Diagnosis and treatment of dementia and Mild Cognitive Impairment

Start

What is a care pathway?

This care pathway is a visual representation, in the form of a pathway, of the recommendations developed in the guideline "Diagnosis and treatment of dementia and Mild Cognitive Impairment", to facilitate the reading and implementation. The objective of the care pathway is, indeed, to provide a methodology for the care of a defined group of people over a defined period of time.
According to the definition of the European Pathway Association (EPA), all key elements for providing evidence-based care (EBM, Evidence Based Medicine) have been included in the elaboration of the care pathway, also taking into consideration values and preferences of individuals and their families/caregivers, including elements useful to facilitate communication and interaction between professionals and people and their families/caregivers in the coordination of diagnosis and treatment process, and defining roles and sequence of activities and impact of necessary and appropriate resources to carry out each step.

How do you interact with this care pathway?

This care pathway is structured as an interactive pdf containing navigable diagrams via clickable icons, which refer to information about the point being explored. Where a page number or pages are indicated, reference is made to the guideline "Diagnosis and treatment of dementia and Mild Cognitive Impairment".

Legend of icons

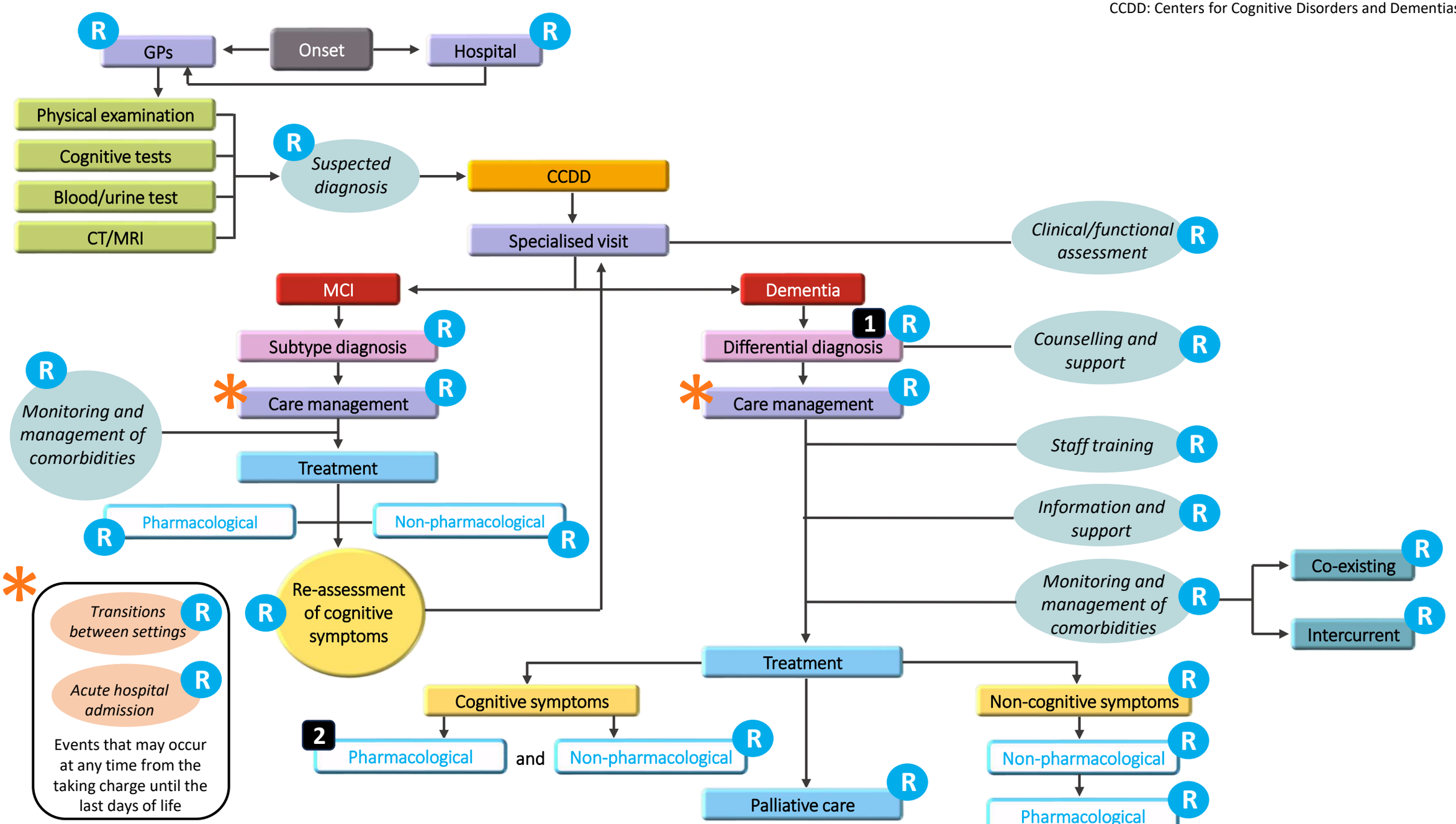
R
Recommendation
Corresponding recommendations are given

1 2
Tables or expansion
of a specific branch of the flowchart

What does this care pathway contain? Click on the button to start

Care pathway

GPs: General Practioners
MCI: Mild Cognitive Impairment
CCDD: Centers for Cognitive Disorders and Dementias



