

NHS Bolton Dementia Template for GP Practices

Screenshot

Dementia Annual Review

1. Mental Health Assessment

To record the assessment data into the patient's medical history, use the areas below.

To print a copy of this section of the assessment, go to section 7.

a) Wandering

Previous data recorded

All Medical History Records - No Patient Selected.

Note - Are there underlying causes to changes in behaviour, such as hallucinations or delusions?

Wanders [DURING THE DAY]

Wanders [AT NIGHT]

Wanders [DURING THE DAY AND AT NIGHT]

NOT wandering

If none of the above codes are appropriate please enter this code and record "No wandering" in the comments box.

b) Agitation

Previous data recorded

All Medical History Records - No Patient Selected.

Note - Is the patient in pain?

Agitated

NOT agitated

If the above code is inappropriate, please enter this code and record "Not agitated" in the comments box.

c) Aggression

Previous data recorded

All Medical History Records - No Patient Selected.

VERBALLY ABUSIVE behaviour

PHYSICALLY ABUSIVE behaviour

ARGUMENTATIVE behaviour

NO abusive behaviour

If none of the above codes are appropriate please enter this code and record "No abusive behaviour" in the comments box.

d) Sleep

Previous data recorded

All Medical History Records - No Patient Selected.

Note - Potentially, a big impact on the Carer.

GOOD sleep pattern

POOR sleep pattern

e) Patient aware of diagnosis

Previous data recorded

All Medical History Records - No Patient Selected.

Patient AWARE of diagnosis

Patient UNAWARE of diagnosis

f) Repeat of dementia screening test

Previous data recorded

[Click here to access Six Item Cognitive Impairment Test \(6CIT\)](#)

All Medical History Records - No Patient Selected.

(If you use the GPCOG assessment you should record the results in the journal using one of the buttons below the link)

[Click here to access General Practitioner Assessment of Cognition \(GPCOG\)](#)

GPCOG [patient examination only]

GPCOG [informant interview only]

GPCOG [Patient and informant interview]

All Medical History Records - No Patient Selected.

**** Important - Please record in the Medical History SDA - NOT as a Scoring test result.**

(LINKS CANNOT BE PROVIDED TO THE MINI-MENTAL STATE EXAM TOOL (MMSE) DUE TO COPYRIGHT RESTRICTIONS.)

Mini mental state

All Medical History Records - No Patient Selected.

g) Depression screening

Previous data recorded

All Medical History Records - No Patient Selected.

[Click here to access 4 item Geriatric Depression Scale \(GDS-4\)](#)

Geriatric depression scale

**** Please record results using this button**

h) Fitness to drive

Previous data recorded

All Medical History Records - No Patient Selected.

Note - DVLA have to be notified of the diagnosis of dementia.

FIT - to drive

UNFIT - to drive

i) Financial Mismanagement

Previous data recorded

All Medical History Records - No Patient Selected.

All Medical History Records - No Patient Selected.

ABLE to manage financial activities

AT RISK of financial mismanagement

Power of Attorney - HELD

Power of Attorney - APPLIED FOR

j) Vulnerability assessment

Previous data recorded

All Medical History Records - No Patient Selected.

All Medical History Records - No Patient Selected.

At risk of PHYSICAL ABUSE

At risk of NEGLECT BY OTHERS

At risk of PSYCHOLOGICAL ABUSE

VULNERABLE adult

Vulnerable ELDERLY PERSON

k) Mental Health Assessment completed

Previous data recorded

All Medical History Records - No Patient Selected.

Ensure you click below to record completion of Mental Health Assessment

Mental Health Assessment COMPLETED

2. Physical Health Assessment

To record the assessment data into the patient's medical history, use the areas below.

To print a copy of this section of the assessment, go to section 7.

a) Appetite

Previous data recorded

All Medical History Records - No Patient Selected.

Appetite - NORMAL

Appetite - INCREASED

Appetite - REDUCED

b) Hearing

Previous data recorded

All Medical History Records - No Patient Selected.

Hearing - NORMAL

Hearing - DETERIORATING

c) Vision

Previous data recorded

All Medical History Records - No Patient Selected.

Vision - NORMAL

Vision - DETERIORATING

PARTIALLY Sighted

Registered BLIND

d) Mobility

Previous data recorded

All Medical History Records - No Patient Selected.

