

Guidance on remote working for memory services during COVID-19

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Version 2 changes

- New section on face to face assessment
- Information on blood tests expanded
- Information on joint clinics added
- Summary flow chart added
- Information on ACE III expanded
- New information on TICS-M
- New information on RUDAS
- Information on Attend Anywhere changed - *It needs to be accessed through **Chrome or Safari***
- Additional resources added



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Introduction

Due to the COVID-19 pandemic, memory service activity has changed significantly. Many memory service staff were redeployed and routine assessments were suspended. Services focused on risk stratification of their caseloads and supporting 'at risk' patients and carers. As we move out of the first acute phase of COVID-19, we need to ensure that people with dementia are able wherever possible to receive a diagnosis and access post-diagnostic support.

Memory services will not be able to operate in the same way as pre-COVID-19 due to the risks inherent in face to face appointments with older vulnerable individuals. However, the importance of a timely diagnosis of dementia is unchanged. Identifying people who are living with dementia will allow them to access additional help and services; this is critical for maintaining their physical and mental health.

The NHS has rapidly changed during COVID-19, with a significant increase in remote consultations; this is key to enabling people to access healthcare during physical distancing. Remote healthcare poses specific challenges for memory services due to patients' age and cognitive impairment, lack of familiarity with or access to digital technology, potential overreliance of the clinician on informal carers and the lack of validation studies for virtual use of cognitive screening instruments.

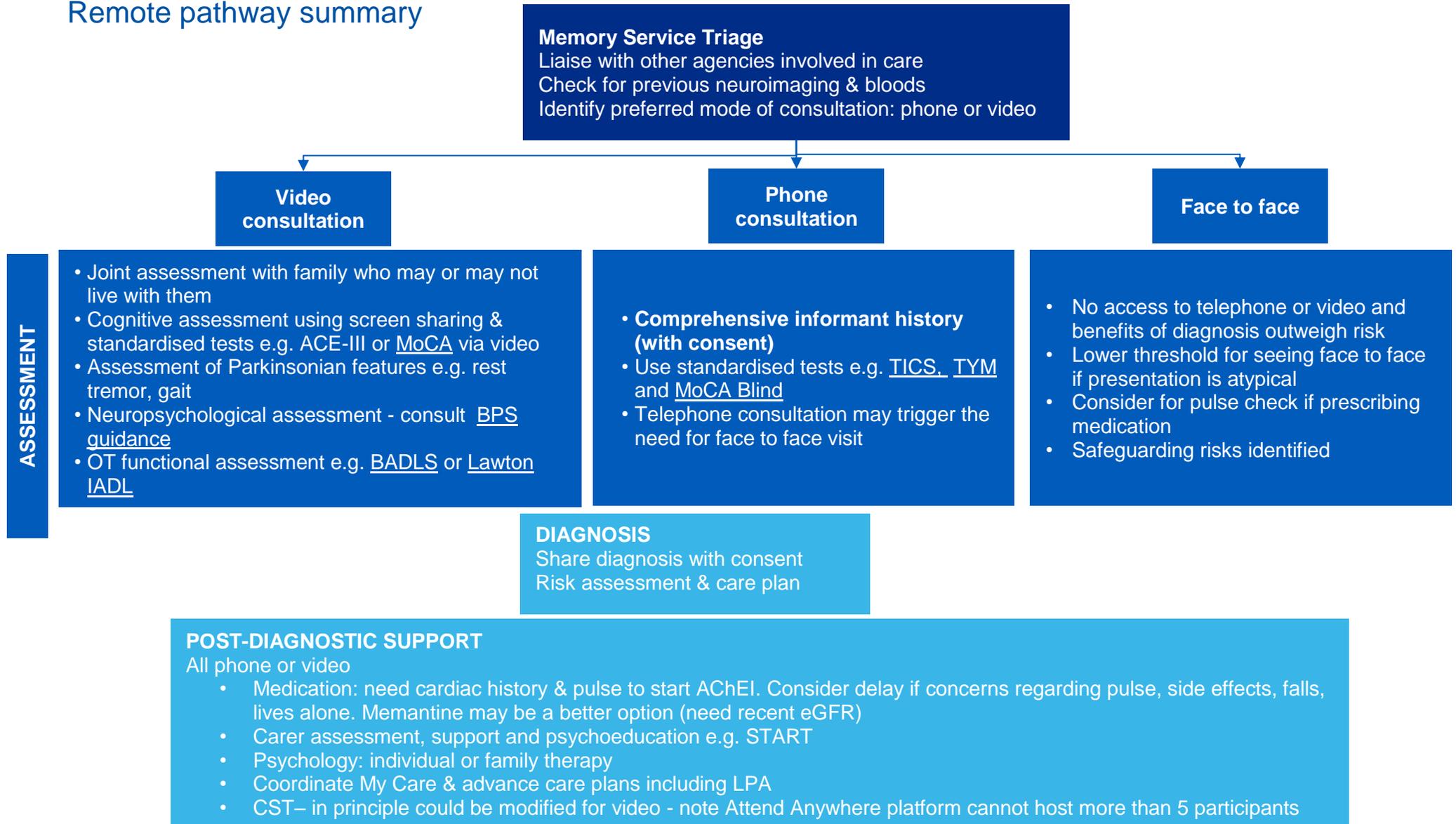
Approaches to assessment need to be personalised. Services need to be pragmatic as the limitations of remote consultations will often present a lesser risk than not assessing patients at all. Staff will need training to support this decision-making process. Following a personalised risk-benefit analysis, patients who are not able to access remote healthcare or have clinical features that require face to face assessment should still be offered an "in person" appointment. The risk to patients and carers of contracting COVID-19 infection will be reduced if they are seen in their own homes. Current infection prevention control guidance including PPE should be adhered to.

