Care pathway for patients admitted with a known diagnosis of dementia

Patient admitted to hospital with known diagnosis of dementia.

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Screening assessment completed and entered onto Electronic Patient System.

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- Core Care Plan for Cognitively Impaired completed on admission.
- 'This is Me' document offered to patient/relatives/carers within 48 hours of admission & completed.
- Provide dementia leaflet and delirium leaflet as appropriate.
- Place magnet on patient boards
- Ensure specific orientation takes place to date / calendar / clock / environment / toilets.

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Treatment plan:
- Pain assessment (Abbey Pain Tool for dementia) / pain control
- MUST score
- SALT / therapy review

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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.

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- Refer to Occupational Therapist / Physiotherapist – if changes in the patient's level of function occur during stay.
- 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 – Involve Kent.

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

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Plan discharge:
- If a Dossette box is required, ensure pharmacy have advanced notification (minimum four 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
  - Involve Kent
- Ensure appropriate signposting to support services is made.
- Information for patients, carers and family – Dementia and Delirium leaflets.