

Occupational Therapy Just Checking Telecare 1 Year Pilot Report

‘Giving People with Dementia a Voice’

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EXECUTIVE SUMMARY

Occupational Therapists from Leeds Partnerships NHS Trust evaluated the effectiveness of the Just Checking system as an assessment tool for people with dementia living alone in their own homes.

During a 12 month pilot in the Leeds Mental Health Intermediate Care Team and a Community Mental Health Team, Just Checking was used for assessment in 55 cases.

The teams concluded that use of Just Checking improved the quality of the assessment and the outcomes for the service user.

Generally people with dementia were managing at home better than expected. The objective data from the system helped to challenge preconceived fears, so that interventions could concentrate on supporting the capabilities of the person, in effect giving them a voice in decisions about their care.

Observation of a client's movements throughout the day and night allowed Occupational Therapists to plan timely, cost effective care which promoted independence and improved the opportunity to be supported at home rather than being admitted to residential care.

The system supported two early discharge cases and changed the views of in-patient staff about the capabilities of the service users to manage at home.

The improved and objective information from the Just Checking system saved time in piecing together information from third parties, and provided a means to monitor the effects of the well targeted care plans, ultimately improving the capacity of the teams.

The use of Just Checking in the Mental Health Intermediate Care Teams was confirmed. The system is being rolled out to all the Community Mental Health Teams, and the Leeds Memory Service.

Introduction

In Leeds City there are approximately 8000 people with dementia, of which around a third live alone. With a forecast 38% rise over the next 13 years (Alzheimer's Society 2007) Leeds is anticipating more than 11,000 people with dementia by 2021.

A significant reason for people with dementia being admitted to 24 hour care is the perceived risks to their safety. Concerns such as getting lost walking in the community, leaving the property at night, poor sleep and changing day/night routines, have been difficult to assess accurately, particularly when a person lives alone.

Assistive technologies have been used for many years to maintain physical independence. Within the past 20 years, 'electronic, computing and telecommunication innovations' have changed how people with physical and cognitive problems have been able to maximise their capabilities and maintain living in their own homes (Doughty et al, 2007). The use of telecare to minimise risks for people living in the community was a well established practice within the directorate but no one had used telecare as assessment tool. 'Activity monitoring' has the potential to help with assessment by providing a better understanding of a person's day and night time activity, particularly when they are spending time alone.

Statutory and Policy Frameworks

The £80 million Preventative Technology Grant, available from April 2006 – March 2008 provided seed funding to local authorities with social services responsibilities, to implement telecare devices and services to help support individuals in the community (Department of Health 2005a). National health and social care policy advocates the positive role that telecare can play in enabling people to stay in their own home, reduce admission rates to residential care and facilitate earlier hospital discharges (Department of Health 2005b, Brownsell, 2006).

The teams in Leeds and the role of Occupational Therapy

The teams involved in the study were:

Leeds Mental Health Intermediate Care and Rapid Response Service, which provides intensive support in their home over a short period of time for people experiencing a crisis with their mental health or dementia, including hospital or in-patient discharge. The focus is on rehabilitation and maintenance of independence.

Leeds North West Community Mental Health Team, one of six CMHTs citywide, a multidisciplinary team which provides assessment, treatment and support, to people over the age of 65 years in the north west of the city. The team works in partnership with other health, voluntary, independent and social care services, in line with local and national strategies.

A large number of referrals to the occupational therapists (OTs) within the teams are for the assessment and treatment of people with memory problems who live alone. The role of the occupational therapist is to work with service users to maintain existing skills and enable them to cope effectively with everyday activities. At the time of referral there is often a considerable degree of actual or perceived risk to the service user.

Common problems faced by the OTs are:

- A lack of objective information
- Difficulty verifying night time behaviour and walking patterns for clients who live alone
- Carer anxiety, with carers fearing the worst
- Perceived or suspected high risk behaviour of the service user (eg going out at inappropriate times or at night)
- Re-admission to hospital or admission to residential care homes due to carer breakdown.

The Just Checking System

Just Checking is an activity monitoring system. Movement sensors in a person's home build a graph of activity, which is accessed via the internet. Data is transmitted from the dwelling to the web-server via the mobile network. The system is wireless, easy to install, portable and designed to be re-used time and time again (Appendix 2).

The Leeds OTs selected the Just Checking system for its ease of use, and because it fits a client centred approach to assessment which focuses on occupations and activities of daily living, in the location that best met the service user's needs and wishes (College of Occupational Therapy 2006).

THE STUDY

Occupational Therapists (OTs) from Leeds Partnerships NHS Trust utilised the Just Checking system over twelve months to aid the assessment of people with dementia who were living alone in their own homes. The project group evaluated the effectiveness of the system in assisting with assessment, and with targeting care packages more appropriately to the needs and wishes of the clients and their carers.

Leeds City Council provided funding for the systems through the Preventative Technology Grant and support was given by the Leeds Partnership NHS Trust Directorate Strategy group.

Aims

The overall aim was to provide evidence that activity monitoring could improve the assessment of people with dementia who live in their own homes, thereby contributing to:

- Prevention of admission as part of acute service provision.
- Facilitation of early discharge, including home leave trials, thereby reducing lengths of stay.
- Improved targeting of home care provision at assessment for those with complex needs.
- Provision of additional evidence for future planning, for 24 hour care assessments and delaying the need for longer term care.
- Efficiencies regarding use of staff time and therefore team capacity.
- Improved experience and outcomes for service users and their carers by improvements in the above areas.

Method

A 12 month pilot study commenced in May 2008.

4 OTs from the Mental Health Intermediate Care Team and Rapid Response teams (MHICT) and a Community Mental Health Team (CMHT) for older people were involved in the installation, use and evaluation of the Just Checking system and its effect on the work of the teams.

Members of Group

Christine Roworth-Project Innovator and Project Co-lead

Alicia Ridout – Project Co-lead

Gemma Wormald - South/West MHICT and North/North East MHICT

Gillian Magee - North/North West MHICT

Sarah Walker - CMHT

Julie Penkett - CHMT

Ellen Bragger – Telecare Occupational Therapist, Just Checking Ltd

Inclusion Criteria:

- Memory problems, with/without dementia diagnosis.
- Living alone at home.
- Difficulties clarifying appropriate care package.
- Further assessment of routine especially at night, (e.g. wandering/ purposeful walking behaviour, sleep patterns, nutritional habits etc).
- Candidates for a trial of home leave from inpatient wards which may add to assessments or facilitate early discharges.
- To support further assessment under the care of MHICT.
- To clarify increasing needs pre admission via MHICT or CMHT care..
- To evaluate levels and impact of deterioration on service users living alone, where there has been concern expressed by others, and admission or move to care may be a consideration.

