
Thornbury
Community
Services
Transitioning Care
Adult
Your care. Our passion.

Snapshot

- Highly bespoke package of care requiring additional training for nurses
- A seamless discharge with a ten-day turnaround
- Collaborative working with new care provider to ensure they felt fully supported
- Client regained independence and quality of life
- Excellent feedback received for TCS from all stakeholders

"Andrew was discharged home in less than 10 days with a full, robust package of care"

Andrew's* background

In 2018, 60-year old Andrew was admitted to hospital via an ambulance after experiencing difficulty breathing. Doctors were unable to give a concrete diagnosis but found upper airway inflammation and swelling around Andrew's vocal cord meaning his airway was no longer safe. A few days later, Andrew had a surgical tracheostomy inserted and remained in hospital for six months. He was medically fit for the last month of his stay, however was unable to be discharged without a package of care in place, one that had failed to be delivered by a previous care provider.

Highly bespoke care plan

TCS was approached by the CCG to provide an interim care package for Andrew whilst they searched for a long-term solution. We quickly allocated a team of highly skilled specialist nurses, and undertook robust risk assessments and clinical planning before creating a detailed and bespoke care plan to meet Andrew's complex needs. Andrew was discharged home in less than 10 days with a full, robust package of care. His case was unlike the typical tracheostomy patient as set up and changing of his equipment needed to be carried out in a controlled environment. We therefore made sure that all of the nurses had additional clinical training so they could confidently carry out all of the necessary requirements. Providing a safe and stable home for Andrew was equally as critical, particularly as he was susceptible to falls, having had two already during his time in hospital. Our care plan detailed preventative steps to reduce the chances of Andrew falling, so that he could maintain his independence once leaving the hospital.

The right method of communication

Effective communication played an integral part to the success of the transition. Andrew was unable to verbally communicate; However, mentally, he was extremely capable. Our team of nurses had to find ways of unlocking information from Andrew which didn't involve the use of his voice, and predominantly a whiteboard was used so he could write down all of his thoughts and messages for the nurses. However, this was made all the more difficult due to his Parkinson's diagnosis which caused his hands to shake, making his handwriting hard to read. Our team of nurses were extremely patient with Andrew and experimented with different communication methods, such as picture books to ensure his thoughts were easily relayed.

The outcome

We worked collaboratively and flexibly with the new care provider to ensure their team of support workers had the opportunity to gain relevant skills and training to effectively take over Andrew's package of care. This provided a more suitable long-term package for the CCG/NHS and the smooth nature of the handover and positive joint working ensured a level of continuity for Andrew and reduced anxieties. He is now enjoying his independence again, including trips to museums and walks around his local town centre. His sister, who was heavily involved throughout, gave wonderful feedback and thanked us for delivering such a seamless transition. Andrew sent a personal thank you card to all of the care team to show his appreciation for the level of care he had received.

***Name has been changed for data protection**

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