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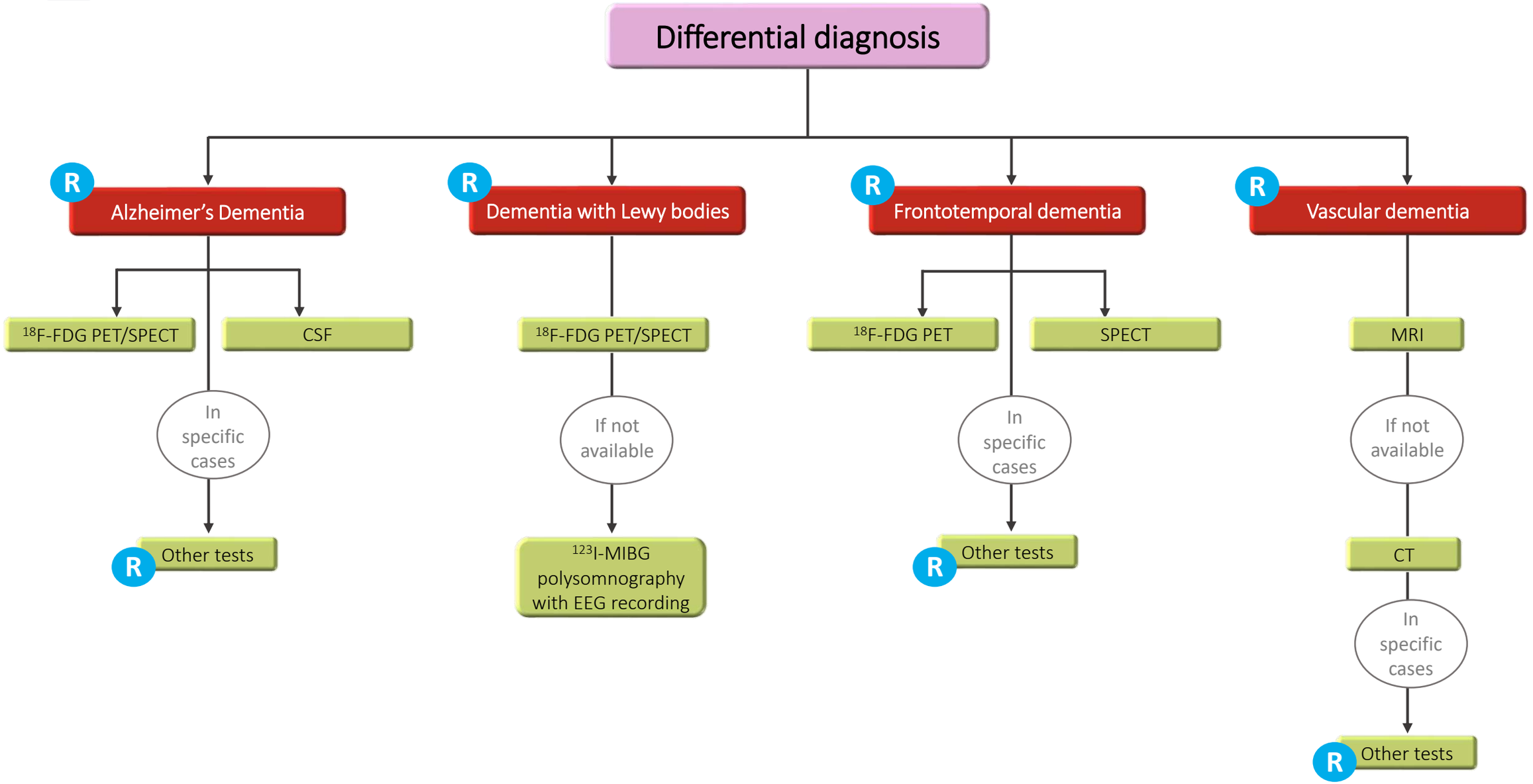
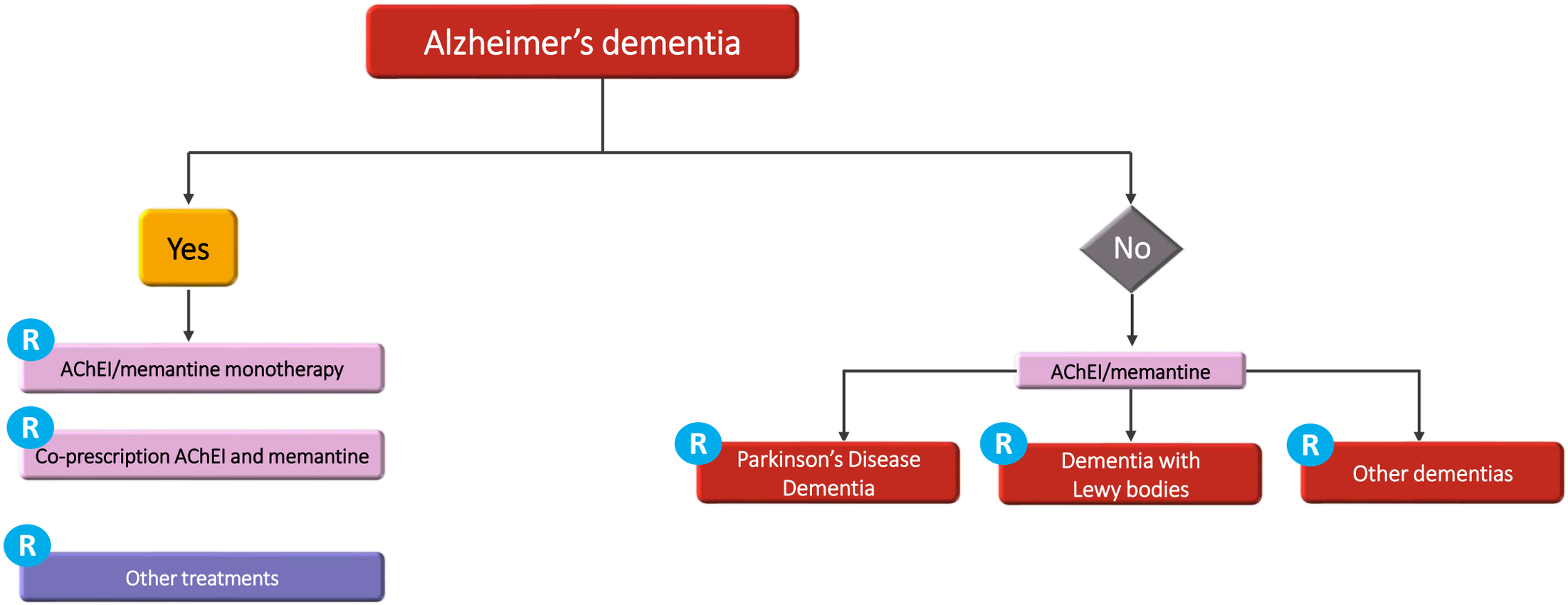
1



Back to main flowchart

2



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Initial assessment in a non-specialist, primary care setting

1

At the initial assessment take a history (including cognitive, behavioural and psychological symptoms, and the impact symptoms have on their daily life):

- from the person with suspected cognitive decline and
- if possible, from someone who knows the person well (such as a family member).

STRONG IN FAVOR

2

If cognitive decline is still suspected after initial assessment:

- conduct a physical examination and
- undertake appropriate blood and urine tests to exclude reversible causes of cognitive decline and
- use cognitive testing and
- prescribe brain CT and/or MRI to exclude secondary causes of cognitive decline.

STRONG IN FAVOR

3

When using cognitive testing to assess people with dementia or someone who knows the person well (such as a family member), use a validated brief structured cognitive instrument such as:

- 10-point cognitive screener (10-CS)
- 6-item cognitive impairment test (6CIT)
- 6-item screener (6-IS)
- Memory Impairment Screen (MIS)
- Mini-Cog
- Test Your Memory (TYM)
- General Practitioner Assessment of Cognition (GPCOG)

STRONG IN FAVOR

4

Do not rule out cognitive decline solely because the person has a normal score on a cognitive instrument and plan a monitoring of cognitive functions in time.

STRONG AGAINST

7

For more guidance on assessing for dementia in people with learning disabilities, see Table 6.

STRONG IN FAVOR

Drugs that may cause or worsen cognitive decline

31

Be aware that some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment

WEAK IN FAVOR

32

Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:

- when assessing whether to refer a person with suspected dementia for diagnosis
- during medication reviews with people living with dementia

WEAK IN FAVOR

33

Consider that there are validated tools for assessing anticholinergic burden (for example, the Anticholinergic Cognitive Burden Scale).

WEAK IN FAVOR

34

For guidance on carrying out medication reviews, see the indications reported in Table 7.

STRONG IN FAVOR

Back to main flowchart

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WEAK IN FAVOR

34

For guidance on carrying out medication reviews, see the indications reported in Table 7.

STRONG IN FAVOR

Distinguishing dementia from delirium or delirium with dementia

35

For people who are in hospital and have cognitive impairment with an unknown cause, consider using one of the following to find out whether they have delirium or delirium superimposed on dementia, compared with dementia alone:

- the long confusion assessment method (CAM)
- 4-A's Test (4AT).

WEAK IN FAVOR

36

Do not use standardised instruments (including cognitive instruments) alone to distinguish delirium from delirium superimposed on dementia.

STRONG AGAINST

37

If it is not possible to tell whether a person has delirium, dementia, or delirium superimposed on dementia, treat for delirium first. For guidance on the identification and treatment of delirium, see Table 6.

STRONG IN FAVOR

Back to main flowchart

Initial assessment in a non-specialist, primary care setting

5

Refer the person to a specialist dementia diagnostic service (Centre for Cognitive Disorders and Dementias) if:

- reversible causes of cognitive decline (including delirium, depression, sensory impairment [such as sight or hearing loss] or cognitive impairment from medicines associated with increased anticholinergic burden) have been investigated and
- dementia is still suspected.