Mobility - FULL

Mobile - OUTSIDE WITH AID

Mobile - IN HOME

CONFINED to chair

BEDRIDDEN

e) Urinary continence

Previous data recorded

All Medical History Records - No Patient Selected.

Bladder - FULLY CONTINENT

Bladder - OCCASIONAL ACCIDENT

Bladder - INCONTINENT

FREQUENCY of micturition

NOCTURIA

f) Faecal continence

Previous data recorded

All Medical History Records - No Patient Selected.

Bowels - FULLY CONTINENT

Bowels - OCCASIONAL ACCIDENT

Bowels - INCONTINENT

g) Weight / BP

Previous data recorded

Last 3 Weight Records - No Patient Selected.

Last 3 Blood pressure Records - No Patient Selected.

Last 3 Medical History Records Where READ_CODE = "16D2.00 " - No Patient Selected.

Weight

Blood pressure

h) Self care / Risk of falls or accidents

Able to perform personal care activity

Unable to perform personal care activity

Does not fall

At risk of accident at home

Number of falls in last year

i) Physical Health Assessment completed

Click below to record completion of Physical Health Assessment

Physical Health Assessment completed

Last 1 All other Clinical Data Records Where READ_CODE = "38C2.00 " - No Patient Selected.

Medication Review

To print a copy of this section of the assessment, go to section 7.

Last 3 Repeat Medication Review Records - No Patient Selected.

1. If the words above state "No data recorded" you will need to add a NEW medication review. (You can use the button below)
2. If a past review IS detailed above, DO NOT use the button below, go to the THERAPY tab to update the review.

ALWAYS update existing reviews rather than setting up new ones

Consider the following:

Use of dementia specific medication	Anti-cholinesterase inhibitors? Memantine?
Use of anti-psychotics	Can the use of anti-psychotics be avoided?
Use of anti-depressants	Is there a need for anti-depressants?
Use of sedatives	Can the use of sedatives be avoided?

All Repeat Masters Records - No Patient Selected.

Add new medication review

4. Impact on Carer / Carer's Needs

To record the data directly into the patient's medical history, use the areas below.

To print a copy of this section of the assessment, go to section 7.

a) Carer information

Previous data recorded

Carer's DETAILS

NAME of carer

Carer - HOME PHONE NUMBER

Carer - MOBILE PHONE NUMBER

All All other Clinical Data Records - No Patient Selected.

b) Relationship to patient

Previous data recorded

PARTNER is informal carer

RELATIVE is informal carer

FRIEND is informal carer

All All other Clinical Data Records - No Patient Selected.

c) Proximity to carer

Previous data recorded

Living WITH CARER

Carer LIVES NEARBY

Carer LIVES AT A DISTANCE

All All other Clinical Data Records - No Patient Selected.

e) Additional information

Previous data recorded

Carer ABLE to cope

Carer UNABLE to cope

Carer's assessment of needs

All All other Clinical Data Records - No Patient Selected.

5. Communication with / Referral to other services

To record the assessment data into the patient's medical history, use the areas below.

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Previous data recorded

Care co-ordinator

Memory Assessment Team

REFER to Memory Assessment team

SEEN IN Memory Clinic

Social Services

REFER to Social Services

SEEN BY Social Services

REPORT RECEIVED from Social Services

Voluntary Services

REFER to voluntary service

RECEIVES HELP from voluntary agency

District Nurse

REFER to District Nurse

DISTRICT NURSE attends

Intermediate Care

REFER to Intermediate Care

Care plan in place

Vulnerable Adult Care Plan

Agreement of care plan

6. Dementia Review Completed

Click below to record completion of Dementia Review

Dementia Review completed

To close guideline, click shutter icon next to question mark icon & return to QOF Dementia guideline

7. Paper copies of assessments (for printing)

Documents have been created to assist with this assessment and can be used in a face to face environment or printed and given to a carer for their completion.

The data will then need to be entered into Vision (using buttons in the relevant sections).

For "technical" reasons, do not complete these forms directly on the computer.

They are designed to be printed off and completed manually.

[Click here to access "MENTAL HEALTH ASSESSMENT" questions](#)

[Click here to access "PHYSICAL HEALTH ASSESSMENT" questions](#)

[Click here to access "MEDICATION REVIEW" questions](#)

[Click here to access "IMPACT ON CARER / CARER'S NEEDS" questions](#)

[Click here to access "COMMUNICATION WITH OTHER SERVICES"](#)