Patients, carers and practitioners speak of the impact of Anticipatory Care Planning

IMPROVING LIVES ACROSS SCOTLAND

A collection of inspiring digital stories on one DVD

Plus:
Your Anticipatory Care Planning Routemap
Taking charge of the future

Anticipatory Care Planning simply gives people greater choice and control over their future care and support.

Thinking ahead and planning for our future healthcare and support is something that few individuals achieve. That is changing in Scotland as Anticipatory Care Planning (ACP) becomes the norm for people likely to experience deterioration in their health. The essence of Anticipatory Care Planning is to help people to have the confidence, control and choice that comes with knowing what might happen, spotting small indications of change and being ready to do the right things with the right supports from the right people. It exemplifies person centred and holistic care and respect for the individual’s goals, wishes and choices.

Improving Lives has been developed to support the spread of Anticipatory Care Planning now being embraced by GPs and their colleagues in primary and community teams. It describes the process from the perspective of the patient, carer and professional and illustrates the range of supports and interventions that people can be signposted to through Anticipatory Care Planning. Most importantly it describes the positive impact that Anticipatory Care Planning is having on people’s lives.

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How To do IT

What a difference to have an Anticipatory Care Plan

Storytellers: Jean Carmichael and Dr Iain Hathorn

Jean Carmichael was told during bouts of excessive vomiting and diarrhoea that her condition didn’t require an emergency ambulance. Only when her GP intervened did she finally get an ambulance. “It was terrifying,” says Jean. That was then. Now, thanks to GP Dr Hathorn, Jean has her own Anticipatory Care Plan. The Out of Hours service and the Ambulance Service are both in the loop about Jean’s Addisons Disease and her husband is trained to give her an injection if serious symptoms recur. District nurses are also on hand to help at any time. “I feel so much more confident now” says Jean who is proof positive of the benefits of Anticipatory Care Planning.

Using Key Information Summary (KIS)

Storyteller: Dr Stuart Cumming

GP Stuart Cumming talks us through (KIS) Key Information Summary and how it helps Forth Valley health and social care services improve outcomes for people through sharing important information from the Anticipatory Care Plan. KIS has been a great boost to the practice team and a vital resource at multi-disciplinary team meetings where a patient’s condition can be reviewed while taking patient and carer preferences into account. “It also allows us to share information with out of hours services, NHS 24 and the ambulance service and will soon be linked to acute wards.” Stuart describes how the KIS can help other teams have the right information and he gives a powerful reminder of its benefits to professionals and patients alike.
Angus Polypharmacy Project

*Storyteller: Dr Douglas Lowdon*

95% of patients more satisfied and 85% feeling better. Locality Geriatrician Douglas Lowdon describes how success for a small pilot in south Angus inspired a larger Polypharmacy project in the region involving 11 health practices, three geriatricians, nine pharmacists, 40 GPS and 900 patients. The results prove beyond doubt the value of medicine reviews in improving patient wellbeing and confidence and provided great learning for all the practitioners. For Douglas, it strengthened relationships between the local geriatricians, GP’s, pharmacists and Practice nurses, improved the quality of care and, at the same time, reduced costs.

Polypharmacy Reviews

*Storyteller: Kay Erskine, a locality pharmacist*

Polypharmacy reviews don’t just allow pharmacists to do the job they trained for, they increase patient satisfaction and help GPs make more informed decisions according to Kay Erskine, a locality pharmacist from Arbroath. It was several years ago that she and her GP colleagues started reviewing patient medications – some prescribed many years earlier and causing adverse side-effects. They set up a series of review meetings, taking care to allay patient fears and involving Care for the Elderly Consultants. The results are invariably positive and through their involvement patients are much more knowledgeable about what they are taking each day and why.
Reablement at Home

**Storytellers: Christine Ranshaw and Angela Thompson**

The change is dramatic. John, once withdrawn, has a new lease of life – he’s more positive and goes out regularly for coffee and lunches. When his wife Christine was diagnosed with breast cancer John’s demeanour and health changed. It hit him really hard – a series of physical illnesses followed before John was diagnosed with delirium. Christine did all she could but became so stressed she called for help. With support from Angela Thompson and colleagues from the reablement service, John and Christine are now in an entirely different place – John is now more independent again, Christine feels better supported as a carer, and they are looking forward to staying together at home.

After all this time

**Stoyteller: Dick**

One small fitting saves 96 year-old Dick’s life and allows him to stay on in his home of 61 years. In the early hours one morning Richard found his father, Dick, in slippers and pyjamas grazed, bruised and bloodied by the side of the road. Because of the telecare alert, Richard was quickly able to find him and guide him home. It was all down to a small piece of smart technology. Six weeks earlier the outcome would have been so different. This is the story of a son determined to keep his father in the home and neighbourhood he loved, and of health and social care professionals that listened, cared, acted together and applied simple technology to make staying at home safer.
**Black and White**

**Storyteller: Christeen**

Dad diagnosed with terminal cancer and Mum with Alzheimer’s Christeen, the main breadwinner in her family, gave up work to care for her parents. After her father died months later, Christeen kept up her mother’s care, without realising the full impact it was having on her and husband Robert’s life. After a negative experience of her first carer assessment where she had simply felt dismissed, Christeen asked for a new carer assessment and experienced something entirely different. This time the focus was on her, her life and her anxieties about her mum’s care. Christeen talks of how she now feels empowered, supported and part of a team with her mum’s care at the centre and her life in better balance.