STRONG IN FAVOR

6

If the person has suspected rapidly progressive dementia, refer them to a neurological service with access to tests (including cerebrospinal fluid examination) for Creutzfeldt-Jakob disease and similar conditions.

STRONG IN FAVOR

Back to main flowchart

Diagnosis of Mild Cognitive Impairment in a specialist care setting

28

Offer a neuropsychological assessment using validated neuropsychological tests, including specific tests for episodic memory, as part of the diagnostic process for MCI and its subtypes.

STRONG IN FAVOR

29

Do not offer biomarkers for the diagnosis and differential diagnosis of MCI.

STRONG AGAINST

Back to main flowchart

Post diagnosis review for people living with dementia

46

After a person is diagnosed with dementia or Mild Cognitive Impairment, ensure they and their carers have access to specialist multidisciplinary dementia services (Centres for Cognitive Disorders and Dementias, CCDDs).

STRONG IN FAVOR

47

Specialist multidisciplinary dementia services (Centres for Cognitive Disorders and Dementias, CCDDs) should offer a choice of flexible access or prescheduled monitoring appointments.

WEAK IN FAVOR

48

General practitioners, when visiting people living with dementia or Mild Cognitive Impairment, or their carers, should assess for any emerging dementia-related needs and ask them if they need any more support.

WEAK IN FAVOR

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Further tests for frontotemporal dementia

24

Be aware that frontotemporal dementia has a genetic cause in some people.

WEAK IN FAVOR

Drugs that may cause or worsen cognitive decline

32

Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:

- when assessing whether to refer a person with suspected dementia for diagnosis
- during medication reviews with people living with dementia

WEAK IN FAVOR

Management strategies for people living with dementia/Mild Cognitive Impairment and co-existing physical long-term conditions

69

For people with dementia or Mild Cognitive Impairment and at least one chronic physical comorbidity, when managing comorbidities (e.g., hypertension, cardiovascular diseases, type 2 diabetes, sensory deficits, urinary tract conditions) refer to the best practices for each condition, considering each person's specific clinical conditions and except in case the administration of standard care could cause more harm that benefit (see Table 6).

STRONG IN FAVOR

Back to main flowchart

Acetylcholinesterase inhibitors and memantine in people with Mild Cognitive Impairment

84

Do not offer AChE inhibitors (donepezil, galantamine, and rivastigmine) and memantine for the treatment of Mild Cognitive Impairment.

STRONG AGAINST

Biological drugs in people with Alzheimer's dementia and Mild Cognitive Impairment

85

Do not offer monoclonal antibodies against the different forms of amyloid β as a treatment for Alzheimer's dementia or Mild Cognitive Impairment*.

STRONG AGAINST

*Three panel members abstained from voting recommendation 85

Repurposing of pharmacological interventions

86

Do not offer the following treatments specifically to slow the progression of Alzheimer's disease or to slow or stop the conversion from Mild Cognitive Impairment to dementia:

- antidiabetic drugs;
- antihypertensive drugs;
- statins;
- non-steroidal anti-inflammatory drugs (NSAIDs), including acetylsalicylic acid.

STRONG AGAINST

Back to main flowchart

Non-pharmacological interventions for cognitive symptoms in Mild Cognitive Impairment

118

Do not consider acupuncture to treat cognitive symptoms in people with Mild Cognitive Impairment.

WEAK AGAINST

119

Do not offer aromatherapy to treat cognitive symptoms in people with Mild Cognitive Impairment.

STRONG AGAINST

120

Consider art therapy to treat cognitive symptoms and improve depressive symptoms and anxiety in people with Mild Cognitive Impairment.

WEAK IN FAVOR

121

Consider physical exercise to treat cognitive symptoms and promote independence in people with Mild Cognitive Impairment.

WEAK IN FAVOR

122

Consider dance to treat cognitive symptoms and improve depressive symptoms in people with Mild Cognitive Impairment.

WEAK IN FAVOR

123

Consider games (e.g., cards, board games) to treat cognitive symptoms and improve depressive symptoms in people with Mild Cognitive Impairment.

WEAK IN FAVOR

124

Consider cognitive rehabilitation to treat cognitive symptoms and promote independence in people with Mild Cognitive Impairment.

WEAK IN FAVOR

125

Offer cognitive training to treat cognitive symptoms in people with Mild Cognitive Impairment.

STRONG IN FAVOR

126

Do not offer specific formulas, including combinations of supplements containing omega 3 fatty acids, phospholipids, choline, uridine monophosphate, vitamin E, vitamin C, vitamin B6, vitamin B12, folic acid and selenium, supplements based on combinations of fatty acids polyunsaturated, such as omega-3 and omega-6, and monounsaturated and multivitamins and/or antioxidants supplements to treat cognitive symptoms in people with Mild Cognitive Impairment in absence of documented deficiencies.

STRONG AGAINST

127

Do not offer ginkgo biloba, ginseng, omega 3, resveratrol or other antioxidants to treat cognitive symptoms in people with Mild Cognitive Impairment.

STRONG AGAINST

128

Do not offer vitamin B and vitamin E supplements to treat cognitive symptoms in people with Mild Cognitive Impairment in absence of documented deficiencies.

STRONG AGAINST

129

Do not offer ketogenic dietary interventions to treat cognitive symptoms in people with Mild Cognitive Impairment.

STRONG AGAINST

130

Do not consider transcranial stimulation interventions to treat people with Mild Cognitive Impairment.

WEAK AGAINST

131

Consider music therapy to treat cognitive symptoms and improve depressive symptoms and anxiety in people with Mild Cognitive Impairment.

WEAK IN FAVOR

Back to main flowchart

Diagnosis of Mild Cognitive Impairment in a specialist care setting

30

Offer people with a diagnosis of MCI regular neuropsychological assessments over time to monitor possible changes in cognitive functions.

STRONG IN FAVOR

Back to main flowchart

Non-pharmacological interventions for cognitive symptoms in dementia

100
Do not offer acupuncture to treat cognitive symptoms in dementia.

STRONG AGAINST

101
Consider aerobic physical exercise to treat cognitive symptoms in people with mild Alzheimer's dementia.

WEAK IN FAVOR

102
Consider non-aerobic physical exercise to treat cognitive symptoms in people with mild to moderate dementia.

WEAK IN FAVOR

103
Consider the combination of aerobic and non-aerobic physical exercise to treat cognitive symptoms in people with moderate dementia.

WEAK IN FAVOR

104
Do not offer specific formulas, including the combinations of supplements containing omega 3 fatty acids, phospholipids, choline, uridine monophosphate, vitamin E, vitamin C, vitamin B6, vitamin B12, folic acid, and selenium to treat cognitive symptoms in people with dementia in absence of documented deficiencies.

STRONG AGAINST

105
Do not offer vitamin E and folic acid supplements to treat cognitive symptoms in people with dementia in absence of documented deficiencies.

STRONG AGAINST

106
Do not offer ginseng, ginkgo biloba, huperzine A, and other herbal supplements, antioxidants such as omega-3, selenium and sodium oligomannate to treat cognitive symptoms in people with dementia.

STRONG AGAINST

107
Do not offer ketogenic dietary interventions to treat cognitive symptoms in people with dementia.

STRONG AGAINST

108
Do not offer light therapy to treat cognitive symptoms in people with moderate to severe dementia.

STRONG AGAINST

109
Consider music therapy to treat cognitive symptoms in people with mild to severe dementia.

WEAK IN FAVOR

110
Do not offer psychotherapy to treat cognitive symptoms in people with mild to moderate dementia.

STRONG AGAINST

111
Consider reminiscence therapy to treat cognitive symptoms in people with moderate dementia.

WEAK IN FAVOR

112
Do not offer therapeutic robots to treat cognitive symptoms in people with dementia.

STRONG AGAINST

113
Consider occupational therapy to support functional abilities in people with mild to moderate dementia.

WEAK IN FAVOR

114
Consider cognitive rehabilitation to support functional abilities in people with mild to moderate dementia.

WEAK IN FAVOR

115
Offer cognitive stimulation to treat cognitive symptoms in people with mild to moderate dementia.

STRONG IN FAVOR

116
Consider cognitive training to treat cognitive symptoms in people with mild Alzheimer's dementia.

WEAK IN FAVOR

117
Offer a range of activities to promote wellbeing and autonomy that are tailored to the person's individual preferences.

