Appendix D

Case Study

Mr F is an 89 year old gentleman who was referred to us via a Social Worker. Mr F had recently been released from prison to a flat that was adapted to meet is need and he was also waiting on a package of care. The Social Work assessment identified concerns around Mr F ability to care for himself due to becoming institutionalised. He was using a wheelchair to support with mobility in prison which the Occupational Therapist felt may not be needed, therefore a reablement/ assessment bed was identified. Mr F was assessed as high risk from self-neglect. Mr F was accepted into the service based on the Social Worker assessment.

Mr F Goal/Recovery and Reablement Plan:

- Practice Kitchen skills
- Confidence building
- Relieve anxiety around socialising.
- Practice activities of daily living - personal care
- Build exercise tolerance and improve distance.

Mr F started working with Home First physio and physio technician from week 1 where he was practicing step transferring from bed to chair and walking a few steps around his room. From Week two Mr F progressed on to a four wheeled walker and walking distance of up to 20 metres with support from 2 persons. By week 4 Mr F was mobilising up to 50 metres with a four wheeled walker independently.
While Mr F worked with Home First therapy staff to improve his mobility, the Residential Care Officers worked with Mr F daily to support with personal care, they also completed kitchen assessments and medication assessments. They worked with Mr F to develop his confidence around others. Initially Mr F wouldn't leave his room, but eventually used the lounge and dining every day, chatting and socialising with other individuals.

The team worked closely with Mr F's Probation Officer, who was happy with the progress Mr F had made since been in BMH, they state he is like a new person, engaging with conversation and with others. The team also liaised with an officer from the Public Protection Unit to ensure Mr F met the requirements of his registration and they liaise weekly with Mr F's social worker to discharge plan.

Mr F has achieved his assessment/ reablement goals and while the outcome is for him to move to a long-term placement near his family. He is leaving BMH with increased mobility and not dependent on his wheelchair. Mr F's confidence has grown, he is engaging socially with others, and he feels like he is part of the community.