The Just Checking system was installed in the service user's home and the main reason for installing the system was recorded.

The system remained in place until there was sufficient understanding of the service user's daily activities to plan care and to monitor the effect of the care package. The system was then removed. Family members that were closely involved were given a log-in so that they too could view the data.

Consent and ethics:

Where the service user was judged to have capacity, a simple explanation of the system was given and consent obtained. Where the service user was deemed to not have capacity, a decision to install the system was made by the OT following best interests principles.

Ethical considerations around consent and capacity were covered in the protocol devised by the pilot team.

Resources required

- Access to team OTs and Clinical Team Managers to deliver training and provide daily clinical management of the use of systems.
- Access to service users fitting the criteria for inclusion.
- Access to data for the evaluation.
- Professional lead's time to support the leadership and coordination of the project over the 12 month period.
- 5 Just Checking systems and web-service for 1 year.
- Just Checking provided training, technical and phone support to staff using the systems. Just Checking's OT assisted with the trial planning and implementation.
- Resources to share and disseminate findings.

Resource Allocation:

Capital Requirements:

5 systems, total cost of £5900, of which £2460 is the first year's annual web-service charge, renewable at the end of the pilot if use of the systems continues.

Revenue Requirements:

A one year web-service subscription for 5 Just Checking systems was included in the project costing above.

It was agreed that replacement of any loss or damage to the Just Checking system would be covered by individual teams' budgets.

Charging policy:

Service users were not charged for the service.

RESULTS

The outcomes have been recorded in the following ways:

1 Analysis of

- Installation data and user profiles
- Reason for referral forms
- Outcomes based on Project Initiation Document
- Staff feedback questionnaire and discussion

2 Case Studies

To provide examples and evidence of the aim.

Number and Length of Installation

Total number of installations, in which data was collected, between April 2008 and March 2009 was 55.

The Just Checking systems were in constant use, with virtually no time when they were not installed with a service user.

	Min. no days	Max. no. days	Average no.days
MHICT	7	46	24
CMHT	5	57	31

Log Ins

Staff log-ins averaged between once or twice a day for the duration of the installation. The pattern of log-ins changed throughout the installation period, with more frequent log-ins during the first few days, and less frequent as time went on.

Where family members were involved and given a log-in, they too logged in on average once or twice a day, although in one case, one family logged in 212 times in 8 days.

Profile of Users

Male/female

	Male	Female	Total
MHICT	8	38	46
CMHT	0	9	9
			55

Age range of service users

	65-69 years	70-79 years	80-89 years	80-89 years	Average
MHICT	1	9	28	8	84.3
CMHT		1	4	4	87.9

Cost

Costs have been based on the 5 Just Checking systems which were used throughout the pilot.

Total costs for the 5 systems were £5900, covering the capital cost of the equipment and the web-service for 1 year. This equates to an average £107.27 per installation/assessment.

The cost of using the system in subsequent years is the web-service subscription only (capital equipment cost has already been covered). Assuming a similar number of installations would be made in a year, the cost reduces to an average of £42 per installation.

Referral Criteria

The referral criteria included two essential criteria:

- Dementia/Cognitive Impairment
- Lived Alone

There were 9 additional criteria on the referral form. One main referral reason was indicated in each case.

	Main reason for referral	MHICT	CMHT
1	Further evidence to support targeting of care	0	
2	Further assessment of routine	17	1
3	Supporting team assessment or diagnosis	0	
4	Assessment to avoid hospital admission	1	1
5	Assessment following deterioration	14	1
6	Concern expressed by others re; safety at home	3	1
7	Assessment of night time routine/activity re wandering/purposeful walking/sleeping	9	5
8	Assessment of changes in activity post medication change	0	
9	Supporting assessment to facilitate early discharge from hospital e.g. home leave	2	
	Total	46	9

The main reasons that the system was installed were:

- to undertake assessment of routines
- to undertake an assessment following apparent deterioration
- to assess night-time activities.

Outcome based on Project Initiation Document

Six potential outcomes were detailed in the Project Initiation Document (PID). Staff considered that in all cases, outcomes 5 and 6 had been achieved (improved efficiencies for the team, improved outcomes for the service users) and that the time they had invested to set up and run the pilot was recouped in the time saved by using the system. They recorded one other main outcome for each case.

	PID Outcome	MHICT	CMHT
1	Prevention of admission as part of acute service provision (MH ICT)	6	
2	Facilitation of early discharge, including home leave trials, thereby reducing lengths of stay (MH ICT)	1	
3	Improved targeting of home care provision at assessment for those with complex needs (MH ICT & CMHT)	16	4
4	Provision of additional evidence for future planning, for 24 hour care assessments (CMHT) and delaying the need for longer term care.	22	4
	No PID outcome recorded	1	1
	Total	46	9
5	Efficiencies regarding use of staff time and therefore team capacity	46	9
6	Improved experience and outcomes for service users and their carers by improvements in the above areas	46	9

The main way the system was utilised was to gather evidence for the planning of care which would delay admission to long term care, and targeting of care for those with complex needs.

Other Practical Issues

Referral for other telecare

5 service users from the CMHT and 4 from the MHICT were referred for other telecare as part of their care plans. 1 of the service users from the MHICT already had a door contacts telecare device in place.

Technical Issues

- The positioning of a sensor resulted in a small patch of damage to paintwork in 2 properties.
- 1 installation initially had a problem with mobile reception, which was overcome by moving the 'controller' unit to a windowsill.
- 1 controller was unplugged when a service user cleaned up in the spare room where controller was located. The controller was left out to show family. (Staff were impressed that the service user was still carrying out the level of cleaning and physically still able to reach that location.)
- 1 controller was switched off and unplugged on a number of occasions by a service user, until it was moved to a more hidden position under a chair in a bedroom.
- At the start of the pilot, there was a problem with the reliability of a small number of the sensors, which were replaced. The need for staff to be assured of a swift response from the supplier to any technical problems was apparent.

Replacement parts

Over the year, 2 door sensors were lost and had to be replaced. In one case this occurred when a service user was moved quickly to an inpatient setting and there was a delay in gaining access to the property to retrieve the system.

Changes to pilot documentation

A new IT system came in during the pilot which superseded some of the paper based forms that had been drawn up at the project approval stage.

Outcomes for service users at 3 and 6 months

Although this was not one of the original objectives of the project, the CMHT followed up its 9 service users and recorded outcomes at 3 months and 6 months.