STRONG IN FAVOR

Back to main flowchart

Diagnosis of dementia in specialist settings

8

Diagnose a dementia subtype (if possible) if initial specialist assessment (including an appropriate neurological examination and cognitive testing) confirms cognitive decline and reversible causes have been ruled out.

WEAK IN FAVOR

10

Offer neuropsychological testing with validated neuropsychological tests as an essential part of the diagnostic process for dementia and dementia subtypes.

STRONG IN FAVOR

11

Use validated criteria to guide clinical judgement when diagnosing dementia subtypes, such as:

- International consensus criteria for dementia with Lewy bodies
- International FTD criteria for frontotemporal dementia (primary non-fluent aphasia and semantic dementia)
- International Frontotemporal Dementia Consortium criteria for behavioural variant frontotemporal dementia
- NINDS-AIREN criteria for vascular dementia
- NIA-AA criteria for Alzheimer's disease
- Movement Disorders Society criteria for Parkinson's disease dementia
- WHO and International criteria for Creutzfeldt-Jakob disease.

STRONG IN FAVOR

12

Offer structural imaging to rule out reversible causes of cognitive decline and to assist with subtype diagnosis, unless dementia is well established, and the subtype diagnosis is clear.

STRONG IN FAVOR

13

Only consider further diagnostic tests if:

- it would help to diagnose a dementia subtype and
- knowing more about the dementia subtype would change management.

WEAK IN FAVOR

Back to main flowchart

Care planning, review and coordination

40

Provide people living with dementia with a single named health or social care professional who is responsible for their Personalized care plan (PAI) within an integrated care pathway. For further indications on how to organize a PAI, see:

- indication 6 from the document "National Guidance for the Clinical Governance of Dementia"[1] issued by the National Committee for Dementia;
- the document "National Guidance for the definition of Integrated Care Pathways for dementia"[2] issued by the National Committee for Dementia.

STRONG IN FAVOR

41

Named professionals should:

- arrange an initial assessment of the person's needs, which should be face to face, if possible.
- provide information about available services and how to access them.
- involve the person's family members or carers (as appropriate) in support and decision-making;
- give special consideration to the views of people who do not have capacity to make decisions about their care, in line with the document "National Guidance for the Clinical Governance of Dementia" issued by the National Committee for Dementia;
- ensure that people are aware of their rights to and the availability of local advocacy services, in line with the document "National Guidance for the Clinical Governance of Dementia" issued by the National Committee for Dementia;
- develop a care and support plan, and:
  - agree and review it with the involvement of the person, their family members or carers (as appropriate) and relevant professionals;
  - specify in the plan when and how often it will be reviewed;
  - evaluate and record progress towards the objectives at each review;
  - ensure it covers the management of any comorbidities;
  - provide a copy of the plan to the person and their family members or carers (as appropriate).

WEAK IN FAVOR

42

When developing care and support plans and advance care and support plans, request consent to transfer these to different care settings as needed.

STRONG IN FAVOR

43

Service providers should ensure that information (such as care and support plans and advance care and support plans) can be easily transferred between different care settings (for example home, inpatient, community, and residential care).

WEAK IN FAVOR

44

Staff delivering care and support should maximise continuity and consistency of care. Ensure that relevant information is shared and recorded in the person's care and support plan.

WEAK IN FAVOR

45

Service providers should design services to be accessible to as many people living with dementia as possible, including:

- people who do not have a carer or whose carer cannot support them on their own;
- people who do not have access to affordable transport, or find transport difficult to use;
- people who have responsibilities (such as work, children or being a carer themselves);
- people with learning disabilities, sensory impairment (such as sight or hearing loss) or physical disabilities;
- people who may be less likely to access health and social care services, such as people from minorities*.

WEAK IN FAVOR

Post diagnosis review for people living with dementia

46

After a person is diagnosed with dementia or Mild Cognitive Impairment, ensure they and their carers have access to specialist multidisciplinary dementia services (Centres for Cognitive Disorders and Dementias, CCDDs).

STRONG IN FAVOR

47

Specialist multidisciplinary dementia services (Centres for Cognitive Disorders and Dementias, CCDDs) should offer a choice of flexible access or prescheduled monitoring appointments.

WEAK IN FAVOR

48

General practitioners, when visiting people living with dementia or Mild Cognitive Impairment, or their carers, should assess for any emerging dementia-related needs and ask them if they need any more support.

WEAK IN FAVOR

[1] Available at: https://www.iss.it/documents/20126/5783571/Raccomandazioni+per+la+governance+e+la+clinica+nel+settore+delle+demenze.pdf/dbf0d6d5-6360-41d9-aa51-74b18f62dad8?t=1626171914860 (Last visited: 30/08/2023)

[2] Available at: https://www.iss.it/documents/20126/5783571/Testo+Linee+di+indirizzo+Nazionali+sui+Percorsi+Diagnostico+Terapeutici+Assistenziali+%28PDTA%29+per+le+demenze.pdf/d5123f6a-2161-6c42-5377-8796cce29fe0?t=1626170681347 (Last visited: 30/08/2023)

* minorities are hereby defined as indicated by the Italian Ministry of domestic affairs: https://www.interno.gov.it/it/temi/cittadinanza-e-altri-diritti-civili/minoranze (Last visited: 30/08/2023)

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Palliative care

157

From diagnosis, offer people living with dementia flexible, needs-based palliative care that takes into account how unpredictable dementia progression can be.

STRONG IN FAVOR

158

Encourage and support people living with dementia to eat and drink, taking into account their nutritional needs.

STRONG IN FAVOR

159

Consider involving a speech and language therapist if there are concerns about a person's safety when eating and drinking.

WEAK IN FAVOR

160

Do not routinely use enteral feeding in people living with severe dementia, unless indicated for a potentially reversible comorbidity.

STRONG AGAINST

161

When thinking about admission to hospital for a person living with severe dementia, carry out an assessment that balances their current medical needs with the additional harms they may face in hospital, for example:

- disorientation;
- a longer length of stay;
- increased mortality;
- increased morbidity on discharge;
- delirium;
- the effects of being in an impersonal or institutional environment.

STRONG IN FAVOR

162

For people living with dementia who are approaching the end of life, use an anticipatory healthcare planning process (see recommendation 41 on advance care planning). Involve the person and their family members or carers (as appropriate) as far as possible, and use the principles of best-interest decision making if the person cannot make decisions about their own care.

STRONG IN FAVOR

163

For standards and measures on palliative care, see Table 10.

STRONG IN FAVOR

164

For guidance on care for people in the last days of life, see Table 11.

STRONG IN FAVOR

165

For guidance, on best interest decision-making, see Table 12.

STRONG IN FAVOR

166

When thinking about admission to hospital for a person living with dementia, take into account:

- any advance care and support plans;
- the value of keeping them in a familiar environment.

WEAK IN FAVOR

167

Consider using a structured tool to assess the likes and dislikes, routines and personal history of a person living with dementia.

