort in 1 or 2 extremities.	**4. No impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE Degree to which skin is exposed to moisture	1. **Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry; linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	1. **Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during the day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during walking hours

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MOBILITY Ability to change and control body position	1. **Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance
NUTRITION Usual food intake pattern	1. **Very Poor** Never eats a complete meal. Rarely eats more than ½ of any food offered. Eats 2 servings or less of protein (meat or dairy) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR Receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION AND SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good	

frequent repositioning with maximum assistance.	relatively good position in chair or bed most of the time but occasionally slides down.	position in bed or chair.

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Clinical Guidelines History and Details

Document Governance	
Supporting Policy	
Executive Sponsor	Chief Nursing Midwifery Officer
Program, Service, Unit, Department or Committee Responsible	Comprehensive Care Governance Committee
Document Author	Miranda Brockman
Consumer Review? Yes or No	No
This Guideline has been endorsed by a Subject Matter Expert (SME)	There are no Order Set or Quick Reference Guides linked