Case Study 2 – Older People Mental Health Service (OPMH)

AZ is a 74yr old gentleman living in supported living- not previously known to services. He was referred to Older People Mental Health by the local District Nurses after he was found to be confused and aggressive following a hospital admission. The Home Treatment Team visited and confirmed the district nurses findings and also found AZ was self-neglecting, his flat was dirty and he had no food in the cupboards. AZ also had no social support other than the warden who felt he required a care home placement.

Through liaison with the district nurses, the Home Treatment Team was able to discount any underlying physical health needs. The Home Treatment Team visited AZ daily, established a working diagnosis of Alzheimer's disease and began a treatment regime. Alzheimer's disease was later confirmed and following discussion at a multi-disciplinary team meeting, a social worker from the Older People Mental Health Team organised an interim care package to negate the immediate risks of self-neglect.

AZ was not very accepting of support and the Older People Mental Health Team spent a lot of time working collaboratively with the warden and the district nurses to build a relationship with AZ. Despite his eventual engagement with carers, AZ remained at risk due to self-neglect and confusion and the warden was of the view that he required a placement. The community psychiatric nurse and social worker maintained a high level of contact with AZ and the warden, to continue assessing and managing the risks presented. The social worker assessed AZ's capacity in relation to his social care needs and ability to manage his finances - he was found to be lacking on both counts. The social worker then involved an Independent Mental Capacity Advocate and arranged a best interest meeting where it was agreed that AZ should remain in the community, as were his wishes, with an appropriate support plan. The community psychiatric nurse arranged for a support worker and regular shopping call to ensure compliance with medication and to maintain AZ's physical health. The social worker also established a long term package of care and worked with the local authority to arrange deputyship for AZ's finances.

The multidisciplinary approach of the team ensured the risks were swiftly managed and that AZ was supported in a manner with which he felt comfortable. Through close working with the local authority the social worker was able to arrange care and deputyship avoiding the need for costly long term placement in a dementia care home.

Dementia adviser and Cognitive Stimulation Therapy were considered but not felt to be appropriate for AZ as he was unable to acknowledge or understand that he has memories issues/diagnosed with dementia.