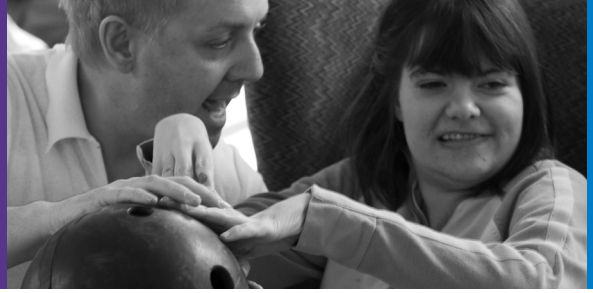

Assessment and crisis management make big impact

West Sussex Integrated Dementia Crisis Service

The ‘Living Well with Dementia’ initiative offers a quick response service to individuals and their families. The team provides information and practical support to maximise independence and delay the need for institutionalised care.

Skills for Health

skillsforcare

Background

This initiative focuses on encouraging individuals to come forward for assessment and diagnosis at an early stage. People are supported to be proactive in making plans for their future, with their families, where appropriate. Underpinning these services is a strong emphasis on integrating specialist dementia services with the wider health and social care system. The Integrated Dementia Crisis Service (IDCS) is a team that brings together the NHS, local authority and the third sector. It works in partnership with social work teams, the community mental health team, GPs, day care providers and commissioners.

Aims

The team supports people with dementia in a person centred way, recognising and responding to identified needs. The aims are to reduce the:

- number of inappropriate admissions to hospital
- length of hospital stays
- inappropriate use of anti-psychotic medication.

How does it work?

The service is for people over the age of 65, with a diagnosis of dementia. It provides a quick and flexible response where there is a sudden deterioration or break down in a person's situation. Referrals to the team come via the helpdesk, from a number of sources including: social work teams, hospital nursing staff, community nursing teams, GPs and residential or nursing homes. A member of the team will visit to assess the situation. They work with the individual and their carers. They seek solutions to stabilise the situation, prevent further deterioration and help with longer term planning. Interventions can take many forms, for example, the team may provide:

- an emergency bed
- domiciliary support
- education and practical support to carers
- telecare services, such as global positioning system (GPS) tracking to keep people safe in the community.

The team has finance for domiciliary services, one emergency bed of its own – but can also access others – and is able to spot purchase other support services. It also works directly with a specialist dementia care at home team, that can provide emergency home based support. The team operates on the principle that better outcomes can be achieved by providing timely and targeted intervention for the well-being of all concerned.

Outcomes

Team members have developed expertise in working with people with dementia at times of distress. One of the services they provide is to share this expertise with other people. They may, for example, be asked by care home staff to work with an individual whose behaviour is becoming more difficult to manage:

"One of the team will work directly with the resident, and then with care staff showing them different ways to work with the person, for example using diversionary techniques." **Liz Coleshill, Team Manager.**

On other occasions, care homes ask for their support if a resident's behaviour becomes more demanding of staff time due to a medical problem, for example as result of a urinary tract infection. When this happens the team can provide one to one support for the person until the medication they have been prescribed for their infection takes effect. By doing this the home is able to cope, minimising the risk of the person being hospitalised.

Supporting Mrs Jones

Mrs Jones, an elderly woman with dementia, was cared for at home by her husband. Her only daughter lived abroad. When Mr Jones died unexpectedly the IDCS team was called in and made a quick assessment of the situation. Although it was evident that Mrs Jones could not manage at home on her own, the team member wanted to make sure that the family could take the time they needed to make decisions about the future. A support package was put in place so that Mrs Jones could stay where she was until her daughter arrived and plans could be discussed. Neighbours, realising that the council was providing support to Mrs Jones, offered to help.

Mrs Jones remained at home until her daughter arrived and was then able to spend time with her daughter, grieving. They could then reach a decision about Mrs Jones' future that they were happy with. The social worker provided support, helping them to find an appropriate home for Mrs Jones.

The team's ability to respond quickly and flexibly meant that Mrs Jones was assisted at a very difficult time in her life, she was able to stay in her own home, supported by paid carers and the neighbours she knew. Her daughter was able to keep in touch with the social worker, and knew that her mother was being cared for.

Had the IDCS service not existed, the most likely outcome for Mrs Jones would have been an emergency admission into either residential care, or hospital. Not only would this have been very distressing and disorienting for Mrs Jones at a time of personal loss, the costs, compared to remaining in her own home, would have been much higher. The input of the IDCS team meant that Mrs Jones' needs could be properly assessed, and she and her daughter were able to manage her transition to permanent care at an appropriate pace, and were supported effectively.

Impact

There have been considerable impacts from the 'Living Well with Dementia' initiative and it has:

- reduced hospital in-patient bed use—between January and December 2011 the average length of stay was 40 days, twenty fewer than the target of 60 days
- reduced the average length of hospital stay—in the year 2011-2012 the average length of stay across the three acute trusts in the county fell from 14 to 10 days for people with a secondary diagnosis of dementia
- provided more personalised support and reduced the amount of anti-psychotic medication prescribed—as a result of specialist input and staff training, care staff are now well trained and able to deliver more proactive and personalised support. A number of residents have consequently had their anti-psychotic medication reviewed, with 53 residents having had their medication either reduced or stopped.

The IDCS Team has:

- reduced hospital admissions—the number of potential hospital admissions was reduced by almost 100 in the past year
- supported and improved hospital discharge—the team facilitated over 80 discharges, so that they ran smoothly and met individual needs
- supported people with dementia and their carers in the transition to different long term living arrangements—375 people have been supported
- contributed to cost savings with medication, anecdotal evidence shows that people are on less medication and for shorter periods with this intervention.

Learning

The team have some key learning points:

- flexibility is essential, both with budgetary, and service provision
- timely, targeted intervention can prevent unnecessary deterioration
- a good outcome results from having skilled workers assess the situation
- risk assessment and management are essential at all times, but especially during the early stages of dementia, where families may need additional support and education
- friends and neighbours are often much happier to be part of a person's care if they are confident that they will be supported and not 'left to get on with it'.

Contacts

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Further information

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