Supporting People with Dementia in Primary Care – Alison Skea

Facilitation Guide

Question 1. The following are real examples of a referrals to Memory Assessment Service (MAS) in their entirety. MAS is a dementia diagnostic service. Have a look and reflect on if they provide enough information to enable an effective triage? Consider what else should be included?

The memory assessment service is a dementia diagnostic service, with that in mind:

- Is there an objective measure of cognition? (GP COG, 6CIT, etc) Could this be normal ageing?
- Has the patient been seen, or is this reported from a family member? If not seen , can excludable causes have been explored?
- Has anxiety/ depression been treated?
- Dementia affects day to day functioning- is this affected?
- Was the person acutely unwell? Have they been reviewed since they recovered?
- If the patient has been brought to the surgery by a family member/ friend- do you routinely ask if 'carer's details can be added to the referral to ensure they attend and collateral history can be provided?
- Are there any risks?

Question 2. Scenario

A . Identifying Safeguarding Concerns: What are the potential safeguarding issues in this case?

Emotional or physical neglect (withdrawal, poor hygiene, malnutrition). Risk of harm from being locked in her room. Potential coercion or loss of autonomy (daughter answering for Mrs. E and limiting her voice).

B . Recognising Signs of Abuse or Neglect : What are the red flags that suggest Mrs. E might not be receiving appropriate care?

Her withdrawn behaviour and lack of engagement. Reports of being locked in her room, which could lead to harm or distress. Indicators of possible caregiver strain and burnout in her daughter.

C. Effective Communication: How can the GP ensure Mrs. E's voice is heard?

Use open-ended, non-leading questions to engage Mrs. E directly (e.g., "How are you feeling at home? Is there anything that worries you?").Conduct part of the consultation privately with Mrs. E, ensuring she feels safe to express concerns.

D . Assessing Risk and Capacity: How can the GP assess Mrs. E's safety and decision-making capacity?

Evaluate her understanding of her living situation and whether she feels safe at home. Consider her capacity to consent to or refuse her current care arrangements.

E . Supporting the Caregiver: What support could be offered to Mrs. E's daughter to prevent caregiver burnout?

Referrals to Social Care for respite care, community support services and carers assessment. Education about dementia care strategies and safety measures that do not involve restrictive practices such as technology enabled care (sensors).

F. Safeguarding Pathways: What immediate actions should be taken if safeguarding concerns are confirmed?

Report concerns to adult safeguarding services while maintaining Mrs. E's confidentiality as appropriate. Arrange a follow-up visit to monitor Mrs. E's well-being. Provide the daughter with resources for caregiving support

G. Ethical Considerations: How can the GP balance Mrs. E's autonomy and safety while addressing the concerns raised?

Ensure any interventions are proportionate and respect her rights and dignity. Discuss the risks and benefits of different actions with Mrs. E and her daughter.

H. Multidisciplinary Approach: What other professionals could be involved to support Mrs. E and her family?

Social worker to assess the home environment and caregiving arrangements. Occupational therapists to improve safety and care strategies. Charities or local support groups (e.g., Alzheimer's Society) for additional guidance and resources

Question 3. Do you diagnose advanced dementia in the care home population?

70% and 80% of care home residents are thought to have dementia & that many do not have a formal diagnosis. A Diagnosis enables access to appropriate support, care planning & in some cases, treatment & gives the opportunity for the patient with dementia to share their preferences for future care with family &carers

- If you don't currently diagnose advanced dementia in people living in care homes, why not?
- Have you considered using the DiADeM tool to guide safe diagnosis? This is a template to aid the diagnosis of people with advanced dementia in care homes (functional impairment? Cognitive impairment? (GPCOG or 6CIT) Corroborating history? Investigations- Bloods normal/ expected? Exclusion- no underlying cause to explain symptoms?
- What would you need in order to do this?

Question 4. What steps are you taking to ensure dementia diagnosis is coded correctly and added to the QOF register?

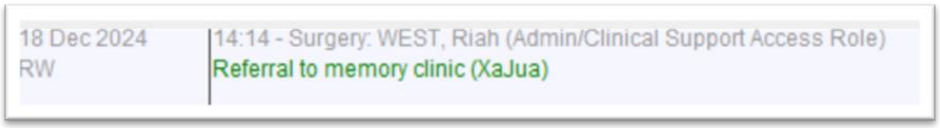
There are 5 QOF points available for establishing and maintaining a dementia register. It is the responsibility of the practice to demonstrate the systems that are in place to maintain a high quality register.

Coding the Dementia Diagnosis Process: There are three common steps and these should have relevant coding. Is this your process? If not could you be missing anything?

1. **'Referral to memory clinic'**
2. **The assessment**
3. **The result** (If the assessment result is not a dementia diagnosis, check what is stated e.g. a diagnosis or a conclusion. The following result could need to be coded:'memory impairment' / ' impaired cognition' (plus) a different diagnosis [examples: mild cognitive disorder, or post-traumatic stress disorder] or 'memory function normal' / 'normal cognition'

Key Reminders:

- Dementia diagnosis – The dementia code should be coded as a major problem. Ideally, the diagnosis letter would have been completed the same day as the assessment, so can be dated as this. However, appreciate this isn't always the case, and so would recommend consistency across your GP practice. Often the diagnosis (problem) is then dated as per the date of the diagnosis letter.
  Codes – Once added, you should be able to see in a few places, but quickest place to find this tends to be in the tabbed journal e.g.:



After a Dementia Diagnosis. Linking coding/ consultations:

- Why link? It helps to see the dementia related consultations, and you should then be able to see if they have had regular support such as reviews at a glance such as by clicking into the major problems.
- Forgot to link to a problem? In tabbed journal -> Click problem -> Select the relevant option (sometimes have to click to show all problems, go onto active problems and select relevant.
- Examples? Appointments reviewing dementia medication, dementia reviews, post-diagnostic follow up appointment(s).

Thanks to Riah West , Dementia Link Worker for the dementia coding reminders

Question 5. Is your practice dementia friendly

Benefits of a Dementia-Friendly GP Practice enhances the patient experience by reducing anxiety and confusion. It can improve communication and care outcomes. It helps build trust with patients and families, fostering long-term relationships. It encourages earlier diagnosis and better management of dementia. By integrating these principles, a dementia-friendly GP practice creates a supportive environment where patients with dementia and their caregivers feel understood, respected, and well-cared for.

- If possible, watch Barbara's story, The Appointment: https://www.hee.nhs.uk/news-blogs-events/hee-news/film-dental-professionals-patients-dementia (if you cannot do than now, people can watch it later, but it helps to prepare for later work)
- Complete the checklist in the ' A Guide to making general practice dementia friendly' https://www.alzheimers.org.uk/sites/default/files/2019-04/2017_dementia_friendly_general_practice_toolkit_guide_notts_derbys_project.pdf
- Discuss your findings
- What 3 things will you do to make your practice more dementia friendly?