Suffolk County Council
Social Services

Caring & Protecting

THE SUFFOLK EXTRA CARE/DEMENTIA DESIGN AND MANAGEMENT GUIDE

Produced in partnership with

Babergh District Council

Forest Heath District Council

Ipswich Borough Council

Mid Suffolk District Council

St Edmundsbury District Council

Suffolk Coastal District Council

Waveney District Council

Age Concern – Access

Orbit Housing

English Churches Housing Group

Suffolk Social Care Services

Suffolk Primary Care Trusts

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EXTRA CARE VERY SHELTERED HOUSING AND PEOPLE LIVING WITH DEMENTIA

1. INTRODUCTION

Very Sheltered Housing offers an alternative to residential care for frail older people. It combines the advantages of high quality, self contained accommodation and the provision of flexible care services based in the scheme. The service enables the tenants to retain control over their own lives while receiving the support they need in a ***safe*** environment.

This document details the additional design criteria, social activities, care and support services to be provided in Very Sheltered Housing schemes offering accommodation to older people living with dementia. It should be read in conjunction with the main very sheltered housing ***'Design and Management Guide'***. It should also be read in conjunction with the Social ***Care*** Services ***'Service Specifications for Domiciliary Care Services'*** ***and Very Sheltered Housing***.

Whilst the Design Brief and Management guide are advisory in nature it should be noted that the standards set within the Social ***Care*** Services Service Specification are obligatory and will be monitored by Officers from the County Council. The purchasing arrangements for the delivery of personal care services to individuals do not include any aspect of the housing provision or housing management service. However, the delivery of effective care and support services, in accordance with the Social ***Care*** Services Service Specification requires the provision of appropriately designed buildings and a high quality housing management service. It is expected that all the functions of social activity, care, support and housing management will be integrated so as to provide a seamless service to the tenants.

2. GUIDING PRINCIPLES

2.1 It is expected that the service will be provided in a manner that accords with the statement of principles set out below. These principles should be applied to the services provided, the general operation of the organisation, working practices and personnel procedures. This applies whether a tenant is in an Extra Care Service or an ordinary Very Sheltered Service but has dementia.

2.2 Each tenant will be respected as a unique individual, with recognition being given to his/her particular physical, psychological, social, emotional, cultural and spiritual needs.

2.3 Care and support must be provided in a manner which offers confidentiality, respect, dignity and privacy and does not erode the tenants' capacity for self care or the contribution made by family carers.

2.4 Guidelines now exist for the protection of vulnerable adults. They apply to :
any person over the age of 18 who is or may be in need of community care services by

reason of mental, physical or learning disability, age or illness, and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or serious exploitation which may be occasioned by the actions or inactions of other people.

2.5 Tenants will be enabled to lead as independent a life as possible so that their ability to exercise choice and achieve personal fulfilment is maximised. The right of the tenant to make his/her own decisions and choices and to incur calculated risks is to be respected and ***supported***. Decisions on the acceptability of risk must balance the views of the tenant and of their representative as recorded on the Care Plan.

2.6 Community Care Assessments will be undertaken for all tenants. Reviews will be undertaken no later than six weeks after a tenant's move and every six months subsequently with a formal review with all parties attending not less than annually.

Anybody can request a review. Urgent reviews will be undertaken within 72 hours
It is the responsibility of the provider to ensure that a review is undertaken.

2.7 There must be a risk assessment undertaken as part of the community care assessment prior to the service user moving into the scheme. Individual care will be drawn up in consultation with the tenant, the family and carers. They will reflect the assessed care and support needs of the tenants. Each Care Delivery Plan will be reviewed regularly, that is a minimum of quarterly and /or after any significant change in the tenants needs.

2.8 Each tenant will be encouraged where appropriate to participate in all decision-making processes and express their views. Where this is not possible an relative/advocate or representative should be available.

2.9 In all aspects of service delivery the needs of the whole person *(ie physical, psychological, social, emotional and spiritual)* should be considered and taken into account, building on the original assessment information. This will require scheme staff to spend time on gaining an understanding of the individual's life history, personality, mental and physical health, relationships, attitudes and aspirations. The planning or provision of the service should always be approached from the tenant's perspective. Systems such as dementia care mapping* have proved to be aids to this process.

