Appendix: C

Reablement Service: Emily's Journey

Background information:	'Emily' is an 80-year-old female who was living independently prior to a fall on the stairs. She was referred to the Reablement Service for initial support, consisting of 4 visits totalling 2.25 hours of care per day, following her hospital discharge.
Admission & health conditions:	Reason for admission: Emily was admitted to UHL after a fall at home having sustained a left clavicle fracture (non-weight bearing for the next 4 / 6 weeks). Main diagnosis: Chest infection which was treated during admission. Background health: Diagnosed with Bipolar and Schizophrenia, Hypertension and Type 2 Diabetes Mellitus. No concerns raised regarding capacity and decision-making.
Reablement intervention:	Emily had soreness/redness on buttocks and central back area. **Action:** Referral made to SPA (NHS Single Point of Access). Referral also made for pain patches to be changed once a week. Pharmacy & GP surgery were not aware of hospital admission and medication. changes. **Action**: Discharge letter taken to surgery and new prescription sent to pharmacy. Emily was using carrier bags to line the commode bowl. **Action**: Packet of commode liners provided. Emily had lost her confidence with taking medication. **Action**: Reablement Assistants helped re-build confidence. Emily was unable to consume a hot drink safely due to hand tremors. **Action**: Steady mug put in place for safer drinks consumption.
Outcome/s upon discharge from Reablement Service:	Reablement support was reduced gradually over her 4 weeks of service, and Emily regained her full independence and required no ongoing care.

Reablement Service: Mr Popat's Journey

Background information:	'Mr Popat' is 81 years of age and was admitted to hospital, with disease progression (leukaemia) and reduced mobility. He was referred to the Reablement Service with 2 calls a day with one care worker and initially 2 weeks of support were allocated.
Goal setting:	The goals that were identified once on the Reablement Service were as follows. - To be able to carry out all care tasks independently. - To regain strength and confidence. - To regain confidence when accessing the bath, there was no equipment required. - To help reduce carer strain.
Actions undertaken upon assessment by the **Allocated Worker:**	The Allocated Worker struck a positive rapport with Mr Popat and through a telephone assessment managed to establish progression to date. Mr Popat also felt comfortable with a particular Reablement Care Worker, which helped improve his confidence levels when accessing the bath. Given the positive progress being made the support was extended for one more week. By the time the follow up call was made Mr Popat had accessed the bath, managed his own care needs and was feeling very confident and positive about his ability to manage without support.
Goals achieved:	Mr Popat has improved independence and increased confidence. Mr Popat is now managing to access his bath independently. He has established his own routine with personal care needs. This has reduced carer strain and increased awareness of support available. Mr Popat, being a private person, was supported by 1 regular Reablement Care Worker, which enabled his dignity and removed a barrier to accepting the support he needed initially. Mr Popat continues to live at home independently where he feels safe and most comfortable.

Outcomes for the Reablement Service:	A very high customer satisfaction rate, with all goals being met. No cost for ongoing commissioned services. Furthermore, given this particular outcome, there was no face-to-face assessment required by the Allocated Worker and equally no financial assessment, making it a much more efficient and an effective way of working in terms of productivity, without compromising on quality.

Reablement Service: Anita's Journey

Background information:	Prior to admission to hospital, 'Anita' was largely independent as a 76 year old, supported by her daughter-in-law with personal care. Anita is very close to her family and enjoys spending time with them.
Admission & health conditions:	Anita was admitted to hospital following a fall, in which she fractured her left neck of femur and had a hemiarthroplasty. She also fractured her left proximal humerus and was placed in a collar and cuff and sling, and this was treated with conservative management. She was non-weight bearing on her left arm and left leg. Anita has type 2 diabetes, Raynaud's Syndrome, Arthritis and Hypertension.
Persons wishes:	Anita wished to remain at home with family support. She wanted to be able to use stairs confidently to access first floor facilities in order to access her bedroom and have some privacy. She hoped to be able to manage showering and personal care independently, to be non-reliant on carer support.
Situation on assessment:	Anita was discharged home where she lives with her son, his wife and their 3 children. A rotunda was put in place, requiring the support of 2 care workers with all transfers.
Reablement intervention:	Initially a package of care via a commissioned care agency was in place with 2 care workers visiting 4 times daily. This was reduced to 2 calls daily, still with 2 care workers. Following Anita's Fracture Clinic review, a referral was made to the Reablement Service where 2 calls daily were in place for support with supervision of transfers, mobility, personal care, emptying commode. This replaced the commissioned care. A referral was made to ASC OT Services, to request bathing assessment Anita's progress was discussed at the Home First Multi-Disciplinary Team (MDT) meeting - fracture clinic details were confirmed in order to inform therapy input. Home First Therapy input was offered to reduce support from 2 care workers. Equipment was provided to aid bathing and toilet transfers.

	Exercises were provided to build Anita's strength and range of movement. Low level equipment was provided – a long handled brush to enable Anita to wash her lower limbs and back without carer support. Input was offered from Community Physiotherapy (NHS) to progress from using the rotunda to a walking frame, to support stairs progression and confidence building. A referral made to the continence service for assessment.
Outcomes on discharge from Reablement:	Following a short period of Reablement, supported by the range of community services within the system Home First offer, Anita was fully independent with transfers, mobilising independently with the support of a walking aid and was building confidence to use the stairs to access her bedroom which was an important goal for her. Anita was able to manage her personal care independently and had returned to her initial abilities. This meant that Anita was not reliant on carer support which was her initial goal. No on-going need for statutory support was identified. This was achieved through MDT working, co-ordination from the Reablement Social Work Team, Therapy support, including the timely input from Home First professionals and the Reablement Service.