APPENDIX 1

1. Mrs P age 63 years is referred to the Home Care Reablement Service, on discharge from hospital. Mrs P has a diagnosis of cancer, and is currently undergoing chemotherapy; she also has multiple sclerosis, which affects her mobility.

   Mrs P lives alone and is usually independent for all her care needs and uses a wheelchair to mobilise.

   The reablement service provided Mrs P with a half hour care visit daily to assist her with personal care. This care provision was reviewed by the senior care assistant one week after hospital discharge, and identified improved ability in her function. The senior care assistant then amended the plan of care, with Mrs P, and requested staff to supervise and prompt Mrs P to become more independent. Mrs P continued to improve during the next two weeks, and again her care was reviewed, Mrs P was subsequently discharged from the service having regained her previous independence.

2. Mr T, aged 82 years, was referred to the home care reablement service, following a break down in his informal care arrangements. Mr T has a diagnosis of dementia and Parkinson's. Mr T lives with his wife who is his main carer; Mrs T is now in poor health and cannot continue in her caring role.

   The reablement service provided a care package four times a day; this included emotional support to Mrs T. On review at two weeks it was identified that Mrs T required increased emotional support and the care visits were increased for a short period of time. By providing additional support, advice and encouragement to Mrs T, she was supported to continue in her caring role with support from carers, which resulted in a positive outcome for Mr and Mrs T.

   The package of care was reduced after 4 weeks, and Mr T was discharged with a package of care twice a day.

3. Mrs W age 84, was referred to the Rapid Access Rehabilitation Service following a fall and fractured clavicle. Mrs W is a very independent lady and lives in sheltered accommodation, with no social care support.

   A multidisciplinary assessment was completed by the Rapid Access Rehabilitation, and identified Mrs W required support with activities of daily living, fracture care and pain management.

   Mrs W was supported at home with a care package. Occupational therapist assistant provided her with additional equipment to support her to maintain as much independence as possible e.g. kettle tipper.

The physiotherapist provided her with an exercise regime to prevent longer-term problems with her fractured arm.

Nursing intervention in relation to pain management and general health needs.

Mrs W was discharged fully independent, with no on going care needs.

4. Mrs X was admitted to hospital for treatment of a chest infection. Mrs X has a diagnosis of Chronic Obstructive Pulmonary Disease. Mrs X did not have any social care support prior to her admission to hospital.

   Following a multidisciplinary assessment in hospital, by the Rapid Access Rehabilitation Service, it was agreed that Mrs X could be supported in her own home and hospital discharge was arranged.

   Mrs X was provided with care and equipment to support her with activities of daily living, which was reviewed on a regular basis as appropriate to her needs.

   The physiotherapist recommended some breathing exercises, to prevent further chest infections.

   On discharge from the service Mrs X was provided with a longer-term package of care, appropriate to her level of need, and family support with shopping and cleaning continued.