Exploring the Impact of Memory Link Workers and Dementia Nurse Specialists on Dementia Care

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INTRODUCTION

The Cardiff and Vale (C&V) Memory Team consists of a multidisciplinary team who coordinate the care of dementia patients via direct and indirect contacts, helping to achieve the Dementia Care Pathway of Standards. (1) In C&V, 5773 people were estimated to have dementia aged over 65. (2)

Memory Link Workers (MLWs) help patients navigate dementia services, focusing on the social aspects of care. They initiate contact post-diagnosis and at 6-monthly intervals, becoming their single point of contact. Clinical Nurse Specialists (CNSs) are Band 6 nurses who liaise with the medical team and receive referrals to assist patients with medication or memory related problems. They also perform diagnostic home assessments.

AIMS

- Map the needs of dementia patients in the local health board
- Understand how patients & carers are utilising the service
- Identify strengths and improvements of the service

METHODS

This is a retrospective service evaluation. The initial dataset consisted of all contacts made between early April and late May 2023 by CNSs and MLWs (n=633). The dataset was organised by hospital number and the top 100 patients were identified from each cohort. Overall 289 contacts were analysed representing 100 patients in contact with CNSs and 100 in contact with the MLWs.

PARIS, Welsh Clinical Portal and written notes were used to collate information on patient demographics and the nature of each contact.

RESULTS

Demographics

The majority of patients were female and the median age was 83. Alzheimer's was the most common diagnosis; the highest recorded severity scores were coded as mild dementia. 78% of patients were noted in clinical records to be frail and 30% had a package of care in place, see Table 1.

Contacts

Of the 289 contacts, the majority were telephone calls, see Figure 1 for breakdown of modes of contact. 70% of contacts were with the next of kin.

Table 1. Additional demographic data

Parameter	Average
Number of Comorbidities	5
Number of Medications	7
Frailty Score	5
Hospital Admission (last year)	0
Number of teams involved in care	2

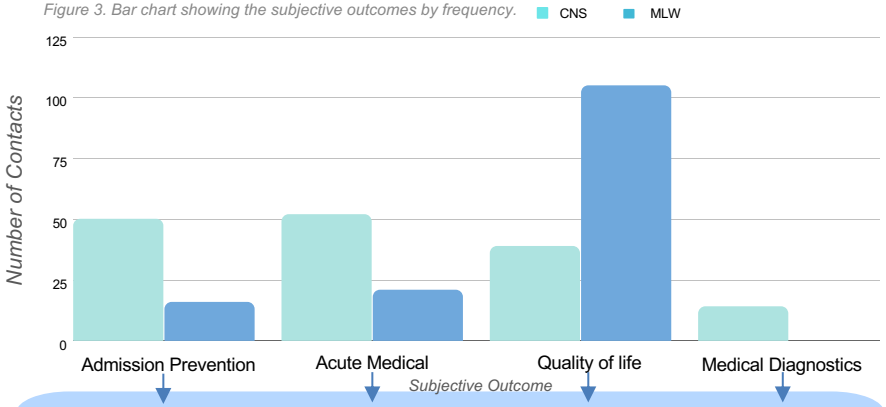
Figure 2. Word cloud showing range of support provided by both professionals, larger words indicate a greater number of contacts regarding that particular issue

Figure 2. highlights the concerns brought to both the CNSs and MLWs. For both CNSs and MLWs, the greatest need identified was social service liaison, this included referrals and escalation of care (39% of contacts).

MLWs provided wellbeing support and advice on a range of concerns such as lasting power of attorney. Other needs MLWs aided with include benefit support, council tax reduction, blue badge and attendance allowance.

CNSs provided medical services of which addressing physical health and medication concerns were the most important. Additionally, they provided information on the diagnosis and manage behaviours families find challenging such as agitation and aggression.

Figure 3. Bar chart showing the subjective outcomes by frequency.



- Identifying deteriorating patients.
- Referrals to community services
- Urgent social care provision
- Early treatment
- Medication reviews

- MDT discussions
- Liaising with GP regarding immediate health concerns e.g. falls
- Medication queries

- Non-pharmacological interventions
- Advice
- Information provision
- Benefit/legal/financial support

- Diagnosing patients in home environment
- Health checks prior to commencing medication
- Understanding diagnosis

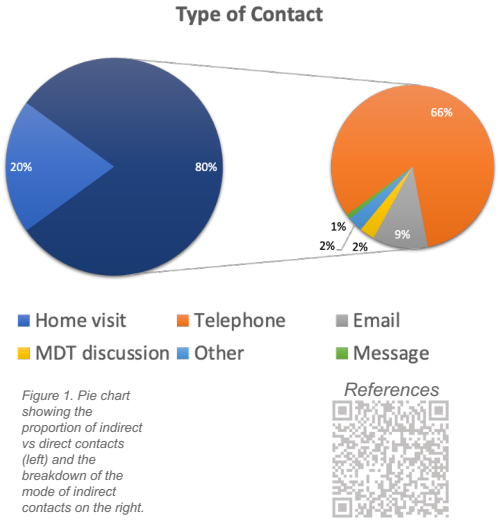


Figure 1. Pie chart showing the proportion of indirect vs direct contacts (left) and the breakdown of the mode of indirect contacts on the right.

References

CONCLUSION

The service addresses a wide variety of needs and is a step towards meeting the Wales Dementia goals.

Strengths:

- Roles of MLW and CNS work in tandem with the wider MDT
- Roles are able to prevent admission through early contact - it identifies deteriorating patients and problems which could lead to hospital admission.
- Addresses acute medical problems through liaison with GPs and referring on to other healthcare professionals.
- 2% of contacts were home assessments to enable diagnosis.
- 75% of contacts improved QoL of patients and carers through collaborative dementia care
- Connects caregivers to social services and respite care.

Improvements:

- Streamlined links to social services to improve access and links to mental health services for patients with complex psychiatric components to their care.
- More frequent contact by MLW could help to provide improved continuity.
- More information/resources to help families gain a realistic understanding of dementia trajectory.