OSCE Express

Session 7 – Community Care Planning

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Course Overview

OSCE Express

1. 11 session guide to common OSCE finals stations
2. Delivered by Foundation Year 1 Doctors
3. Peer-Reviewed Cases + Video Guides provided to all participants (published on MedAll, osceace.com)
4. Preparation for OSCEs...
5. ...And also preparation to be a safe FY1

Disclaimer

This course has been designed to help final year students with practical OSCE exams and is an unofficial resource that covers themes present in the University of Leicester Final OSCEs. We have nonetheless made this course as applicable to other final year OSCEs as possible, but there may be discrepancies in your University's expectations.

OSCE Express sessions are peer-reviewed by junior doctors, but we take no responsibility in the accuracy of the content, and additionally our sessions do not represent medical advice. Please use our sessions as a learning aid, and if you note any errors, do not hesitate to message us at osce.express@gmail.com

Kind regards,

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In Today's Session...

01

Possible scenarios in community care planning station

02

Case examples + paperwork

03

Q&A + Recap

01

Possible scenarios in community care planning station

Layout of the station

Community care planning

01

02

03

- Simulated patient and observed by (ideally) a GP examiner
- More complex consultation skills focusing on more than one area
- Will include some sort of individualised care planning required in the community
- 10 minutes to speak to the patient, warning bell at 8-minute mark.

Top Tips – marking criteria

Identification of Need Clarifies details of event requiring hospitalisation and subsequent problems Accurately identifies patients short and long term care needs post discharge
Care Planning discussion Appropriately explains context and scope of Care Planning to patient Discusses and agrees plan for short term care and support post discharge Discusses and agrees plan for longer term care and support Discusses preferred place of care, DNAR, preferred place of death, LPA
Patient-centred approach Demonstrates empathy and sensitivity in discussion Clearly establishes the patient's wishes and priorities for care – and these are reflected in the agreed care plan. Actively involves the patient in formulating the care plan Communicates clearly avoiding jargon
Holistic care Fully explores both health and social care needs Fully considers breadth of services and agencies available for ongoing care and support Considers family and voluntary sector support.

Excellent	Skilled & Fluent history and care planning discussion Excellent interaction with patient – appears natural Excellent breadth of knowledge demonstrated - no or only minor omissions Assured answers to questions with full explanation showing a deep level of understanding with no/minimal prompting required.

Top Tips – reading time

Community Care Planning Station 10mins

Patient
Jules Nether

Pre-diagnostic information:

You are working as a Foundation Doctor in a local GP surgery.

You are about to see Jules Nether, a 55yr old who has recently been diagnosed with .....

You are expected to:

Take a brief history and discuss care planning with the patient.

Possible scenarios

Advanced care planning

- Patient may have been diagnosed with a **long term condition** that needs an advanced care plan
- This means you may have to talk to the patient about future wishes such as **further treatments, hospital visits** and **ceiling of care**
- May include talking through a **RESPECT** form (know how to fill this out)
- Relative may or may not be present – make sure to keep them involved during the consultation however the patient comes first
- **End of life discussions** – preferred place of death etc

Possible scenarios cont.

Review of frequent hospital admissions

- Frail elderly patients have a **high rate of hospitalis**ation and a GP consultation may be required to review if these visits are necessary
- Take into consideration the **reason for admission** and whether we can manage this in the community before we send the patient to hospital
- Focus on **patient wishes** as well – some patients are very sensible in deciding when they're best managed in the community rather than risking a hospital admission where they are more likely to be deconditioned and pick up bugs

Possible scenarios cont.

Assessment of capacity

- You may have to **assess capacity** of a patient to see if they can make certain decisions
- Remember capacity is **time and decision specific** i.e. a patient may have capacity to decide how many sugars they want in their tea but may not have capacity to decide if they need an emergency surgery
- Need to be aware how to assess capacity and explain to the patient/relative why this is important

02

Case examples and paperwork

Example case 1

Advanced care planning

- You are working as a FY1 doctor in a GP surgery

Mrs Bell has presented with her husband as she was told to discuss a care plan with her GP after her recent hospital admission

- Take a brief history and discuss care planning with the patient
- You have 10 minutes

Example case 1

Advanced care planning

- Please remember to treat it like any other consultation – easy to forget during finals, 3 point patient identification, clarify who they have brought with them, introduce yourself and your role
- Brief history – about her hospital admission, why was she admitted, what did they do at the hospital, frequent hospital admissions, how she feels about going into hospital, smoking history, vaccinations
- Remember she is with her husband – should be asked if it's okay for him to be in the room due to confidentiality, make sure to keep him involved in the consultation but also remember to keep the patient your first priority

Example case 1

Advanced care planning

- What would you ask in the brief history (2-3 mins)
- What aspects of advanced care planning would you cover in this case?

