



Complete Summary

GUIDELINE TITLE

Dementia.

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 1998. 32 p. [35 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Dementia

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management

CLINICAL SPECIALTY

Geriatrics

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Pharmacists

Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

- To improve the quality of care delivered to patients in long-term care facilities
- To provide long-term care facilities with a systematic approach for assessing and managing patients with dementia, including problems both directly and indirectly related to impaired behavior or cognition.

TARGET POPULATION

Elderly individuals and/or residents of long-term care facilities

INTERVENTIONS AND PRACTICES CONSIDERED

- Recognition and diagnosis of dementia
- Care plan for managing the patient with dementia, including the following categories of approaches:
 - Optimize function and quality of life and capitalize on remaining strengths
 - Address specific causes of impaired cognition, and triggers of behavioral symptoms
 - Manage functional deficits
 - Address psychosocial issues
 - Address socially unacceptable/disruptive behavioral symptoms
 - Address related ethical issues
 - Manage related complications, other existing conditions, or adverse reactions to treatments

MAJOR OUTCOMES CONSIDERED

- Level of functioning:
 - Functional assessment measures such as the Activities of Daily Living portion of the Minimum Data Set, the Barthel Index, or the Functional Activities Questionnaire
 - Cognitive function assessment measures such as the Mini-Mental State Examination, the Blessed Orientation Memory-Concentration Test, or other comparable instruments
- Quality of life
- Complications and functional decline

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer relied on the references listed in the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research [AHCPR]) 1996 guideline titled, "Recognition and Initial Assessment of Alzheimer's Disease and Related Dementias," as well as references identified via additional Medline searches, pertinent journal articles, and knowledge of current practice.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based thinking. The groups were composed of practitioners involved in patient care in the institutional setting. Using pertinent articles and information and a draft outline, the group worked to make a simple, user-friendly guideline that focused on application in the long term care institutional setting.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All AMDA clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long-term care setting.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The steps involved in addressing dementia were summarized by NGC:

I. Recognition

Step 1

1. Determine if the patient has a history of dementia
 - Review the patient's recent and/or past physical, functional, cognitive, and behavioral status
 - Look for evidence of previous diagnoses indicating possible presence of dementia. Diagnoses that may indicate the presence of dementia include
 - Alzheimer's, Huntington's, Parkinson's, Lewy Body or Pick's Disease
 - Progressive supranuclear palsy
 - Multi-infarct dementia
 - Drug, alcohol or anoxic encephalopathy or dementia
 - Pseudodementia
 - Organic brain syndrome
 - Senile memory loss
 - Check current medical orders for treatments and medications (e.g. major tranquilizers, anxiolytics, sedatives/hypnotics, antipsychotics, antidepressants) related to behavioral or cognitive problems
 - Search for evidence of specific impairments or symptoms that may suggest underlying dementia

Step 2

2. Review for current signs and symptoms of dementia
 - Function may be assessed by one of several instruments such as the Activities of Daily Living (ADL) portion of the Minimum Data Set (MDS), The Barthel Index, or the Functional Activities Questionnaire (FAQ). Cognition may be assessed using the Mini-

Mental State Examination (MMSE), Blessed Orientation Memory-Concentration Test or other comparable tests

3. Document the assessment
 - Document information that will enable useful conclusions and intervention and in a manner that communicates that information effectively to all members of the interdisciplinary team

Step 3

4. Confirm the presence of dementia
 - If a screen suggest possible dementia, a more detailed assessment may be indicated
 - A neurological, psychological, or psychiatric assessment may help define a more specific path for subsequent evaluation
5. Consider the appropriateness of a work-up
 - Decide if a work-up should be performed and is appropriate. A work-up may help either to identify his or her symptoms or impairments and help guide management. A work-up may not be indicated if the patient has a terminal or end-stage condition, if the information gained would not change the management course, or if the patient refuses treatment. Always weigh the burden of the work-up against the potential benefits of the treatment.
 - A partial work-up sometimes may be indicated, for example, blood test to identify possible treatable conditions

Step 4

6. Verify that the patient meets the criteria for dementia
 - Patients most likely to have dementia manifest impaired mental status and function.
 - Refer to the diagnostic criteria for dementia due to various causes in the guideline document
 7. Define the risk for developing new or progressive dementia
- II. Diagnosis

Step 5

6. Identify the cause(s) of dementia
 - Determining the causes may help prevent further deterioration of help establish a prognosis

Step 6

2. Identify the patient's strengths and deficits
 - Always review the patient's medications, as these often may contribute to impaired consciousness, increasing confusion, or problematic behaviors
 - Soon after admission or a significant condition change, review and define the patient's functional (eating, bathing, grooming, etc.), cognitive, and social capabilities in various dimensions.

