

Person Centered Care

Practice Issues and Conundrums

A View from General Practice & Primary Care

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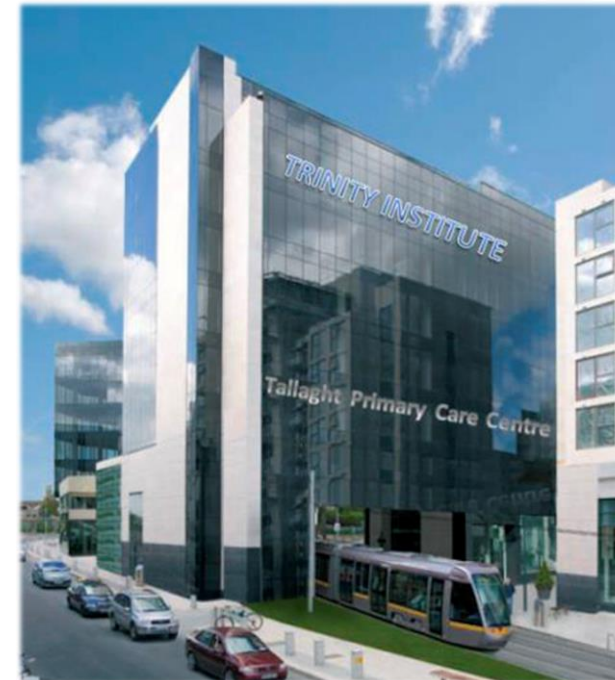




St. Brigid's Hospice



Kildare & West Wicklow



How can we improve the care ?

The Chronic Care Model (www.improvingchroniccare.org)