- ***Dementia Care Mapping is designed to observe the behaviours amongst people suffering with dementia in a communal setting. It tracks the state of their well being and the nature of social interaction which takes place within time limited periods.***

2.10 Services should be designed to achieve the maximum rehabilitative effect. It is important that where they have the ability, tenants are supported to carry out tasks for themselves, even though it would be quicker for staff to undertake tasks directly. As well as assistance with 'hands on' physical rehabilitation, appropriate aids and equipment will be available, assisting in the learning or re-learning of skills and techniques necessary for independent living, the provision of encouragement and support to rebuild confidence or self motivation, etc.

2.11 A range of preventative services should be available to tenants to assist and to preserve or promote their own health and well-being. These will include support and advice and opportunities for maintaining physical fitness, good nutrition and a positive attitude towards ageing. Services could include other therapeutic activities including complementary therapies.

2.12 Services provided should be flexible and responsive to the wishes of the individual tenant. Loss of control over the individual ordering of day to day activities has been found to increase dependency. As far as is practicable, tenants or their representative should be able to exercise control over the timing and type of assistance they receive with tasks that they cannot do for themselves.

2.13 A close working relationship between scheme staff, care providers, assessment teams, GPs, primary health care teams, pharmacists, Health Trust staff and the voluntary sector etc, must be established and maintained to ensure that the health, independence, and the mental and physical ability of tenants are optimised. Specialist medical staff will contribute to the assessment process. Links must be developed with all aligned services to ensure advice and support when needed. Access to Fast Track psychiatric assessment and support is available from Local Health Partnership NHS Trust (see Protocol at Appendix 2).

2.14 Written records will be kept in a locked cabinet within a secure office. Care delivery plans, a shared document detailing people's care, support and activity arrangements will be kept in the tenant's flat. Only the tenant's authorised personnel and family members with the tenant's consent should have access to them.

Knowledge that staff have about an individual is also to be treated as confidential. This information should only be passed on to other staff where it is necessary for the safe and well-managed provision of care. This handover of information should be done in a private and with a professional manner.

Where written or computer records are held, the provisions of the Data Protection Act will apply. Staff and tenants should be advised that an individual has the right to see the information that is held that relates to them. All records kept should be made with this in mind.

2.15 Tenants' access to every day opportunities and facilities should not be restricted because of their needs or disability.

2.16 Tenants should have the support and assistance they need to access everyday opportunities and facilities. Every tenant should have access to an advocate.

2.17 Tenants, their family and/or their representatives/advocates should have full information on the services and choices available to them.

3. CARE MANAGEMENT

3.1 Care staff will be available within the scheme 24 hours a day to provide personal care and support services in line with the agreed individual care plan. However, staff should only provide these services where it has not proved possible to enable the tenant to undertake all or part of the task for themselves.

3.2 Each tenant should have a flexible care and support delivery programme based on the assessed care plan, which identifies targets and outcomes, agreed by the tenant or their representative, care provider staff, scheme staff and the Social Services/Health Assessor. The programme should be reviewed as a minimum every three months by provider staff with the tenant and their representative. The care provider will operate a Key worker scheme, (assigned to work with the tenant and their relatives to establish information that helps in offering care appropriate to their needs) See Appendix 3 – referring to care plan format.

3.3 Day to day changes in the needs of individuals should be monitored and responded to by the care provider in liaison with the care and health assessors for major changes.

3.4 A 'shared' approach should be adopted, where staff work with tenants and their family carers to carry out agreed tasks.

3.5 The scheme will have an emergency call system that enables tenants and staff to summon assistance in an emergency. Response to such calls should be time limited and form part of the schemes internal quality assurance system. It is recommended that response times are monitored electronically through the call system.

3.6 Staff must be familiar with the policy for 'behaviour that challenges the service' and follow correct procedures in managing this behaviour. It is proposed that Countywide guidance be developed in 2003.

3.7 The care provider will not provide care requiring the skills of a qualified nurse. Staff will work with the District and Community Psychiatric nursing services to support tenants. However, if continuous nursing or specialist medical care is required that cannot or will not be delivered appropriately in the scheme, a community care assessment will be carried out to establish whether alternative care arrangements need to be made. Assessors, tenants and their families will work together to ensure that tenants are in the most appropriate accommodation for their changing needs. It is acknowledged that tenants have rights to dwell.

3.8 Medication should be managed in line with the County Shared Medication Policy as detailed in Section 4 of this document.