The nature of the MHICT is that it manages users for a short concentrated period of rehabilitation, after which the case is closed or handed over to a community social care team or community mental health team. It was therefore not feasible for the MHICT to follow up 3 month and 6 month outcomes.

Outcomes at 3 months for CMHT service users

8 stayed at home with a care package in some form
1 was identified as requiring residential care long term

Outcome at 6 months for CMHT service users

1 admitted to hospital
3 identified as now requiring long term residential care
2 still at home with similar care packages
2 unknown outcomes at 6 months

Staff Feedback

Staff feedback was collected by questionnaire to support workers and in a discussion with OT team leaders at the end of the pilot.

The team leaders felt that Just Checking enabled the team, service users and carers to gather additional objective information relating to the service users' daily routines. The system helped in the assessment of risk as well as helping to identify a person's strengths, hence assisting in the care planning process. It improved the quality of assessment and the outcomes for the service user. The team leaders suggested that the more comprehensive information increased the possibilities of supporting a person with dementia in their own home and had the effect of "giving a voice" to those with memory deficits, who could not speak of their needs and abilities.

The assessments have shown that generally people with dementia managed to function more effectively than predicted.

The system provided objective evidence which helped OTs to challenge preconceived ideas and manage risks. The objective data confirms or refutes concerns (particularly from family carers or neighbours), enabling staff to gauge more accurately the service user's daily routine. It was particularly useful for understanding night time activity and potential risks (such as leaving the property at night). One team leader felt she usually had a good idea of the person's capabilities and the likely outcomes, but the system was valuable for convincing other stakeholders (family, other clinical staff) that the person could be supported at home. It aided some cases of supported home leave from hospital, and convinced hospital staff that the time at home could be more extensive.

OTs thought the system had a role in enabling someone to remain in their own home by, in effect, giving service users a means of demonstrating their capabilities (which were often greater than expected.) They cited the system's usefulness in helping to adapt care packages to meet changing needs, extending the time that a person with dementia could be managed at home. The team leader of the CMHT stated that now, she would not like to be without a Just Checking system to call on.

In the case of people who needed to be placed in continuing care, the system helped to ascertain the appropriate time for this.

The team leaders suggested the system improved team efficiency by providing a speedy and objective picture, saving the time that practitioners spend trying to piece together information from hearsay or exaggerated claims from neighbours or stressed families. (Rumours were most prolific in sheltered or shared housing schemes.) This meant that practitioners could concentrate on rehabilitation and devising effective care packages. Although it is difficult to measure, it was felt that ultimately this improved the capacity of the teams.

Support workers felt that the system provided a clearer picture of what was going on, and that this was helpful in scheduling care visits, identifying risks, understanding behaviour (particularly the impact of restless nights and sleep patterns) and reducing the necessity for multiple 'checking' visits. The objectivity of the data was seen as positive evidence for care planning, which could both extend, or shorten if risks were high, the time a person could remain at home.

The teams found the system simple to install and use, with the OTs installing the system as part of a scheduled visit. They liked the fact the team could install the system themselves. Several support workers made comments about the problems with a small number of the sensors at the beginning of the pilot, highlighting the importance of staff confidence in the equipment and the need for a swift solution (from the supplier) to any problems.

Team leaders felt that the system was acceptable to service users and there was limited tampering. In approximately half of cases, the service user was deemed to have capacity and agreed to the system being installed. In the other half of cases the service user lacked capacity, and a decision to use the system or not, was taken using best interests principles. One service user refused the system. Among the 55 installations, one service user was disturbed by the sensors and the system was removed. Two service users unplugged the controller (one during cleaning) but these were plugged back in again by the team.

All staff felt that the system was well received by family carers. They discussed what the data showed, and the service user's response to interventions or care services. Staff felt that families were generally reassured by the data which helped to allay anxieties and concerns.

Family Carer Feedback

Although a number of family carers were sent a questionnaire to provide feedback if they wished, none completed the questionnaire. However, one family carer spontaneously e-mailed the team, with a positive comment on Just Checking, and this has been included in the appendices.

CONCLUSIONS AND DISCUSSION

Just Checking proved a powerful and effective assessment tool for people with dementia, living alone, in their own home. It improved the quality of assessment and as a result, the outcomes for the service user.

Testing Just Checking for its contribution towards the 6 outcomes that were detailed at the start of the pilot (from the Project Initiation Document):

1. Prevention of admission as part of acute service provision (MH ICT)

2. Provision of additional evidence for future planning, for 24 hour care assessments (CMHT) and delaying the need for longer term care.

The experience in the pilot was that people with dementia, living alone, are generally managing better than expected, particularly the expectations of family members. While OTs may consider that risks are at an acceptable level or can be managed, and that a person with dementia can be supported at home, there are other stakeholders to persuade. The objectivity of the activity data helps to challenge preconceived fears and present the case to other parties. In so doing it provides the person with dementia with a 'voice' in decisions about their care. This mirrors findings from other pilots and feedback from practitioners who have been using the Just Checking system (Archer 2009, Dept of Health 2008). Observation of a client's movements throughout the day and night allowed OTs to plan timely, cost effective care which promoted independence and improved the opportunity to be supported at home rather than being admitted to residential care.

3. Facilitation of early discharge, including home leave trials, thereby reducing lengths of stay (MH ICT).

The ability to monitor a person with dementia at home meant that in two cases staff were persuaded to try an earlier period of home leave from Intermediate Care Community Intensive Care (CIC) and then to extend the hours that a patient was able to spend at home. OTs recognise that people with dementia often function better in a familiar environment, and that 'home' is full of cues and reminders which help people to make sense of their world. There are more opportunities to carry out activities in an environment in which they are in charge (eg cleaning, housekeeping, gardening). Getting people back home supports a recovery approach to dementia care. It meets the expressed wish of a majority of clients to stay in their own home for as long as possible.

Use of the Just Checking system supports the new Mental Capacity Act Deprivation of Liberty safeguards which are designed to protect the interests of those who lack mental capacity. The safeguards aim to ensure people can be given the care they need in the least restrictive regimes, and provides rights of challenge against unlawful detention. People with dementia may perform poorly in an unfamiliar hospital ward or in-care facility, and there is a risk that hospital staff will be reluctant to discharge because their perception is that the person will not manage at home. Just Checking provides a tool with which to assess a person, and observe the effect of rehabilitation and care services, when the person is in familiarity of their own home, thereby promoting independence, allowing the person to exercise control over their lives, and fulfilling least restrictive practice.

