

INTERDISCIPLINARY CLINICAL PROCESS – FAMILY MEDICINE GROUP (FMG) OUTREACH SERVICES

MILD OR MAJOR NEUROCOGNITIVE DISORDERS (mNCD or MNCD)

FOLLOW-UP COMPONENT (2)

ENSURE FOLLOW-UP AFTER THE DOCTOR'S DIAGNOSIS ANNOUNCEMENT (FMG OR SPECIALIZED CLINIC)

LEGEND: THE NUMBER INDICATES THE FMG PROFESSIONAL OR THE DEPARTMENT THAT CAN HELP, IF NECESSARY

1 = Social worker **2** = Pharmacist **3** = Community organizations **4** = Other professionals with or outside FMG

1. 1ST PHONE CALL BY THE NURSE FOR ALL MNCD DIAGNOSES (2 TO 4 WEEKS)

- Establish a relationship of trust and partnership with the user and the caregiver.
- Evaluate the need for information, answer questions and propose **PRIORITY TEACHING**.
- Begin the follow-up in the "STANDARD COGNITIVE FOLLOW-UP" section depending on the user's situation and complete the intervention plan (IP).
- Ensure the user and their caregiver have the nurse's contact information.
- If the CLSC or home care services is following up, ask the user for authorization to disclose the new diagnosis.
- Provide info on the next appointment and Alzheimer Society services and the **SUPPORT** for the seniors' caregivers. **3**

PRIORITY TEACHING (a 2nd meeting may be necessary either in person or over the telephone)

- Information on the major neurocognitive disorder diagnosed : [Alzheimer's Disease 1](#)¹ and [Alzheimer's Disease 2](#)² , [vascular dementia](#)³, [Lewy Body](#)^{4a}, [frontotemporal dementia](#)^{4b}. The stages of Alzheimer's Disease ([user](#)⁵; professional, [p. 2](#))⁶
- Advice and suggestions to facilitate the accompaniment of your caregiver ([info-1](#))⁷ ([info-2](#))⁸([info-3](#))^{8b}
- Your medication ([user](#))⁹



2A. VISIT AT 6 MO. (MNCD) THEN EACH YEAR (MNCD and mNCD) – NURSE FOLLOW-UP

Give precedence to the same FMG nurse

Plan the follow-up appointments in advance with the user or the caregiver. Increase the frequency of visits, as required.

- Evaluate physical condition.
- Evaluate mental condition :
 - In the presence of cholinesterase inhibitors or NMDA receptor antagonists, or as required, perform an MMSE;
 - In the presence of behavioural symptoms of dementia ([NPI-R](#)¹⁰ short version), [evaluate the causes \(p. 8\)](#)¹¹ and intervene, if necessary. Refer to specialized resources (e.g., BPSD team), if necessary;
- Uncover the presence of functional issues possibly related to a neurocognitive disorder: **4**
 - Tools to obtain the impressions of a caregiver : [Functional Activities Questionnaires \(FAQ\)](#)¹², [Disability Assessment of Dementia \(DAD\)](#)¹³, [Informant Questionnaire on Cognitive Decline in the Elderly \(IQCODE\)](#)¹⁴, etc.
- Evaluate to determine whether the condition has improved, stabilized or deteriorated with the information obtained previously.
- Continue the follow-up in the "STANDARD COGNITIVE FOLLOW-UP" section according to the user's situation and update the IP :
 - Depending on the evaluation, proceed with the relevant nursing interventions and, as required, refer to the appropriate professionals in the FMG, the network and community organizations. **1 2 3 4**



2B. MEDICAL RE-EVALUATION VISIT depending on the user's progress (doctor and FLSNP)

- Discuss progress with the nurse, user and caregiver (and with other professionals, if they are involved):
 - Discuss the items in the standard follow-up to be given priority.
- If BPSD, determine the causes ([p. 8](#))¹⁵ and intervene, if necessary.
- Decide whether additional consultations are needed (e.g., memory clinic, occupational therapist, neuropsychologist, etc.).
- Discuss the [level of care](#)¹⁶ and the anticipated medical directives ([AMD](#))¹⁷, depending on the clinical situation.
 - Decide whether to continue cholinesterase inhibitors or the NMDA receptor antagonist **2**
 - Complete the drug exception authorization form (if necessary).



