Older People Engagement and Entertainment Report

27 February 2023

Background

North West LEF in partnership with Knightswood Connects organised an Engagement and Entertainment Session on 27 February 2023 in 290 Lincoln Avenue Community Hall focusing on District Nursing Service and Anticipatory Care Planning.

Knightswood Connects is a project set up to share information and connect services with residents in Knightswood and the surrounding area over the age of 50 with the aim to tackle loneliness and isolation.

Over 40 participants heard a short input from Lynda Mutter, HSCP Service Manager, Older People and Primary Care on District Nursing Services before sharing their thoughts and experience of the service. This was followed by a short input from Jennifer Watt, Anticipatory Care Programme Manager with time allocated to gather views and experience of Anticipatory Care Planning.

After a short break participants were treated to music and songs from Michael Bubbles. A lovely end to the session.

District Nursing Services

Lynda Mutter gave a brief overview of the District Nursing Service which operates 24 hours a day, 7 days per week. The service accepts referrals for housebound patients aged 16 and above who require nursing care (assessment, care planning and care delivery) and for patients who are acutely, chronically or terminally ill.

District nurses are involved in the delivery of planned care and unplanned care (urgent care) to individuals with complex and non-complex health problems. Interventions and treatment may be carried over a short term or longer, based on the need of the individual patient. There are six District Nursing Teams in NW Glasgow.

Patients and carers, hospital and out-patient services, Health and Social Care workers i.e. homecare, rehabilitation teams, Social Workers can make direct referrals to the service and GPs can make a written referral directly using the electronic system or by telephone

The District Nursing Single Point of Access service operates from 08:30am - 4:15pm. The phone number is 0141 355 2180. After 4.15pm, the out of hours District Nurse Team can be contacted on 0141 355 1688; there is an answer phone / voice mail messages which is regularly checked.

Patients or carers must have agreed to a referral being made.

What is your experience of District Nursing Services?

Of the small number of people had either direct experience of the District Nursing Service, received care after being discharged from hospital or knew someone who had received a services (cancer patient, end of life) were very positive about the service and the staff. Staff were helpful in explaining procedures, managing expectations and working jointly with other teams and services. A friendly bunch.

One person said it was a 'wonderful service when husband was dying – end of life care. The nurse was wonderful and looked after me too – she was always asking how I was'. It was good he was cared for where he wanted to be cared for – at home

What support or help do you think the District Nursing Service provide?

- Help coming out of hospital
- Checking blood pressure, change dressings/wound,
- Service to someone who lives alone and visibility is not good
- Give people medical help/nursing to help them remain/become more independent

It was confirmed that the District Nurse service provided – wound dressing, pressure ulcer, leg ulcer care, long term condition support, administration of insulin for people with who can't inject themselves, some bloods and injections (B12), catheter and bowel care, palliative and end of life care is a priority care group. There was some confusion in relation to other services such as Rehab Teams and Community Alarm. The contact details for the NW Rehabilitation team was provided to a few people and Health & Social Care Connect to access community alarms was also provided.

HSC Connect – Tel 0141 287 0555 and NW Rehabilitation Team Tel 0141 201 7205

It was confirmed that District Nursing support wasn't just for people on their own it was for anyone who needs nursing care but can't get out easily to community services like community treatment rooms and the GP surgery.

If you needed District Nursing care, how would you access this?

Participants were happy with the referral route and methods - it should be available to everyone who needs it. Participants liked one phone number and easy to access – self referral, family, GP, other services, hospital etc. Participants felt a time limited service was OK – providing a service when needed.

Most of the participants had accessed treatment room services and the phlebotomy service – which again were very good services.

Anticipatory Care Planning (ACP)

Jennifer Watt, Anticipatory Care Programme Manager, advised that Anticipatory Care Planning (ACP) is tool to help people to plan ahead, be more in control and able to manage any changes in their health and wellbeing. At the heart of this, is a conversation about what matters to you and what you would like to happen in the future. You might wish to speak to those people who are important to you, for example a relative or carer, and any health or social care professional you may be involved with. The document might include information such as treatment or interventions you would like or not like to receive, where you wish to be cared for if you become unwell, things you like to do that give you comfort or even who'll look after the dog if you are unable to.

This can be completed by anyone and you can ask for support from a Health and Social Care professional with ACP such as your GP, community nursing services or social workers. However you can also begin to plan own your own by having conversations with friends and family, or using online tools which you find useful. A Summary of the plan can be stored within NHSGGC systems and will act as a guide to ensure you receive the right treatment, in the right place and at the right time (a health or social care professional will need to assist you with the uploading of information to NHSGGC systems).

More information can be found on the Planning for Care pages of the NHSGGC website: www.nhsggc.scot/your-health/planning-for-care/

Do you have an Anticipatory Care Plan (ACP) and if so have you used it?

Only one person out of the group of forty people knew about and had an ACP.

Some people had a will or had a funeral plan in place or had a Power of Attorney set up. One person felt that putting a Power of Attorney (PoA) in place made them feel better and more secure about the future. Another person with a PoA felt that this would ensure that a family member would act on their behalf to avoid disagreement with other family members.

Some of the reasons that people had not thought about ACP was that they were: estranged from their family, had no family, it was an omen if discussed, too difficult a conversion and some people admitted 'they had their head in the sand' when it came to thinking about or talking about ACP, becoming ill or end of life. Some people felt their family knew wishes if they became ill, felt it was not necessary or helpful, believed it was a family matter or felt their family would 'rally round' if they became ill and needed help or looked after.

The majority of participants agreed that it is very difficult to talk about becoming ill or death and participants at the session experience good health and planned to stay active so it did not feel it was the right time to discuss or think about ACP.
Some people felt that it was pointless to record your wishes as 'doctors do what they want – doesn't matter what you say'. What someone thinks is in the best interest of the patient or families can override the wishes of the patient. One participant shared her experience of her husband saying he didn't want to be resuscitated but the doctors did it anyway. It's not a legal document.

DNR and CPR was discussed by the majority of groups – people felt these were more likely to be discussed when patients are nearer end of life or very frail. It was also noted that all the sections covered in an ACP do not need to be completed.

One group discussed how they felt about 'going into hospital'. Only one group members confirmed that her family definitely knew how she felt about going into hospital but for the majority their family did know their feelings. ACP could be used so that everyone would know about the decisions that where important to them when it came to their future health and wellbeing.

How can we encourage people to have an Anticipatory Care Plan?

The benefits of ACP are: a person's views and wishes are recorded; are known and can be discussed; time to talk through all aspects of future planning; guidance for everyone if you take unwell suddenly; can be shared with ambulance staff, GP, hospital staff, homecare, District Nursing, family/friends etc

Some people felt that ACP was a good idea and were very open to having a plan in place and that this would be something they would wish to pass on to relatives. But some people were opposed to the idea of writing something down until it was explained that an ACP could be changed at any time and it was an ongoing conversation and should involve family members/health professionals etc

Ideas on how to promote ACP were:

- Social Media – Facebook
- TV – Question Time, story line in a soap, Panorama
- Discussion at community groups, Men's Clubs etc to talk about and promote ACP – make it easier to talk about what would happen if someone became ill
- A poster in GP Practice and Housing Office – something short and sharp – to start a conversation
- A poster, leaflet, advert on the bus – something to prompt discussion, start difficult conversations, family discussion

Thanks and Close

May Simpson, HSCP Community Engagement officer thanked presenters and facilitators, participants for their input and views, Ann and Sue for their help organising this Older Peoples Engagement and Engagement Session.