2024

Tallaght University Hospital | Ospidéal Ollscoile Thamhlachta

An Academic Partner of Trinity College Dublin

Directory of Services

Dublin Southwest Integrated Healthcare Area

Dublin and Midlands Regional Health Area

AUTHOR: ALISON MURPHY ICPOP OPERATIONAL LEAD

VERSION 3.0

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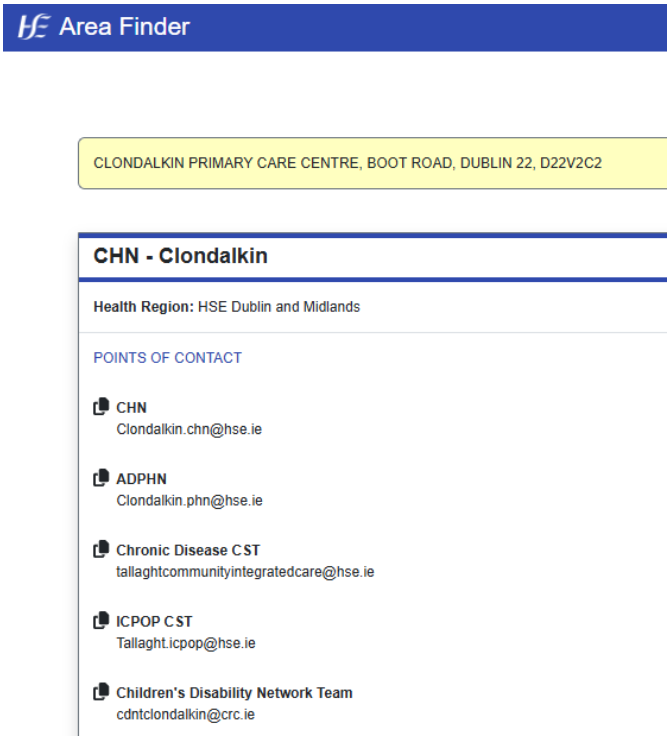
This directory has been developed to be used by healthcare professionals

HSE Area Finder

https://hseareafinder.ie/ is available to check the catchment area of your patient.

This provides email contact details for the Community Healthcare Network (CHN), Public Health Nursing (ADPHN), Integrated Care Programme for Chronic Disease Management Community Specialist Team (Chronic Disease CST), Integrated Care Programme for Older Persons Community Specialist Team (ICPOP CST), Children's Disability Network Team, Community Intervention Team (CIT), Community Palliative Care, and Health and Wellbeing services.



Community Healthcare Network (CHN)

The Community Healthcare Network includes the Primary Care Team including:
General Practitioner, Practice Nurse, Nursing (PHN / RGN), Physiotherapy, Occupational Therapy, Speech and Language Therapy, Dietitian, Social Work, Audiology, Psychology, Podiatry.

The CHN works with community services such as Older Persons Services (e.g. Home Support Services, Nursing Home Support Scheme, Day Centres), Psychiatry of Later Life, Community Adult Mental Health, Community Intervention Team, Palliative Care Team, Pharmacy, Social Inclusion and Disability Services.

Healthlink

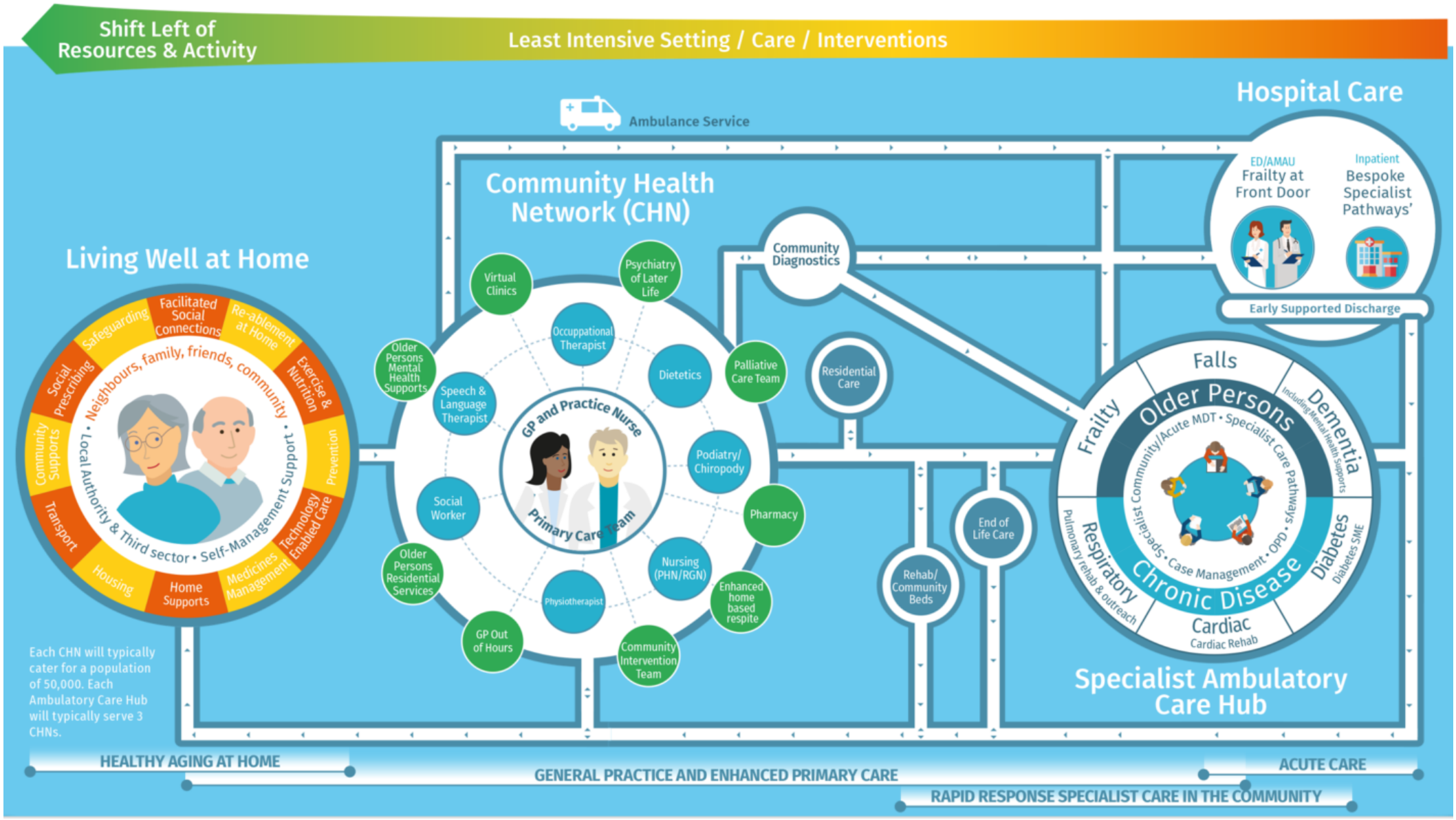
Training videos are available here (includes how to attach a file to a Healthlink referral).

Technology & Transformation YouTube channel available here (includes demo videos & online tutorials for Healthlink & Swiftqueue).

Any GPs that require assistance or training can reach out to Technology and Transformation support team at: support.healthlink@hse.ie

Community Healthcare Organisation 7: Dublin South, Kildare West Wicklow

Sláintecare Service Model



Primary Care Team Referral Pathway

In order to refer a patient to the Primary Care Team (e.g. PHN, Physiotherapy, Occupational Therapy, Speech and Language Therapy, Dietitian, Podiatry / Chiropody, Social Work, Psychology) please use relevant Healthlink pathway or CHN email address outlined below.

