

**CASE STUDY 1**

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| **Area** | Sedgemoor |
| **Type of case study** | Carer Breakdown |

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| **Background**  *Who is this about? What are the current circumstances and reasons for referral to CCS?* |
| Client was referred by Adult Social Care due to Carer Breakdown.  Client is an unpaid Carer for Partner.  During a visit to the Clients home, it was clear that they were struggling. The Cared for Person was becoming progressively more dependent on the Carer for support with everyday tasks. Being an older property, the only bathroom was up a spiral staircase that the Cared for was unable to navigate. They had to use a commode downstairs which Cared for did not like using so was urinating on the floor. The property was on the market and a sale had just fallen through which also impacted on the Carer.  Client was unclear of the process around permanently having their Partner placed in a nursing setting.  Client was worried about finances and how placement would be paid for.  The stress and anxiety of the partner and the sale of the property were causing the Client to have suicidal thoughts ‘Just so it would all stop’ |
| **Holistic Approach**  *What other issues were discovered whilst working with the client?* |
| After a long discussion with the Client, it was very clear that that they were unclear of the whole process with Adult Social Care and how they would move forward with the house sale.  Social Worker was spoken to, and it was agreed that Partner would go into respite for a couple of weeks so Carer could have some time to navigate the areas causing concern.  Finances were a main worry for the Client – Attendance Allowance was applied for. Estate Agents spoken to on Client's behalf to ask that they market the property and try for a quick Sale. Client was put in touch with CAB to ensure all benefits were being claimed.  Review of Care Assessment was requested.  After being in respite client returned home with a re-assessed package of care. Cared for deteriorated and was placed in a nursing home.  Meanwhile Client was approached and agreed to a move to new property and ‘swapped’ whilst waiting for the sale to go through as they could not bear living there any longer. |
| **What Were the Clients Goals?**  *Was there an outcome the client wanted to get to?* |
| To live in a safer environment with Partner and being able to care for them daily |
| **What Interventions Happened?**  *What things did you implement that meant the situation changed for your client?* |
| New Care Assessment was carried out by ASC after Cared for returned from respite and a package of care was put in place although they deteriorated and were placed in Nursing Home.  CAB helped with filling in forms and ensuring clients were on correct benefits.  Client was advised to speak to their Solicitor regarding the swapping of homes before a sale had been completed |
| **Outcome Achieved**  *How are things now for the client? What changed for the client?* |
| Cared for has subsequently passed away whilst in the Nursing Home.  Client is in their new property and sale has gone through.  Benefits have been updated and solicitor sorting Will etc. |
| **Challenges**  *What challenges or barriers did you come across. Did a new group need setting up, was the client resistant?* |
| Cared for deteriorating and needing more care.  Client moving into new property before contracts were signed.  Constant updating benefits with change of circumstances |
| **Client/Other Professional Comment**  *Feedback from the client/other professionals on their experience.* |
| Client – thank you for all your support through this difficult time |

**CASE STUDY 2**

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| **Area** | Home First |
| **Type of Case Study** | Carer support (Discharge to Assess) |

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| **Background**  *Who is this about? What are the current circumstances and reasons for referral to CCS?* |
| * Client is an unpaid carer / next of kin for a service user well known to our service. * The service user historically has not engaged with rehab / care nor wanted to take action to improve their situation. They are alcohol dependent. * Client is currently keeping all the service user’s fresh food at home as the service user’s fridge is broken and they are refusing to replace it. My client is therefore having to go to the service user’s property several times a day with food for them to cook or eat. |
| **Holistic Approach**  *What other issues were discovered whilst working with the client?* |
| My client has been providing informal support to the service user for many years but is really feeling the strain of having to go to their property several times a day. |
| **What Were the Clients Goals?**  *Was there an outcome the client wanted to get to?* |
| To be less relied upon by the service user (SU) and to reduce their carer strain. |
| **What Interventions Happened?**  *What things did you implement that meant the situation changed for your client?* |
| * Discussions with client about what would really make a big difference. A fridge at the SU property would mean my client would only have to go a couple of times a week to replenish the food supply. * Agent found a local supplier of 2nd hand appliances and found an under-counter fridge that was available for delivery. * Discussion with Line Manager that we can access a Crisis Grant to reduce carer strain. * Details of the supplier given to my client who made arrangements for delivery and paid cash. We agreed to reimburse. |
| **Outcome Achieved**  *How are things now for the client? What changed for the client?* |
| My client is now much less tied to the SU so has more free time for their own activities. |
| **Client/Other Professional Comment**  *Feedback from the client/other professionals on their experience.* |
| *“Thanks for all your help, it will make a big difference”* (Client) |
| **Grant Funding**  *Total amount of grant funding secured to achieve these outcomes.* |
| £80 |

**CASE STUDY 3**

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| **Area** | Taunton Deane |
| **Type of Case Study** | Care and respite request |