- To ensure objectivity and accuracy as much as possible, choose and consistently use standardized terminology and appropriate evaluation tools

Step 7

3. Define the significance of any abnormalities
 - Try to define the nature, scope, and severity of behaviors and/or cognitive and functional impairments as accurately and as fully possible. Determine the significance of various symptoms to the patient before addressing management

Step 8

4. Identify triggers for disruptive behavior
 - The interdisciplinary team should assess how the environment may affect the patient with dementia. A simple tool or system such as a "behavior log" to record events related to a challenging behavior episode, may be helpful

III. Management

Step 9

4. Generate an interdisciplinary care plan
 - An immediate assessment and interim care plan is necessary on admission to promptly identify and manage the individual with dementia.
 - A care plan for managing the patient with dementia should include the following categories of approaches, discussed in more depth in steps 10 through 15, below and in the guideline document:
 - Optimize function and quality of life and capitalize on remaining strengths
 - Address specific causes of impaired cognition, and triggers of behavioral symptoms
 - Manage functional deficits
 - Address psychosocial issues
 - Address socially unacceptable/disruptive behavioral symptoms
 - Address related ethical issues
 - Manage related complications, other existing conditions, or adverse reactions to treatments

Step 10

2. Optimize function and quality of life and capitalize on remaining strengths
 - Patients with dementia often benefit from efforts to optimize their function and quality of life, independent of managing their problems
3. Optimize function and prevent excess disability

- Excess disability may result from unrecognized or inadequately treated medical conditions, medications, or various emotional, psychological, and environmental factors
- Ensure that appropriate assessments are done prior to initiating drug therapy
- Monitor closely for any adverse reactions and obtain recommended laboratory testing
- Observe the patient closely for possible symptom progression or general decline, which could be due to the medications, progression of the dementia, or other medical conditions of complications
- Assess the patient periodically to determine the need for continued drug therapy

Step 11

4. Address socially unacceptable/disruptive behaviors
 - Generally, environmental interventions should be tried first while efforts are being made to identify causes, unless the behavioral symptom potentially endangers the patient or others
 - If medical treatments are used initially, they later should be supplemented or replaced by other approaches
 - Staff may reduce or eliminate disruptive behaviors by altering approaches to activities such as bathing or altering the patient's environment to suit specific needs and/or concerns

Step 12

5. Manage functional deficits
 - The staff needs to be aware of these deficits and be trained to assist and compensate for them while helping the patient maximize unimpaired function. The approach should maintain dignity and use whatever capacities remain. Train staff to help these patients with Activities of Daily Living without provoking negative reactions
 - Physicians should try to identify patients who are likely to benefit from such interventions and authorize appropriate evaluations and management

Step 13

6. Address pertinent psychosocial and family issues
 - Work closely with families to help them understand the patient's situation and plans for optimizing function and addressing related issues. Try to help them understand how impairments are defined, causes identified, and management chosen.
 - Obtain and use some of the many resources available on these issues. The Alzheimer's Association has several publications that may be used as a starting point.
 - Physicians should help reinforce for families the realities of the patient's underlying condition, reassure them about the

appropriateness of selected management, and ensure that treatable medical conditions have been identified and addressed, as appropriate

Step 14

7. Address related ethical issues
 - Ethical issues include: defining decision-making capacity and identifying situations that require informal and formal direct or substitute decision making, addressing situations related to everyday life (e.g., patient choice, sexual expression, and socially questionable behaviors), and anticipating and managing circumstances related to possible limitations on medical interventions such as resuscitation and artificial nutrition and hydration
 - To help in decision making, key facility staff should be familiar with relevant federal and state statutes and regulations and use a consistent, well coordinated process for managing ethical issues and documenting patient wishes
 - Whenever possible, involve the patient in decisions, as even partial decision-making capacity may suffice

Step 15

8. Manage risks and complications related to dementia, other conditions, or treatments
 - The nursing staff and physician should anticipate the likely risks and complications for treating dementia, and be prepared to establish a plan to address them as they arise.

