Appendix 2

Case study Mr H

Referral received 11th October 2023 via supported discharge from the acute setting via (Pathway 1 from the trust, which is home with a POC). This was following from a hospital admission from an infection Care commenced 13th October (the day of discharge) with support of 4 calls a day with the assistance of 1 carer.

Therapy attended post discharge to ascertain a therapy plan and person-centred goals. Mr H said he wanted to be supported to regain confidence in managing his own personal care, and bathing. A powered bath lift was supplied, and grabrails to give confidence. Personal care was supported by the care staff while Mr H gained improved confidence post discharge from the acute.

During Mr H recovery period his care and therapy plan were reviewed and amended as he improved. As Mr H recovery has stabilised a full care act assessment was completed on 2nd November 2023. Mr H was fully able to participate in the assessment and able to express his progress and care needs and wishes. The result was that Mr H had recovered to prehospital admission level and was now independent with his care needs and the forma package of care was able to stop, Mr H and the assessor felt that support with medication reminders would be an advantage so a referral to Telecare Services was made for pill dispenser. The outcome being that Mr H was independent and yet assured in the area of medication mitigating the need for ongoing medication monitoring calls from care staff. A very good result for Mr H. Reduction was 14 hours of care.

Appendix 3

Case study Mrs CE

Referral received 5th October 2023 via supported discharge from the acute setting via (Pathway 1 from the trust, which is home with a POC). This was following from a hospital admission from a longstanding medical condition. Care commenced 13th October (the day of discharge) with support of 4 calls a day with the assistance of 2 carers. (2 carers were needed due to mobility issues)

Occupation Therapy and Physiotherapy attended post discharge to ascertain a therapy plan and person-centred goals. Mrs CE said she wanted to be supported to regain confidence in going to the bathroom herself as she has done this herself prior to her hospital admission. Equipment was issued by the OT a Re-Turn (this is a piece of equipment that can be operated by 2 trained staff and Mrs CE for transfers, this is a more inclusive and mitigates the needs for hoisting)

When maximum therapy input and care staff support had stabilised a full care act assessment was undertaken. Mrs CE was fully able to participate in the assessment and able to express her progress and care needs and wishes. This assessment took place 26th October 2023. The outcome was that Mrs CE would need a long-term package of care but now with the intervention of therapy only 1 carer was needed for 30mins a call, a referral to voluntary services that offer socializing events. The care package had reduced from 28hrs per week to 3 ½ a week. Mrs CE was also delighted that she had regained her mobility and independence