Policy for the Assessment and Management of Patients with Altered Behaviours (and symptoms associated with underlying Cognitive Impairment)

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<tr>
<th>Approved By:</th>
<th>Policy and Guideline Committee</th>
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<tr>
<td>Date of Original Approval:</td>
<td>15 September 2017</td>
</tr>
<tr>
<td>Trust Reference:</td>
<td>B30/2017</td>
</tr>
<tr>
<td>Version:</td>
<td>3</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>V2 (April 2018)</td>
</tr>
<tr>
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<tr>
<td>Date of Latest Approval:</td>
<td>24 April 2020</td>
</tr>
<tr>
<td>Next Review Date:</td>
<td>May 2023</td>
</tr>
</tbody>
</table>
CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Introduction and Overview</td>
<td>3</td>
</tr>
<tr>
<td>2  Policy Scope</td>
<td>3</td>
</tr>
<tr>
<td>3  Definitions and Abbreviations</td>
<td>3</td>
</tr>
<tr>
<td>4  Roles and Responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>5  Policy Implementation and Associated Documents</td>
<td></td>
</tr>
<tr>
<td>5.1 Managing Patients with Delirium</td>
<td>5</td>
</tr>
<tr>
<td>5.2 Dementia Care Pathway</td>
<td>6</td>
</tr>
<tr>
<td>5.3 Managing Patients at Risk of Wandering</td>
<td>6</td>
</tr>
<tr>
<td>5.4 Managing the One to One Supervision of Patients with Altered Behaviours</td>
<td>7</td>
</tr>
<tr>
<td>6  Education and Training</td>
<td>8</td>
</tr>
<tr>
<td>7  Process for Monitoring Compliance</td>
<td>10</td>
</tr>
<tr>
<td>8  Equality Impact Assessment</td>
<td>12</td>
</tr>
<tr>
<td>9  Supporting References, Evidence Base and Related Policies</td>
<td>12</td>
</tr>
<tr>
<td>10 Process for Version Control, Document Archiving and Review</td>
<td>12</td>
</tr>
</tbody>
</table>

Appendices

<table>
<thead>
<tr>
<th>Appendices</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  THINK DELIRIUM support tool</td>
<td>13</td>
</tr>
<tr>
<td>2  Dementia Care Pathway</td>
<td>14</td>
</tr>
<tr>
<td>3  'Know Me Better' Patient Summary</td>
<td>16</td>
</tr>
</tbody>
</table>

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

- Appendix Four removed as the booklet is now Standard Nursing Documentation (SND Number 031) available from UHL Print Rooms and on INsite.
- Minor changes to the ‘Policy Monitoring Table’ as the antipsychotic medications audits and audit of FOPAL referrals are no longer undertaken
- Section 5.2 Updated to UHL Well Pathway for Dementia
- Appendix 2 updated to the UHL Well Pathway for Dementia

KEY WORDS

Dementia, delirium, confusion, agitated behaviours, challenging behaviour, behaviour chart, 1:1 supervision, wandering, and security (restraint)
1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester NHS Trust’s (UHL) Policy and Procedures for assessing and managing patients who have altered behaviours (behaviours that challenge), as a result of cognitive impairment.

1.2 This policy draws together a number of previously standalone documents into a single, overarching policy which will better support clinical staff in practice, by avoiding duplication and repetition.

2 POLICY SCOPE

2.1 This policy is applicable to all Trust staff, and Bank, Agency and Locum staff who are involved in the direct care of adult patients who meet all of the following criteria:

a) Where the person is an adult inpatient aged 18 years and over, and:
b) Where the person is suffering from temporary, fluctuating or permanent cognitive impairment, due to a disturbance in their brain or mind (as per the Mental Capacity Act (MCA) 2005).

2.2 This policy includes patients who may lack ‘decision and time specific’ mental capacity, for example to consent to their care and treatment. In those cases staff must also refer to the Trust’s ‘Mental Capacity Act Policy and Procedures’, Trust Reference: B23/2007.

