1 Care Map Information

Quick info:

Definition
Dementia is an acquired, actively progressive and largely irreversible clinical syndrome that is characterised by widespread impairment of mental function generally associated with a decline in activities of daily living and impairment in social function.

Scope
This pathway:

• provides guidance on Primary Sector diagnosis, assessment and management of dementia
• suggests a logical approach to screening and initial assessment in order to identify cognitive disorder, whilst ensuring consideration or exclusion of other pathologies
• provides recommendation regarding aspects of examination, including cognitive screening tools, and investigations necessary to help with diagnosis of dementia
• includes guidance in identifying types of cognitive impairment or dementia, which can be managed in primary care sectors, including mild cognitive impairment, Alzheimer's disease, vascular dementia and mixed dementia
• provides information about other types of dementia more likely to require assistance from specialist services. These include Dementia with Lewy bodies, Dementia in Parkinson's disease, Frontotemporal dementia and others
• provides an approach to the longer term care of people with a diagnosis of dementia (regardless of the place of residence) as well as care of problems which may arise. This approach considers:
  • proactive care, i.e. initial review and long term planning. This includes legal aspects, exploration of functional abilities (including driving), and maintenance of good physical and mental health
  • changes in presentation, i.e. assessment of underlying causes and guidance to manage said causes (either in the primary sector or with assistance of specialist services).

Background
Alzheimer's NZ estimates there are approximately 48,000 known cases of dementia in New Zealand currently. A significant proportion can be managed in primary care.

Prognosis depends on the cause of the dementia and varies from person to person. The median survival from onset is variable for Dementia of the Alzheimer's type. Younger-onset dementia tends to progress more rapidly. Almost all people with dementia eventually develop one or more psychological or behavioural problems.

Key messages for this pathway:

• if suspecting dementia, ask if they have had problems with their memory that have significantly interfered with their ability to function over the last 12 months
• medications, particularly those with significant anticholinergic side-effects may affect cognitive function
• mild cognitive impairment (MCI) describes the situation where a person complains of mild cognitive difficulties, confirmed by mildly abnormal cognitive testing, but there is no evidence of functional impairment

2 Information resources for patients and carers

Quick info:

NZ Resources:

• Alzheimer's NZ
• medical driving assessment
• Supporting families
• Interactive website for carers, people with early dementia. (requires login)
• ACC older falls checklist
• Age Concern services
• Falls risk self assessment
• Gentle directory
• Hand rail installation guide
• Equipment for home safety 2
• Recoverable assistance payment grant
3 Information resources for clinicians

Quick info:

Resources for clinicians:
Assessment Treatment Rehab - 06 3483109 ext 8109
Geriatricians - Call the telephonist 06 3483109
Click here for Glorious Opportunity video (5 minutes)

• the story of a GP who is diagnosed with Alzheimer's at the age of 63. Jennifer gives us a clear insight into the things that she now struggles with daily

NZ Resources
• Alzheimer's NZ
• National Dementia Co-operative
• New Zealand Framework for Dementia Care
• support and management of people with dementia
• mental health and addiction services for older people and dementia services
• dementia New Zealand - improving quality in residential care
• Age concern services
• Interactive website for up to date information and consumer engagement (requires login)

Other Resources
• Dementia Course provided by Goodfellowunit.org

4 Updates to this care map
5 Hauora Maori

Quick info:
As a practitioner you will work with Maori whanau/families. Each Maori whanau is diverse with their own set of values and beliefs, inherited, practised and passed down from generation to generation.

There are some important things that you should be mindful of when working with Maori individuals and their whanau from a holistic approach to working in a Whanau ora or family / whanau centred way.

Key enablers that you should be aware of when working with Maori whanau/families are:
• building relationships and gaining trust
• effective communication with whanau/families
• understanding and involving whanau/families in the treatment planning and care management
• practical things to be mindful of when working with Maori whanau so that you do not breech Tikanga/Principles and practices that are important in Te Ao Maori/the Maori world

Common terms and definitions are noted here.

