Dementia with night-time distress: referral

Assume that today's date is 5 November 2026. You have reviewed Mrs Pacocha at home today. This is original independent practice material; the patient details, assessment findings and individual care arrangements are fictional. You are a registered nurse in the home support team. Using the case notes, write a referral to Ms Dolly Emard, Community Dementia Nurse, requesting assessment of Mrs Pacocha's recent night-time distress, support for her daughter and coordination of replacement overnight support with social care. Communicate when replacement cover must start. Distinguish the recent change from Mrs Pacocha's longstanding preferences and accurately communicate the medical assessment already undertaken. Address the letter to Ms Dolly Emard, Community Dementia Nurse, Home Support Team, Community Nursing Service, 24 Station Road, SW1V 1AA. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Mrs Mikaila Pacocha	☐	☐	☐
2. DOB: 14/03/1947 (79 yrs)	☐	☐	☐
3. Home: 9 Orchard Close, SW1V 1AA	☐	☐	☐
Social background			
4. Lives with daughter; daughter manages regular medicines and meals	☐	☐	☐
5. Daughter exhausted by interrupted sleep; requests practical support	☐	☐	☐
6. Home-support worker each morning: washing and dressing	☐	☐	☐
7. Retired seamstress; collected decorative buttons	☐	☐	☐
8. Daughter asked about online booking for routine clinic appointments	☐	☐	☐
9. Daughter made critical remarks about brother's spending; he has no role in patient's care	☐	☐	☐
Medical history			
10. Alzheimer's dementia diagnosed 2023	☐	☐	☐
11. Routine dental check-up earlier this year; no treatment needed	☐	☐	☐
Usual preferences and function			
12. Lifelong preference: bedtime around 23:00, quiet radio; previously content	☐	☐	☐
13. Baseline: repetitive questions	☐	☐	☐
14. Usually walks independently indoors	☐	☐	☐
Recent change			
15. Past 3/52: new night-time crying, asking to go home, trying front door	☐	☐	☐
Recent change			
16. No leaving home or falls reported	☐	☐	☐
17. Calmer with daughter's reassurance	☐	☐	☐
18. No recent change in usual carers	☐	☐	☐
19. Appetite unchanged	☐	☐	☐
20. No pain reported	☐	☐	☐
Assessment and progress			
21. GP assessment 04/11: no acute illness or delirium identified; cause remains uncertain	☐	☐	☐
22. GP reviewed medicines; unchanged	☐	☐	☐
23. 05/11 nursing visit: daytime behaviour at usual baseline	☐	☐	☐
24. Mrs Pacocha agrees to referral; daughter supports home assessment	☐	☐	☐
Agreed plan			
25. Request Ms Emard: home assessment this week → triggers, individual sleep strategies, carer support; coordinate replacement overnight support with social care	☐	☐	☐
26. Existing morning home-support service does not provide overnight cover	☐	☐	☐
27. Daughter available to discuss night-time episodes during home assessment	☐	☐	☐
28. Interim: daughter supervises through night of 09/11 only; replacement overnight cover required from night of 10/11; not yet arranged	☐	☐	☐
29. GP retains medical management	☐	☐	☐
30. GP safety advice: call 999 for new sudden confusion	☐	☐	☐

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