Community Healthcare Network Rathfarnham, Knocklyon & Ballyboden

Email: ballyboden.chn@hse.ie
Post: CHN3 Primary Care Services, Ballyboden Primary Care Centre, Edmondstown Rd, D16 W3P8
Phone: 01 7785300
PHN: ballyboden.phn@hse.ie / 01 7958165
GP Lead: Dr Patrick Smyth - Paddy.Smyth@hse.ie
Clinical Coordinator: mary.mckeon3@hse.ie
Referral via Healthlink: **CHO7 > CHN Rathfarnham, Knocklyon & Ballyboden > ECC CHN Referral**

Community Healthcare Network Clondalkin

Email: Clondalkin.CHN@hse.ie
Post: CHN5 Primary Care Referrals, Rowlagh Health Centre, Neilstown Road, Clondalkin, D22C9C3
Phone: 01 7955931
PHN: Clondalkin.phn@hse.ie / 01 7955738
GP Lead: Dr Peter Alexander Joyce - Peter.Joyce@hse.ie
Clinical Coordinator: laura.fitzharris@hse.ie
Referral via Healthlink: **CHO7 > CHN Clondalkin > ECC CHN Referral**

Community Healthcare Network Tallaght and Firhouse (Tallaght East - Kilnamanagh, Tymon, Millbrook)

Email: Tallaghtfirhouse.chn@hse.ie
Post: Primary Care services, Kilnamanagh Tymon Primary Care Centre, Airton Road, Tallaght, D24CF75
Phone: 01 9214828
PHN: Tallaghtfirhouse.phn@hse.ie / 01 7957682
GP Lead: Dr Aoife Murphy - Aoife.Murphy26@hse.ie (on maternity leave)
Clinical Coordinator: eimear.oleary1@hse.ie
Referral via Healthlink: **CHO7 > CHN Tallaght and Firhouse > ECC CHN Referral**

Community Healthcare Network Newcastle/Citywest/Saggart (incl. Rathcoole & Tallaght West - Jobstown, Killinarden, Springfield, Brookfield)

Email: TallaghtWestRathcoole.chn@hse.ie
Post: CHN9 Primary Care Referrals, 2nd Floor Russell Building, Tallaght Cross West, D24 DH74
Phone: 01 7957660
PHN: tallaghtwestrathcoole.phn@hse.ie / 01 7957682
GP Lead: Dr Brian Blake - brian.blake@hse.ie
Clinical Coordinator: emma.frame@hse.ie
Referral via Healthlink: **CHO7 > CHN Newcastle/Citywest/Saggart > ECC CHN Referral**

Primary Care Audiology

Adult: Russell Centre (1st Floor) 01 7957616
Paediatric: Russell Centre (1st Floor) 01 7957615
Referrals (Adults GMS only, Paeds everyone <18 – free for students until leave 3rd level)
Email referrals to Audiology.dml@hse.ie
Postal address: HSE Audiology, 1st Floor, Russell Centre, Tallaght Cross West, Dublin 24. D24 DH74
Healthlink referral not available at present

HSE Older Persons Services

Home Support Services

The HSE Home Support Service (formerly called the Home Help Service or Home Care Package Scheme) aims to support older people to remain in their own homes for as long as possible and to support informal carers. The Home Support Service provides you with support for everyday tasks including: getting in and out of bed, dressing and undressing, personal care such as showering and shaving. The support you will receive depends on your individual needs. These supports will be provided by the HSE or by an external provider, approved by the HSE.
Home Support Service, Services for Older People, HSE, Junction House, Kilnamanagh-Tymon Primary Care Centre, Airton Road, Tallaght, Dublin 24
Tel: 01 9214718
Email: homesupport.cho7@hse.ie

Short Stay Respite Service

Older Persons Services, Oak House, Millennium Park, Naas, Co. Kildare, W91 KDC2
Tel: 045 880400
Email: Cho7.Shortstaybeds@hse.ie
Appendix E

Nursing Home Support Service NHSS

This service is governed by the Nursing Home Act 2009 (and subsequent amendments).
Applications require a Care Needs Assessment and a Financial Assessment.
This includes all necessary disclosures regarding finances and property.
2nd Floor, Beech House, 101-102 Naas Business Park, Naas, Co. Kildare W91 RC85
Tel: 045 920 000 (9:00am to 12:45pm) / 045 920172
Email: Naas.NHSS@hse.ie

Local Placement Forum LPF

Tel: 01 7955111
Email: cho7.lpf@hse.ie

HSE Community Nursing / Residential Units

St Vincent's, Athy 059 8643000
Cherry Orchard Hospital 01 7955000
Belvilla, Community Nursing Unit 01 7959230
Maynooth, Community Nursing Unit 01 6292433
Tymon North, Community Nursing Unit 01 7958500
Baltinglass, Community Nursing Unit 059 6451600
The Meath, Community Nursing Unit 01 7085700

HSE Day Care

Older Persons Services, Oak House, Millennium Park, Naas, Co. Kildare, W91 KDC2
Tel: 045 988 369
Email: communityops.cho7@hse

HSE Day Centres

Bellvilla Day Care, Dublin 8
Cherry Orchard Day Care, Dublin 10
St. Mary's Day Care, Rathmines, Dublin 6
Tymon North Day Care, Dublin 24
The Meath Day Care, Dublin 8
Whitechurch Day Care, Rathfarnham

Meals on Wheels

Older Persons Services, Oak House, Millennium Park, Naas, Co. Kildare, W91 KDC2
Tel: 045 988 369
Email: communityops.cho7@hse

HSE Disability Services

Tel: 045 988567
Email: disabilityreferrals.dskww@hse.ie

HSE Social Inclusion Services

Tel: 01 7784350 (8am – 7pm 7 days a week)
Email: rvp@hse.ie

Community Mental Health General Adult Services

Referral pathway for Tallaght area

Tallaght, Clondalkin, Lucan, Ballyfermot, Newcastle, Citywest, Saggart, Rathcoole, Dublin 24, Dublin 6W
Email: mentalhealthopd.tallaght@hse.ie

Referral pathway for James area

Dublin 6, Dublin 16 (Knocklyon, Rathfarnham, Ballyboden)
Email:
Rialto.dh@hse.ie (Covering Drimnagh and Owendoher sectors)
Inchicore.dh@hse.ie (Covering CAMAC sector)
mentalhealthcn@stjames.ie

Louise Casey: Area Manager Dublin South Central Adult Mental Health Service
Oak House, Millennium Park, Naas, Co. Kildare W91 KDC2
Tel: 086 3803538
Email: louisea.casey@hse.ie

Oliver Mernagh: Area Director of Nursing Mental Health
1st Floor Administration Building, Cherry Orchard Hospital, Ballyfermot, Dublin 10
Tel: 087 9846060
Email: oliver.mernagh@hse.ie

Psychiatry of Later Life Dublin South Central Mental Health Services

Tallaght area

Tallaght, Clondalkin, Lucan, Ballyfermot, Newcastle, Citywest, Saggart, Rathcoole, Dublin 24, Dublin 6W
Address: Sheaf House, Exchange Hall, Belgard Square, Tallaght, Dublin 24, Dublin, D24 WK80
Tel: 01 4635240
Email: plldublinsw.admin@hse.ie

St James area

Dublin 6, Dublin 16 (Knocklyon, Rathfarnham, Ballyboden)
Address: Mercer's Institute for Successful Ageing, St James' Hospital, James' Street, Dublin 8
Tel: 01 4103089
Email: mentalhealthcn@stjames.ie

Palliative Care

Referring to Specialist Palliative Care Services - HSE.ie
Irish Association for Palliative Care Service Directory

Tallaght University Hospital
Tel: 01 4142032
Email: palliativecare@tuh.ie

Our Lady's Hospice Harold's Cross
Tel: 01 4068700
Email: patientservices@olh.ie
Community Palliative Care Email: communityharoldscross@olh.ie

Community Intervention Team (CIT)

A Community Intervention Team (CIT) is a health professional team which provides a rapid and integrated response to a patient with an acute episode of illness who requires enhanced services / acute intervention for a defined short period of time.