Remote working in memory services is a significant change to normal practice. Using a [PDSA \(plan, do, study, act\) approach](#) will enable local teams to test changes to process and clinical practice and to reflect on and refine these. Clinical supervision and opportunities for team discussion and reflection are particularly important at this time.

This guidance is not intended to be prescriptive, but to offer advice to memory services on providing remote assessments and post-diagnostic support. It is aimed at staff who do not routinely use video and phone consultations for assessment, diagnosis or post-diagnostic support. The guidance given here is not intended to supersede local policies and procedures, which should continue to be followed



Remote pathway summary



Working with Primary Care

It is important to let local stakeholders, particularly GPs, know that the memory service has re-opened to referrals.

At the present time, people are not presenting to primary care at pre-COVID levels. Memory services should work with primary care to identify people for whom a memory service assessment would be appropriate (e.g. post-delirium follow up), and work with social prescribers and voluntary sector providers to ensure they feel empowered to raise concerns about clients who might be exhibiting symptoms of dementia.

Memory service triage

Robust triage is even more important at the present time to ensure appropriate patients are being assessed by the memory service. Triage processes should identify people in whom it is clear that dementia is unlikely so that appropriate [non-dementia pathways](#) can be followed. This is a particular consideration for people under the age of 65. The [2019 London memory service audit](#) found that 85% of people seen in a memory service under the age of 65 did not have dementia. The Young Dementia Network has created a [decision making tool for GPs](#) to identify signs and symptoms of young onset dementia.

Screening blood tests are generally recommended prior to referral to memory assessment services but increase the number of face-to-face contacts. If the person has had relevant blood tests within the lifetime of the cognitive symptoms, repeat blood tests should not be performed. Primary care may not yet have access to all pathology testing, therefore a degree of flexibility may be required in assessing patients without blood tests.

The triage process should also be used to ascertain whether it is appropriate to use a video or telephone consultation.

Examples where it might not be appropriate to have a remote consultation

- The patient is unable to use video technology and cannot be supported to do so, e.g. by a relative. This is a particular issue due to social isolation restrictions
- Where there are concerns about an informal carer/relative dominating the conversation and you are unable to gain a picture from the patient. This is particularly important if it raises any safeguarding concerns
- Patients who are unable to communicate over telephone or video (e.g. hard of hearing), although people may be able to lip read and use the chat function of video consultations
- The patient has serious anxieties about using technology
- From the available information it is clear that the patient requires a physical examination or has cognitive difficulties that can currently only be assessed face to face e.g. visuospatial deficits.



Deciding who is and isn't appropriate for telephone/video consultations will be a learning curve. It is important to offer patients choice where appropriate. Where attending in person carries significant risk to the patient e.g. some frail older patients with multi-morbidity or terminally ill people, the advantages of video/telephone consultation likely outweigh its limitations.

There will be instances where someone is unable to receive a remote assessment and the benefit of an assessment and diagnosis outweighs the risks of a face to face appointment. Local policies, procedures and infection prevention control measures such as PPE should be followed.

If memory service staff are liable to be redeployed at short notice, then consider booking the appointment for the same/next day if agreeable with the patient.

