Appendix A

DTOC Case Studies; Adult Social Care impact on safe and timely discharges

People & Communities Overview and Scrutiny Committee

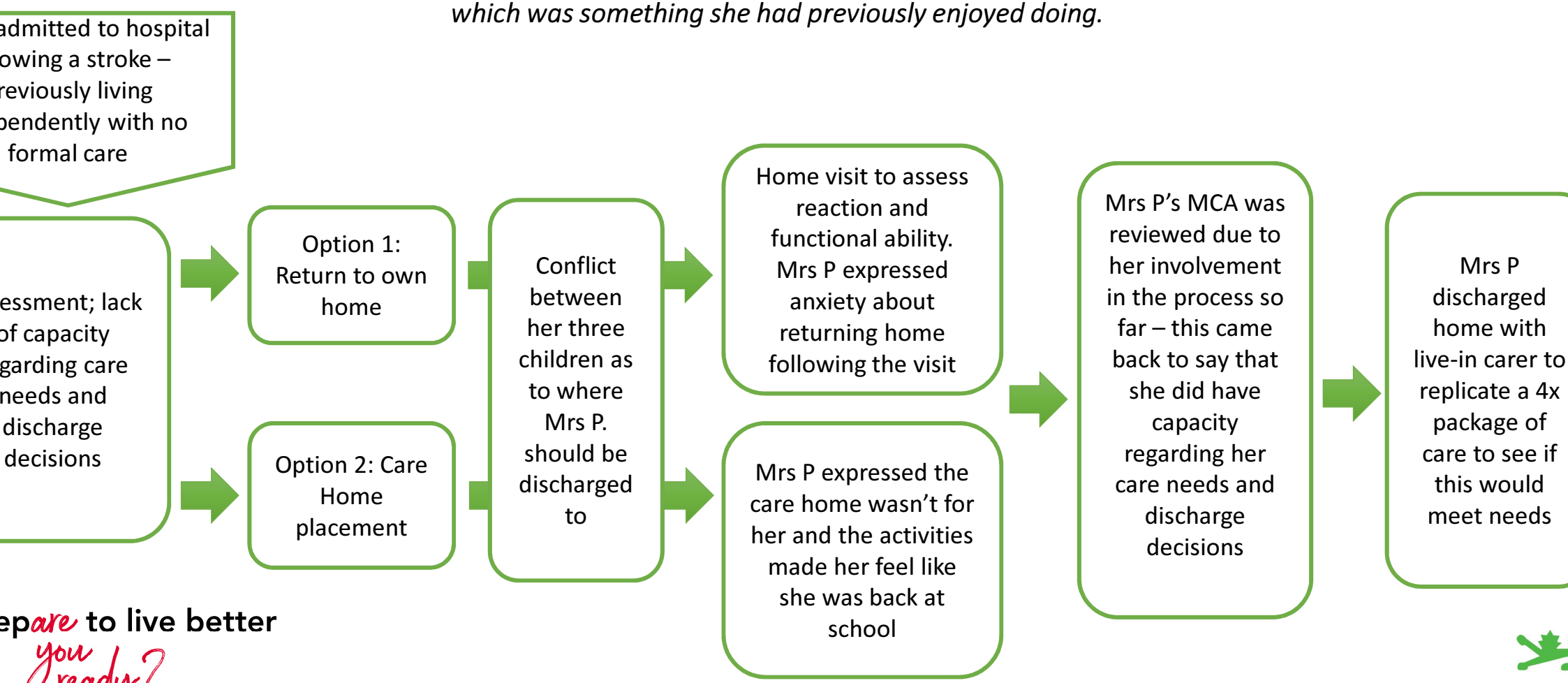
May 2018

epare to live better
you ready?

Dorset County Cou

onflict Resolution

P. suffered a stroke, resulting in Aphasia and cognitive impairment, impacting communication. Mrs P has a good relationship with her th ren and they support her, but not always daily. Over the past year they noted a decline in her cognition and that she had stopped going which was something she had previously enjoyed doing.



