Case 1

Mrs MS 87 years old. Was living independently in a first floor flat with private help once a week to help with domestic chores and heavy shopping because of increasing physical frailty. She was doing all her own cooking and personal care and did go out to the nearby shops. She doesn't drive. One son lives nearby, is supportive and visits regularly. There was no history of confusion prior to admission.

Admitted 8 weeks ago with acute confusion and possible left sided weakness.She was found to have a UTI and was treated with appropriate antibiotics. A CT scan revealed an acute cortical infarct, marked atrophy and evidence of small vessel disease. Over the course of the next 2 weeks she made a complete recovery from the UTI and a complete recovery of limb function but remained disorientated and confused with some neglect. She had 2 falls in the first week with no injury sustained.

She was transferred to a Community Hospital for rehabilitation. She had another fall 2 days after admission and another UTI when she became very confused for 3 days.

Last MDT Meeting

OT: Unsafe in kitchen with complex tasks but can make cup of tea although needed help to find the milk in the OT kitchen. Needs minimal help with washing and dressing lower half. No problems with grooming or feeding.

PT: independent in transfers from bed to chair and chair to stand. Mobilises independently, safer with a frame but needs prompts to use a frame safely. Unsafe on stairs without help

Nurses: Needs prompts to take medication. Continent and independent in toilet. Often rummages through other patients lockers and constantly asks to go home. Needs reorientation at night as cannot find her own bed reliably. (*on further discussion this has not been an issue for past week, nor has she wandered out of the ward for 2 weeks)* Concerned about mood as frustrated and anxious.

Doctors notes:

Discussion regarding discharge when son present 2 weeks ago. MS unable to follow conversation, disorientated in time and place (thought she was still in acute hospital). Unable to discuss the hazards associated with discharge to home.

Treated for a symptomatic UTI the following day. Very confused, wandering and agitated.

Last entry: haemodynamicaly stable, apyrexial. Chatty and converses normally. No evidence of neglect clinically although some minimal evidence in therapy. She wants to go home.

Team view about decision to go home is that she does not have capacity to make decision as she could not follow the converation with the consultant. She is often confused and is at risk of falls. The therapists feel she should not go home and it would be in her best interests to be cared for in a RH, preferably single level. Her son has grave concerns as it is clear that she has had difficulties with personal care whilst an in-patient. The OT thinks she requires an IMCA.

What next?

Case 2

Mrs SW. 59 years old admitted with left TACS 5 days ago. Thrombolysed on admission but without effect. NIHSS 28. Aphasic, difficult to rouse, no apparent comprehension. Noted to have profuse vaginal bleeding 8 hours post admission and an experienced nurse thought there was evidence of vaginal trauma.

Mrs SW lives with husband, one daughter in daily contact. Previously well with no PMH. Heavy smoker.

Since admission has been in fast AF and has developed acute severe pulmonary oedema several times. Currently rate controlled on maximal IV therapy, no pulmonary oedema. Stroke symptoms unchanged. Family present most of the time.

Questions:

1. Does she have capacity to make decisions regarding the investigation of the PV bleed? Is this important?
2. Her husband is fully informed about her clinical situation and is happy "to leave everything to the experts". Do we need to discuss the PV bleed and suspicion of trauma with him? What are the differential diagnoses of the PV bleed?
3. Does she need an IMCA?
4. How do we proceed?