NHS Education for Scotland

General Practice Nursing

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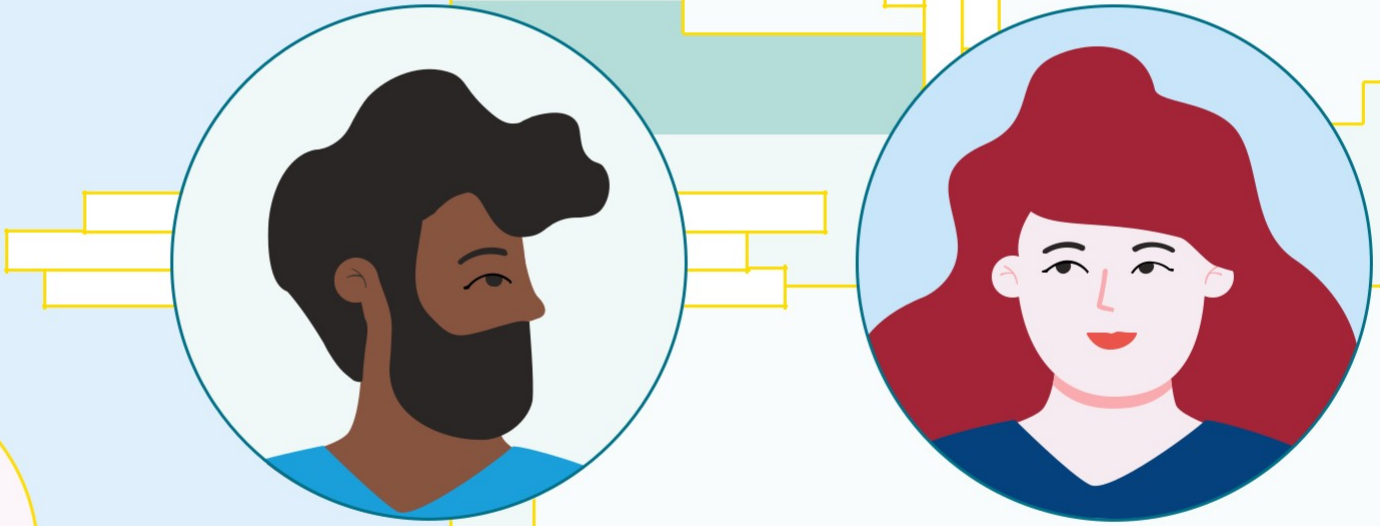


Care & Support Planning in Action — The Way Forward for Improved Outcomes

My previous articles have centered on the House of Care person-centered model of care and my own personal journey. This article will focus on how Care and Support Planning (CSP) conversations can help change the lives of others and the positive impact of powerful conversations we can have within primary care.

Partnership working can enhance the whole individualised journey and is a key element. The CMO's Vision is that by 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine. A CSP approach is a prime example of person-centeredness and making this vision a reality.

Care and Support Planning is a defined process whereby individuals set their own aims and goals with the onus of "what matters" to the individual; the health professional can facilitate the process within a structured approach to help individuals achieve their personal goals.

The **House of Care** is a model whereby the **individual is at the center** of the process, mirroring person centeredness and is a key element when considering "realistic medicine". A link to the summary of "realistic medicine" is below and this link also contains a link to the full report.

https://www.gov.scot/publications/summary-practising-realistic-medicine/

Scotland's House of Care model — each individual is at the centre of a Care and Support planning conversation

Case History — Ann

Taking the time to listen and have a truly shared conversation is invaluable and shared-decision making lies at the heart of CSP. I will discuss a case-study which discusses Care and Support Planning and is a working example of the individualised approach in action.

The patient is called Ann and she is more than happy to share her story as she feels that if even just one person is helped as a result of reading her story this will bring her happiness and contentment. Hopefully her story will inspire others to adopt CSP.