6 Pasifika

Quick info:
Our pasifika community:
• is a diverse and dynamic population:
  • more than 22 nations represented in New Zealand
  • each with their own unique culture, language, history, and health status
  • share many similarities which we have shared with you here in order to help you work with pasifika patients more effectively

The main Pacific nations in New Zealand are:
• Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging The FonoFale Model (pasifika mode of health) when working with pasifika peoples and families.

Acknowledging general pacific guidelines when working with pasifika peoples and families:
• cultural protocols and greetings
• building relationships with your pacific patients
• involving family support, involving religion, during assessments and in the hospital
• home visits
• pasifika phrasebook

7 Dementia Suspected

Quick info:
If a person or family member raises concerns about the person's memory or cognitive function ask the person if they have had problems with their memory and/or cognitive function that has significantly interfered with their ability to function over the last 12 months.

A multi-disciplinary approach, involving more than one appointment is likely to be needed to complete a full assessment.

The assessment can be undertaken in the order that suits the clinical situation.

Involve family members, or significant others, in the assessment process as soon as possible.

Screening may be appropriate at the time of presentation for driver's license application/renewal.
Users of Medtech32 from the Whanganui district can access an advanced form that will assist them in making and recording an assessment of a person suspected of having dementia. This includes many of the tools recommended in this Pathway.

**NB:** If person refuses to visit GP, then need to link family/carer to support services (see Dementia - Management Pathway – ‘support for the carer and family’ node).

### 8 Clinical Presentation (Symptoms)

**Quick info:**
Concerns may be raised by the person and/or family members. Concerns raised by others should always be documented as being raised by others but should be seen as valid as self-reported concerns. Consider differential diagnosis.

Consider dementia when any of the following are present:

**Cognitive Symptoms**
Can include:
- changes in memory
- forgetfulness
- repetitive questioning
- difficulty recalling names and other words
- not knowing common facts
- communication problems (spoken or written language)
- disorientation (time, place, person)
- recognition
- changes in insight and judgement
- changes in cognitive behaviour noted by family/whanau

**Neurological Symptoms**
Can include:
- gait disturbances
- apraxia (loss of ability to perform learned purposeful movements)

**Difficulties with activities of daily life**
Can include:
- getting lost
- taking prescribed medications erratically
- forgetting recipes when cooking
- neglecting household chores
- trouble with shopping
- difficulty handling money
- loss of driving skills
- neglecting hygiene or self-care, look for deterioration in personal appearance
- making mistakes at work

**Psychological symptoms of dementia**
Psychiatric symptoms, personality changes and mood, for example:
- withdrawal or apathy
- depression
- anxiety
- blunting of emotions and disinterest
- suspiciousness, fearfulness, or paranoid beliefs
- insomnia
- psychotic symptoms, including delusions / abnormal beliefs or hallucinations

**Behavioural changes seen in dementia**
Challenging behaviours:
• aggression
• social withdrawal
• disinhibition, inappropriate friendliness or flirtatiousness
• restlessness or wandering

9 History

Quick info:
Person history:
• speak with family, whanau, carer, friends
• neglect
• nutrition
• isolation
• abuse
• driving
• financial
• legal

Family/whanau history:
• establish relationship
• introduce self/person
• identify:
  • key family/whanau members
  • living environment
  • who lives with the person
  • person's/whanau's beliefs and values
  • how they perceive what is happening to them
• work with the person / whanau / family members around care plan and their needs as they determine them to be
• ask if any Iwi provider services are involved

10 Physical Examination

Quick info:
Physical examination:
• review medications:
  • if polypharmacy is present consider referral to WRHN pharmacist for a medication review
• physical examination:
  • baseline vital signs
  • general systems physical examination
  • assess nutrition - consider malnutrition screening
  • neurological examination
• screen for depression
• screen for anxiety
• ask about and observe for:
  • problems with attention, memory, orientation, e.g. confusional stage
  • speech and language
  • performing key roles and activities
  • alcohol consumption and history
11 Initial Cognitive Screening

