Community Dementia Specialist Service

Referral Criteria

The Service provides advice and support to patients and their carers who have either a confirmed diagnosis or suspected memory impairment.

Population covered

- Patient Registered with a Richmond GP
- Aged over 18 years
- Or carer of patient registered with Richmond GP
- Known and open to another HRCH service
- Care home residents

Any acceptance and exclusion criteria and thresholds

Access Criteria for Community Dementia Specialist Service

The Community Dementia Service will have a referral system for adults (aged 18 years and over) with specific memory / cognitive needs and who are registered with a Richmond GP. Referrals will be received via the HRCH Single Point of Access (SPA).

Following an individual holistic assessment, admission to the caseload for a short period of treatment / intervention to support the referring team to manage the patient and carer to promote well-being for those living with Dementia / memory impairment

Exclusion criteria

In order to avoid creating false expectations, or using the Dementia Service inappropriately it is important to list what the service does not provide:

- **Currently receiving active treatment from the CMHT**
- Social care needs (e.g. hygiene, meals, catheter bag emptying.), check visits or social calls
- Collect and deliver prescriptions, except in a crisis
- Under the age of 18 years
Applicable local standards

- Maximum response time from receipt of referral to assessment and/or treatment/ telephone advice is 5 days; The service will contact the patient to arrange appointment at time and venue convenient to the patient.

- Following Triage, if the referral has not met the referral criteria the referrer will be notified with reasons, within 48 hours.

- The Provider shall respond to referrals within the following time periods during day service periods:
  
  **Routine**: contact within 5 days and a visiting date agreed with the patient and referrer dependent on clinical need

Discharge criteria

- Treatment / intervention is complete
- Service user can self-manage safely, with a self-management plan provide, if deemed appropriate
- Service user is transferred to another more appropriate service
- Service user moves out of area
- The service user’s death
- Discharge correspondence and self-management plans to GPs within 2 working weeks after discharge

Days/Hours of Operation
The service shall operate Monday – Friday 8am - 6pm excluding Bank Holidays

The Objectives of the Community Dementia Clinical Specialists are:

- Case finding – supporting patients with memory impairment and their families to obtain a formal diagnosis
- Person centred assessments of the needs of the patient, family and carers of those living with dementia
- Psychological support to help family carers and people with dementia understand and deal with their feelings and emotions
- Practical advice
- Help family carers to improve skills in care giving
- Sign posting to local services both voluntary & statutory
- Supporting clinicians – advising in the management of patients receiving care from other HRCH services
Referral Source

Single Point of Access
Opening times 7 am-7 pm 7 days

Does not Meet Criteria
Refer back to source
With some feedback and direction towards appropriate service

Dementia Specialist Need Identified accept to service
Pass referrals to Dementia Service
Triage for urgency
Liaise with referrer regarding support / consultation
Contact patient to arrange first visit
Community Dementia Specialist to assess patient and agree goals for planned care and visits as appropriate to patients / carers needs

Other Needs Identified
Pass referrals to appropriate service i.e. therapy, podiatry
Notify GP

Refer to other services / agency’s as required
Visit patient/ carer as needs require
Reassess and evaluate care on each visit
Discharge from the service when goals achieved and GP / referrer informed of discharge summary

Refer back to source With some feedback and direction towards appropriate service

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