4. MEDICATION

4.1 **Training**

Proper staff training is essential to the successful implementation of the medication policy. This training must include input from a Pharmacist and shadowing trained staff.

4.2 **The Policy**

The starting point assumes that people will be encouraged to manage their own medication.

Tenants in Extra Care, or in the main body of a Very Sheltered scheme may be unable to

take responsibility for their own medication. A risk assessment will be undertaken and its outcome recorded in the community care assessment and the care delivery plan. Re-assessment may be triggered by an inability to follow a medication routine because of either physical or mental frailty. Strategies for coping with this situation could range from simple supervision of self-medication to the provision of a storage facility that complies with the regulations for all classes of drugs.

Tenants who need help with medication usually fall into the following broad groups:

1) Those who require prompting and supervision to self medicate. Medication will be stored wherever it is most accessible to the tenant in his or her own home unless as otherwise agreed on the care delivery plan.
2) People with any form of dementia or memory loss may be at risk of overmedicating. In this situation medication may need to be stored securely in their own flat.. This must be agreed in the care delivery plan.
3) People whose mental health condition leads them, on occasion, to misuse their medication (eg hoarding/hiding/evading or disposing of their medication) may need to be stored securely. This must be agreed in the care delivery plan.

Below is a non-exhaustive list of possible ways of assisting individuals where difficulties with medications have arisen, pertaining to prescribed and/or non-prescribed medication. In the case of non-prescribed medication, checks should be made in consultation with a GP and/or Pharmacist for compatibility.

This is a non-prioritized list of possible solutions Use of any of them should be discussed with all involved and recorded on the care delivery plan.

1. The use of dosset boxes to assist with either self or assisted medication. If assistance is given then the provider must sign a record. (See Appendix 4)
2. Each flat has a locked medicine cupboard – key may be held by support staff (who do not need to be medically qualified). Staff will follow a set procedure for administration.
3. Ear and eye drops to be administered by staff and signed for. A District Nurse or Health professional should train staff before they undertake this task.
4. That within each flat there is a locked container within a locked medicine cupboard for the safe keeping of controlled drugs. Staff will follow a set procedure for administration.
5. A member of staff administers liquid and PRN medication from the original containers in accordance with instructions as outlined by the GP and Pharmacist.
6. Staff remind tenants to take their medication which is in their flat.
7. Medication can be placed out of sight and/or reach (with the tenant's or their representative's permission).
8. Tenants or their representative reorder medication as and when required **OR** staff are responsible for re-ordering and obtaining prescriptions/dossett boxes and ensuring that adequate medication is held for that tenant.
9. Extra training will be necessary should a tenant require assistance with invasive treatments/injections of e.g. insulin.

Where staff are involved as a consequence of a risk assessment, daily records will be kept in the tenant's care delivery plan that is stored in the tenant's flat. (See sample at Appendix 3). Completed records must be held on the tenant's file. The scheme manager must be made aware of any difficulties in implementing the medication strategies in the care delivery plan and is responsible for overall monitoring.

In the case of any changes to the medication regime, the tenants should be encouraged to return un-needed medication to the Pharmacist. Where workers have taken responsibility for administration of drugs then the staff will take responsibility for this.

5. Staffing

5.1 Staffing levels should reflect the needs of individuals. Staff should receive comprehensive and ongoing training including the following areas:

- ★ ***Person centred approach to working with people with dementia;***
- ★ ***The role of the family/carers in supporting tenants and informing staff.***
- ★ ***A knowledge and understanding of the physiological and psychological effects of dementia;***
- ★ ***Skills in the management of relationships;***
- ★ ***Stress recognition and management, including loss/grief counselling;***
- ★ ***Equal Opportunities;***
- ★ ***Management of behaviour that challenges the service;***
- ★ ***Assessment and Care Planning;***
- ★ ***Communication Skills;***
- ★ ***Rehabilitation;***
- ★ ***An understanding of housing issues, eg housing benefits and welfare rights.***

5.2 Staff will clearly see their role as enablers and facilitators and, only when it is clear that a task cannot be completed, intervene. However whilst rehabilitation is a positive approach, staff must have the skills to understand when this approach is not appropriate.

5.3 Attention will be paid to ensure that opportunities exist for tenants to participate in varied social activities. An activities worker will be employed to ensure this happens. Opportunities should also be provided for worship in a manner appropriate to the individual.