South Dublin CIT
Services:

- IV cannulation & administration of IV antibiotics (OPAT), steroids / other medication (requires PPSN)
- Acute anticoagulation care / INR monitoring
- Acute wound care and dressings (weekend)
- Short term older person support and care
- Care of patients with Respiratory illness, (COPD /Asthma) nebuliser care, peak flow
- Care of end stage renal patients
- PICC and Port care
- Chemo infusion clinic / chemo pump disconnection
- Out of hours emergency care Female and Male U/C Changes / SPC
- Stoma Care
- S/C fluids
- Phlebotomy (pre chemo service)
- Palliative Care support in conjunction with care services already in place
- Injections e.g. innohep

Tel: 087 9792589
Email: southsidecit@hse.ie

GP Community Radiology and Diagnostics

Community Radiology
Russell Centre, Tallaght Cross West. Adults (>16) only.
Referrals via **Healthlink only to: Tallaght University Hospital > Primary Care CxR/General Xray/Trauma/USS/DEXA**

GP Access to Community Diagnostics
https://www.hse.ie/eng/services/list/2/primarycare/community-healthcare-networks/gp-diagnostics/
Affidea Contracted Service*: CT/MRI/Xray – all patients – refer via Healthlink
Alliance Contracted Service*: CT/MRI/Xray – all patients, Smithfield and Clane – refer via Healthlink
HSE Ultrasound Project: Affidea: GMS, DVC only
*Note for contracted services some MRIs not covered, for example, hand/foot/ankle. Please see link above for details.

Integrated Care Programme for Older Persons Community Specialist Team (ICPOP CST)

Email: Tallaght.icpop@hse.ie
Postal Address: ICPOP, Integrated Care Hub, Clondalkin Primary Care Centre, Block B, Level 1, Boot Road, Clondalkin, Dublin 22, D22V2C2
or ICPOP, Level 2, Russell Centre, Tallaght Cross West, Tallaght, Dublin 24 D24 DH74

Tel: 01 77 87992 / 88003 / 87996

Tallaght ICPOP CST catchment area:

- CHN Rathfarnham, Knocklyon & Ballyboden
- CHN Clondalkin
- CHN Tallaght & Firhouse (Tallaght East -Kilnamanagh, Tymon, Millbrook)
- CHN Newcastle / Citywest / Saggart (incl. Rathcoole & Tallaght West - Jobstown, Killinarden, Springfield, Brookfield)

ICPOP CST Service and Referral Pathway

Predominantly a domiciliary based service, with Geriatrician and ANP led clinics.
Each patient is allocated a case manager who completes a comprehensive geriatric assessment in patient's own home.

Referral from Consultant / NCHD / GP directly via **Healthlink: CHO7 > ICPOP CST Tallaght**
Or email referral to Tallaght.icpop@hse.ie

Inclusion criteria:
Signs of frailty, with 2 or more comorbidities, more than 1 event in the last 3-6 months, requires additional input that exceeds the core primary care team e.g.GP, PHN/RGN, SW, PT, and OT (requiring input of **two or more** disciplines), and/or high intensity users of services (both primary & secondary care).
Detailed referral criteria in Appendix D.

Tallaght University Hospital Frailty at Front Door & Nursing Home Service

GEDI (Gerontological Emergency Department Intervention Team)

Tel: 087 1669513 / 01 414 4556
Email: geditеam@tuh.ie

TUH Nursing Home service

- Specialist inpatient team
- Inpatient consultation
- FastTraX fracture service
- Acute admission avoidance

Tel: 01 414 2830 Bleep 2720 / 087 4555633

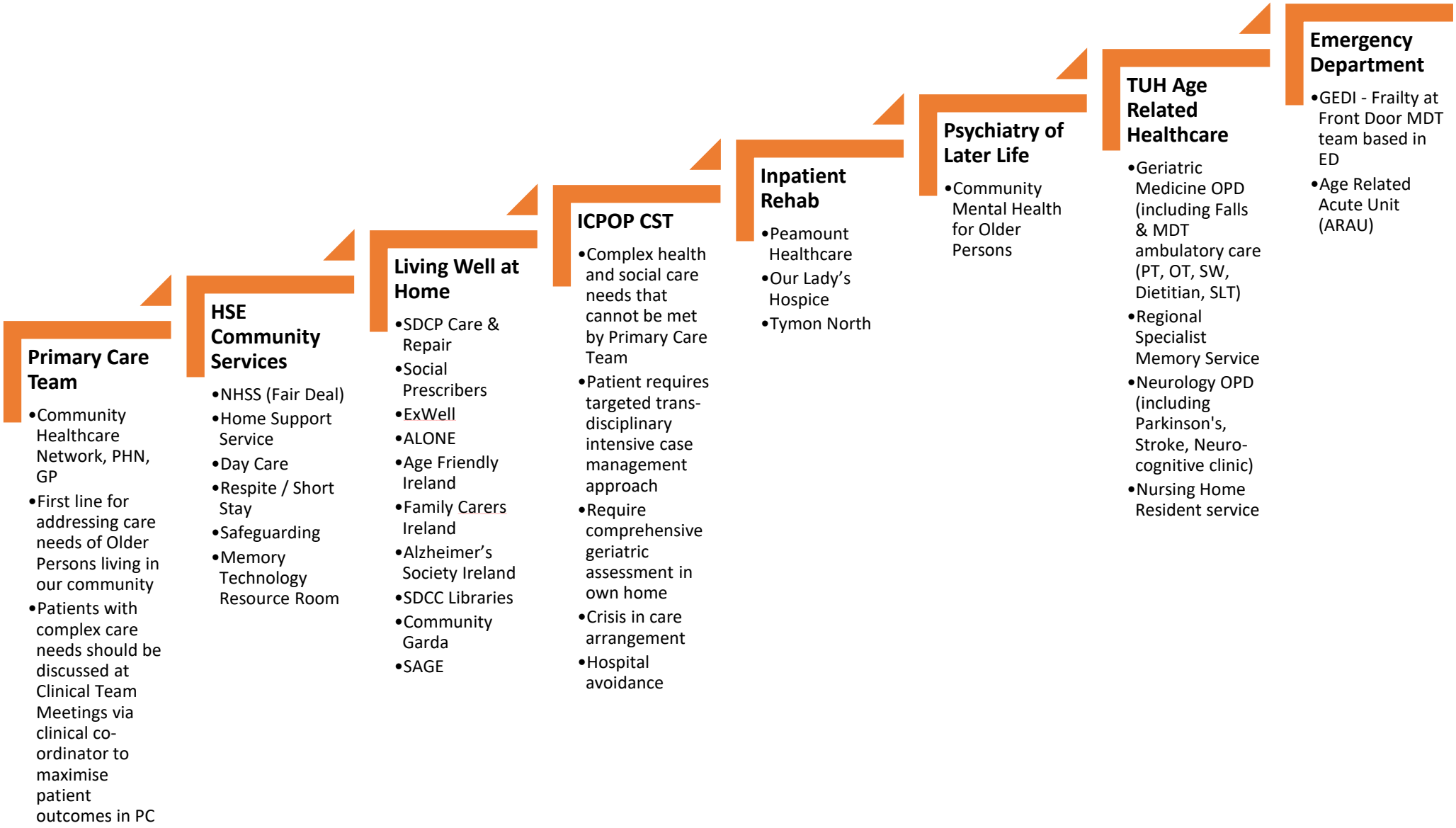
Tallaght University Hospital

Age Related Healthcare OPD

Tel: 01 414 3215
Referrals via Healthlink to Tallaght University Hospital >

- Geriatric Medicine (Gerontology OPD / Falls Clinic)
- Neurology – Adult Referral (Stroke, Parkinson's, Neuro-cognitive clinic)
- Memory Clinic (Regional Specialist Memory Service)

Care Pathway for Older Persons



Integrated Care Programme for Chronic Disease Community Specialist Team (ICPCD CST)

Three multi-disciplinary teams caring for people living with Chronic Disease in the community under the Integrated Model of Care for Chronic disease; Diabetes, Respiratory, Cardiology.