Remote consultations

A remote consultation is one where the patient and clinician are not in the same physical space but communicate via a telephone or video link.

Using remote consultations supports the COVID-19 response by:

- Preventing transmission of the disease by reducing the need for patients to travel to a clinic
- Allowing clinicians to speak to patients who are unable to travel to a clinic e.g. in high risk groups
- Allowing clinicians to work from home e.g. staff in "at risk" groups

The [Long Term Plan](#) made a commitment to transforming outpatient appointments, supporting providers to offer their patients the choice of video consultations where appropriate. It is proposed that this will avoid up to a third of current face-to-face appointments with benefits to patients such as obviating travel time and costs and environmental benefits of reduced road travel. As part of the response to COVID-19, outpatient transformation has been delivered at pace in primary and secondary care, with a move to video consultation as the default position, including a national licence for Attend Anywhere.

Staff will need access to the relevant hardware and software, including a broadband connection and trust-level IT support. They will need to be trained in the new system. Technical performance should be tested by making a dummy call with a lay volunteer. The team should have the opportunity to review, reflect on and update training and processes.

In moving to virtual consultations, services must be aware of equality considerations. It is important to develop systems for safe care that can be delivered over the phone, because not all older people, particularly those from BAME groups, have access to the internet.¹ Some older people may not be able to use their computer equipment without the support of a family member, who may not be able to be present because of physical distancing or isolation rules.



Video consultations

Pre-planning and setting up:

- For any cognitive assessment activity involving visual stimuli, the device will need to be at least as large as a standard iPad (9")
- It might be helpful to have a pre-assessment discussion on the telephone
- Give the patient some information prior to the assessment such as when and how to establish the video connection
- Ask the patient if they would like a family member or friend to join them
- Check requirements for interpretation
- If you are working from home, choose a neutral setting and background so that the patient is not distracted by glimpses of your domestic circumstances.
- Make sure you will not be interrupted, and that background sounds are not intrusive
- Landscape format is felt to be better than portrait as it feels more natural and gives a feeling of a comfortable separation between you and the patient. Adjust your position so that your head is central in the patient's view
- The patient should be able to see your facial expression without straining, and preferably also your hands, as hand gestures are an important part of communication
- Make sure your face is well lit and avoid having a source of bright light behind you

Starting remote consultations:

- Say something like "can you hear me?" and "can you see me?" to ensure optimal technical set up
- Reassure the patient that although you will take notes, the consultation will not be recorded and no medical information will be retained on the platform
- Introduce yourself and explain how the virtual appointment will work
- Agree with the patient what to do in various situations e.g. if they are disturbed or there is a technological failure
- Ensure all other apps/notifications are turned off to avoid distraction on your and the patient's devices
- Some patients will need reassurance that they are receiving the same level of care as in a face to face appointment
- Take and record consent for a video consultation (note this is part of the set-up of Attend Anywhere)
- Introduce everyone in the room (even those off camera) and ask the patient to do the same or confirm they are alone
- Verify patient ID e.g. checking DOB and address (note ID verification is part of the login process of Attend Anywhere)



During the consultation

- Video communication works the same as face to face, but it may feel less fluent and there may be glitches (e.g. blurry picture)
- Be aware that video communication will likely be harder for the patient than face to face.
- Try to make sure only one person is talking at a time
- Keep your vocal cues to a minimum – a slow nod or a smile is better
- Show your interest and attentiveness through eye contact and facial expressions
- Inform the patient when you are otherwise occupied e.g. reading something on another screen
- If you need to interrupt the patient, try a visual signal such as raising your hand
- Rapid gestures or body movements can be distracting – try to slow them down
- Note that people with visuospatial misperception and visual hallucinations may find video conferencing particularly challenging

Closing the consultation

- Be particularly careful to summarise key points (since it is possible something could have been missed) and ask the patient if they need anything clarified
- Confirm (and record) if the patient is happy to use a virtual consultation again.
- To end, tell the patient you're going to close the call now, and say goodbye (before actually closing the connection)

If you are working from home and using your own equipment you should check that your internet access is secure e.g. by using a Virtual Private Network and/or avoiding public Wi-Fi, and that appropriate security features are enabled.

[NHS X guidance](#) states that it is acceptable to use video conferencing tools such as Skype, WhatsApp or Facetime as well as commercial products designed specifically for clinical use.

Attend Anywhere

'Attend Anywhere' is a secure video consultation platform which is being rolled out nationally across the NHS. It needs to be accessed through Chrome or Safari. The platform has the functionality for a family member who does not live with the patient and other clinicians to join the consultation. Attend Anywhere is not appropriate for group sessions such as CST, as no more than five people should join the platform (the quality of image and sound degrades as numbers go up).