WEAK IN FAVOR

Back to main flowchart

Drugs that may cause or worsen cognitive decline

31

Be aware that some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment

WEAK IN FAVOR

32

Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:

- when assessing whether to refer a person with suspected dementia for diagnosis
- during medication reviews with people living with dementia

WEAK IN FAVOR

33

Consider that there are validated tools for assessing anticholinergic burden (for example, the Anticholinergic Cognitive Burden Scale).

WEAK IN FAVOR

34

For guidance on carrying out medication reviews, see the indications reported in Table 7.

WEAK IN FAVOR

Back to main flowchart

Pre-, peri- and post-diagnostic counselling

38

Consider offering people with dementia and their caregivers peri- and post-diagnostic counselling targeted to the specific conditions of each patient (including symptom severity).

WEAK IN FAVOR

39

For the communication of diagnosis and post-diagnostic support see the section "Communication of the diagnosis of dementia" of the document "Recommendations for the governance and clinical management in dementia“[1] issued by the National Committee for dementia.

STRONG IN FAVOR

[1] Available at: https://www.iss.it/documents/20126/5783571/Raccomandazioni+per+la+governance+e+la+clinica+nel+settore+delle+demenze.pdf/dbf0d6d5-6360-41d9-aa51-74b18f62dad8?t=1626171914860 (Last visited: 30/08/2023)

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Care setting transitions

70

When managing transition between care settings consider that:

- In case of hospitalisation, a comprehensive geriatric assessment should be performed on people with dementia on admission to hospital, and any care plan should be shared with the admitting team, while, at discharge, continuity of care should be ensured;
- the NICE guideline on transition between inpatient mental health settings and community or care home settings.

STRONG IN FAVOR

71

For guidance on medicine optimisation and reconciliation, see Table 8. Follow the principles in these guidelines for transitions between other settings (for example from home to a care home or respite care).

STRONG IN FAVOR

Back to main flowchart

Caring for people living with dementia who are admitted to hospital

154

Be aware of the increased risk of delirium in people living with dementia who are admitted to hospital. See Table 6 for interventions to identify and treat delirium.

WEAK IN FAVOR

155

In case of people with dementia admitted to hospital, ensure the availability of a multidimensional assessment, the monitoring and review of all pharmacological treatments, and the reconciliation of pharmacological treatment plans, and any possible issues related to safety, considering the involvement of a pharmacist or pharmacologist. For further indications on the optimization and reconciliation of pharmacological treatments see Table 7 and the recommendation on the reconciliation of pharmacological treatments provided by the Ministry of Health[1].

STRONG IN FAVOR

156

Consider the involvement of a multidisciplinary team in case of people with dementia admitted to hospital to ensure personalized interventions based on a multidimensional assessment of their overall health, including their nutritional status.

WEAK IN FAVOR

[1] Ministero della Salute - D.G. Programmazione sanitaria. Raccomandazione n. 17 - Riconciliazione della terapia farmacologica. Available at: https://www.salute.gov.it/portale/sicurezzaCure/dettaglioPubblicazioniSicurezzaCure.jsp?id=2354 (Last visited: 30/08/2023).

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Staff training

49

Care and support providers should provide all staff with appropriate training in person-centred and outcome-focused care for people living with dementia, which should include:

- understanding the signs and symptoms of dementia, and the changes to expect as the condition progresses;
- understanding the person as an individual, and their life story;
- respecting the person's individual identity, sexuality, and culture;
- understanding the needs of the person and their family members or carers.

WEAK IN FAVOR

50

Care providers should provide additional face-to-face training and mentoring to staff who deliver care and support to people living with dementia. This should include:

- understanding the organisation's model of dementia care and how it provides care;
- initial training on understanding, reacting to and helping people living with dementia who experience agitation, aggression, pain, or other behaviours indicating distress;
- follow-up sessions where staff can receive additional feedback and discuss particular situations;
- advice on interventions that reduce the need for antipsychotics and allow doses to be safely reduced;
- promoting freedom of movement and minimising the use of restraint;
- the specific needs of younger people living with dementia and people who are working or looking for work.

WEAK IN FAVOR

51

Consider giving carers and/or family members the opportunity to attend and take part in staff dementia training sessions.

WEAK IN FAVOR

52

Consider training staff to provide multi-sensory stimulation for people with moderate to severe dementia and communication difficulties.

WEAK IN FAVOR

Involving people living with dementia in decisions about care

66

Ensure that all health and social care staff are aware of:

- the extent of their responsibility to protect confidentiality under data protection legislation and
- any rights that family members, carers and others have to information about the person's care (see recommendation 41).

STRONG IN FAVOR

67

Health and social care professionals advising people living with dementia (including professionals involved in diagnosis) should be trained in starting and holding difficult and emotionally challenging conversations.

WEAK IN FAVOR

Non-pharmacological interventions for cognitive symptoms in dementia

136

Consider interventions aimed at specifically training staff for the management of non-cognitive symptoms in people with dementia.

WEAK IN FAVOR

53

Provide people living with dementia and their family members or carers (as appropriate) with information that is relevant to their circumstances and the stage of their condition.

STRONG IN FAVOR

54

Be aware of the obligation to provide accessible information. For more guidance on providing information and discussing people's preferences with them, see the document "National Guidance for the Clinical Governance of Dementia" issued by the National Committee for Dementia.

STRONG IN FAVOR

55

Throughout the diagnostic process, offer the person and their family members or carers (as appropriate) oral and written information that explains:

- what their dementia subtype is and the changes to expect as the condition progresses;
- which health and social are professionals will be involved in their care and how to contact them;
- if appropriate, how dementia affects driving, and that they need to tell the general practitioner and healthcare staff involved in renewing their licence about their dementia diagnosis;
- their legal rights and responsibilities, see the document "National Guidance for the Clinical Governance of Dementia" issued by the National Committee for Dementia;
- their right to reasonable adjustments (law 68/99[1] with modifications according to the Legislative Decree 151/2015) if they are working or looking for work;
- how the following groups can help and how to contact them:
  - local support groups, online forums, and national charities;
  - financial and legal advice services;
  - advocacy services.

STRONG IN FAVOR

56

If it has not been documented earlier, ask the person at diagnosis:

- for their consent for services to share information
- which people they would like services to share information with (for example family members or carers)
- what information they would like services to share.

Document these decisions in the person's records.

STRONG IN FAVOR

57

After diagnosis, direct people and their family members or carers (as appropriate) to relevant services for information and support (see recommendations 40 and 41 on care coordination).

STRONG IN FAVOR

58

For people who do not want follow-up appointments and who are not using other services, ask if they would like to be contacted again at a specified future date.

STRONG IN FAVOR

59

Ensure that people living with dementia and their carers know how to get more information and who from if their needs change.

STRONG IN FAVOR

60

Tell people living with dementia (at all stages of the condition) about research studies they could participate in.

STRONG IN FAVOR

61

Offer early and ongoing opportunities for people living with dementia and people involved in their care (see recommendation 36) to discuss:

- the benefits of planning ahead;
- lasting power of attorney (for health and welfare decisions and property and financial affairs decisions);
- an advance statement about their wishes, preferences, beliefs, and values regarding their future care;
- advance decisions to refuse treatment;
- their preferences for place of care and place of death.

STRONG IN FAVOR

62

Explain that they will be given chances to review and change any advance statements and decisions they have made.

STRONG IN FAVOR

63

At each care review, offer people the chance to review and change any advance statements and decisions they have made.

STRONG IN FAVOR

64

Encourage and enable people living with dementia to give their own views and opinions about their care.

STRONG IN FAVOR

65

If needed, use additional or modified ways of communicating (for example visual aids or simplified text).

