

Making decisions and managing difficult situations

Living with dementia involves making a wide range of decisions, including those about practical and ethical issues. As dementia progresses, some of these decisions will fall to a carer. Carers often ask at what point they take over the decision-making process, and on what basis they should make them. The answers to these questions will vary between people and situations. However, there are some guidelines that should be used as the basis for all decision making.

As someone's dementia progresses, their cognitive (mental) abilities will decline, which will affect their ability to make their own decisions. When this happens, carers, family and health and social care professionals will need to become more involved in the decision-making process.

This factsheet offers guidance to carers on the relevant law (the Mental Capacity Act 2005). It also offers advice on how to approach decisions in a range of difficult areas.

Mental Capacity Act

It can be difficult to know whether it is appropriate to make a decision for someone with dementia. The Mental Capacity Act 2005 – and its guidance (the Code of Practice) – explains how to decide if someone is able to make decisions for themselves. It also outlines how to help the person and, if they are not able, how to make decisions for them.

The Act is designed to help professional carers, and family carers are not strictly required to follow it. However, they are encouraged to do so. It provides a useful basis for making decisions and many carers find that it reflects what they would do naturally anyway. To find out more see factsheet 460, **Mental Capacity Act 2005**.

The Mental Capacity Act applies in England and Wales. Northern Ireland has different laws around capacity. To find out more about the position there, see factsheet NI472, **Enduring power of attorney and controllership**.

Mental capacity is the ability to make decisions for yourself. It is assumed that every person has capacity unless it is proven otherwise. If you are in doubt as to whether someone can make a particular decision, you will need to assess whether they have this capacity. The Mental Capacity Act and its code of practice provide guidance on this, which is summarised below in Flowchart 1.

If you are making a decision for someone who lacks capacity then you must ensure that it is made in their best interests. To do this, the following questions may be useful:

- Will the person be able to make the decision at a later time? If yes, can it wait until then? For example, they may be recovering from an operation or from an illness or infection.
- Are there other ways you can involve them in making decisions, such as giving prompts, showing pictures or offering a choice of responses?
- What would the person take into account if they were making this decision for themselves? For example, would they prefer a carer of the same gender if they had the choice?
- Does the person have any particular cultural or religious/spiritual beliefs? Do they have any past or present wishes or feelings that can help guide you in making the decision?

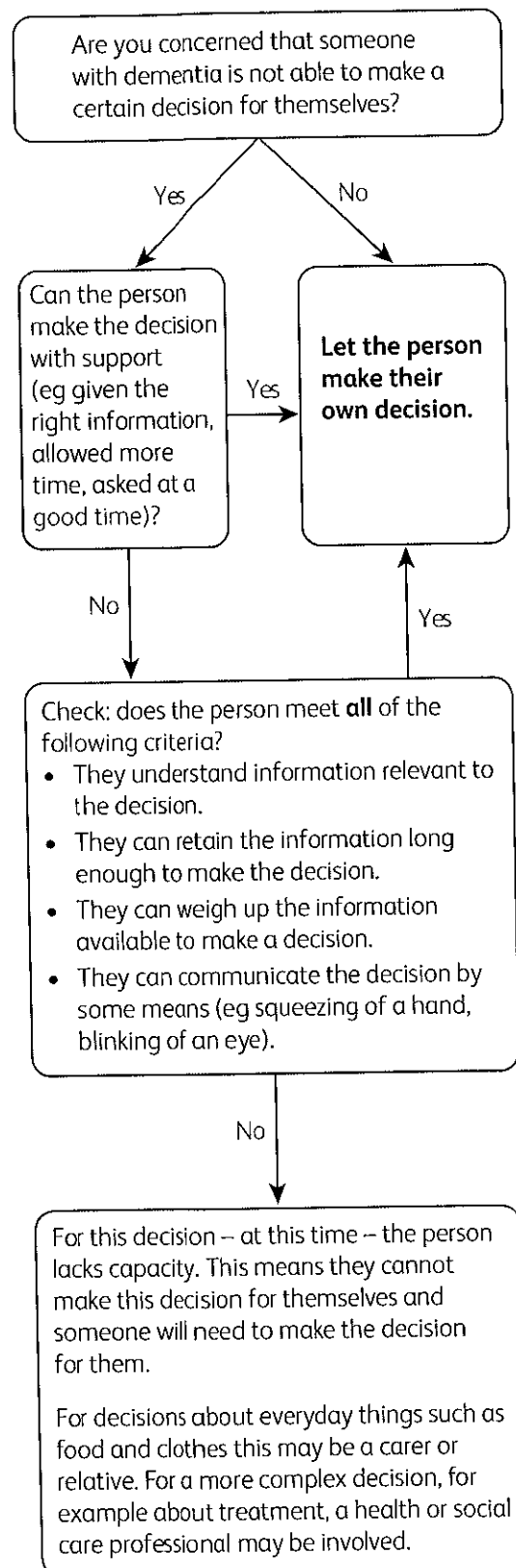
- Is there anyone else, for example family members or friends, who you can consult with when making the decision?

