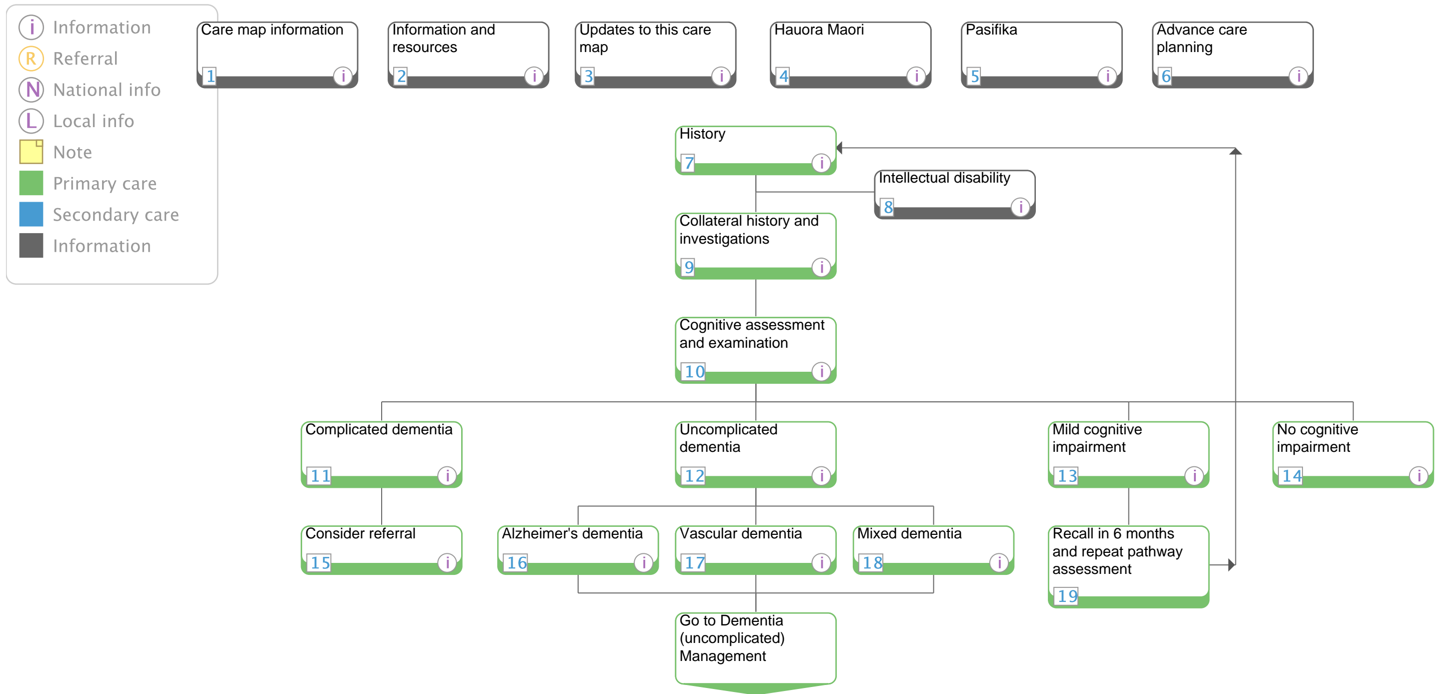
# Dementia - Assessment

Mental Health > Behavioural, developmental and other > Dementia

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# Dementia - Assessment

Mental Health > Behavioural, developmental and other > Dementia

## 1 Care map information

Quick info:

**Scope**

This pathway:

- provides guidance on Primary Sector diagnosis, assessment and management of dementia
- suggests a logical approach to screening and initial assessment in order to identify cognitive disorder, whilst ensuring consideration or exclusion of other pathologies
- provides recommendation regarding aspects of examination, including cognitive screening tools, and investigations necessary to help with diagnosis of dementia
- includes guidance in identifying types of cognitive impairment or dementia, which can be managed in primary care sectors, including mild cognitive impairment, Alzheimer's disease, vascular dementia and mixed dementia
- provides an approach to the longer term care of people with a diagnosis of dementia (regardless of the place of residence) as well as care of problems which may arise. This approach considers: proactive care, i.e. initial review and long term planning. This includes legal aspects, exploration of functional abilities (including driving), and maintenance of good physical and mental health

**Out of scope**

If cognitive impairment is present before the age of 18 years old and remains static thereafter, this is likely to be due to a learning disability or intellectual disability, and would be out of the scope of this Pathway.

