



Age UK Salford's Hospital Discharge, Aftercare and Reablement Service at Salford Royal Hospital Foundation Trust



Background

Age UK Salford run the Hospital Discharge, Aftercare and Reablement Service. This offers support to patients and their families from the point of entry to the Emergency Village at Salford Royal Hospital Foundation Trust, to discharge support, and up to six weeks after a patient has returned home.



Objectives

To provide support including emotional companionship, basic practical support such as collecting medication, preparing meals, shopping, and enabling the person to attend vital follow up appointments.



Approach

An integral part of the support service is to provide a full home safety check which involves a falls risk assessment, and works holistically with the service user to create a tailored plan of support to aid health and wellbeing and return to independence for longer. The service also provides follow up telephone calls to people discharged from A&E to ensure they are managing with daily activities (if they haven't already been seen by the service in the department).



Outcomes

The best way of demonstrating outcomes is through the use of a true story. The story on the next page highlights how this service ensured that someone with early Alzheimer's was supported to eat, drink and take medication, and have meals on the ward with his partner so that she got the emergency treatment she needed.





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True Story

Mrs J, aged 77, attended A&E with acute chest pain and needed to be admitted for immediate surgery.

She was very concerned about her partner, who had recently received a diagnosis of Alzheimer's, and was worried about how he would manage if she stayed in hospital to receive treatment. At this point there was no formal care package in place, no care needs assessments had been undertaken, and there was no family or local support networks upon which they could call.

The Age UK Salford's Hospital team reassured Mrs J that they would support her and her partner throughout this period.

With his partner in the Heart Care Unit, Mr Y was struggling to remember to undertake some practical and personal daily living tasks, for which he usually relied on Mrs J's support.

The Age UK Salford Hospital Discharge, Aftercare and Reablement Team therefore:

- rang Mr Y each morning to remind him where his partner was and to prompt him to eat breakfast and to take his medication,
- visited him at home each day to check that meals had been eaten,
- escorted Mr Y to the cardiac ward, where arrangements had been made so Mr Y could stay with Mrs J throughout the afternoon and have a hot meal with her,
- escorted Mr Y home again, helping him to make a sandwich and pudding, and left messages reminding Mr Y to eat, drink and take medication,
- arranged collection of medication from the chemist.

This daily routine was provided from the point of Mrs J's emergency admission for a total of 10 days until she was discharged home. A final visit was then made to ensure both were settled, with adequate food, shopping, and access to emergency support should this be needed.

Without the immediate reassurance provided to Mrs J, and the support provided to her partner, it is likely that she would not have accepted the surgery and may have been readmitted to hospital in a further crisis.

The interventions provided to Mr Y were not overly intrusive and enabled him to retain his general daily routine, which is important for someone experiencing memory problems.

The emotional support and reassurance enabled Mr Y to open up about his fears for the future, and knowing that he was well supported helped Mrs J to recover as she was not worrying as much about her partner.

As a result the service helped both parties to plan for future emergencies and identified appropriate support networks to enable them to remain together, independently, with knowledge of other services that were able to support them as Mr Y's Alzheimer's progressed.