

Case study

Prevention Assessment Team



The Prevention Assessment Team (PAT) is a multi-disciplinary team made up of the Voluntary sector, WSCC staff and NHS nurses.

The team is tasked to help with low level needs, to improve people's wellbeing. They also give information and advice to enable people to continue living independently.

Partnership working
Financial support provided
Emotional support
Independence maintained

Tom & Sarah^{} – supporting a couple under strain*

Issues/challenges faced:

Tom, 72, has Parkinson's Disease and his wife Sarah is his main carer. Sarah contacted Adults Carepoint (ACP) as she was struggling to cope with her caring role. Tom's condition was deteriorating and he was also suffering from sciatica. Sarah was finding providing the majority of Tom's care tiring and this had put their relationship under considerable strain. A referral was sent from ACP to the PAT via the community team.

Support given:

- After an initial phone call, a visit was arranged with a PAT staff member so they could discuss the situation and go through a wellbeing conversation.
- When asked what outcome he would like to achieve, Tom stated he was unsure of the help available and wanted a broad range of advice. The PAT member talked about each of the care act outcomes to ascertain Tom's priorities.
- **Maintaining nutrition.** Tom used to do the grocery shopping, but this task now fell to Sarah. Online shopping was discussed, and they said they had considered it, but hadn't set anything up. It was agreed that Tom could do this going forward as it was a good way to give back responsibility for the grocery shopping and relieve a task from Sarah. Sarah was happy to continue cooking for them both. Adaptions to their kitchen were also discussed (such as a height adjustable sink) and it was agreed an Occupational Therapy assessment would be beneficial.
- **Maintaining personal hygiene.** Tom requires some support from Sarah with washing and dressing. He had a carer once a week who helps with personal care and provides lunch which enables Sarah to have a break. It was agreed those care calls could be increased in future. They were interested in having a bathroom assessment, so they could consider any adaptations that would be helpful going forward.
- Accessing the Community. Tom has a mobility scooter and a wheelchair. Sarah is able to get the wheelchair in and out of the car and they use this option to go out locally and to the beach. They also venture into the village together using the mobility scooter in the finer weather. The PAT member talked about the Laburnum Centre and the support and activities available. Sarah already attended Carers Support Meetings there. They both agreed that accessing different activities there would give them separate social time away from the home. They were signposted to Driving Miss Daisy. This service would mean that Tom would be able to access the community without the support of Sarah, giving her a break from her caring responsibilities. This was something they both recognised as being important. The couple were left with information on befriending and home visiting services, Driving Miss Daisy, the AUKWSBH Laburnum Centre and a West Sussex Guide.

Outcome

A referral was made to an occupational therapist regarding a kitchen and bathroom assessment. They were able to arrange a hand rail in the shower and provided advice regarding a special chair they felt appropriate. Tom and Sarah planned to attend a Talk Local drop in at the Laburnum Centre but unfortunately that was postponed due to lockdown.

The couple found the intervention of the PAT really

helpful. They had been helped to identify ways to increase Tom's independence and purpose within the relationship and had ideas for social activities which would keep them engaged within the community and give Sarah some respite. In addition, they had arranged practical adaptations around the house. Sarah and Tom were given the contact details of both the PAT and OT should they need any additional support in future.