Complete Summary

GUIDELINE TITLE

Dementia.

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 2005. 28 p. [20 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 1998. 32 p.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- June 17, 2008, Antipsychotics (conventional and atypical]): The U.S. Food and Drug Administration (FDA) notified healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis. The prescribing information for all antipsychotic drugs will now include information about the increased risk of death in the BOXED WARNING and WARNING sections.
- September 17, 2007, Haloperidol (Haldol): Johnson and Johnson and the U.S. Food and Drug Administration (FDA) informed healthcare professionals that the WARNINGS section of the prescribing information for haloperidol has been revised to include a new Cardiovascular subsection.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Dementia

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Geriatrics

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Pharmacists
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

- To offer care providers and practitioners in long-term care facilities a systematic approach to recognizing, assessing, treating, and monitoring patients with dementia, including impaired cognition and problematic behavior
- To help practitioners to provide dementia patients with a systematic assessment and care plan, leading to appropriate management that maximizes functioning and quality of life and minimizes the likelihood of complications and functional decline

TARGET POPULATION

Elderly individuals and/or residents of long-term care facilities who have, or are suspected of having, dementia

INTERVENTIONS AND PRACTICES CONSIDERED

Recognition/Assessment

1. Review patient history
2. Evaluate signs and symptoms
3. Perform diagnostic work-up, if appropriate
4. Determine if patient meets criteria for dementia
5. Identify cause of dementia, if possible
6. Identify patient's strengths and deficits
7. Define the significance of patient's symptoms, impairments, and deficits
8. Identify triggers for disruptive behavior

Treatment

1. Prepare interdisciplinary care plan
2. Optimize function and quality of life and capitalize on remaining strengths
    - Consider using complementary & alternative therapies
    - Prevent excess disability
    - Consider medical interventions if appropriate
3. Address socially unacceptable or disruptive behaviors, using both non-pharmacological and pharmacological interventions
4. Manage functional deficits
5. Address pertinent psychosocial and family issues
6. Address related ethical issues
7. Manage risks and complications related to dementia, other conditions, or treatments

Monitoring

Monitor the patient's progress and adjust management as appropriate

MAJOR OUTCOMES CONSIDERED

- Level of functioning:
    - Functional assessment measures such as the Activities of Daily Living (ADL) portion of the Minimum Data Set (MDS), the Barthel Index, or the Functional Activities Questionnaire (FAQ)
    - Cognitive function assessment measures such as the Mini-Mental State Examination (MMSE), the Clock Drawing test, the Blessed Orientation Memory-Concentration Test, or other comparable instruments
- Signs and symptoms of dementia
- Quality of life
- Complications and functional decline

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

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 stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This guideline was developed by an interdisciplinary workgroup, using a process that combined evidence and consensus-based approaches. The Workgroup included practitioners and others involved in patient care in long-term care facilities. Beginning with a general guideline developed by an agency, association, or organization such as the Agency for Healthcare Research and Quality (AHRQ), pertinent articles and information, and a draft outline, each group worked to make a concise, usable guideline tailored to the long-term care setting. Because scientific research in the long-term care population is limited, many recommendations were based on the expert opinion of practitioners in the field.

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

Guideline revisions were completed under the direction of the Clinical Practice Guideline Steering Committee. The committee incorporated information published in peer-reviewed journals after the original guidelines appeared, as well as comments and recommendations not only from experts in the field addressed by the guideline but also from "hands-on" long-term care practitioners and staff.

All American Medical Directors Association (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 algorithm Dementia is to be used in conjunction with the clinical practice guideline. The numbers next to the different components of the algorithm correspond with the steps in the text. Refer to the "Guideline Availability" field for information on obtaining the full text guideline.

CLINICAL ALGORITHM(S)

A clinical algorithm is provided for Dementia.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

The guideline was developed by an interdisciplinary workgroup, using a process that combined evidence- and consensus-based approaches. Because scientific research in the long-term care population is limited, many recommendations were based on the expert opinion of practitioners in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Expected Outcomes from Implementation of this Clinical Practice Guideline

Implementation of this guideline should:

- Identify patients who are at risk for new or progressive dementia
- Identify the nature and causes of dementia in different patients
- Make appropriate environmental modifications to maximize patient dignity, comfort and safety
- Identify and manage potential sources of excess disability
- Minimize preventable complications and functional decline
- Manage dementia symptoms, consequences, and complications effectively and appropriately
- Respond appropriately to the changing needs of patients with dementia

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

- Maintained or improved function and quality of life prior to the end of life
- Reduced complications and negative consequences of the condition or its management
- Improved resource utilization

POTENTIAL HARMS

- Examples of complications from medical treatment of problematic behavior:
    - Adverse reactions to medication
    - Worsening of disruptive or socially unacceptable behavior
    - Increased lethargy or confusion
    - Cardiac arrhythmias
    - Orthostatic hypotension

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- 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, its 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.
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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

IMPLEMENTATION TOOLS

Clinical Algorithm
Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Dementia. Columbia (MD): American Medical Directors Association (AMDA); 2005. 28 p. [20 references]

ADAPTATION

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

DATE RELEASED

1998 (revised 2005)

GUIDELINE DEVELOPER(S)

American Medical Directors Association - Professional Association

GUIDELINE DEVELOPER COMMENT

Organizational participants included:

- American Association of Homes and Services for the Aging
- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- American Society of Consultant Pharmacists
- National Association of Directors of Nursing Administration in Long-Term Care
- National Association of Geriatric Nursing Assistants
- National Conference of Gerontological Nurse Practitioners

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

Committee Members: Marjorie Berleth, MSHA, RNC, FADONA; Susan M. Levy, MD, CMD; Lisa Cantrell, RN, C; Harlan Martin, RPh, CCP, FASCP; Charles Cefalu, MD, MS; Geri Mendelson, RN, CNAA, MEd, NHA; Sherrie Dornberger, RNC, FADONA; Evvie F. Munley; Sandra Fitzler, RN; Jonathan Musher, MD, CMD; Joseph Gruber, RPh, FASCP, CGP; Mary Tellis-Nayak RN, MSN; Larry Lawhorne, MD, CMD;

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: None available

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 are available:

- Guideline implementation: clinical practice guidelines. Columbia, MD: American Medical Directors Association, 1998, 28 p.
- We care: implementing clinical practice guidelines tool kit. Columbia, MD: American Medical Directors Association, 2003.

Electronic copies: None available

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

PATIENT RESOURCES

None available

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. This NGC summary was updated by ECRI on August 26, 2005. This summary was updated by ECRI Institute on July 25, 2008, following the U.S. Food and Drug Administration advisory on Antipsychotics.

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Date Modified: 11/3/2008


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