**Greater Manchester**

**hospital delirium process for identifying and managing delirium**

Key document 1

Note: this is a working document and will be updated on the dementia united website: [www.dementia-united.org.uk](http://www.dementia-united.org.uk)

**For those over the age of 18 and not under the**

**Influence of drugs and/or alcohol**

**Version 2.0 January 2024**

This document and the other key documents and optional resources listed below can be accessed via the Dementia United website ([ww.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](https://dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))

**Please note this is a guide only and clinical judgement should be exercised, particularly regarding any red flags e.g. delirium following a fall or head injury, new neurology or patients taking anti-coagulation medication.  
  
  
TIME FRAMES:**

Delirium is a medical emergency.

**2-4 hours ??hours**

**2 days**

|  |  |  |
| --- | --- | --- |
| **4AT** | **TI** | **ME** |

**Single Question Delirium SQiD**

New confusion should be identified using the SQiD, Single Question to Identify Delirium (Sands et al, 2010). That is ‘Do you think (the patient) has been more confused lately’ and or seemed more drowsy. If the answer is yes it should prompt further assessment as below. The NEWS2 has an additional category not previously available within the NEWS. The item ‘new confusion’ scores 3. **NEWS2** (*optional resource 6*) [[1]](#endnote-2)

1. **Complete 4 A’s Test for delirium screening**

4 A’s Test for delirium screening (see key document 2 of the [hospital toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[2]](#endnote-3)

* 4 A’s Test for delirium screening (Key Document 2)[[3]](#endnote-4)
* The 4AT is recommended for use for identification of patients with probable delirium. It requires little training and is quick and easy to use. A score of 4 or above suggests delirium +/- underlying dementia
* A score of 1-3 suggests possible cognitive impairment (unspecified)
* A score of 0 suggests cognitive impairment is unlikely to be present

Pay attention to the 4AT guidance notes.

* Testing attention is the key e.g., the months of the year backwards, or count 20 to 1.
* Altered arousal. How sleepy are they? Not holding string of conversation together?
* Liaise with someone who knows the person well to determine if they have become suddenly more confused – family, care home staff, care provider.
* The 4AT has been translated in to 20 different languages and therefore we suggest using these with a translator - accessible [via the link](https://www.the4at.com/4at-translations) [[4]](#endnote-5)

Please note that despite updated guidance on how to assess for new confusion as part of NEWS2, the scoring as currently implemented cannot be relied upon for delirium detection (Vardy et al 2022). The recommendation from NHS England (2023) of the triple assessment using the 4AT, NEWS2 and Clinical Frailty Scale recommended by the Getting It Right First Time (GIRFT) geriatric medicine report may be a meaningful way forward for older patients.

1. **Confirm whether the person has delirium**

NICE Recommendations - Delirium: prevention, diagnosis and management in hospital and long-term care “If indicators of delirium are identified, a health or social care practitioner who is competent to do so should carry out an assessment using the 4AT”[[5]](#endnote-6)

Following any completion of the 4AT please record the outcomes and scores in the patient notes. This is important as those who experience delirium are more likely to experience it again in the future, and those over the age of 65 are more likely to develop dementia. You can download the 4AT assessment from the [Dementia United website](https://dementia-united.org.uk/delirium-toolkit-training-resources/)[[6]](#endnote-7). There is a vast amount of evidence supporting the sensitivity and specificity of the 4AT; please see the appendices for the bibliography for details.

**What is delirium?**

**Definition** Delirium is defined as “a disturbance of consciousness that is accompanied by a change in cognition that cannot be better accounted for by a pre-existing or evolving dementia”

**Characteristics of delirium** defined by the [DSM V criteria](https://cks.nice.org.uk/topics/delirium/diagnosis/assessment/): [[7]](#endnote-8)

* + - Disturbance in attention (reduced ability to direct, focus, sustain, and shift attention) and awareness.
    - The disturbance develops over a short period of time (usually hours to days), represents a change from baseline, and tends to fluctuate during the course of the day.
    - An additional disturbance in cognition (memory deficit, disorientation, language, visuospatial ability, or perception)
    - The disturbances are not better explained by another pre-existing, evolving or established neurocognitive disorder, and do not occur in the context of a severely reduced level of arousal, such as coma
    - There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication or withdrawal, or medication side effect.