Email: tallaghtcommunityintegratedcare@hse.ie
Postal Address: ICPCD, Level 2, Russell Centre, Tallaght Cross West, Tallaght, Dublin 24 D24 DH74
Or ICPCD, Integrated Care Hub, Clondalkin Primary Care Centre, Block B, Level 1, Boot Road, Clondalkin, Dublin 22. D22 V2C2
Tel:

- Cardiology 01-7957532
- Diabetes 01-7957674
- Respiratory 01-7957690

Tallaght ICPCD CST catchment area:

- CHN Rathfarnham, Knocklyon & Ballyboden
- CHN Clondalkin
- CHN Tallaght & Firhouse (Tallaght East -Kilnamanagh, Tymon, Millbrook)
- CHN Newcastle / Citywest / Saggart (incl. Rathcoole & Tallaght West - Jobstown, Killinarden, Springfield, Brookfield)

Referral directly via **Healthlink: CHO7 > Chronic Disease Hub Tallaght**
Or email referral to tallaghtcommunityintegratedcare@hse.ie

ICPCD Diabetes Referral Pathway

Type 2 Diabetes Mellitus

Referral via Healthlink: **CHO7 > Chronic Disease Hub Tallaght > T2DM** >

- T2DM – Consultant Clinic Referral
- T2DM – Dietitian Clinic Referral
- T2DM – Nurse-led Clinic Referral
- T2DM – Podiatry (Mod-High-InRemission Foot) Referral
- T2DM – PreDM Self-Mgmt Programme Referral
- T2DM – Self Mgmt Programme Referral
- Weight Mgmt Prog (Best Health) Referral

Or email referrals to tallaghtcommunityintegratedcare@hse.ie
Referral criteria in Appendix A

Weight Management

BMI ≥ 30 kg/m2 and at least two obesity related complications on this list: type 2 diabetes, hypertension, hyperlipidaemia, sleep apnoea, polycystic ovarian syndrome, osteoarthritis

Referral via Healthlink: **CHO7 > Chronic Disease Hub Tallaght > Weight Mgmt Prog (Best Health) Referral**
Or email referral to tallaghtcommunityintegratedcare@hse.ie

ICPCD Respiratory Referral Pathway

COPD / Asthma only or diagnostic uncertainty
Pulmonary Function Tests

Referral via **Healthlink: CHO7 > Chronic Disease Hub Tallaght > Resp >**

- Resp – Cons Clinic (COPD / Asthma) Referral (must have CxR within the last 12 months)
- Resp – Nurse-led Clinic Referral (must have CxR within the last 12 months)
- Resp – Pulmonary Rehab Programme Referral
- Resp – Spirometry Diagnostics Referral
- Resp - GP Email Advisory Service

Or email referrals to tallaghtcommunityintegratedcare@hse.ie
Referral criteria in Appendix B

ICPCD Cardiology Referral Pathway

Heart Failure

ANP, Consultant
Referral via Healthlink: **CHO7 > Chronic Disease Hub Tallaght > Cardiology**

- Card – GP Email Advisory Service
- Card – Heart Virtual Clinic Referral
- Card – Nurse-led Clinic Referral

Or email referral to tallaghtcommunityintegratedcare@hse.ie
Referral criteria in Appendix C

Community Chest Pain Clinic

Refer via Healthlink: **Tallaght University Hospital > Cardiology** - reference Community Chest Pain Clinic on referral

Health and Wellbeing Services

Dublin & Midlands Staff Health and Wellbeing Resources (Appendix F)

https://padlet.com/dublinandmidlandshealthandwellbeing/dublin-and-midlands-health-and-wellbeing-staff-page-8n4venh2wykti8m1

Dublin & Midlands Public Health and Wellbeing Resources (Appendix G)

https://padlet.com/dublinandmidlandshealthandwellbeing/dublin-and-midlands-health-and-wellbeing-public-page-ms9tft7jfkq9jea1

Sláintecare Healthy Communities

Edel Byrne - Senior Health Promotion & Improvement Officer for Sláintecare Healthy Communities Tallaght & Clondalkin
Tel: 087 7488666
Email: Edel.Byrne6@hse.ie

Tallaght

Alan McDonnell – Health Promotion and Improvement Officer for Sláintecare Healthy Communities Tallaght
Tel: 087 6131061
Email: alan.mcdonnell2@hse.ie

Gráinne Meehan – Sláintecare Healthy Communities Programme Local Development Officer Tallaght, South Dublin County Council.
Email: gmeehan@sdublincoco.ie

Clondalkin

Keith Ryan – Health Promotion and Improvement Officer for Sláintecare Healthy Communities Clondalkin
Tel: 087 9575177
Email: keith.ryan1@hse.ie

David Morrissey - Sláintecare Healthy Communities Programme Local Development Officer Clondalkin, South Dublin County Council
Tel: 086 1360326
Email: dmorrissey@sdublincoco.ie

Health Promotion and Improvement Officer for Community Healthcare Networks

CHN3 Ballyboden, Rathfarnham, St Enda's, Knocklyon, Ballyboden & Edmondstown

Vacant

CHN5 Clondalkin

Mary O'Halloran - Health Promotion & Improvement Officer for Training & Education & **CHN Clondalkin**
52 Broomhill Road, Tallaght, Dublin 254
Tel: 087 9442498
Email: mary.ohalloran11@hse.ie

CHN8 Tallaght (Kilnamanagh, Tymon, Millbrook) & Firhouse

Daniel Russell, Health Promotion & Improvement Officer for Stakeholder Engagement & Communications & **CHN Tallaght & Firhouse**
Email: daniel.russell@hse.ie
Phone: 087 3468214

CHN9 Newcastle / Citywest / Saggart (incl. Rathcoole & Tallaght West - Jobstown, Killinarden, Springfield, Brookfield)

Anne Flanagan – Health Promotion and Improvement Officer for **CHN Newcastle/Citywest/Saggart** & Stop Smoking Advisor
Tel: 087 4344371
Email: anne.flanagan2@hse.ie

Tobacco / Smoking Cessation

Jose Ayala - Senior Health Promotion & Improvement Officer for Tobacco & Chronic Disease Hubs
Tel: 086 8233060
Email: jose.ayala@hse.ie

Tallaght CHN 8 & 9

Alan McDonnell – Health Promotion and Improvement Officer & Stop Smoking Advisor
Fettercairn Community Centre / Kilnamanagh Tymon Primary Care Centre
Tel: 087 6131061
Email: alan.mcdonnell2@hse.ie

Anne Flanagan – Health Promotion and Improvement Officer for **CHN Newcastle/Citywest/Saggart** & Stop Smoking Advisor
Mary Mercer Health Centre
Tel: 087 4344371
Email: anne.flanagn2@hse.ie

Una Delahunt – Health Promotion and Improvement Officer & Stop Smoking Advisor
Brookfield Health Centre / Chamber House
Tel: 087 1702458
Email: una.delahunt@hse.ie

Aisling Foot - Health Promotion & Improvement Officer & Stop Smoking Advisor
Tel: 087 6819991
Email: aisling.foot@hse.ie

Clondalkin CHN5

Keith Ryan – Health Promotion and Improvement Officer & Stop Smoking Advisor
Bawnogue Youth & Community Centre
Tel: 087 9575177
Email: keith.ryan1@hse.ie