This Pathway should be used only for patients in which it will influence the patient management. It is to be used as a guide and doesn't replace clinical judgement.

**Background**

Alzheimer's NZ estimates there are approximately 48,000 known cases of dementia in New Zealand currently. A significant proportion can be managed in primary care.

**Key messages for this pathway:**

- if suspecting dementia, ask if they have had problems with their memory that have significantly interfered with their ability to function over the last 12 months
- uncomplicated dementia can be successfully managed in primary care with referral to secondary care if required
- medications, particularly those with significant anticholinergic side-effects may affect cognitive function
- mild cognitive impairment (MCI) describes the situation where a person complains of mild cognitive difficulties, confirmed by mildly abnormal cognitive testing, but there is no evidence of functional impairment

## 2 Information and resources

Quick info:

Recommended resources for people with dementia and carers:

**Advocacy and Support:**

- Alzheimer's New Zealand
- Neurological Foundation
- Dementia Alliance International
- Memory loss and dementia
- Alzheimer's disease and dementia support
- Optimising Care
- What we can do - carer's brochure

**Legal:**

- Advance care planning
- Enduring Power of Attorney
- EPOA A5 brochure

**Driving:**

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- Dementia and driving
- Dementia and driving
- National Dementia Cooperative
- Medical aspects of fitness to drive

**Staying safe:**

- Steps to take for a person with dementia

**Ministry of Health documents:**

- Support and Management of People with Dementia
- Mental Health and Addiction Services for Older People and Dementia Services
- Improving Quality Residential Care

**Pharmacy**

- Pharmacy Checklist for a Dementia Patient
- Medicines Use Review (MUR)
- Community-based pharmacy services
- Community Pharmacy details and hours

**Other**

- Disability Allowance - Medical Alarm factsheet
- Dementia Books - for adults and children
- Neurological Foundation of New Zealand - Stay Active
  Physical activity for older people fact sheet
- Glorious Opportunity video (5 minutes)
  The story of a GP who is diagnosed with Alzheimer's at the age of 63. Jennifer gives us clear insights into the things that she now struggles with daily.

**Clinician Resources:**

- New Zealand Framework for Dementia Care
- Optimising care for People with BPSD

**Australian Resources:**

- Alzheimer's Australia
- Your Brain Matters

**UK Resources**

- BUPA: Alzheimer's disease
- Alzheimer's UK
- BUPA: Dementia
- Memory loss and dementia
- Understanding NICE guidance: Dementia
- Vascular dementia and high blood pressure
- Health Talk Online
- Alzheimer's and Dementia: dementia and memory problems
- Alzheimer's and Dementia: Alzheimer's dementias
- Alzheimer's and Dementia: drug treatment of Alzheimer's

## 3 Updates to this care map

Quick info:

Date of draft publication: July 2015.

Date of review and republication: April 2017

Date of next review: April 2019

Please see the care map’s Provenance for information on references, accreditations from national clinical bodies, contributors, publication schedule, and the editorial methodology.

## 4 Hauora Maori

Quick info:

Maori are a diverse people and whilst there is no single Maori identity, it is vital practitioners offer culturally appropriate care when working with Maori whanau. It is important for practitioners to have a baseline understanding of the issues surrounding Maori health. This knowledge can be actualised by (not in any order of priority):

- considering the importance of introductions ('whanungatanga') - a process that enables the exchange of information to support interaction and meaningful connections between individuals and groups. This means taking a little time to ask where this person is from or to where they have significant connections
- asking Maori people if they would like their whanau or significant others to be involved in assessment and treatment
- asking Maori people about any particular cultural beliefs they or their whanau have that might impact on assessment and treatment of the particular health issues

**Maori health services**

HBDHB contracts Maori health providers to deliver community based nursing and social support services. A referral to one of these providers may assist Maori people to feel more comfortable about receiving these services.

