THE INDIVIDUAL AND THEIR GOAL

Supporting an individual with enhanced support needs

A transition from long-term nursing care to a home of their own, supported by a bespoke 24-hour care package.

Background and individual circumstances

MR A is an adult with complex neurological needs following a significant acquired brain injury sustained in a road traffic collision on 29 November 2019. The individual was a pedestrian returning home from work when they were involved in a collision with a vehicle near their family home.

Prior to the accident, MR A was living independently in Nottingham and studying for a Law degree at the University of Nottingham. They had paused their studies to return to the family home to support their mother during cancer treatment, who later sadly passed away. MR A previously lived independently, maintained employment and had aspirations for their future.

Following the accident, MR A sustained a severe acquired brain injury, including a subdural haematoma causing compression to brain tissue and a skull fracture. They required emergency neurosurgical intervention, including a craniectomy and insertion of a ventriculoperitoneal (VP) shunt, which has required adjustments over time.

Following hospital treatment and rehabilitation, MR A required specialist neurological nursing care due to the complexity of their physical, cognitive and emotional needs. They remained in a nursing home for approximately seven years, receiving ongoing support from nursing staff and healthcare professionals.

Following detailed assessment and multidisciplinary planning, MR A was identified as having the potential to move into their own home with a bespoke 24-hour care package. The aim was to promote greater independence, choice and quality of life while maintaining appropriate levels of support and risk management.

UNDERSTANDING THE SUPPORT REQUIRED

Complex needs and individualised support

Cognition and communication

MR A has significant cognitive, physical and communication difficulties as a result of their brain injury. They can communicate basic needs, preferences and simple choices; however, they experience difficulties with executive functioning, memory, attention, insight and emotional regulation.

MR A can become fixated on particular topics or ideas and may perseverate on thoughts or requests. They require clear communication, reassurance and repeated information as they do not always recall previous conversations or instructions. Although they can understand verbal requests, they may at times decline to follow guidance due to difficulties processing information and regulating responses.

MR A has limited insight into the impact of their brain injury and is not always able to understand how decisions may affect their health and wellbeing. They lack capacity for some complex decisions and require support in accordance with the Mental Capacity Act 2005 to ensure decisions are made in their best interests while promoting choice and independence.

Physical health and daily care

Physically, MR A has weakness affecting all four limbs, reduced movement on the left side and poor postural control. They are unable to mobilise independently requiring two staff members for all transfers using specialist equipment, including a mobile hoist and sling. They use a specialist moulded wheelchair to support posture, comfort and community access.

MR A requires support with all aspects of personal care, including washing, dressing and oral care. They are able to participate in some tasks with prompts; however, they become easily distracted and cannot complete routines independently.

Due to reduced mobility and inability to reposition independently, MR A is at risk of pressure damage and requires pressure-relieving equipment, regular repositioning and skin integrity monitoring.

MR A also has complex health needs, including a PEG feeding tube and a suprapubic catheter. Staff support with nutrition, hydration, catheter care, continence needs and monitoring for potential complications.

PLANNING AND DELIVERING CARE

A person-centred transition

Our approach

Our person-centred approach was focused on enabling MR A to achieve their goal of living in their own home while ensuring safety and wellbeing.

As a care provider, we coordinated the transition from the nursing home into supported living with a bespoke 24-hour care package. This involved working closely with MR A, family members, commissioners, healthcare professionals and the MDT.

A comprehensive assessment was completed covering physical health, cognition, communication, behaviour, mobility, safeguarding, medication, nutrition and emotional wellbeing. Detailed support plans and risk assessments were developed to ensure staff understood MR A's needs, preferences and potential triggers.

MR A was involved throughout the process, their views and choices considered wherever possible. Where they lacked capacity for specific decisions, the principles of the Mental Capacity Act were followed.

A dedicated and skilled staff team

To support a safe transition, a dedicated staff team was recruited and trained to understand MR A's complex needs.

Staff training covered

- Acquired brain injury
- Positive Behaviour Support
- Mental Capacity Act
- Safeguarding
- Communication strategies
- PEG and catheter care
- Moving and handling
- Risk management

Individualised care plans were developed covering personal care, mobility, nutrition, health monitoring, emotional wellbeing, community access and behaviour support.

Regular supervision, team meetings and management reviews ensured staff maintained consistent approaches and responded effectively to changes in MR A's presentation.

PARTNERSHIP WORKING AND IMPACT

Sustaining support at home

Multidisciplinary working and safeguarding

The successful transition relied on strong partnership working with healthcare professionals, including psychology services and the wider multidisciplinary team.

MR A continues to receive neuropsychology support every two weeks to assist with emotional regulation, insight and behavioural management.

Following a safeguarding incident where MR A became distressed after their mobile phone was temporarily removed due to inappropriate contact with family members, the incident was reviewed with the MDT and psychology clinician.

During this period, MR A became highly distressed, verbally aggressive and made statements relating to suicide. Staff responded promptly by providing reassurance, emotional support and de-escalation. The incident was reviewed to identify triggers, strengthen risk assessments and improve future support strategies.

Family members were also supported to understand MR A's cognitive difficulties and the importance of consistent approaches and Mental Capacity Act principles.

Outcomes achieved

The transition from long-term nursing care into MR A's own home with 24-hour support has been a significant achievement.

They have gained increased choice, greater involvement in daily decisions and improved quality of life by living in their own environment.

- Successful transition to their own home this year, following 7 years in a nursing home.
- Increased independence while maintaining safety.
- Improved involvement in daily routines and decision-making.
- Development of a skilled and consistent support team.
- Strong partnership working between family, professionals and care staff.
- Effective management of complex health, cognitive and behavioural needs.
- Continued access to specialist psychological support.