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 Association

Orwell Housing Association

English Churches Housing Group

Suffolk Adult Care Services

Suffolk Primary Care Trusts

Suffolk Supporting People

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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 and support services based in the scheme. The service enables the residents to retain control over their own lives while receiving the care and support they need in their own homes.

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 **'Suffolk Design and Management Guide'**. (When working in Suffolk it should also be read in conjunction with the Adult 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 Adult 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 and support 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 specification requires the provision of sensitively 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 residents. For some examples of good practice and management tips see appendix 1.

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 resident is in an Extra Care Service or a Very Sheltered Service but experiences a dementia disability. Very Sheltered Housing is not Residential Care Commissioners and providers need constantly to focus on principles of Supported Housing, how care and support come together and how to promote the culture of supporting people in their own home.

2.2 The quality of a VSH service rests on partnership working, often said but critical to success for the schemes, and the effective delivery of service to the resident. A close working relationship between scheme staff, care providers, assessment teams, GPs, primary health care teams, pharmacists, Health Trust staff and the voluntary sector, must be established and maintained. This will ensure that the health, independence, and the mental and physical ability of residents are optimised. Specialist medical staff will contribute to the assessment process. Links must be developed with all aligned services to ensure advice and support to residents and staff is available when needed. Access to Fast Track psychiatric assessment and support is available from the Mental

Health Partnership NHS Trust.

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

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

2.5 In all aspects of service delivery the needs of the whole person (i.e. intellectual, 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 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 resident's perspective.

2.6 Each resident will be encouraged (where they have expressed a wish) to participate in all decision-making processes and express their views. Where this is not possible a family/advocate or representative will be available.

2.7 Residents 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 resident to make his/her own decisions and choices and to incur calculated risks (see appendix 2 Risk Asssement Guidance for Staff) is to be respected and supported. Decisions on the acceptability of risk must balance the views of the resident and of their representative as recorded on the Care and Support Plan.

2.8 A multi-disciplinary assessment, including a Health Action Plan, will be created for all residents. An initial review will be undertaken no later than six weeks after a resident's move and annually thereafter.

Anybody can request a review. Urgent reviews will be undertaken within 72 hours It is the responsibility of the provider to call a review. Families and individuals can also trigger a review.

2.9 There must be a risk assessment undertaken as part of the multi-disciplinary assessment prior to the service user moving into the scheme. A Care and Support Plan will be drawn up by the care and support provider in consultation with the resident, the family and carers. It will reflect the assessed care and support needs of the resident. Each Care and Support Plan will be reviewed regularly, (that is a minimum of quarterly and /or after any significant change in the residents needs).

2.10 Services should be designed to achieve the maximum rehabilitative effect. It is important that where they have the ability, residents 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. These assist the learning or re-learning of skills and techniques necessary for independent living, they provide encouragement and support to rebuild confidence or self motivation, etc.

2.11 A range of preventative services to assist residents and to preserve and promote their own health and well-being are required. 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 resident. Loss of control over the individual ordering of day-to-day activities has been found to increase dependency. As far as is practicable, residents 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 or without supervision.

2.13 Guidelines and procedures now exist for the protection of vulnerable adults. They apply to any person over the age of 18. Lead responsibility for investigating situations rests with the Protection of Vulnerable Adults Team, except in criminal investigations where the police will take the leading role.

2.14 Written records will be kept in a locked cabinet within a secure office. Service delivery plans, a shared document detailing people's care, support and activity arrangements along with Health Action Plans will be kept in the residents' flats. Consideration needs to be given to confidentiality and access to Service Delivery Plans. Only the resident's authorised personnel and family members with the residents' 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 and support. This handover of information should be done in a private place and in a professional manner.

Where written or computer records are held, the provisions of the Data Protection Act apply. Staff and residents will 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 Every resident will have access to an advocate. Residents, their family/advocates should have full information on the services and choices available to them.

2.16 Residents' access to every day opportunities and facilities should not be restricted because of their needs or disability. Residents should have the support and assistance they need to take part in these activities.

