Multidisciplinary Clinicians Roundtable on the National Dementia Strategy

Radisson blu Hotel, 9 April 2013
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1. Introduction and Background

1.1 The Alzheimer Society of Ireland’s Advocacy Work on the National Dementia Strategy

The Alzheimer Society of Ireland (ASI), as the leading advocacy organisation for people with dementia, believes that engaging with all the stakeholder groups is an essential element in our advocacy work to promote the delivery of a transformative National Dementia Strategy (NDS). As an organisation, ASI has already engaged with people with dementia, families, staff, volunteers, other NGOs, allied patient organisations and politicians as part of our advocacy work in relation to the development of the NDS.

We were aware that we had not engaged directly with clinicians in any dialogue around the dementia strategy. Therefore, we held the first Clinicians Roundtable in January 2013, which included psychiatrists of later life, geriatricians, neurologists and neuropsychologists. The discussion focused on the core clinical elements of the NDS with a particular focus on early diagnosis, clinical leadership and younger onset dementia.

It was decided that a second Clinicians Roundtable would be useful to build on the success of this first roundtable and to widen ASI engagement with the broader multi-disciplinary clinicians. It was necessary to ensure that the second roundtable encompassed clinicians from the multidisciplinary healthcare professions that are involved in dementia care. For this reason we invited clinicians from occupational therapy, physiotherapy, social work, speech and language therapy and nursing.

The primary aim of the second Clinicians Roundtable was to engage multidisciplinary clinicians in an open discussion around the forthcoming NDS. It was also envisaged that the roundtable would highlight the ways in which ASI could support clinicians to be actively involved in the development of the strategy.

1.2 Background to the National Dementia Strategy

There is commitment in the Programme for Government that the Irish Government will develop a NDS in 2013. The Department of Health has undertaken a number of initiatives to progress the development of a strategy. In July 2012, the Department of Health initiated a consultation process and invited interested parties to make submissions on their views of what should be contained in the forthcoming NDS.

As part of this process, ASI made a comprehensive submission entitled “Reclaiming dementia; transforming the lives of people with dementia”1. A brief analysis of the submissions2 made by the clinicians groups (Irish Society of Chartered Physiotherapists; Irish Psychiatry of Old Age Nurse Education & Development Group) reveals how consistent the messages are between the patient

2 A summary document containing all submissions received by the Department are available at http://www.dohc.ie/publications/NatStratDemetia_SummaryConsultation.html
organisation and the clinicians. These include a call for supporting early diagnosis, development of community based services and the need for case management.

The next stage of the planning process as outlined by the Department of Health is to develop a terms of reference and appoint members to a working group. The terms of reference and the working group will play a central role in the development of a progressive and successful NDS. It will be critical that members of the working group have a consistent and clear message. One way of facilitating this is to provide space for dialogue, discussion and an exchange of expertise between the key stakeholders within the dementia field.

1.3 Multidisciplinary Care and Dementia

The concept of a multidisciplinary approach to care was highlighted in numerous NDS submissions. This was identified as central to dementia care along the continuum of detection, diagnosis and care: across all settings from the acute hospital, outpatient clinic, residential setting, home and the wider community.

A number of the NDS submissions identified dedicated and flexible community-based services (supported by local multidisciplinary dementia care teams) as a priority to enable individuals to remain in their own home for as long as possible. Respondents highlighted the need for more information on what services were available and how people could access them.

ASI, in its submission, also highlighted the need to develop a small number of specialist centres with a multi-disciplinary team to support the diagnosis and clinical management of younger onset dementia.

1.4 Roundtable Structure

Participants at the roundtable were healthcare professionals from multidisciplinary clinical areas including occupational therapy, social work, physiotherapy, speech and language therapy and nursing.

Participants were invited to the roundtable discussion to share expertise and discuss the core clinical elements of the NDS. Twenty nine clinicians participated in the roundtable.

The roundtable discussion was structured around five themes each one corresponding to a multidisciplinary area as follows:

1. Non-Pharmacological Interventions and Behaviours that Challenge (occupational therapy)
2. Improving Communication (speech and language therapy)
3. Physical Activity for Health and Wellbeing (physiotherapy)
5. The Registered Nurse’s Contribution to Person Centred Care (nursing)

Each thematic area formed the basis of a keynote presentation delivered by an invited clinician from five of the clinical areas represented. The presentation was followed by a twenty minute small group discussion. This allowed each participant an opportunity to input on the five different thematic areas during the course of the roundtable.
The roundtable concluded with a more general open group discussion among all participants of how clinicians can influence the development of the NDS.

