

Cognitive Vulnerability At Care Transitions: Acute Illness, Hospitalisation, And Unrecognised Change

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KEY TAKE AWAY

Acute illness and hospitalisation expose cognitive *vulnerability*, often revealing or accelerating decline that is missed at care transitions. Better anticipation, (re-)assessment, and communication of cognitive change are essential to improve safety, independence, and long-term outcomes.

INTRODUCTION	METHODS / APPROACH	KEY OBSERVATIONS	IMPLICATIONS FOR CARE PATHWAYS	REFERENCES
- Episodes of acute illness and hospitalisation are frequent inflection points in the continuum of care for people living with dementia. - They can precipitate delirium, unmask latent cognitive fragility, and accelerate functional decline—even in previously robust individuals. - Cognitive instability and delirium are often insufficiently recognised, particularly at transitions between care settings. - Decisions at discharge and step-down may be based on assumptions about cognition and capacity that no longer hold, with consequences for safety, independence, and long-term care needs.	- Perspective paper drawing on clinical and research experience to examine cognitive vulnerability at care transitions. - Explores how sudden deteriorations in health can expose latent cognitive fragility and alter baseline function. - Considers the complex relationship between delirium, dementia onset and progression, and functional recovery. - Highlights how gaps in cognitive (re-)assessment and documentation lead to discontinuity across hospital and community interfaces.	- Acute illness can precipitate delirium and may trigger onset or acceleration of cognitive decline. - Cognitive fluctuation and functional decline are common but poorly captured by existing pathway structures. - Gaps in cognitive (re-)assessment and documentation at transitions lead to assumptions that cognition and capacity remain unchanged. - Poor recognition and communication at transitions contribute to discontinuity across hospital and community interfaces. - Missed or poorly communicated cognitive change can drive adverse trajectories: increased readmission, care dependency, and earlier institutionalisation.	- Cognitive vulnerability should be anticipated and actively assessed during episodes of acute illness and at key transitions. - Cognitive (re-)assessment should be systematically documented and communicated across care settings. - Pathways should accommodate fluctuation and uncertainty as inherent features of dementia, not as exceptions. - Key issues for pathway design and practice: - How cognitive change associated with acute illness should be anticipated. - How delirium and its consequences can be better detected and managed. - How to support informed discharge and step-down decisions when cognition is unstable. - How to achieve continuity of information and understanding across settings. - How to monitor and reassess cognition and function after transition.	- Boucher EL, Gan JM, Lovett NG, Smith SC, Shepperd S, Pendlebury ST. Implementation of Delirium Screening at Scale in Older Patients With Emergency Hospital Admission. <i>JAMA Intern Med.</i> 2025 Jul 1;185(7):884-887. - Phelps A, Kingston B, Wharton RM, Pendlebury ST. Routine screening in the general hospital: what happens after discharge to those identified as at risk of dementia? <i>Clin Med (Lond).</i> 2017 Oct;17(5):395-400. - Elias TCN, Jacklin C, Bowen J, Lasserson DS, Pendlebury ST. Care pathways in older patients seen in a multidisciplinary same day emergency care (SDEC) unit. <i>Age Ageing.</i> 2024 Jan 2;53(1):afad257.
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