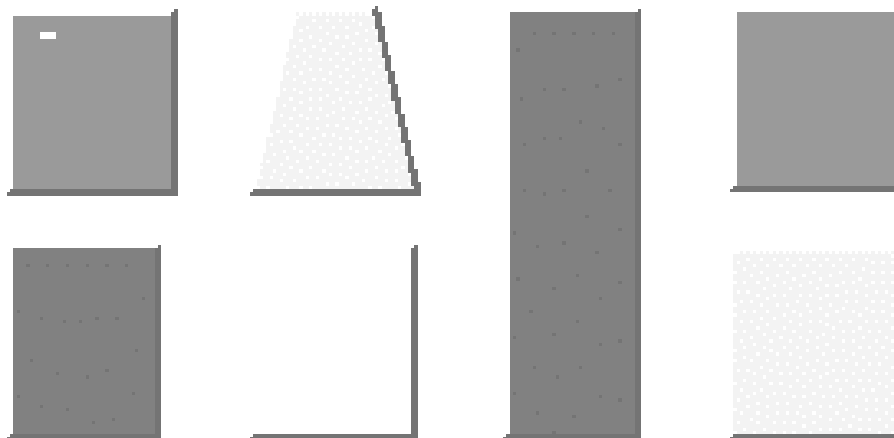


The Core Assessment & Outcomes Package for Older People

FACE SAP Toolset V.5

Training Materials



FACE Recording & Measurement Systems

INTRODUCTION TO THE TRAINING MATERIALS.....	3
1. A TYPICAL TRAINING DAY.....	4
Introduction	4
The Training Day	4
Useful hints.....	5
FACE Training Feedback Form	6
FACE Training Day Reflection.....	7
2. TRAINING VIGNETTES.....	8
Training Vignette: Olive Adams	8
Training Vignette: Graham Braid	12
Training Vignette: Esther Watson.....	15

Introduction to the Training Materials

These Training Materials are designed to supplement the detailed guidance provided in the User's Guide. As a trainer you will naturally need to be familiar with the Users Guide, which provides notes, guidance and prompts for use with the FACE Overview Assessment; and also with 'Meeting the standard', which describes the FACE approach and the underlying rationale of the tools. The Training Materials are in 2 sections:

- ◆ Section 1 describes a typical training day and includes feedback and reflection materials for use in training sessions.
- ◆ Section 2 provides sample vignettes for training purposes.

In training others you will also need to be familiar the User's guide. For more experienced practitioners the User's guide serves as an aide memoire, for more junior members the guide can be used as a starting point for their assessment. The guide is supplied in Microsoft Word format, so trainers may add local notes and reference to local resources as required. Alternatively, sections may be lifted from the guidance to support training sessions or routine use.

1. A Typical Training Day

Introduction

This section briefly outlines a typical training day. Useful hints and sample feedback materials are provided. In all instances feel free to adapt these for local purposes.

The Training Day

Session 1: Setting the scene (1 hour)

First, it is important to communicate a basic understanding of why the FACE assessment is to be used and what the training is about. The day should, therefore, typically begin with a presentation covering the following topics:

1. The policy context – Single Assessment and the NSF.
2. The local context and implementation plan.
3. Why FACE has been selected.
4. What the training day will involve.

Use both local materials and material from sections within the Training materials and User's Guide to support your presentation.

Leave time for discussion and general clarification of what this all means and its impact for particular individuals or services.

Coffee

Session 2: The FACE tools (2 hours)

1. Principles and aims of the Overview tools.
2. Run through of the Overview tools.

Leave time for discussion and general clarification of how to use the assessment, its relationships to other locally-used tools and documentation and process issues.

Lunch

Session 3: A training vignette (1.5 hours).

Explain that completing the assessment using the vignette both ensures consistency and quality of data collected and helps practitioners become thoroughly familiar with the tool. Practitioners should complete the tool in isolation or in pairs. Allow about half an hour for this. This should be followed by feedback and group discussion.