Barbara Starfield



Ed Wagner



Cathy Schoen



Michael Marmot

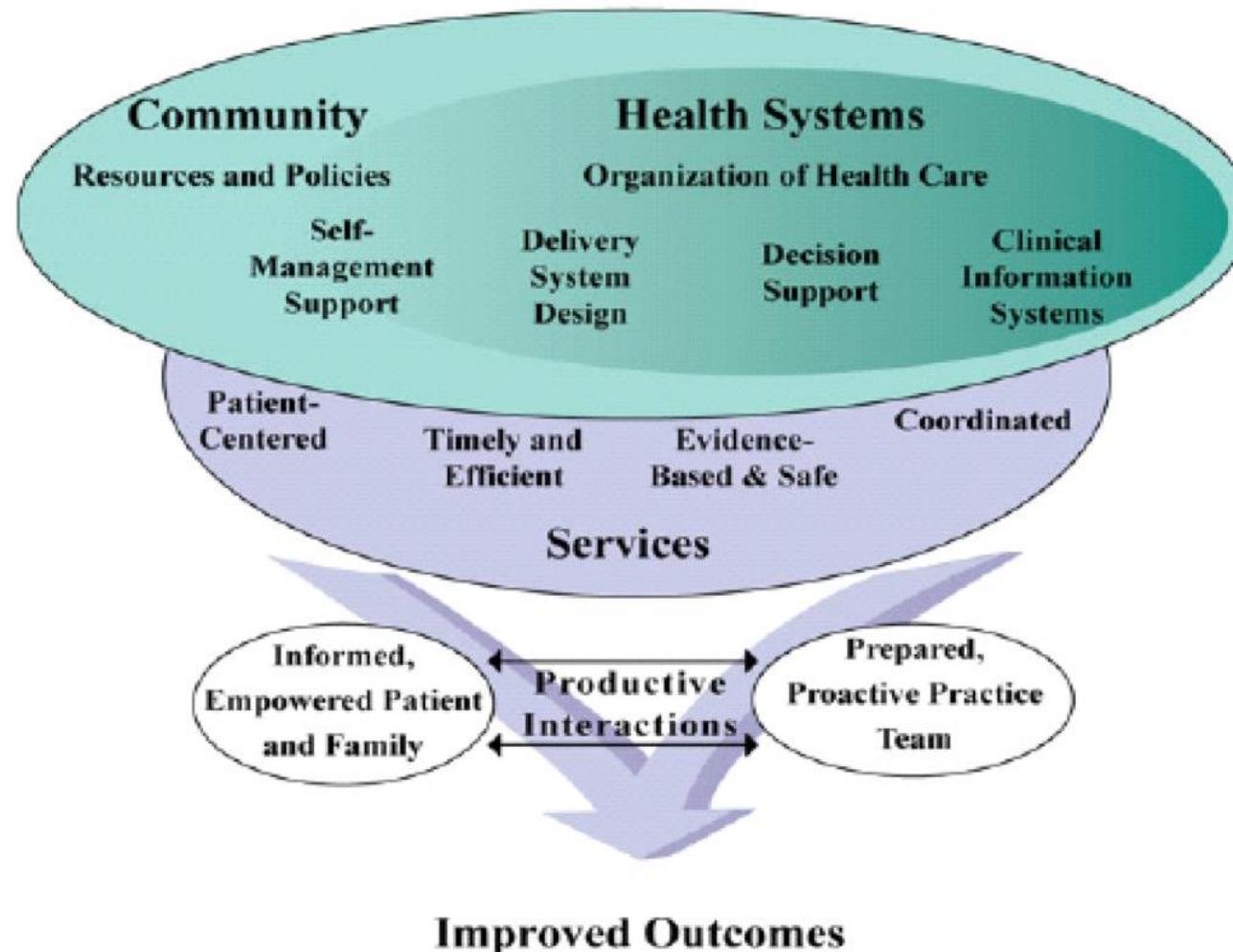
Paul Grundy



The Patient Centered Primary Care Collaborative (www.pcpcc.org)

ICIC's Expanded Chronic Care Model

