The Denmead Practice

MISSION DEMENTIA PROJECT

Author: Kim Badcock RN RM BSc Hons QN

Supported by: Dr Ewan O'Farrell, Debora Stimpson and LehBee Cornwall

INTRODUCTION

There is a predicted exponential rise of people being diagnosed with dementia. Frontline care mainly provided by general practice. How can the primary care deliver a high quality service to meet the needs of patients in a sustainable way?

METHODS

Patients, their families and other stakeholders were engaged to identify problems and solutions within the current pathway. PDSA cycles, confidence interval and benchmarking were applied to measure outcome.

RESULTS

Helping patients come to terms with the diagnosis and support them to live the lives they choose within the boundaries of their diagnosis promotes independence and leads to fewer emergency consultations.

DISCUSSION

Working cohesively with secondary care and the voluntary agencies results in better outcome for patients and clinicians. Linking the surgery to memory café keeps patients on the radar. Effective signposting and early intervention help reduce crisis and keeping patients out of the surgery.

CONCLUSION

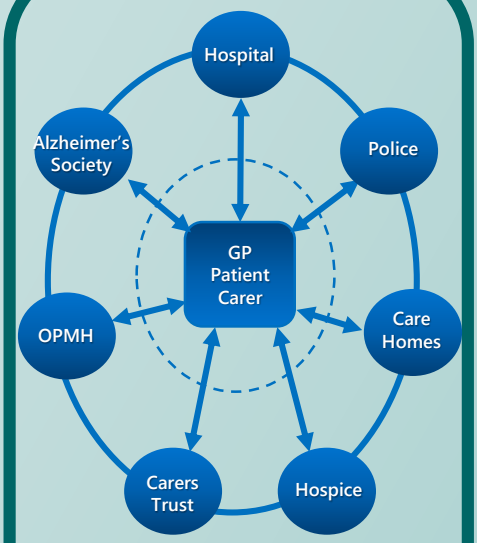
Dementia care delivered by general practice needs to be standardised. A robust pathway prevents gap in patient care. Additional training and support is essential to ensure the right care, is provided to the right patient, at the right time for the best outcome.

Current Dementia Care Setting

- Services are insular, detached and fragmented.
- Lack of communication, structures and processes to enable teams to work collaboratively towards common goals.
- Gaps exist between services which results in delays / costly / inappropriate level of care

What does good patient care look like?

- Breaking down barriers and integrate!
- Teams are linked up with a view to referring the right patient to the right unit at the right time for the best outcome.
- Good communication between teams involved to ensure continuity of care.
- Responsibilities are clearly aligned to different teams with no cost shifting.



OBJECTIVE

To embed dementia care into general practice from pre diagnosis to the end of life with support provided in a familiar and local setting.

- Explore the disconnects in the current pathway
- Identify areas for improvement
- Implement and measure those changes
- Share our learning

HOW?

Dementia Advisor

- Employed by the surgery
- To identify problems
- Explore solutions
- Engage and working with

PATIENT · FAMILIES · SECONDARY CARE · VOLUNTARY ORGANISATION · WIDER COMMUNITY

Dementia Advisor

DESIRED OUTCOME

- Increase the recognition of dementia and the prevalence in the registered patient list
- Support patients and families once diagnosed by liaising with the voluntary agencies, Older Peoples Mental Health, Adults Services and the wider community.
- Work with patients to find out what doesn't happen or work for theme and what we need to change to support them.
- Identify a pathway of care within the general practice that supports patients
- Work with the wider community to support a dementia friendly environment
- Share knowledge within the practice

COMMUNITY ↔ GP SURGERY

Memory Café Keeping patients on radar by links with surgery.

Hampshire Constabulary Missing persons protocol for safeguarding patient

Film Club In local care homes for patients living in the community – breaking down fear of long term care & reduce social isolation.

Library Helping patients access resources

- Robust pathway
- Memory testing
- A go to person
- Patient survey
- Discharge follow ups
- PDSA cycles
- Annual review

SURVEY QUESTIONNAIRE

1. Is it easy for you or your carer to make an appointment at your surgery?
2. When you attend your surgery is it easy for you to book in at reception?
3. When you attend your surgery is it easy to find where you need to go?
4. Did you feel the staff at the surgery treated you with respect and understanding?
5. Do you feel your needs were adequately met during your consultation?
6. Were you involved as much as you and your family want to be in the planning and decisions about your care?
7. Did you feel your surgery helped direct you to the voluntary agencies?
8. Are you aware of the following organisations?
9. Are you and your carers aware of the following community events?
10. Overall how would you rate the care received from the surgery

DIAGNOSIS

Speedier / Earlier diagnosis allows

- Patient time to come to terms with the diagnosis, hence the opportunity to choose to live their lives within the boundaries imposed by the disease.
- Time for families to plan ahead to make the most of the prescious time left with the patient.

