NHS
Rotherham
Clinical Commissioning Group

MAKING A DIAGNOSIS OF ESTABLISHED DEMENTIA WITHIN THE CARE HOME SETTING

A diagnosis of dementia is usually made within memory services. However, some care home residents presenting with advanced dementia may never have had a formal diagnosis. In these cases a referral to memory services is rarely desirable as it is likely to be distressing for the individual and is usually unnecessary.[1]

People with advanced dementia, their families and the staff caring for them, will still benefit from a formal diagnosis. It will enable the person access to appropriate care to meet their needs and prompt staff to consider MCA and DOLs issues where appropriate.

A diagnosis of dementia can be made with a high degree of certainty if ***all five*** criteria listed below are met: ✓

1. Functional impairment

The person is ***no longer fully independent*** in relation to basic activities of daily living, washing, dressing, feeding and attending to own continence needs. The requirement of prompting or supervision of staff constitutes a loss of full independence. ☐

2. Cognitive impairment – 6 CIT assessment

Question	Scoring	Score achieved
1. What year is it?	Correct – 0 points, incorrect – 4 points	
2. What month is it?	Correct – 0 points; Incorrect – 3 points	
3. Give an address phase to remember with 5 components e.g. John, Smith, 42, High St, Wakefield		
4. About what time is it (within 1 hour)	Correct – 0 points; Incorrect – 3 points	
5. Count backwards from 20-1	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
6. Say the months of the year in reverse	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
7. Repeat address phase	No errors – 0 points; score 2 points for every component wrong e.g. 3 errors, 6 points	
TOTAL SCORE:		

6 CIT scores: 7 and below normal; ***8 and above indicate impairment***.

Assessment tools other than 6CIT can be used, if used does score indicate impairment Y/N? **Y/N**

NB. Scores obtained in this patient group would be expected to be at the severe end of scale and for some patients their cognitive impairment will be of such severity that they cannot undertake the assessment. ☐

3. Corroborating History

History of gradual cognitive decline (typically for the last few years) is confirmed by care staff, relatives and medical records. Staff/relatives confirm that in their opinion the patient ***consistently demonstrates both functional and cognitive impairment***. ☐

4. Investigations

Dementia screening ***bloods are normal*** (where clinically appropriate and patient consents to bloods – FBC, U&E, LFT, TFT, Ca, folate, B12, HbA1c, lipids, CRP). If patient lacks capacity to consent to bloods, a best interest decision must be made and documented accordingly.

NB. If intracranial pathology (e.g. subdural haematoma, cerebral tumour) is suspected, referral for a brain scan may be appropriate. Otherwise where dementia is advanced, differential diagnosis is unlikely to affect patient management & a brain scan is unnecessary. ☐

5. Exclusion Criteria

There is ***no acute underlying cause to explain confusion*** i.e. delirium (acute confusional state) is excluded (MSU/CXR)
Mood disorder or psychosis also excluded. ☐

A diagnosis of dementia can be made with a high degree of certainty if ***all five*** criteria listed above are met. ✓

[1] "Guidance for Commissioners of Dementia Services", published by the Joint Commissioning Panel for Mental Health states that patients who present with more advanced symptoms of dementia can be diagnosed and managed by Primary care with or without CMHT help. www.jcpmh.info

With thanks to: Dr Graeme Finlayson, Bradford District Care NHS FT and Dr Subha Thiyagesh, South West Yorkshire Partnership NHS FT for sharing their protocols on which this tool is based and North Kirklees CCG for sharing the tool.