***Central Hawke’s Bay****:*

Central Health
Cnr Herbert & Ruataniwha Streets, Waipukurau
Phone: 06 858 9559 Fax: 06 858 9229
Email: reception@centralhealth.co.nz
Referral Form

***Hastings****:*

Te Taiwhenua o Heretaunga
821 Orchard Road, Hastings 4156
Phone: 06 871 5350 Fax: 06 871 535
Email: taiwhenua.heretaunga@ttoh.iwi.nz
Referral Form

Kahungunu Health Services (Choices)
500 Maraekakaho Road, Hastings
Phone: 06 878 7616
Email: kahungunu@paradise.net.nz
Referral Form

***Napier****:*

Te Kupenga Hauora
5 Sale Street, Napier
Phone: 06 835 1840
Email: info@tkh.org.nz
Referral Form

***Wairoa****:*

Kahungunu Executive (no website)
65 Queen Street, Wairoa 4108
Phone: 06 838 6835 Fax: 06 838 7290
Email: kahu-exec@xtra.co.nz

***Secondary care Maori HealthServices:***
Hawke's Bay DHB - Te Wahanga Hauora Maori Health Services
Phone: 06 878 8109 ext. 5779, 06 878 1654 or 0800 333 671 Email: admin.maorihealth@hawkesbaydhb.govt.nz

**Further Information**
Practitioners should be versed in the knowledge of:

- historical overview of legislation that impacted on Maori well-being
- Maori models of health, such as Te Whare Tapa Wha and Te Wheke when working with Maori whanau
- national Maori Health Strategies:
  - **Mai Maori Health Strategy 2014-2019** - Full file or Summary diagram
  - **He Korowai Oranga**: Maori Health Strategy - sets the Government's overarching framework to achieving the best health outcomes for Maori
- local Hawke's Bay health sector's strategies and initiatives for improving Maori health and wellbeing

**Cultural Competency Training**
Training is available through the Hawke's Bay DHB to assist you to better understand Maori culture and to better engage with Maori people. Contact the coordinator
Email: education@hbdhb.govt.nz to request details of the next courses.

## 5 Pasifika

Quick info:
Pacific people value their culture, language, families, education and their health and wellbeing. Many Pacific families have a religious affiliation to a local church group.
The Pacific people are a diverse and dynamic population:

- more than 22 nations represented in New Zealand
- each with their own unique culture, language, history, and health status
- share many similarities which we have shared with you in order to help you work with Pacific people more effectively
- for many families language, cost and access to care are barriers

Pacific ethnic groups in Hawke's Bay include Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau, Kiribati and Tuvalu. Samoan and Cook Island groups are the largest and make up two thirds of the total Pacific population. There is a growing trend of inter-ethnic relationships and New Zealand born Pacific populations.
Acknowledge The FonaFale Model (Pacific model of health) when working with Pacific people and families.
General guidelines when working with Pacific people and families (information developed by Central PHO, Manawatu):

- Cultural protocols and greetings
- Building relationships with your Pacific people
- Involving family support and religion during assessments and in the hospital
- Home visits

**Hawke's Bay-based resources:**

- HBDHB interpreting service website **or** phone 06 8788 109 ext.. 5805 (no charge for the hospital; charges may apply for community-based translations) **or** contact coordinator at interpreting@hbdhb.govt.nz
- Pacific Navigation Services Ltd Phone: 027 971 9199
- services to assist Pacific people to access healthcare (SIA*)*
- Improving the Health of Pacific People in Hawke's Bay - Pacific Health action Plan

**Ministry of Health resources:**

- Ala Mo'ui Pathways to Pacific Health and wellbeing 2014-2018
- Primary Care for Pacific people*:* a Pacific and health systems approach
- Health education resources in Pacific languages (links to a web page where you can download resources)

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## 6 Advance care planning

Quick info:

**Advance Care Planning:**

Advance Care Planning is a voluntary process of discussion and shared planning for future health care. It involves the person who is preparing the plan, and usually involves family/whanau and health care professionals.

**Advance Care Plan:**

An Advance Care Plan is the outcome of Advance Care Planning. It is formulated by the person and sets out their views about care towards the end of their life. It may also include views about medical care and a wide range of other matters. An Advance Care Plan may include an Advance Directive.

**Advance Directive:**

An Advance Directive is a statement a person makes about their medical care in the future and becomes effective if a person ceases to be competent to make decisions for themselves. An Advance Directive is legally binding if made in appropriate circumstances.

**Competency and Advance Care Planning:**

Competent people have the right to make autonomous decisions that as medical professionals we may regard as imprudent, and sometimes such decisions are a reflection of the person's longstanding personality, beliefs or lifestyle. This right is described in the Health and Disability Consumers Rights Acts.

According to ACP - A Guide for the NZ Health Care Workforce - "in the context of ACP, competency relates to an individual's ability to make a decision regarding their own health care (that is, competence at decision-making or decision-capacity). At a minimum, decision making capacity requires the ability to understand and communicate, to reason and deliberate, and the possession of a set of values".

