**Case Study – Resident Supported in the D2RA Cyflawni Service at Marleyfield House, Buckley. Summer 2023.**

Mrs X was admitted into an acute hospital setting due to her experiencing severe weakness in her legs affecting her mobility and causing a high risk of falls. She was unable to safely remain at home in the care of her husband who is her main carer. Once in hospital, Mrs X was diagnosed with an exacerbation of her MS condition, and assessed by the medical and therapy team to confirm her treatment needs and ongoing rehabilitation/reablement plan.

As a result of her needing further reablement, a 'what matters' conversation and referral to Social Services was made by the ward which identified that her main expressed outcome was to return home with care and support and the care of her husband, and to regain her independence.

The hospital recommendation was that Mrs X would need four double handled care calls (Pathway 1) but preferably a consideration for further reablement within Cyflawni at Marleyfield House[1], under Pathway 2 of Discharge to Recover then Assess (D2RA) process, with the objective of increasing her level of functional and emotional independence to the reduce the level of support she would need in the community.

To promote Mrs X' voice and control to ensure her needs and perspective were actively listened to, the Cyflawni D2RA SW/ Admissions Co-ordinator contacted her to inform her of the reablement ethos within the unit and services provided within it, to enable her to make an informed choice. At this point she declined the placement offer but did explain that she wanted to reflect and speak with her husband and daughter for their advice.

Following Mrs X's discussions with her family, she agreed for them to visit Cyflawni to provide her with further information and gain their advice and support in making a final decision. As a result of this she then accepted the placement and her transfer from hospital was carried out. The approach taken enabled her discharge planning to be timely and her assessment to commence in a more appropriate setting to enable her ongoing rehabilitation to be carried out, and outcomes to be achieved. This also promoted prevention and early intervention reducing the risk of an extended hospital stay and further hospital institutionalisation, deconditioning and other harms associated with a prolonged hospital stay.

During Mrs X's stay in Cyflawni for a period of just under 6 weeks, she was supported by the multidisciplinary team, (SW, Occupational Therapist, Physiotherapist, Technical Instructor, Care of the Elderly Consultant, Advanced Nurse Practitioner and the Reablement trained care and support team). During that period, her needs, feelings and outcomes were discussed frequently by the Social Worker, to ensure her wellbeing needs were being met, and that there was effective co production with her and her family to ensure that they were involved in ongoing care planning design. Under the Social Services and Wellbeing Act 2014', a Carers Assessment was offered to her family, but was

[1] The purpose-built Cyflawni unit was developed specifically as part of the expansion of Marleyfield House Care Home to support independence and reablement and implementation of D2RA with the support of the Welsh Governments Regional Integration Fund Capital Programme in addition to a significant capital allocation from the council.

declined. Advice and support was provided throughout Mrs X's stay to both her and her family to ensure an holistic assessment of needs and outcomes were identified.

During her stay, Mrs W also benefitted from 12 inputs from the Occupational Therapist, including assessments, interventions and a Home Visit to support discharge planning and 16 Technical Instructor/Physiotherapist sessions.

The combination of environment, therapeutic input, culture of promoting independence and of course Mrs X's commitment to achieve what mattered most to her, meant that she was able to return home. From a physiotherapy perspective, Mrs W was back to baseline. Having optimised independence, an assessment of ongoing needed then identified that one morning, single handed call was needed.

A follow up visit was made to the home of Mrs W by the Admissions Coordinator around a month after discharge confirmed that Mrs W was doing very well and other than the scheduling of a routine review, that her case could be closed.

This case study is one which provides an example of how the Service is operated in line with legislation, guidance and good practice.

The voice of Mrs W had been clear throughout her journey from discharge planning from hospital, through the Service provision and in directing the outcomes to be achieved on discharge back home.

*" I want to get home but I want to have some help for my husband as I do worry about him caring for me. I want to be as independent as possible."*

The initial choice was not to be supported in the Service but to go home. The information provided during the initial discussion was informative and supportive but not directive or persuasive meaning that Mrs W and her family were empowered initially to decline but then also to reflect and change their mind.

During Service Provision, Mrs W was able to play a full and active role in setting goals and in line with her wishes, how her husband could be helped to support her was also an ongoing part of discussions and planning.

The words of Mrs W on leaving the Service provided sum up this case study better than anything we can describe……

*"It has been excellent here {Marleyfield House}. I can't fault it. It helped me tremendously."*