Notes were taken at each discussion group by ASI staff present on the day. The notes captured responses to the presentations. Feedback was also noted as well as general comments and suggestions at the open group discussion, which concluded the roundtable. It was agreed that the notes would be collated into a report to document the format and content of discussion on the day.
2. Core Clinical Areas of the National Dementia Strategy

Theme 1: Non-Pharmacological Interventions and Behaviours that Challenge

1.1 Presentation

Adrian Lewis, Senior Occupational Therapist, St. James’s Hospital, gave an overview of the many considerations when looking at using occupational therapy to respond to behaviours associated with the various forms of dementia.

Adrian opened his talk with a focus on the term ‘challenging behaviour’ with a suggestion that this term is better contextualised as responsive behaviour. He then touched on the Person-Occupation–Environment Model within occupational therapy, highlighting the importance of recognising triggers for behaviour, acting early with information and interventions, and thereby pre-empting or preventing certain behaviours. Involving the person with dementia in early conversations around managing behaviour is important for the success of later interventions. He commented on the timing of responses to people’s behaviours and the impact on carers, especially the end result of carer burn out if behaviour is always managed at crisis point.

He also noted the need to focus on facilitating performance as opposed to focusing on reducing risky behaviour. The need for information provision to be applied rather than simply literature-based was also highlighted as was the need to match interventions and treatments to a person’s environment.

Adrian concluded his presentation by discussing the potential benefits and limitations of developing non-pharmacological interventions.

1.2 Response to presentation

Following the presentation, a number of issues were highlighted through group discussion as follows:

- Training and communication for all care staff was identified as central to person-centred occupational therapy.
- The importance of correctly noting how a person communicates when they can still communicate, as this will be useful particularly as they lose their language skills.
- The importance of triggers and a preventative approach to behaviour was discussed.
- The need for a common language between health care professionals was highlighted. Terms used to describe behaviours may be important; there is a shift away from “challenging behaviour” towards “responsive behaviour” or “behaviours that communicate distress”.
- Using the term responsive behaviour places the reasons for triggers for behaviour outside rather than within the person with dementia. It recognises that the social environment can be changed (Alzheimer Society, Ontario, 2011).
- It is important for the NDS to have unified terminology across the board, with all healthcare professional using the same terms.
- Early diagnosis is critical to a behaviour management or a facilitating performance approach but stigma and lack of understanding of dementia can lead to delays with people seeking a diagnosis.
- Having a formal early diagnosis is critical to families and the person with dementia planning ahead.
• With early diagnosis immediate support and advice for families must be prioritised.
• There is a need for greater communication between GPs and multidisciplinary health care professionals involved in dementia care.
• Involving the person with dementia was discussed and the necessity to have a care pathway so that interventions and care progresses according to a person’s need at different stages.
• The need to ensure that staff and families have tools and resources to apply interventions rather than just written material.
• If clinicians and healthcare staff are not provided with the tools to deliver the intervention, the therapeutic window passes and the person with dementia may end up just being medicated; where a non-pharmacological intervention may have been appropriate and beneficial.
• Co-ordination is central to this approach as it calls for a collaborative approach across clinicians for the different issues that present for people.
• Healthcare professionals need appropriate advice and coordination of care.
• Care staff and home-helps within the community, require a lot more training, guidance and support.
• Practical skills for community care staff and families is pertinent especially as these are the people that see the person before crisis point and may be able to assist them to remain in the community for longer.
• A health care professional working in an acute setting spoke about how often people are admitted due to “acopia” which literally means the family cannot cope anymore and so they admit the person with dementia to an acute hospital.
• Due to a lack of community care packages, acute hospitals see admissions for people with dementia often lasting for up to a year, and then they often go on to a nursing home – not back into the community. In this regard, the importance of integrated care pathways was discussed.
• The idea of a contact person when the diagnosis is received was also considered. A central person with a remit to refer to other services and community supports.
• Waiting lists are a serious barrier to co-ordinated and multidisciplinary care pathways.

Theme 2: Improving Communication

2.1 Presentation

Gillian Eggleston, Senior Speech & Language Therapist (SALT) HSE LHO Dublin North Central, gave an insight into the role of speech and language therapy and dementia care.