- This [3-minute video](#) explains the system
- This is an example of an [easy read leaflet](#) for patients
- The Royal National Orthopaedic Hospital has produced a video [patient guide](#)
- NHS Scotland has produced a number of [training videos](#)



Joint working

Platforms such as Attend Anywhere can be used to hold joint clinics for example between a memory service and a Parkinson's clinic.

Video conferencing should be used to hold multidisciplinary meetings and case discussions with other colleagues such as neuroradiology, neurology, learning disability teams and Parkinson's clinics. The sharing screen function can be used to enable colleagues to discuss brain scans remotely (note this should not be used for formal neuroradiology reporting). The Dementia Clinical Network and SWL STP completed a project last year highlighting the benefits of [discussing cases in multispecialty](#) meetings.

Microsoft Teams

Microsoft Teams is freely available to people with an NHS.net account. Microsoft Teams provides secure instant messaging, direct audio and video calls between NHS colleagues and has virtual meeting capabilities. You can find guidance on Teams [here](#).

Telephone consultations

Starting the consultation:

- Have a structure or model for telephone consultations; it minimises the risk of missing something
- Say something like “can you hear me?” to ensure optimal set up
- Introduce yourself and explain how the telephone appointment will work
- Agree with the patient what to do in various situations e.g. if they are disturbed
- Reassure the patient that the consultation is as similar as possible to a standard one, and that the call is confidential/secure
- Take and record consent for a telephone consultation
- Verify the patient ID e.g. by checking DOB and address

During the consultation

- It can help to talk more slowly and clearly
- You may want to ask more questions than you might otherwise in a face-to-face consultation to ascertain facts and to ensure the patient clearly understands what is being said
- Acknowledge that you can't see each other so you will not be able to read each other's body language
- The tone of your voice and how you say things is vital during telephone consultations and can convey confidence in what you say, your state of mind and your attitude
- Due to the lack of visual cues, ask the patient to feedback what they have understood from the conversation more often than you would in a face 2 face consultation
- Paraphrase and summarise back to the caller what they have said throughout the call



Ending the consultation

- Be particularly careful to summarise key points, since it's possible something could have been missed
- Ask the patient if they need anything clarified
- Confirm (and record) if the patient is happy to use a virtual consultation again
- If appropriate, you may want to ask if they would be willing to try a video consultation (with support) next time

Decisions about carrying out phone or video assessments using an interpreter will need to weigh up the additional time required to communicate remotely through an interpreter, the potential to carry out a meaningful cognitive assessment, the extent of collateral information available and the risk to the patient of attending a face to face appointment.

You can find more information in the [NHS clinical guide for the management of remote consultations in secondary care](#)

Information on which patients may and may not be appropriate for remote consultations can be found in the [triage section](#) of this document.

Face to Face consultations

Where it has been determined that a face to face consultation is required, local infection prevention and control policies should be followed. Staff should undertake a risk assessment as per Trust policy.

The decision about whether to conduct the assessment in clinic or at home will be governed by the individual risk assessment based on the age and vulnerability of the person and their household contacts to COVID-19.

The home visit should be limited to the activities that cannot be conducted remotely, for example, pulse check, cognitive testing, functional assessment, neurological assessment and reviewing the home environment. Other aspects of assessment such as informant history should be conducted remotely prior to the face to face assessment.

During the home visit social distancing should be maintained as much as possible, keeping a 2 metre distance from the patient and members of their household. Where possible consider conducting some of the consultation outside if confidentiality can be maintained. No more than one other family member should be present at the assessment to support the patient. Ensure hand hygiene before and after the appointment

A face to face consultation for the purposes of dementia diagnosis should not take place if the patient has suspected or confirmed COVID-19 or they are self-isolating except for exceptional circumstances. This information should be re-checked on the day of the visit.



Screening questions:

- Do you or anyone in your household have coronavirus?
- Do you have a new, continuous cough?
- Do you have a high temperature (37.8 or over)?
- Do you have anosmia (a loss of or change in your normal sense of smell or taste)?
- Does anyone in your household have a new, continuous cough, a high temperature or anosmia (a loss of or change in your normal sense of smell or taste)?
- Have you been told to self-isolate?