It is also crucial that the decision you make is the least restrictive option, ie takes into account someone's rights and freedoms and gives them as much free will and independence as possible. To make sure you are doing this, consider all alternative available options.

Some common areas in which carers may face challenging decisions and choices are outlined below. These include options with different levels of restriction, as well as questions to consider that can help decide a suitable solution. Often a less restrictive option is more effective.

Planning ahead

The Mental Capacity Act provides formal steps that people with dementia can take to have more control over decision-making in the future. One option is to choose someone (or more than one person) they trust to be an attorney, through a legal



document called Lasting power of attorney (LPA). Once registered, the attorney(s) have the authority to make decisions on the person's behalf when they no longer can. The attorney(s) must act in the person's best interests. For more see factsheet 472, **Lasting power of attorney**.

People with dementia can also choose in advance the type of medical treatment they want to refuse in the future by making an advance decision. This is a useful legal document that ensures the person's wishes can be carried out at a later stage when they lack the capacity to decide. See factsheet 463, **Advance decisions and advanced statements**, for more information.

Managing finances

As dementia progresses, there may come a time when the person will struggle to manage their finances and affairs. At some point, they may need extra support, or for someone to manage their money for them.

Someone may have planned ahead and created an Enduring power of attorney (before October 2007) or Lasting power of attorney for health and welfare (after 2007). However, sometimes families struggle to decide when the time is right to register the power of attorney and start acting on the person's behalf.

If the person's ability to manage their finances is concerning, it may help to identify why they are struggling. Given the right information and support, someone may be able to continue to manage their own finances for longer. For example, some people with dementia may have difficulty remembering card personal identification numbers (PIN). A better alternative would be a 'chip and signature' card. The person with dementia only has to provide a signature and does not have to remember any numbers. Some families also set up direct debits for bills so that the person doesn't have to worry about arranging and remembering payments.

For some people, it might be only specific financial decisions that they struggle with. Often people with dementia can continue with day-to-day finances, such as paying for shopping, but may have difficulty with

more complex decisions. For example, the person may find it difficult to change their gas supplier or make choices about investments.

In these situations, carers can consider the least restrictive way of helping them. Some may register a power of attorney, but only use it to manage the more complex decisions, and leave the person to manage their day-to-day finances.

In time, however, it may become apparent to a carer that, even with support, the person with dementia is struggling to cope. For example, they may fail to understand what needs to be paid, overpay for some things, or leave money unaccounted for. In these situations it may be useful for carers to try and build up a picture of how the person manages their money. Carers can either talk to the person about how they are managing, or monitor their finances over time and check that bills are being paid. Acting as the person's attorney can make this easier. This will ensure that carers do not step in when the person is actually in control and spending their money as they choose.

If carers feel that the person can no longer cope or manage their finances, it may be time to consider registering an LPA. If an LPA has not been made then a carer may wish to apply to the Court of Protection to become a deputy. This can also give them the authority to manage the financial affairs of the person with dementia. For more information see factsheet 530, **Becoming a deputy for a person with dementia**. When taking over someone's financial affairs, it is important to make each decision in the person's best interests, and to take account of their past and present wishes.

Things for carers to think about

- What decisions is the person with dementia struggling with?
- Can you support someone to manage their own finances, for example by providing clear and easy-to-understand information?
- Is there support on offer to help someone with their finances, eg chip and signature card, large-print documents, direct debits for bills?

Are there aspects of their finances that the person is managing well, such as day-to-day affairs like doing the shopping?

- Are there any bills that have not been paid? Have any bills or services been overpaid, or any money unaccounted for?

To find out more about the legal powers mentioned, such as Lasting Power of Attorney, see factsheet 472, **Lasting power of attorney**. For Northern Ireland see factsheet NI472, **Enduring power of attorney and controllership**.