Example case 1

Advanced care planning

- She tells you she has once again been in hospital due to an infective exacerbation of COPD
- She was given IV antibiotics and discharged on an oral course
- She doesn't particularly like going into hospital and would only go if it's absolutely necessary
- Her husband is supportive of this and agrees with the plan

Example case 1

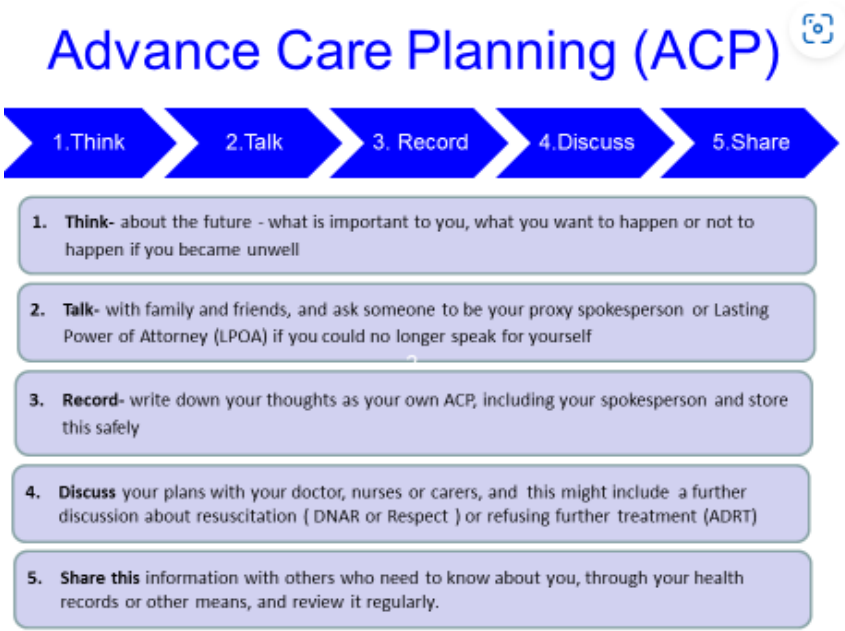
Advanced care planning – Gold standard framework

*‘**Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.’***

International Consensus Definition of Advance Care Planning (Sudore et al 2017)