Ballyboden CHN3

Sally O'Grady – Health Promotion and Improvement Officer & Stop Smoking Advisor
Tel: 087 452 5189
Email: sally.ogrady@hse.ie

South Dublin County Partnership - Tallaght

Samantha Griffin – We can quit coordinator
Tel: 086 0839086
Email: Samantha.griffin@sdcpartnership.ie / info@sdcpartnership.ie

South Dublin County Partnership – Clondalkin

Ola Elian - We can quit coordinator
Tel: 087 6362267
Email: ola.elian@sdcpartnership.ie / info@sdcpartnership.ie

Healthy Food Made Easy

Roisin Eilis - Healthy Food Made Easy Coordinator
Tel: 086 049 0866
Email: roisinellis@sdcpartnership.ie / info@sdcpartnership.ie

Community Food and Nutrition Worker

Clondalkin

Chloe Murphy - Community Food & Nutrition Worker, Clondalkin
Tel: 086 1020922
Email: cmurphy@sdcpartnership.ie / info@sdcpartnership.ie

Parenting Programmes

Tallaght

James Parkin – Parenting coordinator, Barnardos
Tel: 086 6005041
Email: james.parkin@barnardos.ie

Clondalkin

Carol Redmond – Parents Plus Coordinator, Deansrath Family Centre
Tel: 086 1382118
Email: carol@deansrathfamily.ie

Making Every Contact Count MECC

Rosemarie Plant – Senior Health Promotion & Improvement Officer & MECC Lead DSKWW
Tel: 086 8232977
Email: rosemarie.plant@hse.ie

COPD Self-Management Support Group

Mary-Rose Cunningham - Self Management Support Coordinator for Long-term Health Conditions
Health and Wellbeing, Dublin South, Kildare & West Wicklow, Community Healthcare, Oak House, Millennium Park, Naas, Co. Kildare W91 KDC2
Tel: 087 4320202
Email: maryrose.cunningham@hse.ie

Training & Education

Ciara Stewart - Senior Health Promotion & Improvement Officer for Training & Education
Tel: 087 3413952
Email: ciara.stewart@hse.ie

Mary O'Halloran - Health Promotion & Improvement Officer for Training & Education & **CHN Clondalkin**
52 Broomhill Road, Tallaght, Dublin 254
Tel: 087 9442498
Email: mary.ohalloran11@hse.ie

Stakeholder Engagement & Communications

Karina Grehan, Senior Health Promotion & Improvement Officer for Stakeholder Engagement & Communications
Phone: 0876509226
Email: karina.grehan@hse.ie

Daniel Russell, Health Promotion & Improvement Officer for Stakeholder Engagement & Communications & **CHN Tallaght & Firhouse**
Email: daniel.russell@hse.ie
Phone: 087 3468214

Staff Health & Wellbeing

Siobhán Mangan, Senior Health Promotion & Improvement Officer for Staff Health & Wellbeing
Phone: 087-1327399
Email: siobhan.mangan@hse.ie

Planning & Organisational Development

Áine Buggy, Senior Health Promotion & Improvement Officer for Planning & Organisational Development & **Tallaght Integrated Care Hub**
Tel: 087 3636084
Email: aine.buggy@hse.ie

Aisling Doherty, Senior Health Promotion & Improvement Officer for Planning & Organisational Development
Tel: 087 9442498
Email: aisling.doherty2@hse.ie

Living Well at Home Supports

South Dublin County Partnership

Care and Repair Tús Service

Tús Care & Repair provides a free odd job service for people and organisations that are eligible within our local community.
Email: careandrepair@sdcpartnership.ie
Freephone: 1800 938884
Mon-Fri 9am-5pm

Social Prescribing

Social Prescribers work with individuals to improve health and wellbeing by referring into and supporting engagement with a range of non-clinical community-based supports, activities, services and programmes.
Email: info@sdcpartnership.ie

Elizabeth Marnell (Social Prescribing Link Worker Tallaght)
Tel: 086 013 2344
Email: elizabeth.marnell@sdcpartnership.ie

Coco Kenny (Social Prescribing Link Worker Clondalkin)
Tel: 086 137 2084
Email: coco.kenny@sdcpartnership.ie

Darlene Dunne (Social Prescribing Link Worker Tallaght and Clondalkin)
Tel: 086 152 6717
Email: darlene.dunne@sdcpartnership.ie

Patricia Fahey (Social Prescribing Link Worker Migrant Social Prescriber)
Tel: 086 127 7789
Email: patricia.fahey@sdcpartnership.ie

Ex Well

ExWell Medical is an established community-based chronic illness rehabilitation programme with a patient-centred ethos, providing supervised exercise classes and nutrition services to patients with a range of chronic illnesses.
Locations: Clondalkin Leisure Centre, Thomas Davis GAA Club, TU Dublin Tallaght
https://www.exwell.ie/referring-a-participant
Email: info@exwell.ie / nsmyth@exwell.ie
Referrals via email to: referrals@exwell.ie / exwellmedical@healthmail.ie or directly via Healthlink

Ex Well Choir

Meets weekly in Thomas Davis GAA Club; Thursdays at 10am
https://www.exwell.ie/choir

Ex Well weekly Zoom talks

Every Friday at 5pm, Dr Noel McCaffrey and the ExWell Medical team present a lecture on a different medical topic.
https://www.exwell.ie/zoomtalks

Siel Bleu

Siel Bleu holds a range of physical activity sessions which are open for people with dementia and their carers to attend. They also offer one to one classes in person's own home.
https://www.sielbleu.ie/
Address: CRA 20076504 18 Eustace Street, Temple Bar, Dublin 2 D02 WR53
Tel: 01 209 6889
Email: info@sielbleu.ie

HSE Memory Technology Resource Room

The Memory Technology Resource Room is run by an Occupational Therapist and showcases a wide variety of Assistive Technology equipment. People with memory difficulties and their carers will have an opportunity to discuss the benefits of assistive technology equipment and to have a hands experience of this equipment. The Occupational therapist will be able to provide the person with memory difficulties information regards other relevant services that are available in the area and provide strategies and tips to aid with the difficulties associated with memory loss.
https://www.understandtogether.ie/get-support/memory-technology-resource-rooms/
Address: Ballyfermot Primary Care Centre, Ballyfermot, Dublin 10, D10 C973
Tel: 01 7956125
Email: ballyfermot.mtrr@hse.ie

Directory of Activities & Services for Older people in South Dublin County Council

The Directory was produced by South Dublin County Council in conjunction with Age Friendly South Dublin to help older people find information about what's going on every day in their local area.
Email: atroy@sdublincoco.ie / jlumumba@sdublincoco.ie
Website: https://www.sdcc.ie/en/services/community/initiatives/102067_55-planner-booklet-for-sdcc-v7-print.pdf

HSE Patient and Service User Engagement Officer

Mairéad Holland - Patient and Service User Engagement Officer
Health Service Executive, Office of Quality, Safety and Service Improvement,
Dublin South, Kildare & West Wicklow Community Healthcare,
Oak House, Millennium Park, Naas, Co. Kildare, W91KDC2.
Tel: 087 4518970
Email: mairead.holland1@hse.ie

Appendix A - ICPCD Diabetes Referral Criteria

Consultant Led MDT Diabetes Clinic

Inclusion criteria

- New or pre-existing T2DM that needs consultant-led specialist MDT review including:
- Those <40 years old**.**
- Active foot disease or high risk foot as per national model of care for Diabetic foot
- Diabetic eye disease
- Renal impairment - creatinine > 150umol/l or eGFR < 60ml/min
- Uncontrolled CVD risk factors
- Steroid induced hyperglycaemia
- Recurrent hypoglycaemia
- Hypoglycaemia unawareness
- Weight loss with osmotic symptoms +/- ketones
- Must reside within HUB 3 catchment area.
- Patients must be above 16 years of age.

