Southwark Council

Waterside
Care Home

Avon Unit
Case Studies

Est. 1986
Agincare
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NHS
South East London

Southwark Council

Waterside Care Home

Bed Based Reablement

Mr A was living independently at home with his wife and working part time prior to a fall, which led to a spinal injury and hospital admission. Due to Mr A presenting to a hospital outside of Southwark, it was difficult for the hospital based therapy team to assess Mr A's property to determine if it is was suitable for him to return home.

Having never been in receipt of care before, Mr A was referred to the Avon Unit for Bed Based Reablement with the aim of maximising his independence and to facilitate a safe return home. Moving to the Avon Unit avoided the need for Mr A to be repatriated to a hospital local to Southwark, a move that was unnecessary and where he would be at risk of contracting a hospital acquired infection.

Mr A spent 24 days at the Avon Unit where he received daily input from the team. The team supported him to regain his independence, assessed his property for a suitable return home and provided equipment to meet his needs.

On his initial discharge from hospital, the recommendation was for a package of care at home to support him four times a day with continence, meal preparation and personal care; however following his Avon Reablement he was discharged home requiring no package of care, having progressed from a walking frame to crutches and is now able to manage stairs with supervision from his wife.

Mr A has set himself a target to walk the 1km from his home to the Avon Unit by Christmas to say thank you to his team in person.

Discharge to Assess (D2A)

Mr B was residing in Bluegrove Residential Home prior to being admitted to hospital with a deterioration of his Parkinson's Disease. Bluegrove Residential Home felt that they could no longer meet his needs, as he now required nursing support. During his hospital admission he was assessed as requiring a dementia nursing care placement; due to some challenging behaviour and hallucinations brought on by a combination of health complications and a deterioration of his mental health.

Mr B was discharged to the Avon Unit on the D2A (Discharge to Assess) pathway. This was to enable Mr B to have a Continuing Health Care (CHC) assessment and a full Care Act Review. Being outside of the acute setting supported Mr B to settle well and he quickly improved both physically and mentally. His Care Act review assessed that in a stable environment his needs could be met in a standard nursing home, rather than a specialist placement which was what had been suggested in hospital. This ensured that Mr B's needs were more accurately reflected, that he was living with those with similar needs, and that the council's resources were used appropriately.

Through their new CQC nursing registration, Waterside were able to offer Mr B a long term nursing bed on the 1st floor. Therefore, Mr B was able to remain at Waterside, enabling him to remain cared for by staff that had built a good rapport with him and clearly understood his needs. Remaining at Waterside prevented another potentially traumatic move which could have negatively impacted upon his mental and physical health.

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Proud to be working in partnership to increase nursing and reablement capacity across Southwark

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