5.4 Staff will be creative and encourage tenants to explore and try out new things. If something works, repeat it, if something does not work, try something different, or try again in a different way.

5.5 Staff will stay active in developing opportunities for each person living with dementia, rather than responding to crisis and things that go wrong.

5.6 Staff will be committed to the service and learn more about dementia.

5.7 Staff will promote friendships between tenants, relatives and members of the community.

6. IMPROVEMENT AND MAINTENANCE OF QUALITY LIFE

6.1 The tenant's rights to choose when and if to participate in the opportunities must be respected.

6.2 Opportunities will be provided around the needs of individuals. They are likely to include a range of one-to-one and group activities.

6.3 It is acknowledged that people with dementia may need specific activities and/or be actively encouraged to participate in pastimes and events.

6.4 A wide range of daytime activities will be available to enable tenants to maintain existing interests and skills and offer them the opportunity to acquire new ones. Assistance will be provided to those tenants who need it in order to be able to participate in these activities.

6.5 A programme of activities and events to promote relaxation and provide entertainment will be organised. Support and assistance will be provided so that tenants can make use of ordinary community facilities outside the scheme.

6.6 Tenants will be supported in maintaining their network of relationships with family and friends and be offered opportunities for developing new social contacts.

6.7 Tenants will be supported and encouraged in helping one another, family members and friends. There will be opportunities offered to contribute their skills and experience to the life of the wider community. They will also be enabled to participate in discussions concerning the operation of the scheme and the organisation of activities and events.

7. INVOLVEMENT WITH THE LOCAL COMMUNITY

7.1 Very sheltered schemes will foster and strengthen links and networks that tenants have with people in the surrounding community. To achieve this the following areas of work must be undertaken:

- ★ ***The recruitment, training and support of local volunteers to assist in various social activities within the scheme;***
- ★ ***The development of joint projects and activities involving scheme tenants and local schools, youth clubs, community and older people's groups;***
- ★ ***The provision of opportunities for scheme facilities to be used by the wider community.***

8. BUILDING AND DESIGN FOR PEOPLE LIVING WITH DEMENTIA IN EXTRA CARE VERY SHELTERED HOUSING

8.1 Research

Several key pieces of work have been undertaken. Professor Mary Marshall has led a considerable amount of this work at the Stirling University. Within the publication 'Design for Dementia', published by the Journal of Dementia Care *(Mary Marshall et al 1998)*, Mary Marshall looks at the impact of the environment on people living with dementia and their social care needs. *Martin Bedwell for Rowntree & Marshall, Phipps book titles: (To be advised)*

8.2 A 'Home for Life'

"It is rarely good for any of us to move especially in the latter stages of life as this can be very stressful. Having said this many people with dementia thrive in a new environment if it better suits their needs. Sadly, the general rule of thumb seems to be that the more mentally disabled you are the more disabling the environment provided". *(Coons, 1991.)*

8.3 A Disability Approach

It is very easy to emphasise the gloomy aspects of this mainly terminal disease because it does have such a devastating impact on the lives of people living with dementia, their families and friends. Only recently has a more optimistic approach emerged. This optimism is not related to treatment and medication to any extent since drugs are only efficacious with a minority of people.

The optimism derives from an increased understanding of the impact the built and social environment has on people with dementia. In the UK the major exponent of this 'new culture of dementia care' was the late Tom Kitwood. Kitwood and others suggest that people with dementia function at very different levels with the same level of neurological damage. Some other factors are clearly at work and these seem to include the background and personality of the person and the impact of both the buildings in which they live and the people relating to them. If the buildings and the support workers relate to people as individuals, reinforce their sense of *well being* and provide opportunities for them to practise their remaining skills, then the people with dementia are helped to function at their greatest potential.

As far as design is concerned it is helpful to see **dementia as a disability**. This approach provides clear pointers to the disabilities for which a building needs to compensate.

Dementia as a disability is characterised by:

- ★ ***Impaired memory;***
- ★ ***Impaired reasoning;***
- ★ ***Impaired ability to learn;***
- ★ ***High level of stress;***
- ★ ***Acute sensitivity to the social and built environment.***

There is a national consensus on building design for people with dementia. These can be separated into two areas. One being the principles of design, the other an agreement on design features.