Ann (72) lives alone and I first spoke to her on the phone when I was handling her blood results in the practice. She was diagnosed with diabetes in 1983 and had a left above knee amputation in 2005 and her right leg was amputated 2016. I had never spoken to or met Ann before at this point.

Social History

Widowed in 2008 and lives alone with her beloved two cats. She has a son and a daughter. Retired, she helped her husband run his own business. Wheelchair bound. Lives in a small town with local amenities.

Lifestyle

Tee-total. Long-term smoker 15-20 a day, did stop 1993 but re-started. She has a varied diet. She is limited in exercise due to her diasability. No motivation to stop smoking.

Care & Support Planning in Action

I phoned Ann about her blood results and she sounded low in mood. She had low sombre vocal tones. She said she was fed up she wasn't getting out and about. The thing that was bothering her the day I phoned was the fact she needed an additional aid to help her move about in her bed. So I referred her to the physiotherapist.

The next time I phoned Ann she still sounded low in mood, the aid the physiotherapist had given her was useful and helped her move in her bed but she wasn't getting out and about and had lost her confidence. She felt trapped and isolated in the house.

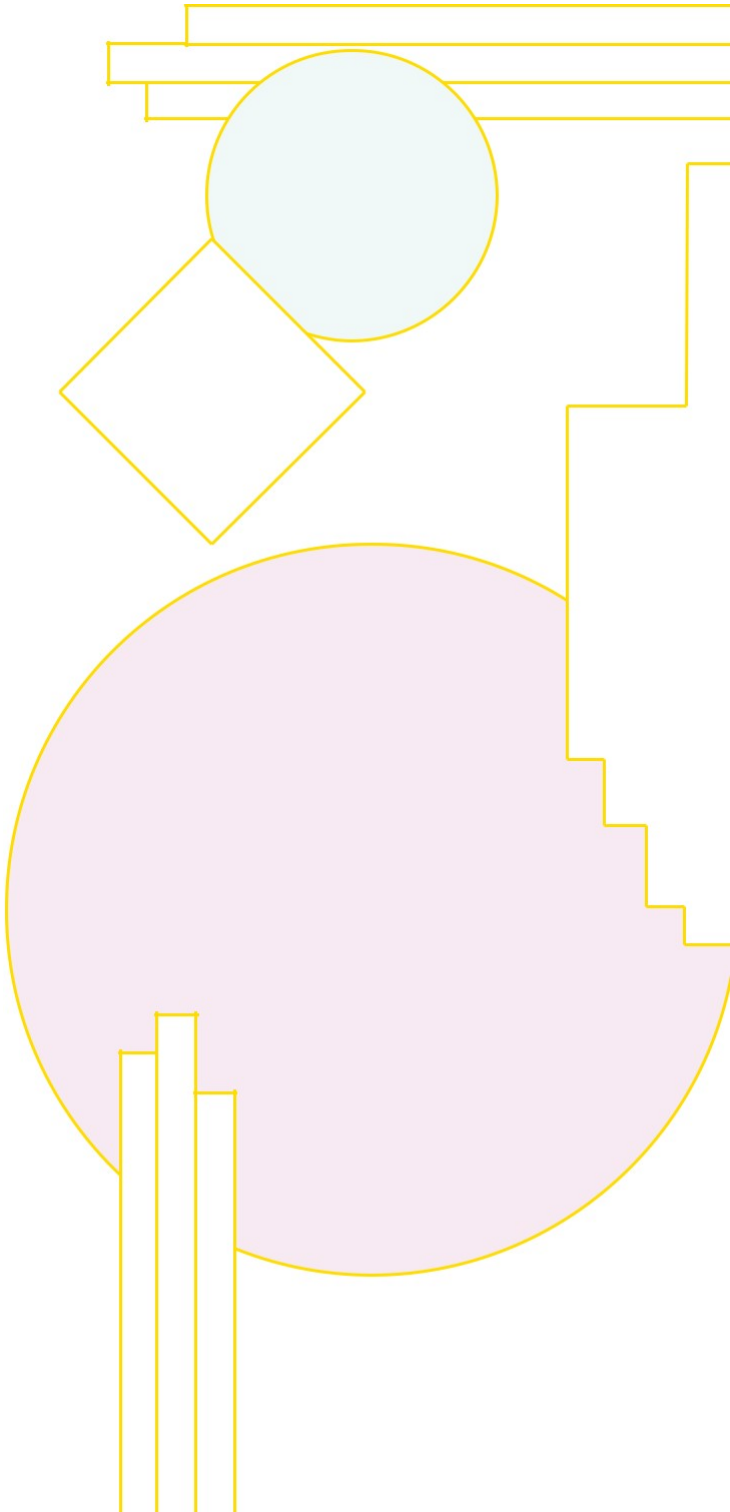
A Care and Support Planning approach ellicited that it was very important for Ann to get out and about in her wheelchair; she estimated that getting out to a church group scored 9/10 in importance to her. We disussed the little steps that she could take to go back to her church group.

