‘A’ for Adjustment Framework

Here are 2 case studies to bring together your learning from the 5 ‘A is for Adjustment’ sessions.

Use these 2 case studies at the end of your learning to reflect on some of the learning outcomes can be applied into day-to-day scenarios.

Case study – John	
Adjusted care John is a 50 year old man who has a learning disability and autism. He has been admitted to hospital from a care home after having a stroke. He seems quite confused and has a tendency to lash out and shout, although it is difficult to understand what he is shouting about. The ward staff try to treat John in the same way they treat everyone else.	Equity v equality
Attitude However, the shouting and lashing out has made some of the ward staff rather nervous, and they tend to try to avoid him. You overhear a conversation between staff about John’s quality of life. They were querying whether he should be treated as ‘after all, what does he have to look forward to’. John does not want to eat and his stomach is quite swollen. The care home support staff do visit but they don’t know John very well. There have been a lot of changes in the care home. His mum also visits when she can (she is 87 years old and quite frail). John is much calmer when she is there.	Fear and anxiety (who is afraid of whom) Negative assumptions Seeing the person – not the disability
Approach John does have a Hospital Passport although the document is a bit out of date. The Passport describes John as someone who likes company and who particularly likes talking about the Star Wars films. He volunteers at the local Oxfam shop and is well known in the local neighbourhood.	Sources of information
The passport also talks about the importance of diet and exercise for John as he is prone to constipation. He needs a high fibre diet with plenty of vegetables. You are surprised to read this as the care staff say he loves chips and pizza. However, when you talk to his mum, she confirms that he has always needed a high fibre diet. She thought this is what he was eating at the home.	Awareness of common conditions Informed consent
The Passport says that when John is in pain or discomfort, he has a tendency to shout.	What has changed?
Assessment	Risk factors

You note that John has not had his bowels open since he was admitted two days ago. You ask the carers about his bowel habits in the home. An examination confirms that he is constipated, and using the information in the hospital passport you assess that he is in pain and discomfort. The stroke has also made mobility difficult for John. **Action** You talk to John's mother about how best to approach John. She has some Star Wars books and suggests using those to talk to John. John needs medication and an enema to help him open his bowels. He has clearly been constipated for a while. You get advice from his mother about how to talk to John about this. You use some easy read information. Once this is resolved, John becomes much calmer and stops shouting. You find some easy read information about diet to help John understand what he needs to eat. You also ask the dietician to write some guidance for the care staff on diet. You update his passport and RA flag	Symptom recognition Involving family and carers Involving family/carers Guidance Easy read information Supporting care staff Update records

Case Study 2 – Rita	
Adjusted care Rita is 17 years old and has attended a GP appointment with her Mum, who is concerned by Rita's lack of interest and energy, 'not being her usual self'. Rita has a severe learning disability, very limited verbal communication and physical disabilities requiring an adapted wheelchair and careful postural management. The GP they see is a locum and has not met Rita or her Mum before; The GP realises that it will be difficult for Rita to get into the room he is using and so moves to the Nurses room which is bigger. He also tells the receptionist that this appointment will take longer.	Equalities Act Reasonable Adjustment Physical adaptations v Personal adaptations
Attitude The Doctor asks if Rita and her Mum if they are happy to be seen by a male doctor; they say they are but would prefer a female to be present and to help with any personal contact, so the Doctor asks the (female) Nurse to be present. He also asks Rita if she wants her Mum to be present which she indicates she does. The Doctor asks Rita how she is feeling, Rita raises both hands to her face, looks away and starts to cry. The Nurse tells Rita not to worry and asks if she likes music, Rita puts her hands down and gives a thumbs up – the Nurse finds some gentle music on the radio and Rita smiles	Values Seeing the person – not the disability Sources of information
Approach Mum shows them that Rita has a Communication Book which has pictures of different actions that Rita makes and what they mean - raising her hands means 'no', or 'go away'; thumbs up means 'yes'. The Doctor uses the book to check that Rita is happy for him to ask Mum some questions and gets a thumbs up. Mum tells them that Rita has been less responsive and quieter than usual, not interested in her food and sleepy. The Doctor asks the nurse to take some observations which show a temperature and BP in normal range but fast and shallow breathing with low oxygen saturation.	Informed consent What has changed? Risk factors Symptom recognition
Assessment The Doctor checks back on Rita's notes to see what her 'usual' readings are; he sees from Rita's last annual health check (when she was well) that her temperature and BP are usually lower than the normal range ('unique wellness'), indicating that things are not now as they should be for Rita. The Doctor wants to listen to Rita's chest, he is concerned about dysphagia; he asks Mum and Rita about what she eats and if there is any choking. Mum reports that there should be no problem at home as she has always provided a diet recommended since Rita was much younger, however she was told that Rita had choked on an ice cream when she went out for the day with her local club, they had thought an ice cream would be OK for Rita. Rita is becoming upset again, the Doctor tells Mum how important it is that he listens to her chest, he asks the Nurse to talk to Rita,	Awareness of common conditions Unique wellness/unwellness Involve family

check she is OK for the examination and to help her with her clothes; he withdraws to give them some space. Mum agrees that an examination should go ahead and with the Nurse helps Rita to calm and comply, the nurse notices red marks on Rita's chest from the strap on her wheelchair and mentions this to the doctor. Listening to Rita's chest the Doctor is concerned that there is an infection; the Doctor is concerned about aspiration and potential pneumonia; he arranges for Rita to go straight to hospital for further investigations. **Action** The Doctor asks the Nurse to help Rita and Mum with the transfer to hospital. He phones ahead to make sure that the hospital is aware of Rita's needs, putting this in her notes and sending a copy to the hospital. The Doctor checks that Rita has Additional Information available on her Summary Care Record and that the necessary information about her Dysphagia is recorded along with her eating and drinking requirements and the pressure area concern. The Doctor also calls the local Learning Disability team to let them know and to ask for the Speech and Language Therapist / Dietician to review Rita's diet and develop eating and drinking guidelines for Rita to share them with her Mum and her club; he also shares the concerns around pressure care and asks for an assessment of Rita's postural management.	Pass on / share information and learning Update records Guidance and information for family and carers

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