Integrated Dementia Care
Pathway for Acute Hospital Wards

Patient is admitted to your ward

Follow ward delirium algorithm for all patients

If known diagnosis of dementia?

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
  + “Diagnostic Pathway for Suspected Dementia” (see reverse)
  + Initiate DCB if delirium is ruled out and high suspicion for dementia

No

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
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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