This referral cannot be processed without:

- Bloods Results taken within the last 3 months including Hba1c, Renal/lipid/liver profiles and FBC +/- Haematinics if indicated)
- Medication History- including current diabetes medication and any agents previously used that were stopped and rationale.
- Medical History
- Latest retinal screening report.

Exclusion criteria for Consultant Led MDT Clinic

- Type I DM/LADA, Monogenic diabetes, and secondary diabetes eg: pancreatitis-induced diabetes.
- Cystic fibrosis related diabetes
- Emergency care needs (e.g. DKA/HHS/sepsis)
- Antenatal/pre-pregnancy diabetes care
- paediatric or adolescent diabetes
- Patients on an insulin pump
- Patients requiring MDI- basal/bolus insulin regimes
- Post-transplant diabetes
- Patients with low estimated glomerular filtration rate (eGFR<30)/dialysis/transplant

Diabetes Nurse Led Clinic

Inclusion Criteria

Patients with new or existing diagnosis of Type 2 DM who require Diabetes CNS review including:

- Patients with suboptimal diabetes control
- Patients requiring basal insulin/GLP1 initiation or review.
- Steroid induced hyperglycaemia
- Recurrent hypoglycaemia
- Hypoglycaemia unawareness
- Unresolved issues with self-monitoring of blood glucose
- Must reside within the HUB catchment area
- Patients must be above 16 years of age

  This referral cannot be processed without:
  - Bloods Results taken within the last 3 months including Hba1c, Renal/lipid/liver profiles and FBC +/- Haematinics if indicated)
  - Medication History- including current diabetes medication and any agents previously used that were stopped and rationale
  - Medical History
  - Latest retinal screening report

Diabetes Nurse Led Clinic Exclusion criteria

- Type I DM/LADA, Monogenic diabetes, and secondary diabetes eg: pancreatitis-induced diabetes.
- Emergency care needs (e.g. DKA/HHS/sepsis)
- Antenatal/pre-pregnancy diabetes care
- Post-transplant diabetes
- Cystic fibrosis related diabetes
- Patients on insulin pump
- Patients Requiring MDI- basal/bolus insulin regimes
- Patients with T2DM and active foot disease (e.g. active ulcer, Charcot's)
- Patients with low estimated glomerular filtration rate (eGFR<30)/dialysis/transplant

Once your referral has been accepted, your patient will be reviewed by an ANP or CNS whom will revert back to you with an individualised treatment plan and recommendations.

Referral criteria for Weight Management (1:1 or group)

Inclusion criteria

- BMI ≥ 30 kg/m^2 and at least two obesity related complications on this list: type 2 diabetes, hypertension, hyperlipidaemia, sleep apnoea, polycystic ovarian syndrome, osteoarthritis
- Patient's consent

Exclusion criteria

- Bariatric surgery in the last 2 years
- Progressive or unstable CKD Stage 3a and 3b Note: stable 3A and 3B will only be accepted with additional eGFR levels provided to demonstrate this)
- CKD Stage 4 or 5, or on dialysis
- History of complex physical or intellectual disabilities*
- Complex mental health needs*
- Pregnancy
- Active eating disorder
- PKU and other metabolic conditions requiring a therapeutic diet
- On multiple injections per day, such as a basal bolus insulin regime (i.e. on 4 injections daily) or a mixed insulin regime (i.e. Novomix BD)

** Please refer to relevant community disability network team or community mental health services*

Referral criteria for Pre-diabetes

Inclusion criteria

- HbA1c 42 - 47 mmol/mol

  Or
- Fasting plasma glucose between 6.1 – 6.9mmol/l - Confirmed with a repeat test done on a different day
- Patient's consent

Exclusion criteria

- Bariatric surgery in the last 2 years
- History of T2DM
- Progressive or unstable CKD Stage 3A and 3B (Note: stable 3A and 3B will only be accepted with additional eGFR levels provided to demonstrate this)
- CKD Stage 4 or 5, or on dialysis
- History of complex physical or intellectual disabilities*
- Complex mental health needs*
- Pregnancy
- Active eating disorder
- PKU and other metabolic conditions requiring a therapeutic diet

Referral criteria for Type 2 diabetes – 1:1

Inclusion criteria

Confirmed diagnosis of Type 2 diabetes
Patient's consent

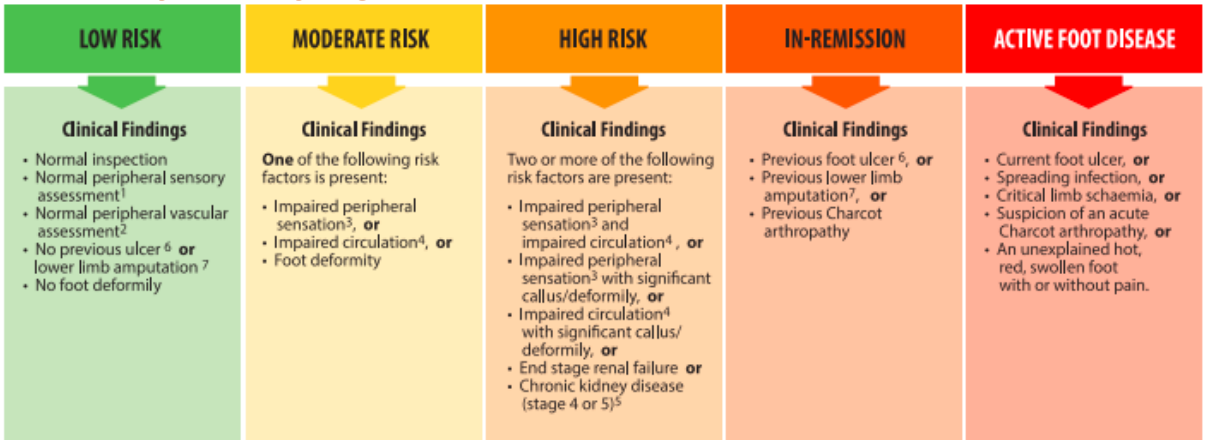
Exclusion criteria

Gestational diabetes - refer to maternity hospital dietitian
Progressive or unstable CKD Stage 3a and 3b
(Note: stable 3A and 3B will only be accepted with additional eGFR levels provided to demonstrate this)
CKD Stage 4 or 5, or on dialysis
Progressive or unstable CKD Stage 3a and 3b, CKD Stage 5, or on dialysis
Type 1 DM/LADA/MODY
On multiple injections per day, such as a basal and bolus insulin regime (i.e. on 4 injections daily) or a mixed insulin regime (i.e. Novomix BD)
[NOTE: those on basal insulin only will be accepted]
Where T2DM management is not the initial priority (e.g., malnutrition - refer to primary care dietitian)
Cystic fibrosis related diabetes
Post-transplant diabetes
PKU and other metabolic conditions requiring a therapeutic diet

Referral pathway for Discover Diabetes – Type 2 Group Education Course

Referrals to the Discover Diabetes Type 2 Course can be done via self- referral. It is open to all adults with newly diagnosed and pre-existing type 2 diabetes. Patients can sign themselves up to DISCOVER via the HSE website: **https://www2.hse.ie/conditions/type-2-diabetes/courses-and-support/discover-diabetes/**

Community Podiatry High Risk Foot Clinic Referral Criteria



Diabetic Foot Model of Care, HSE 2021: https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/moc/diabetic-foot-model-of-care-2021.pdf

Low risk ➢ does not meet referral criteria for community diabetes high risk foot clinic

Moderate risk ➢ refer to community diabetes high risk foot clinic for assessment

High risk ➢ refer to community diabetes high risk foot clinic for assessment

In-remission ➢ refer to community diabetes high risk foot clinic assessment

Active foot disease ➢ does not meet referral criteria for community diabetes high risk foot clinic – refer directly to TUH or SJH Podiatry Dept. or ED.

