Case Study (Joanne Appleby)

My name is Laura, I am 88 years old and I currently live alone in my own home. I have been very unwell over the last 18 months with heart failure and vascular problems in my legs, which has caused me to fall frequently. As a result I have lost a lot of confidence in walking around my property and I no longer go out. I also have urinary incontinence, diabetes and arthritis. I have been hospitalised on a few occasions over the last year due to falls and also because of confusion caused by urinary tract infections. However, I feel I function better at home and would prefer to remain living at home for as long as I can.

I live downstairs now in my front room. I have a hospital bed, a commode, and 4 care calls daily to enable me to do this. My only son lives in America but I do have a nephew, Barry, who supports me as much as he can. However Barry is 72 years of age and lives on the other side of Sheffield so this is taking a toll on his own health.

Service

By rapidly establishing open discourse and trust, between an Age UK Sheffield Independent Living Coordinator (ILC) and Laura, the struggles and difficulties she was experiencing were identified. Assistance was then given to enable Laura to manage her physical health and finances and get back in control of her life.

The ILC role includes: problem-solving, researching solutions, acting as advocate, accessing benefits advice, support planning, sign-posting and facilitated access to peer and professional support, and social contact. ILCs are expected to be creative, resourceful and ‘think out of the box’ as they challenge prevalent misconceptions and low expectations.

Outcome for the client

Laura was supported to write an “Okay To Stay” Plan in collaboration with her nephew Barry and also the community nursing team. This plan records how patients at high risk of hospitalisation, manage at home and lists strategies they employ to stay within their home environment. The aim is that patients with these plans will not be admitted to hospital unnecessarily because of miscommunication thus saving the NHS money.

Barry was supported to discuss respite options and how to access these. By accessing respite when needed, carer stress can be reduced leading to the carer being able to cope better longer term. This then means the caring relationship does not break down and paid for care or emergency hospital care is less likely to be required

Feedback was subsequently received from the Northern General Hospital stating that Laura’s Ok to Stay plan was invaluable in securing emergency respite for Laura in a quicker than average time scale.

Laura was referred to “A Call in Time” for telephone befriending to reduce feelings of social isolation

Laura was referred to the home library service to enable her to access books, audio books, DVD’s and CD’s. This enabled her to spend her time in a more enjoyable way and again reduced feelings of social isolation. Laura was issued with a free carbon monoxide alarm to make her home environment safer.