Coffee

Session 4: Next steps (1 hour)

1. Discussion of broader issues/next steps in implementation.
2. Completion of feedback form.
3. Completion of reflection form (optional).

Useful hints

- ◆ When completing the Overview Assessment using the vignettes there will inevitably be slight variation in recording between different practitioners, partly due to real differences in approach or understanding and partly due to limitations of the training exercise. The vignette only provides so much information – in real life full details can often be explored if required. It is important to point out the level of consistency being achieved as well as discussing real differences of perspective.
- ◆ Select a vignette that most clearly relates to the setting in which the attendees will be using the tools. (Note that the Miss Adams and Esther Watson vignettes are variants of each other and should not both be used in a session.)
- ◆ Make sure that users have received copies of the tool and User's guide well in advance of the session.
- ◆ Allow plenty of time for discussion of concerns and process issues, especially at the beginning. If practitioners are anxious or unclear about such issues they may find it hard to focus on the detailed training.
- ◆ When you are organising a training session you may wish to invite practitioners at all levels and from all disciplines in order to make the most of sharing skills, and to discuss ways of sharing information and working together.
- ◆ You might wish to organise training sessions for new practitioners as a matter of routine.
- ◆ To help ensure that practitioners maintain consistency you might also like to arrange review/refresher sessions after a year. This approach may be useful to ensure that newly qualified practitioners and practitioners new to your service are not left out of the training loop.

FACE Training Feedback Form												
Your feedback will be used to help improve training. Please complete the following:												
Session 1: Setting the scene	Not useful	1	2	3	4	5	6	7	8	9	10	Very useful
Session 2: The FACE Approach	Not useful	1	2	3	4	5	6	7	8	9	10	Very useful
Session 3: Training vignette	Not useful	1	2	3	4	5	6	7	8	9	10	Very useful
Session 4: Next steps	Not useful	1	2	3	4	5	6	7	8	9	10	Very useful
Overall impression of the day	Not useful	1	2	3	4	5	6	7	8	9	10	Very useful
Were there any elements that you think could have been added or omitted to the day (e.g. more discussion time)?	Comments:											
How clear and coherent was the presentation of the training?	Not clear	1	2	3	4	5	6	7	8	9	10	Very clear
Were there any aspects that you had hoped to learn that were not covered?	Comments:											
Do you have any comments on the venue? Was it suitable?	Comments:											
Please answer YES or NO to the following questions by ticking the relevant box:												
Did you have the opportunity to see the assessments beforehand?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>								
Did you have the opportunity to see the User's guide beforehand?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>								
Do you know which people you will be assessing?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>								
Do you know if you will be training other staff?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>								
Would you like to become involved in training other staff? If YES give your name to the trainer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>								
Any other comments:												

FACE Training Day Reflection

What was the overall purpose of the day?

Were the learning outcomes met? If not why not?

What is the relevance of the training to my work?

Is there anything I need to do / learn more about before I can apply what has been learned into active practice?

Action plan:

What resources will I need to access in order to support my action plan? (*e.g. who will be able to help...further reading...time frames*)

How will I know if I my action plan is successful?