Telling the truth

Situations may arise where a person with dementia asks questions that leave carers feeling unsure about whether to answer honestly. This could be because the answer would be distressing to the person – for example, reminding them that a relative or partner has died. In cases such as these, carers can look for different ways of handling the situation.

If the person says something that you know is not true or possible, try to see past what they are saying, and instead look at the emotions behind it. For example, if they are asking for their mother, who is no longer alive, it may be that they are feeling scared or need comforting. By meeting the needs behind what is being said, it can be possible to offer emotional support while avoiding a direct confrontation over the facts.

In some situations you may decide that not telling the truth is in the person's best interests. If you do decide that the truth would be too distressing for the person, there are other options available.

- Distraction – for example, to distract a person away from asking for their deceased mother, you could ask questions like 'Your mother? Tell me about her'. This allows someone to talk about the person and can also help convey their emotions. Other distractions include a change in conversation, or an activity.

- 'Bending the truth' – it may be possible to convey a message without telling the truth or lying. For example, if someone asks where their

mother is, instead of explaining that they have died, a carer could answer with 'don't worry, she is safe'.

- Lying – this should only be done as a last resort when other options are not appropriate, and to do anything else would cause serious distress.

Each case should be judged individually and the course of action should be chosen to suit the specific time and situation. An ideal solution is one that you feel comfortable with and also considers the person's interests.

Things for carers to think about

- Is there a message behind the question that indicates an emotion or unmet need, eg fear, loneliness or disorientation?
- Is the person likely to understand what they are being told? Are there ways of making it easier for them to understand?
- Would knowing the truth cause the person significant distress? If so, would the consequences of telling the truth outweigh the need?
- Are there ways of telling the person the truth that would be less upsetting?
- Are there some things that are essential to be honest about?
- Will not telling the truth make things more difficult in the long run?
- From your knowledge of the person, what do you think they would want?

Driving

A diagnosis of dementia does not mean a person has to stop driving straight away. However, they will eventually have to give up driving voluntarily or be required to stop at some point as the condition progresses.

How this is handled requires careful consideration. The safety of the person with dementia, their passengers and the general public must be prioritised.

Discussing the issue while the person is still able to make decisions enables families to agree on a course of action before things worsen. It is important to involve the person with dementia in the decision, and focus on the condition, rather than on the individual, as the reason for stopping driving.

The law

A person that receives a diagnosis of dementia and wants to continue to drive must, by law, inform the Driver and Vehicle Licensing Agency (DVLA) in Great Britain or the Driver and Vehicle Agency (DVA) in Northern Ireland. They should also inform their car insurance company of the diagnosis or the policy may become invalid.

If someone receives a diagnosis of dementia and refuses to tell the DVLA/DVA, carers should make all efforts to encourage them to do so. As a last resort, the person's GP may inform the DVLA/DVA without the person's consent, following guidelines issued by the General Medical Council. A GP may also help with explaining the medical reasons behind how dementia affects driving.

If the person wishes to keep driving, the DVLA/DVA will request a report from the person's GP or consultant. They may also require the person to take a driving assessment at an accredited mobility centre. This may be helpful in getting professional guidance and evidence about whether the person needs to stop driving. It removes the responsibility from the carer and this might help to reduce conflict about the decision, because the person with dementia cannot blame them for the outcome. Also, the person may accept the news or be more easily convinced if they hear it from a professional.

It can be a difficult situation if the person continues to drive in spite of medical advice or after having their licence cancelled. This is because they may lack insight into their condition or are in denial about their

diagnosis. Families and carers should make all possible efforts to encourage the person to stop driving immediately, for legal and safety reasons. Parking the car out of sight can remove a visible reminder. Some carers also resort to hiding the car keys.

Things for carers to think about

- Is the person becoming less confident behind the wheel?
- Have they had near misses or minor bumps or scrapes since being diagnosed with dementia?
- Do you or other passengers feel unsafe when the person is driving?
- Can you help them stay independent in other ways?
- How would you feel if they had an accident when driving?
- Can you enlist the help of a professional such as the GP (to help encourage them to stop)?
- Would it be helpful to seek formal testing at a driving assessment centre?

To find out more on this subject see factsheet 439, **Driving and dementia**, which lists some of the practical benefits of stopping driving, and booklet 1504, **Driving**, which is written for a person with dementia and also lists some useful information.