2.3 It does not include patients who are displaying violent or aggressive behaviours towards staff or others, where there is no cognitive impairment due to a disturbance in their brain or mind. In those circumstances staff must refer to the Trust’s ‘Policy for Management of Violence, Aggression and Disruptive Behaviour Policy (including restraint guidance)’, Trust Reference: B11/2005.

2.4 This policy does not cover situations where a patient is receiving care and treatment in circumstances where the levels of restriction and restraint could constitute a deprivation of liberty. In those cases staff must refer to the Trust’s ‘Deprivation of Liberty Safeguards Policy and Procedures’, Trust Reference: B15/2009.

2.5 This policy does not cover patients that have absconded, or are missing from the Trust. In those cases staff must refer to the Trust’s ‘Missing Patient – Adults’ Policy, Trust Reference: B15/2005.

2.6 This policy does not cover situations where adult patients require rapid tranquilisation. In those cases staff must refer to the Trust’s ‘Guidelines for Rapid Tranquilisation of disturbed adult patients’, Trust Reference: B11/2016.

2.7 This policy cannot cover every individual scenario, or every possible reason for a person’s altered behaviour(s). If staff face a difficult or unusual situation involving a person with altered behaviour(s) then they should escalate their concerns to their line manager / department lead and the Consultant in charge of the person’s care and treatment.
3 DEFINITIONS AND ABBREVIATIONS

a) **Altered Behaviours/Behaviour that Challenges** – these are altered behaviours which present risks to patients/others, and require additional safeguards to be in place. The types of behaviours include agitation, wandering, disorientation and confusion.

b) **Cognitive Impairment** - in the context of this policy, this means a noticeable and measurable decline in cognitive abilities, including memory and thinking skills. The person may have difficulty remembering, learning new things, concentrating, or making decisions that affect their everyday life.

c) **Dementia** - describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. A person with dementia may also experience changes in their mood or behaviour.

d) **Delirium** - sometimes called ‘acute confusional state’ is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually develops over 1-2 days. It is a serious condition that can be associated with poor outcomes. However, it can be treated if dealt with urgently.

e) **Disturbance in the brain or mind (MCA 2005)** - an impairment of the mind or brain, or some sort of disturbance that affects the way their mind or brain works. Examples of an impairment or disturbance in the functioning of the mind or brain may include the following: • conditions associated with some forms of mental illness • dementia • significant learning disabilities • the long-term effects of brain damage • physical or medical conditions that cause confusion, drowsiness or loss of consciousness • delirium • concussion following a head injury, and the symptoms of alcohol or drug use.

f) **Wandering** - for the purpose of this policy, wandering means a ‘locomotion that is non-direct or more simply it is travelling about without any clear destination. It can take the form of pacing, lapping or a random pattern. Wandering cannot always be prevented or even reduced. A balance needs to be found between prevention of actual risk and enabling the person to have freedom of movement’ (Algase et al, 2001).

4 ROLES AND RESPONSIBILITIES

Responsibilities within the Organisation

4.1 The **Chief Executive and Board of Directors** have overall responsibility for Trust compliance with the Law and Trust Policies and Procedures.

4.2 The **Chief Nurse** is the Board Director with lead responsibility for this policy.

4.3 The **Deputy Chief Nurse** is the Nominated Deputy for the Chief Nurse.

4.4 **Clinical Directors, General Managers and Heads of Nursing** are the leads for disseminating the policy to staff within their Clinical Management Groups.
4.5 The Older People and Dementia Nurses provide day to day advice and support where concerns are raised about the ongoing management of patients with altered behaviours, as a result of dementia and/or delirium.

4.6 The Adult Safeguarding Nurse Specialists provide day to day advice and support to UHL staff where concerns are raised about a person’s mental capacity to consent to/decline care and treatment.

4.7 The Director of Estates and Facilities is responsible for ensuring that Security Personnel are aware of and comply with the relevant aspects of this Policy.