The Care Model



MAKING EVERY CONTACT COUNT



What problems do we experience
in this area of care ?

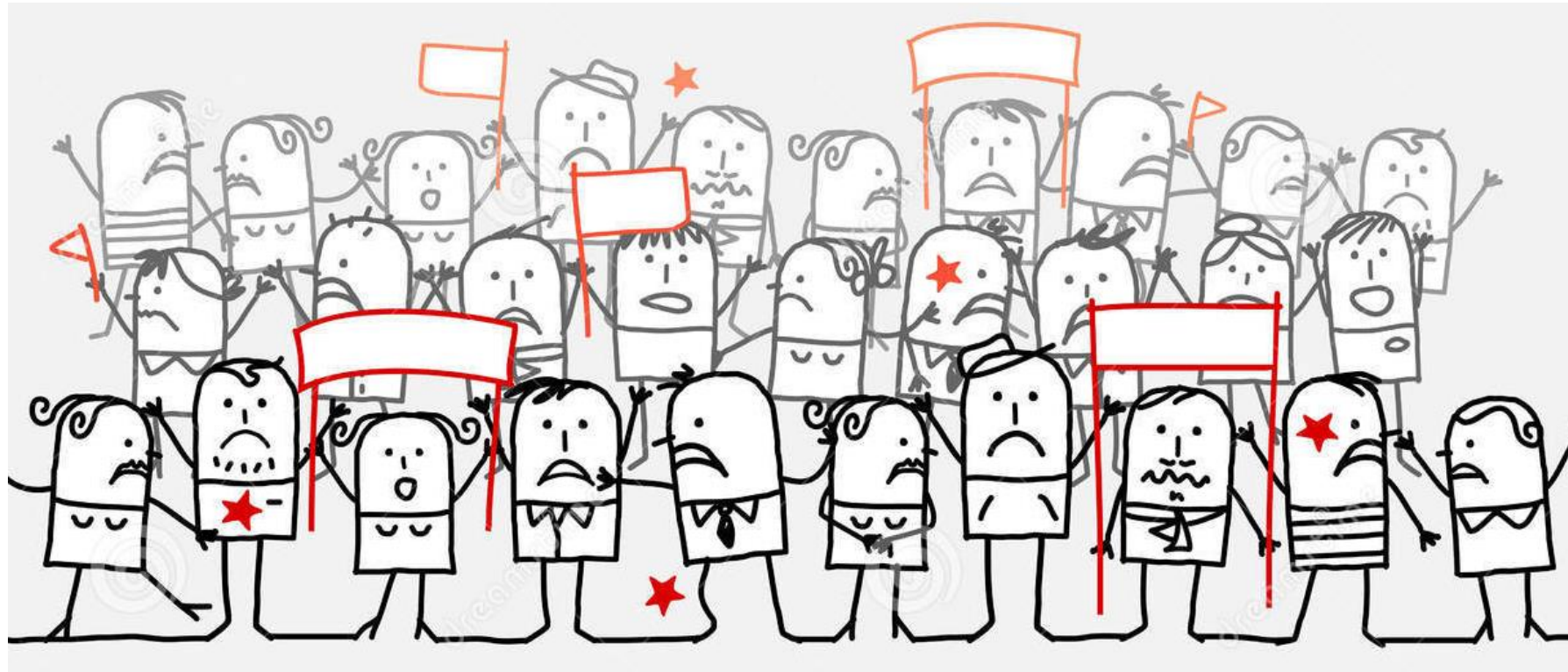
What do we find useful in this area of care ?