Walking about

It is common for some people with dementia to spend long periods of time walking around in their home or trying to leave their home to walk outside. Walking like this is not meaningless 'wandering' – it usually represents a response to a need. The person may be searching for someone or something, be bored or restless, or be attempting to relieve pain or discomfort. They may also have enjoyed walking in the past and want to continue doing this. This behaviour can cause concern for carers, especially when it comes to the person's safety.

Sometimes carers consider locking doors and windows to prevent the person from coming to any harm. This is a very restrictive practice and needs to be considered carefully. It must only be done as a last resort after considering other options. It is important to remember that you should never lock a person with dementia in the home if they are alone. If you are worried to the point that you feel there is no safe alternative, call social services immediately and ask for an urgent assessment.

Finding the right solution

Help in finding a better, ie less restrictive, solution to walking about may be available. An assessment from social services (called a 'care needs assessment') can be requested and may provide some alternative options. One solution could be accompanying the person when walking for some of the way, and then moving their attention to something else so that you can both return. If walking is caused by boredom, providing meaningful activities for the person may help. If the person does walk alone and gets lost, they could carry identification to help ensure their safe return. Alzheimer's Society Helpcards can be filled in with important details about the person with dementia, and can help if someone finds them when they are lost.

Some carers consider using assistive technology products, such as a tracking device, to help find the person. There is also a 'panic button' they can press if they get lost. Tracking devices are beneficial as they provide people with dementia and their carers with a better sense of independence and reassurance. However, they do raise ethical concerns if the person is unable (lacks the capacity) to consent to carrying the device. If tracking devices are used then the person must be consulted about this. Risks and benefits must be carefully weighed up, and any decision taken must be in the person's best interests and be the least restrictive option available.

In some cases, after trying all alternative options, it may be decided that locking the door is the best solution. Discuss this decision first with any other people who are involved in the person's care. The person must not be put at any kind of risk as a result of this decision. As this is a considerable restriction of the person's choice and freedom of

movement, doors should be locked for the minimum period necessary and only when they are not alone in the house. Extra support may help to limit how much this really needs to be done. Carers should look into what is available in the area – for example, through social services.

Things for carers to think about

- What triggers the walking about?
- Are there any helpful solutions to dealing with this?
- Will assistive technology products, such as a tracking device, be appropriate?
- Are there less restrictive alternatives to locking the doors?
- What would happen if the person were able to walk about?
- What would be the consequences of locking the doors?
- How would you feel if the person had an accident, having been either locked in the house or allowed to walk about?
- What extra help and support is available in the area?

To find out more, see factsheets 501, **Walking about**, and 437, **Assistive technology – devices to help with everyday living**. For information on having a person's need assessed see factsheets 418, **Assessment for care and support in England**, W418, **Community care assessment in Wales**, or NI418, **Community care assessment** (for those in Northern Ireland).

Challenging behaviour

As the dementia progresses, many people develop behaviours that can be challenging. This includes restlessness and aggression. Aggression is not just about physical acts but can be shown in other ways, including verbal aggression. These behaviours can be distressing, both for the person and the carer.

If a person with dementia becomes aggressive, it is important to remember that they are not 'behaving badly' and are not to blame. Their behaviour may be a direct result of changes in their brain, or be caused by a general health problem, such as pain from an infection. These behaviours can also reflect problems related to the care the person is receiving, or their general environment or social interactions. In this case, the behaviour is best viewed as an attempt to communicate an unmet need, rather than as a direct symptom of dementia. If a person is being aggressive, they should be assessed by their GP in the first instance to identify any possible underlying causes.

Healthcare professionals may look at prescribing certain medications, often antipsychotic drugs, as a way of improving someone's behaviour. However, these drugs can have severe side effects and a significant impact on a person's quality of life. Therefore, it is vital to first consider other options that do not involve medication when deciding how best to help someone who is behaving aggressively.

Think about whether there are any specific triggers or circumstances which cause the person to become aggressive. Keeping a diary can help with this. For example, does the person become aggressive at a specific time of day or when carrying out a certain task? Aggression can often be an expression of how someone is feeling, such as frustration at not being able to do something or not being understood. It might be that the person is bored, frightened or even humiliated by the situation.