4. Improved targeting of home care provision at assessment for those with complex needs (MH ICT & CMHT).

Care visits could be timed to be of maximum benefit to the client. Better targeted care packages improve the use of scarce home care resources, and support a recovery approach to dementia care.

5. Efficiencies regarding use of staff time and therefore team capacity.

The improved and objective information from the Just Checking system saved significant time in piecing together and evaluating information from third parties (neighbours, family members). OTs could be sure that the care plans, interventions that they put into place are based on objective information, rather than on supposition. They can be confident that the plan more closely meets the person's needs and they can quickly observe and judge the effect of the plan. Just Checking improved the use of staff time and ultimately the capacity of the team.

6. Improved experience and outcomes for service users and their carers by improvements in the above areas.

The care plans and therapeutic interventions are targeted to be effective both in resource use and in giving the best outcomes for the service users. Interventions were found to promote the independence of the service user, as the risks were noted and managed and the interventions were more client-centred. Family carers were reassured by the charts and the service user's response to the interventions. They were able to target their own input to best effect, and manage the demands of their caring role.

RECOMMENDATIONS

The pilot confirmed that activity monitoring is a powerful tool in assessment and care planning for people with memory problems, living alone. The recommendations for Leeds are:

1. Commit to the continued use of Just Checking in the Mental Health Intermediate Care Service.
2. Roll out the use of Just Checking in the city's Community Mental Health Teams.
3. Increase awareness of the system amongst ward staff, with training and information packs, so that they can consider the option of earlier supported discharge or home leave.
4. Purchase a Just Checking system to use in the city's Memory Services. This is an early intervention service, which works on memory prompts and aids, maintenance of daily routine and function and intervention work with people who have memory loss. The activity monitoring system could help to establish a benchmark of daily living patterns, against which significant changes could trigger a step up in supportive services to help prevent hospital or residential care home admission, and maintain the service user within their community.
5. Consider the use of activity monitoring with other client groups with cognitive or communication difficulties: acquired brain injury, adults with learning disabilities.
6. Consider the use of activity monitoring in the development of new services. There has been a preliminary discussion about the role activity monitoring could play in a city-wide night service, in which mobile staff could respond only to those who are up in the night and requiring assistance.

Implications for occupational therapy

Activity monitoring provides an objective view of a person's capabilities in their own home. The more comprehensive information that activity monitoring provides potentially changes clinical reasoning on a case. It informs better, client-centred care, which fits the philosophy of occupational therapy.

Activity monitoring also helps to target resources, with the right size, frequency and need-led care packages which support a service user's capabilities.

Impact on service users.

Activity monitoring provides a new means for people with dementia to communicate their capabilities, in effect giving them a 'voice'.

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DEFINITIONS

Occupational Therapy as defined by the World Federation of Occupational Therapists as a profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life.'

Telecare is defined as 'the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living' (Dept of Health 2005c)

APPENDIX 1 - CASE STUDIES

Case Study 1

Name: Mrs K

Age: 83

Diagnosis: Dementia

Reason for Referral to Occupational Therapy / Just Checking

Mrs. K was referred to MHICT for assessment of her mental health and functional ability. She was experiencing paranoid ideation regarding her son. She was known to mental health services and had a diagnosis of dementia. It was felt that at the time of referral she had a UTI and had been prescribed antibiotics by her GP.

Prior to referral Mrs. K was due to move into 24 hour care but had recently changed her mind. The family and consultant psychiatrist expressed concerns re. her ability to safely cope at home as it was believed she spent the majority of time in bed and had been neglecting her ADL's.

Outcome of Initial Assessment

MHICT completed the initial assessment and discussed Just Checking with Mrs. K. Initially she was reluctant to have the system installed due to paranoid ideas about her son being able to "see what she was doing". The system and its benefits were further explained to her over the course of an 72 hour assessment period.

It was unclear if Mrs. K had capacity to consent to installation as she did not understand the concept and could not retain the information regarding the system. The potential benefits of installation were discussed with MHICT Clinical Team Manager (as recommended by the project protocol) and it was agreed that Just Checking would be installed to monitor activity patterns objectively.

Intervention/Care Plan

It was agreed that MHICT would initially visit x2 daily to -

- Assess the impact of Mrs. K's beliefs on her functional ability and relations with her son, as he provided support with shopping and laundry.
- MHICT OT would complete a functional assessment of personal cares and meal preparation.

On several occasions MHICT had difficulty accessing the property and had to telephone family members for access-on these visits Mrs K was found to be in bed and unable to hear the door.

Family members reported they thought Mrs K was disorientated to time due to the amount of time Mrs K spent in bed. This was discussed with Mrs K over a number of days; she stated she often went to bed as she was "bored". Just Checking data demonstrated that Mrs K was not disorientated to time, she left the bedroom at an appropriate time each morning and went to bathroom, but her daily activity pattern was diminishing. Her charts showed she often got up at the same time, 10.00 and went into the kitchen and lounge, after an hour she went back to the bedroom, where she would stay until MHICT visited about lunch time. This was also the case during the evening, once MHICT had visited, 18.00 Mrs K would immediately go to the bedroom, occasionally going to the bathroom during the night

Outcome

Using the Just Checking data to assess daily activity and discussing routines and interests with Mrs. K, MHICT were able to adjust visit times and increase input to x3 daily to 'extend' her day. The team created an activity planner for Mrs. K to remind her of MHICT input and basic tasks that she identified required completing.

- With the support of MHICT Mrs. K was able to regain a morning routine, including compliance with medication.
- Daily visits and Just Checking data demonstrated that Mrs. K was attending to personal hygiene needs in the bathroom, but due to her beliefs about her son she had been wearing dirty clothes as she would not allow him to do her laundry.
- OT assessment concluded that Mrs. K could make hot drink and sandwiches independently but required support when preparing hot meals/snacks.

After several weeks of MHICT input and compliance with her medication Mrs. K's beliefs about her son subsided and she allowed him to continue his previous support.

MHICT reduced visits to x2 daily-AM and PM. As previously discussed with Mrs. K re. her lack of social interest and reported "boredom"; it was agreed with Mrs. K and her family that MHICT would refer her to Community Rehab Team and Community Support Team. It was felt that the Rehab team could support Mrs. K in exploring meaningful activities within her local community. The Community Support team would continue to visit twice daily – AM for medication and breakfast prompts and PM for preparation of a hot meal with a view to recommending Home care if Mrs. K decided to remain at home.