What can we do differently ?

Are we, as GPs, well placed to make a difference ?

What might good end of life planning look like ?

How GPs & Practice Nurses see it.....



~~4000 GPs & 1800 PNs~~ - **5000 of each**

What might good EoLP look like ?



GPs & Practice Nurses are trusted, available, and good at discussion of difficult issues...
They use electronic medical records...



Continuity





Conflicted
Frustrated
Sad
Uncertain
Pressurised



Why *we don't* Think Ahead

- Cultural / Societal
- Avoidance
- Busyness
- Complex and Fragmented Care
- Legal uncertainties – fear of men in black !
- End of Life Care is not a professional value....
- Professional inexperience / unease

Don't know when to....***procrastination***

Why *do we need* to Think Ahead ?

- Avoid additional uncertainties
- Reduce costs
- Alleviate suffering
- ***It often feels good to !***



When....How to...Where to....



Katharine Sleeman





When to Think Ahead ?

- **Today !**
- At 50 years of age
- At 6-8 weeks after a new/significant diagnosis
- Over 65's – perhaps biannually
- On admission to a Nursing Home

Many right answers

Two wrong ones.... 'Never' and 'Later'

When to Think Ahead ?

Shift the conversation from

Acutely unwell / Pre arrest / Ventilated patient

to several years earlier.....

.....in the Community



The conversations work best for a clinically stable, autonomous patient

Think Ahead



Presenting it to patients....

Are we ready to 'Think Ahead' ? Acceptability study using an innovative end of life planning tool.

O Shea B, Brennan B, Martin D, Bailey O, McElwee O, Darker C, 2014, IMJ Vol 107, No 5.

N=100 stable patients, aged 40 to 70 yrs, in the General Practice Setting

Study supported by The IHF

Was 'Think Ahead' difficult to understand ?

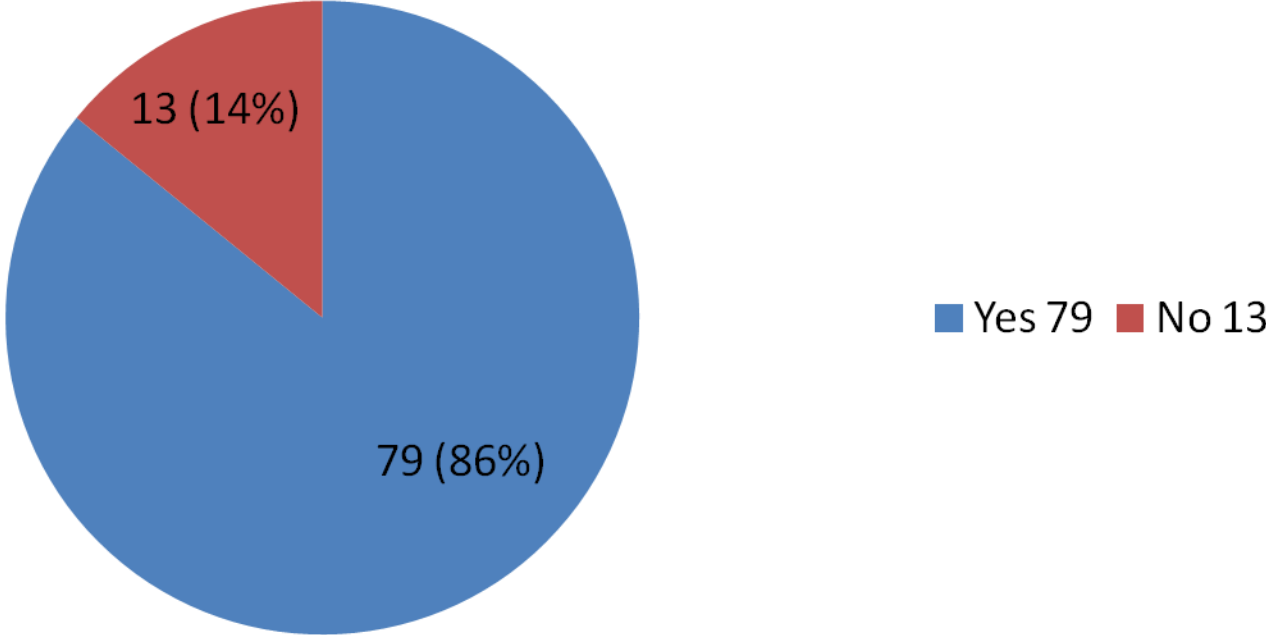
- 63% reported 'no difficulty' in filling in the folder.
 - Areas that caused difficulty for some were “Care Preferences”.
“I don't understand the issues around CPR and ventilation”.
 - Some difficulty completing parts of the document in the “Legal” and “Key Information” sections.