Quick info:
Formal cognitive testing using a standardised instrument, recommended:
- Montreal Cognitive Assessment (MOCA) or
- 6-item Cognitive Impairment Test is recommended (see 6CIT); with CDIS (Clock Drawing Interpretation Score)

When interpreting test scores, take into account:
- physical, sensory, or learning disabilities - may invalidate results (see note below)
- language background - test should be in person's first language, ideally with use of interpreter if needed
- educational level - the score for the MOCA should be increased by one point if ≤12 years of education
- communication difficulties that make test difficult (see note below)
- hearing and vision - ensure person is using reading glasses and wearing hearing aids if needed
- psychiatric illness
- physical/neurological problems

Characteristics of memory impairment (adapted from Neurological Foundation of New Zealand) & approximate ranges for cognitive screening tools.

Consider an interpreter where English is a second language.

NB: people in an unfamiliar environment may behave differently – consider an assessment in their own home.

NB: some conditions that are associated with lifelong intellectual impairment can also be associated with dementia. Assessment of cognition can be difficult in such individuals as cognitive screening tools tend to presume a “normal” level of literacy and education as well as a prior “normal” level of day-today function. In such cases, a corroborative history of change in cognition and function is critical.

12 Investigation

Quick info:
Initial investigations:
- bloods:
  - full blood count (FBC)
  - Urea & electrolytes (U&E's)
  - liver function test (LFT)
  - thyroid stimulating hormones (TSH)
  - fasting lipids
  - calcium
  - B12/Folate
  - glucose/HbA1C
Cognitive Impairment Assessment Dementia Suspected

Mental Health > Behavioural, developmental and other > Dementia

- C-reactive protein (CRP)
- mid-stream urine (MSU)

13 Cognitive Assessment

Quick info:
If further clarification is needed complete one of the following:
- The General Practitioner assessment of COGnition (GP COG) or
- Rowland Universal Dementia Assessment Scales: a multicultural mini-mental state examination (RUDAS). This tool is a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance (tool is best used for low education and language barriers)

When interpreting test scores, take into account:
- physical, sensory, or learning disabilities - may invalidate results
- language background - test should be in person's first language, ideally with use of interpreter if needed
- educational level - the score for the MOCA should be increased by one point if ≤12 years of formal education
- communication difficulties that make test difficult
- hearing and vision - ensure person is using reading glasses and wearing hearing aids if needed
- psychiatric illness
- physical/neurological problems

Characteristics of memory impairment (adapted from Neurological Foundation of New Zealand) & approximate ranges for cognitive screening tools.
Consider an interpreter where English is a second language.

References
- Journal of the American Geriatrics Society 2002 Brodaty
- The need to distinguish screening from diagnostic assessment
- Mental Capacity

14 Differential Diagnosis

Quick info:
It is important to consider co-morbidities and differential diagnoses.
An estimated 10% to 20% of cases of dementia syndrome are caused by other conditions:
- depression
- delirium - 4AT Tool
- drug and alcohol issues (see advanced form in Medtech - "Dementia Assessment")
- pernicious anaemia/low B12
- thyroid disorder
- psychosis
- Parkinson's disease
- stroke
- syphilis, borrelia, or HIV (perform test if there is clinical suspicion or high risk)
- carcinoma
- sleep disorders / sleep apnoea

Medications, particularly those with significant anticholinergic side effects may affect cognitive function, e.g:
- antidepressants
- antihistamines
- antipsychotic medications
- opiates
15 Carry out Initial Risk Assessment