TO BE FOLLOWED DURING ALL STEPS IN THE PROCESS ACCORDING TO THE USER'S AND CAREGIVER'S SITUATION**Medications 2**

- A. Determine whether there are any [undesirable effects](#)¹⁸, observance, need for titration for cholinesterase inhibitors or the NMDA receptor antagonist.
- B. Inform the user and the caregiver of the monitoring to be done after their level of knowledge and understanding has been evaluated.
- C. Monitor and optimize the rest of the medication, paying particular attention to the medication that may have become potentially inappropriate.

Physical and mental conditions

- F. Evaluate physical condition: weight, hydration, oral-dental health, elimination, mobility and falling, pain, language problem, sleep (wandering), etc.
- G. Evaluate mental condition, particularly delirium, hallucinations, signs of distress, anxiety, depression and risk of suicide; and intervene, if necessary. 1
- H. Promote cognitive health by encouraging the adoption of healthy living habits ([tobacco](#)¹⁹, [diet](#)²⁰, [physical activity](#)²¹, [stress](#)²², [alcohol](#)²³), the management of risk factors ([HTA](#)²⁴ [[G](#)]²⁵, [diabetes](#)²⁶ [[G](#)]²⁷) and support for therapeutic observation.

Legal aspects 1 3

- I. [Decision making](#)²⁸ : respect individual choice.
- J. [Plan the future](#)²⁹ : [will](#)³⁰; [power of attorney, protective supervision and mandate](#)³¹.
- K. Find out about available financial measures (tax credits, direct allowance, financial exoneration program).

Security

- L. Ability to drive: [have an early discussion](#)³² about possibly giving up driving and find out what alternatives exist (means of transportation) 1; contribute to the risk assessment ([road test](#))³³.
- M. Evaluate in-home safety (fire, poisonings, wandering outside, etc.) and provide standard advice. 4
- N. Review and determine, if need be, the ability to agree to care and the presence of difficulties or issues relating to [aptitude](#)³⁴ administering possessions and personal care. 1 4
- O. Watch for signs of negligence or [abuse](#)³⁵. 1

Preservation of quality of life to keep the person at home for as long as possible

- P. Encourage various means to be taken to maintain [quality of life at home](#)³⁶ 1 3 :
 - Teach strategies regarding [meals](#)³⁷, [personal hygiene care](#)³⁸, and [sleep](#)³⁹.
- Q. Find out about possible assistance provided by [community organizations](#)⁴⁰. 1 3
- R. Refer to home care to optimize functional autonomy, safety, etc., and transfer the IP. 4
- S. Discuss alternative remain-at-home solutions, if necessary. 1 3 4

Prevention and interventions on the behavioural and psychological symptoms of dementia (BPSD)

- T. Establish the [biographical history](#)⁴¹ (disclose it to home care and other places, if relevant). 3
- U. Teach the [basic approach](#)⁴² (p. 5) to the caregiver, while including [communication strategies](#)⁴³ 3; [reorient](#) (p. 8)⁴⁴, if necessary.
- V. Teach the [non-pharmacological approach](#) (p. 9 et seqq.)⁴⁵ if responsive behaviours, depending on the possible cause(s) of the BPSD. 4

Caregiver 1

- W. Discuss the transition to a change in roles ([stress](#))⁴⁶ ([intimacy](#))⁴⁷ ([ambiguous grief](#))⁴⁸.
- X. Evaluate burnout, e.g., Zarit scale, the risks of suicide and homicide, etc.
- Y. Evaluate priority needs and find out about available resources, including respite, if relevant. 3 4
- Z. Re-evaluate the psychosocial context, and refer, if necessary:
 - Anticipate another assistance plan if the regular caregiver were to experience an emergency (e.g., hospitalization).

*** The process is a help tool. A professional's clinical judgment in deciding the intervention and timeframes takes precedence. All proposed tools are for information purposes.

* Exponent references and the Internet link refer back to the REFERENCES document.