Should 'Think Ahead' be changed ?

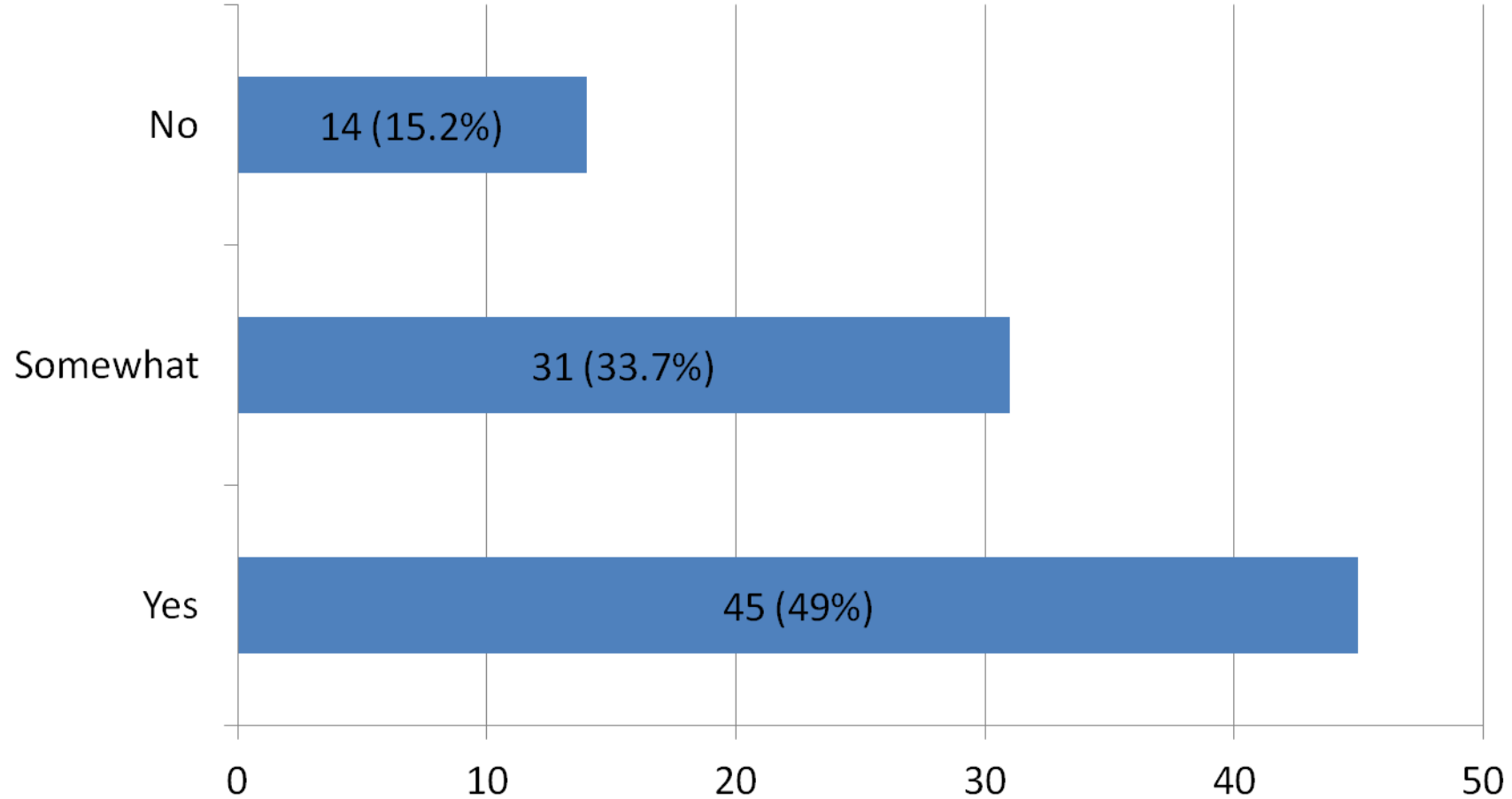
NO - 83.7%

- Suggestions for additional information
 - People or groups that should be contacted at the time of a person's death ?
 - How often the Think Ahead document should be reviewed ?
 - Church or religious organisations to be notified ?

Should 'Think Ahead' be introduced more widely?



Has reading 'Think Ahead' caused you to discuss it with your family?



Was 'Think Ahead' upsetting ?

74% reported they did not find 'Think Ahead' upsetting.

26% reported some parts caused upset.

– Two main areas were identified: “When I Die” and “Care Preferences”

– Sample responses include

- “the idea of organ donation and switching off the life support machines”
- “when you are sick you may feel differently about the choices you have made compared to when you are well”.



'Think Ahead' is very effective at

- having the work done,
- often, with the family,
- outside of the consultation.....



Research

Eoin J Dunphy, Sarah C Conlon, Sarah A O'Brien, Emer Loughrey and Brendan J O'Shea

End-of-life planning with frail patients attending general practice:

an exploratory prospective cross-sectional study

Study supported by The IHF

BJGP 2016



Supportive and Palliative Care Indicators Tool (SPICt™)



The SPICt™ is a guide to identifying people at risk of deteriorating and dying. Assess for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating with limited reversibility; is in bed or a chair for 50% or more of the day.
- Dependent on others for most care needs.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/ or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of one or more advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; swallowing difficulties; difficulties with nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Review supportive and palliative care needs and care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate care plan.

Please register on the SPICt website (www.spict.org.uk) for information and updates.

