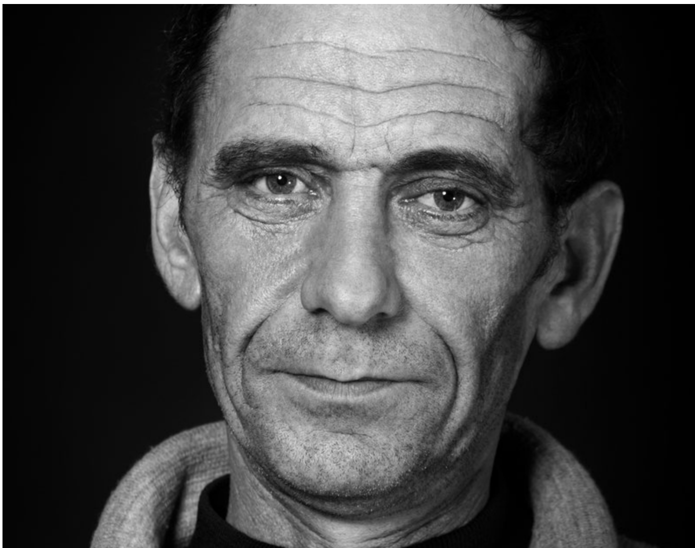
Case Study:
Mr M, Male aged, 55 years
Professional involved:
Band 7 Clinical Practitioner



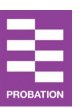
Story

Mr M had been living rough on the streets in his local town for 10 years. He previously lived with his mother but due to her passing away, he was back on the streets.

Having moved to a local hostel and during a drop-in clinic, Mr M was seen by the Homeless Nursing Team. He was diagnosed with Tinea Pedia (TP), ulcers on his feet and self-neglect. The Clinical Practitioner was able to see to Mr M's TP and ulcers and once healed, continued to visit him to wash his feet. Mr M had been known by the staff as an alcoholic but the Clinical Practitioner picked up there was either a learning difficulty or disability. Mr M was considered to have Korsakoff's Syndrome and an appointment was made to see the mental health street outreach team (SOT) nurse.

The Clinical Practitioner referred Mr M to social services for safeguarding and an assessment to the Learning Disability Team for his mental capacity. Unfortunately, due to the onset of Covid-19, Mr M's appointments were cancelled, however, the SOT continued with face-to-face visits throughout the pandemic and lockdowns.

The LD team eventually discharged Mr M and suggested a referral to CWPT for an assessment around mental health and alcohol related dementia. The Clinical Practitioner liaised with the GP to request a diagnosis of Korsakoff's Syndrome. Mr M would have to be seen by a Psychiatrist to confirm the diagnosis. Due to his vulnerable state, the hostel staff had also applied for an advocate for Mr M as it was suspected that he was being financially abused by family members.



A speech and language therapist was also bought onboard, however, Mr M didn't always turn up for his appointments. However, the Clinical Practitioner agreed that he could carry out a joint assessment as part of the wellbeing appointment with Mr M. Eventually, Mr M was able to follow some speech and language strategies provided by the therapist who passed this onto the hostel staff. Mr M could explain to staff how he saw the world and the staff could adjust their care for him according to his perspective.

After a referral to CGL, Mr M was given help with his alcohol dependency. Joint visits were agreed with the Clinical Practitioner alongside the MDT's, safeguarding, social services, WDC, and hostel staff. Following a refurbishment of the hostel, Mr M was placed into a B&B with support from the Clinical Practitioner and hostel staff (x2 daily, initially). Mr M had a tour of the B&B and settled in well, as he had a room of his own. The Clinical Practitioner and hostel staff communicated with Mr M with a mix of communication aids from the speech and language team, in addition to drawing pictures themselves.

Outcome

He really enjoyed the B&B and began to thrive. A property then become available in a sheltered housing complex. Mr M moved in and has been there since January 2021.
In addition to all of his Covid-19 vaccinations, Mr M has support package, a social care practitioner and now support visiting his GP from his support team. Mr M had not visited his GP in 20 years before this intervention. He now takes regular medication for his cholesterol and blood pressure and despite a few bumps along the way Mr M is doing well. He is happy, safe and warm and is able to communicate with others

and is supported in a world that he does not understand and found extremely difficult to cope with.