PERSON-CENTRED APPROACH IN CARE TRANSITION

A guide towards better patient's experience in transition of care

Care Transition Community of Practice

In Collaboration with
Singapore Association of Social Workers

OUR APPRECIATION

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THE CARE TRANSITION COMMUNITY OF PRACTICE (COP) THANKS EVERYONE WHO WAS A PART OF THE JOURNEY IN THE PRODUCTION OF THIS GUIDE:

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- *Wong Loong Mun*
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CONTENT

LONG CHEY MAY

President
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I write this foreword with pride, like a parent who feels a sense of joy that one of her children has achieved a milestone. This is especially when this Communities of Practice (COP) had invested a lot of thought and effort into this challenging project which has now come into fruition with the publication of this guide.

The COP, comprising Social Workers across many institutions, is one of the COPs formed with support and oversight from the Singapore Association of Social Workers (SASW). This is following the signing of an undertaking between the Ministry of Health (MOH) and the Singapore Association of Social Workers (SASW) in 2017.

The objective of this COP is to help facilitate knowledge creation for related professional topics in the health and social service sectors.

Care Transition is at every Medical Social Worker's (MSW) heart and is a core function of the MSW, as clients transit from one care setting to another and in their recovery journeys. Together with a multidisciplinary team, MSWs assist clients and family members to formulate the appropriate care plans and help facilitate and execute those plans. They also help mobilise resources and follow through on the clients' recoveries. Adopting a Person-Centred Approach (PCA) will allow practitioners to have a common understanding and ensure that the clients' journeys across all formal and informal settings will be seamless. This guide will not just help the individual social workers but potentially also provide a philosophy and approach to care that ensure high standards of care is provided by healthcare institutions, e.g. residential and centre-based service providers. Such an approach addresses the six key domains in care transition and ensures the key elements, i.e. clients' dignity and respect, are weaved into the day-to-day practices and operations.

Singapore's healthcare sector is going through a transformation and this guide aims to enable new and experienced social workers to better perform their roles and responsibilities in both the acute and Community Care sectors. It will also alleviate the pain and confusion experienced by the clients' family members when the clients transit from one place to another. The case studies are good ways to demonstrate how the PCA is carried out and how it differs from the general approach. The cases will also highlight the merits of PCA so that the social worker may better understand and meet the needs of the clients.

I congratulate the team for the production of this guide. It would serve as a useful reference for the social work profession as they evolve to provide supportive care and services to the clients and their families in the community.

CARE TRANSITION IS AT EVERY MEDICAL SOCIAL WORKER'S (MSW) HEART AND IS A CORE FUNCTION OF THE MSW, AS CLIENTS TRANSIT FROM ONE CARE SETTING TO ANOTHER AND IN THEIR RECOVERY JOURNEY.

WONG LOONG MUN

Principal Consultant
Chief, Care Transition Division

Increasingly, we witness families with ageing parents requiring a more structured and community-based support to help care for their loved ones. This is particularly when care is complex and challenging, overwhelming the strengths and resources of the families.

It is therefore important to engage the various health and social care professionals to put together various types of assistance that addresses diverse care needs. It is also essential to be committed to exploring how to provide the best care in different settings.

The Agency for Integrated Care (AIC) plays a key role in the development of Community Care services. We work closely with the Ministry of Health (MOH) and Ministry of Social and Family Development (MSF) to actively network with the social work professionals to research, plan and organise various study trips for social workers and their administrators in the health and Community Care sectors.

They observed and learned best practices; and worked together to synergize local implementation, and develop local practices and care models. The delegates were enthusiastic to review and reflect their roles and functions to contribute, help and enhance the quality of life of the seniors. They have also worked closely with the hospitals and relevant social care sector to pilot the stroke self-management program and formed various workgroups to review the delivery of care services.

We believe in prioritising the client's values and best interests which has always been at the heart of the social work practice. So, it is heartening to have a group of social workers from the hospitals and the nursing homes come together to form a Community of Practice (COP). The COP shared their views and challenges and explored how we can improve the well-being and emotional health of our seniors and their families as they transit from hospitals to nursing homes.

The COP aims to improve the care experiences of senior residents and promote the adoption of person-centred processes. To do so, they have developed a guide to illustrate how the Person-Centred Approach can be applied through the various psycho-social domains of care transition. The guide also addresses how, at the organisational level, management can facilitate and support these processes. This guide is timely and can also be used as a teaching and training tool for new social workers in community care services.

AIC congratulates the group for the guide, and warmly invites home- and centred-based partners to adopt the guide's recommendations as we strive to build a humane, caring, nurturing and trusting culture and community.

WE BELIEVE IN PRIORITISING THE CLIENT'S VALUES AND BEST INTERESTS WHICH HAS ALWAYS BEEN AT THE HEART OF THE SOCIAL WORK PRACTICE.

CHAPTER 01

ABOUT

CARE TRANSITION COMMUNITY OF PRACTICE

OUR PEOPLE

We are medical social workers (MSWs) working in government restructured hospitals and voluntary nursing homes (VNH). Formed in March 2016, we are sponsored by the Singapore Association of Social Workers and are funded by the Social Work Development Fund under the Ministry of Health.

OUR INTEREST

Our interest lies in improving client experience in care transition to achieve seamless transfer between hospitals and nursing homes.

We aim to achieve this through:

- Refining care transition to be more person-centred.
- Building closer partnerships between hospitals and nursing homes.
- Aligning processes for smoother client transfer and case management.

OUR STRATEGIES

- Create awareness and foster understanding on care transition issues faced by both hospitals and nursing homes.
- Co-create solutions with hospitals and nursing homes to provide seamless care transition.
- Garner stakeholder support for person-centred care and for the proposed solutions to care transition issues.

ABOUT PERSON-CENTRED APPROACH IN CARE TRANSITION

In developing the Person-Centred Approach in Care Transition Guide (PCA@CT Guide), we have referenced the Person-Centred Approach Toolkit. The toolkit was developed by the Care Transition Community of Practice which is sponsored by the Social Service Institute.

This PCA@CT Guide deep dives into how the PCA philosophy can be applied to the processes involved in transferring a client from the hospital to a nursing home for continued care, and thus making the transfer a more seamless and pleasant experience for the healthcare organisation and for the client and the family.

WHO SHOULD USE THIS GUIDE?

Staff in hospitals and voluntary nursing homes.

WHAT IS IN THIS GUIDE?

It contains a care transition model developed with the PCA principles at its core. This model has six domains: pre-admission, social information, financial assistance, health, adjustment, and long-term care planning and preparation.

The next chapter will show how the model works through the use of case studies.

HOW SHOULD STAFF USE THIS GUIDE?

We hope that MSWs will use this guide to refine their current care planning practices. We also hope that they will adopt the PCA way from the moment care arrangement is discussed to after the client has settled down in a nursing home.

Senior MSWs can use this guide to train or assess the ability of staff in applying PCA. Trainers for PCA will also find this guide relevant and helpful in teaching as well.

MODEL FOR PERSON-CENTRED APPROACH IN CARE TRANSITION

PHILOSOPHY	RESPECT INDIVIDUAL	PROMOTING CHOICES	GROWTH & DEVELOPMENT		BEST INTEREST FOR THE INFIRMED	CULTURAL COMPETENCE & SOCIAL DIVERSITY
SIX - DOMAINS	**PRE-ADMISSION** From deciding placement to preparation for the transition	**SOCIAL INFO** In-depth understanding of P & handing over of information	**FINANCIAL COUNSELLING** Assessment/review; financial assistance; explain payment terms	**HEALTH** Understanding of condition, treatment options, plans, prognosis & follow-up	**ADJUSTMENT** To feel safe, love and belonging, whilst maintaining self-identity, and rebuild life in NH	**LONG-TERM CARE PLANNING & PREPARATION** Goals of care, periodic review, Lasting power of attorney "(LPA) and end-of-life" issues
MSW LEVEL	Involve P in deciding care plan Help P come to terms with transition to NH Address expectation, concern, requests	Information from other SP Underlying reasons Complex dynamics & wisdom of managing P & F Joint conference	Seek underlying concern & dynamics Proper handover to reduce repetition RH & NH align messages	Pre-empt differences in care level at H-NH Clear handover of info among H-NH-P/F Attend to P's responses to condition Involve P	Orientation Provide choices Relationship building Knowing P; address concern Engage in meaningful activities	Discharge planning, if possible Continuously engage family, reviews issues impacting P. Psychoeducation of long-term issues
ORGANISATION LEVEL	Culture to promote Person-Centred Care Multi-disciplinary practice	Align KPI & appraisal to measure PCA Collaborate with other organistaion & across different discipline for better care	Supervision & support that encourage PCA Set processes to involve family		Manpower support Engage community	Clear policy & guidelines, but allow flexibility Continuous quality improvement

We shall take it that the care-transition process begins when the care team engages the client about his/her long-term care in a nursing home. This discussion may occur a few times as changes in a client's medical condition may need many hospital and nursing home re-admissions.