4.8 All Staff who work with patients who have behaviours that challenge must comply with this policy. All staff are responsible for identifying which policies are applicable to their area of work and for following Trust policy documents. All staff must attend relevant training, as appropriate for individual role. If staff require further guidance they should consult their department or line manager, or the person in charge at the time.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

This policy is supported by the associated documents as detailed below, which must be used in conjunction with this policy.

5.1 Managing Patients with Delirium

5.1.1 Delirium is a common problem which occurs in many people who are admitted to hospital.

5.1.2 It is associated with increased morbidity and mortality, with increased risk of institutionalisation on discharge.

5.1.3 Patients who develop delirium also have a longer length of stay and are more likely to develop hospital acquired complications such as falls and pressure sores. They are also more likely to develop dementia. Despite this, reporting of delirium is poor in the UK, indicating that awareness and reporting procedures need to be improved (NICE CG 103).

5.1.4 It is the responsibility of the attending nurse or doctor to screen for a delirium by identifying whether the patient is more confused or withdrawn than their usual baseline.

5.1.5 If the initial screen is positive then the nurse and doctor should refer to the THINK DELIRIUM Support Tool (Appendix 1) and follow advice regarding investigations for a potential cause of delirium.

5.1.6 Once a cause of the delirium has been identified then this must be managed appropriately. Where there is difficulty in managing the delirium then reference should be made to the General Management section of the THINK DELIRIUM Support Tool.
5.1.7 Any antipsychotic or sedative medication use should only be used when all other (non chemical) management plans have been exhausted and be restricted to those with dangerous symptoms. This must be used under supervision of a senior member of the medical team and reference to the THINK DELIRIUM Support Tool to ensure that the delirium has been managed appropriately.

5.1.8 The episode of delirium including date of onset, type of delirium, identified causes and treatment plan must be clearly documented by the doctor in the patient’s medical notes. By documenting an episode of delirium this prompts early recognition of future delirium episodes.

5.1.9 Patients with a diagnosis of delirium must be given the UHL information leaflet on delirium for information and advice.

5.1.10 Prior to discharge the THINK DELIRIUM Support Tool should be referred to, to ensure that the community teams are aware that the patient has had an episode of delirium and if any follow up is required. The episode must be clearly documented on the ICE letter.

5.1.11 The ‘Prone to Delirium’ (PTD) code on the special register of patient centre should be added to the patient’s record, to alert professionals if the patient is admitted to UHL in future.

5.2 **UHL Well Pathway for Dementia**

5.2.1 The UHL Well Pathway for Dementia (Appendix 2) is to be used on all adult inpatients with a known or suspected diagnosis of dementia within 4 hours of admission.

5.2.2 The Well Pathway for Dementia provides details to support a person with a known or suspected diagnosis of dementia from admission through to discharge.

5.2.3 The Pathway provide guidance and prompts for staff to consider when supporting a patient with dementia or suspected dementia.

5.3 **Managing Patients at Risk of Wandering**

5.3.1 Many people with cognitive impairment are compelled to walk about, a symptom often described as wandering. For example, up to 60 percent of people with dementia may wander. Walking can provide significant benefits for people with dementia, and should not be discouraged from doing so as this can make agitation and distress worse. However, at times wandering can present some risks, particularly in the acute hospital setting.

5.3.2 Patients with altered behaviours, who are also mobile, are at risk of wandering.

5.3.3 Nursing staff should inform the patient’s significant others, and have proactive discussions about risk, supervision and helpful interventions including completing the ‘Know Me better’ Patient Summary (see appendix 3).
5.3.4 A patient who is wandering must have a 24hr Behaviour Chart and a Patient Observation Care Plan commenced (found within the Nursing Booklet - Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on INsite).

5.3.5 A patient who is wandering must be observed as a minimum every 30 minutes and this should be documented.

5.3.6 It is the responsibility of the nurse in charge (NIC) of the patient to assess the level of supervision required for the patient with wandering behaviours (see section 5.4).

5.3.7 Patients at risk of wandering must be nursed in a high observation area within the ward area, where possible, away from main thoroughfares and exits. Ward doors should be closed as such a physical barrier can simply prevent wandering out of a clinical area.