8.4 The Consensus on the Principles of Design:

- ★ ***Compensation for a disability;***
- ★ ***Maximisation of independence;***
- ★ ***Enhancement of self esteem and confidence;***
- ★ ***Demonstrate care for staff;***
- ★ ***Be orientating and understandable;***
- ★ ***Reinforce personal identity;***
- ★ ***Welcome relatives and the local community;***
- ★ ***Allow control of stimuli.***
- ★ ***Response to peoples need to be safe to move around their environment safely***

8.5 The Consensus on Design Features include:

- ★ ***Small size;***
- ★ ***Familiar, domestic, homely style;***
- ★ ***Plenty of scope for ordinary activities*** *(unit kitchens, washing lines, garden sheds)****;***

- ★ ***Unobtrusive concern for safety;***
- ★ ***Different rooms for different functions;***
- ★ ***Considering Age-appropriate furniture and fittings;***
- ★ ***Safe outside space;***
- ★ ***Personal space big enough for lots of personal belongings;***
- ★ ***Good signage and multiple cues where possible*** *(eg sign, smell and sound)**;***
- ★ ***Use of objects and colour orientation;***
- ★ ***Enhancement of visual access;***
- ★ ***Controlled stimuli especially noise.***

There are several factors which make designing for dementia a challenge - these include:

- ★ ***Cost*** *- the consensus is that small is the key, the maximum size of any specialised service should be 14 tenants. The desirable size is between 6 and 12.*

- ★ ***Regulations*** *- this applies in particular to fire and environmental regulations. The use of smart technology has to be a consideration in these areas and is widely used in other countries to overcome some of the difficulties around legislation and inspection.*

- ★ ***Cultural Appropriateness*** *- consideration must be given to the ethnic background of potential users when designing environments.*

People with dementia will vary in terms of their physical abilities and will make very different demands on the environment in this respect, eg in terms of continence, mobility or the need for terminal care. They will also have very different behaviours. Some people with dementia cope by walking great distances. Others can be extremely anxious and agitated and require to see staff at all times.

9. SMART TECHNOLOGY

9.1 The Use of Smart Technology in Very Sheltered Housing

The use of such technology can prove to be very helpful in assisting disabled people to function at their optimum level. It has proved helpful in the care of people living with dementia.

Areas which should be considered in individual tenant areas when building or refurbishing Very Sheltered Housing schemes are the high risk areas including:

- ★ ***Danger from fire;***
- ★ ***Danger from falls;***
- ★ ***Danger from wandering and getting lost.***

For example:

- ★ *The light is automatically turned on dimmed in the bedroom and full in the bathroom when the individual gets up at night, and turns off when they are back in bed, in order to prevent falls.*

- ★ *The cooker is turned off if left on and overheating, and the staff are alerted to the cooker in question via a pager system (an isolation switch will make safe all electrical equipment);*

- ★ *Magnet detectors on exit doors from flats can alert staff when the doors are opened, for example at night. Care Delivery Plans may indicate its use if there is a danger of the Tenant wandering and getting lost. The aim is not to prevent people*

wandering but to ensure they find the way back without disturbing other tenants.

★ *Infra-red detectors and/or pressure mats that detect movement in any space can also be used to alert staff to individuals wandering at night.*

9.2 Ethical Considerations

There are ethical considerations to the use of smart technology. It is essential therefore that wherever it is used that the following procedures are adopted:

★ ***Information must be given to tenants and relatives/representatives. Written information about the possibilities of the technology proposed and individuals legal rights about saying "yes" or "no" to having it.***

★ ***An assessment of needs, hazards and wishes of the individual must form the basis of recommending the use of such technology in each flat in the scheme.***

★ ***Tenants and relatives/representatives must be involved with the recommendations, especially those solutions which could be considered surveillance.***

★ ***Tenants and relatives/representatives must agree to the recommendations that will be entered on the tenant's Care Delivery Plan.***

★ ***Any use of smart technology must be reviewed on a regular basis to take account of changing needs.***

SUPPORT WORKER - ROLE SPECIFICATION

1. **Date of Issue:**

2. **Title of Role:** **Support Worker**

3. **Accountable to:** **Care Provider/Scheme Manager**

4. **Objectives of the Post:**

4.1 To maximise the tenants capacity for independence and self care and to minimise the physical, psychological, emotional, social and environmental causes of dependence.

4.2 To improve and maintain the tenants quality of life and capacity for self fulfilment and assist with personal and domiciliary care tasks as necessary.