2.17 Schemes should look outwards and be seen as a Community Resource. This provides benefits for both the residents and the local community many of whom need and enjoy the social and therapeutic activities available within the scheme.
Some of the scheme services could also be extended to the local community including care and support, access to alternative therapies etc

3. CARE and SUPPORT MANAGEMENT

3.1 Staff will be available within the scheme 24 hours a day to provide personal care and support services in line with the agreed care and support plan. Staff will enable the resident to undertake all or part of any task for themselves and will offer assistance when needed.

3.2 Each resident should have a flexible care and support plan drawn up by the care and support provider and based on the assessed care plan. This identifies targets and outcomes, agreed by the resident 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 resident and their representative. The care provider will operate a Key worker scheme that will ensure that the care and support plan is followed.
Health Action Plans belong to the residents and contain their wishes and aspirations in terms of their health care. They will be drawn up by the resident their family and the key worker. Particular attention must be given to health and Dementia related matters e.g. diet,

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

3.4 A 'shared' approach should be adopted, where staff and family carers work with residents to carry out the Care and Support Plan.

3.5 The scheme will have an emergency call system that enables residents and staff to summon assistance in an emergency. Additional Assisstive Technolgoy may be required for people. Response times to such calls will form part of the schemes internal quality assurance system. It is recommended that response times and numbers of calls are monitored electronically through the call system.

3.6 Service providers must have a policy for 'behaviour that challenges the service' and all must consistenly follow the agreed service delivery to manage this.

3.7 The care provider will not provide care which requires the skills of a qualified nurse. Staff will work with the Community Psychiatric and District nursing services to support residents. However, if continuous nursing or specialist medical care is required that cannot or will not be delivered in the scheme, a multi-disciplinary review will be carried out to establish whether alternative care arrangements need to be made. Assessors, residents and their families will work together to ensure that residents are in the accommodation that best meets their changing needs. It is acknowledged that residents 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

Detailed and up to date 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.

Residents 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 and Support 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.

Residents 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 resident in his or her own home unless otherwise agreed in the Care and Support Plan.

2) People with any form of dementia or memory loss may be at risk of mismedicating or overmedicating. In this situation medication may need to be stored securely in their own flat. This must be agreed in the Care and Support Plan.

3) People's mental health condition may lead them to misuse their medication (e.g. hoarding/hiding/evading or disposing of their medication). In this circumstance, medication may need to be stored securely away from the indivduals flat. This must be agreed in the Care and Support plan.

At Appendix IV there is guidance on medication polices that has been agreed by Social Care, Health (including pharmacists), and provider services.

5. Staffing

5.1 The Scheme Manager's role is central to the success of the scheme (**For further details click here).** Staffing levels must ensure that the needs of the residents are met. Staff should receive comprehensive and ongoing training to include the following areas:

- Person centred approach to working with people with dementia;
- The role of the family/carers in supporting residents and informing staff.
- A knowledge and understanding of the physiological and psychological effects of dementia;
- Strategies to help staff continue to support people with behaviour that challenges
  Skills in the management of relationships;
- Stress recognition and management, including loss/grief counselling;
- Equality and Diversity;
- Management of behaviour that challenges the service;
- Assessment, Care and Support Planning;

- Communication Skills;
- Rehabilitation; (including encouraging residents to adopt and rediscover new skills.
- An understanding of housing issues, (e.g. housing benefits and welfare rights).

5.2 The staff role is that of enablers and facilitators and, only when it is clear that a task cannot be completed, will they intervene. Staff must also have the skills to understand when direct assistance is needed.

5.3 Attention will be paid to ensure that opportunities exist for residents to participate in varied social activities. An activities worker will be employed to ensure this happens. Opportunities should also be provided for residents to be involved in activities that reflect their cultural and religious beliefs.

5.4 Staff will be creative and encourage residents 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 residents, relatives and members of the community.

5.8 Staff need to be encouraged to focus their attention not just on what people cannot do but also to celebrate and promote what they can.

6. IMPROVEMENT AND MAINTENANCE OF QUALITY OF LIFE

6.1 The resident's rights to choose when and if to participate in the wider life of the scheme must be respected. People with Dementia may have additional needs but they should not be discouraged from participating in anything that they may have an interest.