If any possible underlying causes have been addressed and the person is still behaving aggressively, there are a number of simple non-drug treatments that may help. These include life story work and reminiscence therapy, social interaction, aromatherapy, talking therapies, animal therapy, music and dance therapy and massage. For more on these see factsheets 444, **Talking therapies (including counselling, psychotherapy and CBT)**, and 434, **Complementary and alternative therapies**.

If these approaches do not help the person and their symptoms are severe or distressing, then medication may be necessary as a last

resort. Medication treatment should be reviewed regularly (after six and/or 12 weeks). If antipsychotics are prescribed, their use should be monitored by a health professional, such as the GP, and stopped after 12 weeks, except in extreme circumstances.

Things for carers to think about

- Does the person's behaviour pose a direct or immediate threat to themselves or other people?
- Has the person been assessed by their GP to check whether they have an infection or are in pain?
- Is the person comfortable and well cared for?
- Is the person helped to lead an active life, with interesting and stimulating daily activities?
- When the person is aggressive, how do you and others react?
- What non-drug approaches have been tried?
- If drugs are being prescribed, have the risks, side effects and benefits been discussed with you and the person with dementia? When will treatment be reviewed?

To find out more see factsheets 509, **Dementia and aggressive behaviour**, and 408, **Drugs used to relieve behavioural and psychological symptoms in dementia**.

Refusing to take medication

Sometimes, people with dementia refuse to take their prescribed medication. This can be because the medicine is hard to swallow, tastes unpleasant or causes side effects such as nausea. It is important not to assume that the person is just being 'difficult'.

If this situation arises, you should raise it with the person who prescribed the medication. The prescriber will be able to decide whether or not the person has the capacity to decide for themselves not to take their medication. If the person does not have capacity, then the prescriber will be able to make a decision about what is in their best interests. When making this decision, the prescriber should talk to the person's relatives and carers, and other professionals involved in the person's care. If a health and welfare Lasting power of attorney has been set up, it is up to the attorney to make the decision, with the help of the prescriber.

If it is decided that taking the medication is the best option, then this should be done through the least restrictive means available. In some situations, taking the drug in a different form may be easier than swallowing a pill. For example, some dementia and painkiller drugs are available as a patch or an oral solution.

As a last resort, it may be necessary to hide the medication in the person's food or drink. However, this 'covert medication' can affect how the medicine is absorbed, and should only be done with the written approval of the person's GP, consultant or pharmacist.

Things for carers to think about

- Are there some situations where the person is more comfortable taking the medication, and others less so – eg, in a particular setting or with the help of a particular person?
- Can you tell from the person's reaction that they dislike the taste, or that the drugs cause unpleasant side effects?
- Does the person have capacity to refuse to take their medication?
- Have you asked the GP about alternative forms of the medication?
- If you are tempted to try hiding medication in food, have you had this approved by a qualified medical professional first?

To find out more about some of the drugs that people with dementia may be given, and the possible side effects, see factsheets 408, **Drugs used to relieve behavioural and psychological symptoms in dementia**, and 407, **Drug treatments for Alzheimer's disease**.

Going into residential or nursing care

As a person's dementia progresses, they will need more support and care, and there may come a time where full-time residential or nursing care is needed. If the person cannot make this decision for themselves, it is often left to the carer or family to make the decision about moving them into a care home. Being prepared for this eventuality early on, and having discussions as early as possible, can help to make the decision slightly easier when the time comes.

A carer's decision to move someone they care about into residential or nursing care is often very difficult. Sometimes carers feel as though they have let the person down, which can prompt feelings of guilt. Families can consider other care options and alternatives – for example, seeing what other care and support can be provided within the home. A family may wish to have a community care assessment through the local social services. Others may consider whether sheltered accommodation or assisted living is more appropriate.

Respite care (sometimes referred to as replacement care) is another option, and could be the first step towards longer-term residential care. This offers the person with dementia a chance to experience residential care on a short-term basis and offers the carer a break from their caring duties.

Carers or relatives of a lesbian, gay, bisexual or transgender (LGBT) person will have to consider additional factors when selecting the right care home. This could be choosing a gay-friendly home or one that has an anti-discrimination policy or anti-gay bullying policy. Look for organisations that feature lesbian and gay couples in their brochures. For further information on this topic see factsheet 482, **Moving into a care home – advice for lesbian, gay and bisexual people**.

It may help to discuss the decision with a social or health care professional, such as a social worker or the person's GP or consultant. Often they can give families their professional opinion on the type of care that someone needs. A social worker can carry out a needs assessment, which can help with deciding the level of care someone needs and the right care setting.