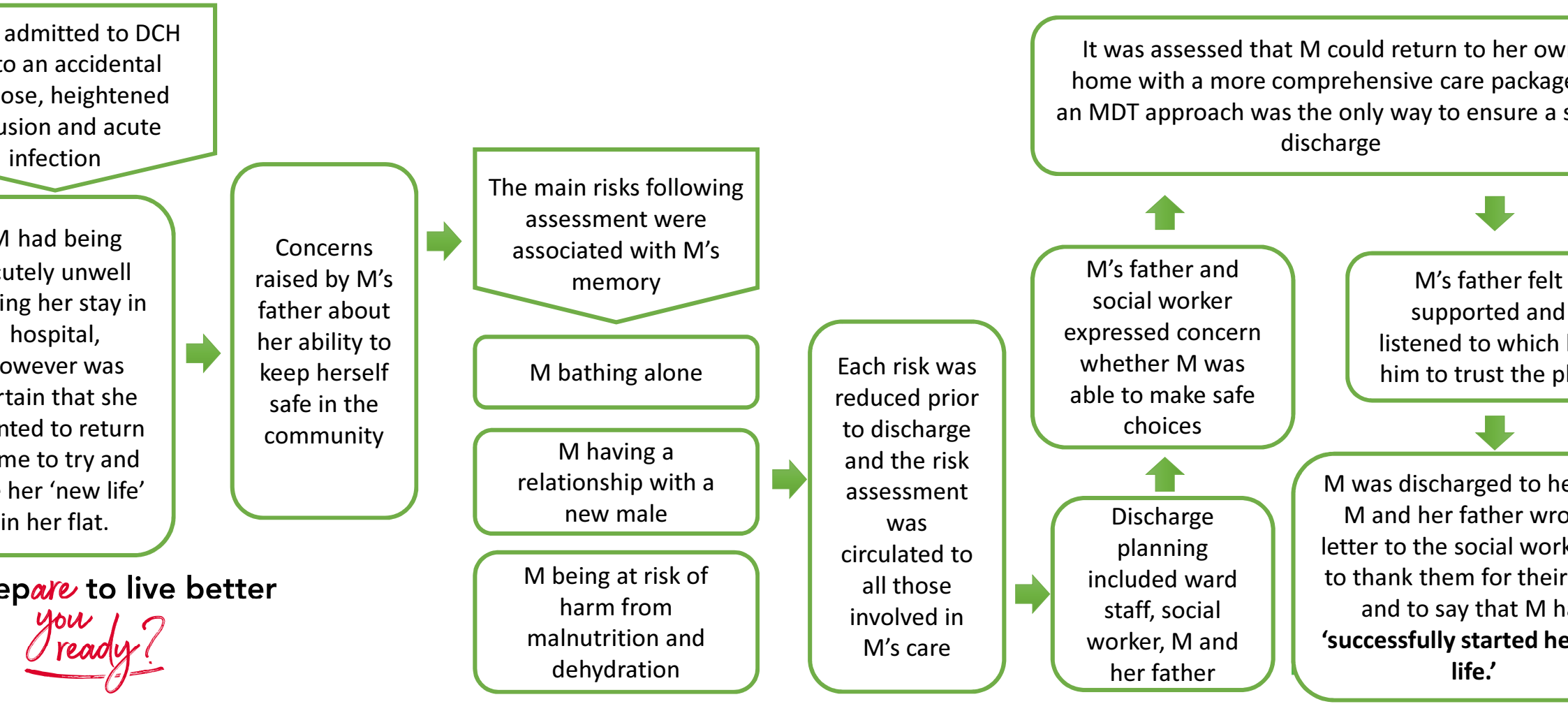
epare to live better

you ready?