6.2 To prevent social isolation 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 residents to maintain existing interests and skills and offer them the opportunity to acquire new ones. Assistance will be provided to those residents who need it in order to be able to participate in these activities.

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

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

6.7 Residents 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 with people in the surrounding community. To achieve this the following areas of work must be undertaken:

- Focused attempts should be made to recruit local people into the staff team
- 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 residents 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.
    - Encouragement to enable local services to be delivered within the scheme e.g. library cafe

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 whilst 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.

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 particularly related to treatment and medication since drugs are only efficacious for some people for some time. 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.
- Acute sensitivity to noise

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:
Design must:

- Compensate for a disability;
- Maximise independence;
- Enhance 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.
- Respond to people's need to move around their environment safely
- Provide opportunities for integration and interaction.

8.5 The Consensus on successful Design Features include:

- Small number of flats grouped (in Suffolk we work on max of 8 flats grouped within a scheme);
- Familiar, domestic, homely design;
- Plenty of scope for ordinary activities (unit kitchens, washing lines, garden sheds);
- Unobtrusive concern for peoples safety;
- Different rooms for different functions located within the group of flats (a minimum of 2 is needed);
- Furniture and fittings that reflect the needs and aspirations of the resident group;

- Safe outside space;
- Personal space big enough for lots of personal belongings;
- Good signage and multiple cues where possible (e.g. sign, smell and sound);
- Use of objects, colour orientation, and other visual clues;
- Enhancement of visual access;
- Controlled stimuli especially noise, (especially in bathrooms).
- Wandering loops (internally and externally).

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 residents. The desirable size is between 6 and 12. (It should be noted that there will be people who have developed Dementia living elsewhere within the scheme)
- Regulations - this applies in particular to fire and environmental regulations. The use of smart technology is 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 cultural requirements of potential residents 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. They will also have very different behaviours. For example some people are constantly seeking reassurances or the loo and may walk to find it – so space is essential

9. ASSISTIVE TECHNOLOGY

9.1 The Use of Assistive Technology in Very Sheltered Housing

The use of such technology can be very helpful in assisting disabled people to function at their optimum. It has proved useful in the care of people experiencing a dementia disability. Ethical considerations must be taken into account.

When building or refurbishing Very Sheltered Housing schemes, consideration should be given to individual resident areas.

- Danger from fire;
- Danger from falls;
- Danger from getting lost.
- Danger or damage to self, others or property.

For example:

Danger from falls:

- 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.

Danger from fire:

- 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);

Danger from getting lost:

- Magnet detectors on exit doors from flats can alert staff when the doors are opened, for example at night. Care an Support Plans may indicate its use if there is a danger of the Resident wandering and getting lost. The aim is not to prevent people wandering but to ensure they find the way back without disturbing other residents.

- Locator Technaogy enables staff to identify within five meteres where an individual may be through a combination of a special mobile phone, texting and providing a GPS service
- Infra-red detectors and/or pressure mats that detect movement in any space can also be used to alert staff to individual's movement at night.

Danger/damage to self:

- Sensors turn off taps or special plugs release the water when there is a danger of overflowing in sinks.

9.2 Ethical Considerations

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

- Information must be given to residents and relatives/representatives. Written information about the possibilities of the technology proposed and individual's 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.

- Residents and relatives/representatives must be involved with the recommendations, especially those solutions which could be considered as 'surveillance'.

- Residents and/or relatives/representatives must agree to the recommendations that will be entered on the resident's Care and Support Plan.

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

APPENDIX 1

GOOD PRACTICE INFORMATION

Staff should be creative and encourage residents 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.

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 sensitive information must be recorded as soon as possible and 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 residents so if they are missing and police help is sought a recent photo is available to give them.

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

   Obtain life history immediately and from the resident as much as possible as their of their life will be different from that of their family and friends this will assist communication by including areas of their life in the conversation.

   Behaviours that challenge the service almost always come from an inability to clearly communicate. If the behaviour can be linked to life events there is a clearer path for communication and therefore an ability to work more positively with individuals and steer their behaviour into less challenging and more normative areas.

