

A joined – up approach to  
post – diagnostic support

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# Introduction and Background.

- For the last year the Stewartry CMHT have been developing a pathway which will provide enhanced person-centred support to people with a diagnosis of Dementia.
- This follows the recommendations of the SIGN Guidelines (2006), that “Patients and carers should be offered information tailored to the patients’ perceived needs, and that good communication between healthcare professionals, patients and carers is essential.”

# Introduction and Background.

- The pathway enables people with a diagnosis of Dementia, their carers, and healthcare professionals to work through aspects related to diagnosis at a pace that suits everyone.
- Again SIGN Guidelines (Section 5) point to the fact that some people with a Dementia want to know about diagnosis, whereas others may not but may do in the future.
- The pathway developed helps the healthcare professional identify areas where more information and support may be required.

# Who Are We?

- The Stewarty Community Mental Health Team is made up of various members of the Multi-Disciplinary Team who provide a holistic approach to supporting people and their carers with various mental health difficulties.
- A substantial proportion of our work involves supporting people with a diagnosis of Dementia.

# Joined – Up Approach.

- Team Leader.
- Consultant and Staff Grade Psychiatrists.
- 2 Full Time and 1 Part Time Nurses.
- 1 Memory Clinic Link Worker.
- 1 Occupational Therapist.
- 1 Support Worker.
- 1 Elderly Mentally Infirm Care Manager.
- 1 Mental Health Officer and 1 Social Work Student.
- 1 Team Secretary.

# Referral Process in Team.

- Referrals get presented at CMHT meeting.
- Appropriate staff member allocated depending on needs of the person referred.
- Initial assessment is completed and fed back to team.
- Decision made for way forward depending on persons needs and speciality of team member - memory clinic, 3/6 month review, further testing (CT Scan etc), care package, legal issues or NFA.

# Memory Clinic.

- Person is seen at Memory Clinic by Consultant or Staff Grade Psychiatrist.
- If not already done, full physical examination and blood tests to rule out other causes of cognitive impairment.
- Further cognitive testing by Memory Clinic Link Worker-ACE MMSE Demtect.
- Discussions with family/carer to find out more about the history/progression of symptoms, changes of cognition, behavioural/personality changes, physical history, and impact on person.

# Memory Clinic.

- Diagnosis usually given by Psychiatrist at this time unless further Neuropsychological testing or scans required.
- Discuss diagnosis with person, carer and Memory Clinic Link Worker.
- Depending on diagnosis, Acetylcholinesterase medication may be prescribed.
- Referred back to CMHT for appropriate team member to support and follow up with checklist.

# Post Diagnosis Checklist.

- CMHT have developed a comprehensive checklist for all team members to work with post diagnosis.
- Although all CMHT members use this, Memory Clinic Link Worker usually is the first person to make contact with person and carers after diagnosis.
- Checklist acts as a guide for CMHT to work with person and carers at their pace.
- Allows all concerned to identify specific areas that require further education and support.

# Post Diagnosis Checklist.

- Checklist covers many topics that we have found people wanting to know more about after a diagnosis of Dementia is given, and also some that most people are not aware of, but are also of importance.
- Usually allow ourselves approximately 12 weeks to complete the checklist, but this is very flexible depending on the person and their carers needs.

# Post Diagnostic Checklist.

- Diagnosis/further info
- Medication
- Social impact
- Current support
- Carers assessment
- Challenging behaviour
- Relationship issues
- Activities of living
- Welfare benefits
- Income maximisation
- POA
- Named Person
- Advanced Statements
- Driving/DVLA
- Referral to other agencies

# Post Diagnostic Checklist.

- Once the checklist is complete the person and their carers have various options regards future treatment depending on their needs.
- Continued support from CMHT.
- Support via social services care package.
- Support from external agencies.
- 6 Monthly/Yearly reviews at Memory Clinic
- Medication monitoring.
- Discharge with ability to re-refer any time.

# Joint working in the Future.

- Joint – working has provided an approach in which various members of the Multi-Disciplinary Team can work together to provide best possible care for people.
- Due to the diversity of the professions, various aspects of care are looked at from various angles, which gives the person and their carers more options, and better holistic care.
- Plan to roll this pilot pathway out to all of the Dumfries and Galloway CMHT's in the near future.

# Thanks for Listening.

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