Case Study 2

Name: Mrs V

Age: 79

Diagnosis: Dementia

Reason for Referral to Occupational Therapy / Just Checking

Mrs V was referred to MHICT upon admission to The Manor, a Community Intensive Care (CIC) unit, following incident at home where she fell in the bath whilst using it as a toilet. Mrs V injured her shoulder and as a result of such and in addition to her history of memory impairments and previous mental health services input, she was admitted to a CIC bed.

Whilst at The Manor Mrs V began to display aggressive behaviour towards staff and other service users. Her daughter felt that this was a result of being in a different environment with strangers and was concerned that her mother would become labelled 'violent' or 'aggressive'.

It was agreed that as Mrs V was able to complete basic ADL's at The Manor it would be beneficial for her to have 2-day period of home leave, supported by MHICT, to assess her within her own environment. It had been reported that Mrs V may be disorientated to time and when unwell experiences hallucinations.

Outcome of Initial Assessment

The initial assessment was completed by MHICT OT.

- Mrs.V was orientated to place and person but not time.
- She was observed making a snack and hot drink safely and independently.
- Mrs.V was able to make an informed decision and demonstrate capacity regarding the Just Checking system, therefore it was installed during the initial assessment.

Intervention/Care Plan

- It was agreed that MHICT would visit Mrs.V x2 daily- mid morning to observe for evidence of self care and meal preparation and 18.00 to observe for evidence of meal preparation.

Outcome

As Mrs.V's presentation improved and there were no episodes of aggression during her time at home, it was agreed by all that she would be discharged from The Manor with continuing support and assessment from MHICT.

Over the following week it became evident that Mrs.V's memory impairments impacted on her abilities to recall her daily routine. MHICT used the data from Just Checking to alter visit times and support Mrs.V in regaining her previous routine.

- Mrs.V remained at home with the initial support of MHICT x2 daily.
- Her needs were assessed and she was referred to the Community Support Team (CST) for continuing support regaining functional skills and her daily routine.
- Mrs.V's daughter was pleased that her mother had been given an opportunity to prove her skills at home and no longer was being labelled 'aggressive'.
- Short term-Mrs.V remained at home with support from CST.

Long term-CST recommended that Mrs.V could be supported at home with two visits from Home Care, one at lunch time to prompt her to make a sandwich, as she had retained this skill. The other visit was early evening to assist in making a hot meal and prompt Mrs.V to start her evening routine.

Case Study 3

Name: Mrs H

Age: 82

Diagnosis: Alzheimer's disease

Reason for referral to Occupational Therapy/Just Checking

Mrs H lives alone in a privately owned house. Her son lives locally and provides considerable practical and emotional support for his mother. He is willing to continue with this input in order to enable his mother to remain in her own home.

Home care visit 3 times a day to assist with meal provision and prompt Mrs H with Medication. Mrs H scored 15/30 on the Mini mental state examination and is currently prescribed Aricept 5mg daily.

The Just Checking Assessment was put in place after Mrs H received a visit from her two daughters who live in New Zealand. They came to stay with her for a two week period and contacted the CMHT shortly after their arrival. They expressed concern that their mother did not recognise them and they described her as restless and disorientated at night. On several occasions she had opened the outside door and proceeded to go out into the driveway at night. Her daughters believed this was how she normally presented at night time and felt she needed to move to residential care as soon as possible for her own safety. Mrs H was keen to continue living at home and her son agreed this would be in her best interests providing she was not going out at night as his sisters had feared. The Just Checking System was installed when Mrs H's daughters returned home to New Zealand and was used to aid an ongoing OT assessment.

Outcome of Initial Assessment

Just Checking was installed for two weeks with Mrs H's consent.

- It became evident Mrs H was opening and shutting the back door before going to bed at 8 or 9 pm as part of the process of locking up for the night.
- Mrs H did not go out of the house at night during the Just Checking Assessment.
- Mrs H was settled in her bedroom for 8 -9 hours at night.
- Mrs H was spending a minimal amount of time in the bathroom/toilet.

Intervention/Care plan

Mrs H's home care package was reviewed to include:

- An increase to 4 home care visits a day to include an evening visit to help orientate and reassure Mrs H before going to bed.
- Home care begun to assist Mrs H with bathing Home care commenced leaving soft drinks for Mrs H to drink between visits to increase her fluid intake as she was susceptible to UTI's.
- Day centre attendance was introduced.

Outcome

Mrs H managed to continue living at home with support for a further 11 months.

Her son and daughters accepted reassurance that she was not going out at night. Her daughters acknowledged her increased confusion and behaviour during their stay was likely to be due to the change in her routine and the presence of her daughters who she did not consistently recognise.

Update March 2009

Mrs H's dementia has continued to progress and her MMSE score is currently 10/30. She feels she does not wish to be on her own anymore. Mrs H is considering a move to residential care and is currently on a six week trial in a local residential home.

Case Study 4

Name: Mrs R

Age: 87

Diagnosis: Alzheimer's disease

Reason for Referral to Occupational Therapy/Just Checking

Mrs R lives alone in a one bedroom bungalow. She has a supportive family who live locally and visit once a day. A home care package is in place three times a day in include support with meal provision and personal care.

Mrs R was seen for review in the out patient clinic with her daughter-in-law who reported her confusion had worsened recently. She had filled her kettle with milk and had been trying to plug the TV aerial into an electrical plug socket. Mrs R was losing weight and home care was finding she was throwing meals in the bin after they had left. On testing she scored 15/30 on the MMSE. Her prescribed medication includes Aricept and Trazodone.

The OT and clinical support worker made a joint visit to see Mrs R. The kettle was switched on with no water in when we arrived and Mrs R was unable to smell the fumes from this. Home care notes indicated she has been left soup for lunch but this had been poured into the sink and waste bin.

She was happy to engage with us and repeatedly sought reassurance that she would receive further visits that day and that would visits again soon. Mrs R and her family agreed to the Just Checking system being installed and it was used to aid the OT functional assessment.

Outcome of Initial Assessment

Just Checking indicated:

Mrs R sleeps on the sofa in the living room. (This was confirmed by Mrs R and her family).

She makes frequent visits to the bathroom (about 30 times a day are recorded).

Mrs R rarely goes out in the daytime and she does not go out at night. However, the front door is opened frequently eg. up to 60 times a day and only eight of these can be attributed to home care or family visits.

Mrs R moves frequently between the kitchen and living room.

Intervention/Care Plan

Liaison with Social Worker and home care agency to request longer visits to enable home care to encourage Mrs R to eat prepared meals.

GP visits/check whether Mrs R had a UTI.

Information given to the family about kettles with safety cut outs to prevent them boiling dry.

Prompt notices displaying adjacent to plug sockets and kettle.