Note that older people commonly present with [atypical symptoms](#) of COVID-19 and people with dementia may be less reliable at reporting symptoms. Delirium (hyper and hypoactive) is a common presentation of COVID-19 in older people, if possible speak to a relative or carer to ascertain that there has not been an acute change in cognition, behaviour or alertness.

Clinicians need to ensure that home visit bags have necessary PPE, clinical waste disposal and hand sanitiser

Personal protective equipment

[PHE guidance](#) states that when providing direct care with a patient **who is not** currently a possible or confirmed case of COVID-19 the below PPE should be worn

- Disposable gloves
- Disposable apron
- Fluid-resistant surgical mask and eye/face protection – when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids. Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session.

Staff will need training on putting on and removing PPE. Useful links:

- [Putting on PPE](#)
- [Taking off PPE](#)
- [Quick guide to putting on and taking off PPE](#)
- [Video guide putting on and removing PPE](#)
- [PPE guidance](#)

Memory service assessment

Collateral information

To support remote assessments, it is useful to gain as much collateral information as possible prior to assessing the patient. This may include obtaining additional information from the GP or other professionals involved in the person's care.

History from an informant will need to be gained separately if they do not live with the patient. You may want to include a validated tool such as the [IQCODE](#) which can be delivered on the phone or via video consultation.



Cognitive tests via telephone

MoCA

The [blind version of the MoCA](#) can be delivered [over the phone](#) and has been validated for mild cognitive impairment diagnosis after stroke/TIA.² It is limited in its ability to assess visuospatial and complex language tasks compared with a face to face MoCA.

TICS (Telephone Interview for Cognitive Status)

[TICS](#) is the most widely translated and validated telephone-based screening tool for mild cognitive impairment and dementia.³

TICS is designed to be administered via the telephone and takes 10-15 minutes to complete. It assesses orientation to time and place, attention, short-term memory, sentence repetition, immediate recall, naming to verbal description, word opposites and praxis.

There are various modified versions of the TICS that are usually referred to as the TICS-M and which generally reflect each other, although they have different total scores. Caution is required when interpreting various cut off scores as it is not always clear what version of TICS the literature is referring to.

One of the modified versions of TICS (TICS-M) has 13 items and is scored out of 39. It takes about 10 to 15 minutes to complete and it correlates with MMSE and ACE-R.⁴ A [norms calculator](#) has been developed for use with this version of TICS.⁴

Another version of TICS-M which is scored out of 41 has been shown to have high diagnostic validity for identification of dementia among ethnically diverse older adults.⁵

There is a cost associated with using TICS and the various versions are copyrighted. You can purchase the TICS tool and manual [here](#). You can request a quote to use a modified version of TICS [via this form](#), and also to request to adapt a modified version of TICS to make it more appropriate for the UK, e.g. asking for the name of the 'Prime Minister' instead of the 'Vice President'.

Tele-Test Your Memory (TYM)

The TYM test is a short cognitive test comprising of 10 tasks presented on 2 sides of a single sheet of card. It has been validated and correlates with scores on standard tests.⁶ Most people take about 5 minutes to complete the TYM. Because the patient fills in the TYM test themselves, it can be reviewed remotely by a clinician. The test should be completed under the supervision of a relative or healthcare professional.

In a pilot study an envelope was sent to patients containing the TYM test, which was marked "not to be opened before nurse phones". There was also a stamped addressed envelope for the patient to return the completed test to the clinic nurse. The nurse phoned at a prearranged time to complete the test. The pilot found a strong correlation between the telephone TYM score and the clinic ACE-R.⁷



The TYM test can be supervised by a relative⁸ whilst maintaining a 2 metre distance. It could also be administered by video consultation.

To download the TYM including information on scoring, register [here](#) (it is free of charge without copyright issues)

There are several other telephone cognitive tests which are discussed in [this review](#).

The Mini-Mental State Examination has been adapted for telephone administration and has 26 points. The scores of the Telephone MMSE have been shown to be strongly correlated with MMSE scores.⁹

Non-standardised tests

Components of cognitive testing can also be completed via the phone and although this will not give a validated test score it will enable you to gain an understanding of cognitive deficits to aid clinical decision making. For example, orientation to time, place and person, arithmetic skills, verbal recall, knowledge of recent news events, single word and sentence repetition, word definitions, verbal fluency and frontal tests such as cognitive estimates and proverb interpretation can all be assessed over the phone. A patient's spontaneous speech can be assessed by phone and elements of motor speech disorders such as apraxia of speech or dysarthria can be tested.

Cognitive tests via video consultation

MoCA

The full version of the MoCA can be administered via [video conferencing](#). The patient will need a white sheet of paper, a pencil and an eraser.