Additional features that may accompany delirium and confusion include:

* Psychomotor behavioural disturbances such as hypoactivity, hyperactivity with increased sympathetic activity, and impairment in sleep duration and architecture.
* Variable emotional disturbances, including fear, depression, euphoria, or perplexity.

**Delirium subtypes** Delirium has been classified into subtypes depending on the changes is level of consciousness:

* Hyperactive (restlessness, agitation, non-purposeful walking, insomnia)
* Hypoactive (drowsiness, somnolence, withdrawn)
* Mixed: alternating hyperactive and hypoactive subtypes

**Differential diagnosis of delirium**

The differential diagnosis of delirium includes dementia, depression, non-convulsive epilepsy, psychosis and stroke.

If the diagnosis is unclear, assume delirium and treat reversible causes whilst seeking a second opinion. Consider a referral to liaison psychiatry or neurology if a neurological condition is suspected.

It is well acknowledged that older people are at higher risk of developing delirium; however it is important to consider delirium in younger people with complex or serious medical conditions, including patient’s with diagnoses of severe mental illness/learning disability.

The table below provides information on how delirium, dementia and depression differ, which we hope will assist with making the diagnosis.

**Table of 3 D’s – Delirium, dementia and depression**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Delirium** | **Dementia** | **Depression** |
| **Onset** | Sudden (hours/days) | Usually gradual and progressive (months and years) | Gradual (weeks/months) |
| **Duration** | Usually less than a month | Years to decades | Months, can be chronic |
| **Course** | Reversible, when causes identified | Not reversible, progressive deterioration | Recovers within months, can relapse |
| **Alertness, levels of consciousness** | Fluctuates (sleepy/agitated) known as hyper or hypo types | Generally normal or slowed | Generally normal |
| **Attention** | Fluctuates, difficulty concentrating, easily distracts | Generally normal | May have difficulty concentrating |
| **Sleep** | Change in pattern, often awake through the night and more confused | Can be disturbed / night time wandering and confusion possible as disease progresses- | May experience early morning wakening, or difficulty in getting off to sleep |
| **Thinking** | Disorganised - jumping from one idea to another | Abstract thought problems, poor judgement, sometimes problems word finding | Slower, preoccupied with negative thoughts e.g. hopelessness/ helplessness/ self-depreciation |
| **Perception** | Illusions, delusions and hallucinations common | Generally normal in early stages | Generally normal |

**If delirium is not diagnosed**, manage as appropriate. If delirium is diagnosed, continue with steps outline below.

If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia, manage the delirium first. **[2010] NICE** **[[8]](#endnote-9)**

Ensure that the diagnosis of delirium is documented both in the person's record or notes, and in their primary care health record. **[2010] NICE**

1. **Complete the Greater Manchester hospital delirium TIME Bundle (Triggers, Investigations, Management, Engagement) (Key Document 3)**

If delirium is strongly suspected or diagnosed, initiate the [Greater Manchester hospital delirium TIME Bundle (Triggers, Investigations, Management, Engagement) (Key Document 3 of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[9]](#endnote-10)](https://dementia-united.org.uk/wp-content/uploads/sites/4/2021/07/Hospital-Delirium-TIME-Bundle-.docx).

