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Dementia Care Pathway

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Type of document	Guidance
Target audience	All clinical staff
Document purpose	Guidance for the detection, assessment and management of dementia

Approving meeting	Mental Health LES Group	Sept 2016
Implementation date	October 2016	

CWP documents to be read in conjunction with	
CC40	Guidance and Responsibilities for the Prescribing of Medicines to Treat Alzheimer's Type Dementia

Document change history	
What is different?	Stable patients taking anti-dementia medication can be discharged to primary care for annual review of their clinical condition
Appendices / electronic forms	N/A
What is the impact of change?	Discharging stable patients from the service will free clinical capacity to respond to the increased demand for memory assessments, and reduce lengthy waiting times

Training requirements	Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Learning and Development (L&D)

Document consultation	
East locality	N/A
Wirral locality	N/A
West locality	Older Adults Psychiatry Consultants, CMHT Team Manager and Clinical Leads. Old Age Psychiatry and West Locality Clinical Directors
Corporate services	CWP Pharmacy Team
External agencies	West Cheshire CCG APC, Integrated Provider Hub, GP Mental Health Local Enhanced Service Network

Financial resource implications	None

External references
1. NICE guidelines CG42. Published date November 2006. Updated May 2016
2. NICE technology appraisal guidance TA217. Published date March 2011. Updated May 2016
3. NICE guidelines CG180. Published date June 2014
4. NICE guidelines CG181. Published date July 2014 Last updated: July 2016
5. NICE guidelines CG35. Published date June 2006

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Select		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Select	

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Dementia Care Pathway*

Introduction

This document is a tabular summary of the dementia care pathway and is supported by other documents in this package.

The basic structure of the pathway is based on guidance issued following the National Service Framework for Older People, which suggested the framework of looking at Detection, Initial Assessment, Initial Management and Specialist Referral all of which take in Primary Care settings. This has been expanded further to include Specialist Assessment, Specialist Management and Specialist Discharge which will take care in Secondary Care settings

For the diagrams in the Cognitive Pathway, Challenging Behaviour Pathway and Delirium Pathways, the same format is used and shown down the left side of each pathway.

* excluding learning disabilities clients

Detection		Prevalence: 3% of people aged 65 20% of people aged 80 Means of detection: Self-referral Family and others concerns Screening tests
Initial Assessment (see also Cognitive and Delirium Pathways)	Focussed history	Onset and pattern of symptoms Progression of illness Effect on Activities of Daily Living (ADLs) Principal risks (fire, neglect) Current support (spouse, family, statutory and voluntary agencies) Behavioural and Psychological symptoms (wandering, aggression, psychotic) Family history of dementia **It is always useful to speak to an informant** (Carer, relative or friend)
	Physical examination	To exclude physical cause for illness and maximise physical health
	Medication Review	To consider medication as a cause of symptoms and to rationalise drug treatments e.g. anticholinergic burden Consider alcohol and illicit drug use
	Blood tests	FBC, U+E, LFT, TFTs, B12, folate, Vitamin D
	Appropriate assessment tools	6 item Cognitive Impairment Test (6-CIT) Mini-Mental State Examination (MMSE) Montreal Cognitive Assessment (MoCA)

Initial Management	Counselling Treat any physical problems to optimise physical health Optimise Vascular Risk Factors: - If patient in Atrial Fibrillation follow NICE guidelines on treatment, i.e. should be initiated on an anticoagulant if no contraindications - Control BP, cholesterol, Diabetes Mellitus Treat any associated depression - follow NICE guidelines Arrange Appropriate Support: Family and Private Agencies Locality Social Services Advice on Attendance Allowance Welfare Benefits Check Advice about driving: If memory problems identified, then explain to the client that they have - an obligation to inform DVLA of this - to inform their insurance company Consider inclusion on QOF Dementia Register **N.B.** Medication for the behavioural and psychological symptoms of dementia is not first line treatment and should be used only when other approaches have failed (see Challenging Behaviour Pathway)

LEARNING POINT

People living alone with dementia are likely to present to services differently to people living with others.
They are more likely to present with more severe illnesses and in crises, rather than early in their condition

Specialist Referral	Routine Referrals	**When to refer:** Diagnosis unclear Rapid progression or unusual symptoms Severe risks If suitable for anti-dementia drug treatment - Probable diagnosis of Alzheimer's Disease - Pulse above 50 - Likely compliance with any planned treatment All Referrals should include your details of your **initial assessment** and **management**, including **results of blood and screening tests**, together with details of **Past Medical History** and **Current Medication,** including consideration of anticholinergic burden. For consideration of anti-dementia drug treatment an **ECG** is required only **if there is a cardiac history, bradycardia, or irregular pulse** **Acceptance of referrals may be delayed if insufficient information is provided** **To help with engagement with Clinical Services, please include details of family and other contacts with the referral**
	Urgent Referrals	Severe agitation and aggression Immediate risks to safety that cannot be mitigated by simple measures Urgent referrals should be made by **telephone contact only and *must* follow an initial assessment** within the previous 24 hours. They will usually only be accepted after discussion with the referrer. Joint visits may be requested.

Specialist Assessment (see also Semi-structure interview and outcomes of Assessment documents)		Full History and Cognitive examination Diagnosis according to standardised criteria (ICD10) Global Assessment of level of dementia Assessment of current support and care needs Assessment of Behavioural and Psychological Symptoms of Dementia Assessment of co-morbid psychiatric symptoms (e.g. depression)
Specialist Management	Non-pharmacological interventions	Advice/Counselling regarding diagnosis Behavioural and psychological interventions to improve BPSD Support from CMHT OPMHS where indicated Referral for practical help and support through Social Services, Home care services, Day Care, Meal provision, respite and permanent care Referral to Age UK and Alzheimer's Society
	Anti-dementia drugs	**People with Alzheimer's disease** **Initiation** Consideration of treatment safety Documentation of carer's views Likely compliance with treatment Initiation on lowest cost AChEI Titration to maximum tolerated dose **Review appointments** (in shared care, where agreed locally) Secondary care to assess for side effects during dose titration **Discontinuation** Severe or unacceptable side-effects Patient requests discontinuation, *or* Carer requests discontinuation, *or* Specialist suggests discontinuation

		People with other dementias The use of anti-dementia drugs in conditions other than Alzheimer's Disease is not recommended for cognitive symptoms by NICE, although they may be used for BPSD in Lewy Body dementia and Dementia associated with Parkinson's Disease (see NICE guidance for Parkinson's Disease)
	Other Medications	**Review of medications** that may worsen/affect cognition In patients with AF, treat with an anticoagulant, unless contra-indicated (follow NICE CG180 on treatment of Atrial Fibrillation, June 2014) Lipid lowering medication is prescribed in all patients with raised cholesterol in accordance with NICE guidance CG181 and local joint lipid modification guidelines. Consider risperidone titrated to a maximum of 1mg BD for BPSD. This is a licensed indication for use up to 6 weeks **See Challenging Behaviour Pathway for full advice**
Specialist Discharge (from active follow up)		Stable situation Care needs met as far as possible Patient or carer requests discharge (if have capacity for this decision) Discharge to primary care for ongoing monitoring where agreed locally Pulse check to be done in primary care every 12 months for patients on ACI (donepezil, rivastigmine, galantamine), or earlier if patient presents with possible symptoms of bradycardia.