

**Transforming Lives:
Partnership Reported
Telecare Case Studies
2008-11**

DEMENTIA

2008/9

We can report two incidences of telecare smoke alarms being activated. One resulted in the fire service attending a service user's home where a fire had taken hold and required him to be lifted out of his home by the fire service and the fire brought under control. The other was an elderly service user suffering from dementia that had left a pan on her cooker before falling asleep, again the fire service were called to attend and made the situation safe. These two examples highlight the effectiveness of telecare despite the limited number of packages we have in place presently.

Something as simple as a chair sensor for a client (a retired farmer with severe dementia) has enabled him to sit at ease in his armchair in his lounge watching his beloved fields/farm animals/goings on. This has settled him after being confined to bed, and means his quality of life is greatly enhanced and his relatives are assured of his safety with responsive services to hand.

A lady with dementia was in hospital. She lives with her elderly husband and has a history of night time walking. This lady was unlikely to return home due to lack of management of the walking issue. We provided a wander alert linked to an onsite carer pager. This allows her husband to be awoken via a pager and a gradual light. He can in turn get to the front door and street to support his wife to return home. This was a direct alternative to long-term care and we are hoping to trial a GPS locator system to further increase this lady's support.

A year ago, a client's son approached us. He was increasingly concerned for his mother's safety, due to her dementia and associated wandering. There was a real possibility of residential care being required. Instead, we installed door exit monitors while the son provided a GPS enabled mobile phone (placed in the client's handbag). While the operation of the equipment has meant considerable input from our control room operators and the client's family, the outcome has been positive. One year later, this lady is still living independently in her own home.

Mrs M was a very independent person and lived on her own. She began to experience memory impairment, and dementia was diagnosed. Her daughter supported her to remain in her own home, but as Mrs M's health declined, she

sought advice from social services. It came to light during assessment that Mrs M had on more than one occasion wandered during the night, but had been assisted to return home safely by a neighbour. Her daughter had become very anxious about these incidents.

Fortunately the worker involved in the case had a sound knowledge of telecare, and advised Mrs M and her daughter about the use of property exit sensors. With their agreement the sensors were fitted and Mrs M was able to continue living at home. Her daughter became less anxious, knowing that she would be alerted if her mum went outside at night. The quality of both their lives was enhanced. Gradually Mrs M accepted some assistance with personal tasks from home care services. Her health deteriorated further and she moved into a care home some 6 months later.

Mrs F is 85. She was admitted to hospital due to a recent illness. During the discharge process it became apparent that Mrs F was forgetful, and she was diagnosed with dementia.

Her family informed staff that she had a history of sleepless nights and were worried that she may wander outside of her home during the night. There were other concerns regarding her safety, which included a risk of fire, as Mrs F is a heavy smoker. After discussion and agreement with Mrs F and her family, smoke detectors, temperature extreme sensors and a property exit sensor were installed in her home.

Mrs F was discharged home and her family continue to be involved in her care but report that worry and stress had been greatly reduced. There have been a few false activations of equipment by family when leaving her home at night, but they informed staff that this provided added reassurance that the equipment works.

Mrs W is 44. She suffers from dementia, and was admitted to hospital in June 2008 after being found wandering in the street, unable to say who she was or where she lived. She was discharged from hospital in December 2008 once a telecare package, involving door contacts, a key safe, a smoke detector, a heat sensor, and flood detectors was provided in her home. Mrs W is now living independently and safely within the community once more.

2009/10

Mrs B is a 79 year old lady who, lives alone and has advanced dementia. She has a very stringent routine that has assisted in maintaining her in her own home. Her son visits every morning on his way to work and her daughter spends most of the day with her. However, her family initially struggled to cope with a need for evening visits after an incident when Mrs B lay on the floor all night, until found the following

morning. Two years ago Mrs B had received an initial package of telecare support that included smoke and heat detectors. After her fall, her family contacted the telecare service to see if there was any additional equipment that could assist. Home monitoring equipment was then installed, allowing members of her family to use the internet each evening to ensure that she is in bed.

Mr E is 79 and has dementia. He lives alone with the support of his daughters and attends a local day centre. He started to have falls in his home but was not able to use his community alarm to call for help. His daughters were very concerned at the risk of further falls and worried that he was possibly increasing this risk by getting up in the night. A telecare 'memo-minder' (a device which plays pre-recorded messages when it senses movement) was installed with a message from his daughter telling him to go back to bed, but this made him think she was in the house and go looking for her, so it was removed.