Gillian framed her presentation on the significance of SALT to dementia care across the care pathway from diagnosis to end of life care. She highlighted key issues around improving communication between the person diagnosed with dementia and the family and health care professionals. She also spoke about referral to SALT services at an early stage in diagnosis and what the SALT can offer to the person with dementia and their carers. At present this rarely happens. If the SALT is involved it is usually on a very specific issue for e.g. a swallowing issue and more often than not much later on in the disease trajectory.
She also touched on the difference across geographic areas in terms of accessing SALTs as well as the need to prioritise the SALT as part of the multidisciplinary team. She spoke specifically about end of life feeding and the issues that present and could be avoided if crisis decisions were not being taken. Gillian specifically highlighted the use of artificial feeding noting that for people with dementia, artificial hydration and feeding when compared to hand feeding has no evident benefits in terms of survival (Meir et al, 2001; Murphy and Lipman, 2003).

Gillian concluded by highlighting the need to educate the wider field of health care professionals and informal carers on the role and significance of the SALT. She noted the need to look at equity of services and early referral to the SALT. She also touched on the idea of advance directives and training in communication strategies and management of eating, drinking and swallowing difficulties for all carers, both professional and familial.

### 2.2 Response to presentation

Following the presentation, a number of issues were discussed as follows:

- A discussion took place around feeding difficulties and family distress around feeding. Weight loss is a big worry for families as they find it very difficult to accept or understand.
- Responsive behaviours around food are a big issue in acute care settings.
- Research is currently being conducted in acute settings around how to facilitate improved eating by modifying the social environment around feeding time. Volunteers are made available to assist with making meal time a more enjoyable and social occasion to see if it improves food intake.
- Issues around the lack of equity to accessing SALT services across the country.
- Suggestions were made relating to how the NDS should include automatic referrals to a Palliative Care team and a Multi-Disciplinary Team (MDT).
- A case management approach to dementia would mean that the SALT is engaged from the outset.
- When referred to a MDT people should have a key-worker so when difficulties arise they can be referred to the appropriate healthcare professional.
- A general discussion took place around the NDS prioritising more services, referrals, and care pathways.
- Alternative feeding was discussed and a general consensus that standardised criteria/guidelines around PEGs should be in the NDS.
- Greater co-ordination between clinicians would mean more referrals to the SALT from other health care professionals.

**Theme 3: Physical Activity for Health and Wellbeing**

### 3.1 Presentation

Aine O’Riordan, Senior Physiotherapist, Primary Care, HSE LHO Dublin North Central, talked about physical activity in general, the role of physiotherapy and the importance of collaboration across disciplines. Physiotherapy is introduced as a clinical, cost effective and accessible intervention. It preserves and promotes activity for people with dementia. Physiotherapy interventions improve the quality of life for people with dementia and reduce the burden of care.
Aine highlighted the importance of physical activity for general health and wellbeing; independence and social participation. She noted the significant role that healthcare professionals and carers play in a person’s life with regard to attitudes to physical activity. The physiotherapist plays a key role in assessment, intervention and continued education/training.

Aine concluded her talk with a note on the crucial role of collaboration across primary care teams; community services; home care agencies and other support groups and specialist services. She also identified the crucial role that physiotherapists play in delivering the UK National Dementia Strategy. She then ended her presentation with a call for physical activity champions!

3.2 Response to presentation

The presentation gave rise to a number of discussion points as follows:

- A general discussion took place around a physiotherapist’s workload, which highlighted how time pressure and a large number of patients can mean people with dementia are not a priority. Workloads give rise to physiotherapists selecting the easier or more rehabilitative cases and avoiding the more challenging cases.
- Group interventions were discussed as an excellent idea. They encourage fun activities and socialising and also the idea that a MDT could effectively be involved and feed into a group intervention.
- Fitness programmes in the community could be modified for people with dementia and families.
- Educating the carer about looking after their health and manual handling should be included in an intervention.
- Ageist attitudes to people with dementia can act as a barrier to a person seeing the importance of physical activity.
- Fear of risk and falls was discussed and the ways in which this fear of risk curtails people’s freedom, independence and dignity.
- Research shows huge benefits of physical activity for people with dementia for reducing the risk of falls, improving quality of life and even improving cognitive outcomes.
- Physiotherapists need a lot of specific training in this area and the person is usually treated in conjunction with another condition as opposed to just the dementia.
- A discussion around risk and assessment took place with a general focus on education needed for families and carers and healthcare professionals.
- Physiotherapists may not be picking up people with dementia in the early stages; therefore the interventions may be coming too late for the person. The strategies that people are given or shown need to be given at appropriate times in an appropriate way and they need to be individualised.
- Possible ideas for future developments were discussed such as promoting positive behaviours through exercises and social interactions; modifying existing programmes for people with dementia; and dementia specific exercise classes.
4.1 Presentation

Social Worker John Brennan, from the Special Interest Group on Ageing at The Irish Association of Social Workers, introduced participants to the key issues presenting for social work and dementia care.