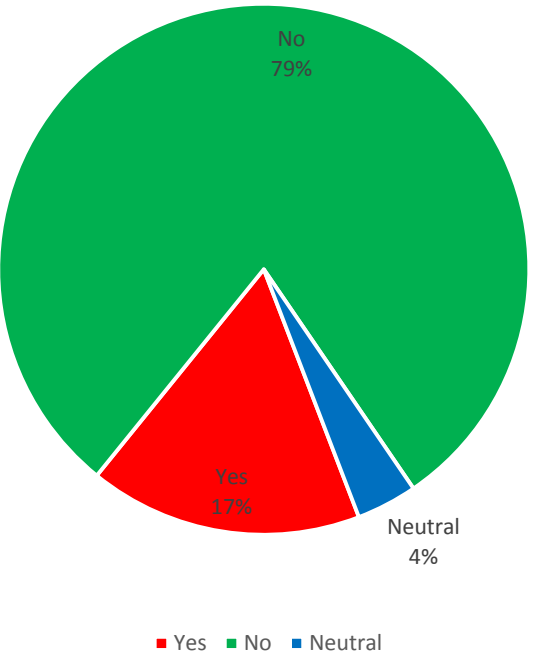
SPICt™, March 2015



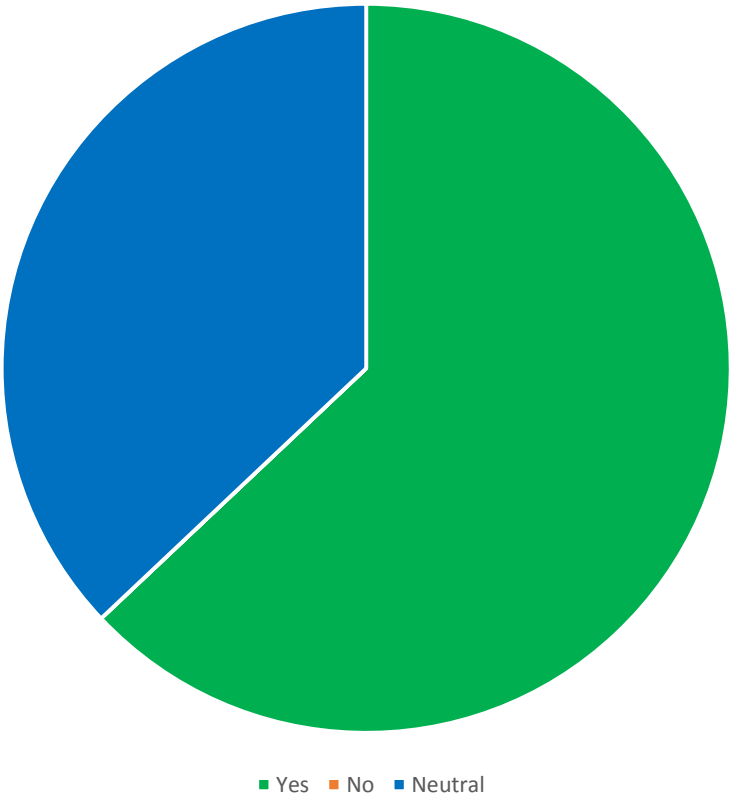
“Found it very helpful. This area is like a list of jobs I need to sort but never got around to”

Results

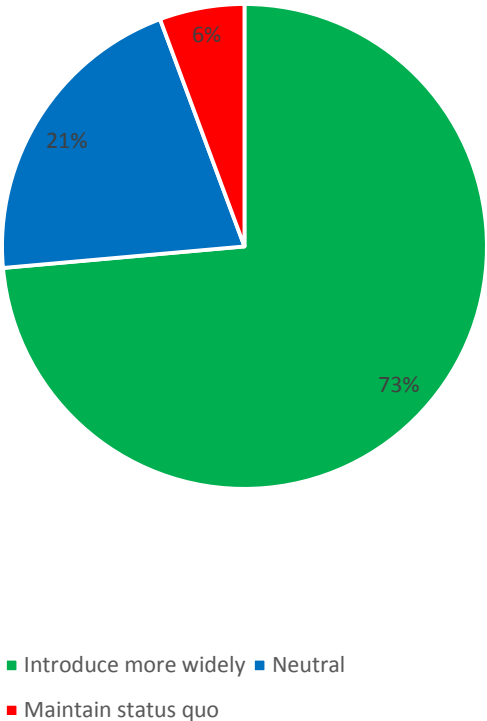
Did you find any part upsetting?



Do you feel this document would be of interest to people generally?



Do you feel it would be better to introduce the document more widely?



Comments from SPICT Survey

'Makes you think positively about things, puts things into perspective...'

'Found it very helpful. This area is like a list of jobs I need to sort but never got around to...'

'A lot of people won't go and get it, a GP should bring it up....'

'Opened a door allowing the family to start talks....'

Improving Practice ICGP

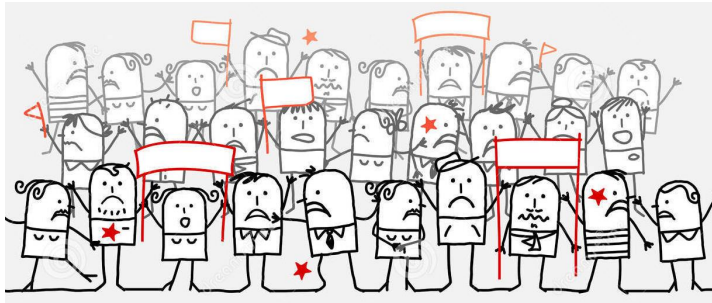


Think Ahead - Quick Reference Guides (Dementia & Nursing Home Medicine)
Integrated Care Guidelines (COPD, Diabetes, Heart Failure)