Review

2. Training Vignettes

Training Vignette: Olive Adams	
Name	<i>Olive Adams</i>
Title	<i>Miss</i>
Marital/partnership status	<i>Spinster Lives alone</i>
Ethnic origin	<i>White British</i>
DOB	<i>15/12/1922</i>
Address	<i>Flat 6b, 42 Warren Street, Manton district, Haverton City</i>
Occupation	<i>Retired nanny.</i>
Medical History	<i>Cardiomyopathy (enlarged heart). Oedematous legs (swollen). Now resolved. Congenital malformation right hip. History of falls. Chest infection 6 months ago.</i>
Medication at home	<i>Uses dossette box which is filled weekly by Joanne Robins (private home carer). Paracetamol 1g as required for hip pain. Valsartan 80mg daily for her heart condition (potential side effect, low blood pressure). Frusemide 40mg daily prescribed for leg oedema to reduce fluid, (potential side effects: dizziness, light headedness, lowered blood pressure). 1 aspirin tablet (not prescribed) someone told her aspirin was good for the heart. Erythromycin 250mg (antibiotic) ad hoc (left over from treatment for chest infection 6 months ago) (Miss Adams has a bit of a cough starting).</i>
Home description	<i>Housing association Flat. 2nd floor. Lift & stairs. City suburb location. Nearest shop 10 minutes walk (corner shop/post office, over 2 main roads). Gas central heating, Miss Adams looks after with no difficulty.</i>
Access	<i>Entry phone at front door to block of flats.</i>
Contacts information	<i>Sister Frances who lives 1 hour's bus ride away. Verlie Thomas & Frederick Smith (former charges of Miss Adams) Mr. & Mrs Albert Evans (Church members) 1 phone call from sister every 2-3 weeks, no visiting. 3rd Sunday each month out to lunch with Verlie & Frederick after church. Weekday visit from Mr & Mrs Evans (on Tuesday) they are church contacts who help manage her finances). Mr Evans will be going into hospital shortly for a knee operation. Mrs Evans will not be able to give any support or help with finances for several months.</i>

Private home care for 3 hours, 2 days per week Tues/Fri (does main shopping). Provided by Mrs Joanne Robins.

Information supporting the assessment

When asked initially Miss Adams stated that her main problem at the moment is pain in her hip. Upon discussion, however, she did also admit to finding it "a bit harder to manage" than she used to and acknowledges that she does need "occasional help around the house".

She reports that her congenital hip problem has never been a real problem apart from stopping her running as a child. However, it did prevent her from learning to drive as an adult. However, she now reports that the pain in her hip is a "right nuisance". She told Joanne that her hip was giving her a lot of trouble at night especially when she got up to go to the toilet. She says the pain wakes her several times at night and she is getting very tired. She is just about able to turn in bed though it is painful. She has become unable to get off to sleep just lately, instead lying awake for several hours before dropping off. At times stiffness also makes it hard for her to get in and out of a chair, especially if she has been sitting for long periods. She also finds it hard to get in and out of bed. She takes paracetamol for the pain but it "doesn't really help much". She would like something done about the pain but won't countenance a hip replacement.

The heart problem was diagnosed 2 years ago after a brief hospital admission following a fall (Miss Adams was annoyed as she had never taken alcohol or smoked so couldn't understand why she should be ill). She was lucky not to have had a fracture at that time. Social services home care was arranged on discharge but Miss Adams did not like the carer. Verlie suggested private home care and Joanne was interviewed. Luckily she took along her son to the interview and Miss Adams took a shine to both of them.

Her heart condition seems reasonably well-controlled by the medication. Miss Adams does not always remember to take the medication. She has also on occasions taken twice the recommended dose, having forgotten that she has already had her tablets. She likes to take all her medication with cranberry juice which she says helps her swallow the pills. Joanne doesn't know how she can get confused with her medication as she uses the dossette box. She is unable to open regular medicine pots. Luckily, Joanne passes the GP's & chemist on her way in to Miss Adams flat so picks up medication when required. Miss Adams does say that she feels a bit "floaty" sometimes when she takes her Frusemide tablet. She sometimes thinks that she would like to miss that tablet out.

During the 6 years that Miss Adams has lived in the flat, the caretaker has found her to be generally pleasant until the last month or so. He has noticed that over the last few weeks there has been a definite mood change and she has been quite offhand and irritable at times. He also stated that she had been looking tired of late. This was corroborated by Mrs. Evans who also noted the change in mood and a definite weight loss (her clothes hang off her body now). When Miss Adams is asked how she feels in herself she says that she is "bright as ever" and will not discuss the matter further.