We would advise working through the TIME bundle document, as it is intended to provide a systematic approach to identifying causes and undertaking investigations. Eliminate each possible trigger as needed, being mindful that that delirium is often caused by more than one trigger. Apply the same principle to using the Greater Manchester hospital delirium management and engagement guidance - for medical teams (Key Document 4a of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[10]](#endnote-11) and for non-medical teams (Key Document 4b of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[11]](#endnote-12)

**Triggers**

Some *Optional Resources* are included in this toolkit, but you may have appropriate tools that you already use in your organisation. The links to the *Optional Resources* are provided in the toolkit contents document are can be [accessed on the Dementia United website](https://dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit/)[[12]](#endnote-13)

*(The optional resources – in italics - are suggested as examples however you may have other appropriate tools already in use in your organisation).*

***Optional resources***

* [*Abbey Pain Scale*](https://www.apsoc.org.au/PDF/Publications/Abbey_Pain_Scale.pdf)[[13]](#endnote-14)
* [*Pain Assessment in Advanced Dementia Scale (PAINAD) - MDCalc*](https://www.mdcalc.com/pain-assessment-advanced-dementia-scale-painad)[[14]](#endnote-15)
* *Greater Manchester Nutrition and Hydration materials*
  + [*Paper Weight Arm band can be used to indicate malnutrition if weighing someone is not possible*](https://www.ageuk.org.uk/salford/about-us/improving-nutrition-and-hydration/the-paperweight-armband/) [[15]](#endnote-16)
  + [*Greater Manchester Nutrition and Hydration materials – Monitoring food, fluid intake, and oral hygiene*](https://dementia-united.org.uk/wp-content/uploads/sites/4/2020/10/08B-Urine-chart-with-fluid-and-food-intake.pptx)[[16]](#endnote-17)
* [*Health Education England Mouth Care Assessment Guide*](https://dementia-united.org.uk/wp-content/uploads/sites/4/2020/10/09-HEE-Mouth-Care-Assessment.pdf) *[[17]](#endnote-18)*
* [*Bristol Stool Chart*](https://www.bladderandbowel.org/wp-content/uploads/2017/05/BBC002_Bristol-Stool-Chart-Jan-2016.pdf) [[18]](#endnote-19)

* *[Hints and tips for anticholinergic burden (ACB) medication reviews](https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1491&checksum=226d1f15ecd35f784d2a20c3ecf56d7f)) [[19]](#endnote-20)*

**“***Delirium is more common among fallers, and there is a consistently elevated risk of falls among patients with delirium. Falls and delirium share many risk factors and should be considered within a common patient safety pathway for routine assessment, prevention, and management in hospitalized older adults.” (Sillner et al 2019)*

When working through the systematic process for identifying triggers, consider falls risk assessments and noting increased vulnerability to falls, which will require frequent review and a management plan.

**Investigations**

Local organisation blood request forms stating **“Urgent Delirium Bloods”**

|  |  |  |  |
| --- | --- | --- | --- |
| FBC | UE | LFT | Calcium Magnesium |
| CRP | Glucose | Phosphate |  |

Diagnosis of urinary tract infection (UTI) should not be made on the basis of urinalysis alone.

* If considering a diagnosis of UTI as a cause or a contributor to delirium, this should be supported by the history (frequency, dysuria, new incontinence), examination (fever, suprapubic pain, urinary retention) and diagnostics (cloudy urine on inspection, raised inflammatory markers). If UTI is considered as a differential diagnosis, a mid-stream or catheter specimen of urine should be sent for culture.
* [*Bury UTI Assessment Too*l](https://www.buryccg.nhs.uk/download/document_library/your-local-nhs/plans_policies_and_reports/medicines_optimisation/Assessment-Tool-Version-1.4.pdf) [[20]](#endnote-21) may be valuable to reference
* *[Newcastle Urine Collection pack from Sterisets International](https://my.supplychain.nhs.uk/Catalogue/browse/159/specimen-collectors?CoreListRequest=BrowseAll) (obtaining a sample when someone is wearing an incontinence product)*[[21]](#endnote-22). This can be purchased via NHS Supply Chain item FSW1451.