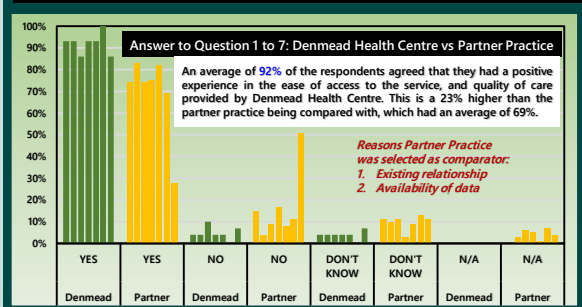
PATIENT

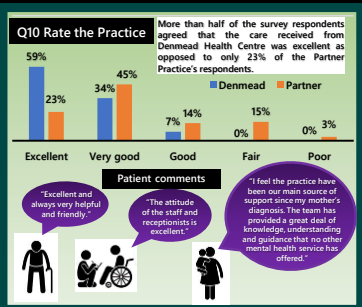
- Well informed patients understand what is to come, hence more likely to take the responsibility to conduct their own journey through the stages of the disease. This may reduce emergency consultations and prevent the need for premature residential care.
- Patient can feel safe, supported and valued, which promotes independent living, keeping active socially and physically.

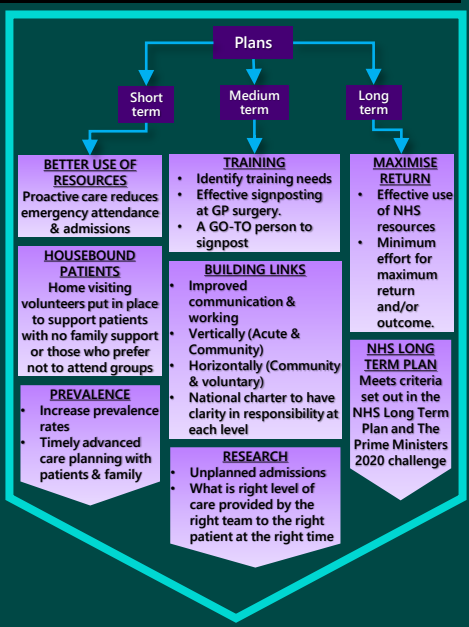
DEMENTIA ADVISOR

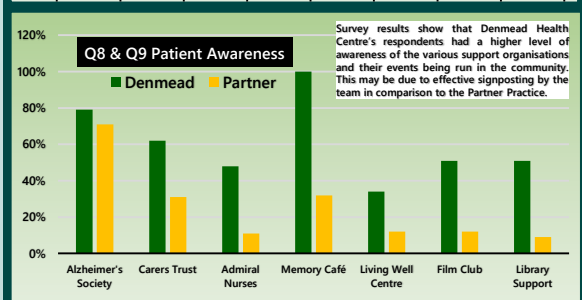
When the role no longer funded, the skills and way of doing things that are cognitively embedded in brains, develops commitment and motivates the team to work towards providing the best patient care for best outcome.

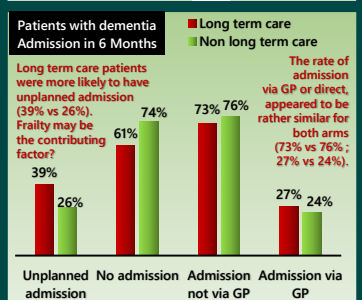
RESULTS ⇨ DISCUSSION ⇨ CONCLUSIONS











PREVALENCE
Starting to increase
Earlier & speedier diagnosis
Allows families time to plan ahead before disease progresses

SURVEY
Staff skills - effective signposting ➔ Patients support reduces stress, anxiety and GP appointment.
Quality of care - Patient better informed. Involved in care decision making ➔ Feeling in control, increased autonomy.
Signposting - Access to voluntary agencies for help & support ➔ Ability to adapt to diagnosis, engaged with their treatment, and live well within boundaries of the disease.

DISCHARGE
Common reasons for admission - falls & Infection. Longer / more frequent hospital stay. Patients in long term care showed a higher rate of hospital admission ➔ possible faster disease progression ➔ at an increased risk of hospital acquired infection.
Impact on patient ➔ Poor quality of life | Shorter life span | Increased medical intervention
Impact on hospital ➔ reduced bed capacity

Memory café
Clinical presence with direct link to surgery and other organisations pivotal

Observations helps to shape clinical decisions

- A better use of NHS resources
- Improved communication
- Easy Local Access to support and advice

- Making access to help & support easier for patient
- Reduce the need to see GP / practice nurse
- Reduce recurrence of crisis

- Patients are relaxed
- Easier to observe
- More accurate data

Leading to:
Early identification ➔ diagnosis ➔ intervention

CONCLUSIONS

Short term actions

- Maintain an active memory cafe with more to be set up soon.
- Improve communication across the services
- Setting up a social befriender service is underway with The Living Well Centre.
- Missing person protocol is being rolled out
- Working with other surgeries to improve practice on the basis of the results mission dementia has shown

Medium term actions

- Standardising care pathway as it is currently missing
- Rolling it out to the wider community
- Measure outcome in 12 months