How to complete the visual section: use screen sharing function where possible

- **Trails:** Show them the trail and say: "please **tell me** where the arrow should go next to respect the pattern I am showing you"
- **Cube:** Show them the cube and say: "copy the cube"
- **Clock:** "draw a clock. Put in all the numbers and set the time to 10 past 11"
- **Animal naming:** "Tell me the name of these animals"

Orientation section:

- **Date:** "look straight at the camera and tell me today's date, day of the week, month and year" (to avoid people looking at bottom right hand of screen where the date is shown)
- **Place:** "from what clinic/department am I calling you from"
- **City:** "what city/borough is our clinic/department located in"



ACE III

Anecdotally the ACE III has been completed via video conference. A carer will need to be with the patient during the testing. The carer will need a pencil and four blank sheets of paper. The carer will need to show the writing and drawing tasks to the camera and a screen shot taken by the clinician as a record. Screen sharing functionality can be used to show the patient visuals such as the fragmented letters.

Resources:

- ACE III remote assessment [form](#)
- ACE III remote assessment [clinician guide](#)
- ACE III remote assessment [carer guide](#)
- ACE III remote assessment [pictures for screen sharing](#)

RUDAS

The RUDAS is a validated cognitive assessment tool for culturally and linguistically diverse older people and can be administered via video consultation.¹⁰

When administering the RUDAS via video consultation, it is recommended that these slight adaptations are made:

- Hand actions should be performed at chest height rather than on a desk
- A felt tip pen should be used instead of a pencil to improve visualisation

Bear in mind that some tests may not be validated in BAME populations or people for whom English is a second language and may not be appropriate for people with limited education.

Neuropsychological assessment

Acceptability of a virtual neuropsychological assessment is low in the older population;¹¹ however virtual neuropsychological assessment should be offered where clinically appropriate. Test selection will depend on the technology the patient has access to and can use without imposing additional cognitive burden. Third party assistance may be required for some tests. Contact by phone may still be used for screening purposes and is recommended to assess for current risk and vulnerabilities.

For remote neuropsychological assessment the [BPS guidance](#) should be used by the team clinical psychologist and appropriate tests selected based on the guidance.



Neuroimaging

There may be challenges in obtaining neuroimaging during the initial recovery phase of COVID-19. During triage, check if the patient has had a brain scan within the lifetime of the cognitive symptoms. If so, source the scan and ask for it to be re-reported (if required), ideally providing the radiologist with up to date clinical information.

The vast majority of patients referred to memory services who are under the age of 60 do not have dementia. These patients should have a thorough assessment before a clinical decision is made on whether to refer for neuroimaging.

Some patients might not need neuroimaging for a dementia diagnosis, for example people with moderate-to-severe dementia with a clear history of decline over several years. Please see our [neuroimaging guidance](#) for further scenarios and details.

If neuroimaging is not available use clinical judgement to give a working diagnosis where possible.

Giving a diagnosis of dementia remotely

If you feel you have enough clinical information to establish a diagnosis then the patient and their next of kin (where appropriate) should be informed of the diagnosis, assuming consent for this has been obtained.

If delivering a diagnosis on the telephone it is important to explain to the patient that you can't see each other and therefore you cannot judge their body language. Explain that you may need to give them some distressing information which would normally be done face to face. Tell the patient and carer that because you can't see them to gauge their reaction, you will pause between giving pieces of information to ask them if they are happy for you to continue.

It is important to send written information about dementia to the individual and their household following the consultation.

Sub-typing

If further investigations, e.g. neuroimaging, are required to establish the subtype but are not available then it would be acceptable to give a working diagnosis of unspecified dementia whilst awaiting further investigations. However, bear in mind that neuroimaging is most helpful for "ruling out" structural pathology and that subtyping is generally based on clinical features. Discussing patients with senior colleagues can be a useful alternative where investigations aren't available.

One of the diagnostic criteria for Dementia with Lewy bodies is parkinsonism.¹² You can assess parkinsonian features such as rest tremor, bradykinesia and gait via a video link. If you are unable to do this ask the relatives questions about their walking including slowness, loss of arm-swing, difficulty turning or navigating small spaces such as doorways, unsteadiness or falls.



Considerations for Occupational Therapists

Functional assessments are difficult to conduct remotely; however, it is possible to make observations using virtual technology and this may be useful for assessments of mobility, particularly transfers. Carers could also send a live stream video indicating difficulties and then recommendations can be made by the Occupational Therapist. Some activities of daily living measures could be administered over the phone, such as the [Bristol Activity of Daily Living Assessment](#) and the [Lawton Instrumental Activities of Daily Living](#).