Routine chiropody care for non-diabetic patients and low risk diabetic patients please advise apply for chiropody card if eligible (full medical card and over 65) to avail of assessment and treatment via that HSE supported scheme.

Community Podiatry Referral Form

Hub 1: The Meath PCC	Hub 2: Ballyfermot PCC	Hub 3: Tallaght	Hub 4: Kildare
01- 795 8030	01- 795 8030	01 795 7519	045- 908 524

Central Email: podiatry.cho7@hse.ie ***all referrals to be sent electronically***

For Office Use Only	**Referral:** ☐ Accepted	**Risk Category:** ☐ Active ☐ In Remission ☐ High ☐ Moderate
Date Received:	**Referral:** ☐ Rejected ☐ Re-directed	**Reason:** ☐ Low Risk ☐ Inappropriate

Referrer Details:

Name: **Date of Referral**:

Profession:☐GP ☐ PHN ☐PN ☐Other:_____

Tel: Email**:**

Patient Details:

Patient Name:	Date of Birth:
Address:	Tel:

GP Details:

GP Name: GP Address:

GP Tel:

Diabetes Mellitus (DM):	**Current HbA1C:**
☐ DM Type I ☐ DM Type II ☐ Other:_____ **Treatment:** ☐ Diet ☐ Injectables ☐ Oral Hypoglycaemic Agents (OHAs)	_____mmol/mol (IFCC) Date:

Relevant Medical History:

☐ Atrial Fibrillation ☐ CKD 4/5 ☐ COPD ☐ Heart Failure ☐ Hypercholesterolemia ☐ Hypertension ☐ Retinopathy ☐ Previous Vascular Surgery

Reason for Referral (tick) – Anything to the right refer directly to LEVEL 4 HOSPITAL

☐ Impaired Ipswich Test /10g Monofilament ☐ Impaired Vibration Perception ☐ Impaired Circulation to Lower Limbs ☐ Previous Foot Ulcer ☐ Previous Lower Limb Amputation ☐ Previous Charcot Arthropathy ☐ Foot Deformity (HAV, Claw toes etc)	**☐ Current Foot Ulcer** **☐ Spreading Infection** **☐ Critical Limb Ischaemia** **☐ Suspected Acute Charcot Arthropathy** **☐ Unexplained Hot; Red; Swollen Foot With or Without Pain** **☐ Other - specify:**_____

Does this patient attend: ☐GP for diabetes care **OR**

☐Consultant / Hospital: _____

Any patient with a diabetic foot ulcer; foot infection, acute Charcot arthropathy or critical limb ischemia should be referred directly to the Hospital Diabetes Clinic or Emergency Department

Appendix B - ICPCD Respiratory Referral Criteria

ICPCD – COPD / Asthma Respiratory CST

The respiratory integrated care (RIC) team is primarily nurse- and physiotherapist-led care.
Patients will not always be reviewed by a consultant, only if clinically indicated.
The RIC team provides *episodic* care; once care has been optimized, patients will be discharged back to the care of GPs for ongoing Chronic Disease Management in the community. Onward referrals will be sent if required. Re-referrals will be seen promptly, please specify that the patient is known to us.
A full report will be provided to GPs on discharge. There is no access to CT scan in the Integrated Care Hub.

COPD / Asthma Inclusion criteria

Patients above 16 years of age and

- confirmed/suspected COPD and/or asthma
- chest x-ray done in the last 12 months (please include report and location of scan or if CT/CXR is already completed please include report)
- On referral please include;
    - when the patient was originally diagnosed/history of symptoms
    - details of any recent exacerbations patients (community or acute care)
    - details of any changes in current management including inhaler therapy
    - results of blood tests, imaging or other previous investigations

COPD / Asthma Exclusion criteria

- other confirmed/suspected respiratory diagnosis
- attended respiratory specialist in the past 12 months (inc TUH, Peamount, private health)
- pregnant

Pulmonary Function Tests

Performed and Interpreted by a Senior Respiratory Physiologist

PFT Indications for Referral

- Lung crackles/wheeze on auscultation
- Poorly controlled asthma/COPD
- History of smoking
- Increased number of exacerbations
- Recurrent RTIs
- Increased shortness of breath on exertion
- Persistent cough which may be worse at night
- Chest tightness
- Reduction in activity tolerance

PFT Contraindications to Referral

- Myocardial Infarction in last week
- Unstable aortic aneurysm
- Advanced dementia/inability to follow instruction
- Active Chest Infection requiring antibiotics
- Infectious Exacerbation within last 6 weeks

Pulmonary Rehabilitation

- An 8 week programme of exercise and education for people with chronic respiratory disease
- Aims are to improve exercise tolerance, decrease sensation of breathlessness and improve quality of life
- A selection of outcome measures will be measured pre and post rehabilitation
- A Discharge summary will be sent to the GP/Consultant and/or referrer upon completion

Pulmonary Rehabilitation Inclusion Criteria

- Diagnosis of Chronic Respiratory Disease (COPD, Asthma, bronchiectasis, lung fibrosis)
- mMRC score 1-4 (see below)
- No evidence of unstable asthma, IHD, decompensated heart failure, uncontrolled arterial hypertension, neuromuscular or muscuolskeletal disorders that could affect exercise training
- No suspected underlying malignancy
- Motivated to attend an 8 week outpatient programme in a group setting
- Safe and independent to exercise with supervision

Modified Medical Research Council (mMRC) Dyspnoea Scale

0	I only get breathless with strenuous exercise
1	I get short of breath when hurrying on level ground or walking up a slight hill
2	I walk slower than people of the same age because of breathlessness or have to stop for breath when walking at my own pace
3	I stop for breath after walking about 100 yards or after a few minutes on level ground
4	I am too breathless to leave the house

Appendix C - ICPCD Cardiology Referral Criteria

Heart Efficiency Clinic Referral Criteria

- Signs and symptoms of Heart Failure
- NTproBNP > 400 (recently reduced from 2000)
- Please include recent bloods (incl NTproBNP) and ECG
- Exclusion: Current Chest pain/suspected Arrhythmia, advanced dementia, patient unwilling to attend

Integrated Community Chest pain Clinic Inclusion/Exclusion Criteria

Inclusion criteria

- Age ≥ 30
- New onset chest pain **without a definite non-anginal cause i.e. GORD/Costochondritis**.

Exclusion criteria

- Unstable severe chest pain at rest, refer to the emergency department.
- Non-anginal chest pain as per NICE criteria (i.e. chest pain with a definite reproducible musculoskeletal /GORD cause)
- Patients who have already been assessed in the emergency dept./TUH Chest pain clinic for chest pain assessment within the previous 3 months.
- Uncontrolled hypertension (Systolic > 180mmHg, Diastolic >110mmHg)
- Suspected new valve disease.
- Palpitations as **main** complaint

Please include in the referral letter

- Presenting complaint with details including if exertional
- Cardiovascular risk factors
- Recent blood results for lipids, HbA1c, renal, liver, TFTs, FBC
- If also complaining of ‘shortness of breath/dyspnoea’ as a co-existing symptom please

Appendix D - ICPOP Referral Criteria

Inclusion Criteria

- Signs of frailty, with 2 or more comorbidities, more than 1 event in the last 3-6 months, requires additional input that exceeds the core primary care team e.g.GP, PHN/RGN, SW, PT, and OT (requiring input of **two or more** disciplines), and/or high intensity users of services (both primary & secondary care).
- Referral from GP / Consultant / NCHD
- Over 65 years of age
- Living in catchment Dublin Southwest Integrated Healthcare Area CHN 3, 5, 8, 9
- Patient requires specialist assessment as urgent based on changing needs or declining level of function.
- Patient classified as High Falls Risk based on World Falls Guidelines requiring multifactorial falls risk assessment and requiring input exceeding core primary care team. https://www.bgs.org.uk/wfg
- Patient requires targeted transdisciplinary intensive case management approach to manage complex health and social care needs, which require timely input of older persons community specialist team.
- Patient requires specialist assessment of newly presenting difficulties with cognition or function within the home, or with significant safety concerns within the home.