Lifestyle monitoring was suggested to Mr E and his daughter and they were keen to try it. Mr E's records showed a great deal of night time activity in and out of the bathroom, bedroom and kitchen as well as around the front door.

Mr E's daughter took copies of these reports to her father's next consultation with his Geriatrician and this information enabled the Consultant to prescribe medication to reduce anxiety and give Mr E a good night's sleep. Within a few days Mr E's night time activity was reduced to a couple of bathroom visits. He was still going to the front door a great deal during the day – 128 occasions on one day – so the Consultant, who had been planning to reduce his dose, increased the medication.

Mr E suffered a major stroke in March; the lifestyle monitoring system detected lack of movement in the morning and activated a red alert.

Mrs W is an elderly lady with severe dementia who wished to remain at home. Her son who is her main carer supported this wish but was concerned about his mother's activity during the night. Home activity monitoring equipment was installed to allow a professional assessment of the situation. Her son also requested that he be able to access monitoring data and this was arranged. The equipment picked up a pattern of movement in the middle of the night. It also showed that she opened her door sometimes during the night she wasn't leaving the house. As a result a door contact was fitted, linked to her son's mobile phone. Mrs W's son has been reassured that his mother is not at risk and he is happy for her to continue living in her home with support. Because the monitoring equipment is unobtrusive there has been no disruption for Mrs W, and the information gathered has allowed her social worker to introduce changes to her care package that enhance the support she receives.

2010/11

A short term telecare package was provided for Mr A, a dementia sufferer whose family went travelling for 3 weeks, leaving him alone in the house he shared with them. With a bed sensor and heat/smoke detector package he managed to remain in his home with only 2 check visits per week instead of 2 daily, saving 36 visits

Mr C started locking his doors because his wife was always leaving or trying to leave the house. She then started to climb out of windows - on one occasion climbing out of a kitchen window before dropping five feet to the ground and clambering through bushes. Mr C was afraid to sleep, and worried each time he went to the toilet. He was also not getting proper sleep during the night. A multi entry victimisation unit (£19.95) was installed (comprising six sensors, a receiver and two activation key fobs) which alerted him any time a door or window was opened and highlighted which door or window it was. This has had a tremendous impact on him and his wife, reducing stress, worries and helping to protect her dignity.

Mrs L is an 82 year old woman who has been walking at night. A 'Just Checking' assessment revealed higher than usual levels of nocturnal activity but could identify no pattern to predict when an event would occur. Over the winter the weather and extreme cold posed a high risk to this frail individual from both hypothermia and falling. Mrs L was disorientated each time the police spoke to her and took her home. During the 'Just Checking' assessment process, telecare options were being discussed and, given family insistence that Mrs L remain in her sheltered house, it was agreed that the 'Just Checking' system would be left in place to act as an emergency exit sensor.

A case conference was convened. The telecare implementation to date was explained and ratified by that meeting and a SeN-CiT+ was installed to provide an alert to night time activity and a text alert exit sensor direct to a family responder. Mrs L always takes her bag with her when she goes out and has regular care visits, so it was assessed that she would be a suitable user of GPS location equipment operating with a set boundary. This meant that at night time the family responder would receive an alert that she had opened the front door and if she had left the house Mrs L could be quickly located and returned safely to her home. The implementation was agreed by the Council legal advisor as being appropriate.

Our telecare coordinator met with Mrs L and explained that GPS location tracking would mean she would never be lost again, since family could quickly find her and help her return home. The agreement was that the morning care visit would include helping Mrs L to put the device on charge and the evening care visit would include helping her to place the device in her bag. The boundary and the exit sensor are

activated between 23:00 and 06:00 leaving Mrs L free to attend events within the sheltered housing complex.