WEAK IN FAVOR

[1] Law, March 12, 1999, n. 68 (https://www.gazzettaufficiale.it/eli/id/1999/03/23/099G0123/sg) (Last visited: 30/08/2023).
[2] Legislative Decree, September 14, 2015, n. 151 (https://www.gazzettaufficiale.it/eli/id/2015/09/23/15G00164/sg) (Last visited: 30/08/2023).

Supporting caregivers of people with dementia

73

Offer carers of people living with dementia a psychoeducation and skills training intervention that includes:

- education about dementia, its symptoms and the changes to expect as the condition progresses
- developing personalised strategies and building carer skills
- training to help them provide care, including how to understand and respond to changes in behaviour
- training to help them adapt their communication styles to improve interactions with the person living with dementia
- advice on how to look after their own physical and mental health, and their emotional and spiritual wellbeing
- advice on planning enjoyable and meaningful activities to do with the person they care for
- information about relevant services (including support services and psychological therapies for carers) and how to access them
- advice on planning for the future.

STRONG IN FAVOR

74

Ensure that the support offered to carers is:

- tailored to their needs and preferences and to what they want it to achieve (for example, providing information on carer's employment rights for carers who work or want to work)
- designed to help them support people living with dementia
- available at a location they can get to easily
- provided in a format suitable for them (for example individual or group sessions, or online training and support)
- available from diagnosis and as needed after this.

STRONG IN FAVOR

75

Advise carers about their right to the following and how to get them:

- a formal assessment of their own needs, including their physical and mental health
- an assessment of their need for short breaks and other respite care.

STRONG IN FAVOR

76

Be aware that carers of people living with dementia are at an increased risk of depression. For guidance on identifying and managing depression, see Table 6.

WEAK IN FAVOR

Palliative care

157

From diagnosis, offer people living with dementia flexible, needs-based palliative care that takes into account how unpredictable dementia progression can be.

STRONG IN FAVOR

165

For guidance, on best interest decision-making, see Table 12.

STRONG IN FAVOR

Back to main flowchart

Drugs that may cause or worsen cognitive decline

32

Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:

- when assessing whether to refer a person with suspected dementia for diagnosis
- during medication reviews with people living with dementia

WEAK IN FAVOR

34

For guidance on carrying out medication reviews, see the indications reported in Table 7.

STRONG IN FAVOR

Back to main flowchart

Management strategies for people living with dementia/Mild Cognitive Impairment and co-existing physical long-term conditions

68

Ensure that people living with dementia have equivalent access to diagnosis, treatment, and care services for comorbidities to people who do not have dementia. For more guidance on assessing and managing multimorbidity, see Table 6.

STRONG IN FAVOR

69

For people with dementia or Mild Cognitive Impairment and at least one chronic physical comorbidity, when managing comorbidities (e.g., hypertension, cardiovascular diseases, type 2 diabetes, sensory deficits, urinary tract conditions) refer to the best practices for each condition, considering each person's specific clinical conditions and except in case the administration of standard care could cause more harm that benefit (see Table 6).

STRONG IN FAVOR

Back to main flowchart

Assessing intercurrent illness in people living with dementia

150

Consider using a structured observational pain assessment tool:
- alongside self-reported pain and standard clinical assessment for people living with moderate to severe dementia;
- alongside standard clinical assessment for people living with dementia who are unable to self-report pain.

WEAK IN FAVOR

151

For people living with dementia who are in pain, consider using a stepwise treatment protocol that balances pain management and potential adverse events.

WEAK IN FAVOR

152

Repeat pain assessments for people living with dementia:
- who seem to be in pain;
- who show signs of behavioural changes that may be caused by pain;
- after any pain management intervention.

STRONG IN FAVOR

Treating intercurrent illness in people living with dementia

153

For managing the risk of falling for people living with dementia refer to the standard treatment for the prevention of falls (see Table 6).
When using this guidance:
- take account of the additional support people living with dementia may need to participate effectively;
- be aware that multifactorial falls interventions may not be suitable for a person living with severe dementia.

STRONG IN FAVOR

Back to main flowchart

Management of non-cognitive symptoms in people with dementia

132

Before starting non-pharmacological or pharmacological treatment for distress in people living with dementia, conduct a structured assessment to:

- explore possible reasons for the person's distress and
- check for and address clinical or environmental causes (for example pain, delirium or inappropriate care).

STRONG IN FAVOR

134

Ensure that people living with dementia can continue to access psychosocial and environmental interventions for distress while they are taking antipsychotics and after they have stopped taking them.

STRONG IN FAVOR

136

Consider interventions aimed at specifically training staff for the management of non-cognitive symptoms in people living with dementia.

WEAK IN FAVOR

Back to main flowchart

Management of non-cognitive symptoms in people with dementia

133

As initial and ongoing management, offer psychosocial and environmental interventions to reduce distress in people living with dementia.

STRONG IN FAVOR

135

For people living with dementia who experience agitation or aggression, offer personalised activities to promote engagement, pleasure and interest. For people living with dementia who experience agitation or aggression, offer personalised activities to promote engagement, pleasure and interest.

STRONG IN FAVOR

137

Consider providing access to therapeutic gardens for the management of non-cognitive symptoms in people living with dementia who experience BPSDs.

WEAK IN FAVOR

138

Consider interventions of active and/or receptive music therapy for the management of non-cognitive symptoms in people living with dementia who experience BPSDs.

WEAK IN FAVOR

139

Consider psychological treatments in people with mild to moderate dementia who experience mild to moderate depressive symptoms and/or anxiety.

WEAK IN FAVOR

140

Consider the use of therapeutic robots in people with dementia who experience depressive symptoms, anxiety and/or agitation.

WEAK IN FAVOR

141

For people living with dementia who have sleep problems, consider a personalised multicomponent sleep management approach that includes sleep hygiene education, exposure to daylight, exercise, and personalised activities.

WEAK IN FAVOR

Back to main flowchart

Management of non-cognitive symptoms in people with dementia

143

When using antipsychotics:

- use the lowest effective dose and use them for the shortest possible time;
- reassess the person at least every four weeks, to check whether they still need medication.

STRONG IN FAVOR

144

Only offer antipsychotics for people living with dementia who are either:

- at risk of harming themselves or others or
- experiencing agitation, hallucinations or delusions that are causing them severe distress.

STRONG IN FAVOR

145

Stop treatment with antipsychotics:

- if the person is not getting a clear ongoing benefit from taking them and
- after discussion with the person taking them and their family members or caregivers (as appropriate).

STRONG IN FAVOR

146

Do not offer valproate to manage agitation or aggression in people living with dementia, unless it is indicated for another condition.

STRONG AGAINST

147

Do not routinely offer antidepressants to manage mild to moderate depression in people living with mild to moderate dementia, unless they are indicated for a pre-existing severe mental health condition.

STRONG AGAINST

148

Do not offer bupropion to manage depressive symptoms in people living with dementia.

STRONG AGAINST

149

Be aware that for people with dementia with Lewy bodies or Parkinson's disease dementia, antipsychotics can worsen the motor features of the condition, and in some cases cause severe antipsychotic sensitivity reactions For more guidance, see the advice on managing delusions and hallucinations in Table 6. Be aware that interventions may need to be modified for people living with dementia.

WEAK IN FAVOR

Back to flowchart 1

Diagnosis of dementia in specialist settings

9

If Alzheimer's disease is suspected, include a test of verbal episodic memory in the assessment.

STRONG IN FAVOR

Further tests for Alzheimer's disease

14

If the diagnosis is uncertain (see recommendation 13) and Alzheimer's disease is suspected, consider either:

- ^{18}F-FDG PET, or perfusion SPECT if ^{18}F-FDG PET is unavailable or
- examining cerebrospinal fluid for:
  - total Tau and phosphorylated-Tau 181 and
  - amyloid β 1-42/amyloid β 1-40 ratio or amyloid β 1-42

If a diagnosis cannot be made after one of these tests, consider using the other one.