Miss Adams never married: preferring instead to look after the children in her care. She was fond of all her charges and Verlie & Frederick have often said how kind she was to them, this being one of the reasons why they continue to visit. Apart from a sister who lives about an hour's bus ride away there is no other family. This relationship can be acrimonious at times so they only communicate by telephone about once every 3 weeks.

Miss Adams is well turned out and made up. She is an independent lady and still manages to get to the shop a couple of times a week mainly for a chat and to pick up her pension (Mondays & Wednesdays) despite the obvious difficulty in walking. She can find her way there and back easily enough. However, her mobility has deteriorated over the last month. The trip now takes

twice as long and she has to stop en route several times for a rest, including, a rest in the park which she really enjoys. She is not able to carry any shopping.

On several occasions Miss Adams has had to contact the caretaker when she had forgotten to take her door keys with her to the shops – reportedly “not like her at all”. It has also been noticed that she now finds it impossible to use the stairs and relies on the lift.

Miss Adams has had several falls in the last couple of months: the last one being around 3 weeks ago: luckily it was on a day when Joanne was due to visit; otherwise she would have had difficulty raising the alarm. Apart from being unable to get to her feet, she was only shaken up so didn't go to hospital. Joanne reported that Miss Adams had fallen over the telephone cable which is continuously left trailing from the hallway to the living room. Miss Adams does not want the socket moving to prevent this hazard.

Miss Adams' great love was to go into town on the bus once a week to have a look round the shops. She also stopped off at one of the bakeries for coffee and cream cake. The bus drivers on that route were considerate and used to help her get on and off the bus. A change in company policy no longer allows this to take place and she now relies on Joanne to accompany her into town occasionally, preferring to use the bus. It is easier to get on the bus rather than get into a car. She needs help with the latter.

Joanne helps Miss Adams have a shower twice a week. The rest of the time she washes her hands and face in the narrow bathroom cluttered with towels and treasured old bottles of perfume and bath salts (Miss Adams likes it this way). When Joanne is away on holiday or other reasons, Miss Adams does without her shower and other housework duties being done. At these times the flat becomes jumbled but she won't not allow anyone else to do any clearing up.

Her bed is quite high, making it difficult to get in and out of. This is a problem at night when she needs the toilet. She will not use a commode. She has great difficulty getting washed in the mornings when Joanne is not around to help as she can only comfortably reach her hands and face. She is quite unable to bend down to wash her own feet. Being a bit out of breath with a cough also makes it harder for her to wash.

Joanne has spoken to Mrs Evans about a smell of urine in the flat. Despite lots of air freshener it wouldn't go away. Joanne thought that Miss Adams might be incontinent of urine as her undergarments did suggest a problem; no one has dared talk to Miss Adams about it yet. Joanne suspected that underwear was not taken off except when she was there, and Miss Adams was probably unable to physically remove them.

For breakfast Miss Adams drinks cranberry juice and a cup of tea. She has never enjoyed eating in the mornings. For lunch she snacks on toast or sometimes a tin of beans that Joanne prepares. There is no evidence of meals being cooked on the days when Miss Adams fends for herself. She has said in the past that she does not like to cook but she does make 3 or 4 cups of tea during the day. Joanne states that when she first worked for Miss Adams she was able to perform more household tasks. When Mr. & Mrs. Evans visit they usually take round roast beef sandwiches (her favourite) and have lunch together. Recently the sandwiches have just been picked at so Mr. Evans usually finishes them.

Meals on wheels had been suggested recently but Miss Adams was not pleased and would not entertain it. She wanted to eat when she chose to and not be reliant on others. Joanne brought in snacks from home in the hope that Miss Adams would increase her calorie intake and during the last few days they have started to disappear. However, it is not clear if they are being consumed or thrown away. When Verlie & Frederick take her out she still manages to eat a good

meal.

Apart from walking to the local shop Miss Adams likes to read the newspaper and watch TV. She has to wear glasses for reading but prefers not to. There are lots of pictures on the living room wall from her days as a nanny and she likes to relate stories from these happy times. She would quite like to go to church during the week. However, Mr. & Mrs. Evans do not have a car and Verlie & Frederick are busy the rest of the month with their respective families and so are unable to offer any extra help at this time.