There are six clear domains that we can see in the whole process of care transition, and the actions and interventions should be grounded in the philosophy of Person-Centred Approach, which is also very similar to the Social Work principles and ethics.

LEGEND

P : Patient

F : Family

RH/H : Restructured Hospital/Hospital

NH : Nursing Home

SP : Service Provider

THE SIX DOMAINS OF CARE TRANSITION

1 PRE-ADMISSION

Pre-admission starts from talking to the client about his/her condition in preparation for subsequent discussions on care planning. Applying PCA to care planning means involving the client in deciding on his/her care plan.

It also involves supporting the client in coming to terms with his/her need for nursing home care. Addressing the client's expectations, concerns and requests are also part of the process in getting him/her well-adjusted to a nursing home.

2 SOCIAL INFORMATION

Part of our process in arranging for nursing home placement involves gathering information about:

- The client and his/her family, e.g. family dynamics and who is the primary caregiver.
- The underlying reasons for nursing home application, e.g. primary caregiver is unable to care for the client due to the severity of the client's condition or strained family relationships.
- Other useful details on how to manage the client and the family, e.g. how to help them adjust to nursing home care.

These crucial pieces of information will only be useful if there is a good handover between the members of the care teams, the client, and the family. Ensuring good information flow is therefore important. Sometimes, a joint conference with the family may be needed to support this.

3 FINANCIAL COUNSELLING

This domain includes conducting eligibility assessments, reviews, application of financial assistance and explaining how the payment term works.

A PCA approach would involve understanding any issues affecting a client's and the family's ability to pay for the needed healthcare services. It also involves doing a proper handover of information so that the client and the family need not undergo repeated interviews.

Additionally, there should be an alignment in messages between referral source and the nursing home. This helps to reduce misunderstandings and set appropriate expectations.

4 HEALTH

MSWs play a key role in applying PCA in care transition in this domain. What they can do is to ensure that all the stakeholders involved - client, family, healthcare organisations - understand the client's condition, the treatment plans and the follow-up care needed as a client transits from a hospital to a nursing home.

This includes anticipating differences in levels of care and facilitating clear handover of information. Involving the client in the discussion of his/her health issues and attending to his/her concerns would help prevent future misunderstandings and disagreements regarding the treatment and/or care plan.

5 ADJUSTMENT

A major psychosocial concern in care transition is whether the client is adjusting well to the nursing home. Being well-adjusted means the client:

- Feels safe and loved, and has a sense of belonging in a different environment (these are part of the Maslow Hierarchy of Needs)
- Is able to maintain a sense of autonomy and identity
- Is able to re-build his/her life in a new place

The work needed to achieve this includes getting to know the client as a person and providing him/her with an orientation. It also involves helping the client build new relationships with other people, allaying his/her concerns, engaging him/her in meaningful activities and providing options that support the client in maintaining a sense of autonomy and identity.

6 LONG-TERM CARE AND PLANNING

As part of the adjustment process, a discussion with the client and/or family members on the objectives and details of the client's long-term care plan is needed. This includes subsequent reviews on the client's situation.

This means that the care team will need to continuously engage the family and review issues that may impact the client. The care team also needs to explore the possibility of discharge and reconnecting the client with the family/community.

Other future planning details to be considered include, establishing Lasting Power of Attorney (LPA), Advance Care Planning (ACP) and last rites preferences. Much of these issues would need a psychoeducation to be carried out first and followed-up by further discussions.

MSWS AS CHANGE AGENTS

To truly attain person-centre care calls for change at all levels of the system. It is easy to focus on the change needed by the larger system and diminish the individual's contribution to each step of the process.

No doubt there are immediate organisation and system factors that we would also need to advocate for change. However, as MSWs, there are areas that are within our control and can take action on to apply PCA to the care transition process.

It does not mean that when others do not change, we cannot change. Just like in therapeutic intervention, we always believe that change has to start from oneself.

Hence, this guide focuses on empowering the people who can effect this level of change – the MSWs.

HOW ORGANISATION CAN SUPPORT

The organisation has to decide if providing person-centred care is its business goal. If so, the organisation has to provide the structure to enable and encourage the individual staff to adopt PCA in caring for the client.

CHAPTER 02

PHILOSOPHY

OF PERSON-CENTRED APPROACH

GENERAL APPROACH IN CARE TRANSITION

Traditionally, healthcare focused on medical diagnosis, treatment, looking at the disability and deficits, where major treatment decisions were made by the professionals. Care arrangement was decided by the family, who often felt that they were none-the-wiser and hence looked to the professionals to help them with decision-making. Client was seen as the sick person, powerless and required care. Information was shared across settings via reports. Responsibility of care ended when the client left the hospital. At the nursing home, care was focused on ensuring the physical needs are being met. Schedules, routines and activities were determined by the facilities. Work of the staff was task-oriented. Quality of care was defined by regulations and professional standards. The facility lacked a sense of home, and could potentially lead to a sense of isolation and loneliness.

PERSON-CENTRED APPROACH IN CARE TRANSITION

Person-centered care in care transition involves embracing the core values of social work

In line with our core values to treat each person in a caring and respectful manner, and to be mindful of individual differences, and cultural and ethnic diversity, person-centred approach takes on the belief that the client is someone who is well aware of his/her care needs and can express them in some ways, whether verbal or non-verbal. This is regardless of whether the client has the mental capacity to make decisions independently.

The consistent review of such expressed needs forms the foundation of our intervention and services in a person-centred way. This is especially so in providing individualised care. This care is also delivered in partnership with the client's family and healthcare teams.

THE RATIONALE FOR USING A PERSON-CENTERED APPROACH IN CARE TRANSITION

McMillan (2013) found that the use of person-centred approach in care transition is associated with greater patient satisfaction and perceived quality of care. The Health Innovation Network also shared that offering care in a more person-centred way can improve outcomes for professionals in areas such as job satisfaction, reduced emotional exhaustion and increased sense of accomplishment (as cited in Pol-Grevelink, 2011).

10 KEY ELEMENTS OF THE PERSON-CENTRED APPROACH

1 RESPECTING THE INDIVIDUAL

Every individual is unique

- Identify and understand client profile. This includes life history, personality, preferences, wishes and goals. MSWs are to check with client and/or family members, if possible.
- Craft social work interventions or activities that tap on the client's strengths and interests. This provides meaning-making opportunities that develop the client's sense of purpose and belonging.
- Encourage persons-with-dementia to reminisce therapeutically. This encourages healthcare teams to understand their behaviour through the lens of their life history and identities.
- Believe that nursing homes can and should provide clients with a good quality of life. MSWs can advocate this view to nursing homes, clients and their family, and work with them to improve the overall experience in a nursing home.

2 ADOPTING A HOLISTIC APPROACH

Use the Bio-Psychosocial-Spiritual framework

- Identify areas important to the client's well-being, then prioritise needs for intervention and carry out periodic reviews.
- Develop strategies with a multi-disciplinary team to meet client's care needs.

3 BUILDING AND ENHANCING RELATIONSHIPS AS PART OF PSYCHOSOCIAL CARE

The quality of our life is the quality of our relationship

- Includes intra-personal relationship with self, i.e. self-concept, perception, expectation and motivation (Ganesh Sahu).
- Includes inter-personal relationships with the care team, other clients, the new environment and neighbourhood, and continuity of relationship with family.

4 FACILITATING GROWTH AND DEVELOPMENT

- Involve client in identifying his/her goals and the barriers to the achievement of those goals. Also, formulate strategies and solutions and chart the client's progress towards said goals.
- Encourage clients to build their sense of self-worth and competency.