Quick info:
Carry out assessment of:
- concerns raised by others
- risk of falls:
  - occupational therapy
- medical aspects of fitness to drive (NZTA)
- mobility scooter
- firearms
- drug and alcohol issues (see Advanced Form in Medtech)
- smoking status and history
- social isolation
- not having an enduring power of attorney
- neglect
- malnutrition/weight loss
- vulnerability to exploitation (elder abuse prevention toolkit)
- risk of suicide and history of previous attempts
- risk of harm to self or others
- review prescribed medications to identify if exacerbating drug action/interactions:
  - consider liaison with the person's community pharmacy or a referral to clinical pharmacist via Medtech outbox document for a clinical medication review
- carer stress/burnout

16 Diagnosis Decision

Quick info:
The main distinction between memory loss due to aging, and memory loss due to dementia, is that problems in age related memory loss do not affect daily functioning or the ability to live independently. Age-related memory loss is not a precursor to mild cognitive impairment or dementia. Cognitive impairment syndromes can be classified based on severity. Memory problems in older people may be associated with the normal ageing process. Others may present with memory problems that are severe enough to meet the criteria for mild cognitive impairment (MCI). A significant minority may meet the clinical criteria for dementia.

Characteristics of memory impairment (adapted from Neurological Foundation of New Zealand) & approximate ranges for cognitive screening tools.

Resources:
- diagnosing dementia
- memory changes
- breaking bad news: Diagnosis: Informing the person with dementia and their family/whanau, carer, friends

17 Types of Dementia

Quick info:
See following nodes for information on these different types of dementia.

**Likely to be able to diagnose in primary care:**
- Dementia of the Alzheimer's type
- Vascular Dementia
- Mixed Vascular/Dementia of the Alzheimer's type

**Likely to require specialist input:**
- Frontotemporal Dementia
- Lewy Body Dementia
- other types of dementia

Information sourced from [Alzheimers.org.nz](https://www.alzheimers.org.nz)

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### 18 Dementia

Quick info:

The development of multiple cognitive deficits which involve memory impairment and functional impairment likely indicate a progressive disease process such as a dementia. Dementia without complications is usually manageable by the general practice team. However, where complications are present referral to the Specialist Health of Older People Team may be required. **Once you have made a diagnosis of dementia you are advised to complete initial referrals, interventions and develop a management plan.**

Please see Dementia - Management Pathway initial review for further advice.

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### 19 Normal Cognitive Ageing

Quick info:

Some individuals who report difficulties with memory and have normal cognitive testing may just be aware of their normal changes in memory that occur with aging, others may be experiencing deterioration from superior functioning.

Some people with mild cognitive impairment will have a normal 6-CIT score. Patients may need more inclusive screening tools - MOCA or RUDAS. If there is any doubt about the diagnosis, consider following the pathway for those with objective evidence of cognitive impairment.

In all cases:
- refer to “Reassurance and Lifestyle Advice” node
- discuss enduring power of attorney and advance care planning (refer ACP pathway)

In some cases:
- consider re-screening in 12 months time

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### 20 Mild Cognitive Impairment with Objective Evidence

Quick info:

Objective change in cognitive testing with little or no impact on function and/or activities of daily living is known as mild cognitive impairment (MCI).

There are two main types of MCI seen amnestic and non-amnestic. Separate consideration should be given to non-amnestic MCI or a MCI with overlaying qualities such as anxiety or depression.

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### 21 Dementia with Complications

Quick info:

Complicated dementia includes:
- early onset under 65 years of age
- diagnosis unclear
- rapid decline
22 Dementia without Complications

Quick info:
Once you have made a diagnosis of dementia you are advised to complete initial referrals, interventions and develop a management plan.
Please see Dementia - Management Pathway for detailed advice.

