NHS
South Yorkshire
Integrated Care Board

Mild Cognitive Impairment (MCI) check list and further information

ICD – 11 definition: There are several definitions for MCI, however ICD -11 describes it as 'mild neurocognitive disorder', characterised by the subjective experience of a decline from a previous level of cognitive functioning. This decline is accompanied by objective evidence of impairment in performance on one or more cognitive domains relative to that expected given the individual's age and general level of intellectual functioning that is not sufficiently severe to significantly interfere with independence in the person's performance of activities of daily living. The cognitive impairment is not entirely attributable to normal aging.
Whilst many people with MCI will remain stable or even improve in cognition, the conditions do involve an increased risk of dementia. As a result, many places will review their MCI patients on an annual basis. Some GP practices keep their own MCI registers to facilitate the monitoring and recalling of patients for review. Where concerns arise a referral to the memory service is advisable.
Diagnosis of MCI should be clearly recorded, and it is recommended **that READ Code Eu057** is used.

The *Faculty of psychology of older people are due to publish further MCI guidance* **https://www.bps.org.uk/member-microsites/dcp-faculty-psychology-older-people/resources**

Guidance for Primary Care:

Follow up reviews of people with mild cognitive impairment

What you are trying to do is to determine whether, since the time of the last assessment, there is evidence of a decline in memory and/or thinking which is sufficient to impair personal activities of daily living. If there is, the person has developed dementia. If the person's memory has improved since the last assessment or is stable, the person does not have dementia.

1. Take a brief structured history from an informant, (a relative, partner, friend or carer who knows the person well and has seen them regularly over the preceding year). This should preferably be done face to face – remember to check with the patient that they are happy for you to speak with their relative, generally easy to do if both attend the appointment.

If time is short it is best to concentrate on questions which inform you as to whether the person's impairments are affecting their activities of daily living. The following might be appropriate questions (some are adapted from the IQCODE):

1. *a) Since we last saw you, has there been any change in your relatives' memory or thinking?*
2. *b) Have these changes led to any change in ability to carry out their daily activities?*
3. *c) Has there been any change in their ability to remember where things are usually kept?*
4. *d) Has there been any change in their ability to work familiar household appliances, for example the television remote control, washing machine, cooker etc?*
5. *e) Has there been any change in their ability to make decisions on everyday matters?*

6. *f) Has there been any change in their ability to handle money for shopping or deal with financial matters such as pensions or dealing with the bank?*

2. Cognitive assessment. It is useful if time allows to repeat the cognitive assessment that the person has had before. It is vitally important the same cognitive tool is used to check the patients' cognition because what you are looking for is evidence of change. But cognitive decline alone does not mean dementia – there must be evidence of impaired ADL function too.

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