5.3.8 If the patient is sensitive to over stimulation from noise and light levels, then consider a quieter area on the ward.

5.3.9 Ensure the patient is wearing a pre-printed identity band and ensure the person is appropriately dressed to promote dignity.

5.3.10 Provide appropriate signs and cues (words and/or pictures) for orientation purposes including personal photographs/clocks to identify personal bed space and the toilets.

5.3.11 Assess the patient for evidence of physical discomfort such as hunger, thirst, pain and desire to go to the toilet. Refer to the Know Me Better Patient Summary for guidance.

5.3.12 Ensure carers have flexible visiting should they wish to contribute to supporting patients whilst they are in hospital.

5.3.13 Ensure the patient is supervised for all tests and procedures outside of the main care setting and where possible re-orientate the person on their return.

5.3.14 Where possible accompany the patient whilst they wander/walk. This may help reassure the patient making them feel more secure in hospital. It may be beneficial to accompany the patient for a longer walk away from the clinical area if this is safe to do so.

5.3.15 Consider referring the patient to specialist groups such as the Frail Older People’s Advice and Liaison Team (FOPAL) for advice on managing behaviours that carry risks. See INsite for contact details.

5.3.16 If a patient who is assessed as at risk of wandering goes missing from the clinical area, please refer to the UHL Missing Patients Policy - Adults (Trust Reference Number: B15/2005).

5.3.17 Staff must complete a Datix incident form where unsafe, and potentially unsafe, wandering has occurred.
5.4 Managing the One to One Supervision of Patients with Altered Behaviours

5.4.1 In the hospital environment, some patients may require more than general level of observation when they present with altered behaviours that challenge due to an impairment in their brain or mind.

5.4.2 These patients may present a risk to themselves or others. Heightened levels of observation may need to be employed as a management strategy to minimise such risks. For the purpose of this guideline this is referred to as one to one supervision.

5.4.3 It is the responsibility of the attending nurse to use the ‘Managing Adult Agitated Patient Flowchart’ for all patients exhibiting behaviour that challenges (found within the Nursing Booklet - Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on INsite).

5.4.4 Relative/Carers must be informed of decision and rationale for one to one supervision by the responsible nurse or Nurse in Charge (NIC) and this should be documented in patient’s notes.

5.4.5 When it is deemed that a patient requires one to one supervision then the ‘Standards for the Provision of One to One Supervision’ must be applied (found within the Nursing Booklet - Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on INsite). All one to one supervision must be reviewed every 24 hours by the Nurse in Charge/Ward Manager with consultation of the Multi-disciplinary team to ascertain if one to one supervision is still required and the rationale for terminating one to one supervision must be clearly documented in patient’s notes.

5.4.6 All patients receiving one to one Supervision from a nurse must have a Know me Better Patient Summary commenced, a ‘Patient Observation Care Plan’ and ‘24 Hour Behaviour Chart’ completed (found within the Nursing Booklet - Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on INsite).

5.4.7 When it is deemed that a patient requires one to one supervision from a security guard this must be agreed with a Head of Nursing or Deputy in hours and a Duty Manager during the night time period and a ‘Security Guard Monitoring Form’ completed (found within the Nursing Booklet - Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on INsite).

5.4.8 All patients receiving supervision from a security guard must have a ‘Checklist when using Security Officers for one to one Supervision of Patients’ completed initially after 30 minutes of requiring a security guard and then every 24 hours (found within the Nursing Booklet - Altered Behaviours, available from UHL print rooms as Standard Nursing Documentation, Document Number 031 and on INsite).

6 EDUCATION AND TRAINING REQUIREMENTS
6.1 All staff in UHL must complete the Trust Dementia Awareness Category A training e-learning module which is accessed on HELM.

6.2 All clinical staff that has direct clinical contact with patients must complete the Trusts Dementia Category B training. This is a face to face workshop for all staff excluding medical staff who can complete a combined e-learning module for category A and B dementia awareness training.