On an odd occasion Joanne visits with her little boy for an hour or so, Miss Adams reverts to the role of nanny: reading stories etc. Joanne is a little upset at the moment. She is struggling to pay her bills and is looking for a more full time position and this news has not been accepted well by her employer.

Miss Adams looks after her own money and has a small private income which helps to pay Joanne. There have been arguments once or twice when Joanne has asked her for money to pay small purchases or repairs and Miss Adams has claimed there has not been enough change. Miss Adams also claimed on one occasion that money had gone missing from her purse but Joanne had persuaded her that she was mistaken.

The flat is in reasonable repair. It is well-lit outside and reasonably well-situated for the shops. Joanne makes sure that the household appliances are always kept in good working order, and Mr Evans will sometimes carry out minor repairs and maintenance.

None of Miss Adams' neighbours are close to her. She is just about on nodding terms with them despite having lived there for 6 years. She does talk to the people who own the local shop and they provide a chair for her to sit and rest before her "return trek" as they call it.

The caretaker who looks after the block of flats expressed some concern about Miss Adams to Mr. and Mrs. Evans on their last visit. He has noticed that she has left her front door ajar on a number of occasions. This was observed on his nightly security check of the building, he has not seen her outside the flat at these times. Miss Adams said she does not remember these incidents and says that the caretaker must be confused or mistaken. She was also quite verbally abusive to him the last time she saw him.

Mr. & Mrs. Evans have been extremely worried about Miss Adams' ability to cope when they have to step back from visiting for a while. They have contacted Miss Adams' GP who said he would arrange for an assessment to be carried out.

Training Vignette: Graham Braid	
Name	Graham Braid
Title	Mr
Marital/partnership status	Married
Ethnic origin	White British
DOB	27/03/1923
Address	16 Betts Lane, Old Forden, Norwich, NR7 2AB
Occupation	Retired Civil Servant
Medical History	Rheumatoid Arthritis. Hypertension. Pulmonary Embolus. Deep Vein Thrombosis. Affective Bipolar Disorder. Asthma. Epilepsy.
Medication	Mr Braid has 12 separate medications daily. These include inhalers that he is able to manage himself but all other tablets need to be administered by his wife. He is allergic to Penicillin.
Admission details	Mr Braid was admitted as an emergency to the Norwich Dist General Hospital on March 4 th 2005 where he underwent surgical repair to a ruptured aortic aneurysm, followed by a two week period in the intensive care unit. He was subsequently transferred to an acute surgical unit where his post operative medical and therapeutic care continued. On April 11 th he was deemed medically fit for discharge planning and a referral was made to the social work department for appropriate discharge assessment. The FACE Overview assessment is the tool of choice.
Background	
<p>Lives with wife Muriel in a small village 6 miles from city centre and 6 miles from son Richard who visits most weekends and manages his parents' financial affairs. He moved from London 5 years ago to be closer to son but they don't enjoy a particularly close relationship. Because of longstanding physical and mental health problems, Mr Braid has been rather an isolated man, non smoker, non drinker and with few hobbies. He used to enjoy DIY and gardening but now he spends his days either reading or watching the television. He enjoys documentaries about the second world war and gardening programmes.</p> <p>Their bungalow is 10 years old, recently redecorated throughout with newly installed gas central heating. Has equipment and adaptations to aid activities of daily living (raised armchair, ramps to front and back door, rails in bedroom and bathroom, bath aids, hospital type bed and commode)</p> <p>His general health steadily deteriorated following the move and this has severely limited his social contacts and community activities. He was a regular church goer but has become disinterested and suggests that his wife shouldn't become too involved with the local church because as his main carer she must attend to his care, organise household chores and shop (village store 5 minutes walk, supermarket 3 miles, no bus service but she drives and GP surgery / pharmacy 5 minutes by car). Personal care services arranged and funded privately. Carer visits x 1 daily. Prior to hospital admission when his care needs dramatically increased he refused to allow extra home care visits. The Community Psychiatric Nurse was visiting periodically but there was no District Nurse involvement.</p>	
Information supporting the assessment	
At the time of assessment Mr Braid was being nursed in bed because he was reluctant to sit out, refused to be hoisted and remained immobile. For all personal care he required input from 2	