The telecare has been in place 7 weeks; Mrs L was walking on average every third week. In 7 weeks Mrs L has only been outside her home for a few minutes on a handful of occasions at night and has returned indoors voluntarily. Mrs L is very curious about the devices and has managed to raise 'tamper alarms' on several occasions but we are reviewing these on a regular basis to ensure the optimum settings. Mrs L has recently been out in the early evening before she had her GPS locator in her bag and was returned home by the police. We are reviewing the protocols and have suggested that the GPS locator charging time is reduced to between the breakfast and lunchtime care visits. There is no plan to increase the boundary use because the aim is not to prevent Mrs L going out, but to ensure she may be found and returned safely if necessary. At this point the police will be asked not to stop Mrs L on sight because she is locatable and due to the frequency of care visits and family visits she will not have been out for more than an hour. This will be reviewed as the year progresses to ensure that the protocols minimise the risk from cold weather in the winter.

It has been suggested to the family that they use this time to agree between themselves how long a family response is feasible and to look at a selection of care homes to assist them with future planning. This telecare has been paid for through the care plan and not through TDP funding; this starts to make it sustainable and it can be recycled and used for another service user if Mrs L no longer needs it. The family and the care manager have both expressed satisfaction with the telecare and the family are discussing making a digital story for us to help other families understand the benefits. In conjunction with the technology provided, a range of more simple interventions have been discussed and some implemented; this is a good example of delivering a holistic approach to dementia care.

Mr R lived with his daughter in her own home. She was his main carer for roughly 15 years. Mr R had a long standing diagnosis of Korsicoff's dementia and was latterly diagnosed with terminal cancer of the jaw and oesophagus.

Mrs D was very committed to caring for her father and to doing this for as long as possible but was unable to get an unbroken sleep due to Mr R being unsettled at night. Door contacts were put in place in 2007 to alert Mrs D that her father was trying to leave the house and they remained in place until March 2010 when Mr R no longer made attempts to go out of the front door.

As Mr R's illness worsened Mrs D's sleep was being disturbed more often; while Mr R was no longer attempting to leave the house, he was getting out of bed and moving around downstairs.

It was agreed to install door contacts to Mr R's bedroom door that connected to a vibrating pillow in Mrs D's bedroom. This system was fitted with a key switch so there was flexibility to turn it off and on as required.

As Mr R deteriorated further the internal door contacts were replaced with a bed monitor package. No longer mobile for any distance, Mr R was spending most of his time in his bedroom and suffered a couple of falls out of bed when attempting to reach his commode. The telecare package was again adjusted; the vibrating pillow pad was removed and a mobile pager added.

Mr R passed away in June 2010. Mrs D expressed her thanks. She was impressed with the range of equipment available and the ability to tailor this to meet changing needs. Mrs D felt that the systems had enabled her to get more sleep at night, which in turn ensured that she was able to continue caring for her father as she wished to. She also felt that being able to keep Mr R in familiar surroundings saved causing him upset as he did not adapt well to new ones due to his dementia.

Mr X, a service user with fairly advanced dementia, had become increasingly aggressive and confused, raising staff concerns regarding his behaviour

Mr X lives in a 'housing with care' (HWC) complex. Several female service users whose flats were located on the same floor as Mr X's flat reported that 'someone' was knocking on their doors in the early hours of the morning. The manager and staff of the HWC complex became apprehensive as the frequency of these disturbances increased. The HWC team manager conferred with the Telecare Service regarding the use of the 'Just Checking' system. Discussions took place with the family who had power of attorney regarding Mr X's finances and welfare. The implications, if it was found that Mr X was leaving the flat in the early hours of the morning and knocking on the doors of other tenants, were fully explained to the family. Consent to install the 'Just Checking' system was gained.

The equipment generated a chart of activity incorporating *the bedroom, the front door area, the bathroom and the front door contact*. Carer activity was noted and discounted prior to undertaking analysis of the data. When analysing the remote data collected, the following movement patterns were noted. There was activity in the flat throughout the night (12:30 am – 5:00 am) for several weeks. When *front door contact* activity showed thick lines, these were compared to the times reported by other service users that their front doors had been knocked. On these occasions the times matched.

Mr X's dementia deteriorated during the period of assessment with Mr X being intercepted on several occasions by other service users when trying to leave the complex after 10:00 pm in his night clothes. Following a further risk assessment the Crisis Care service organised overnight care to ensure Mr X was safe until the allocated community care worker completed a further assessment.