6.3 Delirium training is incorporated into the Dementia Awareness Category B training for all clinical staff.

6.4 All clinical staff that have direct clinical contact with patients must complete the Trust’s e-learning modules titled ‘Basic Consent/Mental Capacity Act/Deprivation of Liberty Safeguards’.

6.5 For staff providing one to one supervision, training in ‘Holding skills for Patients with Dementia training’ is recommended. This training is provided by the UHL Health and Safety Team and can be booked via HELM.
## 7 Process for Monitoring Compliance

### 7.1 Policy Monitoring Table

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential to job role training in Consent / MCA and DoLS</td>
<td>Head of Safeguarding</td>
<td>HELM records / reports</td>
<td>Bimonthly</td>
<td>Safeguarding Assurance Committee</td>
</tr>
<tr>
<td>Improvement in Delirium coding</td>
<td>Older People and Dementia Team</td>
<td>Audit discharge letters</td>
<td>Annual</td>
<td>Through Dementia Strategy Action Group</td>
</tr>
<tr>
<td>Improved recognition of delirium through Documentation Audit</td>
<td>Older People and Dementia Team</td>
<td>Audit the documentation of delirium within the medical notes of those coded with a diagnosis of delirium</td>
<td>Annual</td>
<td>Through Dementia Strategy Action Group</td>
</tr>
<tr>
<td>Patients with a known diagnosis of dementia will have a patient profile or Patient Summary completed as part of an admission</td>
<td>Patient Experience Team</td>
<td>Ward spot check audit. Audit of patient profile</td>
<td>Annually</td>
<td>Through Dementia Strategy Implementation Group</td>
</tr>
</tbody>
</table>
8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Evidence Base


c) Delirium: prevention, diagnosis and Management. Nice Guideline CG 103


Policies Available on INsite

a) UHL Mental Capacity Act Policy (Trust Ref: B23/2007)

b) UHL Deprivation of Liberty Safeguards Policy and Procedures (Trust Ref: B15/2009)


d) Missing Patient Policy – Adults (Trust Ref: B15/2005)

e) Guideline for the Rapid Tranquilisation of disturbed adult patients (Trust Ref: B11/2016)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 The latest version of the Policy will be uploaded and available through INsite Documents and the Trust’s externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system.
10.2 This policy and procedures contained within it will be reviewed after 3 years by the Policy Authors.
Appendix 1

GENERAL MANAGEMENT OF DELIRIUM

Hypoxia / electrolytes - Treat hypoxia, electrolyte imbalance and follow specific guidelines if appropriate.

Constipation
Fit to stool, adequate hydration, a soft stool and enemas if required and encouragement to sit on the toilet or enemas if appropriate.

Pain
Non-steroidal anti-inflammatory drugs (NSAIDs) or other options e.g. patching

Observe and assess
Heightened level of suspicion may require cognitive assessment to monitor progress

Avoid moves
Avoid multiple ward transfers

‘Know Me Better’
Complete a profile with the help of the family/care

Vision / Hearing
Ensure patient has their glasses and hearing aids if appropriate

Avoid distress
Avoid infusions, aerosols or splashes that can cause distress

SoGo
Sit out, get up, encourage mobilization, refer to ‘Get moving to get home’

Sleep
Engage in activities during day, musical music; avoid excess noise

DOLS
Complete DOLS assessment if patient at risk of Deprivation of Liberty

Nutrition
Prompt oral nutrition – offer regular drinks, snacks and ‘finger foods’

PONSAL
For complex and challenging patients only (Full PONSA N PAH NUTRITION module)

MANAGING BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS

Wandering
Provide close observation within a safe and minimally disturbed environment (refer to DOLS)

Act in patients best interest, allow wandering if in a safe environment

Risk relates to help seeking meaningful directions

Refer to UHL wandering policy

MANAGEMENT – For ICU patients please refer to ‘ICU Delirium guidelines’

V3 approved by Policy and Guideline Committee on 24 April 2020 Trust Ref: B30/2017

Next review: May 2023
Appendix 2
## Appendix 3

### Know me better Patient Summary

**Patient details** This document is to be completed by / for people who cannot consistently communicate their own needs. Please be as thorough and descriptive as you like - the more information you provide, the more we can adapt the care we provide to suit you. If you need more space please ask staff for a ‘Know Me Better Patient Profile’

Name: .................................................. I like to be called: .................................. Date: ..................................

