Appendix A

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

People & Communities Overview and Scrutiny Committee

May 2018





inflict Resolution

P. suffered a stroke, resulting in Aphasia and cognitive impairment, impacting communication. Mrs P has a good relationship with her to 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.

admitted to hospital owing a stroke — reviously living bendently with no formal care

essment; lack of capacity garding care needs and discharge decisions Return to own home

Option 1:

Option 2: Care Home placement Conflict
between
her three
children as
to where
Mrs P.
should be
discharged
to

Home visit to assess reaction and functional ability.
Mrs P expressed anxiety about returning home following the visit

Mrs P expressed the care home wasn't for her and the activities made her feel like she was back at school

Mrs P's MCA was reviewed due to her involvement in the process so far – this came back to say that she did have capacity regarding her care needs and discharge

decisions

Mrs P
discharged
home with
live-in carer to
replicate a 4x
package of
care to see if
this would
meet needs

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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 Bidal thoughts – she has 3 sons, is divorced and largely supported by her father. Following M's heat attack she spent 10+ years in Especialist brain injury unit out of county, before being discharged to her own independent flat with morning reablement visits.

Each risk was

reduced prior

to discharge

and the risk

assessment

was

circulated to

all those

involved in

M's care

admitted to DCH to an accidental ose, heightened usion and acute infection

I had being utely unwell ing her stay in hospital, owever was tain that she nted to return me to try and her 'new life' in her flat.

Concerns
raised by M's
father about
her ability to
keep herself
safe in the
community

The main risks following assessment were associated with M's memory

M bathing alone

M having a relationship with a new male

M being at risk of harm from malnutrition and dehydration It was assessed that M could return to her ow home with a more comprehensive care package an MDT approach was the only way to ensure a discharge



M's father and social worker expressed concern whether M was able to make safe choices



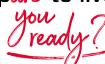
Discharge planning included ward staff, social worker, M and her father M's father felt supported and listened to which him to trust the p



M was discharged to he
M and her father wro
letter to the social work
to thank them for their
and to say that M h

'successfully started he

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If-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 j 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 sel 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 ould not recall times or medications

R's personal care remained poor

Attempts to take Mrs R off-ward required much encouragement

She was discharged epare to live better

from S2, but soon after put on a DOLS

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



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

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 working together with the family

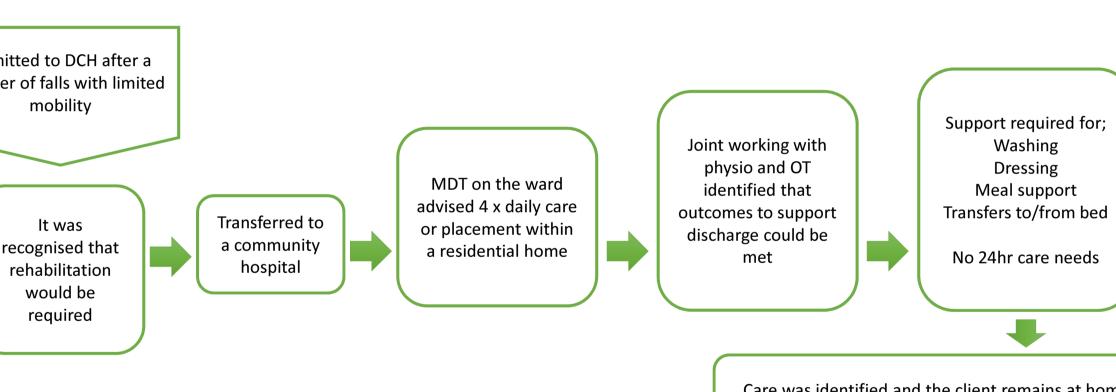
A daughter visited and clea the property with a skip provided from the housing association

The ward, Housing Associa 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

DT Discharge to Own Home

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



Care was identified and the client remains at home with 3 x daily care

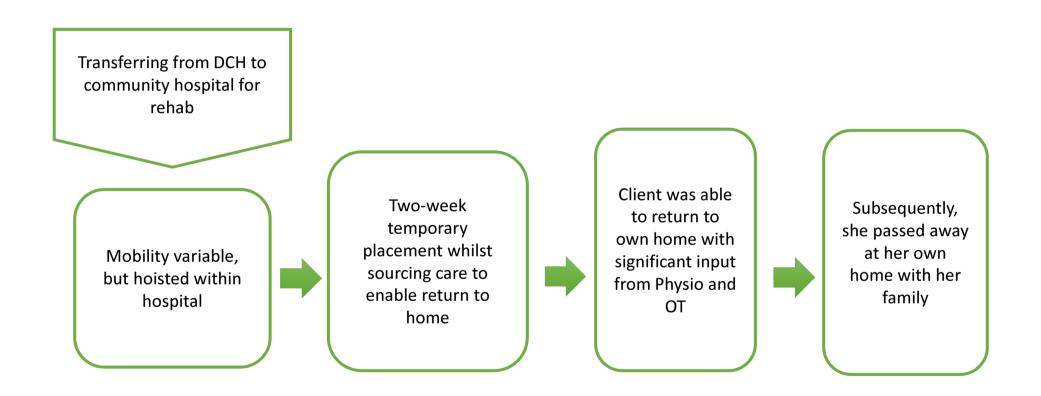
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pported Return to Home Discharge

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



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