AQUEELA CASE STUDY

Specialist knowledge & intervention – Lindsay Lord, Salford

AT A GLANCE

CHALLENGES

- Resistance to accepting the diagnosis, with person only interested in medication or cure
- Family pressing for specific treatment types, which may not be in best interest of patient

AMSC INPUT

- Referral to specific physio services
- Education and support in managing the condition at home to avoid the need for a care home

"This role has helped me to deliver care and support to the people who need it most. I wanted to show people with advanced MS that they matter, that even small changes can make a difference, that we have not given up on them and they should not give up on themselves."

– Lindsay Lord, Salford AMSC

SITUATION

Aqueela has highly active Relapsing Remitting MS and is experiencing recurrent hospital admissions for pneumonia. They have been declining additional holistic support. They have been deemed to be at high risk of pressure sores, due to lack of turning from home carers. Other symptoms include urinary problems, constipation, spasticity, ataxia, cerebellar signs, early dysphagia, dysarthria and refusal of PEG.

BACKGROUND

- Aqueela is 32 years old and was diagnosed with highly active relapsing remitting MS when they were 20 years old. They have been treated with Lemtrada.
- Family are currently providing care but are resistant to accepting diagnosis. Their focus is on medication and cures rather than other forms of intervention. For example there is no hoist or pressure care.
- GP is involved but appears to be more aligned to the familiar cultural concerns rather than the best interests of the person with MS.

CAUSES AND INTERVENTIONS

- The AMSC reviewed pressure areas and their management, along with an assessment of current lifestyle and the risks of skin breakdown.
- A referral was placed to a Community Neurological Rehabilitation Team for physiotherapy.
- Education and support was provided to the person with MS, to encourage them to maintain their own mobility and independence, to prevent the need to transfer into a care home.
- Ongoing support is being given to help patient continue with their more proactive regime.

OUTCOME

- Hospital admission avoidance.
- Reduced the potential need for the person with MS to move into a care home.