5 RESPECTING THE INDIVIDUAL'S AUTONOMY AND SELF-DETERMINATION

Promoting choices

- Provide a variety of activities, including individual and group-based, to meet the client's differing needs.
- Provide information in an easy to understand manner to allow the client to make informed decisions.

6 MAINTAINING NON-JUDGMENT

- Be open and objective with the information shared by clients.
- Maintain professionalism in assessment and intervention.

7 PRESERVING CONFIDENTIALITY

- Obtain information only for the purpose of improving the client's welfare.
- Non-disclosure of a client's personal information without client's consent. This is except for compelling professional reasons such as when the client's safety is at risk or when compelled by the law to do so.

8 PROMOTING CULTURAL COMPETENCE AND SOCIAL DIVERSITY

- Engage client with basic conversational languages that they can understand.
- Organise cultural activities and events that are significant to the clients and promote a greater sense of awareness and acceptance amongst clients for one another.

9 ADVOCATING FOR THE INFIRMED'S BEST INTERESTS

- Safeguard the interests and rights of clients who lack the capacity to make informed decisions.

10 ADHERING TO ETHICAL RESPONSIBILITIES IN THE CLIENT'S CARE SETTING

- Uphold core responsibility to safeguard and promote the welfare of clients. Protect clients from any potential form of exploitation or harm.
- Social workers are to undergo continuous professional training to ensure competency in providing good quality care to clients.

ETHICAL CONSIDERATION

Case worker should be mindful that PCA may not be applicable to all situations, such as when client's self-determination may lead to more harm to himself/herself or to others. Ethical consideration should be given to these situations. Social workers would need to do a reality check, and manage and balance various needs and perspectives.

Examples:

- When client is in a state of self-neglect, admission into a nursing home may be needed against client's wishes.
- When faced with a difficult family, organisational constrains, and unsuccessful engagements with the family, hospital may have to stand firm to execute a care plan that balances the best interest of the client with sustainability to the care system.

In such instances where the individual's autonomy and self-determination may need to be overrided, there are other elements of the Person-centred Approach that we can adhere to. PCA can also still be applicable to other aspects of care such as helping the client adjust to the life in a nursing home.

CHAPTER 03

PRE-ADMISSION

PERSON-CENTRED APPROACH DURING THE PRE-ADMISSION STAGE TO A NURSING HOME

This stage involves preparing the client and the family for the client's transition to a nursing home. This chapter showcases how PCA is used to address common issues faced at this stage.

WHY USE THE PERSON-CENTRED APPROACH IN THE PRE-ADMISSION STAGE?

Often times, clients who are unable to adjust to living in a nursing home would develop mood and behavioural issues. It can be so severe that they are re-admitted to the hospital.

There are also clients who insists on immediate discharge home. They may then experience a decline in health as the necessary care arrangements could not be established in the short-time frame.

These situations arise due to the client being under-prepared for the transition to a nursing home. Some may not have agreed to the transfer and others may even be unaware of the move. These factors then trigger a lot of distress and anxiety in the client.

The client's family may also have a different idea of the type of care that is provided at a nursing home, and this can be poles apart from what is provided in real-life.

So, while the nursing home is able to provide good care to the client, the mismatch in expectations can cause disappointment and anger, and lead to complaints about the nursing home.

For the hospital, a distressed client and/or family during the care planning stage can lead to resistance and unnecessary delay in discharge. This can also impose ethical dilemmas on the care team. All these could lead to complaints about the care.

Hence, preparing the client and the family well for care transition at the hospital level is very important. We also advocate placing the client's best interests at the centre of our approach. This also means that we should work with the end in mind, by taking a long-term view of the client's goals, care needs and preparation required, and assisting the client and family to make decision around them.

Mr Lim

THE CASE OF MR LIM

Mr Lim's son decided to admit Mr Lim into a nursing home as his wife, whom Mr Lim shares a difficult relationship with, was against Mr Lim returning to stay with them. The son pacified Mr Lim by suggesting that the care plan made was for short-term rehabilitation. Mr Lim felt bitter about the betrayal when he came to know the truth, and transferred his anger onto the nursing home staff and other residents. His relationship with the son also turned irreconcilable.

ADOPTING A PERSON-CENTRED APPROACH

All hospital care teams will carry out care transition. The following shows how they can include PCA into their current practices.

A) PROVISION OF INFORMATION

General Approach

Inform the family about the client's medical conditions and care needs without the client knowing.

Person-Centred Approach

Inform the client and the family together about the former's medical conditions and care needs.

This should include moderation of their expectations of the client's rehabilitation potential.

Thereafter, attend to their questions and concerns with sensitivity and at their own pace.

B) DISCUSSION OF CARE PLANS AND DECISION-MAKING MATTERS

General Approach

Discuss with the client's family about the care plan and decisions are made by the family. Client is left out of the process.

Person-Centred Approach

Discuss with the client and the family about the care plan together.

Share full details on the situation with both parties. E.g. care needs, family resources required and limitations.

Listen to the views of the client and family separately if there is a contradiction.

Facilitate family conference thereafter and mediate between the client's and the family's preferred care options. Address their concerns, fears and expectations.

Mr Sim

CASE STUDY: RESPECTING WISHES; PACING WITH CLIENT; OPEN DISCUSSION; UNDERSTANDING LIMITATIONS

Mr Sim's relationship with his wife and two sons have been estranged for many years. He receives financial support from the younger son but the family is not involved in his care.

During his hospitalisation, Mr Sim expressed a desire to return home. The hospital MSW held a family discussion to explore the chances of doing so. Discussion touched on accommodation and care for Mr Sim, and also what are the concerns and needs of each family member.

Mr Sim wanted to be able to come and go as he likes while staying with the family. The family wished for him to care for himself independently.

The discussion helped all parties come to an agreement and Mr Sim was discharged home. However, it soon became clear that Mr Sim was unable to manage on his own due to his repeated hospital admissions.

During the last admission, the family expressed their thoughts that perhaps Mr Sim would receive better care at a nursing home given how his conditions have declined. The MSW then engaged Mr Sim to talk about his conditions, care needs and the family situation.

Through the discussions, Mr Sim recognised that his care needs are beyond what he can manage on his own. Also, he accepted that a nursing home is better equipped to care for him given his conditions and would also provide him with a better quality of life. He agreed to be transferred to a nursing home.

A pre-admission counselling session and signing of the required documents was done with his son at his workplace during lunch time as he could not take leave. Transfer of client to a nursing home was successfully finalised.

General Approach

Get the client and the family to decide on the care plan within a rigid and short time frame. E.g. some hospitals set the time-frame as two days.

Person-Centred Approach

Pace with the client and the family to understand their dynamics and difficulties. Be understanding of the time frame different family needs to work out their challenges. An interim plan could be suggested. Agree on a time frame for them to get back on the care plan.

Mr Omar

CASE STUDY: FULLER INFORMATION AND MORE TIME FOR CONSIDERATION

Mr Omar was on nasogastric tube (NGT) feeding when the nursing home placement was decided. Family was initially fine with halal food being unavailable at the nursing home as getting support for this high care needs as an NGT client was prioritised.

During site assessment by the nursing home, a nurse shared that there is an upcoming review of Mr Omar's NGT needs, and if successful, he will be placed on oral feeding.

Given this development, the family expressed their wish for Mr Omar to have access to halal food. Family then withdrew the current nursing home placement and waited for one that serves halal food.

C) APPLICATION AND NEXT STEPS

General Approach

The client is excluded from the discussion even though the client is able to make decisions.

Going along with the family's decision to place the client in a nursing home.

Person-Centred Approach

Engage the client in a conversation about nursing home placement as a last resort in terms of care options.

Involve the client in the decision-making process if he/she has the capacity to do so. Attend to and address the client's reactions, thoughts and concerns about the care decision.

The client should be willing to sign the nursing home application form and is clear of what is being signed.

General Approach

The client's reluctance or doubts regarding nursing home placement were not addressed. This may be done out of fear that the client will resist transferring to a nursing home.

Person-Centred Approach

Hospital MSW could accompany the client for pre-admission counselling at the nursing home to provide support.

Nursing home MSW should provide an orientation of the home and further reassure the client.

Mdm Lee

CASE STUDY: ACTIVE LISTENING, THOROUGH PREPARATION AND RESPECTING CHOICES

Madam ("Mdm") Lee is in her 40s and is married with young children. She was found to have a terminal illness and was given a year to live. In view of her growing care needs, she opted to be cared for at a nursing home instead.