Request for homecare to ensure water is in kettle when they leave.

Carbon monoxide detector to be installed in living room as Mrs R sleeps in the sofa.

Mrs R encouraged to consider day centre attendance.

Outcome

Mrs R is keen to continue living at home. Her family feel reassured that she is not going out at night and that she appears fairly settled at night in the living room.

However, there are ongoing concerns regarding Mrs R's weight loss. She is throwing away fresh food from her fridge on a daily basis prior to home care arriving and is still throwing away the majority of prepared meals.

The CMHT continue to review and support Mrs R at home. It is likely she will need to move to 24 hour care if her physical and mental health continues to deteriorate.

Case Study 5

Name: Mrs C

Age: 87

Diagnosis: Vascular Dementia

Reason for Referral to Occupational Therapy/Just Checking

Mrs C's niece raised concerns via the out patient's clinic that she was becoming increasingly disorientated in time. Other residents at her housing complex had reported she was knocking on their doors at inappropriate times, both early in the morning and late at night. They were concerned she may actually be leaving the building at night and getting lost. Her niece was also unsure whether she was eating regularly as there was no evidence of cooking taking place in Mrs C's apartment. Mrs C insisted she was eating her main meals out in Leeds and Harrogate on a daily basis.

Outcome of Initial Assessment

An Occupational Therapy Functional Assessment was carried out and this included the installation of the Just Checking System. Sensors were placed in each room with Mrs C's consent, and additional sensors were put in the fridge and on the main door to the apartment.

It became clear Mrs C has a regular daily routine. We discovered she goes out at around 9am each morning to buy fruit for breakfast at a local store. We were also able to confirm she goes out again between 10.30am and 2.30pm every day.

During the period of assessment she always returned to her flat during daylight hours.

There was no evidence to suggest she was leaving her flat at night for long enough to go out of the building, but it was clear she did occasionally leave the flat at night or early in the morning to seek reassurance about the time from other residents.

We identified that Mrs C goes to bed around teatime; hence she gets up again about 1am at which time she often becomes disorientated and calls upon neighbours to seek clarification of the time.

Intervention/Care Plan

A Telecare memo minder was installed and set up to be triggered by a movement sensor in the hallway between the hours of 9pm and 8am. This prompts Mrs C not to go out between these hours.

Mrs C was encouraged to use aids to orientation including clocks, diary and written prompts.

ID cards were provided for Mrs C to carry in her purse, handbag and coat pockets. Mrs C was assessed going out and about on the buses and we ascertained she was safe crossing roads and was in fact well known in several cafes in Leeds and Harrogate.

Outcome

The Family were reassured Mrs C was not going out at night and was in fact maintaining a good diet.

Mrs C was able to maintain her independence and continue living in her apartment and going out on a regular basis in the daytime.

There were less reported instances of Mrs C disturbing other residents at inappropriate times.

Further OT assessment of Mrs C's ability to manage daily living tasks is continuing and her care plan continues to be revised to meet her changing needs.

Case Study 6

Name: Mr M

Reason for Referral to Occupational Therapy/Just Checking

Mr M was referred to the Mental Health Intermediate Care Team following an outpatient appointment with sector psychiatry. His family had raised concerns regarding an increase in confusion, deterioration in his functional abilities and were concerned that he may require 24 hour care.

His family reported that Mr M has been presenting as anxious and restless and was requiring increased support with meal preparation. He was also contacting them more frequently during the night.

Outcome of Initial Assessment

Mr M showed good insight into his difficulties and was willing to accept input from the MHICT.

There was evidence of word finding difficulties and the occasional inappropriate response to questions asked.

He described feeling low in mood and anxious at times, particularly at night. He was disorientated to time and person, reporting that he felt confused most of the time and had poor short term memory problems.

He reported losing confidence in his abilities and no longer went out alone due to feeling unsafe. Also there had been reports of weight loss.

An OT assessment was carried out which highlighted that Mr M became increasingly anxious when preparing meals and drinks, seeking reassurance throughout.

The Just Checking system was installed to further assess Mr M's routine, particularly nocturnal behaviour. The system was in place for a total of 4 weeks. The information gathered confirmed that Mr M was restless over night with no significant periods of rest. He appeared to have very little structure or routine to his day.

Intervention/Care Plan

The MHICT care team started by visiting three times daily to assess Mr M's mental state for evidence of low mood, anxiety, confusion and disorientation and the impact it was having on his functioning. Mr M responded well to input from the carers and a referral was made to the Community Support Team for rehabilitation of daily living skills. They increased their input to four visits daily as Mr M became increasingly confused and was experiencing day/night reversal.

A referral was made to Social Services for a home care package as it was identified that Mr M would require long term support.

He reported enjoying the visits by the Community Support Team and the structure and routine this provided his day.

Outcomes

The information gathered from Just Checking was discussed with the psychiatrist and Mr M was commenced on Mirtazepine 15mg nocte. This resulted in him becoming more settled over night and relaxed during the day. The improvements were noted by the Community Support Team as he became less anxious during activities and responded well to prompting. The Just Checking charts showed a more improved structure to his day and clear day/night periods.

He was given a diagnosis of probable Alzheimer's disease and commenced on Aricept 5 mg which was later increased to 10mg. Mr M remains at home and now has a home care package in place providing four visits per day, to encourage him with meal and drink preparation, medication compliance and personal care. He also has a day centre place.

Family Carer Feedback

Dear xx

That graph, just checking is brilliant; I rang mum and no reply. Looked on the graph and she was in bed at quarter to 5 Friday. I rang again and got her up. Most nights are calm, Also Friday, some one came in the flat at quarter to 11 until 5 to 11. Mum was at the day centre. I really worried about this and now realise it was the carer checking that fridge to do the shopping.

APPENDIX 2 - JUST CHECKING SYSTEM

Just Checking Professional is used for assessment, and planning care services. It is designed to be moved among service users and is quick and simple to install by any member of a community social care/mental health team.

Each kit has its own system number (30xxx) on the back of the controller and on the base of the carry case.



Equipment

- 5 movement sensors
- 2 door sensors
- Controller which receives data from the sensors and uploads it to a web-server via integral mobile phone unit. Controller is plugged in to a mains power socket.
- Velcro pads
- Robust carry case
- Installation instructions and video

Features

- No telephone line required.
- Data uploaded every 5 minutes, so the system is virtually real time.
- Sensors are radio based and require no wiring. Sensors are installed with supplied Velcro pads.
- Additional sensors can be added for larger properties.

