Deirdre Cullen

Co-Ordination of Supports

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KINSALE COMMUNITY
RESPONSE TO DEMENTIA

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Building collaboration and integration

The consortium model of collaborative working provided a forum for integrated and close working relationships with people who would not normally ‘ have sat at the same table before’

It brings together people with similar interests and purpose who share a commitment to active participation at a community level.

This method of working recognizes the strength of a coordinated response bringing together people from private industry, education, people with Dementia, Carers, people from Health care work and local Government.

Case example of coordinating role of Dementia Care Coordinator… Joan 62 Years.

Quotes from GPs involved with K-CoRD:

“ there was a huge reassurance that when you had somebody that was diagnosed with dementia you had a clear pathway on how you were going to manage them, and that pathway involved the referral to the dementia Care Coordinator”

“ if you are organising what is an extremely complex care programme, you need somebody at the helm that you can touch base with because we don’t have time day-to-day to do that “

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The importance of having a key point of contact.

Different approaches were taken to coordinating the provision of supports and services, in some areas it was a designated clinical role and in others existing PHNs with access to infrastructure of supports provided this service.

A single point of contact in the area for dementia, advice, information and support.

Providing specific guidance, information and support to a person with dementia and their family/carers.

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Initial assessment of need, with skill in valuing and hearing the person with dementia and family members voice and wishes regarding supports, capturing life history and interests and the opportunity to spend as much time as required in this process

Developing a personalized support plan that utilizes a combination of natural, informal and formal services as indicated by the person with dementia and their family's needs and wishes

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Developing and coordinating a range of interventions including exercise, therapies and social activities for people with dementia based on evidence and best practice

Initiating immediate response in crisis situations (example)

Promoting and embedding a personalised approach to service deliver across the primary care teams and associated services.

Providing specialist advice, guidance, information and support to health and social care professionals

Support to the PHN and other health professionals in implementing responses to situations where challenging behaviour and other issues present

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Key findings

- Based on the learnings from the four sites a dementia specialist from a clinical background has been identified as a specific role to support point of contact and co-ordination of services.

- This role can draw from existing skills and expertise within the health and social care system.

- An important note is that case management should remain with the key worker locally.

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Additional non clinical functions *(some have already been talked about)*

Promoting Dementia Awareness Raising initiatives including community collaboration.

Developing **Training and Education** opportunities to staff, family and volunteers.

Promoting integration for people with dementia in community participation.

Supporting the development of peer to peer support Groups for persons with dementia and family/carer

Supporting the development of a volunteer Network

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OUTCOMES

- Personalised supports are being co-ordinated and delivered taking account of a persons societal/community and clinical/medical need.
- Natural, informal and formal services to support individual need are being harnessed to provide a personalised community response to people with dementia.
- Specialist clinical knowledge is supporting people with dementia.
- Collaborative and integrated working with local key workers is supported with specialist input.