Key links for specialist advice:
- Community Geriatrician:
  - for geriatric consult/opinion
    - 06 348 1234 page # 051
- Community Psychiatric Nurse, Older Persons Team:
  - for psychogeriatric advice
    - 06 348 3484
- Community Psychiatric Nurse, Older Persons Team:
  - for psychogeriatric advice
    - 06 348 3238
- Psychogeriatrician:
  - for psychogeriatric advice
    - 06 348 3172
- Consultant Physician and Geriatrician:
  - for geriatric consult/opinion
    - 06 348 1234 page # 009
- Memory Service
  - Assessment, Treatment and Rehabilitation (ATR) in-patient unit Whanganui Hospital, 100 Heads Road, Whanganui | 06 348 1234 ext. 7291

23 Mild Cognitive Impairment

Quick info:
Mild cognitive impairment (MCI) is a "grey area" between normal age-related memory loss and dementia, and is defined as objectively impaired neuropsychological test performance but with intact activities of daily living.
Most people are able to maintain their cognitive ability at a functioning level throughout their life.
Approximately 20% of people aged over 65 years have mild cognitive impairment. For some people, mild cognitive impairment is a precursor to dementia. A recent meta-analysis reported that the annual conversion rate from mild cognitive impairment to dementia is approximately 5-10% per year. Many people with mild cognitive impairment, however, did not progress to dementia even with ten years follow up. Between 3-11% of people aged over 65 years and around 33% of people aged over 85 years have dementia. Amnestic Mild Cognitive Impairment is the most common presentation, with mainly aspects of memory/recall or a combination of areas affected in cognitive testing. Amnestic MCI is best managed in the primary sector.
Non Amnestic Mild Cognitive Impairment is indicated when individuals present with a reduced cognitive score but the areas of deficit are not in memory or recall but rather in orientation, executive function and/or visuospatial skills. This group of people may warrant further investigation by a specialist service as the features may predict development of other types of dementia particularly frontotemporal and Lewy Body dementia.
24 Reassurance and Lifestyle Advice

Quick info:
Include diet, physical and social activities.

Advice on diet:
- low fat, high in fruit, vegetables and omega 3 fatty acids (oily fish) and increase dairy / calcium to reduce risk of fractures

Advice on activity:
Exercise has the most proven benefit for maintaining cognitive function. An increased level of fitness is associated with improved memory and learning and a reduction in age-related cognitive decline. Cumulative exercise from normal activities of daily living (ADL), such as:
- vacuuming, collecting the mail, walking to the shops, should be encouraged as well as consideration for referral for formal exercise participation

Encourage social engagement and intellectual stimulation:
Bowls, bridge, Mahjong, church, Age Concern, Grey Power, U3A, Sudoku, RSA, cafes, Men's shed, knitting circle, bingo group, Kaumatua programmes or reconnecting with previous social activities.

Resources:
- activity and exercise:
  - Neurological Foundation of New Zealand - Stay Active
  - physical activity for older people fact sheet
- alcohol and the older person
  - alcohol and older people
- nutrition and diet
  - healthy eating and lifestyle for older people
- memory strategies
  - memory strategy booklet
- reducing risk factors
  - "What's good for the heart is good for the brain"

26 Management of Mild Cognitive Impairment

Quick info:

Management:
- promote reduction of vascular risk factors
- provide advice on exercise and diet
- encourage social engagement and intellectual stimulation
- involve family
- advance care planning
- enduring power of attorney
- driving
- arrange re-screening in 12 months

NB: Cognitive enhancing medication (e.g. Donepezil) is not indicated in mild cognitive impairment, and may be potentially harmful.

Further articles of interest:
- Timely Diagnosis of Dementia: Can we do better?
- Clinical referral patterns and cognitive profile in mild cognitive impairment
- Diagnosis and Treatment of Dementia: 3. Mild Cognitive Impairment and Cognitive Impairment Without Dementia

27 Social Engagement and Intellectual Stimulation

Quick info:
Include diet, physical and social activities (see "Reassurance and Lifestyle Advice" box)

**Encourage social engagement and intellectual stimulation:**
- bowls, bridge, Mahjong, church, Age Concern, Grey Power, U3A, Sudoku, RSA, cafes, Men's shed, knitting circle, bingo group, Kaumatua programmes or reconnecting with previous social activities
- Living Well with Dementia - Alzheimers New Zealand

**Resources:**
- memory strategies:
  - memory strategy booklet
- reducing risk factors:
  - "What's good for the heart is good for the brain"

### 28 Enduring Power of Attorney / Advance Care Planning

**Quick info:**

**Enduring Power of Attorney (EPA):**
- EPA information - MSD
  - phone 0800 273 674

**Price list for EPA:**
- Public Trust $195 for health and welfare and $195 for property
- Armstrong and Barton $200 for health, welfare and property
- CLAW - will complete the paperwork at no cost. There is a cost for filing it at court which is $200.

