Primary Healthcare Derby Ltd

James' Story



Background

James was admitted to Perth House following a hospital stay after being involved in a road traffic collision that resulted in a fractured back. As part of his discharge planning and ongoing recovery, he was referred to the Complex Care Team to provide support during his transition back to independent living at home.

Initial Assessment and Goal Setting

The Complex Care Team Coordinator visited James at Perth House to introduce the service and discuss his recovery goals and support needs. During this conversation, James expressed a strong desire to improve his mobility and regain his independence. As a keen hiker prior to his accident, his main aspiration was to become mobile enough to return to walking and outdoor activities.

Prior to discharge, the physiotherapist and social care assessor completed a comprehensive assessment, outlining the support already in place and providing details of James's current functional abilities and ongoing needs.

Returning Home

Four days after discharge, the Complex Care Team visited James at home to complete an assessment and review his situation.

During the visit, several challenges were identified:

- His telephone was not working, leaving him unable to contact services or access support independently.
- Without a phone or internet connection, he was unable to complete online grocery shopping.
- He was still awaiting installation of his Carelink telecare system.
- He had not taken his prescribed medication or insulin that day because he was waiting for a District Nurse visit.

Although James advised that a friend was due to help resolve the telephone issue the following day, immediate action was required to reduce risks and ensure his basic needs were met.

Coordinated Multi-Agency Support

- A referral was made to Derbyshire Fire and Rescue Service (DFRS) for a Safe and Well Check to help identify and address any home safety concerns.
- Community Access Point and Rapid Response (CAP and RR) Nursing Team was contacted after James disclosed he had missed both medication and insulin doses. Arrangements were made for a nurse to visit and administer the required treatment.
- Disability Direct was contacted to explore temporary support with shopping while James remained unable to access the internet.

Ongoing Intervention

Following their Safe and Well Check, Derbyshire Fire and Rescue Service contacted the Complex Care Team with concerns that James still had:

- No working telephone.
- No internet access.
- No Carelink installation.

The team then contacted Carelink and discovered that attempts to arrange installation had been unsuccessful because James could not be contacted. Recognising the importance of resolving

The Complex Care Team acted quickly to coordinate support from a number of agencies:

these issues, the Complex Care Team Coordinator carried out a further home visit.

During this visit:

- James's landline had been restored.
- A friend had helped him purchase a new mobile phone.
- James was unfamiliar with using the mobile phone, so the Coordinator provided practical support and guidance to help him use it confidently.
- Carelink was contacted directly and an installation date was arranged.
- The Coordinator contacted James's internet provider, who arranged for an engineer to attend and restore his internet connection.

Outcomes

Through proactive intervention and effective multi-agency working, the Complex Care Team helped James overcome several barriers to independent living following his discharge home.

Key outcomes included:

- Restoration of telephone access and improved communication.

- Support to develop confidence in using a mobile phone.
- Arrangements for Carelink installation to increase safety and reassurance.
- Escalation of medication concerns, ensuring insulin and medications were administered safely.
- Coordination with external agencies to maintain access to shopping and essential services.
- Reconnection of internet services, supporting James's independence and ability to manage daily tasks.

Conclusion

This case highlights the importance of timely, person-centred intervention following hospital discharge. By working closely with James and coordinating support across health, social care, telecare, and community services, the Complex Care Team was able to address immediate risks, promote independence, and support James in progressing towards his long-term goal of improving his mobility and returning to the activities he enjoyed before his accident.