John opened his presentation with a focus on the issues that present for the person with dementia such as communication, dignity, human rights, autonomy, changing relationships and loss of their role. He then talked of the issues that present for carers such as lack of information/knowledge, lack of caring skills or lack of awareness of skills, personal ill-health, old age, abuse, stress and other emotional responses. John then outlined how this understanding of the person with dementia and their carer was central to social work, which seeks to understand the situation in the context of their individual stories whilst supporting them and their families emotionally and practically through change and loss over time. All of this, he advised, needs to happen within a context of human rights.

John then outlined some of the social work responses, which included assessment, planning, coordinating, crisis intervention/management, information and education, emotional support/counselling, advocacy work, family work and practical supports around housing and medical finances etc.

He concluded by highlighting key concerns for the NDS such as appropriately balancing the medical and the social; implementing policy to care at home; prioritising education, information and training; promoting research; developing appropriate legislation and focusing on quality of life and human rights. The challenges, he suggested at the end of his presentation included developing a perspective that is anti-ageist and non-discriminatory; involving service users; maintaining professional discretion and autonomy in face of increasing bureaucracy; communicating with those who have a dementia; developing good inter-professional work and developing efficient and seamless services.

4.2 Response to presentation

Some of the key points raised in response to the presentation included:

- A general discussion took place about care in the home and pressure on carers. It was felt that families feel they are being asked to do too much without appropriate home care packages. This discussion also highlighted the need for flexibility in services – the person may need different types of services e.g. not the traditional hands on care but supervision or night time care.
- A discussion around human rights took place and the need to shift away from doing things for people to doing things with people. The former produces disempowerment and learned helplessness.
- The role of social work was highlighted as badly needed given that families require so much support from social workers.
- A need to focus on relationship centred care in addition to person-centred care was discussed.
- The equity of homecare packages was also raised but again with social work it is an issue of lack of resources.
• Access to dementia specific services was raised.
• A case management approach was suggested with social work as the lead.
• Quality of home/day care services was raised and what assessments are being provided this included questions as to whether the person is qualified to do this, are the private home care agencies assessing on their level of need as opposed to the person’s level of need?
• Care plan must be appropriate to need as it changes with time for people with dementia.
• A general discussion emerged about a clinical lead for dementia with some believing the National Care Programme for Older People was too wide and a specific dementia care programme is needed.
• Inappropriate and lack of services for younger people impacted by dementia.
• Resources are a big issue and therefore some people are being denied services because of their age, which needs to be challenged by a clinical care programme.

Theme 5: The Registered Nurse’s Contribution to Person Centred Care

5.1 Presentation

Linda Kearns, Deputy Director of Nursing, Our Lady’s Hospice and Care Centre and the All Ireland Gerontological Nurses Organisation (AIGNA), presented an overview of person centred care for people with dementia and the role of nurses.

Linda used the McCormack & McCance (2010) Person-centred Nursing Framework to explore the key issues of person-centred care. The model has four elements: the care environment; care processes; prerequisites; and outcomes. She noted how person-centred care was about letting older people with dementia live their life and a move away from institutionalised task-focused care to ensuring older people are living their daily life. Person-centred care was also about allowing older people to take risks and ensuring appropriate measures to reduce the risk are in place. Overall, Linda highlighted that this care model was about working together with people on the things that are important to them without the restraint of rituals and routines. A key challenge for the NDS, she maintained, was incorporating this person-centred care model.

Linda then spoke about risk and the ‘Nothing Ventured, Nothing Gained’: Risk Guidance for People with Dementia (NHS, 2010) report as well as giving an insight into concepts around risk enablement/positive risk management. She concluded by outlining the role of the nurse such as leadership; assessment of risk and balancing it with quality; promotion of independence; contribution to the development of person-centred care; advocate for person-centred care; assessment and care planning; working collaboratively with other health care professionals and the person and their family. She then finished by identifying education needs of nurses and highlighting, once again, the necessity to include person-centred care in the NDS.