WEAK IN FAVOR

15

Be aware that the older a person is, more likely they are to get a false positive with cerebrospinal fluid examination.

WEAK IN FAVOR

16

Do not rule out Alzheimer's disease based solely on the results of CT or MRI scans.

STRONG AGAINST

Back to flowchart 1

Further tests for dementia with Lewy bodies

19

If the diagnosis is uncertain (see recommendation 13) and dementia with Lewy bodies is suspected, use ^{123}I-FP-CIT SPECT.

STRONG IN FAVOR

20

If ^{123}I-FP-CIT SPECT is unavailable, consider as an alternative:

- ^{123}I-MIBG cardiac scintigraphy or
- polysomnography with EEG

WEAK IN FAVOR

21

Do not rule out dementia with Lewy bodies based solely on normal results on ^{123}I-FP-CIT SPECT or ^{123}I-MIBG cardiac scintigraphy.

STRONG AGAINST

Back to flowchart 1

Further tests for frontotemporal dementia

22

If the diagnosis is uncertain (see recommendation 13) and frontotemporal dementia is suspected, use, with semi-quantitative reading, either:

- ^{18}F-FDG PET or
- perfusion SPECT.

STRONG IN FAVOR

23

Do not rule out frontotemporal dementia based solely on the results of structural, perfusion or metabolic imaging tests.

STRONG AGAINST

Back to flowchart 1

Further tests for vascular dementia

25

If the dementia subtype is uncertain (see recommendation 13) and vascular dementia is suspected, use MRI. If MRI is unavailable or contraindicated, use CT.

STRONG IN FAVOR

26

Do not diagnose vascular dementia based solely on vascular lesion burden.

STRONG AGAINST

Back to flowchart 1

Further tests for Alzheimer's disease

17

Do not use *ApoE* ε4 genotyping or electroencephalography to diagnose Alzheimer's disease.

STRONG AGAINST

18

Be aware that young-onset Alzheimer's disease has a genetic cause in some people.

WEAK IN FAVOR

Back to flowchart 1

Further tests for frontotemporal dementia

24

Be aware that frontotemporal dementia has a genetic cause in some people.

WEAK IN FAVOR

Back to flowchart 1

Further tests for vascular dementia

27

Be aware that young-onset vascular dementia has a genetic cause in some people.

WEAK IN FAVOR

Back to flowchart 2

Acetylcholinesterase inhibitors, memantine, and new biological treatments for Alzheimer’s dementia and Mild Cognitive Impairment

77

The three acetylcholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild to moderate Alzheimer's dementia under all of the conditions specified in recommendations 82 and 83.

STRONG IN FAVOR

78

Offer donepezil as monotherapy for managing moderate to severe Alzheimer’s dementia based on the conditions specified in recommendations 82 and 83.

WEAK IN FAVOR

79

Memantine monotherapy is recommended as an option for managing Alzheimer’s dementia for people with:

- moderate Alzheimer's dementia who are intolerant of or have a contraindication to AChE inhibitors or
- severe Alzheimer's dementia.

Treatment should be under the conditions specified in recommendation 82.

WEAK IN FAVOR

80

For people who are not taking an AChE inhibitor or memantine, prescribers should only start treatment with these on the advice of a specialist (neurologist, geriatrician, psychiatrist) who has the necessary knowledge and skills. Only specialists in Centres for Cognitive Disorders and Dementias (CCDDs) can provide refundable prescriptions for these drugs within the National Health System.

WEAK IN FAVOR

81

If prescribing an AChE inhibitor, treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative AChE inhibitor could be prescribed if it is considered appropriate when taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.

WEAK IN FAVOR

82

When using assessment scales to determine the severity of Alzheimer’s dementia, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the results and make any adjustments they consider appropriate. Healthcare professionals should also be mindful of the need to secure equality of access to treatment for patients from different ethnic groups, in particular those from different cultural backgrounds.

WEAK IN FAVOR

83

When assessing the severity of Alzheimer’s dementia and the need for treatment, healthcare professionals should not rely solely on cognition scores in circumstances in which it would be inappropriate to do so. These include:

- if the cognition score is not, or is not by itself, a clinically appropriate tool for assessing the severity of that person’s dementia because of the person’s learning difficulties or other disabilities (for example, sensory impairments), linguistic or other communication difficulties or level of education or
- if it is not possible to apply the tool in a language in which the person is sufficiently fluent for it to be appropriate for assessing the severity of dementia or
- if there are other similar reasons why using a cognition score, or the score alone, would be inappropriate for assessing the severity of dementia.

In such cases healthcare professionals should determine the need for initiation or continuation of treatment by using another appropriate method of assessment.

WEAK AGAINST

Discontinuation of acetylcholinesterase inhibitors and memantine in Alzheimer’s dementia

89

Do not stop AChE inhibitors or memantine in people with Alzheimer’s dementia because of disease severity alone.

STRONG AGAINST

Back to flowchart 2

Co-prescription of acetylcholinesterase inhibitors and memantine in Alzheimer's dementia

87

For people with moderate Alzheimer's dementia who are already taking an AChE inhibitor consider memantine in addition to the AChE inhibitor.

WEAK IN FAVOR

88

For people with severe Alzheimer's dementia who are already taking an AChE inhibitor offer memantine in addition to the AChE inhibitor.

STRONG IN FAVOR

Discontinuation of acetylcholinesterase inhibitors and memantine in Alzheimer's dementia

89

Do not stop AChE inhibitors or memantine in people with Alzheimer's dementia because of disease severity alone.

STRONG AGAINST

Back to flowchart 2

Biological drugs in people with Alzheimer’s dementia and Mild Cognitive Impairment

85

Do not offer monoclonal antibodies against the different forms of amyloid β as a treatment for Alzheimer’s dementia or mild cognitive impairment.*

STRONG AGAINST

* Three panel members abstained from voting recommendation 85

Repurposing of pharmacological interventions

86

Do not offer the following treatments specifically to slow the progression of Alzheimer's disease or to slow or stop the conversion from mild cognitive impairment to dementia:

- antidiabetic drugs;
- antihypertensive drugs;
- statins;
- non-steroidal anti-inflammatory drugs (NSAIDs), including acetylsalicylic acid.

STRONG AGAINST

Back to flowchart 2

Acetylcholinesterase inhibitors and memantine for Parkinson's disease dementia

90

Offer AChE inhibitor[1] for people with mild or moderate Parkinson's disease dementia.

STRONG IN FAVOR

91

Consider AChE inhibitor[2] for people with severe Parkinson's disease dementia.

WEAK IN FAVOR

92

Consider memantine[3] for people with Parkinson's disease dementia, only if AChE inhibitors are not tolerated or are contraindicated.

WEAK IN FAVOR

[1] Rivastigmine capsules is currently the only AChEI with an indication for the treatment of mild to moderate PDD. Use of donepezil, galantamine and rivastigmine patches is off label.
[2] Use of AChEI, including rivastigmine capsules, for the treatment of severe PDD is off label.
[3] Use of memantine for the treatment of PDD is off label.

Back to flowchart 2

Acetylcholinesterase inhibitors in dementia with Lewy bodies

93

Offer donepezil or rivastigmine to people with mild to moderate dementia with Lewy bodies.

STRONG IN FAVOR

94

Only consider galantamine for people with mild to moderate dementia with Lewy bodies if donepezil and rivastigmine are not tolerated.

WEAK IN FAVOR

95

Consider donepezil or rivastigmine for people with severe dementia with Lewy bodies.

