What is a Care Planning Meeting?

- ‘involves a number of family members, the patient and the hospital personnel in discussions concerning the patient’s illness, treatment and plans for their discharge or their care outside the hospital’
  - Hansen, P, 1998

- Increasingly common decision-making forum in the hospital setting but there is limited research into the process and experience of such meetings.

- Although this forum is intended to encourage active participation and empowerment of older people and their families in decision making, doubts exist as to whether they effectively carry out this role
  - Efraimsson E, 2004
Health Care Practitioners

- Have divergent understandings of what constitutes a ‘family meeting’ and differing terms for this process
  - family meetings
  - family conferences
  - discharge planning conferences
  - care planning meeting

- HCP’s have a significant role to play in facilitating and enabling active participation of patients in these meetings, but need for education and training
  - Hedberg, B 2008
Research Design

- Chosen to describe, evaluate and offer a mechanism for the development of service delivery as it is inherently practical, change orientated, cyclical and participatory in nature
  - le May & Lathlean, 2001

- AR is ‘Any systematic enquiry, large/small, conducted by professionals and focusing on some aspects of their practice in order to find out more about it and eventually to act in ways that they see as better or more effective’ (Oberg and Mc Cutcheon, 1987, P.117)
ACTION RESEARCH CYCLE

Observation

Implement Change

Reflection/Analysis
### Methodology: Phase I and Phase II

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<th><strong>OBJECTIVE</strong></th>
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<td>Describe in rich detail the current processes that occur within Care Planning Meetings.</td>
<td>Participant Observation</td>
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<td>Gain insight into the subjective experiences of older people and their family members during family meetings.</td>
<td>Questionnaires</td>
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<td>Examine staff members experiences of Care Planning Meetings and suggestions for improvements.</td>
<td>Staff Focus Groups (Phase I only)</td>
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Findings (I)

- Participation levels of Pt’s varied: those with higher levels of cognitive impairment (CI) had lower levels of participation.
- Family members - higher levels of participation than Pt’s
- Consistently good eye contact maintained between MDT and family
- Poor eye contact with Pt’s
- Pt’s with CI were often ‘talked over’ with usage of 3rd person by MDT and family members
- All attending Pt’s believed they had been included in the decision-making process
- All Pt’s and family members believed they had been given adequate opportunities to ask questions and express opinions
- Family members often surprised that older person with a CI included in the meeting
- Two family members believed final decisions had already been made by Medical Team and MDT prior to the meeting
Phase I: Changes Implemented

- MDT Critical Reference Group established.
- Name changed to ‘Care Planning Meetings’
- Patient Information Leaflet developed
- Further examine Care Planning meetings held with inpatients with cognitive impairment.
Findings (II)

- Inequalities found in participation levels - MDT dominated the discourse in all CPM’s observed-asymmetry in participation

- Pts with low level of verbal participation appeared to have high levels of non-verbal participation

- Barriers to communication; dominance of MDT and family members, usage of 3rd person, poor eye contact and praxis inconsistencies from MDT relating to addressing patients directly. All Pt’s reported a desire for involvement and participation, even those who exhibited little or no verbal participation during their CPM

- All Pt’s believed they were given adequate opportunity to participate, ask questions and voice opinions

- No association found between levels of CI and Pt participation within CPM’s.
Phase III

- Development and implementation of Education and Training Programme for MDT
  - Teodorczuk 2009, Kurtz, SM., 2009
Main paradox; Pt’s exhibited low levels of verbal utterances but participation indicated by eye contact and body language. All felt they had been given adequate opportunity to participate, ask questions and voice opinions.

Why are Pt’s not appearing to desire more active participation?

Are they frail older patients who no longer want to actively participate (Ekdahl et al, 2010) or is it a strategic choice by Pt’s to empower themselves by allowing family members to assume a dominant role ?(Huby et al. 2004)

Our findings support literature which suggests that for older patients, participation means having the opportunity to ask questions and obtain information (Fisher et.al, 2006) and the importance of the therapeutic relationship was also highlighted.

Participation should be defined by whatever level the patient is most comfortable with (Guadagnoli and Ward, 1998)

To foster a climate encouraging optimal Pt participation, a framework promoting an individualised approach is also recommended.
Research Challenges

- Small sample size (participant observations)
- Low attendance of patients at CPM’s in Phase I and data not audio-recorded
- MDT as Co-researchers
- PAR – but not truly participatory
- Preconceived ideas resulting from being a practitioner in study site
Practice Implications:

‘Everyone hears only what he understands’
Goethe

- Pre-Meeting preparation: elicit desire to participate/attend, ask individual to write down what they want to discuss/questions/therapeutic relationship
- Turn to face Pt when addressing them and do so in 1st person
- Slow pace of speech, short pieces of information, simple language, good eye contact
- Body language
- Ask direct questions, check understanding
- Two way dialogue
Closing Thought

‘...the skill and effort that we put into our clinical communication does make an indelible impression on our patients, their families and their friends. If we do it badly, they may never forgive us; if we do it well they may never forget us’.

Buckman BMJ 2002
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