During site assessment, she was forthcoming and cheerful. She was also able to hold a conversation very well and is clear with what she wants. She wanted to view the nursing home and the ward she would be staying in first.

A pre-admission counselling session and a tour of the nursing home was arranged. The admission agreement was discussed with Mdm Lee too. During the tour, Mdm Lee shared some concerns but the nursing home MSW and care team addressed them promptly.

Some adjustments were made and Mdm Lee agreed to be admitted. However, after a period of consideration, she spoke to her hospital MSW and withdrew her nursing home application.

While Mdm Lee was not admitted, the assessment process displayed active listening by both MSWs to the needs and concerns of the client. In turn, both MSWs took her lead. Notably, expectations of care were also discussed thoroughly during the sessions.

General Approach

Did not prepare the client for nursing home admission once the client is placed on the waiting list.

The client is moved to the nursing home without advance notice.

Person-Centred Approach

Keep the client informed of the application process. Continue to address any concerns that may arise and share information about the nursing home.

Try to understand the reasons for any special requests and find a middle ground if the client's expectations are beyond the means of the nursing home.

Prepare clients for life in a nursing home, e.g. share about the common rules and regulations.

General Approach

Only informing the family on the transfer date and the belongings to bring along.

Person-Centred Approach

Inform both the client and the family about the transfer date and the items that need to be brought along.

Discuss with the client on what other personal items he/she would like to bring. Assist to check with the nursing home whether those items are allowed.

For a client without next-of-kin ("NOK"), consider the feasibility of bringing the client home to get the personal items.

CHAPTER 04

SOCIAL INFORMATION

PERSON-CENTRED APPROACH IN GATHERING INFORMATION FOR THE CLIENT'S ADMISSION TO A NURSING HOME

This chapter depicts the common pitfalls faced in gathering details from the client and the family in preparation for the client's transfer to a nursing home. It also showcases how MSWs can address the pitfalls with solutions based on the PCA.

WHY USE THE PERSON-CENTRED APPROACH IN THE INFORMATION GATHERING STAGE?

Knowing the lifestyle, medical and family history etc. of our clients is an important feature of the PCA in transition care.

It is needed for the creation of an individualised discharge plan for a client's admission to a nursing home. Therefore, it is crucial to engage the client and the family at this stage.

Speaking to them can also reveal other useful information about their care preferences. This can support the care professional to create a more holistic plan that meets their varied needs. In turn, this may improve the client's and family's experience with the care transition process.

While informing clients about the care options available is important, applying PCA in care transition requires the decision-making responsibilities to be shared among the client, family and care professionals.

MSWs should work with the client and the family through the professional use of self, using inter-personal skills and emotional intelligence to build relationships with the client and the family. This relationship should be based on openness and empathy.

MSWs should also communicate clearly and sensitively when gathering highly personal details from them.

Mr Teo

THE CASE OF MR TEO

Mr Teo has moderate dementia and is married with no children. His wife is his caregiver. The elderly couple used to attend a day care center together. The couple was later admitted to a hospital as Mrs Teo had a critical medical condition while Mr Teo had no substitute caregiver.

Besides speaking to Mr Teo and his siblings to gather more information about their social and financial status, the social workers from the hospital and day care centre also met up to discuss and share information. This includes triggers for his mood issues and ways to prevent or manage it.

His preferences and habits were also discussed. The information was later shared with the nursing home. The nursing home care team was then able to work closely with Mr Teo and the extended family to create a holistic care plan for him. The MSW was later able to secure a place for Mrs Teo in the same nursing home.

ADOPTING A PATIENT-CENTRED APPROACH

Gathering of information to plan for assessments and interventions is important to an MSW. The following shows how this process can be enhanced with the PCA.

INTRODUCTION

General Approach

Engage medical team and access case notes to gather client's social information.

Person-Centred Approach

Engage the client in the ward and check with the client and the family on who will be the main decision-maker in the client's care planning process.

Share the role of an MSW in planning for the client's discharge and work with the client and the decision-maker on the care plans.

General Approach

Asking for social information from the client, the family, and other caregivers in an investigative/checklist style.

Person-Centred Approach

Explain to the client, the family and other caregivers (if any) of the need to share social information with the MSW.

Gather supporting documents to process the agreed discharge plan. E.g. application to a nursing home or to community care facilities.

Should an individual show discomfort/anxiety in sharing information in front of the family, the MSW needs to respond sensitively.

The MSW may consider letting the individual share the details and any relevant documents separately to reduce the discomfort felt.

GATHERING OF SOCIAL INFORMATION

General Approach

The MSW meets with the NOK only to gather social information about the client.

Client is excluded from the process.

Person-Centred Approach

Instead of depending solely on the client's NOK to provide information, the MSWs need to engage the client in care assessment and planning too. This ensures that a more holistic assessment and care plan will be made.

It does not mean that the details shared by the NOK is not important. In fact, their sharing will give MSWs an insight into their thoughts on the client and how they view the situation.

The MSWs can also learn more about what the family thinks the main issues are, what are the dynamics at play and the relationships they have with the client.

These valuable insights will support the MSW in developing a better understanding of the client and the family.

Mr Teo

THE CASE OF MR TEO: MAINTAINING CONFIDENTIALITY AND RESPECTING THE PERSONHOOD OF THE CLIENT WITH DEMENTIA

During the process of gathering social information, the MSW first reassured Mr Teo and his NOK that the information being shared would be kept confidential.

It is easy for others to dismiss people with dementia. Even though Mr Teo has moderate dementia, he is able to provide some account of his life. Mr Teo shared many unique experiences which his siblings may not even be aware of.

The information shared enabled the MSW to develop a better understanding of Mr Teo's life and also of the family dynamics. This in turn supported the MSW in making a more holistic care assessment.

General Approach

MSWs will check with the client and NOK to find out if they are being supported by other financial assistance schemes or care services.

After which, MSW will get them to go to the relevant organisations on their own to find out more about the services and support they need.

Person-Centred Approach

Check with the client and the family if they know which organisations to approach and what information they need to gather.

If they are unsure or are not able to do so, the MSW is to seek the client's and the family's consent to approach these organisations on their behalf. MSW to record the consent, if given.

In situations where various organisations are involved, the MSW could arrange for a case conference with all parties. The meeting will enable the sharing and comparing of social information amongst the healthcare professionals about the client.

This would reduce the duplication of details across organisations and the number of times the client and the family are interviewed. This then lessens any unnecessary stress and frustration that the client and the family may experience.

Mr Teo

THE CASE OF MR TEO: EMPOWERING THE CLIENT AND THE FAMILY

For Mr Teo's care plan, the MSW must first find out how much Mr Teo and his siblings know of the community care resources available to them. The MSW can then educate them and act as a broker to link Mr Teo up with these services.

However, it is important to note that educating the client and the NOK on the care options available, and then empowering them to make the final decisions, is far more important than making the decisions for them.

General Approach

Focusing solely on getting as much social information as possible during conversations with the client and the family. Their emotions regarding the situation are not addressed.

Person-Centred Approach

Pause the discussion to acknowledge the client's and the NOK's emotions. Give them time to process their feelings.

Instead of focusing on asking all the questions as planned, the MSWs need to assess the situation and decide when is it more important to address their feelings first.

This builds trust and rapport with the client and the family. The safer they feel with the MSW, the more they will share about themselves in future discussions.

Mr Teo

THE CASE OF MR TEO: BEING SENSITIVE TO THE EMOTIONS OF THE CLIENT AND THE FAMILY AND PACING WITH THEM

The MSW tuned-in to the emotions and body language shown by Mr Teo and his siblings as they shared social information during family discussions.

The MSW could sense distress and discomfort and stopped the discussions from time-to-time to allow them to acknowledge and reflect on their feelings.

The MSW also provided emotional support and reassured them that it is up to them to decide what they want to share and that the sharing can be done across a few sessions.

TRANSFER OF SOCIAL INFORMATION

General Approach

Asking the family member to sign consent forms even though the client has the mental capacity to do so.

E.g. nursing home application forms.

Person-Centred Approach

If the client has the mental capacity to make decisions, the care team should engage the client to explain the purpose of the forms. After which, allow the client to decide if he/she wants to sign the forms. Refer to page 28 and 31 for the approach in handling client's refusal to consent.