PARKINSON'S DISEASE

2008/9

The client is a 90 year old frail gentleman living alone. He has Parkinson's disease resulting in poor mobility and a stooped posture. He uses a Zimmer frame with 1:1 support for mobilising. He can be forgetful at times and will try and walk without support or his mobility aids. He is unable to manage the stairs and has to sleep in the sitting room. He uses a commode beside his bed. The client does not appear to have insight into his rapidly deteriorating health and the need to wait for assistance when mobilising. He is trying very hard to maintain his independence which increases the level of risk when he is alone at home, specifically during the night, when he will try to use the commode independently, resulting in increasing falls.

The client is high priority for a residential placement. Crossroads care has been increased to supplement his attendance at a day centre. His family decided to provide sleep in cover in conjunction with a nocturnal bed monitor installed on 25th October 2008. The alarm was placed in an upstairs bedroom to notify the carer if he exits bed during the night.

Feedback from the family indicates that the alarm has been very beneficial in providing reassurance. They no longer lie awake listening for him. Unfortunately the alarm was discontinued after one week due to the client realising that family members were on site, and he vacated the bed much more frequently seeking social contact. His family felt this was unsustainable for them and withdrew from sleeping in. Two night support visits are now in place.

2009/10

No case studies reported

2010/11

Mr K is 53 years old and lives with his son and daughter who are both young adults.

Mr K was diagnosed with Parkinson's disease in 1994 and now has marked dyskinesia, which can give impaired control over muscle movement, resulting in spasmodic involuntary movements and potential falls. His medication was not always being taken at the correct times, resulting in poor control of his condition.

Mr K was admitted to hospital after becoming unwell with a urinary tract infection (UTI). On admission he was confused, disorientated and physically frail. He received treatment for the UTI, had extensive physiotherapy and a medication review, and was assessed for a care package to allow him to return home.

Prior to admission his sister filled a dosette box with his medication and his family prompted him to take it. At the discharge planning consultation, discussion took place about the difficulty he has in remembering to take his medication as well as the problems in using the dosette box due to the tremor in his hands.

On the advice of a telecare outreach worker he was provided with a telecare package comprised of a lifeline unit, pendant, smoke detector and a Pivotell medication dispenser with a tipper. He was given the opportunity to familiarise himself with the equipment in hospital and this proved to be successful.

Mr K returned home with a care package after 3 months in hospital. The amount of support required from his family has reduced and they are no longer required to prompt him to take his medication. His sister still continues to fill the dispenser, but is more confident that he will be able to manage. Mr K also feels that he is more independent and after being home for 4 weeks his care package was reduced by 1 visit a day.

EPILEPSY

2008/9

A fall detector and wearing a pendant has provided full cover to a young adult whose parent has to regularly respond to her sudden onset epileptic seizures. The presence of the pendant enables the parent to both call for help without leaving the client, and administer first aid.

Telecare equipment has been provided to a young woman who has epilepsy and a 2 year old child. She has a history of falling down the stairs. She can now be left alone with the child and feels greatly reassured.

2009/10

No case studies reported

2010/11

Mrs M is 37 and is married with 2 children aged 6 and 8. Her husband works full time. Mrs M has long standing epilepsy and mental health problems. Her memory has been greatly affected due to seizures over the years.

She has care input every day to help her care for her children; this is in the form of verbal prompts and reminders, as she is physically able to carry out all tasks. Mrs M wanted to be more independent in caring for her children and to be able to go out on her own without getting lost.

Mrs M was provided with a personal digital assistant (PDA) device programmed with cognitive support software. Prompts and reminders give routine to her days and remind her to collect the children from school and carry out parenting duties without the need for carers. This has proved very effective and carers report that she is responding to and acting upon the prompts appropriately.

Her phone SIM card is to be added to the device, which will allow her to use it as a mobile phone and for it to be used for travel training and possibly as a locating device.

Mrs M is pleased with her increased independence; her self esteem has increased and she has asked if we can add in an exercise programme to the PDA to improve her fitness and help with weight loss.

Miss P is 32. She lives alone and works full time. She has a diagnosis of epilepsy. She is an existing community alarm service user as she sometimes requires help following a seizure. Her father supports her when she has seizures but worries that he can't always be there or know where she is; Miss P's work involves visiting people in the community, for which she uses public transport/taxis.

Her seizures occur day and night, with sufficient warning to raise an alert. The seizures alter her level of awareness and mostly the help she requires is for someone to talk to her, until she recovers and recognises where she is.

Miss P is very practical and proactive in managing her condition, and is determined to continue in her job and to keep up with leisure activities. She wanted to depend less on her father but to feel safer when out.

