Integrated Dementia Care Pathway for Acute Hospital Wards

National Dementia Office

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

OLDER PEOPLE

Patient is admitted to your ward

↓

Follow ward delirium algorithm for all patients

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Known diagnosis of dementia?

← **YES**

→ **NO**

YES

↓

Continue to follow ward delirium algorithm
+
Follow additional dementia care bundle below

NO

↓

Is the 4AT score ≥2, or is the person disoriented to person/place/time?

YES

↓

Continue to follow ward delirium algorithm
+
Follow "Diagnostic Pathway for Suspected Dementia" (see reverse)
+
Initiate DCB if delirium is ruled out and high suspicion for dementia

NO

↓

Continue to follow ward delirium algorithm

Dementia Care Bundle (DCB)

STAFF GET TO KNOW INFORMATION ABOUT THE PERSON

- Seek nursing home transfer document, if relevant
- Complete and use "Getting to know me", This is Me" or similar document: give document to the family, and follow-up on return within 24 hours; document is kept in the patient folder at the end of bed to be read by all staff supporting the patient
- A personalised care plan is informed by this document (nursing and medical notes)
- Involve patient and family in care as much as possible/appropriate

ASSESSMENT AND SPECIALIST REVIEW

- Perform a comprehensive assessment of care needs (particularly communication, nutrition/hydration and continence needs)
- Include the primary carer's needs as appropriate (i.e. being discharged home)
- If indicated, refer to occupational therapy, speech and language therapy, physiotherapy, dietician, mental health (older adult, liaison), specialist palliative care, social work and patient support services
- **Complete referral to Dementia CNS/ANP, as per local protocol (typically complex case or anticipated discharge difficulties)**

ADVANCED CARE PLANNING

- Clarify as soon as possible if patient has an advanced care plan or advanced healthcare directive in place
- If not, assess if this needs to be completed during this admission (e.g. markers of advanced dementia, advanced frailty, weight loss, dysphagia, etc.), or if it can wait till community follow-up (see below)

INTEGRATED DISCHARGE

- Commence discharge planning within 48 hours of admission (see HSE Code of Practice for Integrated Discharge Planning 2014)
- On discharge, communicate to the GP and PHN (or residential care Director of Nursing):
  - Any update on dementia status (cognition, function, any delirium, prognosis)
  - Any changes to care plan especially advance care planning; any referral to palliative care or long term care

FOLLOW-UP IN COMMUNITY

- Arrange follow-up with Memory Assessment Support Service or Dementia ANP/CNS/Advisor/Coordinator as indicated (e.g. distressing non-cognitive symptoms or responsive behaviour; carer burden/burn out; rapidly progressing course; need for future care planning; unmet dementia symptoms)
  (Usually refer to service that diagnosed or last assessed the person for their dementia; liaise with CNS dementia if unsure)
- Arrange other appropriate Community Management with PCT / integrated care team / mental health team as indicated

Note: This pathway can be modified to suit local context, resources and other protocols

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Diagnostic Pathway for Suspected Dementia on Acute Hospital Wards

Admission to Ward

Possible Dementia?

Typical indicators of possible dementia include:
- 4AT score 2 or 3 without obvious other cause
- Delirium episode with only minor illness
- Family concerned re. dementia
- Staff concerned re. dementia

Treating hospital team to complete initial dementia work-up

- Most important is to document collateral history (from family, GP, PHN)
  NB duration and course of cognitive decline; effects on functional activity

- Perform formal cognitive test (e.g. MMSE, MoCA) only if delirium is ruled out or fully resolved. In-hospital cognitive scores can be lower than usual due to illness/anxiety but can give an approximate indication of cognitive function

Primary hospital team to arrange specialist diagnostic review:

Arrange out-patient follow-up for when patient is medically well (more usual path)
- Arrange out-patient memory clinic or specialist clinic follow-up
- At discharge, inform GP of possible diagnosis and details of follow up; include whether patient and family are aware of possible diagnosis

Seek in-patient specialist review (less common path)**
- Refer to CNS/ANP Dementia if available

Deciding on most appropriate service to review the patient:
- Under the age of 65: neurologist review is most appropriate usually
- Age 65 or above:
  - Geriatric medicine: if frail, medical complexity, known to service
  - Mental Health Service: if pronounced behavioral issues/psychosis; known to service
  - Neurologist: if atypical features (e.g. rapid decline, possible seizures)

CNS/ANP Dementia will indicate most appropriate service, if unsure

** Reasons for seeking in-patient diagnostic review include:
- diagnosis is necessary for safe discharge
- apparent moderate-severe dementia but no formal diagnosis
- rapidly deteriorating cognition or atypical features
- patient unlikely to return for out-patient review and no community in-home diagnostic service

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