If the client is not able to make decisions, the MSW is to engage the family member who is the main decision-maker for the above process.

It is also important to highlight to the client and the family member that the information shared by them on the forms would be shared with other healthcare organisations involved in the client's care.

Explain to them that this is needed to ensure that those healthcare organisations have the same understanding of the client's care needs. It would also reduce the need for them to repeat themselves.

Check with them on whether there are any concerns regarding the sharing of information. Address concerns promptly.

MSW to contact community care facility if there are further questions or there are issues that need to be highlighted.

CHAPTER 05

FINANCIAL COUNSELLING

PERSON-CENTRED APPROACH DURING FINANCIAL COUNSELLING FOR NURSING HOME ADMISSION

This chapter depicts the common pitfalls and the solutions that MSWs can apply to achieve a more Person-Centred Approach during financial counselling.

WHY USE THE PERSON-CENTRED APPROACH IN FINANCIAL COUNSELLING?

Typically, in Singapore's culture, financial matters relating to treatment and care would be left to the NOK if a family member is around to assist. The client is usually excluded from the process.

This is because it is a deeply held belief that the client should focus on recovery and not worry about money matters. Thus, the application of PCA should consider local culture and be thought more of as a family-centred approach when it comes to financial counselling.

In Singapore, treatment and care at the hospital are largely affordable and there is financial support available for those who are unable to pay. However, there are instances where a client worries about payment.

There could also be disagreements over payment terms which can delay nursing home admission. This may not be in the client's best interest in terms of the provision of appropriate care.

Funding and systemic issues exists as well but this chapter will focus on the areas where MSWs have control over.

As much as we want to create standardisation of our financial assessment practices, this area of our work is very much value-laden, from ourselves as MSW, from individual family members and clients, and from organisation management or medifund committee per se. We would have to be aware of different perspectives and help family navigate the system.

Mdm Ang

THE CASE OF MDM ANG

Mr Ang is 82 years old and lived with his wife in a three-room HDB flat. The couple is childless. Mr Ang had a stroke and his wife, who is also frail, felt that it would be in their best interest for him to be cared for in a nursing home.

Mr Ang had always managed the household finances and Mrs Ang had no oversight of their financial health. Although they have a sizeable nest egg, Mrs Ang was unaware of it and worried about the cost of Mr Ang's stay in a nursing home. Also, they did not qualify for Medifund at that point in time.

Sensing Mrs Ang's worry, the MSW quickly addressed her concerns by:

- Sharing of the Pioneer Generation Disability Assistance Scheme and accompanying her to apply for it at AICare Link
- Teaching her simple banking procedures, budgeting and financial planning skills. This empowered Mrs Teo to become more financially savvy
- Pacing with the couple and introducing the option of a lease-buy-back scheme as part of a long-term plan
- Sharing of information on making an LPA.

They were also reassured that they can review their eligibility for other financial schemes and revisit the lease-buy-back scheme and LPA when both are more settled at the nursing home.

ADOPTING A PERSON-CENTRED APPROACH

Financial counselling and the development of a care plan starts with an assessment of the family's situation. This includes financial resources, availability of caregivers, relationships between family members and their willingness and ability to support the client.

Periodic financial counselling and reviews are conducted even after nursing home admission. In some cases, families are very cooperative and open to sharing financial information. Others are more reserved and are cautious about over-sharing. Hence, clear explanation of the financial counselling process is needed.

A) GATHERING INFORMATION

General Approach

MSW asks family for financial information and related documents without explaining why the details and materials are needed.

Person-Centred Approach

Hospital MSW explains to the client and the family why the financial information and related documents are needed. I.e. for financial assessment.

General Approach

Take financial information at face value without understanding the family's genuine financial status. E.g. Family says that they cannot afford the bills due to their credit card debts, MSW does not try to understand the reasons for the credit card debts.

Person-Centred Approach

Explain to the client and the family of the need to provide reasons in their application for financial assistance and thus, the MSW requires a deeper understanding of their financial status.

Assure the family and the client that due consideration will be given to various areas of concern. E.g. family dynamics, individual financial commitments and future plans.

If allowed, gather information from other family members to create a clearer picture of the financial issues.

B) PROVIDING INFORMATION

General Approach

Give verbal explanation of the list of information needed.

Person-Centred Approach

Provide a standardised list of the information needed. MSW can also include customised features as per the unique needs of each family.

This is so that other family members can help to compile the details and documents.

Go through the list with the client and the family to ensure clear understanding.

General Approach

Sharing of estimated charges with the family and the client without being sensitive to their feelings.

Not being attuned to the family's and/or client's non-verbal cues. E.g. they may feel anxious over the costs.

Person-Centred Approach

Support the client and the family in exploring the financial resources that are already available to them. E.g. assistance from family, lease-buy-back scheme, rental etc.

Explore relevant financial assistance schemes with them, e.g, PioneerDAS and ElderShield. Support them in applying to the various schemes to allay their anxiety over co-payment.

Discuss long-term planning matters including LPA or deputyship application. However, be sensitive to the family's feelings and pace with them. Family may need more time to discuss.

General Approach

Provide inappropriate amount of information.

Person-Centred Approach

Check with the client and the family that they understand the information given and are not overwhelmed by it.

Otherwise, ask for other family members to be involved during financial counselling, or provide the information in bite-size pieces.

C) FOLLOW-UP AND HAND-OVER

General Approach

Handing over an insufficient set of financial details and supporting documents to the nursing home.

Client and family may need to repeat the assessment process at the nursing home.

Person-Centred Approach

Hospital MSW to provide a complete set of information to the nursing home, if possible.

It is recommended to give the nursing home MSW a call to seek clarification, when needed.

General Approach

Informing the client and the family on the outcome of their financial assistance applications without explaining that eligibility is subjected to periodic review and is not permanent.

Person-Centred Approach

When sharing the outcome of their financial assistance applications, take the time to explain about the periodic reviews that are conducted to assess the client's continued eligibility to those same schemes.

Also, share that the results for re-applications may depend on the client's and the family's changing situations.

General Approach

Lack of co-ordination between hospital and nursing home MSWs, and with the client and the family for post-transfer financial support.

Person-Centred Approach

MSWs (both hospital and nursing home) are to discuss about possible future application to MediFund with the client and the family, if relevant.

Share details like the application process, the documents needed and the scope of MediFund assistance. Also, try to ensure that this process is as streamlined as possible for the client and the family.

Explain the difference in scope of assistance (e.g. non-standard drugs) and share with the client and the family possible solutions. Otherwise, manage their expectations.

USEFUL LINK

HHMT: Household Means Test

https://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/subsidies_for_government_funded_ILTC_services.html

https://www.moh.gov.sg/content/dam/moh_web/Forms/Means-test%20Declaration%20Form(Aug%202017).pdf

FA: Financial Assistance process in the NMTS

https://www.moh.gov.sg/content/dam/moh_web/Forms/Financial%20Assistance%20Declaration%20Form(April%202015).pdf

CHAPTER 06

PHYSICAL HEALTH

PERSON-CENTRED APPROACH IN MANAGING PHYSICAL HEALTH DURING TRANSITION TO A NURSING HOME.

This chapter touches on a few important areas related to a senior's physical health. This includes illnesses that are typically experienced by a senior, the impact of ageing, the loss of their physical health, functional decline, onset of illnesses, and the grieving process that comes with the passing of a loved one.

It will also address the appropriate strategies that healthcare professionals can adopt to assist seniors undergoing the above phases.

WHY USE THE PERSON-CENTRED APPROACH TO MANAGE THE PHYSICAL HEALTH OF A SENIOR?

A Person-Centred Approach to providing care is growing in importance in the healthcare sector. Data has shown that clients with acute coronary syndrome who receive person-centred care report higher general self-efficacy than those in the control group after six months. (Pirhonen, Olofsson, Fors, Ekman, & Bolin).

It is a challenge to shift from the current care model which is more medically-driven to one that is more person-centred.

Given the MSW's strength in the latter approach, they can play a key role in influencing the current care model so that it holistically addresses the client's physical and psychosocial needs too. E.g. sharing with the care team on "how a client experiences care".