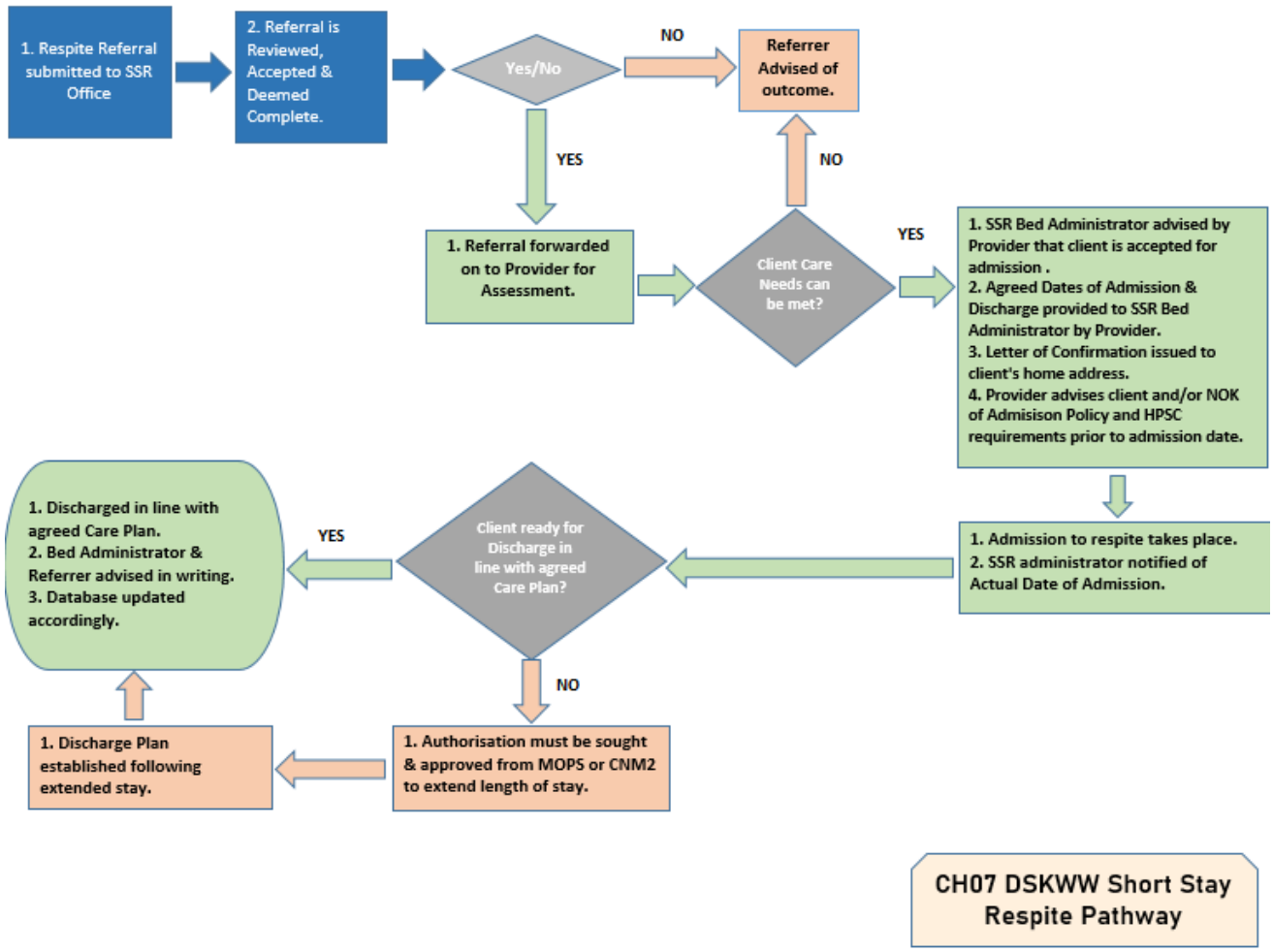
Exclusion Criteria

- Where care needs could be met within Primary Care and / or where clinical need is **uni-disciplinary** e.g. Physio / Occupational Therapy; these referrals should be sent to the relevant Community Healthcare Network: https://hseareafinder.ie/
- Where care is being provided by other health care professionals at the time of referral, and it is apparent that they are working to meet patient's goals. Duplication of service should be avoided.
- Housing or grant referrals for Occupational Therapy. Please process via the normal pathways.
- Patients who are inpatients who do not have a defined discharge date.
- Patients / Carers solely seeking advice and information regarding entitlements can be directed to the Citizens Information Service unless there are literacy concerns.
- Referrals where there are Safeguarding Vulnerable Adult concerns should be sent directly to the DSKWW/CHO7 Safeguarding Vulnerable Adults Team: Tel: 045 920410.
  Email: Safeguarding.CHO7@hse.ie
- Referrals where there are concerns raised about child abuse, current or retrospective, should be referred to the relevant Tusla Child Protection Social Work Service: Tel 045 839312 Email: am.dswkww@tusla.ie.

Tallaght ICPOP Community Specialist Team (CST)

- Please note Tallaght ICPOP CST is a **short-term intervention** and does not replace the Community Healthcare Network / Primary Care Team.
- Patients are **not** discharged from Primary Care to ICPOP CST; they are referred for a specialist geriatric assessment and intervention and remain open to the Community Healthcare Network / Primary Care Team.
- In order to meet the urgent needs of patients in crisis; non-urgent care needs, which may include aids and appliance provision, remain the responsibility of the Community Healthcare Network / Primary Care Team.
- The ICPOP CST are **not** responsible for where there are gaps in service provision in the Community Healthcare Network / Primary Care Team.

Appendix E – Short Stay & Respite Pathway



Appendix F – Dublin & Midlands Public Health and Wellbeing Resource

Health and Wellbeing Public Padlet Page

Access Health and Wellbeing services and resources for the Dublin South City and West, Dublin South West and Kildare West Wicklow areas below.

Follow the Link:

https://bit.ly/DubandMidHealthandWellbeingPublic

Or

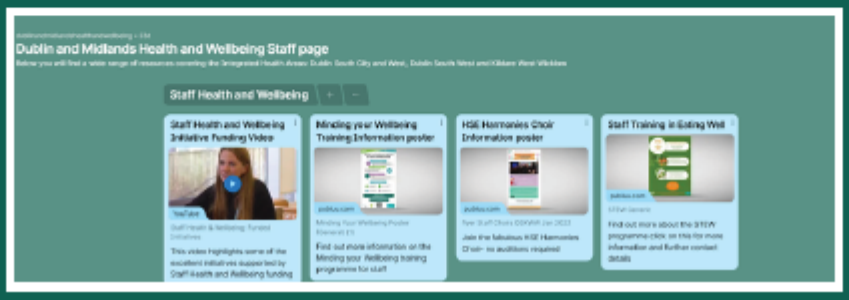
Scan the QR code

FSS Bhaile Átha Cliath
agus Lár na Tíre
HSE Dublin and Midlands

Appendix G – Dublin & Midlands Staff Health and Wellbeing Resource

Health and Wellbeing Staff Padlet Page

Access Health and Wellbeing services and resources for HSE staff in the Dublin South City and West, Dublin South West and Kildare West Wicklow Integrated Health Areas below.



Follow the Link:
https://bit.ly/DubandMidHealthandWellbeingStaff

Or

Scan the QR code

FSS Bhaile Átha Cliath
agus Lár na Tíre
HSE Dublin and Midlands

Enquiries to: Alison Murphy | Alison.murphy1@hse.ie | 087 3359931