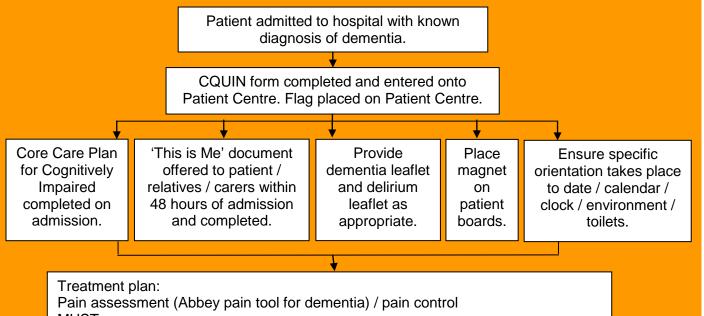


Care pathway for patients admitted with a known diagnosis of dementia



MUST score

SALT / therapy review

Undertake cognitive assessment:

- Baseline AMTS on admission and repeat AMTS pre-discharge.
- Ensure mental capacity / best interests / DOLS principles are followed at all times and clearly documented in patient's healthcare records.
- Refer to OT / Physio if changes in the patient's level of function occur during
- Refer to Integrated Discharge Team.
- Psychiatric Liaison referral if any change in behaviour or sudden onset of confusion.
- All carers should be offered a referral and referred to carers support services -(Carers First or Involve Carers).

Medical teams in conjunction with psychiatric teams to review antipsychotic therapy or request a review within 12 weeks of discharge by GP via eDN

Plan discharge:

- If Dossette box required, ensure pharmacy have advanced notification (minimum 4 hours)
- Liaise with Community Mental Health Services, GP, next-of-kin, care agencies, Social Services
- Liaise with Dementia Services in the community as part of continuing care
- Assess support required for carers:
 - Consider their needs
 - Carers First / Involve Carers
- Ensure appropriate signposting to support services is made.
- Information for patients, carers and family Dementia and Delirium leaflets.

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