To do so, MSWs need to understand:

- The client's medical conditions, the treatment options and the outcomes of the conditions
- What they mean to the client and how will the client's life be impacted
- How has the client experienced, perceived, and managed his/her conditions previously and how will the client manage in the future
- What are the client's and the family's goals of care. The meanings attached to the conditions will differ from client-to-client. This drives the differences between how each client experiences and manages his/her health

Mdm Chen

THE CASE OF MDM CHEN

Mdm Chen, aged 72, has Parkinson disease and is the sole caregiver to her son who has an intellectual disability. She had a fall as her condition progressed and sustained a severe lower limb fracture.

She underwent rehabilitation at a community hospital. However, her condition did not improve enough to allow her to return home. Nursing home admission seemed the best course of action.

Meanwhile, her son was temporarily cared for by a cousin who expressed difficulties in meeting the son's care needs. Mdm Chen became worried about her son's long-term care.

She rejected nursing home placement and asked to continue with community rehabilitation, hoping to be able to care for her son at home.

Her care team tried to explain that her care needs are high and that it would be in her best interest to be supported by a nursing home. However, Mdm Chen, being a devoted mother, could not be convinced to change her mind.

ADOPTING A PERSON-CENTRED APPROACH

Using a medically-focused approach to change Mdm Chen's mind about nursing home admission did not work. This is because she had other personal and family concerns that needed to be addressed.

These include:

- Her loss of independence and her role as a caregiver
- Her son's long-term care needs
- Being separated from her son if she was to be supported by a nursing home

Thus, in addition to a client's medical needs, it is important to be able to appreciate and address the client's other significant concerns. This will help to prepare and convince the client to accept the proposed care plan.

A) PROVISION OF INFORMATION

General Approach

Informing the family about the client's medical conditions and care needs without the client's knowledge.

Person-Centred Approach

Give both the client and the family the full picture. E.g. the client's medical conditions, care needs, how conditions might progress, treatment options, and care plan.

General Approach

Withholding explanation on how the client's conditions will be managed. E.g. what procedures will be needed and what are the follow-up plans.

Person-Centred Approach

Clearly and promptly explain to the client and the family about the procedures and follow-up plans. This is so that they can see the impact and journey ahead. This will help reduce their anxiety and give them ample time to prepare.

General Approach

Did not explain to the client and the family on the care provided at a nursing home in full details.

Person-Centred Approach

Explain to the client and the family the differences between the care provided by a nursing home and a hospital.

Do not assume that they know the differences. Manage their varied responses and expectations on the level of care provided at the nursing home.

B) COLLECTION OF INFORMATION

General Approach

During pre-admission site visit, nursing home staff collects wrong information from the wrong hospital staff.

Person-Centred Approach

During pre-admission site visit, nursing home staff should look for the registered nurse-in-charge and doctor-in-charge if information on the client's nursing and medical care is needed.

Check with the staff on whether he/she is familiar with this client too.

C) PROCESSING OF INFORMATION

General Approach

Informing the client and the family of the client's condition without checking if they understood the information shared, or if they need support in processing it.

Person-Centred Approach

Ask the client and the family if they have any questions after sharing information on the client's conditions. Respond to their queries.

Understand what the conditions mean to the client and the family. Attend to their reaction and response sensitively at their pace.

General Approach

Explain treatment options and make recommendations without understanding the client's values and care goals.

Person-Centred Approach

Besides explaining the treatment options, understand what are the client's care goals and what do they mean to the client.

Understand his values, preferences and past experiences. Use his values and goals to make appropriate recommendations. Let the client decide on treatment options.

D) ATTITUDE

General Approach

Treating the client as a passive care-recipient and reinforce sick-role.

Person-Centred Approach

Empower the client with knowledge on his disease for self-management.

Understand how the client has been managing previously and draw out his concerns and strengths.

Use client's strength to reinforce self-management. Set recovery goals with the client or discuss how he/she wishes to manage the conditions.

UNDERSTANDING THE MEDICAL CONDITIONS FACED BY SENIORS

It is important for all care staff to educate themselves about the conditions, symptoms, treatments and disease progression faced by the client.

Care staff should understand how the client's cognitive, physical, social and emotional functions could be affected. This is so that they will be able to appreciate the impact on the client's life more holistically. E.g. impact on social life, job and social roles, meaning, daily routine, family and financial stress.

The Giants of Geriatrics was a term coined by the late Professor Bernard Isaacs to highlight the major conditions associated with ageing. It talks about how seniors with such conditions will experience an impact on their independence, personal autonomy and finally on their quality of life.

Immobility
Results in limitation of lifespace and is associated with significant functional decline and increased risk of incontinence.

Instability
A fall that resulted in fractures can lead to a loss of confidence in mobility. Fall risk factors include sensory decline, problems with the central nervous system, cognitive function decline, musculoskeletal problems, and effects of medication.

Polypharmacy
Multiple medications. Adverse drug reaction is often present. Symptoms include, confusion, depression, falls, incontinence decrease in one's ability to manage his/her activities of daily living ("ADL").

Intellectual impairment
Dementia, delirium and depression. Interferes with social and occupational functioning.

Incontinence
Increases the risk of infection and it carries a huge social stigma with it. It places financial and social strain on the family too.

CHAPTER 07

ADJUSTMENT

PERSON-CENTRED APPROACH IN SUPPORTING THE CLIENT'S ADJUSTMENT TO NURSING HOME LIFE

This chapter depicts the common pitfalls and how we can better support clients to adjust to this change by using person-centred care.

WHY USE THE PERSON-CENTRED APPROACH IN THE ADJUSTMENT PHASE?

Earlier we mentioned that complaints can arise from the client and the family when the former is unable to adjust well to life in a nursing home.

The client may show psycho-emotional and behavioural issues, experience a decline in health and undergo many hospital re-admissions. These issues can heavily tax all parties involved. I.e. the client, family, nursing home and hospital.

Just as we expect to be supported when adjusting to a new workplace, it is equally important that a new nursing home client gets the support he/she needs to adapt to a new living environment.

Successful adjustment starts from the very beginning – the pre-admission stage. This continues through admission and post-admission.

First impressions always last. So, how a nursing home welcomes the new client to be part of its big family, what kind of tone it sets, and how it reassures the client and his/her NOK, should be guided by person-centred care.

Likewise, getting a client to adjust to a new routine and culture requires the use of the PCA to support him/her to feel psychologically safe in this new environment. All these need the combined efforts of the staff and management.

Though there is a system level constraint, there are practices within the MSW profession that can bring about more person-centred care in a nursing home. For instance, advocating for flexibility for supportive NOK who have genuine difficulty adhering to normal visiting hours.

This chapter will identify the other areas within the influence of the MSW in allowing residents to adjust to life in a nursing home.

Mr Rahim

THE CASE OF MR RAHIM

Mr Rahim was uncertain about staying at a non-Muslim nursing home as he was worried that he would not fit in.

To support him to adapt to his new home, the staff arranged for him to be seated with other Muslim clients during meal times and get them to talk to him.

A Muslim staff also showed him where the prayer room is and introduced the home's routine and activities. Additionally, he was introduced to a few Chinese clients who are able to speak Malay at a reminiscence session.

He quickly bonded with the staff and some clients. He also found his role in assisting the nursing home by helping to set the dining table which the staff recognises and appreciates.

ADOPTING A PERSON-CENTRED APPROACH

Below depicts how the PCA would look like in the adjustment phase for nursing home clients.

A) ORIENTATION

General Approach

Inform the client and the family about the care schedule, use of call bells, fall risk education, care schedule, arrangement for medical appointments and payment terms.

Person-Centred Approach

Orientate the client and his/her family to the,

- Client's living space in the nursing home, e.g. dining area, sitting hall and garden
- Client's roommates
- Care staff, including operation personnel and directors
- Care schedule
- Safety precautions
- Other administrative matters
- Feedback channel

B) INTERACTION WITH STAFF AND CLIENTS

General Approach

Allowing the client to mingle on his/her own.

Person-Centred Approach

Find out more about the client's interests, hobbies, languages spoken and temperament.

Group clients with similar interests, language and communication abilities together. This encourages the client to build new relationships and to enjoy the activities available in the nursing home.

Provide quiet area for clients who prefer to be alone.

General Approach

Staff is familiar with and manages the physical care needs of the client.

Person-Centred Approach

Staff should also know the client as a person through interactions with the client, the family and the MSW.

Assess the client holistically. Find out his/her preferences, strengths, values, beliefs and talents. Put together an individualised profile that can be shared with other care staff. However, keep sensitive information confidential.