Dorset County Cou

DT Approach to Safe Discharge

a 45 year old woman who has suffered brain injury following a heart attack in her 30's. She has a history of alcohol use, seizures cidal thoughts – she has 3 sons, is divorced and largely supported by her father. Following M's heat attack she spent 10+ years in specialist brain injury unit out of county, before being discharged to her own independent flat with morning reablement visits.



epare to live better

you ready?

lf-Neglect OPMH Discharge

, a 69 year old female was detained under S2 of the Mental Health Act - her husband suffered a cardiac arrest and had been deceased f ast a few hours before being found. Mrs R had a history of self-neglect and had not left her home for many years prior to admission, he sband appeared to be her main carer (unclear how much he did for her), the emergency services found Mrs R in a state of long-term se eglect. Mrs R had disengaged from GP, dental and optometry support for several years and had never claimed her pension. She has two daughters, but had lost contact with them over the years.

s R presented as ed on admission and on-compliant with care

time she started to ge with medication, equired prompting uld not recall times or medications

s R's personal care remained poor

Attempts to take Mrs R off-ward required much encouragement

She was discharged from S2, but soon after put on a DOLS

Multiple attempts to enable Mrs R to sort hr accounts were made, but eventually stopped due to refusal to engage

Mrs R was confused with events from many years previous when she was able to self-manage and did not believe that she needed support from carers if she went home

The ward assessment advised that they would be concerned about Mrs R returning home as they did not believe she would engage with a package of care – they felt that residential care would be a more suitable option

A plan was made workin together with the famil

A daughter visited and clea the property with a skip provided from the housi association

The ward, Housing Associat CMHT, DWP, Millbrook an care agency were also invo to enable her discharge wit a day visits

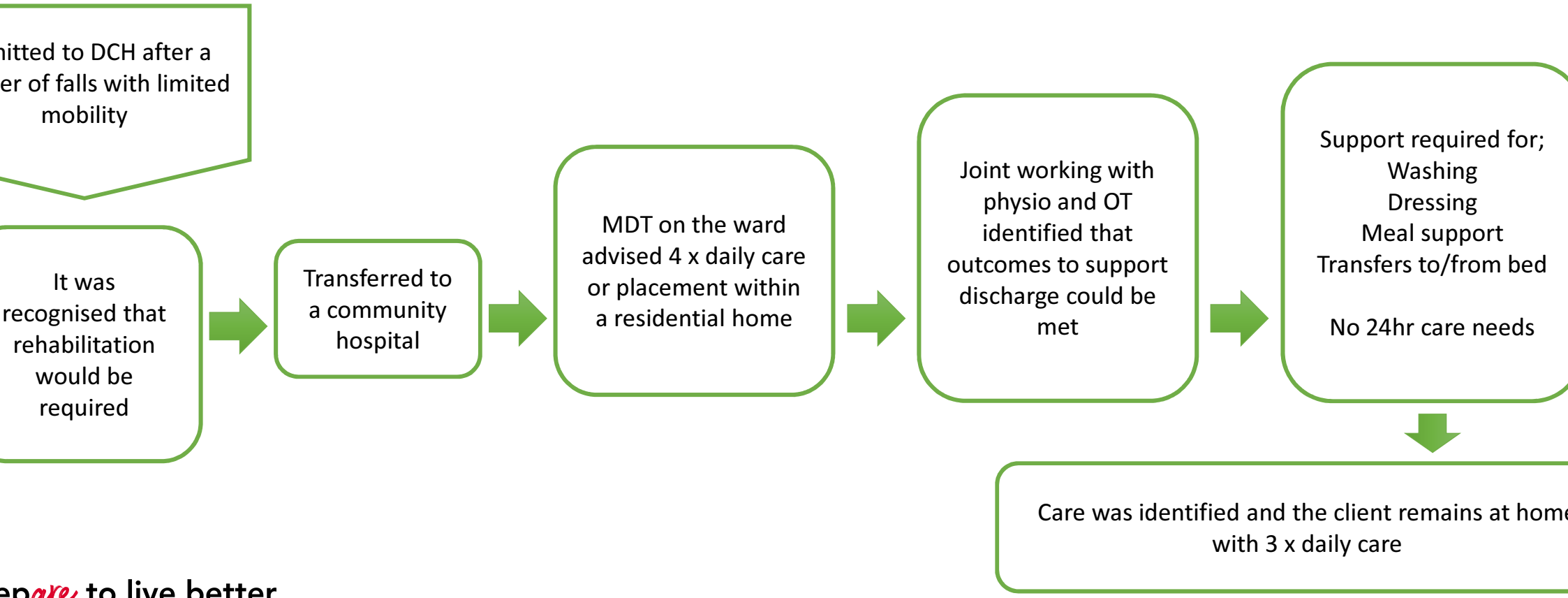
Mrs R has been home for month now without incide