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**Can we catch you before you fall again?**

**Storytellers: Carolyn Wilson, Liz Adams and Elizabeth Cummings**

This question led to a new collaborative approach in Perth and Kinross, which has already reduced the number of repeat falls in its target group by over 40%. Following up on people attended by the rapid response team after a repeat fall, the team’s approach kicks in. Physical assessments, medicine reviews, nutritional and mobility guidance follow at home. For 92 year-old Elizabeth the service is a real confidence boost. The team taught her how to get in and out of bed, adapted her chair, her home surroundings and she attends NHS Tayside’s Falls Clinic. With referral to falls prevention services, falls needn’t be an inevitable consequence of ageing.
I can breathe again

Storytellers: Jill McLean and Jean Gordon

When Jill McLean, a clinical pharmacist in Angus, and the multi-disciplinary team reviewed Jean Gordon’s long list of medications they saw an opportunity to make a small change. With COPD and having previously suffered a heart attack Jean was on a range of repeat medications. When Jill explained the benefits and side effects, Jean understood more about her medicines and agreed to stop one of the drugs. The result was remarkable. Before, any exertion at all caused Jean to be breathless – now she has a new lease of life. To her, one small change has been a godsend. “I can breathe again” says Jean.

Out of the box

Storyteller: Aileen

With time short and their wishes for end of life care unmet by conventional means it is time to find a creative solution. Occupational Therapist Aileen tells a story of how one newly retired man, diagnosed with advanced cancer was able to live out his final wishes. As a regular rambler, he wanted more than anything to get out of the house but stairs were proving a barrier too far. The family tried but hated the stair-lifting equipment and with little time on their hands the team had to act fast. An inspired adaption in the form of a temporary pathway through the back garden gave him a chance to make that last trip to the West Highland Way. This story shows the powerful impact of prompt access to the right equipment or adaptation.
Some Simple Tweaks

*Storyteller: Morag*

Morag describes her role as a district nurse and care manager. “Care management can simply be understanding what’s there and coordinating the existing supports”, says Morag. “It’s not as daunting as I first thought. Take one gentleman – referred after a hospital admission. We found him confused and living on his own. The house was clean and tidy and a neighbour took care of housekeeping, paying bills and preparing food. At first alarm bells rang – a car in the drive and a neighbour seemingly in control of his money. We found it was problems with his medicines that was at the root of his hospital admissions. A few tweaks and while the neighbour is still his main support she is far better equipped to do so.”

Sheila’s Choices

*Storyteller: Fiona*

Mum Sheila, days away from returning home from the hospice, made the decision not to accept any more medical interventions. “It’s sometimes harder to say no”, says daughter Fiona. When the doctors were preparing for a blood transfusion Mum was tempted to accept but found the courage to say no. Sheila had already turned down a second treatment of chemotherapy and now looks forward to spending her time at home. “We are comfortable talking to Mum about her funeral and the hymns she would like sung. We have a package of care and support at home and we are all happy her wishes have been respected.” This is a story is about the importance of patient and family choice and supporting autonomy in end of life care planning.
Challenging the System

**Storyteller: Dr Tona Fernandez-Ares**

Jimmy, posted missing by his son, sets the ball rolling in Ayrshire resulting in a dramatic turnaround for a man who’d spent 109 days of the previous year in hospital. Chest problems and alcohol excess were compounded by housing and social stress. Now he lives in a home he likes and has even started driving again – his alcohol intake is down and his smoking controlled. He no longer needs frequent acute treatments for his COPD and a man once dismissed with the line “Nothing will ever work for him” is finding life on the up. This is an inspiring story of agencies working together to deliver integrated and person centred care that is truly life changing.

In the same boat

**Storytellers: Barbara, Jack, Penny, Sadie, Sheila and Willie**

Barbara, Jack, Penny, Sadie, Sheila and Willie all now breathe more easily thanks to the Wishaw COPD self management group. Each talks of a newfound companionship and gentle competition as they learn and exercise together. This is a compelling story of individual and collective triumph through pulmonary rehabilitation and peer support for self management. “The classes and exercise are great.” “Met some great people and heard some great speakers.” “I can now exercise at home without worry because I know I won’t get an attack. Found out so many ways to help my breathing.” “Being with people in the same boat helps you emotionally as well.”
Carol’s Journey

Storyteller: Carol Duncan

Carol, diagnosed with MS reached an all time low after the birth of her child. She found herself immobilised, blind and terrified. A period in hospital and a range of treatments restored her sight and gave her back movement. But it didn’t stop there. Physiotherapy at home then helped her get back on her feet and counselling built her emotional strength and gave her back control of her life – something she “thought she’d lost”. MS is still there but Carol feels more positive and has learned to take each day as it comes. Hear why she has nothing but praise for all the people who supported her physical, emotional and psychological recovery.
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We are very grateful to all who have generously shared their stories. A special thanks to Janette Barrie, Nurse Consultant, NHS Lanarkshire, and to Marie Curran, JIT Improvement Lead, for their enthusiastic support in compiling the collection.

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