IV. Monitoring

Step 16

8. Monitor the patient's progress and adjust management accordingly.
 - Monitor the patient's progress periodically, using the same methods and criteria as used for initial problem recognition and definition. Staff should be as objective as possible and use consistent terminology and designated assessment tools and techniques.
 - The physician should periodically review the patient's condition and risk factors with the nursing staff

CLINICAL ALGORITHM(S)

A clinical algorithm is provided that summarizes the steps involved in addressing dementia, including recognition, diagnosis, management, and monitoring the condition.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based thinking. Scientific research in the long-term care setting is scarce, and the majority of recommendations are based on the expert opinion of practitioners in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Expected process improvements: This guideline should help produce the following process improvements:

- Identify individuals at risk for new or progressive dementia
- Make appropriate changes in the individual's environment
- Define the pathologic basis and nature of functional, cognitive, emotional, and behavioral changes
- Respond appropriately to a patient's changing needs
- Identify and manage potential sources of excess disability
- Minimize complications and functional decline
- Manage dementia symptoms, consequences, and complications effectively and appropriately

Anticipated care outcomes: As a result of the above, the following patient-related outcomes may be anticipated:

- Reduced excess disability
- Maintained or improved function and quality of life
- Reduced complications and negative consequences of the condition or its management
- Optimum resource use

POTENTIAL HARMS

The medical treatment of behavior and impaired cognition may cause any of the following adverse effects:

- Adverse reactions to medication
- Drug interactions
- Worsening of disruptive or socially unacceptable behavior
- Increased lethargy or confusion
- Cardiac arrhythmias
- Orthostatic hypotension

QUALIFYING STATEMENTS

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This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical

condition of a particular patient. The American Medical Directors Association and the American Health Care Association, their heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

- I. Recognition
 - Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG
- II. Assessment
 - Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes
- III. Implementation
 - Identify and document how each step of the CPG will be carried out and develop an implementation timetable
 - Identify individual responsible for each step of the CPG
 - Identify support systems that impact the direct care
 - Educate and train appropriate individuals in specific CPG implementation and then implement the CPG
- IV. Monitoring
 - Evaluate performance based on relevant indicators and identify areas for improvement
 - Evaluate the predefined performance measures and obtain and provide feedback

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 1998. 32 p. [35 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (reviewed 2003)

GUIDELINE DEVELOPER(S)

American Health Care Association - Professional Association
American Medical Directors Association - Professional Association

SOURCE(S) OF FUNDING

Funding was provided by educational grants through Bayer Pharmaceuticals, Eisai, Inc./Pfizer, Eli Lilly & Company, Merck & Company, Novartis Pharmaceuticals, Parke-Davis, and Wyeth-Ayerst Laboratories.

GUIDELINE COMMITTEE

Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Members: Sarah Greene Burger; Thomas J. Cali, PharmD; Laura Fain, RN; Janet George, RN; Janet M. Harrington, MSN; Carolyn Harris, RN; Keith Knapp; Steven Levenson, MD, CMD; Geri Mendelson, RN, M.Ed., MA; Reg Warren, PhD; Christine Williams, M.Ed.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

According to the guideline developer, this guideline was reviewed by the original Steering Committee and is still considered to be current as of Jan 2004. This review involved new literature searches of electronic databases followed by expert

committee review of new evidence that has emerged since the original publication date.

GUIDELINE AVAILABILITY

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following companion documents are available:

- Guideline implementation: clinical practice guidelines. Columbia, MD: American Medical Directors Association, 1998, 28 p.
- Altered mental states. Columbia, MD: American Medical Directors Association, 1998, 20 p.

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com.

The guideline developers recommend that the guideline should be used in conjunction with the "Nursing Facility Minimum Data Set and Resident Assessment Instrument" (MDS/RAI), as well as with appropriate "Resident Assessment Protocols" (RAPs).

These tools are available from the U.S. Health Care Financing Administration (HCFA), 7500 Security Boulevard, Baltimore, Maryland 21244; Telephone: (410) 786-3000; Web site: www.hcfa.gov.

NGC STATUS

This summary was completed by ECRI on July 12, 1999. The information was verified by the American Medical Directors Association as of August 8, 1999.

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