WEAK IN FAVOR

96

Consider memantine for people with dementia with Lewy bodies if cholinesterase inhibitors are not tolerated or are contraindicated.

WEAK IN FAVOR

Back to flowchart 2

Acetylcholinesterase inhibitors and memantine for types of dementia other than Alzheimer's disease

97

Only consider AChE inhibitors or memantine for people with vascular dementia if they have suspected comorbid Alzheimer's disease, Parkinson's disease dementia or dementia with Lewy bodies.

WEAK IN FAVOR

98

Do not offer AChE inhibitors or memantine to people with frontotemporal dementia.

STRONG AGAINST

99

Do not offer AChE inhibitors or memantine to people with cognitive impairment caused by multiple sclerosis.

STRONG AGAINST

Back to main flowchart

Table 6. Reference documents for managing specific conditions.

Condition	Reference documents	Source
Multimorbidity	*Linea guida inter-societaria per la gestione della multimorbilità e polifarmacoterapia*	SNLG 2021
	Multimorbidity: clinical assessment and management	NICE-NG56
	Older people with social care needs and multiple long-term conditions	NICE-NG22
Delirium	Delirium: prevention, diagnosis and management in hospital and long-term care	NICE-CG103
Diabetes	*La terapia del diabete mellito di tipo 2*	SNLG 2022
	Type 2 diabetes in adults: management	NICE-NG28
	Type 2 diabetes in adults	NICE-QS209
Hypertension	Hypertension in adults: diagnosis and management	NICE-NG136
Cardiovascular/ obesity problems	Cardiovascular disease: risk assessment and reduction, including lipid modification	NICE-CG181
	Terapia del sovrappeso e dell'obesità resistenti al trattamento comportamentale nella popolazione adulta con comorbilità metaboliche	SNLG 2022
Incontinence	Faecal incontinence in adults: management	NICE-CG49
	Urinary incontinence in neurological disease: assessment and management	NICE-CG148
Sensory disabilities	Hearing loss in adults: assessment and management	NICE-NG98
Falls/fractures	Diagnosi, stratificazione del rischio e continuità assistenziale delle fratture da fragilità	SNLG 2021
	Fratture del femore prossimale nell'anziano	SNLG 2021
	Falls in older people: assessing risk and prevention	NICE CG161
	Falls in older people	NICE-QS86
	Hip fracture: management	NICE-CG124
Oncological diseases	*Tumori dell'anziano (parte generale)*	SNLG 2022
Depression	Depression in adults: treatment and management	NICE-NG222
Parkinson's Disease	Parkinson's disease in adults	NICE-NG71
Specific Learning Disability	Mental health problems in people with learning disabilities: prevention, assessment and management	NICE-NG54

Table 7. Quality statements from NICE Quality standard 120, referring to NICE guideline 5 (NG5)[1]

Quality statement 1. People are given the opportunity to be involved in making decisions about their medicines.
Quality statement 2. People who are prescribed medicines are given an explanation on how to identify and report medicines-related patient safety incidents.
Quality statement 3. Local health and social care providers monitor medicines-related patient safety incidents to inform their learning in the use of medicines.
Quality statement 4. People who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission.
Quality statement 5. People discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.
Quality statement 6. Local healthcare providers identify people taking medicines who would benefit from a structured medication review.

[1] Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. [NG5] Published: 04 March 2015. https://www.nice.org.uk/guidance/ng5; Medicines optimisation. [QS120] Published: 24 March 2016. https://www.nice.org.uk/guidance/qs120

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Table 8. NICE Guideline "Medicine optimisation" (NG5)[1] recommendations.

Organisations should ensure that robust and transparent processes are in place, so that when a person is transferred from one care setting to another: • the current care provider shares4 complete and accurate information about the person's medicines with the new care provider and • the new care provider receives and documents this information, and acts on it. Organisational and individual roles and responsibilities should be clearly defined. Regularly review and monitor the effectiveness of these processes. See Quality statements 4 and 5 in Table 7 on medicine optimisation. When sharing information consider the GPDP regulations (Regulation UE 2016/679, General Data Protection Regulation).
For all care settings, health and social care practitioners should proactively share complete and accurate information about medicines: • ideally within 24 hours of the person being transferred, to ensure that patient safety is not compromised and • in the most effective and secure way, such as by secure electronic communication, recognising that more than one approach may be needed.
Health and social care practitioners should share relevant information about the person and their medicines when a person transfers from one care setting to another. This should include, but is not limited to, all of the following: • contact details of the person and their GP; • details of other relevant contacts identified by the person and their family members or carers where appropriate – for example, their nominated community pharmacy; • known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced (see the NICE guideline on drug allergy); • details of the medicines the person is currently taking (including prescribed, over-the-counter, and complementary medicines) – name, strength, form, dose, timing, frequency and duration, how the medicines are taken and what they are being taken for; • changes to medicines, including medicines started or stopped, or dosage changes, and reason for the change; • date and time of the last dose, such as for weekly or monthly medicines, including injections; • what information has been given to the person, and their family members or carers where appropriate; • any other information needed – for example, when the medicines should be reviewed, ongoing monitoring needs and any support the person needs to carry on taking the medicines. Additional information may be needed for specific groups of people, such as children*.
Health and social care practitioners should discuss relevant information about medicines with the person, and their family members or carers where appropriate, at the time of transfer. They should give the person, and their family members or carers where appropriate, a complete and accurate list of their medicines in a format that is suitable for them. This should include all current medicines and any changes to medicines made during their stay.
Consider sending a person's medicines discharge information to their nominated community pharmacy, when possible and in agreement with the person.
Organisations should consider arranging additional support for some groups of people when they have been discharged from hospital, such as pharmacist counselling, telephone follow-up, and GP or nurse follow-up home visits. These groups* may include: • adults, children and young people taking multiple medicines (polypharmacy); • adults, children and young people with chronic or long-term conditions; • older people.

[1] https://www.nice.org.uk/guidance/ng5

* Statements are taken from Guidelines that refer to populations that also include pediatric and young adult patients.

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Table 10. Quality standard [QS13][1] End of life care for adults.

Quality statement 1. Adults who are likely to be approaching the end of their life are identified using a systematic approach.
Quality statement 2. Adults approaching the end of their life have opportunities to discuss advance care planning.
Quality statement 3. Adults approaching the end of their life receive care that is coordinated between health and social care practitioners within and across different services and organisations.
Quality statement 4. Adults approaching the end of their life and their carers have access to support 24 hours a day, 7 days a week.
Quality statement 5. Carers providing end of life care to people at home are supported to access local services that can provide assistance.

[1] https://www.nice.org.uk/guidance/qs13

Table 11. Quality standard [QS144] [2] Care of dying adults in the last days of life.

Quality statement 1. Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering.
Quality statement 2. Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan.
Quality statement 3. Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.
Quality statement 4. Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options.

[2] https://www.nice.org.uk/guidance/qs194

Table 12. Quality standard [QS194][3] Decision making and mental capacity.

Quality statement 1. People aged 16 and over who may lack capacity to make decisions are supported with decision making in a way that reflects their individual circumstances and meets their particular needs.
Quality statement 2. People aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, are given the opportunity to discuss advance care planning at each health and social care review.
Quality statement 3. People aged 16 and over who are assessed as lacking capacity to make a particular decision at the time that decision needs to be made, have a clear record of the reasons why they lack capacity and the practicable steps taken to support them.
Quality statement 4. People aged 16 and over who lack capacity to make a particular decision at the time that decision needs to be made have their wishes, feelings, values and beliefs accounted for in best interests decisions.

[3] https://www.nice.org.uk/guidance/qs144