Web-service

The web-service provides password protected access to the activity charts and the features to manage the change of service user. It retains all the historical data for each service user and provides statistical information about when the equipment was used and who with. Staff who are using the system can ring the Just Checking helpline for support when they are installing or using the system. The web-service is paid annually, or for 3 years and covers:

- Access to the activity charts and management system
- Unlimited number of users
- All mobile network charges
- Annual battery replacement (automatic reminder, and battery pack send out each year).
- Replacement Velcro
- Helpline for staff

APPENDIX 3 - PROJECT INITIATION DOCUMENT

1. Name of Project: Just Checking Telecare Pilot

2. Project Aims:

- To support improved assessment processes for people with memory problems who live alone in their own homes.
- To facilitate early discharge, shortened hospital stays and admission avoidance for the target group of people.
- To provide additional evidence in support of improved targeting re home care and 24 hour care assessments.

Due to the pioneering nature of the project the staff will also be expected to disseminate preliminary findings to colleagues with the aim of a) promoting the use of Telecare and b) to share examples of good practice with other teams using the systems across the country.

3. Resource Allocation:

Capital Requirements:

5 units at a total cost of £5900 of which £2460 is an annual charge for a web based system, renegotiable at the end of the pilot.

4. Revenue Requirements:

Just Checking requires an annual fee to be paid for each system to access the web based system. A one year fee (for all 5) has been included in the project costing above. Service users will not be charged for the service.

5. Resources required to deliver the project:

Access to team OTs and CTMs to deliver training and provide daily clinical management of the use of systems.

Access to service users fitting the criteria for inclusion.

Access to data for the evaluation.

Professional leads time to support the leadership and coordination of the project over the 12 month period.

Just Checking to provide technical and other support to staff using the systems.

Resources to share and disseminate findings.

6. Team Membership:

Ellen Bragger, 'Just Checking' OT and trainer.

Jeanette Dowden, Telecare Project Manager, Leeds

Alicia Ridout, Practice Development Lead OT

Christine Roworth, OT - project innovator and co-project lead.

MH ICT & CMHT Ots

Team CTMs

CSM rep

Social Work manager

Project Sponsor: Gary Hostick

Project Manager: Alicia Ridout (Christine Roworth)

7. Key Tasks and Milestones:

Task	Time frame
1. Purchase of 5 systems and completion of training	End March
2. Agreement of data collection methods/systems	End March
3. Six month review & interim evaluation	End October
4. Evaluation & report	End March 2009

8. Benefits:

The pilot will aim to provide evidence of:

1. Prevention of admission as part of acute service provision (MH ICT).
2. Facilitation of early discharge, including home leave trials, thereby reducing lengths of stay (MH ICT).
3. Improved targeting of home care provision at assessment for those with complex needs (MH ICT & CMHT).
4. Provision of additional evidence for future planning, for 24 hour care assessments (CMHT) and delaying the need for longer term care.
5. Efficiencies re use of staff time and therefore team capacity.
6. Improved experience and outcomes for service users and their carers by improvements in the above areas.

9. Start Date: April 2008 Completion Date: April 2009

Appendix

Inclusion Criteria:

- Memory problems, with/without dementia diagnosis.
- Living alone at home.
- Difficulties clarifying appropriate care package.
- Further assessment of routine especially at night, regarding wandering/purposeful walking behaviour, sleep patterns, nutritional habits and so on.

Focus on patients who may be:

- Candidates for a trial of home leave from inpatient wards which may add to assessments or facilitate early discharges.
- To support further assessment under the care of MH ICT.
- To clarify increasing needs pre admission via MH ICT or CMHT care.
- To evaluate levels and impact of deterioration on service users living alone at home where there has been concern expressed by others and admission or move to care may be a consideration.

APPENDIX 4 - PROTOCOL

Principles

The Department of Health has endorsed the use of assistive technology as one means of supporting vulnerable people to live at home. Developing the use of assistive technology for older people with mental health problems is part of the Older People's Mental Health Strategy (2007-2010.) However, awareness of ethical dilemmas regarding the potential for invasion of privacy must always be a consideration in the use of any assistive technology with vulnerable people.

Project Aims:

- To support improved assessment processes for people with memory problems who live alone in their own homes.
- To facilitate early discharge, shortened hospital stays and admission avoidance for the target group of people.
- To provide additional evidence in support of improved targeting re home care and 24 hour care assessments.

Due to the pioneering nature of the project the staff will also be expected to disseminate preliminary findings to colleagues with the aim of a) promoting the use of telecare and b) to share examples of good practice with other teams using the systems across the country.

Process for Obtaining & Installing the System

There are 5 Just Checking units available for use across the Older Peoples Directorate, 3 within Mental Health Intermediate Care teams (North west/north, West South & North East/East) and CMHT (South/SouthEast) Each of these units will be stored in a locked cupboard at 3 base sites when not in use (2 at Linden house, 2 at Towngate house and one at Aire Court).

The 'Just Checking' system will be allocated and installed by members of the Just checking Telecare Pilot and with completion of the appropriate documents (see Appendices).

There is no charge to the service user for time-limited use of this system through this pilot scheme's approval.

Allocation

Each OT will assess the need for allocation against the inclusion criteria (See below) using the Referral Checklist (Appendix 1). Each OT is expected to promote the involvement and co-operation of service users as fully as possible in the use of the Just Checking system. This should involve, as a minimum, discussion with the service user about the system and its purpose prior to its use. During this discussion capacity should be assessed and documented within the notes (See Installation Checklist Appendix 2).

PID Inclusion Criteria

Essential criteria are:

- The service user lives alone and experiences memory problems.
- Difficulties clarifying appropriate care package.
- Further assessment of routine especially at night, regarding wandering/purposeful walking behaviour, sleep patterns, nutritional habits and so on.

Focus on patients who may be;

- Candidates for a trial of home leave from inpatient wards which may add to assessments or facilitate early discharges
- To support further assessment under the care of MH ICT
- To clarify increasing needs pre admission via MH ICT or CMHT care.
- To evaluate levels and impact of deterioration on service users living alone at home where there has been concern expressed by others and admission or move to care may be a consideration.

The referral will then either be accepted or declined. If declined the reasons for such will be feed back to the referrer.

Once the referral has been accepted the Key OT will follow and completed the process as stated on the Installation Checklist. (Appendix 2) A standard covering letter and/or Just Checking leaflet is available for agencies/other professionals or family (Appendix 3).

Capacity

When the initial discussion with the service user leads to a conclusion that the service user does not have capacity to consent to the Just Checking system's use, it is vitally important that staff are clear in their determination of best interest specifically in relation to the use of Just Checking. When an OT has identified a case where capacity is unclear and/or there are other factors influencing the decision they should discuss the potential benefits of use of the system with their line manager.