Where possible continue to order and review equipment (home adaptations and assistive technology) via telephone/video link. Providers such as Medequip are continuing to deliver equipment using infection control procedures.

It may be useful for Occupational Therapists to assist in establishing routines and supporting carers to find ways of being creative in their caring roles, while still allowing people to have some autonomy and independence in their activities of daily living.

Occupational Therapists could offer support and advice to manage behaviours that challenge (the [Kingston Standardised Behavioural Assessment](#) can be administered over the telephone) and give ideas regarding meaningful activities for people to engage in while socially isolating.

Care home considerations

People in care homes are likely to have more advanced dementia; a collateral history from care staff or family members will be helpful in establishing the diagnosis. For diagnosing advance dementia in care homes the [DiADeM](#) tool could be used via video conference with the support of care home staff.

Consider the benefits of a diagnosis at this time and if it is in the patient's best interests; for example, will a diagnosis lead to the resident's care plan being updated and support the care home staff in looking after them.

Where possible, memory services or community mental health teams should support care homes by giving advice and guidance on key challenges such as implementing isolation for people who walk with purpose and supporting people with behavioural and psychological symptoms of dementia.



Post-diagnostic support

Medication

The threshold to start medication will be higher; safe prescribing might require patients diagnosed with dementia to be reviewed at a later date when face to face contact is possible. This is particularly important for people who live alone and in whom it is difficult to assess compliance. The risks and benefits of starting medication at this time should be discussed with the patients and their family (as appropriate) including potential side effects.

If it is decided that it is not the right time to start medication, then ensure that this is revisited at a later date.

Services will need to consider how they will assess heart rate, whilst minimising patient contact, prior to prescribing cholinesterase inhibitors; for example:

- Check if there is a recently recorded heart rate in the primary care record
- Check if another healthcare professional has face to face appointments and ask them to do a pulse check e.g. district nurse
- If the patient is having blood tests as part of their screening, ask if their pulse could be checked
- Ask if the patient or their family (who they live with) have a fit bit/smart phone that can measure pulse rate
- Some patients have automatic blood pressure machines at home which can also record the pulse rate
- Some primary care services are running a 'drive through' service which the patient could attend for a pulse check
- Some family members may feel comfortable taking the person's pulse, although this should be considered a last resort if no other options are available

If none of the above are possible, weigh up the risk of a face to face visit with the benefit of starting cholinesterase inhibitors. This should also be considered if an ECG is required.

If you are unable to assess heart rate and the patient has moderate or severe Alzheimer's disease, consider starting memantine and adding a cholinesterase inhibitor at a later date. eGFR needs to be checked prior to initiating memantine. A blood test taken within the last six months would generally be considered acceptable in a patient without known kidney disease.

If primary care does not routinely initiate dementia medication in your area and the memory service does not have access to electronic prescribing, then discuss whether the GP is willing to write the first prescription. This will enable electronic prescribing and pharmacy delivery of medication (which reduces face to face contact). Medication reviews should be performed virtually by the memory service or primary care (dependent on local pathways). You can find further information about anti-dementia medication, who needs an ECG and prescribing pathways [here](#).



Dementia advisers/navigators

Some memory services have dementia navigators as part of their team, while other services access dementia advisers via referral to the Alzheimer's Society or other voluntary sector organisation. The patient and/or their carers should be offered a telephone or video appointment by the dementia advisor service. Information about dementia and signposting to other services can be followed up with information sent via post.

It is important at this time to give additional information about managing during COVID-19 and social isolation, including looking after mental health, hand washing reminders, developing a routine, arranging food and medicines, staying active and keeping connected.

Information on the Alzheimer's Society dementia connect support line can be found [here](#) and admiral nurse dementia helpline [here](#).

The Alzheimer's Society is running Singing for the Brain groups using a [virtual format](#)

You can refer someone to the NHS volunteers scheme for help collecting shopping and medication [here](#). People living with dementia and their carers can self-refer [here](#)

Carer Psychoeducation

Strategies for Relatives (START) Intervention

Due to anxieties surrounding COVID-19 and the closure of day centres and respite facilities due to social isolation restrictions, support for carers is more important than ever.