Miss P was provided with a locating device (a mini telephone with built in GPS and the option to set a 'geofence' (safe area)). If she goes outwith the geofence, or presses the panic/alert button, an identified person and/or response centre is alerted by text message and/or e-mail. They can then access a secure website showing her location.

Miss P now feels safer when out working; if she has a seizure and is in a confused state, she can be reassured by contact centre staff until she recovers or helped in accordance with set guidelines and protocols. She is able to continue to engage in leisure interests locally and now has the confidence to visit family and friends further afield. Her father has been provided with greater reassurance and he and Miss P have been able to achieve a more normal father/daughter relationship.

Miss T, a 19 year old woman with epilepsy, was sleeping in her mum's bedroom. This caused a lot of anxiety and stress within the family home; her younger sister was jealous and her father had to sleep on the sofa in the living room. Mum was not getting a proper night's sleep as she was listening out for her daughter having a seizure. After an assessment, an epilepsy sensor was installed (£170.00) in Miss T's own bed that activates a pager in her parent's room. She now sleeps in her own room, her sister is happy about this, dad gets to sleep in his bed and Mum gets a good night's sleep.

A student social worker asked for advice in a complex epilepsy case. Mrs Y has very frequent seizures, normally managed by her family. Her husband needed to attend hospital for four sessions of chemotherapy and there was family anxiety that we would insist on his wife moving to a care home in the short term because of other pressures on the other family carers. The situation needed sensitive handling because anxiety was exacerbating things and this family had never asked for social

service help before. We successfully introduced an Emfit sensor in the bed to avoid a need for waking night staff and reduce anxiety for the family. The student social worker completed the installation and trained the family and care staff in what they needed to do. The family of Mrs Y was able to continue their lives as normally as possible and having gained confidence in us and in telecare we anticipate being able to suggest other equipment that might support them in their role as carers in future.

FALLS

2008/9

Mrs W is an 80-year-old lady. She experienced a period of illness, which resulted in decreased mobility, and a loss of confidence, and was admitted to an intermediate care facility for rehabilitation. The staff had concerns with regards to her safety and a risk of her falling when she returned home. She had a bed occupancy sensor fitted, which was configured to work in conjunction with her bedside light. She was also supplied with a fall detector. Both Mrs W and her daughter reported that having these devices assisted in rebuilding her confidence. Mrs W felt after a few months that she did not want to use the fall detector any more, as she no longer required it.

2009/10

S is a 92-year-old lady. S sustained a fall and as a consequence had become very weak. She was very dependent on her daughter to do most things for her and was admitted to an intermediate care centre. Whilst there a physiotherapist assessment confirmed weakness in her lower limbs and reduced balance, making S prone to falls. S spent approximately 10 weeks at the intermediate care centre before going home, during which time she received regular physiotherapy and was supported by staff to regain a degree of independence.

In preparation for discharge a care manager discussed the case with the Telecare Co-ordinator who advised that a bed occupancy sensor and a fall detector could be installed, but initially had some reservations with regards to the suitability of the fall detector, believing that S might not be able to adapt to wearing the device. However, both S and her daughter wished to pursue the option.

The equipment was installed on the day S was discharged home. There were some teething problems but, despite the initial reservations of the Telecare Co-ordinator with regards to the fall detector, S managed very well. In the mornings, a home carer assisted S with her personal care and with positioning her fall detector.

S's daughter is aware that her mum is frail and still at risk of falling, but now sleeps better at night knowing that if her mum does fall, staff will be alerted and will respond quickly. She feels that she can now spend quality time with her Mum.

This equipment has supported S's independence and enhanced the quality of her life without placing any restrictions on her lifestyle. Although S continues to experience some falls, she is able to continue living at home. Early intervention enabled S to become accustomed to the equipment. Habits have been established that have lasted. It has also improved her daughter's quality of life, giving her piece of mind and helping to reduce the anxiety that she had previously experienced.

2010/11

Mr E is a 90 year old man who had been residing in a Council nursing home. He was very unsettled and was asking to return home frequently during family visits.

Mr E experienced a number of falls whilst in the nursing home. He has mobility problems but requires the toilet frequently during the night. As Mr E would be living alone it was agreed to try a bed exit monitor as a way of notifying his family if he did not return to bed after 20 minutes. His son and daughter live locally and on his return home it was agreed that they would respond overnight to the bed exit monitor and call out warden response if required, whilst mobile wardens would respond to any calls received from a pendant.