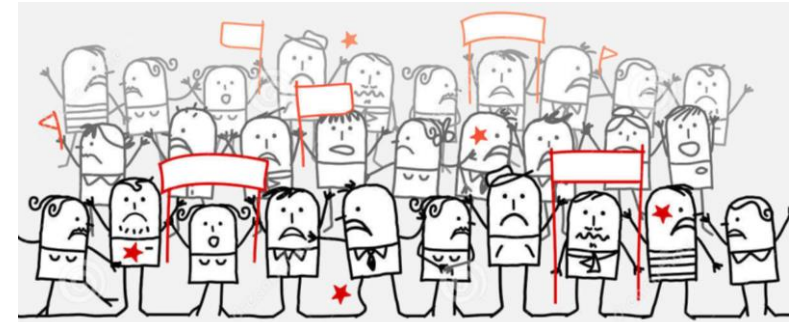
ICGP Blended Learning Module www.icgp.ie (IHF Supported)

- Background material
- Videoed consultations with people / families / GPs
- Suitable for use by The Practice Team
- Focus on experience and consultation skills

Back at the
Practice



What can we do
in Just a Minute ?



1. People have a right & a need to know if they are at risk of dying in the intermediate term.....
2. A practical approach, delivered with sensitivity may be best...
3. The risks of silence are much greater than risks of discussion

Key Principles

All clinicians require to be skilled in the practice of brief interventions....



No engagement

Thinking about it

Planning to do something about it

Actually doing something about it

Simple clear communications, reflexively tailored to the individual....

What we say.....

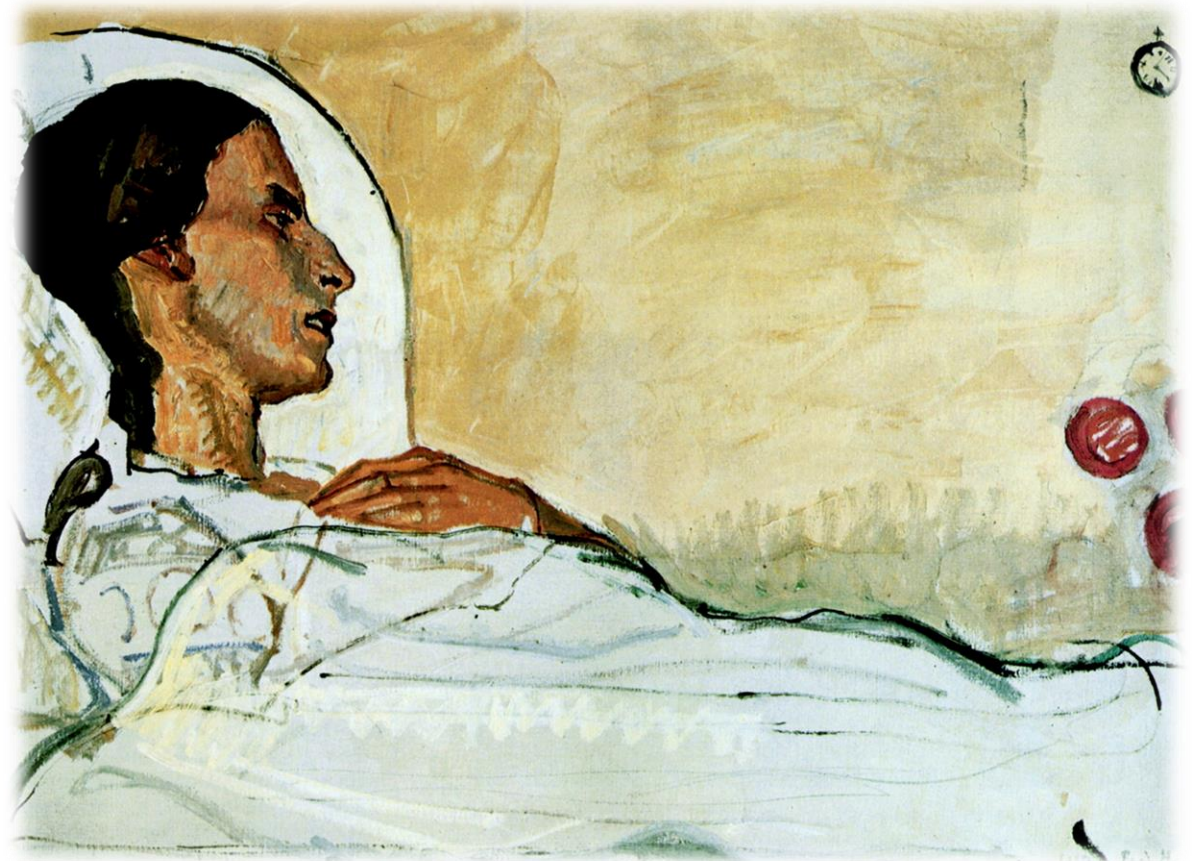
'Time is short'

'It is getting rather difficult, but we should be able to do something about it'

'Comfort Care'

'Prepare for the worst'

'We will all look after you'



What we say...