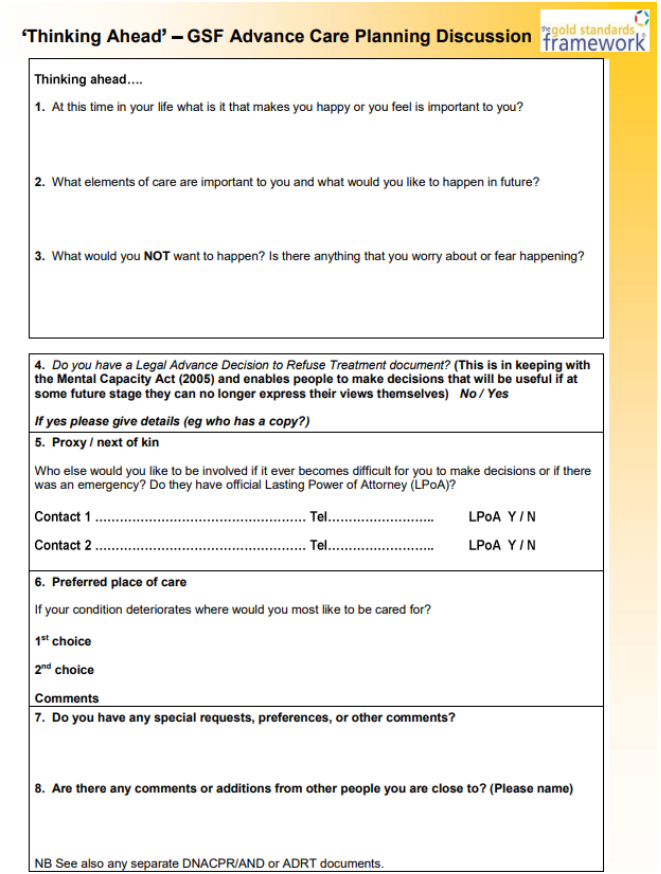
Example case 1

Advanced care planning – Gold standard framework



Example case 1

Advanced care planning – Gold standard framework



'Thinking Ahead' – GSF Advance Care Planning Discussion

the gold standards framework

Thinking ahead....

1. At this time in your life what is it that makes you happy or you feel is important to you?

2. What elements of care are important to you and what would you like to happen in future?

3. What would you **NOT** want to happen? Is there anything that you worry about or fear happening?

4. *Do you have a Legal Advance Decision to Refuse Treatment document?* **(This is in keeping with the Mental Capacity Act (2005) and enables people to make decisions that will be useful if at some future stage they can no longer express their views themselves)** ***No / Yes***

If yes please give details (eg who has a copy?)

5. Proxy / next of kin

Who else would you like to be involved if it ever becomes difficult for you to make decisions or if there was an emergency? Do they have official Lasting Power of Attorney (LPoA)?

Contact 1 ..... **Tel**..... LPoA Y / N

Contact 2 ..... **Tel**..... LPoA Y / N

6. Preferred place of care

If your condition deteriorates where would you most like to be cared for?

1st choice

2nd choice

Comments

7. Do you have any special requests, preferences, or other comments?

8. Are there any comments or additions from other people you are close to? (Please name)

NB See also any separate DNACPR/AND or ADRT documents.

Example case 1

Advanced care planning – Gold standard framework summary

- Includes **lasting power of attorney**, advance decisions, **advance statement**, life sustaining treatment
- Take into account **social circumstances**, wishes of patient (and family), **beliefs** including religious and cultural factors
- What they would like to happen, **what they hope doesn't happen**
- Signpost towards DNAR – **if they don't wish to discuss at this point don't pressurise them**
- Safety of the patient now – do they need any extra help now to ensure we can follow their future wishes as planned

Example case 2

End of life planning

- Some patients however may require a consultation solely based on end of life planning
- This is slightly different to advanced care planning as it purely focuses on one thing
- You may be asked to fill out a RESPECT form – know the different components to it
- RESPECT form is NOT a DNACPR (this is just one part of it)
- Does need co-signing by a consultant for it to be valid