5.2 Response to presentation

The general points raised in response to the presentation included:

• A general discussion on person centred care took place with some of the key points being a focus on knowing the individual but letting the person be themselves; importance of the environment for person-centred care; difficulty of providing individual care in residential
settings; attributes of professionals must be person centred also; at home it is about matching activities to the person and enabling them through their environment.

- Person centred care needs to be about normalisation, this is where intellectual disability has come from and where dementia needs to go to.
- The need to have person centred outcomes was raised and not just doing person centred thinking – more fundamentally about the rights of the individual.
- Good quality relationships are nearly more important than the services people receive.
- A ‘Communication Passport’ was suggested as a necessary tool for people with dementia to communicate their needs, likes and dislikes.
- Advanced care directives would also be required to make person-centred care practical to implement.
- People with dementia need to be given their own input into issues like end of life care planning: with the new Assisted Decision Making (Capacity) Bill this may become more common. The autonomy this will give people with dementia was also identified.
- Risk was discussed with a focus on having a risk document. Creative thinking is important to promote activities and not risk.
- Dignity and risk was discussed and the fact that we all take risks it is what makes us human, this is such an important aspect of the care for people with dementia.
- People with dementia do benefit from risk reduction falls programme – we are moving away from encouraging people to sit down and not be mobile.
- A tailored approach to risk is needed.
- There are challenges posed by HIQA, which aims to reduce risk, whereas allowing some risk may be better person-centred care.
3. How clinicians can influence the development of the National Dementia Strategy

The policy vacuum surrounding dementia care is underpinned by the lack of a framework and process for addressing dementia as a growing public health issue. The development of a NDS, therefore, will be a benchmark for further progress in dementia policy. It will join a number of other critical strategy and legislative developments that have taken place over the last year such as the National Carers Strategy; the National Positive Ageing Strategy; the Health and Well Being Strategy; and the Assisted Decision Making (Capacity) Bill.

In developing the strategy, it will be critical for the Department of Health to engage with experts to translate expertise into strategy. The experience and expertise of multidisciplinary clinicians will not only inform the broader strategic framework underpinning the NDS, but equally, it will play a key role in the successful implementation and resourcing of it.

To date, some clinicians have inputted into the early stages of the development of a NDS through submissions as part of the public consultation process. Therefore, the roundtable offered clinicians both an opportunity to build on this input and to develop ideas for further influence in a collaborative manner. Table 1 summarises their thoughts in this regard:

Table 1: Suggestions on influencing the development of the NDS

<table>
<thead>
<tr>
<th>Participants discussed a number of ways in which the development of the dementia strategy could be influenced:</th>
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<tbody>
<tr>
<td>• Thematic approach throughout the strategy would be effective in utilising clinical knowledge.</td>
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<td>• It will be important for the Department of Health to understand the multidisciplinary approach needed to address dementia detection, diagnosis and care.</td>
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<td>• There is real conflict between what clinicians want to do for people with dementia and what is possible within the current health care structures. Reform of existing health care structures will be necessary for a strategy to be successfully implemented and resourced.</td>
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<td>• Training supports for staff, home care workers, and informal family carers will be central to the success of a strategy.</td>
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<td>• Funding needs to be allocated and a clear dementia budget identified.</td>
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<tr>
<td>• Clinicians can play a lead role in identifying ways that money can be recycled and innovatively used rather than reinventing the wheel. However, additional resources will be needed but they will be offset by longer-term savings.</td>
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<td>• The strategy must be communicated across various Government departments such as housing, finance, welfare etc. as policy in many areas impacts on strategic approaches to addressing dementia care.</td>
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<td>• An identified clinical care programme will be very important alongside the development of a NDS.</td>
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<td>• Working together and sharing knowledge in a collaborative way will enhance the ability of clinicians to influence development and the ASI could play a role in this based on the roundtable model.</td>
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<td>• Ageism and stigma also need to be included in the dialogue about a successful strategy.</td>
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<td>• A panel of clinicians could be facilitated by the ASI.</td>
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</tbody>
</table>
Appendix 1:

Agenda

Clinicians Roundtable on the National Dementia Strategy

9 April 2013, Radisson Hotel, Golden Lane, Dublin 2

09:30 Arrival and refreshments

10:00 Welcome and overview, Maurice O’Connell, CEO The Alzheimer Society of Ireland

Core Clinical Elements of the National Dementia Strategy

10.10 Theme 1: Non-Pharmacological Interventions and Behaviours that Challenge
Presenter: Adrian Lewis, Senior Occupational Therapist, Psychiatry of Later Life, St. James's Hospital