With the profile, the MSW and other care staff will be able to work towards respecting the client as a person.

General Approach

MSW getting to know the client during admission.

Person-Centred Approach

Nursing home MSW to regularly interact with the client, address and review his/her concerns and advocate for him/her.

C) MAINTAINING PERSONHOOD

General Approach

Expect the client to follow the rules, regulations and schedule set by the home. Client's concerns and special requests may be overlooked.

Person-Centred Approach

Engage the client to understand and appreciate his/her concerns and special requests. Find out why these concerns and requests are important to the client.

If possible, cater to the requests and needs or look for alternatives. Otherwise, sensitively explain to the client and attend to his/her responses.

THE CASE OF MR SIM (CONTINUED FROM PAGE 29): FLEXIBILITY IN ATTENDING TO NEEDS

Mr Sim, a new nursing home client, negotiated with the staff to allow him to keep his handphone and radio. He wanted to keep in touch with his neighbourhood friends and was also hoping that his family in Indonesia would one day contact him. His radio had been part of his daily entertainment. The nursing home MSW purchased an earphone for him so that the other clients would not be disturbed.

General Approach

Develop a care plan without the client's inputs.

Person-Centred Approach

Involve the client when care staff is planning for goals of care and different modes of therapy.

Keep in mind the Biopsychosocial–spiritual needs of the client. Carry out regular reviews.

General Approach

Provide standard activities to engage the client.

Person-Centred Approach

Share information about the client's interests and preferences with the care team, e.g. occupational therapist and art therapist. This is so that they can organise activities or therapies that are more aligned with the client's interest.

Allow the client to choose from a variety of meaningful activities that preserve his/her sense of usefulness and dignity.

MSW can organise therapeutic group work to address assessed needs.

GETTING TO KNOW MR SIM AND WORKING THROUGH ISSUES

Nursing home MSW and ward staff observed that Mr Sim seemed unhappy and often shouted at others. He also refused to attend his hospital medical appointments. The MSW made efforts to get to know Mr Sim better.

The MSW found out that Mr Sim felt frustrated and helpless over how he was all alone in Singapore. He also felt sad that his family in Indonesia had not contacted him in a long time.

Mr Sim underwent counselling and received much emotional support. The staff also supported him to make new friends with others and to give him a greater sense of belonging. On-going work is still needed for Mr Sim to become fully adjusted to life in a nursing home.

General Approach

Standard layout and design of a client's sleeping area.

Person-Centred Approach

Explore the possibility of allowing clients to personalise the bed area with items like photographs, posters or with other items of sentimental value. This supports the client in easing into a new environment and to make the sleeping area feel more homely.

General Approach

Do not provide spiritual /religious support to the client.

Person-Centred Approach

Explore spiritual/religious issues with client and provide appropriate services, e.g. pastoral support, or assistance to contact the client's religious group.

Create a quiet room with different religious items for use.

D) INVOLVEMENT OF FAMILY

General Approach

Family is usually engaged at the pre-admission or admission stages.

Person-Centred Approach

Continuously involve the family in the adjustment phase and thereafter. Provide psychoeducation to the family to raise awareness of possible adjustment issues.

Encourage home leave and outings with the client's family and to celebrate family events together.

Work with the family to find out more about the client's pet peeves, triggers points and previous coping method to support the adjustment.

CHAPTER 08

LONG-TERM CARE PLANNING & PREPARATION

PERSON-CENTRED APPROACH IN LONG-TERM CARE PLANNING WITH CLIENT AND HIS/HER FAMILY

This chapter highlights how long-term care planning and preparation would benefit the client and how the PCA can be applied to this stage.

WHY USE THE PERSON-CENTRED APPROACH IN LONG-TERM CARE PLANNING AND PREPARATION?

After the client settles down and is less anxious about life in a nursing home, the client may have some concerns, anxiety and/or expectations about the future.

This is an area often overlooked until it is triggered by an event such as a decline in the client's condition, loss of mental capacity or a change in family's circumstances. This may result in uncertainty over a client's stay in the nursing home.

Staff can be caught up with administrative work arising from those changes and may not have addressed the client's concerns and needs fully.

It is thus important for the client, the family and the nursing home to begin planning for long-term care holistically upon admission. MSW may assess for opportunities to engage the client and the family in meaningful conversations on their long-term care plans. This can occur during different stages of the client's stay in the nursing home.

Naturally, not all clients are prepared to discuss their long-term plans and need to have their pace respected. On the other hand, there may be clients who are ready to start planning but need guidance.

According to Dr Etre, the well-known psychoanalyst, Eric Erikson, "characterised the final stage of life as a time of reflection with the task of looking back on life and integrating it into a coherent and acceptable whole." Drawing from this, nursing home staff can support the client on reflecting on his/her past achievements, reconcile negative past experiences, reconstruct their meaning of life and ease overall adjustment.

Mr Suresh

THE CASE OF MR SURESH

Mr Suresh had stated his wish for palliative care in his Advance Care Planning (ACP). However, his wife, who was his healthcare spokesperson asked for one more round of chemotherapy in hopes of buying more time with him. The care team agreed to the wife's request.

However, the care team wondered later if a deeper discussion with the wife while Mr Suresh was still lucid could have helped her better understand and honour his care wishes.

Nevertheless, should the spokesperson still decide against a client's wishes, the healthcare organisation may convene a family discussion on what are the best care options for the client that are in line with his/her care wishes.

ADOPTING A PERSON-CENTRED APPROACH

Adopting PCA also involves being attuned to Maslow's Hierarchy of Needs which involves supporting clients to reach self-actualisation. This requires staff to be curious about the clients' past experiences and achievements in order to help them achieve a greater life acceptance.

A) REBUILDING LIFE

General Approach

Clients passively taking part in activities pre-planned for them.

Person-Centred Approach

Involve clients in the planning of their activities or tasks, tapping on their strengths and interests. For example, inviting a client who used to be an art teacher to lead an art and craft activity for the other clients.

General Approach

Client receives standard care from nurses.

Person-Centred Approach

More-abled clients are encouraged to take up roles in supporting certain daily tasks such as laundry-folding, food serving, or being a buddy to new residents.

B) ENGAGEMENT OF FAMILY

General Approach

Family is contacted only when necessary. E.g. when updating on the client's medical conditions, or when conducting financial re-assessment.

Person-Centred Approach

Periodically engaged the client and the family to review the client's long-term care plans.

Significant family milestones and changes in family dynamics may be opportunities to revisit or even start conversations on long-term care plans.

C) ADVANCE CARE PLANNING

General Approach
ACP is done for clients who are seriously ill.

Person-Centred Approach
Appreciating ACP as part of the Person-Centred Approach to understanding a client's long-term care goals. Facilitate the discussion for clients who are ready.

General Approach
Last rites may not have been discussed.

Person-Centred Approach
For clients who are open, conduct last rites planning with the client and the family. Pace with them for the discussion.

Identify client's preferences.

Assist the client with preparation of his/her last rites. E.g. ask whether the client wants to buy a columbarium niche and to choose what clothes to wear.

Provide assurance to the client that his/her dignity and preferences would be preserved.

D) FINANCIAL PLANNING AND LASTING POWER OF ATTORNEY

General Approach
Deputyship is introduced when the client accumulate outstanding bills in the nursing home.

Person-Centred Approach
Introduce LPA to clients who have the mental capacity and to their families.

Explore possible avenues of financing the client's long-term care. E.g. selling of property, using reverse mortgage or renting out the flat to generate income.

General Approach
For clients who have lost their mental capacity, families apply for deputyship on their own and are unsure of the process.

Person-Centred Approach
Families are provided with information on applying for Court Appointed Deputyship and are journeyed with along the process.

E) DISCHARGE PLANNING

General Approach

Family or nursing home may be caught off-guard by the client's decision to discharge or there is a change in the client's condition.

Focus is on immediate practical arrangement upon discharge.

Person-Centred Approach

Pace with the client and the family to plan and prepare them for an appropriate care arrangement.

Consider the client's goals, recovery potential, care needs ahead, and changes in family's dynamics and abilities. Also, discuss with the client and the family on long-term care possibilities, e.g return home with community support and transfer to a hospice.

Nursing homes, hospitals and community partners are to work together to support the client's long-term care and well-being in the community.