**What are your options for an early discharge and support at home?**

* Increase support from care agency/family; if available
* Increase frequency of review by clinical team that are in the community and can review e.g., Crisis Team or other urgent care teams
* Consider involvement of Community IV therapy team for access to faster treatment
* Intermediate Care options and access to the therapy/urgent assessment for equipment
* Virtual ward; contact to consider as an option for more intensive overview
* [Bringing hospital care home: Virtual Wards and Hospital at Home for older people](https://www.bgs.org.uk/virtualwards) [[22]](#endnote-23) highlights that there Is consistent evidence supporting early discharge as well as admission avoidance with hospital at home.
* NHS England principles for hospital at home include:

Ensure that patients are given clear information on who to contact if their symptoms worsen, including out of hours. There should be clear pathways to support early recognition of deterioration and appropriate escalation processes in place to maintain patient safety. Training on escalation processes should also be provided to carers, staff, the MDT, etc as necessary.

* Any conveyance to a step-down unit requires handover of probable delirium and what part of the assessments have been completed.
* If there is a specific decision that needs to be made urgently, and the person lacks the mental capacity to make that decision (following an assessment of their capacity that is specific to the decision); then health and social care professionals have a duty of care to talk to family or carers as part of the best interest decision making, as well as taking in to account the patient’s wishes – please refer to the [Mental Capacity Act - Guide for Family, Friends and Other Unpaid Carers](https://www.elft.nhs.uk/sites/default/files/2022-01/mental_capacity_act_-_guide_for_family_friends_and_other_unpaid_carers.pdf) [[23]](#endnote-24); [Mental Capacity Act Code of Practice](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice) [[24]](#endnote-25)

**Management**

You can download the Greater Manchester hospital delirium management and engagement guidance –for medical teams (Key Document 4a of the hospital delirium toolkit) and for non-medical teams (Key Document 4b of the hospital delirium toolkit)

* Greater Manchester hospital delirium management and engagement guidance –for medical teams (Key Document 4a of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[25]](#endnote-26)
* Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[26]](#endnote-27)

We would advise working through the key documents 4a and 4b, as they are intended to provide a systematic approach to managing and treating delirium. Not all the guidance within the documents will apply, plus there will be value in returning to this document to consider further management and engagement approaches.

**Greater Manchester hospital delirium management and engagement guidance –for medical teams (Key Document 4a of the hospital delirium toolkit)** includes information on:

* Medication review, monitor **trajectory of the delirium**, considerations for referring for **specialist advice**.
* **Recovery** from delirium and **prevention**.

**Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b of the** [**hospital delirium toolkit**](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit)**)** includes detailed consideration on delirium management:

* Continue to **treat other conditions**
* Assess and **manage pain**
* Manage **medications**
* Monitor and reduce the **risk of the person developing pressure ulcers**
* Monitor and reduce the **risk of falls**
* Meet the **needs of reassurance, orientation and occupation**
* Meet the **needs of physical comfort and well-being**
* Meet the **needs to feel safe, secure and receive comfort and reassurance when distressed**
* *Video animation about meeting the needs of someone with dementia, includes aspects as mentioned above in terms of meeting the needs, as we know that people with dementia are at higher risk of developing delirium.* [Fundamental needs in dementia – an animation from the CAIT and Newcastle Model series](https://www.youtube.com/watch?v=R0C2ug7AbTY)[[27]](#endnote-28)
* *Video looking at minimising the use of restraint with two case studies; in a care home and in hospital, in the context of delirium* [*Freedom to choose and dignity in care - SCIE*](https://www.scie.org.uk/providing-care/dignity-in-care/freedom/)*[[28]](#endnote-29)*

**Engagement**

* **E**ngagement with family and informal carers (see key document 4b of the [hospital delirium toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit))[[29]](#endnote-30) is crucial to the management of delirium.
* **The Greater Manchester delirium leaflets** ([long version](https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Long-Version-June-2023.docx)[[30]](#endnote-31) and [short version](https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Short-Version-June-2023.docx)[[31]](#endnote-32)).
  + Please go through the Greater Manchester delirium leaflet (long version) with the person with delirium and their family and complete the ‘person centred care plan’.
  + The shorter delirium leaflet has been translated in to 16 languages and is available as a written leaflet, audio and films resource.
  + We have a [Delirium: Top tips for carers and family members guide](https://dementia-united.org.uk/wp-content/uploads/sites/4/2024/02/Delirium-top-tips-for-carers-or-family-members.pdf)[[32]](#endnote-33). Please share this along with the leaflets when meeting up with or speaking with carers and/or family members.