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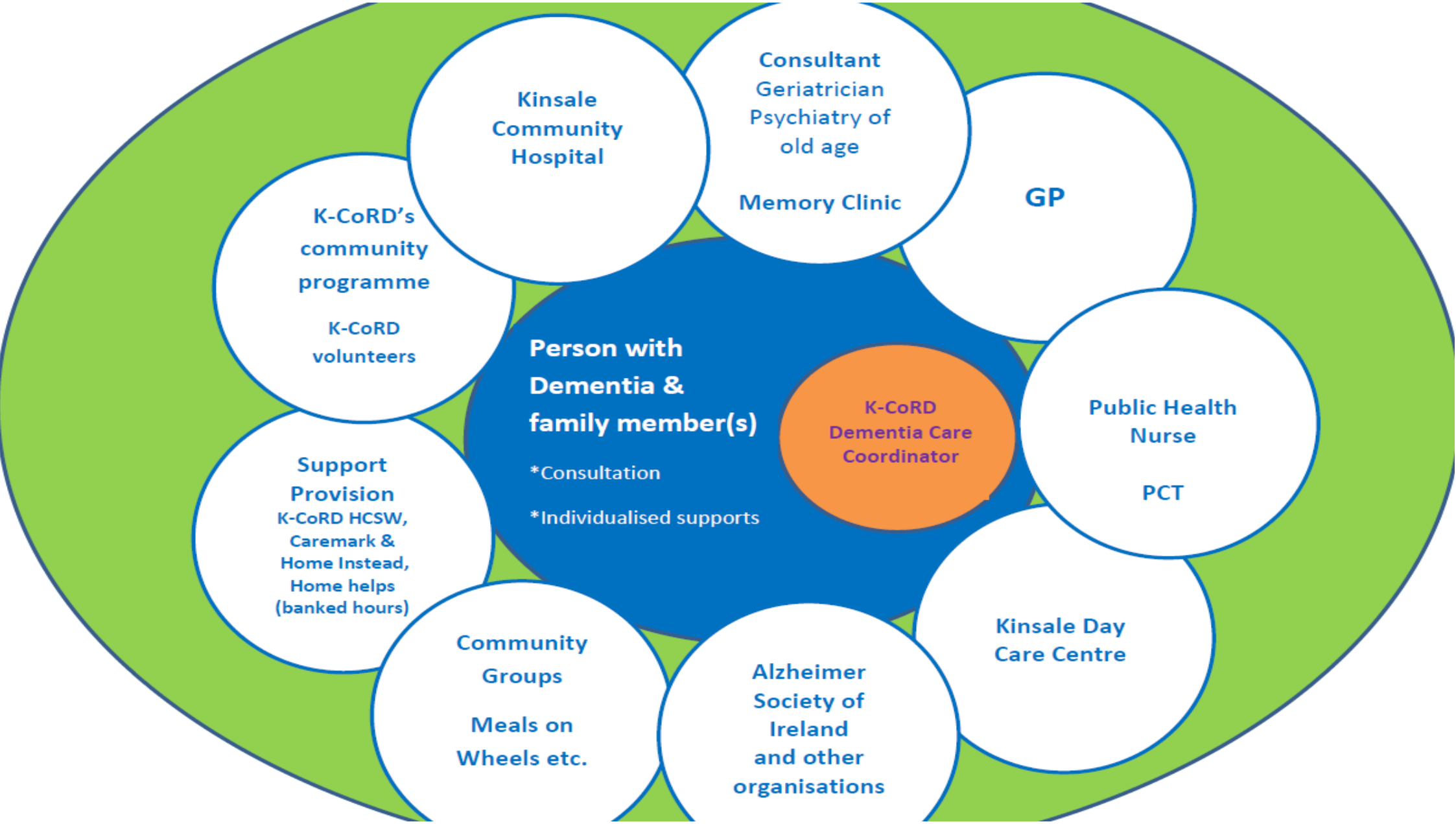
- Key to the success of the coordination of supports for the person with Dementia is the collaborative working

- Multi-disciplinary Primary Care Team meetings are an optimum forum to support, prioritise, coordinate and review cases.

- A specific dementia Care Review meeting was held monthly as part of this project, it was felt that the clients with Dementia may not get ‘the spot light’ if integrated into the normal PCT meetings.


Kinsale Community Hospital
Consultant Geriatrician Psychiatry of old age
Memory Clinic
GP
K-CoRD's community programme
K-CoRD volunteers
Person with Dementia & family member(s)
*Consultation
*Individualised supports
K-CoRD Dementia Care Coordinator
Public Health Nurse
PCT
Support Provision
K-CoRD HCSW, Caremark & Home Instead, Home helps (banked hours)
Community Groups
Meals on Wheels etc.
Alzheimer Society of Ireland and other organisations
Kinsale Day Care Centre

Recent opening of Kinsale Primary Care Centre.. K-CoRD presenting the Art Quilt to the community .

Supporting people to live in their local communities “requires major cultural and organisational changes”