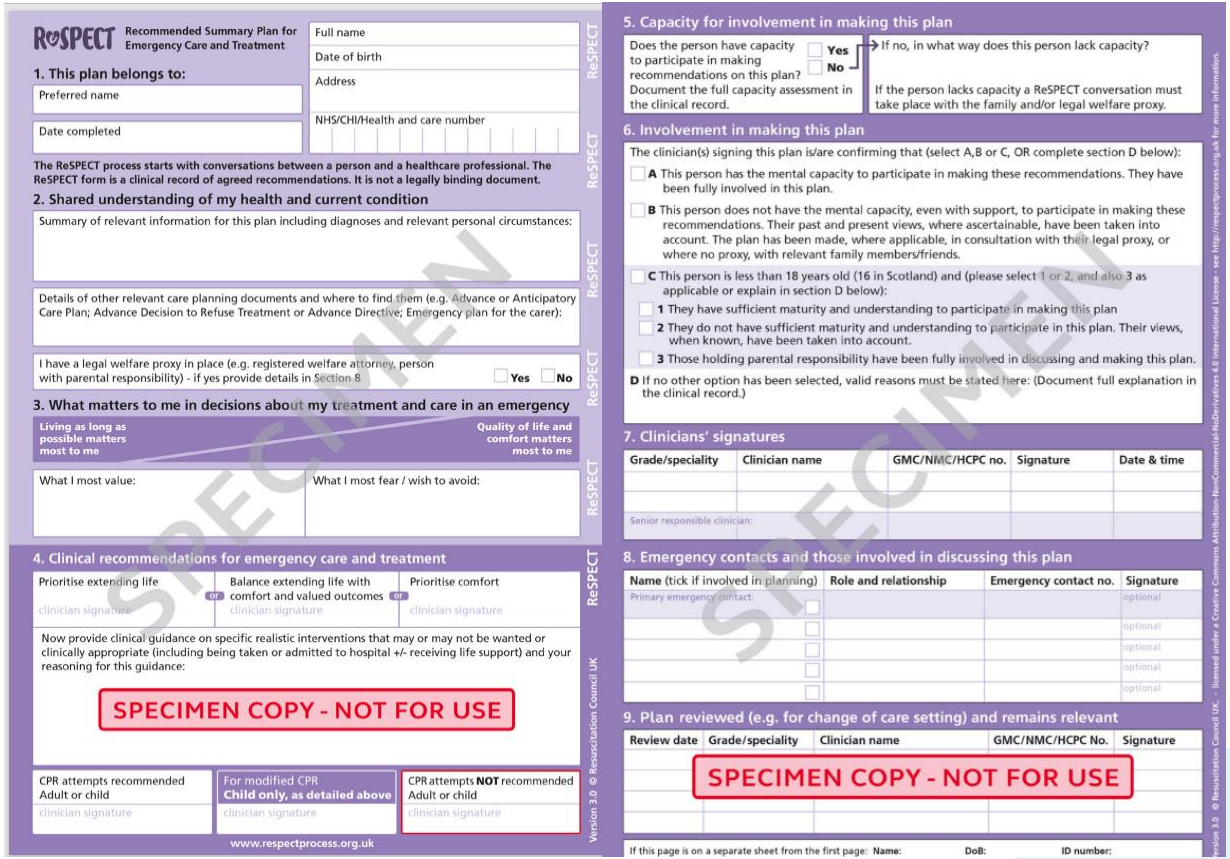
Example case 2

- What are the components of a RESPECT form?
- When would you fill out a RESPECT form?
- Is the RESPECT form a medical decision or not?

- If you haven't already, please do try and fill out a respect form or at least see it being filled out – common F1 job too!

Example case 2

End of life planning – RESPECT FORM



ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name
Date of birth
Address
NHS/CHI/Health and care number

1. This plan belongs to:
Preferred name
Date completed

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition
Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ Yes ☐ No

3. What matters to me in decisions about my treatment and care in an emergency
Living as long as possible matters most to me
Quality of life and comfort matters most to me
What I most value:
What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment
Prioritise extending life (clinician signature) or Balance extending life with comfort and valued outcomes (clinician signature) or Prioritise comfort (clinician signature)

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

SPECIMEN COPY - NOT FOR USE

CPR attempts recommended Adult or child (clinician signature)
For modified CPR **Child only, as detailed above** (clinician signature)
CPR attempts **NOT** recommended Adult or child (clinician signature)

www.respectprocess.org.uk

5. Capacity for involvement in making this plan
Does the person have capacity to participate in making recommendations on this plan? ☐ Yes ☐ No → If no, in what way does this person lack capacity?
Document the full capacity assessment in the clinical record.
If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan
The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):
☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):
☐ **1** They have sufficient maturity and understanding to participate in making this plan
☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.
D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Plan reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

SPECIMEN COPY - NOT FOR USE

If this page is on a separate sheet from the first page: Name: DoB: ID number:

03

Q&A and recap

Top Tips

1. Practise practise practise!! (with friends/clinical groups)
2. Aim for concise history taking and keep to time
3. Geeky medics/med school checklists
4. Ask for supervision of history taking and care planning during GP rotation – focus on empathy, communication skills and triadic consultation skills

TOP TIPS FOR ANY CCP STATION

- EMPATHY EMPATHY EMPATHY
- Listen to the patient – they will tell you everything!
- Don't pressurise the patient
- Acknowledge all present in the consultation
- CUES will be everywhere in this station – they may want to talk about something uncomfortable etc
- Be familiar with all the legal jargon – be ready to be asked about it by the patient
- This station is all about getting the patient to think about things – major decisions DO NOT have to be made for you to pass the station
- Summarise if you blank out :)

Questions?

Next Session...

Feedback

Thanks!

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Cases: **osceace.com/osceexpress**

Please don't hesitate to contact me at sara.sabur@uhl-tr.nhs.uk for any questions regarding finals