**Optional resources**

* [*Alzheimer’s Society “This is Me” document*](https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me) *[[33]](#endnote-34)*
* *John’s campaign* [John's Campaign](https://johnscampaign.org.uk/) [[34]](#endnote-35) *Dementia Friendly Hospital Charter 2020* [National Dementia Action DF HOSPITAL CHARTER 2020 [[35]](#endnote-36)](https://nationaldementiaaction.org.uk/wp-content/uploads/2020/11/DEMENTIA-FRIENDLY_HOSPITAL_CHARTER_2020-v2.pdf)

* [Eating and drinking well – supporting people living with dementia](https://wessexahsn.org.uk/img/projects/Living%20with%20Dementia%20A4-1569934855.pdf)  *[[36]](#endnote-37)*

**Recovery from delirium**

Recovery and assessing for **returning to baseline** and plan for discharge. **Consider early discharge home**, with support from community team and following discharge to assess guidance.

* Any pre work completed (e.g. the 4AT and/or TIME bundle) can be conveyed to a community team to continue the person’s delirium assessment and management. Let the community team know that you have shared the delirium leaflet with the patient and family, including completion of the ‘person centred care plan’ within the leaflet.

**Consider prevention of delirium*.*** We know that patients in high-risk categories are at higher risk of developing delirium.

**Who is at higher risk of getting delirium?**

People who have one or more of the following are at a higher risk:

* Age 65+
* Diagnosis of dementia
* Having sight or hearing loss
* Being in a new and unfamiliar environment
* Having had delirium before
* Having more than one illness
* Having had recent surgery, for example, for a broken hip

**How can you assist with the prevention of delirium?**

* Encourage the person to eat little and often if they are struggling to eat a big meal. A number of small meals are as good as three big meals.
* Encourage the person to drink six to eight cups, for example water, a day.
* Ensure the person has their glasses and is wearing these as needed.
* Ensure the person has their hearing aids and check these are working.
* Make sure the person has a good night’s sleep.
* Make sure the person is going to the toilet regularly, to avoid becoming constipated.
* Look for signs for pain and try to keep pain under control.

**Prevention emphasis on the following:**

* Regular medication review including side effects of medications taken or omitted - delirium can be a side effect of medications such as steroids or opiates. Consider anticholinergic burden (ACB)
* Reduce risk of infection e.g., minimising use of catheters
* Adequate oxygenation with appropriate investigation and management of hypoxia.
* Maintaining independence and mobility and promoting meaningful activity and engagement.
* Promote familiar surroundings and reorientation within a dementia friendly environment and reduce slips, trips and fall hazards.
* Providing delirium prevention education/resources to at risk groups and their families/carers to prevent the occurrence of delirium and what to do if they suspect delirium

It is important to note delirium on any discharge documentation going to the GP and wider community colleagues, including any care providers.

The Centre for Perioperative Care, working in collaboration with the British Geriatrics Society, has published a [Guideline for the care of people living with frailty undergoing elective and emergency surgery](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bgs.org.uk%2Fresources%2Fguideline-for-the-care-of-people-living-with-frailty-undergoing-elective-and-emergency&data=05%7C01%7Chelen.pratt5%40nhs.net%7Cff8bf8fd88df45d17ac708dbbf70479c%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638314261171395301%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=h7sAcx4S2h6lO9zzoMnnKMlCsjjKJndxan5LEC%2FnWIY%3D&reserved=0) [[37]](#endnote-38). The guideline encompasses the whole perioperative pathway; which includes specific recommendations for the prevention, detection, assessment and management of delirium in Emergency Departments, preoperative outpatient departments, surgical wards and theatres as well for primary care referrers and transfers out of hospital.  The guideline has been written for healthcare professionals involved in delivering care throughout the pathway as well as for patients and their carers, managers, and commissioners.