people, didn't initiate any tasks e.g. washing or grooming and was poorly motivated. He required assistance to feed and had no appetite. The Dietician advised supplements to his normal diet and encouragement. He declined physiotherapy and occupational therapy input. Most professionals found him very uncommunicative but there was no concern about his sight or hearing. He demonstrated no confusion or disorientation and was able to make his wishes known. The decision for advising against rehabilitation was made when Mr Braid constantly declined to comply with therapeutic intervention.

His nursing needs at that time demonstrated that he required frequent intervention for the following :

Management of continence. He was urinary incontinent and had had a trial without catheter but which had been reinserted recently. His continence with bowels was variable and he was nursed with pads in case of accidents.

Management of tissue viability. Waterlow score 25 (very high) very vulnerable pressure areas with a healing pressure sore. (infected with MRSA which had been treated with antibiotics and daily dressings, now improved and no longer requiring a dressing) He was nursed on an electric bed with appropriate low air loss mattress.

He was being repositioned regularly throughout the 24 hour period both to protect his skin and make breathing easier.

Administration of medication. Because he still suffered from a sore throat following his need for ventilation in ITU his medications remained in syrup form (to be reviewed). There was a multipharmacy oral regime and he wasn't always compliant. His daily prescription was 14 drugs including Warfarin, Prednisilone, inhalers, night sedation, analgesia, cardio, anti inflammatory, antidepressant and night sedation.

The nursing assessment suggested that Mr Braid remained vulnerable and at risk because of his physical frailty and low psychological state and required daily access to registered nurse intervention.

His medical consultant advised that the repair to his ruptured aorta was successful but that he was depressed since the operation and some questions remain regarding his previous psychiatric assessments.

Mrs Braid was very anxious at the thought of her husband being discharged home stating that she had not been coping well before his admission and certainly wasn't prepared to accept his discharge until he had completed a period of rehabilitation as had been discussed with the ward doctor.

Shortly after this conversation Mr Braid's son Richard telephoned the social work department and requested that all further liaison with the family should be conducted through him and that no one should discuss anything with either his father or mother.

He confirmed that prior to admission his father's health had been failing and he was increasingly dependent on his wife. She was finding his lowness of mood and double incontinence a particular problem.

He was particularly concerned that his father was thought to be fit enough to be discharged. He reminded the hospital team that his father had recently had a life threatening condition and considered it far too soon to be considering discharge. He gave an account of how difficult it had been for his mother to cope with him prior to this hospital admission. Just prior to admission he had been particularly chesty and required treatment for an exacerbation of asthma (a longstanding condition) He spent most of his time in bed or a chair, refusing to use his walking frame and was increasingly immobile, incontinent and complaining of a sore bottom. Unfortunately due to his mental health problems he remained low in mood, uncooperative, not compliant with medication and refusing to allow extra outside help to support him and his wife.

He remained convinced that his father required a period of rehabilitation to improve both his physical condition and his mental well-being and a recently prescribed antidepressant should be given time as it could influence his ability to undertake rehabilitation. He was angry and didn't agree that his father fully understood when talking to the ward doctor that it looked as though he had reached his potential and may need to be discharged to a nursing home if his wife couldn't cope. He considered that his father remained medically unstable, confused and would benefit from a longer period of hospitalisation.

On being introduced to Mr Braid he seemed pleasant but reluctant to engage in conversation. He appeared to understand his situation and agreed that it was appropriate for his discharge to be considered. He felt fairly comfortable and only experienced pain on moving. He thought that this was mostly due to stiffness from his arthritis and hoped that he could soon recommence the tablets that he used to take. The 'stuff I take now isn't much good and is a syrup. I couldn't swallow tablets when I was in intensive care because I had a sore throat. I'm better now and think they should put me back on my tablets.'