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| **Background**  *Who is this about? What are the current circumstances and reasons for referral to CCS?* |
| Referral from MDT - client has dementia and the partner is the main carer.  The partner has been struggling to manage for some time but things are escalating. Client has become more verbally aggressive, swearing and more resistant to care.  Partner is currently managing all personal care but is struggling.  Client is non-compliant with partner, shouting and telling them they are “not my partner”. Partner is finding it very distressing. Seen by GP and referred to me. |
| **Holistic Approach**  *What other issues were discovered whilst working with the client?* |
| Agent allocated this referral as both the client and partner were struggling to cope.  Agent visited the clients at home. Both were very settled and calm. The client’s partner gave a brief medical history of them both and explained that they (Partner) are undergoing treatment for Cancer.  On meeting the couple it was obvious that the partner is suffering from burn out. Agent and carer spoke at length regarding how an Adult Social Care assessment works and the benefits that would come from this as critical point has been reached and agreed to refer for an ASC assessment.  Agent explained to the couple about Micro-providers and how this may be a way to alleviate some of the pressure at least until an ASC assessment can be arranged. Agent put a request for immediate help on the micro-provider work group and received two answers from micro-providers with immediate capacity. Their numbers have been given to the couple to contact them. The couple are happy to fund this in the short term.  They also expressed an interest in having a stairlift installed to help get the client up and down stairs. Agent signposted them to a local supplier to visit and look a viable option as the property is relatively new and the couple were concerned about the fixture of a stairlift on the walls.  They are currently relying on having a mobile phone handy, but Agent explained that this would not help if the partner had an accident as the client would not be able to access the phone easily due to dementia. We spoke about a Deane Helpline/Somerset Lifeline and the partner is going to investigate this. This may also help to alleviate some of the worry they have regarding getting the client around the house without falling.  The partner wanted to know where they could get a wheelchair for the client so Agent signposted to the British Red Cross Mobility shop.  They would also like some help to access other support groups which would benefit them both. |
| **What Were the Clients Goals?**  *Was there an outcome the client wanted to get to?* |
| The client would like to be able to access the upper floor of their property without having to be virtually carried upstairs which they both feel is very unsafe.  Both the client and partner would like to get a wheelchair to make getting to appointments etc easier.  They would both like to get some help regarding personal care and respite.  Ideally, would like to access more support groups too. |
| **What Interventions Happened?**  *What things did you implement that meant the situation changed for your client?* |
| * Completed an Adult Social Care Referral and a request for a Carers support referral too. * Request for immediate help on the micro-provider group and received two answers from micro-providers with immediate capacity. Their numbers have been given to the couple to contact them. * Gave the client details of the British Red Cross mobility Aids shop so that they can find a reasonably priced wheelchair. * Found out that the couple both used to sing in various choirs so have also suggested attending a Singing for the Brain group with the Alzheimer’s Society. |
| **Outcome Achieved**  *How are things now for the client? What changed for the client?* |
| The client is now being cared for by both the partner and a wonderful Micro-provider.  The partner has now got access to respite time.  They have been allocated a referral and assessment for Adult Social Care for both cared for and carer.  They have been allocated a stairlift assessment.  They have been able to source a wheelchair for appointments and visits.  They have booked to go to Singing for the Brain classes. |
| **Challenges**  *What challenges or barriers did you come across. Did a new group need setting up, was the client resistant?* |
| The client was resistant to leaving the house as they needed access to a wheelchair.  The partner was afraid of the client falling downstairs in the home and the client was afraid of falling. |
| **Client/Other Professional Comment**  *Feedback from the client/other professionals on their experience.* |
| The client and partner have expressed gratitude for the assistance and support. |
| **Grant Funding**  *Total amount of grant funding secured to achieve these outcomes.* |
| No grant funding needed. |

**CASE STUDY 4**

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| **Area** | West Somerset |
| **Type of Case Study** | Carer Support |

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| **Background**  *Who is this about? What are the current circumstances and reasons for referral to CCS?* |
| Client self-referred to Village Agent. Client is carer to partner who has chronic health condition, and their physical condition has recently changed considerably placing more demand on client.  The client has no additional care support in the place at present, additional equipment has been supplied to support the condition of partner and to make caring easier.  The client wants more information about what support/solutions may be available if things change. |
| **Holistic Approach**  *What other issues were discovered whilst working with the client?* |
| The client did not want to meet at home, a convenient meeting point was arranged, and we discussed how things were for them at present, what concerns they had and what they wanted to achieve now and in the future.  The client explained they were now finding it more difficult to have time for themselves and had stopped going to things they had previously enjoyed. They realised it was important to still go out but could not see a way of doing this at present.  The client did not enjoy cooking but was becoming fed up with ready meals. |
| **What Were the Clients Goals?**  *Was there an outcome the client wanted to get to?* |
| * To know what support there is for carers. * To see if it would be possible for them to take a break if needed as worried about burning out. * Future realistic options for care provision and potential costs involved as self-funding. * To find out more about housing options if required |
| **What Interventions Happened?**  *What things did you implement that meant the situation changed for your client?* |
| Having worked with the couple before I knew the client liked to research and read information before making any decisions/conclusions.  After my meeting I emailed the client with all the appropriate links to websites.   * Taking time to listen to client and understand their current position, concerns, frustrations and expectations, talking through options and scenarios. * Provided information about Homefinder and how this could be an option if their current property was no longer suitable. * Signposted to Somerset Carers Website * Explained the benefit of a Carers Assessment and provided links to website to start the process of requesting an assessment. * Provided details of Local Care Homes/Residential Homes who provide short term respite solutions and cost estimates. * Signposted to local support groups applicable to partners health condition. * Signposted to local Carers Group * Signposted to other food suppliers who specialise in pre-cooked healthy meals. * Provided details/costs of how a Micro Provider could support client to allow them to go out again and have personal time, supplied guidance for appointing a MP and offered Village Agent support to source MP as and when required. * Signposted to Pairly website. |
| **Outcome Achieved**  *How are things now for the client? What changed for the client?* |
| * The client is now better informed of options/solutions they can use now and, in the future. * The client has all the links to be able to read and research at a pace that suits them but also knows a Village Agent can provide support should they need it. |
| **Challenges**  *What challenges or barriers did you come across. Did a new group need setting up, was the client resistant?* |
| None |
| **Client/Other Professional Comment**  *Feedback from the client/other professionals on their experience.* |
| “Thanks for all that, reading through that lot will keep me out of trouble for some time! And thanks again for this afternoon.    Speak/text/email again soon”. |
| **Grant Funding**  *Total amount of grant funding secured to achieve these outcomes.* |
| Not applicable |