North Northamptonshire Council

Transforming North Northamptonshire Council's Adult Social Care Provider Services 2022

Case examples

Case example 1: Small changes, Big differences

Following a period of illness and recent hospital admission, Mrs C had been left with weakness in all four limbs, poor core control, fatigue and significantly reduced mobility. Prior to admission Mrs C had been independent with mobility, all daily activities and was driving. Her goal was to return to this level of function, and she was determined to achieve this. Mrs C required a stand aid and assistance of 2 carers to support a transfer. She was also requiring support with personal care.

Mrs C actively engaged with Physiotherapy and Occupational Therapy during a period of time. Mrs C was able to return home without formal care support. Mrs C had made significant improvements during the period of reablement and physiotherapy. She had achieved independence with activities of daily living and was able to mobilise more than 20 metres with 2 walking sticks or a 4-wheeled walker. Equipment was provided at home to maximise independence and ensure safety and a further referral was made to community Physiotherapy to allow Mrs C to continue her journey of recovery.

If Mrs C was discharged home without the opportunity for reablement, it would have had a significant impact on her recovery, and she may not have achieved the goals she set out to achieve. There is evidence which shows that deconditioning can occur if rehabilitation and treatment is delayed. This can also then lead to possible dependence on long-term social care. We know that there is a significant wait for Community Physiotherapy, which would assist her positively in her recovery, but any delay would be detrimental to physical and mental health and general wellbeing.

Case example 2: Mrs M

Mrs M had a period of stay at a hospital. She was initially assessed as needing 4 30-minute calls a day due to lack of confidence and the need for routine building. She required support with her personal care, as she couldn't manage some aspects of this. Mrs M also needed support with dressing due to mobility access issues. Upon leaving hospital, Mrs M was prescribed more medication than she was on before, so she also needed support with this aspect of her care also.

Reablement will have worked with Mrs M to support her with her personal care and dressing needs by putting a long-handled sponge and grabber in place. They then would have worked with her to show her how to use these safely and effectively, which would then build personal confidence. It was identified that Mrs M knew that she needed to take her medication, but she was becoming confused, as there were so many new boxes. As a result, Reablement would have contacted her pharmacy and arranged for blister packs to be put in place. When the blister packs arrive, Reablement would be able to monitor this for a few days until they were sure she was able to take her own medication independently.

Reablement implement solutions by discussing people needs in MDT meetings. Reablement would be able to end a service with no further actions. In Mrs M's case, she would have left feeling happy and independent once more.

If Mrs M did not receive the support from Reablement, she would have potentially needed access to a long-term package of care. This could have had a substantial impact on her mental health, as she did want to be independent, and wanted to have an active social life. If she were to have 4 care calls a day, it would limit her social interactions.