He gave a personal preference for going home but thought that his wife couldn't cope with him. He was reluctant to explore any further options stating that his son would be making all the necessary arrangements. During this conversation he expressed a wish to die as it seemed to be the easiest solution. He certainly seemed to be very low in mood.

Training Vignette: Esther Watson	
Name	<i>Esther Watson</i>
Title	<i>Miss</i>
Marital/partnership status	<i>Single Lives alone</i>
Ethnic origin	<i>White British</i>
DOB	<i>13/05/1968</i>
Address	<i>Flat 38c, 54 Branwell Road, Middlethorpe</i>
Occupation	<i>Worked previously at a local supermarket.</i>
Medical History	<i>Mild learning disability. Hypertension, high cholesterol and has suffered a stroke. Knee injury sustained in a fall 6 months ago. History of recent falls.</i>
Medication at home	<i>Bendrofluazide 2.5 (1 tab). For her hypertension, is a diuretic. Simvastatin 20mg at night. For high cholesterol. Atenolol 50mg (1 tab). For hypertension, can cause dizziness. Clopedergrol 75mg (1tab) Pain relief used when person can not take aspirin.</i>
Home description	<i>Housing association flat. Suburb location. Nearest shop 20 minutes walk (supermarket/post office, pub over several main roads)</i>
Access	<i>Entry phone at front door to block of flats.</i>
Contacts information	<i>Sister, Martha, lives 2 hours drive away with her family. Rebecca Siddiqui and Ray Coakley (friends). Mr Richard Law and Mrs Linda Law (family friends). Her sister calls her every week. They have a good relationship but they visit each other very infrequently. Her mother is in residential care in another town and has Alzheimer's. Esther is unable to visit regularly. Esther meets her friends Rebecca and Ray as regularly as she is able. Regular twice weekly visits from Mr and Mrs Law. They are family friends who help her manage her finances and household affairs and who take her out occasionally. Mr and Mrs Law will soon be going abroad for 6 months to stay with their daughter in Canada, so will be unable to offer their usual support to Esther.</i>
Information supporting the assessment	
<i>Esther is a single woman who lives on her own in a housing association flat and has done so for several years. As a child and teenager she lived with her mother. Her mother was diagnosed with Alzheimer's four years ago and is in residential care in a neighbouring town. At school Esther met Rebecca and Ray and they have stayed friends since. Mr and Mrs Law first met Esther as a child as they have been friends of the family for over 30 years. They visit at least twice during the week, but Mrs Law says this is becoming harder to do, as Mr Law has stopped driving since developing a visual impairment. They have to catch two buses from their home to visit Esther.</i>	

Apart from her mother and a sister who lives two hours' drive away she has no other close family. The relationship with her sister is good and Martha (Esther's sister) telephones at least once a week. Mrs Law reported that Martha is a very busy woman as she has four children under 8 and is also looking after her terminally ill mother in-law, so she visits very infrequently. Esther does not like making the journey to her sister's alone and has not visited for several years.

Mrs Law contacted Social Services as she has become increasingly worried about Esther's health and ability to cope. She is worried that Esther is becoming a "little low". This is the point at which the assessment began.

Esther stated that at the moment her main problems are feeling "fed up" at no longer being able to work, and pain in her knee. Upon further discussion, however, she also admitted to finding it difficult to travel around and manage as well as she used to.

Esther has a mild learning disability due to complications at birth and has an I.Q of 67. She is not in contact regularly with the Community Learning Disability team although she has had some contact in the past few years over specific issues.