Although a move to residential or nursing care can be an emotionally difficult time, some carers do find that there are benefits. Some feel that the quality of care provided is better than they can provide themselves. Others feel that it is in the person's best interests to be in residential or nursing care. There are also social benefits of living in a residential or nursing home. Residents can interact with one another and build new friendships, as well as take part in the activities that care homes can provide.

This change does not mean you will have a less important role in the person's wellbeing. Talk about your continuing involvement in the care of your relative with the staff of the home. It may help you decide whether residential or nursing care is the right decision for you and your relative.

Things for carers to think about

- Is the person able to make a decision about their care, and where to receive it, for themselves?
- Have you considered other options, such as care in the home or respite care?
- Is there a point at which you would feel unable to cope, when residential or nursing care would be the only option?
- What would be the benefits for you and your relative if they moved to a residential or nursing home?
- Have you taken into account the person's needs when selecting a care home if they are lesbian, gay, bisexual or transgender?

- Have you considered any cultural, religious or spiritual beliefs the person with dementia may have when choosing a suitable care home?
- Have you discussed the person's care needs with a health or social care professional?
- In what ways might residential or nursing care staff be able to provide better care than you?
- If your relative goes into a residential or nursing home, in what ways might you still be able to be involved in their care?
- What factors help make your relative feel comfortable, safe and content? Do the local residential or nursing homes offer this?
- If your relative goes into a residential or nursing home, what would the impact be on them, you, and other people?
- Do you think your feelings (good or bad) about placing your relative in a care home could change over time?
- With whom can you discuss your feelings?
- Has your relative ever expressed any opinions about going into a residential or nursing home?

To find out more about moving into nursing or residential care see factsheets 476, **Moving into a care home**, and 482, **Moving into a care home – advice for lesbian, gay and bisexual people**.

For more about respite care see factsheets 462, **Replacement care (respite care) in England**, W462, **Respite care in Wales**, or NI462, **Respite care in Northern Ireland**.

Alzheimer's Society also has a downloadable guide to selecting a care home. You can find it at alzheimers.org.uk/carehomeguide.

Artificial feeding

In the advanced stages of dementia, some people lose the ability to swallow safely or even to swallow at all. This usually occurs within days or weeks of the end of their life. In these circumstances, and if the person cannot make the decision for themselves, someone else might have to decide how best to feed them. They may have to decide to give food or fluid through a tube. This is known as artificial feeding or hydration. For more information see factsheet 531, **End of life care**.

The person may have already anticipated this type of treatment and decided to refuse it through an advance decision (see 'Planning ahead'). If not, and if someone has a personal welfare LPA, then the attorney can speak with the doctor or medical professional to make a decision. For more information, see factsheet 472, **Lasting power of attorney** for more details.

If there is a disagreement about what is best, the Court of Protection can be asked to decide. While the Court can make decisions quite quickly, in the meantime the person will continue to be offered life-sustaining treatment. If there is no personal welfare LPA in place, families and carers should still be consulted by medical staff when making these decisions. However, generally it is the medical professionals that will make the final decision.

For many carers, the issue of artificial feeding or hydration is not wholly clear, and discussing the stopping of food or fluids is very difficult. Some may feel that to do so is morally wrong. This decision is complex because there is no clear evidence that someone nearing the end of life will always benefit from artificial feeding or hydration, either to relieve symptoms or prolong life. Loss of the ability to swallow can be a natural part of the dying process. At this stage the focus of care should move away from trying to prolong life, and towards achieving good quality of life – and good quality of death.

It is important to think about the person's best interests, including any relevant religious or moral beliefs that they hold. It is also important to remember that any aspect of treatment, including stopping food and drinks, should not mean the person will be left in pain or discomfort.

Things for carers to think about

- What alternatives to artificial feeding or hydration are there, if any?
- Are there any indications that this might be just a temporary phase?
- Would artificial feeding or hydration affect the person's dignity or be against their beliefs?
- Would they have chosen to be fed or hydrated artificially if they could have foreseen the situation?
- Would the person's quality of life be improved if they were artificially fed?
- Would artificial food or fluids cause them distress or make them uncomfortable?
- What do others think? Have you discussed the matter honestly and openly with friends, relatives and professionals?
- What emotional support have you been offered at this very difficult time?

To find out more see factsheet 531, **End of life care**.