   Providers, in particular large and diverse organisations are reluctant to give their scheme staff the permission to act flexibly in order to meet the needs of the residents with Dementia. For this group staff must have the support and authority to make a decision in a timely fashion, (with an agreed risk assessment) that is best for the resident.

   It is helpful to keep a record of known "trigger points" for individual residents so that staff are aware of possible events that may create issues for service users.

   Keeping up to date with the latest developments in Assisstive technology is always useful.

APPENDIX 2

RISK ASSESSMENT

RISK ASSESSMENT - GUIDANCE FOR STAFF

This has been designed for working with Older People who are considering a move into very Sheltered
Accommodation.

Risk:
'A chance or possibility of danger, loss or injury or other adverse consequences'
(definition found in concise Oxford Dictionary)

The purpose of this document is to help identify and assess the presenting risks to those individuals who are considering a move into Very Sheltered accommodation. It can also be used to assess people's risk who are currently living in a scheme.

There is no reason why Very Sheltered Housing cannot be a very real option for adults with dementia, confusion or customers with a whole range of mental health problems, given good risk assessment and management.

It is important that we understand the scope of the opportunities and choice offered by this type of care and housing provision and how we can take advantage of this resource to meet the needs of our Service Users.

Whether we are considering a placement in mainstream Very Sheltered accommodation or within an Extra Care service, it is critical that we accurately assess the individual's needs before making this recommendation. An up to date evaluation of risk is an intrinsic part of this assessment.

Assessment of risk should be an on-going and multi-disciplinary shared responsibility. When working towards an aim of Very Sheltered housing, the named assessor takes the lead role in collating information from professionals and other relevant people. This is in order to build up an accurate reflection of an individual's circumstances. The Scheme Manager may take on this role with an existing resident.

It is true to say that different professionals may view the issue of risk in different ways; a rule of thumb could be to weigh up risk-taking in terms of comparing and balancing likely harms with likely benefits. It is hard to predict what will happen in the future because human behaviour is unpredictable. However, a thorough risk assessment should highlight those aspects of behaviour which could potentially cause harm, and the seriousness of the consequences, as well as suggestions for these risks to be avoided or reduced.

This form should be completed alongside your Community Care Assessment or Review.

This form has been structured in line with current relevant legislation, namely The Community Care Plan, The Residents Charter, The Human Rights Act and the Vulnerable Adults procedures.

The customer must be fully involved in the discussion of risk and in the completion of the form.

RISK ASSESSMENT
For older people considering moving into Very Sheltered Accommodation

Some consequences of risk are:

Getting hurt	Getting ill	Hurting someone else
Losing money	Being abused	Abusing someone else
Being lonely	Being afraid	Being humiliated
Getting lost	Being used	Being embarrassed
Damage to property	Becoming distressed	Embarrassing other people

PERSONAL DETAILS
Name of Customer:
Address:
Date of Birth:
GP:
CPN:
Next of kin or relevant other:
Presenting health issues relevant to this assessment:
Assessor and date:

1. Describe an activity or situation which may involve risk, using your care plan as a guide. Below are some activities for consideration. Please tick which you feel would present a risk to your customers and any others
   Accessing the flatClimbing the stairsMobilising within the complex
   Preparing a hot mealPreparing hot drinksBeing alone
   Preparing a hot drinkManaging financesShopping
   Getting up in the morningGoing to bed at nightLeaving the flat unsupervised
   Getting up in the nightUsing the toiletEating/Drinking
   Managing personal careTaking medicationSocialising/Interacting with others
   Others (please specify)
2. What kind of risk is it? It is important to be clear about the kind of risks being taken, the form which the potential harm would take and who the risk is to. How serious are the consequences?
   RISKWHO TO?POTENTIAL HARM
   1
   2
   3
   4
   5

3 How likely is the risk to happen? This may be a hard question to answer but you will need to explore the likelihood of any harm resulting from risk taken.

Identified Risk 1:
How long ago did this happen?
Has it happened before?

How often has/does it happen?
Would it only happen in a particular set of circumstances?
What is the likelihood of it happening again?

Identified Risk 2:
How long ago did this happen?
Has it happened before?