Helpful websites:

- The code of rights
- Advance care planning guide Ministry of Health
- Advance care planning resources

## 7 History

Quick info:

Take a careful history.

Listen to the patient's story and document the time-frame of symptoms. Ask if they have been more forgetful in the last 12 months in ways that have significantly affected their life.

If the time-frame is short (ie hours or days) consider delirium using CAM tool

Areas to discuss:

- impairments in daily functioning - continence and toilet hygiene, bathing, eating and drinking, cooking, shopping, dressing, shaving/hair care, socialising, housework, gardening, transport, managing money, employment
- cognitive symptoms - memory, language, insight, judgement, problem solving, processing speed, concentration and attention, ability to use objects
- behavioural changes - apathy, sleeping problems, restlessness, agitation, calling out, repetitive behaviour, wandering, socially inappropriate behaviour, aggression, disinhibition, changes in eating and drinking behaviour
- psychiatric symptoms - depression, anxiety, affective instability, psychosis, personality change:
  - complete the Geriatric Depression Scale (GDS) or Hamilton Anxiety Scale (HAS)
- neurological symptoms - gait, balance, vision, speech and language, Parkinsonism, upper motor neuron symptoms
- risks - safety in the home, financial mismanagement, wandering, elder abuse, aggression towards others, inappropriate/unwanted sexual behaviour, alcohol and drug misuse, medication adherence issues, dangerous driving, severely compromised self-care.
- emotional stress indicators - loss of interest and motivation, anxiety and sudden mood changes, anger at self as well as dependent older person, feelings of isolation, feelings of guilt, low self-esteem.
- physical - weight loss, frequent colds or infections, backache or headache.

Look for reversible causes:

- psychiatric disease, especially depression (often called pseudodementia)
- mediations that may worsen dementia
- alcohol or drug abuse

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- metabolic causes e.g. hyponatremia, hypercalcaemia, hepatic and renal dysfunction
- structural brain disease eg subdural haematoma

Use the **"o please remember me" mnemonic** - this refers to cognitive deficits which you will be looking for in your history:

- O - orientation
- P - perception
- L - language
- E - executive function
- A - attention and apraxia
- S - speed of processing
- Remember - memory
- Me - personality change & I am a person

## 8 Intellectual disability

Quick info:

People with an intellectual disability are an important subpopulation who were included in the Ministry framework. They develop dementia earlier, particularly people with Down's Syndrome, who can present from age 35 onwards. Best evidence work from the United Kingdom (UK) indicates the need for different assessment tools as they already have cognitive impairment. GPs would need to do:

- dementia screen
- physical examination including assessing vision and hearing

Other complexities are that they may be non-verbal, have challenging behaviour as part of their presentation, often develop epilepsy secondary to the dementia and tend to decline physically.

GPs would then refer onto Te Korowai Whariki ; the intellectual disability and mental health team (Sandy Smith is the nurse); Dr Plesner is the medical officer based at Wellesley Road but employed by Capital and Coast DHB. They would use the Dementia Screening Questionnaire for Individuals with Intellectual Disabilities (DSQIID) and the Adaptive Behaviour Assessment System (ABAS) functional assessment tool.

## 9 Collateral history and investigations

Quick info:

Collateral history:

- assess or arrange collateral history from family, caregivers, or close friends
- consider using General Practitioner Assessment of Cognition (GPCOG) informant interview

Investigations:

- CBC
- TSH
- HbA1c
- electrolytes
- creatinine
- Calcium
- B12
- folate
- ferritin
- LFTs
- CRP
- MCS urine

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**If meets criteria for Computerised Topography (CT) then refer onto appropriate specialist (Older Persons Mental Health, geriatrician or neurologist) who will order CT.**

Selective use of CT brain scanning is recommended in the following situations:

- age less than 60 years
- rapid (over 1-2 months) unexplained decline in cognitive function
- recent and significant head trauma
- unexplained neurological symptoms e.g. new onset severe headache or seizures
- history of cancer
- use of anticoagulants or history of people with bleeding disorder
- history of urinary incontinence and gait disorder early in the course of dementia (suggesting normal pressure hydrocephalus)
- any new localising sign (e.g. hemiparesis or Babinski sign)
- unusual or atypical cognitive symptoms or presentation (e.g. progressive aphasia)
- gait disturbance

## 10 Cognitive assessment and examination

Quick info:

Cognitive assessment and examination

- check baseline weight (nutritional status)
- review investigations
- complete a physical examination including cardiovascular and neurological examination to exclude differential diagnoses