1. **List of full links to resources**

   **NEWS2: Additional implementation guidance | RCP London.** <https://www.rcplondon.ac.uk/projects/outputs/news2-additional-implementation-guidance> [↑](#endnote-ref-2)
2. **4 A’s Test for delirium screening (Key Document 2)**

   www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit/ [↑](#endnote-ref-3)
3. **4 A’s Test for delirium screening (Key Document 2)**

   [www.dementia-united.org.uk/wp-content/uploads/sites/4/2020/10/02-4AT.pdf](http://www.dementia-united.org.uk/wp-content/uploads/sites/4/2020/10/02-4AT.pdf) [↑](#endnote-ref-4)
4. **4AT Translations**

   [www.the4at.com/4at-translations](http://www.the4at.com/4at-translations) [↑](#endnote-ref-5)
5. **NICE Recommendations - Delirium: prevention, diagnosis and management in hospital and long-term care**

   [www.nice.org.uk/guidance/cg103/chapter/Recommendations#assessment-and-diagnosis](http://www.nice.org.uk/guidance/cg103/chapter/Recommendations#assessment-and-diagnosis) [↑](#endnote-ref-6)
6. **Delirium toolkit training resources - Dementia United (see ‘how to complete the 4AT’)** <https://dementia-united.org.uk/delirium-toolkit-training-resources> [↑](#endnote-ref-7)
7. **NICE DSMV criteria**

   https://cks.nice.org.uk/topics/delirium/diagnosis/assessment/ [↑](#endnote-ref-8)
8. **NICE Recommendations - Delirium: prevention, diagnosis and management in hospital and long-term care**

   [www.nice.org.uk/guidance/cg103/chapter/Recommendations](http://www.nice.org.uk/guidance/cg103/chapter/Recommendations) [↑](#endnote-ref-9)
9. **Greater Manchester hospital delirium TIME Bundle (Triggers, Investigations, Management, Engagement) (Key Document 3)**

   www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit/ [↑](#endnote-ref-10)
10. **Greater Manchester hospital delirium management and engagement guidance –for medical teams (Key Document 4a)**

    [www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit) [↑](#endnote-ref-11)
11. **Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b)**

    [www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit) [↑](#endnote-ref-12)
12. **Greater Manchester Hospital Delirium Toolkit - Dementia United**

    <https://dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit> [↑](#endnote-ref-13)
13. **Abbey Pain Scale**

    https://www.apsoc.org.au/PDF/Publications/Abbey\_Pain\_Scale.pdf [↑](#endnote-ref-14)
14. **MD Calc Pain Assessment Advanced Dementia Scale**

    https://www.mdcalc.com/pain-assessment-advanced-dementia-scale-painad [↑](#endnote-ref-15)
15. **The Paperweight Armband Age UK Salford**

    https://www.ageuk.org.uk/salford/about-us/improving-nutrition-and-hydration/the-paperweight-armband/ [↑](#endnote-ref-16)
16. **Greater Manchester Nutrition and Hydration materials – Monitoring food, fluid intake, and oral hygiene**

    www.dementia-united.org.uk/wp-content/uploads/sites/4/2020/10/08B-Urine-chart-with-fluid-and-food-intake.pptx [↑](#endnote-ref-17)
17. **HEE Mouth Care Assessment**

    https://dementia-united.org.uk/wp-content/uploads/sites/4/2020/10/09-HEE-Mouth-Care-Assessment.pdf [↑](#endnote-ref-18)
18. **Bristol Stool Chart**