An Enduring Power of Attorney (EPA) is a legal document that can protect you and what is precious to you. There are two types of EPAs:

- property – covers your money and assets and can come into effect before you lose mental capacity. You may have more than one attorney for this EPA
- personal care and welfare – covers your health, accommodation and associated care decisions, and comes into effect only if a medical professional or the Family Court decides you have become ‘mentally incapable’. You may have only one attorney for this EPA

An EPA means only the people you trust – your ‘attorney/s’ – can make decisions about your life and/or your treasured possessions, such as your house, money and belongings. You are referred to as the ‘donor’. An EPA can protect you from financial abuse because you have chosen that person or people yourself. That means your wishes are more likely to be respected, and that decisions should be made in your best interest. An EPA can also save your family the cost and stress of having to get a court order to make decisions about you and your property and finances should something happen to you.

When you’ve decided who you’d like as your attorney and what you want them to do, you need to arrange a lawyer, a qualified legal executive or a representative of a trustee corporation (like Public Trust) to be your witness. They will make sure you understand all your options, what the EPA document means, and that it meets all legal requirements.

Creating an EPA does cost money but there are ways to bring down the cost. Being organised, knowing what you want and filling out the forms before seeing your witness will mean the process takes less time and can therefore be cheaper.

Some lawyers and other legal professionals offer a [SuperGold Card](https://www.supergold.co.nz) discount so make sure you ask. They may also let you pay the cost off over time. Making an EPA when you make your Will or need to see your lawyer about another matter can also help you save on costs.

The following forms are available to download from the [MSD website](https://www.msd.org.nz):
- EPA form - personal care and welfare
- EPA form - property
- EPA form - certificate of witness
- EPA form - certificate of non-revocation and non-suspension

Also discuss the need to have an [advance care plan](https://www.elderplan.org.nz/advance-care-planning)
Overview
This document describes the provenance of Whanganui Regions Cognitive Impairment Assessment Dementia Suspected and Dementia Management Pathways. These localised pathways were last reviewed and updated in September 2016.

The purpose of implementing the CCP Programme in our District is to:
- Enhance accuracy of referrals
- Use best practice guidelines
- Have all information found in one place
- Enhance partnerships and collaboration across services
- Improve patient outcomes through seamless care across primary and secondary care

To cite this pathway, use the following format:

Editorial methodology
This care map has been based on a Map of Medicine Care Map developed according to the Map of Medicine editorial methodology. The content of the Map of Medicine care map is based on high quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience (see contributors section of this document). This localised version of the evidence-based, practice informed care map has been peer-reviewed by the WDHB and WRHN Collaborative Clinical Directors and Leaders Forum and with stakeholder groups.

Consumer engagement
Development of the Whanganui Collaborative Clinical Pathways focuses on person-centred care and an experience based co-design approach where consumers are invited to consult with the Health Promoter / Community Developer (who sits on each pathway working group). Consumers are asked prior if possible, or if not at the very start of the pathway process to share their experiences to assist in designing services that work for them and their families, critiquing and feeding back on suitable consumer information and resources which can then be incorporated into the pathways. Feedback obtained ensures we address consumer challenges and needs within the pathway and provide suitable services, information and resources for consumers. Additional information on patient centred care is provided by following this link http://www.kingsfund.org.uk/projects/ebcd. and experience based co-design of health care services at http://www.kingsfund.org.uk/projects/ebcd.

References

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Disclaimers
CCP Leadership Team, Whanganui

It is not the function of the CCP Leadership Team to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.