How often has/does it happen?
Would it only happen in a particular set of circumstances?
What is the likelihood of it happening again?

Identified Risk 3:
How long ago did this happen?
Has it happened before?

How often has/does it happen?
Would it only happen in a particular set of circumstances?
What is the likelihood of it happening again?

Identified Risk 4:
How long ago did this happen?
Has it happened before?

How often has/does it happen?
Would it only happen in a particular set of circumstances?
What is the likelihood of it happening again?

4 What are the benefits and gains for the customer in taking the risks outlined above? We need to ask here what would be the consequences for him/her of not doing the things which present risk?

RISK	BENEFITS	CONSEQUENCES OF NOT TAKING THE RISK
1		
2		

3
4
5

5 What can be set against the risk in order to minimise it? Things to take into consideration here could be the customer's own experience, physical strength or motivation, level of insight/awareness, the ability of the staff at hand to respond, or a specific piece of ADL equipment. We need to list here the possible risks and action to reduce them. This could include a multi-disciplinary meeting

RISKACTION TAKEN TO MINIMISE THE RISK

1
2
3
4
5

6 Who needs to be informed or involved in the decision about the risk? Who else needs to know about these decisions & this assessment? Wherever possible, the person themselves must be central to this process & involved in any discussion & decision making. You will need to make a judgement about if, how and when to involve carers and relatives.

7 Action points agreed and by whom, with target dates

8 Date of next meeting to review decisions made

Assessor……..Date ……

Scheme Manager (for existing residents) ……..Date……..

Customer …… Date……..

APPENDIX 3

ROLE OF HEALTH PERSONNEL IN SUPPORT
EXTRA CARE SERVICES
OLDER PEOPLE MENTAL HEALTH SERVICES

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.

Extra VSH Requirements from the Health Team

Prompt 'fast track' support from Community Psychiatric Nursing Teams. This must include assessment, care planning and the provision of regular specialist input to support particular treatments to individual residents. This works best if there is a named individual responsible for liaison with the scheme. This individual will also offer advice and support to the staff team on the needs of the residents. This work relates not only to those with Care Planning Approach regimes but also to others who relay on a close working relationship between specialist and primary health care services, (does an individuals confusion relate to their increased level of dementia or an infection?).

1. Extra care staff have access to a direct referral service.
2. Prompt assessment by a qualified specialist health professional in order to identify key problems and to propose ways with the resident/family/advocate to resolve identified problems.
3. Access to a specialist health professional who will give appropriate support to and work with residents and carers on specific programmes of care. The frequency and approach of these having been previously agreed via assessment and the Care and Support Plan.
4. CPN Team to provide regular supervision and support to the Very Sheltered Housing Team's learning/training programme.
5. Consistent liaison between CPNs, named assessors, therapists and other involved professionals.
6. The Health service personnel will respond within 24 hours to an urgent request for assistance.
7. It is expected that there will be a nominated link person from the CPN Team who provides regular support and input.
8. Regular joint reviews of residents on operational issues.

APPENDIX 4

MEDICATION

This is a non-exhaustive list of possible ways of assisting individuals where difficulties 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 and Support 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.

2. Each flat has a locked medicine cupboard. If indicated in the Service Delivery Plan the key should 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. Within each flat, where required, 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 will administer liquid and PRN medication from the original containers in accordance with instructions as outlined in writing by the GP and Pharmacist.

6. Staff may remind residents to take their medication which is in their flat.

7. Medication can be placed out of sight and/or reach (with the resident's or their representative's permission).

8. Residents or their representative reorder each indivduals 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 resident. The arrangement must be recorded on the residents Care and Support Plan.
9. Extra training for staff to ensure that the task is undertaken within best practice will be necessary if it is agreed that a resident requires and will be offered assistance with invasive treatments/injections, (e.g. insulin).

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

In the case of any changes to the medication regime, the residents should be encouraged to return un-needed medication to the Pharmacist. Where responsibility for administration of medication is with the staff, then they will take responsibility for this.

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	Thu	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	Thu	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	Thu	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	Thu	Fri	Sat	Sun	Discontinued	
Dosage	Other instructions										

Date Initial Check