1. **The first step was to phone her friend for support and see if she would attend with her. She did not want to go alone.**

2. **The second step was to arrange a date to go — she decided a date after her family had been visiting. She identified the second week in July (this was 2018).**

3. **The third step was to attend the group with her friend for support but she would ensure the group was still up and going.**

However, on questionng Ann score was only 4/10 for confidence that she could actually do this. With "high importance" and " low confidence" people, our roles as health care professionals is to help people to build upon their confidence. As the community HCSW Louise knew Ann very well; I liased with her and she brought the CSP summary to Ann and helped her confidence incrementally by putting Ann's wheelchair to the door initially; so that Ann could see birds and the blue sky. Ann loves nature and this helped her condidence. Gradually she ventured further with the HCSWs support. Ann's ramipril was being titrated a t the time and Louise was making contact for BP and bloods — this seemed to help the relationship and Ann's support network and confidence.

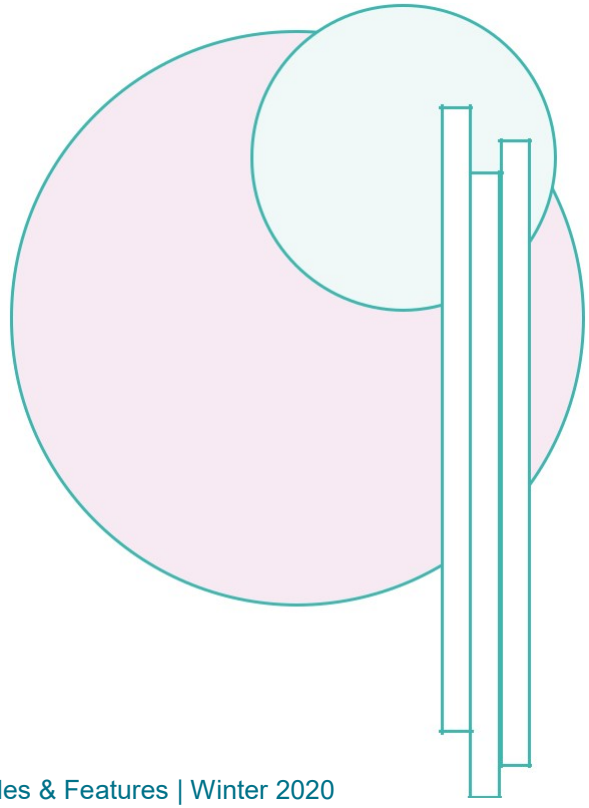


Ann reached her goal of attending the church group on the second week of July as planned. When I spoke to her after that (when handling results) she said “there is no stopping me now!”. Her voice was cheery and not the voice I initially encountered. Her vocal tones where now chirpy. Louise the HCSW reported a big differnce in Ann’s morale and well-being too.