Cognitive assessment tool - suggest using Montreal Cognitive Assessment (MoCA):

- useful for people who are more highly educated
- sensitive to early dementia
- in many languages
- limitations - takes 10-15 minutes to complete
- MoCA scoring and instructions

Other alternatives include:

- GPCOGNZ *(requires password):*
  - validated in general practice setting
  - takes 4-5 minutes
  - available in other languages
  - includes a family/whanau interview
  - developed for general practice screening
  - limitations - not validated extensively in secondary care setting
- Mini-Mental State Examination (MMSE)

## 11 Complicated dementia

Quick info:

There will be situations where the diagnosis is not clear, or the presentation is complicated, for example:

- hallucinations
- complex social situations
- rapid decline
- challenging behavioural or psychological symptoms
- suspected Lewy-Body or frontal temporal dementia
- unexplained neurological symptoms and signs

Referral suggestions:

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- <65 consider neurologist
- if behaviour and/or psychological symptoms (BPSD) atypical features consider Older Person Mental Health referral
- if medical co-morbities in an older person e.g. Parkinson's or frailty consider Geriatrician or Care Cluster team referral
- if pre-existing intellectual disability refer to Te Korowai-Whariki

Resources:

- Lifestyle Advice
- Neurological Foundation of New Zealand - Stay Active
- Physical activity for older people fact sheet

## 12 Uncomplicated dementia

Quick info:

If information gathered indicates cognitive deficits, including memory loss, present for at least 12 months representing a significant decline, impairing day-to-day and/or social function and you have excluded all other differential diagnoses, then dementia is highly likely.

An attempt should be made to sub-catergorise the dementia. Refer to the following pathway nodes:

- Alzheimer's dementia
- vascular dementia
- mixed dementia

**Contacts for advice**

Dr Plesner - HBDHB:

- Elaine.Plesner@hawkesbaydhb.govt.nz
- 06 878 8109

Ian Hosford - HBDHB:

- ian.hosford@hawkesbaydhb.govt.nz
- 06 878 8109

Dr Lucy Fergus - HBDHB:

- lucy.fergus@hawkesbaydhb.govt.nz
- 06 878 8109

Resources:

- Lifestyle Advice
- Neurological Foundation of New Zealand - Stay Active
- Physical activity for older people fact sheet

## 13 Mild cognitive impairment

Quick info:

With mild cognitive impairment (MCI) there is concern regarding change in cognition with minor impairment in social and occupational functioning. Whereas in dementia, the degree of impairment creates significant occupational or functional impairment.

MCI is a "grey area" between normal age-related memory loss and dementia, and is defined as objectively impaired neuropsychological test performance but with **intact activities of daily living**. Most people are able to maintain their cognitive ability at a functioning level throughout their life. Approximately 20% of people aged over 65 years have MCI. For some people, MCI is a precursor to dementia.

A recent meta-analysis reported that the annual conversion rate from mild cognitive impairment to dementia is approximately 5-10% per year. Many people with mild cognitive impairment, however, did not progress to dementia, even with ten years follow up.

Between 3-11% of people aged over 65 years of age and around 33% of people aged over 85 years have dementia.

**Recall in 6 months for review**

Resources:

- Lifestyle Advice
- Neurological Foundation of New Zealand - Stay Active
- Physical activity for older people fact sheet

## 14 No cognitive impairment

Quick info:

Some individuals who report difficulty with memory and have normal cognitive testing may just be aware of their normal changes in memory that occur with aging, others may be experiencing deterioration from superior functioning.

In all cases:

- refer to Lifestyle advice
- discuss enduring power of attorney (EPOA) and advance care planning (ACP)

In some cases:

- consider re-screening in 12 months time

Resources:

- Your Brain Matters
- Neurological Foundation of New Zealand - Stay Active
- Physical activity for older people fact sheet

## 15 Consider referral

Quick info:

Referral suggestions:

- <65 consider neurologist
- if behaviour and/or psychological symptoms (BPSD) atypical features consider Older Person Mental Health referral
- if medical co-morbities in an older person e.g. Parkinson's or frailty consider Geriatrician or Care Cluster team referral
- if pre-existing intellectual disability refer to Te Korowai-Whariki

## 16 Alzheimer's dementia

Quick info:

