Case study

Patient came to Martello for rehab

Background – the context, e.g. who?/where?/when?
Rehab patient came to Martello for rehab and discharge planning following a CVA and a two month stay in hospital.
What it was like before
Patient was admitted to Glangwilli following a stroke. Prior to the stroke the patient was living independently in a bungalow. Patient was using a stick to mobilise outdoors and was independent indoors. Patient had a supportive daughter living locally.
What it is like now
Patient spent a number of months at Glangwilli following her stroke which left her with right sided weakness affecting her mobility and function. Patient was discharged from Glangwilli to Martello for rehab and therapy led discharge planning. On arrival patient was mobile with a frame and supervision at all times. All care for washing and dressing, meals and overnight toileting. Patient began working twice weekly with therapist and therapy assistant with daily input from care staff carrying out an extensive exercise programme. Patient achieved her goals within 5 weeks and was now ready for home. Patient was now independent with a stick, able to wash and dress herself and use commode at side of bed overnight independently. Patient was able to make drinks but still needed supervision and support for meal preparations due to reduced right upper limb function secondary to the stroke, however, this was improving.
What happened to make the changes come about?
Full engagement from Martello carers to engage with patient daily to complete her exercise programme and complete her goals Patient went home with reablement and an extensive home exercise programme to continue rehab (meal prep – increase exercise tolerance) in her own environment. ICT Physio liaised with community Stroke Physio (Kate Roch) for input and ongoing management of increasing upper limb tone and progression of mobility from frame to

stick on discharge. OT support worker met stroke physio with the patient jointly at home for initial handover.

Ongoing reablement support with an aim to achieve goals within 3-4 weeks and plan for third sector ongoing support as no formal care should be needed