'Time is short'

'Comfort Care'

'Prepare for the worst'

What we mean

'You're Dying'

'You're Dying'

'You're Dying'

Doctors & Nurses find it extremely difficult to mention / discuss death & dying
(But we can and are getting better at it...)

What do you say ?

We're in a very difficult situation with this...

Is there anything you want to ask me about ?

Is there anything you'd like to discuss ?

Is there anything that you're particularly worried about ?

Is there anything that you're afraid about ?

Use of silence, touch and body language.....

This is a new situation for you / us to be in....

This is different for everyone...

Things are getting very complicated ?

We're in a very difficult situation with this...

Is there anything you want to ask about ?

Is there anything you'd like to discuss ?

Is there anything that you're worried about ?

Is there anything that you are bothered or afraid about ?

**If you become very unwell again, how would you like
your medical care organised ?**

Use of silence, touch and body language.....

Think Ahead



Think ahead
Speak for Yourself

The gift of peace of mind for you and your family

Think Ahead encourages you to:
THINK about how well those close to you would know your wishes if you could not speak for yourself. **TALK** about these wishes with those close to you or with a GP, solicitor or accountant. **TELL** the key people in your life about your wishes.

An initiative of  **FORUM on END of LIFE**
FORUM ON END OF LIFE

The **Think Ahead form** is available **FREE** through your local Citizen's Information Centre and Pharmacies or can be downloaded at www.thinkahead.ie

Supported by





- Complete 'Think Ahead' for yourself
- Communicate EoLP as core professional value
- Challenge / advise all Clinical Staff



Preserving the voice of the individual....

- Shift EoLP to an earlier time, with well people....
- Have EoLP reflected in Integrated Care Guidelines (HSE, ICGP, RCPI)
- Single GP EoLP Consult at outset of CD, NH Admission, or at 70 years
- Better management at care transitions – Electronic Medical Records
- More GPs, and a lot more Practice Nurses....(Slaintecare)
- Continue to apply and develop evidence based care
- Engage more directly with People, and with Voluntary Sector
- EoLP in the social and clinical domain, rather than the legal domain
- Understand - We will improve care...

Acknowledgements

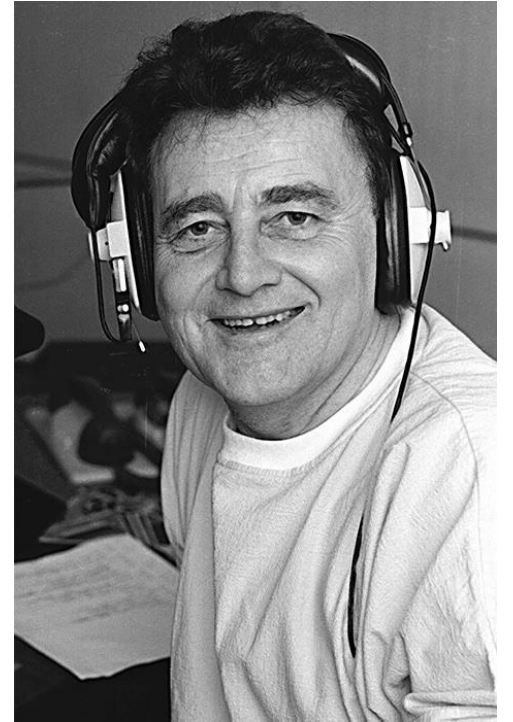
Colleagues at The ICGP, The IHF & The HSE
The Team at The Bridge Medical Centre, and The People who attend us
Larry, and everyone with the guts to go on his show

Apologies

To people hurt or neglected in their interaction with our services....

Commitment

For all of us, to be better at this.....together.



Dying in Ireland.....

Can we do better for ourselves ?

