Serious illness Group workshop (tables 3 & 4)

Instructions

Outcome - **Tables 3 & 4 consider what happens when an older person gets a serious illness.**

Table 3 – **Mr Phillips case unexplained weight loss** (discuss for 15 minutes)

Table 4 – **Look at Stroke case histories?** What are you experiences in hospital and primary care? (discuss for 15 minutes)

The two groups then combine and collaborate to compare notes in order to do a (not longer than) 5-minute presentation at the end on how doctors and patients deal with <u>serious illness in the elderly</u> and what it means to you.
This isn't about right or wrong answers in terms of management, much more about the patient's family's and your attitudes and feelings.

The presentation can involve all or just a few of you – can just be a summary of your discussion or innovative and entertaining. The Aim is to educate the res of the audience quickly

(If you have time to spare and you will have a total of an hour in total – go back into groups and discuss the other work).

The material is on subsequent pages but don't feel you have to include this, think globally, think about your own families, young and old. Think about your own experiences and stories too.

Table 3. material

Mr Phillips is 84, he has had a fit and active retired life.

He developed a persistent cough following a presumed URTI some 3 months ago and this is affecting him when he is eating-'the thing that is really bothering me doctor, is the weight loss-I have lost 7lbs in the past 2 months.'

How would you go about investigating the gentleman?

What if tests were normal?

There is a lot to explore here – not just the obvious medical investigation and treatment, but also the family, the 'ICE' and the psychological and social.

Table 4. material

UK and US cases – how typical?

Case study:
Stroke patient's speedy treatment

Brian West, 73, from Pinner, was one of the first patients to be treated in the North West London Trust's new Hyper Acute Stroke Unit at Northwick Park Hospital.
He describes the experience as "miraculous". He collapsed at 2:30am on a Monday, feeling sick and dizzy with weakness in his legs. His wife called an ambulance and he managed, with help, to get downstairs when the paramedics arrived.
'I was taken to A&E and then immediately given a scan,' he says. "Then they gave me these clot-busting drugs to re- move the obstruction that had caused the stroke. About 7am my wife left and by 8am I was offered breakfast.

'I felt fine. By mid afternoon Dr [David] Cohen came round and saw me. He asked how I was and I said I was fine. Then a physiotherapist called and asked if I wanted to try walking, which I did. By the following day I was fit to go home.'
Mr West was not unfamiliar with stroke. He had one three years previously following a triple heart bypass and was in hospital following complications for three and a half months. So the experience this time – in and out of hospital in less than two days – was a revelation for him.
The London stroke project aims to reduce deaths by 500-600 per year, in addition to significantly reducing long-term disability. With eight HASUs and 24 SUs ready to go for the 19th July go-live date across the capital, the intention will be dramatically

Increasing Clients' Longevity and Quality of Life

American CASE HISTORY (compare with the UK)

RECOVERY FROM A STROKE

Mrs. P was an independent, cheerful and busy 74-year-old widow who ignored her high blood pressure for years, until she suffered a stroke that left her paralyzed on the left side and unable to speak clearly. Her only son worked in Japan and couldn't spend more than a week with her following the stroke. After a week in the hospital, Mrs. P was transferred to its rehabilitation unit, where her progress was deemed too slow to meet Medicare criteria and she was rapidly discharged. The hospital social worker arranged for her transfer to one of the few available beds in a lower- to mid-quality nursing home.

Mrs. P's trustee visited her several days later and found her crying in bed. The remains of breakfast and lunch were on her clothing, her bed was saturated with urine and her hair was unkempt. She was in the middle of the three beds in the room; one of her roommates called out continually. The only nurse assigned to the floor was unavailable to speak with the trustee and the Director of Nursing was out of the building.

The trustee contacted a care manager that afternoon about Mrs. P's status, requesting an assessment. That evening, the care manager visited Mrs. P and concluded in an interview that she was mentally alert despite her speech impairment. Mrs. P expressed her desire to leave the nursing home and return home. The care manager had her sign a professional consent for a medical records review, then had the evening supervisor authorize it as well.
From the chart, the interview with Mrs. P, and a conversation with her physician, the care manager determined that a slower paced rehabilitation program was needed. Because of an ongoing working relationship, she arranged for Mrs. P's admittance to a high quality nursing home the next day, and for participation in their excellent rehab program for stroke patients.

The care manager also arranged for a physician who specialized in rehabilitation to manage her program. Mrs. P remained there for six weeks. The care manager visited weekly to observe progress, participate in care conferences, and provide support. She also worked with Mrs. P on home discharge plans.

During this time, the care manager met the trustee at Mrs. P's home to see if it could be made accessible for her. With Mrs. P's and her son's approval, a ramp was built for the back door, the bathroom door was widened, and grab bars were installed in the bathroom. The soft double bed was replaced with an electric twin bed, a tub transfer bench and Swedish shower were installed, a Lifeline emergency call button was ordered, and phones with programmed buttons were installed in the kitchen and bedroom. The cost of all modifications was approximately $2400.

When Mrs. P was discharged after six weeks of speech and occupational therapy, she was walking with a leg brace and quad cane. She could dress herself, use the bathroom alone, and speak adequately in short sentences. She needed help with bathing, laundry, shopping, and significant cooking, but could warm up food in the microwave.
The care manager arranged for a personal care aide three days a week, three hours a day, at about $40 a day. The aide helped her bathe, and did laundry, grocery shopping, and meal preparation under Mrs. P's directions. The trustee arranged to sell the car, and the care manager helped her apply for Metro Mobility.
The trustee's timely intervention, the superb rehab service, her determination, and the care manager's coordination of services facilitated an excellent recovery and return home-a far different outcome from that which would have occurred had Mrs. P. remained in the original nursing home.