



Case Study – Dementia

Care and Support for a Client with Mild Dementia

Mrs Y is 81 and living on her own in a maisonette in a village setting. She is suffering from short-term memory loss and mild confusion, however whilst she can she wishes to remain in her own home.

There were several reports that Mrs Y would leave all her doors and windows open when she left the house, and would also do so at night. As such, concerns were expressed for Mrs Y's safety at night. Her family live fairly locally and see their mother as often as possible, but due to family commitment were unable to visit her at night. It was therefore decided that Mrs Y needed someone to visit her late evening to ensure the doors and windows were secure for her safety.

Allied Healthcare were commissioned to provide a package for 1 hour's evening visit each day to ensure Mrs Y's doors and windows were secure, and all electrical appliances were safely off. The workers were also able to ensure that Mrs Y had eaten her meals and taken her prescribed medication. As we were able to provide excellent continuity of Care Worker, we were able to utilise our Care/Support Diaries to monitor if Mrs Y was showing any deterioration in her condition.

Mrs Y looks forward to the workers visiting in the evening to have a chat and see a friendly face; they are able to prompt her if she has forgotten her medications and ensure that she remains healthy. The visits also gives reassurance to Mrs Y's family, knowing their mother has been checked on before bed and her home is secure. These factors allow Mrs Y to remain in her own home.

Care and Support for a Client with Moderate Dementia

Mrs R suffers from moderate dementia and her Son Mr J is her main Carer. As Mrs R's dementia has progressed it has been difficult for Mr J to maintain permanent employment and it was recognised that Mr J needed respite support to ensure that he continued in full time employment to support his own family. As Mr J is Mrs R's main Carer and also her legal guardian, Mr J chose to accept direct payments for the respite care for Mrs R. This was important as it allowed Mr J to fund respite in a flexible manner that best suited him and his mother.

Allied worked with Mr J to identify a flexible Key Worker who would be able to work around his work commitments and enable to have the respite from caring from Mrs R as her dementia worsened. This Key Worker provides a range of support for Mrs R, including personal care tasks, meal preparation and taking her out into the community. This ensures that Mrs R is able to continue with her chosen lifestyle, and that there are no differences between the support that we provide and the support that her son gives to her.

As a result of our service, Mr J been able to continue in full-time employment and is able to use the direct payments to purchase respite care for his mother in a flexible way.

Case Study – Mrs A

Mrs A was an 89-year-old lady who had been diagnosed with Alzheimer's disease, Parkinson's disease and diverticulitis. She lived at home with her husband, who had been acting as her sole carer. Due to her progressing diseases, he was no longer able to care for her alone.

Allied were requested to provide cover for 4 nights a week (22:00 – 06:00) and two sits during the day, one for two hours, one for three. The continuing care case manager visited Mr. and Mrs. A in their home to carry out an assessment, based on the Activities of Daily Living Roper et al (1980). Mr. A, and Mrs. A (to the extent that her reduced cognitive function allowed), was actively involved in this process. A plan of care was agreed between Mr. and Mrs. A and the Allied continuing care case manager. Because of Mrs. A's dementia, her community psychiatric nurse (CPN) was also consulted on this, to ascertain what help or expert advice he could offer.

The effect of the implement of the care package was immediately evident. Mr. A had not been sleeping very much; as he worried his wife may get up and fall or injure herself without him waking. He had also only rarely been able to leave the house as Mrs. A could not be left alone, and he found it very challenging to take her out. He had missed his own hospital appointments because of it, and simple tasks like shopping were difficult to organise.

When care started, he was able to get a good night sleep four nights a week, although it understandably took a little time for him to learn to trust the carers. The two-day sits meant that he was now able to make it to his own hospital appointments and do his weekly shopping. The stress he had been suffering from slowly eased, and it became apparent that this had also been affecting Mrs. A. After the initial phase of getting used to the carers, she also appeared less stressed and anxious.

After Allied had been providing care for approximately nine months, Mrs. A's condition had deteriorated, and her husband felt he required more assistance. It was her progressing Alzheimer's disease that was the main cause for concern. She had become more aggressive and had lashed out at her husband and carers. He no longer felt he could manage washing and dressing her alone in the mornings, as this had become quite difficult. The district nurses and the PCT continuing care nurse agreed, and Allied were requested to provide a carer for two hours each morning to assist Mr. A.

Due to the aggression she had shown towards her husband and carers, the Allied continuing care case manager requested a joint visit with the CPN. This was arranged and the two worked together to assess the risk and devise strategies to reduce it and devise an appropriate care plan. The carers who would be visiting received specialist dementia training from the Allied training team, and met with the Allied continuing care case manager to talk through the specific needs of Mrs. A and her care plan. Regular meetings were also arranged to discuss and evaluate the case, and carers were told to contact the case manager if they had any concerns or if the situation changed at all. Regular contact was kept with the CPN to discuss the effectiveness of management strategies and seek expert advice when required.

As a result of this, hospitalisation was avoided each time there were significant changes in Mrs. A's condition. These changes were, and still are, identified in their earliest stages, discussed with the CPN and new management strategies and care plans devised. Changes in Mrs. A's medical condition are also identified early, discussed with the

relevant health care professional, be it the G.P., Parkinson's nurse or hospital consultant. This, again, helps reduce the risk of the necessity for inpatient assessment or treatment. The Allied continuing care team continue to visit regularly, obtain feedback from Mrs. A, Mr. A and carers, and liaise with NHS staff as appropriate.

Mr. and Mrs. A remain happy with the service they are receiving from Allied. Mr. A is able to have a quality of life that would not be possible if he was still caring for his wife alone. He has also stated how happy he is that he has been able to keep his wife at home and that she has not had to go into residential care. This is something he desperately wants to avoid. From very early on in the package, Allied have been able to send the same carers the vast majority of the time. Mr. A has stated this is something he is very pleased about. He has nothing but praise for these carers and is very grateful to them for the difficult job they do.

The PCT also remain satisfied with the service provided by Allied. They receive regular feedback from us, regarding Mrs. A's psychiatric and medical condition, as well as information on the logistical side of the package. They continue to choose Allied for many of their new care packages.