DiADeM Tool

Diagnosing Advanced Dementia Mandate (for care home setting)

A diagnosis of dementia is usually made within memory services. Some care home residents with advanced dementia have never had a formal diagnosis. In these cases a referral to memory services is rarely desirable. It is likely to be distressing for the individual and is usually unnecessary¹.

People with advanced dementia, their families and staff caring for them, still benefit from a formal diagnosis. It enables access to appropriate care to meet individual needs and prompts staff to consider MCA and DOLs issues where appropriate.



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.

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?

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.

Y / N

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.



Investigations

Dementia screening *bloods are normal* (where clinically appropriate and patient consents to bloods). 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.



Exclusion Criteria

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

A diagnosis of dementia can be made with a high degree of certainty if **all five** criteria listed above are met. If dementia is confirmed, please add this patient to your GP practice dementia register using the recommended <u>codes</u>. Consent should be sought for this from the person themselves or a family carer where the individual lacks capacity.

NB. Where a diagnosis of dementia is confirmed, a copy of the completed DiADeM tool should be saved into the patient's notes as it forms part of their clinical record.

¹ "Guidance for Commissioners of Dementia Services", published by The Joint Commissioning Panel for Mental Health states patients who present with advanced symptoms of dementia can be diagnosed and managed by primary care with or without CMHT help. <u>www.jcpmh.info</u>. Thanks to: Dr Graeme Finlayson, Bradford District Care NHS FT and Dr Subha Thiyagesh, South West Yorkshire Partnership NHS FT.

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Disclaimer: Healthcare professionals must make their own decisions about assessment and care on a case-by case basis, using their clinical judgement, knowledge and expertise and in consultation with other key staff and family carers. This tool is not intended to replace physician judgment in assessing individual patients. Ratification of this tool for local use should follow the usual process within all affected organisation(s). Departure from local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken. The authors of this tool accept no responsibility for any inaccuracies or information perceived as misleading. The authors assume no legal liability or responsibility for the accuracy, completeness or clinical efficacy of this guidance.