The bed exit monitor was reviewed shortly after it was installed. A concern raised was that the bed exit monitor appeared to be going off but when family checked on Mr E he was in bed asleep. After discussion it became apparent that Mr E was rolling over and off the bed exit monitor onto the other side of his bed, although this had not been normal behaviour for him previously.

A second bed exit monitor mat was purchased and installed and this has reduced the number of false activations and now the mobile warden response service answers any activation to allow the family respite.

Mr E is much more settled and happy at home than he had been in the nursing home and his family are reassured that there is an appropriate response to any falls he experiences.

Mrs V is 56. She was referred due to falls and neurological problems that cause her severe problems with pain and balance. She had community alarm equipment in her home where she had to press her pendant for assistance if she had a fall; at time of referral she had called for assistance on 2 occasions.

Mrs V said that she had recently woken up and found herself lying on the floor thinking she was in her bed but when fully awake it became apparent to her that she must have suffered a black out and had been on the floor for over 5 hours before coming to. She said she couldn't go on like this as she was terrified of collapsing and having a severe injury or dying and nobody finding her for days.

Mrs V confided that she has been feeling very low due to her illness and had been prescribed anti depressants by her GP and that she had tried to take her own life by swallowing excessive amounts of medication.

She was asked if she would be willing to try a new automatic fall detector. It was explained that this would automatically send a call to the control room if she were to collapse on the floor. Mrs V was a bit reluctant as she had tried a different fall

detector in the past and couldn't cope with the high amount of false alarm calls it caused, but agreed to give it a try.

The new fall detector has proved a success. On a follow up visit Mrs V said it had been great and she had worn it to bed and felt it was much better than the previous one she had used.

During the last visit to check on the continued suitability of the equipment, Mrs V threw her arms around the care co-ordinator and told her that she had changed her life and she would never be able to thank her enough. She said that due to having the security and peace of mind that if anything were to happen to her she would get help, she no longer felt alone anymore and that her mood had lifted. Her GP, family and friends have all noticed a great change in her. Mrs V said she was now in discussions with her GP to begin reducing her anti depressant medication and was getting out more with the help of her sister who visits regularly and that this was all down to having more peace of mind.

LEARNING DISABILITY

2008/9

One client with Down's syndrome has managed to move alone into her own tenancy with reassurance provided to an aging parent that help can easily be called for.

Ms J is 19. She has a mild learning disability, and lives with her parents, although she hopes to move into her own tenancy in the near future.

Ms J suffers from epilepsy and has a history of falls. Her parents were concerned about her having a nocturnal seizure during the night and them being unaware of it. They had resorted to using a baby monitor during the night, which left Ms J with very little privacy.

As Ms J is working towards independent living, her parents were keen to see if telecare equipment could be used to support her more effectively and discreetly during the night. A telecare package was installed comprising:

- A fall detector for wearing during the day.
- An epilepsy sensor to detect nocturnal seizures, linked to a telecare base unit in her parent's bedroom to alert them during the night.

Ms J has reported that her telecare package has given her a lot more privacy, and is really pleased that she doesn't have to have a baby monitor in her room any more. She also feels more independent because her parents are happy to leave her alone in the house now.

Her parents have indicated that the telecare package has had a dramatic impact on their lives, providing them all with more freedom and choice.

Prior to having her telecare package installed, Ms J was regularly admitted to hospital on an emergency basis for treatment of injuries associated with her epileptic fits. Since having her telecare equipment installed 8 months ago, Ms J has only had to be taken to hospital once for treatment for a minor head wound. On all other occasions, either her epilepsy sensor or Ms J herself has been able to alert her parents when she has felt a seizure coming on.

Mr M has a learning disability. He works in supported employment as a litter picker. The job involves learning new routes through housing estates that are unfamiliar to him. He was having difficulty managing time spent on individual streets and also remembering the routes.

A Personal Digital Assistant (PDA) was provided for Mr M. This equipment provides a task-scheduling programme and also photographs of the streets and routes for helping to manage Mr M's daily work tasks. Training on how to use the PDA was provided for Mr M and his job coach.

