Example A

Background

- Polly* has fallen at home
- 81 years old
- Lives with husband who has dementia
- Recent wedge fracture in her back and knee replacement
- Normally reasonably independent (Rockwood of 5)

*** Not real name, but based on real life example from SCAS service**

Joint holistic MDT Assessment identified the following problem list:

- Constipation
- Poor medication management
- Nausea and pain
- Poor nutrition
- Loss of ability to complete own personal care / domestic care tasks
- Care needs not met

Development of problem list following holistic assessment by service

Proactive response by team = reduction in multiple appointments / crisis management. Commissioners will need to identify what services are available within their regions

Care plan actions during and post visit (non conveyance):

- GP to review pain medication and prescription of laxatives and anti sickness medication
- Falls review undertaken, pendant alarm arranged
- Referral to wider team to monitor pain management, nutrition, bowels and nausea
- Bed / bed lever ordered for downstairs
- Referral to Orthopaedic consultant

Patient Feedback

"I'm so glad I didn't have to go to hospital"

Patient experience is key. Delivering this service will maintain an individuals independence to enable them to remain at home