10.20 Group discussion and feedback

10.40 Theme 2: Improving Communication
Presenter: Gillian Eggleston, Senior Speech and Language Therapist HSE LHO Dublin North Central

10.50 Group discussion and feedback

11.10 Theme 3: Physical Activity for Health and Wellbeing
Presenter: Aine O’Riordan, Senior Physiotherapist, Primary Care, HSE LHO Dublin North Central

11.20 Group discussion and feedback

11.40 TEA/COFFEE BREAK

11.50 Theme 4: National Dementia Strategy: A Social Work Perspective
Presenter: John Brennan, Social Work Manager, The Mater Hospital

12.00 Group discussion and feedback

12.20 Theme 5: The Registered Nurse’s Contribution to Person Centred Care
Presenter: Linda Kearns, Deputy Director of Nursing, Our Lady’s Hospice and Care Centre and the All Ireland Gerontological Nurses Organisation (AIGNA)

12.30 Group discussion and feedback

12.50 How clinicians can influence the development of the National Dementia Strategy
Next steps
Role of The Alzheimer Society of Ireland?

13.10 Final remarks, Maurice O’Connell, CEO The Alzheimer Society of Ireland

13.15 LUNCH (light lunch provided)
Appendix 2: List of Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Surname</th>
<th>Clinical Area</th>
<th>Location</th>
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<tbody>
<tr>
<td>Laura</td>
<td>Barragry</td>
<td>Speech &amp; Language Therapy</td>
<td>Cheeverstown House</td>
</tr>
<tr>
<td>Niamh</td>
<td>Barrett</td>
<td>Speech &amp; Language Therapy</td>
<td>HSE LHO Dublin North Central</td>
</tr>
<tr>
<td>John</td>
<td>Brennan</td>
<td>Social Work</td>
<td>Mater hospital</td>
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<tr>
<td>Deirdre</td>
<td>Carolan</td>
<td>Speech &amp; Language Therapy</td>
<td>Our Lady of Lourdes Hospital</td>
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<tr>
<td>Carmel</td>
<td>Collins</td>
<td>Occupational Therapy</td>
<td>Hospice Foundation</td>
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<tr>
<td>Fiona</td>
<td>Crehan</td>
<td>Physiotherapy</td>
<td>St. Vincents Hospital</td>
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<tr>
<td>Niamh</td>
<td>Davis</td>
<td>Speech &amp; Language Therapy</td>
<td>HSE LHO Dublin North Central</td>
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<tr>
<td>Sarah</td>
<td>Donnelly</td>
<td>Social Work</td>
<td>Tallaght Hospital</td>
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<tr>
<td>Gillian</td>
<td>Eggleston</td>
<td>Speech &amp; Language Therapy</td>
<td>HSE LHO Dublin North Central</td>
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<td>Marie</td>
<td>Fitzpatrick</td>
<td>Nursing</td>
<td>Cheeverstown House</td>
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<td>Bronagh</td>
<td>Flynn</td>
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<td>Sarah</td>
<td>Gately</td>
<td>Physiotherapy</td>
<td>Siel Bleu Ireland</td>
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<tr>
<td>Matthew</td>
<td>Gibb</td>
<td>Social Work</td>
<td>St. James’s Hospital</td>
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<tr>
<td>Linda</td>
<td>Kearns</td>
<td>Nursing</td>
<td>Our Lady’s Hospice Harold’s Cross</td>
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<td>Gibin</td>
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<td>Lawlow</td>
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<td>HSE LHO Dublin North Central</td>
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<td>Adrian</td>
<td>Lewis</td>
<td>Occupational Therapy</td>
<td>St. James’s Hospital</td>
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<td>Mary</td>
<td>Manning</td>
<td>Nursing</td>
<td>NMPDU (Dementia Education Programme)</td>
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<td>Una</td>
<td>McMahon</td>
<td>Speech &amp; Language Therapy</td>
<td>Beaumont Hospital</td>
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<td>Lorraine</td>
<td>McNamee</td>
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<td>Aine</td>
<td>O’Riordan</td>
<td>Physiotherapy</td>
<td>HSE, Dublin North Central</td>
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<tr>
<td>Patricia</td>
<td>Quinn</td>
<td>Physiotherapy</td>
<td>Leopardstown Park Hospital</td>
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<tr>
<td>Ann</td>
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