Although social isolation is most common in the elderly, younger adults (e.g. housebound and disabled) may also be affected by both social isolation and loneliness. Reduced social contact, being alone, isolation and feelings of loneliness are associated with reduced quality of life which indeed initially Ann had. Those who work within primary care are in a unique position to identify people who may be lonely such as Ann. General Practice Nurses and Community Nurses are in contact with the three groups most at risk 1) very old people 2) bereaved people, and 3) people with disabilities, such as Ann. An excellent resource can be accessed below.

https://patient.info/doctor/social-isolation-how-to-help-patients-be-less-lonely

Care and Support planning conversations whether face-to-face or on the telephone can help identify a multitude of problems such as social isolation and GPNs and Community Nurses as well as other members of the Primary Care Team are in a core position to signpost individuals and help them plan their own goals and signposting others to services that may help; signifying the “more than medicine approach”.

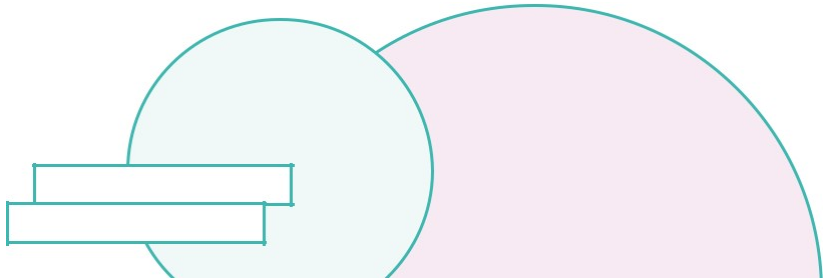


Ann’s goals were S M A R T

S — SPECIFIC
M — MEASURABLE
A — ACHIEVABLE
R — REALISTIC T
— TIMELY

The mnemonic above is very helpful when having care and support planning conversations as SMART objective goals are easier to attain.

Another outcome with Ann getting out more and being more active is that her August 2018 HbA1c level reduced to 56 compared with a level of 59 in May 2018. For Ann the beneficial outcome is that she feels much better and feels happier within herself. She is going from “strength to strength”. Ann, this year (2019), has also went on to successfully complete Reiki training (levels 1, 2 and 3) — by home tuition. This was a thing she always aspired to do — but now had the confidence.



Conclusion

Identifying what “really matters” to individuals when we communicate can get to the core of how an individual feels. Conversations can become more meaningful and nurses report increased job satisfaction. “I now feel I am making a difference” was a comment from one of our nursing team. Involving the whole team is crucial and this example also illustrates partnership working. In Ann’s case she had a strong bond with Louise the HCSW, and I was a facilitator in the Care and Support Planning process. It was Louise who helped build upon Ann’s confidence to help her reach her goal. Care and Support Planning can take many shapes and forms – the emphasis is on the individual at the centre of their own care with health care professionals being catalysts to help others plan and achieve their own goals and live fulfilled lives.

Partnership Working

Please be in touch if you need any further information about the “House of Care” and “Care and Support Planning” or you have any questions or comments.

Further information and resources can also be found at:

1. The Health Foundation has a good resource on Person Centred Care and Self Management: **http://personcentredcare.health.org.uk/**
2. The Coalition for Collaborative Care in conjunction with NHS England have produced a handbook for care and support planning: **http://coalitionforcollaborativecare.org.uk/news/personalised-care-and-support-planning-handbook-launched/**
3. The Year of Care Partnership has a valuable resource and for practitioners wishing to find out more: **http://www.yearofcare.co.uk/**
4. RCGP also has an excellent resource including a YouTube video on Care and Support planning: **http://www.rcgp.org.uk/clinical-and-research/clinical-resources/collaborative-care-and-support-planning.aspx**
5. The Kings Fund has a nice critique of the House of Care from Angela Coulter **http://www.kingsfund.org.uk/blog/2013/10/supporting-people-long-term-conditions-what-house-care**
6. **https://patient.info/doctor/social-isolation-how-to-help-patients-be-less-lonely**
7. **https://www.gov.scot/publications/summary-practising-realistic-medicine/**

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