Esther was diagnosed with hypertension 3 years ago. This has been managed well by Esther with the help of her GP. Esther also has high cholesterol and this has not come down at all. Esther had a stroke a year ago. Before her stroke Esther worked in a local supermarket as a shelf stacker/sales assistant on a full-time basis. However, following the stroke she had to give this up as she didn't have the same mobility as before. Esther has made a relatively good recovery from her stroke, though she was left with a slight limp. She was a patient of the Physiotherapy service for three months following her stroke but no longer sees them.

Six months ago Esther fell and injured her knee. She went to see the GP several days after the fall who prescribed pain relief. Esther still takes the same pain relief but this no longer seems to be effective. According to Rebecca, Esther's personal hygiene has slipped since her stroke and, following the fall and injury to her knee, her limp has worsened and her mobility has decreased. Esther has told Mrs Law that she "misses work and would like to go back".

Esther says that the pain in her knee is "a constant niggle" that gets much worse at night and when she tries to walk for more than a few minutes. She is losing a lot of sleep as the pain wakes her during the night. The pain is especially bad at night if she has been out and about during the day. She often feels very tired during the day.

Esther had used to shop and look after her personal care very well. However, her mobility has deteriorated over the last few months. Getting to the shops and back takes much longer than it used to. Sometimes Esther uses a stick but not always as she "feels silly" using it. She is not able to carry any large amounts of shopping and so cannot buy much at a time. This also makes it difficult for her to collect her prescription medicines. Her flat is on the third floor and she has trouble getting up and down the stairs, so uses the lift which is kept in good working order by the Housing Association.

Esther has fallen several times in the last few months. The last time was about two weeks ago. Her friend Ray arrived for a visit an hour or so after it happened. She was bruised and very shaken up but didn't want to "cause a fuss" or see the doctor. Esther said that she had tripped over the shoulder strap of her bag which was lying on the living-room floor.

Esther likes to go to the main shopping centre in town and to look around. She finds it difficult to walk there currently and is worried about taking the bus on her own as she doesn't know where to get off.

Esther says that she sometimes finds it hard getting into and out of bed. Her bed is quite high. She also sometimes finds this a problem at night when she needs the toilet. She finds getting in and out of the bath very difficult, so has "a good wash" instead. Getting dressed can take a while, especially if her knee is very painful.

Mrs Law has reported that Esther is not taking "such good care of herself" lately. She does not take the same care with her clothes and hair that she used to, and she appears to have lost a little weight. Mrs Law also reports that Esther can sometimes be "a bit snappy" which is unlike her.

Esther has never been a great eater. She says that "she doesn't really think about eating during the day". She has said in the past that she does not like to cook. When she goes out with Rebecca and Ray she does eat with gusto. Esther does drink squash and tea during the day.

Esther likes to watch the television and listen to music on her CD player. She has to wear glasses when watching the TV but prefers not to. She would like to go out more regularly during the week with her friends. She would particularly like to go with Rebecca and Ray to the cinema and the local library and perhaps even to an evening class. Esther is not sure which class she would like to take but she is interested in pottery or needlework. She says that the local school has classes in the evening but she does not know how to apply or what to do.

Mr Law helps Esther to manage her finances and advises her when he visits of what bills need to be paid.

The flat is in reasonable repair and Mr Law makes sure that the appliances are in good working order and that the décor is of a good standard. If anything needs doing he gets in touch with the Housing Association or appropriate workmen. Esther is on good terms with her neighbours though she has no real friendships amongst them and would be unwilling to ask them for help as she feels she "would be a nuisance".

Mr and Mrs Law are worried about how Esther will manage for the 6 months while they are abroad. They have contacted her GP who said he would arrange for an assessment to be carried out.

Esther worked at the supermarket for several years as an assistant stocking the shelves and sometimes helping others on the till. This she says involved a lot of standing and moving about. When she had her stroke Esther was no longer able to work and resigned. Esther desperately wants to get another job and would ideally like to work at the same supermarket as she had many friends there. Esther does not think she could do the same job again because of the problems with her knee. Esther didn't discuss leaving her job with anyone and she hasn't approached anyone about getting another job.