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Dementia Care Advisers

25 April 2017

Context

- Role originally established in 2014 – supportive advice and signposting for all newly diagnosed residents – linked to Memory clinic, and 3rd sector dementia support services

- Role well established and valued by all stakeholders over 2 years

- 2014-16 Period of growth and change
  - As dementia diagnosis rates increased – increased demand for services
  - Profile of dementia raised as a specific condition and as part of complex needs with other long term needs
  - Care Act implementation – more focus on carers needs
  - Additional network of supportive services and liaison – through Older person as Mental Health subgroup
  - Launch of Each Step Together programme

- Maternity leave offered opportunity to take stock, review and absorb learning form other models of DCA support – nationally and across Berkshire

Activities September 2016 – to date

- Increased staffing to 1.2 wte - two DCAs with complementary and different skills and experience to widen scope of role
- One Nurse and one specialist in Cognitive Stimulation therapy
- 136 new referrals in 7 months with a wide spectrum of neurological conditions
- Refresh all promotional information and proactive engagement with all contact points across wider H&SC system eg practice nurses, public Daily Living Made Easy Event in October.
- Speedy response and onward referral to targeted community support- EST approach
- Proactive relationship with Memory clinic - DCAs involved in last week of Introductory Course for better client/carer face to face contact
- Holistic and sustained support to dementia patient and family – better carer identification and support
- Targetted advice on acquisition of relevant equipment and use of assistive technology (with demonstrable impact on falls related NEL admissions) Telephone triaging to identify those near crisis and offer immediate pre-emptive support with immediate access to other health and social care specialist advice

Impact – resident stories

- More joined up information sharing (RIO/CCG/PARIS) reinforces the "Tell your story once" objectives for residents and targetted support without repeating historical information
- More timely and creative interventions to promote independence and reduce risk of crisis
- Tailored support for different types of dementia diagnosis – and links to other long term conditions
- Shorter waiting times for referral implementation eg reduced 6 week waiting time for Day Centre referrals to 1 week- EST
- Whole person – lifelong support – not just at initial diagnosis – gateway to ongoing advice and support throughout patient journey
- Patient and Carer – supported individually and together – multigenerational households
- Better/ increased use of other dementia related services

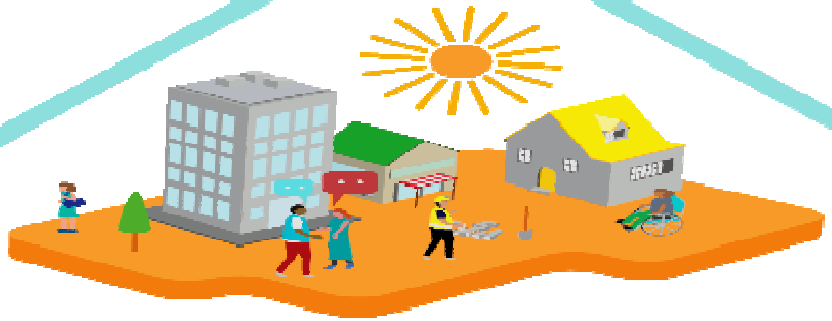
EST.

1 Conversation 1 : Listen & Connect

Listen hard. Understand what really matters. Connect to resources and supports that help someone get on with their chosen life, independently.

2 Conversation 2 : Work intensively with people in crisis

What needs to change urgently to help someone regain control of their life? Put these into an emergency plan and, with colleagues, stick like glue to help make the most important things happen.



3 Conversation 3 : Build a good life

For some people, support in building a good life will be required.

What does 'a good life' look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organized?

Mr S

Mr S is an 81 year old with Alzheimer's Disease.
He was diagnosed in 2015 but he has difficulty accepting it and his family have decided not to speak about it with him as it upsets him so much. They describe him as having a Peter Pan personality.
Unable to discuss as he refuses to have a conversation about being "old person".
Dgter lives nearby and is concerned as he is not eating and has been losing weight.
Developed leg pain and can not access his local coffee shop.
Now taken to his bed
Dirty crockery now building up, so Dgter called DCA for advise.

EST actions
DCA visited, needs discussed;
Refused POC in the past, did not want to attend any groups
DCA discussed using a personal assistant with Mr S and his Dgter.
Same person coming in he would be more relaxed and accepting.
Work on personal care, go in late and encourage him to get up.
Encourage meals- Breakfast, coffee, etc.
Encourage outdoor mobility
Accompany him out- re-establish routine
Support plan completed.

Outcome;
PA- via CareBank, number of C.V's able to choose. Developing rapport and daily routine due to review in 2 mth's. Mr S Dgter- thanked DCA for giving them this option and Mr S is delighted with his new P.A.

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Questions.