4.3 To work as a member of the wider team to ensure the needs of the tenant are met in a manner that respects their dignity, privacy, rights and maintains their independence.

5. **Duties and Responsibilities:**

5.1 To assist with the assessment of tenant's needs and the compilation of a programme of care in conjunction with the tenant and their representative or advocate.

5.2 To assist tenants following an assessment, with all areas of personal care that they are unable to complete for themselves. This should be in line with the programme of care.

5.3 To maintain daily records of the daily activities of tenants and report any significant changes to the manager.

5.4 To encourage and support tenants with mobility problems and disabilities to achieve their maximum independence. To be competent in assisting tenants to use equipment and aids to daily living.

5.5 To assist and encourage the promotion of continence and to sensitively manage incontinence.

5.6 To support tenants who are terminally ill including their family and friends.

5.7 To maintain confidentiality at all times.

5.8 To encourage and support tenants to participate in social activities.

5.9 To encourage and support tenants in all aspects of daily living where it is clear they are unable to complete the task for themselves.

5.10 To respond to the emergency call system as directed.

5.11 To make visitors welcome and support tenants in offering refreshments.

5.12 To maintain records of tenants' daily activities reporting significant events to the manager on duty.

5.13 To attend staff meetings and prepare written reports as required.

5.14 To attend regular training as required.

5.15 To promote positive attitudes to ageing.

5.16 To support tenants in maintaining their networks with family and friends.

5.17 **To have due regard to the requirements of Health and Safety matters at all times**

5.18 Any other duties as required.

APPENDIX 1

GOOD PRACTICE INFORMATION

Staff should be creative and encourage tenants to explore and try out new things. If something works, repeat it, if something does not work, try something different, or try again in a different way.

RISK ASSESSMENT

Risk assessments are not difficult to undertake, often it requires little more than the application of common sense.
They are designed to identify the risk and hazards to the individual; minimise and remove them if possible and create a workable and agreed plan when it is not possible.

Risk assessment, however, certainly takes some thought and time but is essential in a measured approach to balancing tenant's safety and fulfilment, and worthwhile for covering staff against adverse outcomes.

The process needs to incorporate a thorough consideration of the risks involved against the possible benefits to be achieved. The risk assessment must be sensitive to the person's rights and wishes.

Risk management needs a proactive approach not a reactive one, dealing with perpetual crisis and emergencies. It is important that all workers involved with the risk assessments and the decisions made are fully supported by their own organisation, outside professionals and relatives. It is important to remember that experienced workers who are well supported develop more flexible and creative assessments than inexperienced or unsupported workers do.

CONFIDENTIALITY

Good Practice Points

1. Avoid passing on information unwittingly, for example through talking to colleagues about work related matters in public.
2. Do not remove files from their safe storage areas unless absolutely necessary.
3. Any written records should be completed as soon as possible and they should be kept securely to prevent confidentiality being breached.
4. Never promise to keep a secret.
5. Always respect an individual's right to keep information confidential, but do explain that there are some things that you must share with other professionals.

Management Tips for Extra Care VSH

1. Photos taken (with permission) of all tenants so if they are missing and police help is sought a recent photo is available to give them.

2. All tenants have a card with their name and address in their purse/wallet when they go out, with their agreement.

3. Training and advice on diversion techniques and management strategies should be given to all staff.

Complaints

Lead responsibility for investigating situations rests with Social Care Services (except in criminal investigations where the police will take the leading role).
Any person who has knowledge of, or suspicion that, a vulnerable adult may be suffering harm, or is at risk of significant harm, should refer their concerns to the Social Care Services

Risk Assessments

Care Delivery Plans include a statement of known risks and, if applicable, the 'Next of Kin:, or representative and tenant should sign to ensure that risks are known and understood.

Subsequent risk assessments must be undertaken for all tenants and should follow the care provider's risk assessment policy. All relevant people involved with the process must agree and subscribe to identified risks. The minimum signatures to the assessment should be tenant (wherever possible), Keyworker, Manager, Social Worker/CPN, and relative or external advocate

Risk assessment is continual and is essentially a practical and pragmatic process. A formal review is required as part of the community care review.

