Dementia – Clinical Protocol

Assessment and Recognition

1. Identify individuals who have been diagnosed as having dementia or otherwise irreversibly impaired cognition.

    a. Many individuals with a recent hospitalization still have delirium for some time after discharge. Delirium may be especially problematic in individuals with underlying dementia.
    b. Prominent symptoms may include reduction in alertness, appetite, attention span, function, and responsiveness; alternating agitation and lethargy, fluctuation in level of consciousness, hallucinations, and delusions.

2. Identify individuals taking cholinesterase inhibitors or other medications used to try to stabilize cognitive function, or medications ordered to manage problematic behavior or impaired mood or cognition, such as antipsychotic medications and mood stabilizers.
3. The staff and physician will evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes.
4. The staff and physician will review the current physical, functional, and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complications, and functional impairments.
5. The staff and physician will jointly define the decision-making capacity of someone with dementia, including the extent to which the individual can participate in making everyday decisions and considerations about healthcare treatment choices, including life-sustaining treatments.

Cause Identification

1. As needed (for example, when the diagnosis is unclear, a basis for the diagnosis cannot be readily identified, or the individual's cognitive function is borderline normal or better), the physician will verify or reconsider the diagnosis of dementia and identify other possible coexisting psychiatric conditions.

    a. Individuals with dementia can also have a personality disorder, mental illness, psychosis, delirium, depression, adverse drug reactions (ADRs), or other conditions causing or contributing to impaired cognition and problematic behavior.
    b. As needed, the physician may obtain a psychiatrist or neurologist consultation to assist with diagnosis, treatment selection, monitoring of responses to treatment, and adjustment of medications.

2. As needed, the physician will document the basis for conclusions about the causes of a resident's dementia or impaired cognition; for example, multi-infarct disease, Alzheimer's disease, Lewy Body Disease, etc.
3. The physician will order any diagnostic tests indicated to clarify the nature or causes of dementia and identify other co-existing or alternative causes of cognitive impairment and problematic behavior; for example, thyroid dysfunction, adverse drug reactions, hypoxia, etc.

continues on next page

Treatment/ Management

1. For the individual with confirmed dementia, the staff and physician will identify a plan to maximize remaining function and quality of life.

    a. The physician will help define potential benefits and risks of medical interventions, including cholinesterase inhibitors and other medications used to enhance or stabilize cognition.
    b. The physician will address conditions and factors that may be causing additional cognitive impairment or increasing risks in the individual with dementia; for example, by adjusting or discontinuing medications that adversely affect cognition or behavior, increase risk of fluid and electrolyte imbalance, cause anorexia or weight loss, etc.

2. Identify and address ethical issues and related treatment options; for example, management of continued functional decline or unplanned weight loss in someone with late-stage dementia.
3. The physician will order appropriate medications and other interventions to manage behavioral and psychiatric symptoms related to dementia based on pertinent clinical guidelines and regulatory expectations.

    a. Medications should be targeted to specific symptoms and should be used in the lowest possible doses for the shortest possible time, unless a clinical rationale for higher doses or longer-term use is documented.

4. Facility staff should minimize environmental stimuli in areas where the residents with dementia are present (i.e. TV shows that include violence, loud music and/or overhead paging).

Monitoring and Follow-Up

1. The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician.
2. The physician will help staff adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, etc.
3. The physician and staff will review the effectiveness and complications of the long-term use of medications used to enhance cognition and of psychoactive medications used to manage behavioral and psychiatric symptoms related to dementia and will adjust, stop, or change such medications appropriately.