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| **Case Study 1 – Mary**  Mary\* lives in a rural area of Somerset and was recently discharged from hospital into our D2A services.  She was not physically able to wash & dress, independently transfer or perform any tasks in the kitchen. She was identified as needing a package of care and whilst she was waiting for an assessment for ongoing care, she was a member of our goals trial.  The goals trial involved a therapist completing a task analysis digital form which broke down Mary’s reablement goals into a more granular level. This break down was available to the enablers who were visiting Mary each day, they could see how independent Mary was with each step on her previous visit and could update how she had progressed on each new visit. Mary’s case manager was then able to see how she was progressing day by day.  As the days progressed, Mary became more and more independent. Her 4 visits a day was gradually stepped down to 2 visits a day. Once Mary had achieved her goals of transferring with physical assistance, her goals were reset, and enablers were able to continue working with her using the form to progress each part of her goals. By the end of her time in the service, Mary was able to transfer more independently with the support of equipment.  Having shared visibility of goals, steps to achieve these and Mary’s progress available to all professionals involved in Mary’s care enabled everyone to work together to further increase Mary’s independence.  “I can see progress and make decisions with confidence and evidence” – Provider Case Manager |

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| **Case Study 2 – Maddie**  Maddie came onto our service in late September needing 4 visits a day. She had identified multiple ambitious goals to work on to build up towards living independently.  Throughout Maddie’s time in the service, her reablement provider gave regular updates on Maddie's progress against her goals in cluster calls (regular team meetings) and along with her assigned key worker, actions were agreed to support Maddie’s progress, remove any blockers and delays and continue to increase her independence. For example, when Maddie had progressed with her goals for specific reablement visits and they were no longer required, it would be agreed to remove them.  The provider, key workers and other professionals met regularly during cluster calls to discuss Maddie’s progress, supported by a central excel to record up to date information and any actions taken.  When the wrong medication was supplied, the provider was able to flag this quickly, and the key worker worked with a village agent to correct the medication and minimise the impact to Maddie.  As more of Maddie’s visits were stepped down, it was noted that she was struggling to remember to take her medication, again this was flagged quickly and the key worker worked with a pharmacy technician to source a blister pack.  When it was discussed that Maddie was managing fully independently apart from weekly shopping, her key worker took the action to explore support with this.  Shortly after, a micro-provider was sourced to help Maddie with her shopping and she was discharged without any formal support having achieved all of her reablement goals. |