[NICE recommends](#) that carers should be offered a psychoeducation and skills training programme.¹³

[START](#) is a form of psychoeducation offered to carers on a one to one basis. Whilst this is normally conducted face to face, it has also been offered to carers by phone prior to COVID-19 in instances when carers had other commitments or lived too far to attend sessions. It can also be delivered via video consultation. No adjustments need to be put in place to offer this intervention remotely.

START consists of 8 sessions. It should be tailored slightly to include conversations about COVID-19 in session 6 – 'Planning for the future' and session 7- 'Planning pleasant events'.

The Alzheimer's Society is planning to run the Carer Information and Support Programme (CRiSP) virtually; if you normally refer into this service, please contact your local Alzheimer's Society.



Cognitive Stimulation Therapy

This intervention cannot be offered over the telephone. In principle it could be modified to be offered via video conferencing. However, there is no evidence base to support this. Be aware of limitations of platforms such as Attend Anywhere that cannot host more than 5 participants.

Some services have been running virtual CST and have suggested:

- If the person is unable to use the virtual platform or unable to access help offer them a 1:1 training on the technology prior to the session
- Have a group co-facilitator who can assist with any technology difficulties
- Send an activity resource pack prior to the session
- Shorten the sessions due to fatigue when using a virtual platform

Consider other interventions that can be beneficial e.g. enjoyable activities. The Health Innovation Network has curated a list of [online resources and activities](#) to help keep people with dementia stimulated whilst being confined during the COVID-19 crisis.

Local resourcing prioritisation should be considered; due to additional carer stress we recommend prioritising carer education and dementia navigation over cognitive stimulation therapy.

Advance Care Planning and Coordinate My Care

Conversations around end of life can be challenging, particularly in these difficult times.

Early honest and sympathetic communication with patients and those important to them can enable an opportunity for future care wishes to be expressed. It is important that people do not feel pressurised into holding such conversations and making decisions before they are ready but are offered an opportunity to discuss their future care.

Advance care planning needs to be discussed in a sensitive manner, with consideration of the current NHS climate, and where possible, by a clinician who knows the patient.

Creation of a [Coordinate My Care](#) (CMC) plan enables all urgent care professionals (including London Ambulance Service and NHS 111) to view important patient information including patient's wishes, clinical recommendations and clinical contacts 24/7. Where possible, people with an existing Advance Care Plan should have this documented on CMC. People who have been appropriately identified could be approached to start a CMC plan [with those important to them](#) through [MyCMC](#). CMC is not just for people in their last year of life; as London's digital urgent care planning platform, it is beneficial for anyone who may come into contact with urgent care services.

You can find information on joining CMC [here](#) and training [here](#)



Additional COVID-19 resources

RCGP: [top tips for successful video consultations](#)

RCGP: [top tips for COVID-19 telephone consultations](#)

Dementia UK: [COVID-19: information for families looking after someone with dementia](#) - includes information on self-isolation, tips on activities, games and physical exercise as well as helplines

Alzheimer Europe has collated [resources](#) on support for people living with dementia and their carers and these will be updated on a regular basis

Alzheimer's Society: [COVID 19 tips-for-dementia-caregivers](#) - guidance for carers as well as professionals; includes ideas on managing 'walking with purpose', responding to dementia related behaviours and social isolation

Alzheimer's Society: [Support for people with Dementia COVID-19](#) - information and support for people with dementia who are feeling lonely and isolated

The Help Hub [Coronavirus online free therapy sessions](#) - can link both a person with dementia and their carer to voluntary therapists to get therapy over the phone

Rare Dementia Support UCL: [Living with dementia and COVID-19: an emergency kit](#) - includes dementia specific support, legal and financial guidance, home activities and advice for carers

List of [helplines and key websites](#) for people with dementia and carers

Health Innovation Network: [Activities for older adults during COVID-19](#) - a range of online resources and activities to help keep patients stimulated

British Psychological Society: [Supporting older people and people with dementia during self-isolation](#)

Shout [mental health text messaging service](#) - this is particularly useful for people who are unable to discuss their feelings openly via phone while isolating with family

Video produced by the Newcastle Dementia Service: [Meeting the Needs of People with Dementia Living in Care Homes during Covid-19](#)

Alzheimer's Scotland: [website to support people to live well with dementia](#)

Meri Yaadain: [Information leaflets](#) for BAME dementia families

BGS: [Managing COVID-19 in care homes](#)

Music for dementia: [guide for people with dementia and carers during COVID-19](#)



Thinkability: An app which gives carers ideas on activities they can carry out with people they are caring for with dementia, based on CST principles . Please note there is a cost to download.

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