If the outcome of the capacity assessment concludes that the service user has capacity to consent to, or decline, the Just Checking system's use, the service user's views and wishes must be respected in all cases.

When the referral has been accepted for the Just Checking system, allocation for each system will be in date order, unless there is an urgent need for one. In this case negotiation will be had within the Key OTs to temporarily transfer systems for an agreed assessment period. At the end of the assessment period for that service user, the expectation is that system will be returned as soon as possible to the originating OT. All loans and reasons from such will be documented and feedback to a central point.

The following standards for Just Checking have been agreed by the Pilot team-

- The system will be in situ for a maximum of 4 weeks.
- Data will be reviewed a minimum of once weekly by the Key OT or MHICT team.

Training/Equipment issues

Leeds PFT have a year contract with Just Checking to cover maintenance of the equipment and a subscription for the web service. Therefore if the equipment isn't performing properly Just Checking should be contacted (01564741822) whilst also keeping Ellen Bragger (Ellen.Bragger@justchecking.co.uk) informed of any such issues.

Just Checking will provide training sessions for staff, which cover how the equipment should be sited and how the website is set up and used to read information. These training sessions should enable staff to feel confident in installing and using the package. The movement sensors fix to the wall with tape, and do not require specialist fitting. Consideration needs to be given as to where they should be sited in order to give the most useful information for each individual i.e. which doorways, corridors etc. The Control Box does not have to be fixed down, but again thought should be given to where it is positioned e.g. out of sight if it is likely that the service user may turn the unit off.

Just Checking will provide support via the telephone (01564741822) and will talk people through individual installations as necessary.

Installation

Installation of the Kit, the Installation Checklist (Appendix 2) and creation of the web account will be completed by the Key OT. Carer/family feedback forms to be given/sent where consent has been gained.

Reviewing the data

The data will be reviewed (minimum x1 weekly) by the Key OT and/or team members, with the results assessed and documented as appropriate.

De-installation

The OT/team will discuss with the Service User when the system will be de-installed. The OT will de-install the system, complete the Installation Checklist, including Service User feedback, close the web account and document a summary as appropriate.

Throughout the process each OTs will keep a copy of the Key documents (Referral Checklist, FACE and MOPOT tool).



Appendix 1

Checklist for use of just checking (To be completed by allocated worker prior to allocation of just checking system)

Re: Service user NHS Number:.....

Allocated Worker: Team:.....

	Yes	No
Are there difficulties clarifying appropriate care?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a need for further assessment?	<input type="checkbox"/>	<input type="checkbox"/>
Does the service user have capacity?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, does the service user consent to installation?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, does the service user consent to share information?	<input type="checkbox"/>	<input type="checkbox"/>
Does the service user live alone?	<input type="checkbox"/>	<input type="checkbox"/>
Does the service user have memory problems?	<input type="checkbox"/>	<input type="checkbox"/>

If the service user does not have capacity, please attach mental capacity assessment (including determination of best interest).Reasons for use (including assessment period and level of urgency).

Service user has consented to share information with:.....
.....

Line managers approval: Yes No

If no, reason not approved:

Referrer and date



Appendix 2 – to be completed by allocated worker

Written agreement for Just Checking

Re: Service user NHS Number:

I accept that the Just Checking System will be

loaned to the address of : (address)

..... for the period of

I accept that the Just Checking System remains the property of Leeds Partnership Foundation Trust throughout this period and that it will be returned to the department.

I accept that the Just Checking System website will be checked by a Leeds Partnership Foundation Trust Employee on a confidential basis on at least a once weekly frequency.

.....
Signature – Service User/Carer

.....
Name (Please PRINT) – Service User/Carer

.....
Staff Member (PRINT Name)

.....
Dated



Please circle supporting evidence source: FACE CPA Reports Verbal Feedback MOPOT

Name NHS No.....

Allocated OT/Team

Referrer (Name, Role Contact no.)

Criteria/Issue

Comments/Evidence

- Memory problems
- Lives alone
- Further evidence to support targeting of care package
- Further assessment of routine
- Supporting team assessment or diagnosis
- Assessment to avoid hospital admission
- Assessment following deterioration
- Concern expressed by others re safety at home
- Assessment of night time routine/activity re wandering/purposeful walking/sleeping
- Assessment of changes in activity post medication change
- Supporting assessment to facilitate early discharge from hospital e.g. home leave

Current Involvement

- Home Care:

Planned, In place, Under review, CST

- Professionals (list)
- Carer (unpaid/informal) Please name, with relationship to person referred

Other information

.....

.....

REFERRAL ACCEPTED

REFERRAL DECLINED - Please state reasons

Referrer informed



CARER (Care worker) FEEDBACK ON JUST CHECKING SYSTEM

What do you think of the 'Just Checking' system?

.....
.....
.....

What were the best aspects?

.....
.....
.....
.....

Where there any areas of concern?

.....
.....
.....
.....

If you have log in access, how useful have you found this?

.....
.....
.....
.....

How do you feel we could improve the use of the system?

.....
.....
.....

Many thanks for your help.



INSTALLATION CHECKLIST

System Number 30	NHS No.	Account Name:
OT/Team	Date & Time Installed	Date & Time de-installed

Discussed system with Service User
 (Max installation 4 wks, Min data review x1 weekly)

Leaflet given

Capacity
 Assessed and documented in notes

Need to involve CTM

Consented to inform to following services/other parties and discuss/allow access to data where appropriate

.....
.....
.....
.....

SENSOR	ALLOCATED (Please initial)	SENSOR CHECKED	COLLECTED (Please initial)
Bed			
Bath			
Lounge			
Kitchen			
Ex1			
Front Door			
Back Door			
Control Unit			

Any additional information re. allocation

.....
.....
.....

WEB ACCESS GIVEN TO	AGENCY AND ROLE	TYPE OF ACCESS

SERVICES INFORMED	DATE	METHOD

Care Plan Completed/updated

Date:.....

SUMMARY FROM JUST CHECKING DATA
- - - -

FEEDBACK DISCUSSION WITH SERVICE USER

Name:

Signature:

**Christine Roworth-Gaunt,
Occupational Therapist**

Leeds Partnership NHS Foundation Trust
Asket Croft, Asket Drive
Leeds LS14 1PP
tel 0113 305 7003

Just Checking Ltd

Appledore Lodge, Blind Lane,
Tanworth in Arden, Warwickshire B94 5HT
tel 01564 741822 info@justchecking.co.uk

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