CHAPTER 09

AT THE ORGANISATION LEVEL

HOW ORGANISATION CAN SUPPORT

TEN SUGGESTIONS FOR CHANGE

1. Instil a culture that promotes person-centre care
Clients have psychosocial needs and personal preferences. It would be helpful in engaging clients using the person-centred approach. Organisations should therefore encourage the adoption of PCA.

2. Align key performance indicators and appraisal to measure PCA
Include ways to evaluate PCA within the key performance indicators in the appraisal. This would emphasise the importance of adopting PCA in the organisation and its expectations that PCA is applied in the day-to-day care of clients.

3. Provide the supervision and support that encourage PCA
Supervision of staff includes providing guidance to staff in their practice when adopting PCA. It also includes giving support when they face barriers or difficulties.

4. Boost manpower support
Manpower shortage can be a real barrier, it should be addressed to alleviate the stress faced when providing care to clients.

5. Have clear policy and guidelines, but allow for flexibility
Organisation should draw up clear policy and guidelines to direct how the PCA should be carried out. The guidelines should include room for flexibility to meet the needs of different clients and their families.

6. Practice multi-disciplinary care
Care planning and the formulation of a holistic care plan should include the views of different healthcare professionals in the client's care team.

7. Collaborate with other organisations and across different disciplines to provide better care
Co-ordination among different organisations and disciplines is important to provide seamless care transition and continuity of care to the client. This includes recognising limitations in care expertise and referring to relevant professionals or service providers.

8. Involve the family
Frequent updates could be provided to the family and address their concerns promptly, if any.

9. Engage community
Actively involve the community in providing activities within or outside of the organisation. This can help to lessen the manpower constraint to some extent. It also supports the clients in feeling more connected to the community.

10. Carry out continuous quality improvement
Cultivate a culture that actively promotes creative and innovative ideas that improve processes and the quality of care provided to clients.

CHAPTER 10

GLOSSARY

GLOSSARY

"Advance Care Planning" is the process of planning for your future health and personal care.

"Care Transition" is the co-ordination and continuity of healthcare during a movement from one healthcare setting to another or to home. In this guide, we refer to it as from hospital to nursing home. However, many of the elements can be adapted for care transition to other care settings.

"Community Hospital" provides medical services for patients who require a short period of medical, nursing and/or rehabiltiation care, usually after their discharge from the acute hospitals.

"Community of Practice" is a group of people who share a profession and common interest in a particular domain. The community learn from each other through the process of sharing information and experiences.

"Different Modes of Therapy" may include expressive art therapy, pet therapy, diversional therapy etc.

"End-of-Life Issues" can broadly encompass issues that a client and significant others may be concern about towards the end-of-life and thereafter. It may include medical and care decisions, planning of the last rites, making a Will, and considering the spiritual aspects that bring about peace upon death and dying.

"Holistic Care Assessment" involves assessment of all domains/sub-domains including the physical, emotional, mental health, spiritual, environmental, social, sexual, financial, and cultural needs of an individual. An awareness of the individual's history, culture, beliefs, identity, abilities, strengths, views and self-assessment is essential.

"Lasting Power of Attorney" is a legal document that a person who is at least 21 years of age(donor) to voluntarily appoint one or more persons (donee(s)) to make decisions and act on his/her behalf should he/she lose the capacity to make his/her own decisions. Donee(s) may be appointed to act in two broad areas – personal welfare and/or property and affairs matters.

"Maslow Hierarchy of Needs" is represented as a pyramid, with "physiological needs" at the bottom level, followed by "safety", "belonging and love", "esteem", and finally "self-actualisation and transcendence" at the highest level. Maslow theorised that the individual's most basic needs (the bottom level) must be met before they become motivated to achieve higher level needs.

"Multi-disciplinary Practice" is a comprehensive approach to a patient's care that involves different medical and allied health care professionals working together to consider all treatment options and develop an individual care plan for each patient.

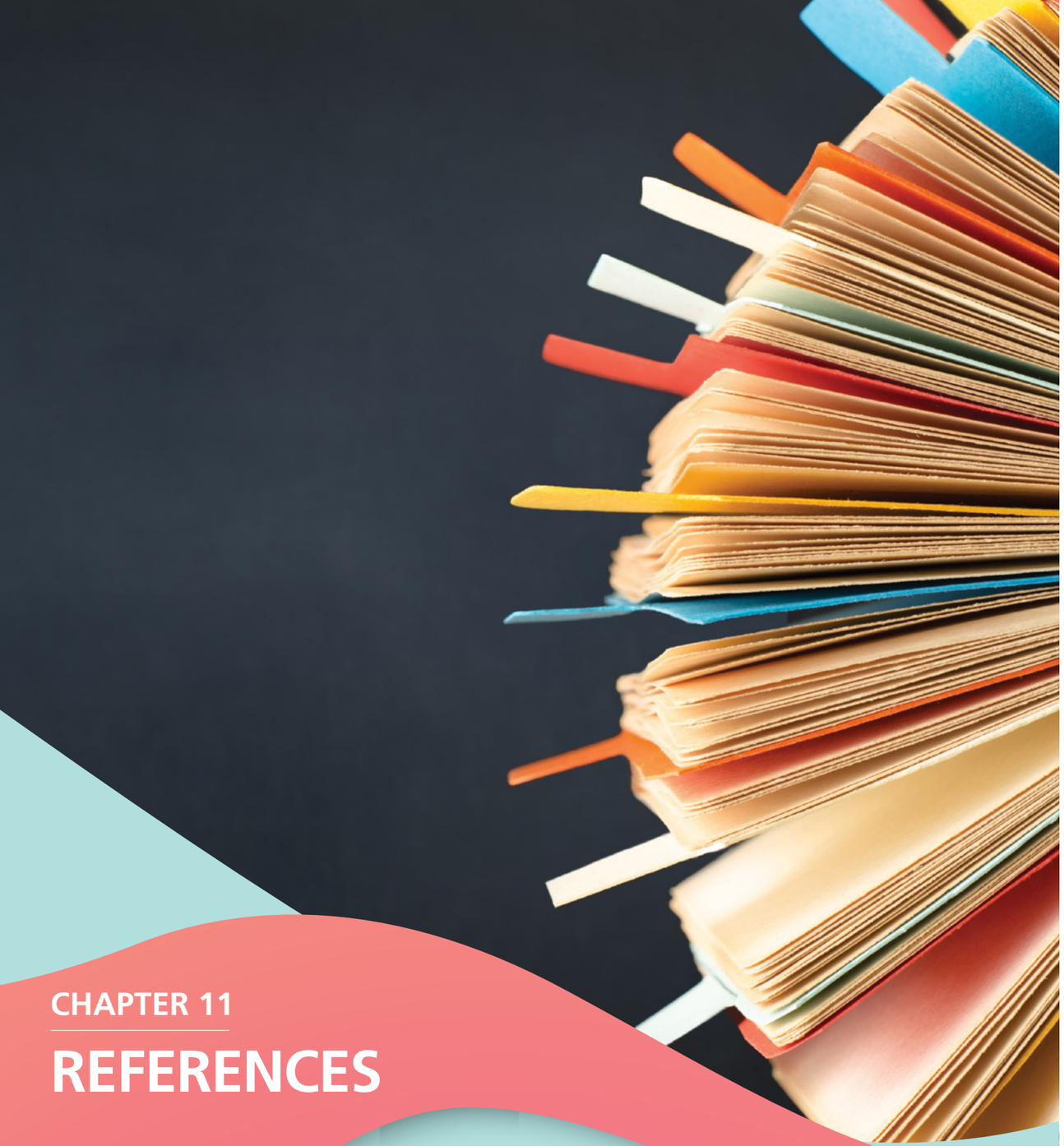
"Person-centred Approach Toolkit" describes its application through the four pillars: Philosophy, People, Place and Programmes.

"Self-concept" can be defined as their "knowledge and beliefs about themselves – their ideas, feelings, attitudes, and expectations".

"Self-identity" refers to the perception or recognition of one's characteristics as a particular individual, especially in relation to social context.

"Self-management" of disease refers to the ability of the individual, in conjunction with family, community and healthcare professionals, to manage symptoms, treatments, lifestyle changes, psychosocial, cultural and spiritual consequences of health conditions.

"Significant Family Milestones" is any event important to the family, which may include, but not limited to birth, graduation, changes in marital status, retrenchment, retirement, onset of illness, decease of any family members, etc.



CHAPTER 11

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