    https://www.bladderandbowel.org/wp-content/uploads/2017/05/BBC002\_Bristol-Stool-Chart-Jan-2016.pdf [↑](#endnote-ref-19)
19. **Hints and tips for anticholinergic burden (ACB) medication reviews**<https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1491&checksum=226d1f15ecd35f784d2a20c3ecf56d7f> [↑](#endnote-ref-20)
20. **Bury Assessment Tool**

    https://www.buryccg.nhs.uk/download/document\_library/your-local-nhs/plans\_policies\_and\_reports/medicines\_optimisation/Assessment-Tool-Version-1.4.pdf [↑](#endnote-ref-21)
21. **Newcastle Urine Collection pack from Sterisets International**

    https://my.supplychain.nhs.uk/Catalogue/browse/159/specimen-collectors?CoreListRequest=BrowseAll [↑](#endnote-ref-22)
22. **Bringing hospital care home: Virtual Wards and Hospital at Home for older people**

    <https://www.bgs.org.uk/virtualwards> [↑](#endnote-ref-23)
23. **Mental Capacity Act - Guide for Family, Friends and Other Unpaid Carers**

    <https://www.elft.nhs.uk/sites/default/files/2022-01/mental_capacity_act_-_guide_for_family_friends_and_other_unpaid_carers.pdf>; [↑](#endnote-ref-24)
24. **Mental Capacity Act Code of Practice** - Gov UK

    <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> [↑](#endnote-ref-25)
25. **Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4a)**

    [www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit) [↑](#endnote-ref-26)
26. **Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b)**

    [www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit) [↑](#endnote-ref-27)
27. **Fundamental needs in dementia – an animation from the CAIT and Newcastle Model series**

    <https://www.youtube.com/watch?v=R0C2ug7AbTY> [↑](#endnote-ref-28)
28. **Freedom to choose and dignity in care - SCIE**

    [https://www.scie.org.uk/providing-care/dignity-in-care/freedom](https://www.scie.org.uk/providing-care/dignity-in-care/freedom/) [↑](#endnote-ref-29)
29. **Greater Manchester hospital delirium management and engagement guidance –for non-medical teams (Key Document 4b)**

    [www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit](http://www.dementia-united.org.uk/greater-manchester-hospital-delirium-toolkit) [↑](#endnote-ref-30)
30. **Greater Manchester delirium leaflet: long version**

    https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Long-Version-June-2023.docx [↑](#endnote-ref-31)
31. **Greater Manchester delirium leaflet: short version**

    https://dementia-united.org.uk/wp-content/uploads/sites/4/2023/08/Greater-Manchester-Delirium-Leaflet-Short-Version-June-2023.docx [↑](#endnote-ref-32)
32. **Delirium: top tips for family members and carers**

    <https://dementia-united.org.uk/wp-content/uploads/sites/4/2024/02/Delirium-top-tips-for-carers-or-family-members.pdf> [↑](#endnote-ref-33)
33. **Alzheimer’s Society “This is Me”** **document**

    https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me [↑](#endnote-ref-34)
34. **John's Campaign**

    https://johnscampaign.org.uk/ [↑](#endnote-ref-35)
35. **National Dementia Action DF Hospital Charter 2020**

    https://nationaldementiaaction.org.uk/wp-content/uploads/2020/11/DEMENTIA-FRIENDLY\_HOSPITAL\_CHARTER\_2020-v2.pdf [↑](#endnote-ref-36)
36. Ea**ting and drinking well – supporting people living with dementia** https://wessexahsn.org.uk/img/projects/Living%20with%20Dementia%20A4-1569934855.pdf [↑](#endnote-ref-37)
37. **Guideline for the care of people living with frailty undergoing elective and emergency surgery** https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bgs.org.uk%2Fresources%2Fguideline-for-the-care-of-people-living-with-frailty-undergoing-elective-and-emergency&data=05%7C01%7Chelen.pratt5%40nhs.net%7Cff8bf8fd88df45d17ac708dbbf70479c%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638314261171395301%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=h7sAcx4S2h6lO9zzoMnnKMlCsjjKJndxan5LEC%2FnWIY%3D&reserved=0

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