Smart Technology

The use of '*Smart Technology*' should only be considered as part of an assessment of risk and its use be agreed with the tenant or the representative. *(See reference in section titled Building and Design for People Living with Dementia in Extra Care Very Sheltered Housing.)*

APPENDIX 2

PROPOSED ROLE OF OLD AGE PSYCHIATRY SERVICE IN SUPPORTING VERY SHELTERED HOUSING (DEMENTIA)

In meeting the needs of people with dementia in Very Sheltered Housing schemes, a joint approach is essential and clearly an important constituent of this support will be the Health input.

VSH Requirements from Health Team

Prompt 'fast track' support from Community Psychiatric Nursing Teams includes assessment, care planning and the provision of regular specialist input to support particular treatments of therapeutic programmes to individual clients.

1. Prompt assessment by a qualified specialist health professional in order to identify key problems and to propose ways with Tenant carer resolve identified problems.
2. Access to a specialist health professional who will give appropriate support to and work with Tenants/carers on specific programmes of care. Frequency and approach having been previously agreed via assessment and care plan.
3. CPN Team to provide regular supervision and support to the Very Sheltered Team's learning/training programme.
4. Consistent liaison is required between CPNs, named assessors, therapists and other involved professionals.

Quality Indicators/Measures

- The Health service will respond within 24 hours to a request for assistance.
- It is expected that there will be a nominated named link person from the CPN Team who provides regular support and input.
- Regular joint reviews of tenants and operational issues.

APPENDIX 3

EXTRA CARE TENANTS

Suffolk County Council and their partners are currently developing a standard document for care plan recording. Some examples of existing Care Plans are shown here. They are all currently in use in Extra Care or other housing services.

Provider Care

Personal Profile

Name: Prefers to be called:

Most recent events leading to acceptance of tenancy:

Name of Psychiatrist or CPN:

Longer ago:

Family life:

Personal interests and taste/lifestyle:

Occupational experiences:

Educational experiences:

Cultural issues (ethnicity; social class; beliefs) :

Tenant's understanding of the world at the moment is:

Risk assessments attached to the care plan: Yes/No

The issues from the past that need to guide care in the present are:

Description of disability at: (date)

Memory:

It is helpful if you	It is unhelpful if you

Judgement/Ability to make decisions or choices:

It is helpful if you	It is unhelpful if you

Level of anxiety:

It is helpful if you	It is unhelpful if you

Activities and stress reducers for this person are:

Possible style of care planning in VSH

Provider Care

Date: Date of review:

Name of Tenant: Prefers to be called:

Summary:

Number of hours per week in total:

Risk assessments attached: Yes/No

How is independence to be supported:

Personal care:

Assistance with meals:

Social Life:

Emotional and Intellectual needs:

Daily Recording Sheet **Name of Tenant:**

Date	Time In	Time Out	Duties undertaken (If a check visit say what has been checked)	Next carer to monitor or check	Hours total today is:	Initials of carer

Information for tenants:

You have the right to comment or complain about your service.
You may complain to your named assessor (social worker) or any member of staff at Heathcote House.

You may express your concerns verbally or in writing, whichever is comfortable for you.
We want to hear your views about the service.

From time to time we will organise meetings for tenants. Please come and contribute your ideas.

You have the right to see any personal information that we have recorded about you.
Please feel free to read these sheets of paper and you can ask to see any information stored in the office about you.

If you have any concerns about your care plan or the way in which the service is being provided to you please speak with your named assessor (social worker) or the Scheme Manager.

MEDICATION RECORD CHART

Name: Joe Bloggs Flat 21 **W/E:** February 29th

Medication Details		**Time**	Initial when medicines given and accepted Enter A when resident is absent. Enter B when medicine refused.							
Medication Name	Strength and Form		Mon	Tue	Wed	Thur	Fri	Sat	Sun	Discontinued
Dosage	Other instructions									

Date Initial Check

Medication Details		**Time**	Initial when medicines given and accepted Enter A when resident is absent. Enter B when medicine refused.							
Medication Name	Strength and Form		Mon	Tue	Wed	Thur	Fri	Sat	Sun	Discontinued
Dosage	Other instructions									

Date Initial Check

Medication Details		**Time**	Initial when medicines given and accepted Enter A when resident is absent. Enter B when medicine refused.							
Medication Name	Strength and Form		Mon	Tue	Wed	Thur	Fri	Sat	Sun	Discontinued
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Medication Details		**Time**	Initial when medicines given and accepted Enter A when resident is absent. Enter B when medicine refused.							
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