epare to live better

you ready?

DT Discharge to Own Home

t lives in a village where her bungalow looks out to the local pub. Supported by her daughter who has just turned 70, family are important with grandchildren living locally. Prior to admission they were receiving support via a direct payment

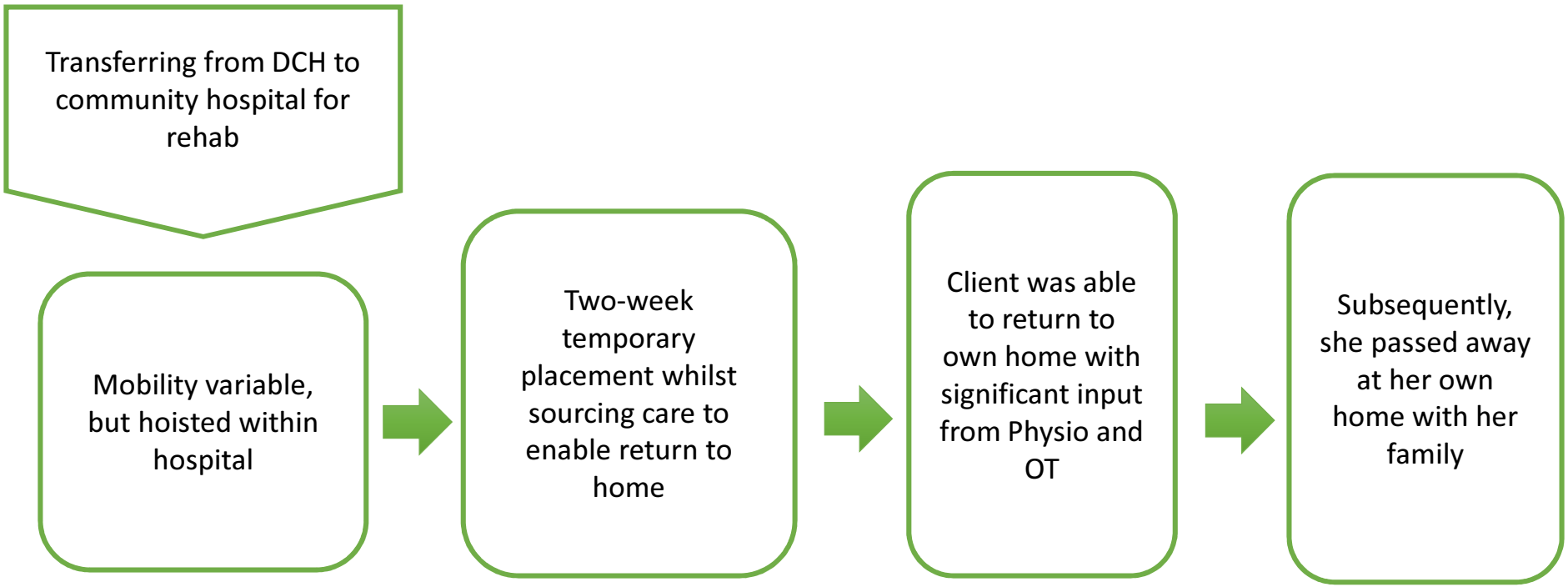


epare to live better
you ready?

Dorset County Cou

pported Return to Home Discharge

The client was admitted to Dorset County Hospital following a fall, she previously lived with her daughter in a park home.



epare to live better
you ready?

Dorset County Cou