The PDA is enabling Mr M to carry out his job more independently. It is also assisting him to expand his work responsibilities by increasing his ability to learn more routes. It has helped with his time management and reduced his reliance on his job coach. His family also report increased self-confidence in relation to his work.

2009/10

No case studies reported

2010/11

D, who has learning disability, had his 24 hour care package reduced by 5 hours daily with the simple installation of a smoke detector and a community alarm. Subsequent installation of a door sensor allowed this to be reduced to 9 hours a day. Mr D has capacity and appears to have been over-protected by a care package which was badly in need of review.

OTHER

2008/9

One homeless service user has been able to move from supported accommodation to independent living due to the support of telecare. His medical condition makes him vulnerable and he can now readily access emergency services, which on one occasion has saved his life.

Mrs H is 84. She lives in a local authority tenancy. Although not diagnosed with dementia, Mrs H has poor short-term memory and presents as confused at times. She is supported at home by Home Care and until recently only had a dispersed alarm and pendant as part of her support package.

Although Home Care are providing meals for her, it was noted by them on several occasions that Mrs H continued to cook for herself, and there was evidence of burnt pots and food and at times the cooker was left switched on. Both the cooker and fire are powered by gas.

A Mobile Warden response service was arranged for Mrs H, as she had no local contacts able to respond to passive alarm equipment, and smoke and gas alarms have been installed. She retains her pendant so she can call for help in any other emergency situation. When activated, the smoke and gas alarms register at a control centre, where specific instructions are in place to contact the emergency services to attend.

The installation of the passive alarm equipment has enabled Mrs H to continue to cook if she chooses and has removed the necessity to install a cooker isolator switch.

Within a few days of installation in a client's home, lifestyle monitoring equipment was clearly showing that she is spending most of her time, by day and night, in the lounge. This raised the question as to whether she is actually going to bed at all and her social worker has been informed.

The equipment also recorded that she had opened her front door on a number of occasions close to midnight and during the very early hours of the morning. This was reported to her GP by the family, resulting in the early detection of a urinary tract infection, for which she was given treatment.

It is now planned to consider whether the use of additional telecare sensors would be appropriate at this time (risks associated with the demonstrated behaviours appear to be minimal and managing the response during the night may be difficult for the

family). A door open alert or property exit alarm or bed occupancy sensor could potentially help keep the client more safely at home.

The family feel the lifestyle monitoring equipment has given them an objective insight into their mother's living pattern when she is alone in her home. They have found this very reassuring (she has been awaiting a place in a residential home for over a year) and proactive in managing any deterioration in her condition.

Officers have now concluded lifestyle monitoring equipment will undoubtedly have a cost effective impact on care arrangements and long term placements and have strongly recommended that the partnership invest in this equipment as a helpful assessment tool for Occupational Therapy and Social Work practice teams to use for promoting independence and safety.

2009/10

Mr F is a 60 year old man with Korsakoff's syndrome resulting in confusion and wandering at night. He also has severe memory loss. Due to his condition, and to allow him to remain at home, he had a 24 hour care package to support him. A telecare package was installed, including smoke and heat sensors and a property exit sensor. Since the installation of the equipment Mr F has not required overnight care. His brother lives close by and if any of the sensors are activated he is able to attend within a short time.

Mrs J is a 90 year old lady who received a community alarm service in March 2007. In December 2008 she became unwell and was admitted to hospital in a confused state. She was treated for a urinary tract infection and although fit enough to be discharged from hospital she was admitted to a local nursing home for a period of respite. Mrs J made a good recovery but it was felt she would not cope if she returned home so permanent residency was sought. In May 2009 a 6 week review meeting took place that established Mrs J was not settling in the nursing home and wished to return to her own home. Her family were supportive and willing to act as responders should a door alarm be activated. This alarm was fitted, together with smoke and gas alarms and Mrs J returned home for a 4 week trial period at the beginning of June 2009. To date there have been no activations from the equipment and Mrs J has settled back into her home.

2010/11

Mrs G is a 53 year old lady with Motor Neurone Disease. She lives with her husband and has 2 daughters (not living at home) who are both deaf. Since being diagnosed her ability to communicate with her daughters via text or e-mail had diminished due to decreasing hand function. Mrs G has now been supplied with an environmental

control system, which gives her the ability to control her door entry, lights and heating. But most importantly we have given her a means of controlling her computer and therefore of allowing her to maintain 2 way contact with her daughters.
