A Sunfield Case Study

How complex health needs are best supported by working together

Introduction
David came to Sunfield in April 2007, with a diagnosis of severe autism, epilepsy, motor difficulties, and sensory and communication difficulties. This case study illustrates how David's additional complex needs were highlighted, and catered for, by teams working together here at Sunfield, and with close liaison with relevant external professionals.

Background
Based on David's detailed initial assessment at Sunfield, a care plan was devised to meet his needs and staff training provided for his epilepsy management and seizure intervention. His epilepsy is complex, with periods of deterioration requiring ongoing monitoring, support and liaison with consultant neurologist. In October 2008, further tests were carried out in response to David's excessive thirst, which resulted in a diagnosis of Type 1 Diabetes. Key staff supporting David were then additionally trained to support this diagnosis. As David reached puberty, he also developed acne which proved resistant to many of the treatments offered by the Health team.

The Journey
David is insulin dependent and needs close monitoring of his diet, foot care, eyes and epilepsy. He requires fully trained familiar staff at all times, to remain safe and healthy. David's diagnosis of Type 1 Diabetes was life changing, as it would be for anyone; but taking into account his severe autism, it was to prove even more challenging, for his family and his staff team.

On diagnosis, Sunfield began working with the relevant specialist acute community service and, although Sunfield found David's diagnosis challenging, he adapted to his diagnosis very quickly. He refused to let his diabetes get him down or prevent him from enjoying life.

Awareness training was put into place at Sunfield, which included a clear understanding of the condition; monitoring, testing and recording David's blood-sugar/ketone levels; responding to concerns; calculating insulin doses with each meal; and administering insulin appropriately, while always striving to maintain David's dignity.

Risk assessments were carried out, and provisions adapted for David. Infection control guidelines were also reviewed. All care plans were reviewed and diabetic protocols written up. The focus remained on keeping David healthy, with minimal referrals to hospital, and allowing him to continue with his daily routine at Sunfield and engage in recreational activities. As far as possible, the aim has been to keep David at the centre of his care, rather than his medical needs.

David now has his blood sugars reviewed weekly, via email with the specialist community diabetic nurse who will advise Sunfield if any adjustments need to be made to his insulin/diabetic care regime. David attends three-monthly reviews at the diabetic clinic, six-monthly specialist eye appointments, and has monthly chiropody checks at Sunfield.

The Conclusion
Since his diagnosis in 2008, David has only had two unplanned acute hospital admissions. He is a young man with a big personality, great sense of humor, a healthy appetite and a love of the outdoors, who really enjoys his visits home every other weekend. Sunfield has embraced the challenge and David continues to develop new skills and to enjoy his life to full; owed in part to the dedicated care and collaborative philosophy at Sunfield.

David is due to transition to adult services in 2016, so discussions are underway to identify and agree a suitable care provider, where he can continue to receive a high level of support. Funding assessment criteria has been completed in the line with Department of Health Guidance. Preparation for his move is being coordinated by Sunfield's Transition Coordinator, with invaluable input from David parents, key worker, care team, education and health team staff. We will continue to work together to ensure that David transitions successfully, with a person-centered approach ensuring his complex needs are met, along with his personal preferences.