**DSMIV criteria for Alzheimer's Disease**

1. There are multiple cognitive deficits including both A & B:

- A - memory impairment (impaired ability to learn new information or recall previously learned information)
- B - one or more of the following:
  - aphasia (language disturbance)
  - apraxia (impaired ability to carry out motor abilities despite intact motor function)
  - agnosia (failure to recognise or identify objects despite intact sensory function)
  - disturbance in executive function (i.e. planning, organising, sequencing, abstracting)

2. The cognitive deficits (1A and B) each cause significant impairment in social or occupational functioning and represent a significant decline from the previous level of functioning

3. Delirium has been ruled out

4. The course is characterised by gradual onset and continuing cognitive decline

5. The following has been ruled out:

- other central nervous system conditions that cause progressive deficits in memory and cognition e.g. cerebrovascular disease, Parkinson's disease, Huntington's disease, subdural haematoma, normal pressure hydrocephalus, brain tumour
- systemic conditions that are known to cause dementia e.g. hypothyroidism, vitamin B12 or folate deficiency, niacin deficiency, hypercalcaemia, neurosyphilis, HIV infection

- substance induced conditions

6. The disturbance is not better accounted for by another Axis 1 disorder e.g. major depressive disorder, schizophrenia

## 17 Vascular dementia

Quick info:

**DSMIV criteria for Vascular Dementia**

1. there are multiple cognitive deficits including both A & B:

- A - Memory impairment (impaired ability to learn new information or recall previously learned information)
- B - One or more of the following:
  - aphasia (language disturbance)
  - apraxia (impaired ability to carry out motor abilities despite intact motor function)
  - agnosia (failure to recognise or identify objects despite intact sensory function)
  - disturbance in executive function (i.e. planning, organising, sequencing, abstracting)

2. The cognitive deficits (1A and B) each cause significant impairment in social or occupational functioning and represent a significant decline from the previous level of functioning
3. Focal neurological signs and symptoms (e.g. exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity) or laboratory evidence indicative of a cerobrovascular disease (e.g. multiple infarctions involving cortex and underlying white matter) that are judged to be etiologically related to the disturbance
4. Delirium has been ruled out

**Code based on prominent features**

290.41 - with delirium: if delerium is superimposed on the dementia

290.42- with delusion: if delusions are the predominant feature

290.43- with depressed mood: if depressed mood is the predominant feature

## 18 Mixed dementia

Quick info:

**DSMIV criteria for mixed dementia:**

- has features of both Alzheimer's and vascular disease

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collaborative clinical pathways

OURHEALTH HAWKE'S BAY Whakawateatia

# Dementia Provenance Certificate

## Overview

This document describes the provenance of Hawke's Bay's District Health Board's Dementia Pathway. It was developed in April-May 2015 and first published in July 2015. A review of the Pathway is due in July 2016.

The Collaborative Clinical Pathways programme is one initiative stemming from the *Transform and Sustain* agenda. The main aims of CCP are to:

- → Identify opportunities to improve how health and disability care is planned and delivered within the district to improve patient access to a wider range of health services that are both closer to home and reduce avoidable hospital admissions.
- → Provide health professionals throughout the Hawke's Bay district with best practice, evidence-based clinical pathways that are available at the point of care.

Outcomes we expect to achieve include faster access to definitive care, improved health equity and outcomes, better value from publically-funded resources, and better patient experience through clear expectations, improved access and greater health literacy. These outcomes are clearly aligned to the NZ healthcare *Triple Aim* and *Better, Sooner, More Convenient* policy directions.

## Editorial methodology

This Pathway was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of Medicine editorial methodology. It was developed by individuals with front-line clinical experience (see Contributors section of this document) and has undergone consultation to gain feedback and input from the wider clinical community.

Map of Medicine Pathways are constantly updated in response to new evidence. Continuous evidence searching means that Pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the Pathways through the quarterly publication cycle.

An update to this Pathway is scheduled for 12 months after first publication. However, feedback is welcomed at any time, with important updates added at the earliest opportunity within the Map of Medicine publishing schedule (the third Friday of each month).

## References

This Pathway has been developed according to the Map of Medicine editorial methodology. Its content is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. Feedback on this Pathway was received from stakeholders during a consultation process.


| 1 | American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author. |
|---|---|


## Contributors

**The following individuals contributed to this Pathway:**

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Map editing and facilitation

- Hannes Meyer (Facilitator)
- Helen Morris (Map of Medicine Editor)
- Mary Wills (Head of Strategic Services, HBDHB)

## Disclaimers

**Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay**

It is not the function of the Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.