Other useful organisations

Age UK

Tavis House
1–6 Tavistock Square
London WC1H 9NA

T 0800 169 2081 (advice line)
W www.ageuk.org.uk

Age Cymru – Wales

Tŷ John Pathy
13/14 Neptune Court
Vanguard Way
Cardiff CF24 5PJ

T 08000 223444 (advice line)
W www.ageuk.org.uk/cymru

Age NI – Northern Ireland

3 Lower Crescent
Belfast BT7 1NR

T 0808 808 7575 (advice and information)
W www.ageuk.org.uk/northern-ireland

Provides information and advice for older people in the UK.

Citizens Advice Bureau (CAB)

Various locations
W www.citizensadvice.org.uk

Your local CAB can provide information and advice in confidence or point you in the right direction to further sources of support. To find your nearest CAB, look in the phonebook, ask at your local library or look on the website (above). Opening times vary.

Carers UK

20 Great Dover Street
London SE1 4LX

T 020 7378 4999 (general enquiries)
0808 808 7777 (free carers' line)
E info@carersuk.org
W www.carersuk.org

Charity that aims to help carers recognise their own needs. It provides information, advice and support for carers and campaigns on their behalf. Leaflets and factsheets are available free to carers. There is a network of local branches and carers groups throughout the UK run mainly by carers and former carers.

Court of Protection

PO Box 70185
First Avenue House
42–49 High Holborn
London WC1A 9JA

T 0300 456 4600
E courtofprotectionenquiries@hmcts.gsi.gov.uk
W www.gov.uk/courts-tribunals/court-of-protection

Part of HM Courts and Tribunal Services. Makes decisions, and appoints other people to make decisions, for people who lack the capacity to do this for themselves.

Driver and Vehicle Licensing Agency (DVLA)

Swansea SA99 1TU

T 0300 790 6806 (Drivers' medical enquiries)

W www.dft.gov.uk/dvla

www.gov.uk/contact-the-dvla

www.gov.uk/dementia-and-driving (questionnaire form for those with a medical condition that will affect their driving).

Government-funded agency that issues driving licences and vehicle registration documents in Great Britain.

Driver and Vehicle Agency (DVA)

Driver Licensing Enquiries
County Hall, Castlerock Road
Coleraine
Co Londonderry BT51 3TB

T 0300 200 7861

E dva@doeni.gov.uk

W www.nidirect.gov.uk/motoring

Government-funded agency that issues driving licences and vehicle registration documents in Northern Ireland.

Drivers Medical Group

DVLA
Swansea SA99 1DF

T 0300 790 6806

W www.gov.uk/contact-the-dvla

The Drivers Medical Group in DVLA promotes road safety by establishing whether drivers who have medical conditions are able to satisfy the medical standards required for safe driving.

Elderly Accommodation Counsel

3rd Floor, 89 Albert Embankment
London SE1 7TP

T 0800 377 7070

E info@firststopadvice.org.uk

W www.eac.org.uk

www.housingcare.org

Charity that provides detailed information on all types of accommodation for older people in the UK. It can also offer advice and guidance to help people choose the type of accommodation most suited to their needs.

Office of the Public Guardian (OPG)

PO Box 16185
Birmingham B2 2WH

T 0300 456 0300 (customer services, Monday, Tuesday, Thursday and Friday 9am–5pm; Wednesday 10am-5pm)

E customerservices@publicguardian.gsi.gov.uk

W www.gov.uk/government/organisations/office-of-the-public-guardian

The Office of the Public Guardian provides an easy-read booklet on decision making around the Mental Capacity Act. It can be accessed at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/365631/making_decisions-opg601.pdf

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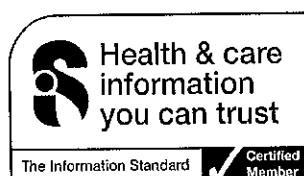
Factsheet 484LP

Last reviewed: March 2016
Next review due: March 2019

Reviewed by: Natalie Melling,
Approved Mental Health Professional
(Mental Health Act), Independent
Social Worker, Best Interests Assessor
(Mental Capacity Act)

This factsheet has also been reviewed
by people affected by dementia.

A list of sources is available on
request.



Alzheimer's Society National
Dementia Helpline

England, Wales and Northern Ireland:
0300 222 11 22

9am–8pm Monday–Wednesday
9am–5pm Thursday–Friday
10am–4pm Saturday–Sunday

alzheimers.org.uk

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