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# Opportunities that the Genio grant funding allowed K-CoRD to develop for people with Dementia in Kinsale

- Building collaboration and integration between agencies
- Community awareness & education
- Developing Personalised Supports
- Care co-ordination
- Community supports mobilisation
  ( AT, EIPAHA, Memory café, Day Care Centre support, carers support, Arts Programme, social events)

## 1. 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'

People with similar interests and purpose who shared a commitment to active participation at a community level.

This method of working recognized the strength of a coordinated response, people from private industry, Education ( UCC , CIT), carers, Health care and local Government ( CCC and Kinsale UDC).

- Multi-disciplinary Primary Care Team meetings are an optimum forum to support, prioritise, coordinate and review cases. People with Dementia were often not prioritised for discussion at these meetings.

- Under K-CoRD a specific Dementia Care Review meeting was held monthly as it was felt that people with dementia may not get 'the spot light' if integrated into the normal PCT meetings.

# 2. Community Awareness and Education

- Initially **information evenings** were held to develop consortium and recruit local volunteers.
- We linked with Kinsale Community **School** ( TY and BTYS )
- VISION Art and supported **social events** were held
- We engaged with **CCC** and Age Friendly Town ( seats, parking )
- We held training with local **business** sector (OT student / intern.. plaques )
- Health Care Assistant and family carer **training**
- G P and Primary Care team **education** **(**Dr. Tony Foley GP reference Guide and PREPARED )

# 3. Personalised Supports

# Personalised Supports

- Need to consider the wider needs of the person, what they can do, their skills and interests, not focusing on deficits.
- A response to the person rather than 'one size fits all' .
- Appropriate supports as chosen by the person/family .
- Need to be flexible and responsive , in or outside the home.
- Supports provided by dementia skilled staff and volunteers knowledgeable in principles of personalised working.
- Menu of community appropriate supports available

K-CORD
KINSALE COMMUNITY
RESPONSE TO DEMENTIA

## 4. Care Coordination

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.

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

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

## Care Coordinator key Roles

**Initial assessment of need** with skill in valuing and hearing the person with dementia and family members 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**

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

e.g. Kinsale Community Hospital Respite support, Friday evening call. Prevent admission to CUH, Carers support during Hospital Admission

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

- **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 expertise within the health and social care system.

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

*Additional non clinical functions:*

**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

# 5. Community Mobilisation and awareness building.

## Opening of Kinsale Primary Care Centre and unveiling of K-CoRD Art work