About this story

This case study highlights the partnership and interdisciplinary practices of a HACC assessment service and a community health service in providing services and support to a client with identifiable goals. A joint visit identified short-term intervention strategies and programs that were implemented to improve capacity.

Meet Lucy

Lucy was caring for her 93-year-old legally blind husband, but she needed help herself. She experienced two falls three years ago, a few months apart. In the first fall Lucy broke her left shoulder; in the second she broke her right leg. On top of that she was struggling with osteoarthritis in her legs and back, shortness of breath associated with asthma, and hypertension.

Before the falls Lucy was active. She attended group exercise classes and had generally been ‘on the go’ all her life. Lucy had even backpacked around Europe with a friend when she was younger.

A loss of confidence

After the falls Lucy soon began to worry about moving around the community safely. She wasn’t using any mobility aides and was independent in all other activities of daily living. She said she felt confident when shopping if she had a trolley to lean on, but she really wanted to build her confidence and physical strength enough to be able to walk independently without the fear of falling.

A care plan was developed that included walking down the street with a community care worker for 30 minutes twice a week to help lift her confidence.

At a second assessment, this time with a council assessment officer and exercise physiologist in her home, Lucy said that her head felt separate from her legs, and her legs didn’t move when and how she wanted them to. She talked about ‘jelly legs’ after a session in the pool that left her feeling panicked enough to call for help. Lucy stopped the pool sessions because she became too frightened of falling again. But, with the twice-weekly walking with the community care worker, Lucy began to feel more confident in walking on her own.

Going for goal number two

In order to achieve her second goal of improving her physical strength the exercise physiologist gave Lucy simple strength-building exercises that would take only her 10–15 minutes a day to complete. A referral was also made to a physiotherapist, for assessment and referral to the ‘Make a Move’ (MAM) Falls Prevention program.

In a follow-up phone call to Lucy she said that the MAM Falls Prevention program had led to a ‘definite improvement’ in her fitness and explained that she had ‘loosened up’. She had also found that the walking and home exercises have given her the confidence to be able to walk on her own and she no longer required the support of a council worker.

A few follow-up calls later and a final consultation with the physiotherapist Lucy has now been discharged from the community health service.
Reflections

Do you have good relationships with other service providers?
What are the triggers for a 'joint assessment'?
How do you assess the carer’s needs?
What is done in your service to build a person’s confidence?