S. Number: .................................. Completed by: .................................. The language I speak is: ..................................

### Communication

**Do you have any difficulty communicating?**
- Yes [ ] No [ ]

**Do you have impairment of:**
- Vision [ ] Hearing [ ] Other [ ]

**Do you use:**
- Glasses [ ] Hearing aid(s) [ ] Details [ ]

**Do you mind wearing your glasses / hearing aid?**
- Yes [ ] No [ ] I am: Prone to wandering [ ] At risk of falls [ ]

### Getting About

**How do you normally get about:**
- Need assistance [ ]
- Walk independently [ ]
- Walk with a stick [ ]
- Walk with a trolley [ ]
- Stay in the chair or bed [ ]
- Other [ ]

### My usual routine and care

**I can:**
- Wash myself [ ]
- Dress myself [ ]
- Toilet myself [ ]
- Clean myself after toileting [ ]

**I need help with all of the above:**

**I am incontinent of:**
- Urine [ ] Faeces [ ] I wear pads [ ] I have a catheter [ ]

### Relaxation and Sleep

**How do you like to relax:**
- Talk [ ]
- Read [ ]
- Listen to music [ ]

**Details:**

**How do you sleep:**
- Be quiet [ ]
- Watch television [ ]

**Details:**

**What helps you to sleep?**

### Eating and drinking

This section, in part relates to any advice you have been given by the dietician / speech and language therapist regarding food and / or drink

**I have not been given any advice regarding food / drink [ ]**

**I eat:**
- Soft diet [ ]
- Fork mashable [ ]
- Pre-mashed [ ]
- Pureed [ ]

**If thickened, what stage:**
- Thickened fluids [ ]
- Good appetite [ ]
- Poor appetite [ ]
- Small portions [ ]

**I use a spouted beaker [ ]**

**Do you wear dentures or dental plates?** Yes [ ] No [ ] **If yes, do you wear them: all the time [ ] only when eating [ ]**

**Do you have a special diet?**

**What are your food / drink likes?**

**What are your food / drink dislikes?**

### Memory

**I am sometimes forgetful, but I don’t have dementia [ ]**

**I am often forgetful, but I don’t have dementia [ ]**

**I have dementia [ ]**

**I am currently more confused than my normal self [ ]**

**I am currently more drowsy/withdrawn than my normal self [ ]**

**I have had an episode of delirium previously [ ]**
### Taking medication:

<table>
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<tr>
<th>I prefer to take my medications as:</th>
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<tr>
<td>Tablets □</td>
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Do you have any preferences for taking your medications? (e.g., type of drink, time of day)

---

### Important things in my life

**Family that are important to me:**

---

**Pets that are important to me:**

---

**Routines that are important to me:**

---

**Hobbies and interests I have:**

---

**Places that are important to me:**

---

**Jobs and life events important to me:**

---

### Emotional support:

**Things that upset or distress me:**

---

**How you can help me if I am upset or distressed:**

---

**How I may react to upsetting or distressing things:**

---

**How will you notice if I am in pain:**

---

### Spiritual and Cultural needs:

**I am religious? **Yes □ No □

If yes, which religion?

---

**Is there any way we can help you to follow your spiritual or religious beliefs?**

---

**I have the following spiritual or religious beliefs:**

---

### Are there any aspects of your care that your family would like to be involved in?

---

---

If you wish for someone close to you to be involved in your care please provide their details here:

Contact Name: .......................................................... Contact Details: ..........................................................

If you feel there is more in-depth or additional information that would be useful for us to know about you please ask staff for a ‘Know Me Better Patient Profile’ to complete. If a full ‘Know Me Better Patient Profile’ has been completed please tick here: □