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ENABLING PATIENTS TO REMAIN IN THE COMMUNITY IN COLLABORATION WITH THE MULTI-DISCIPLINARY TEAM AND RECONCILING DIFFERENCES IN EXPECTATIONS

Dr Quek Si Min Ginny

ABSTRACT

Madam L, a 75-year-old Chinese female, was admitted for amputation of her toe due to underlying osteomyelitis and subsequently required community step down care for management of her wound. Underlying fixed ideas and perceptions were the reasons behind her poorly controlled asteatotic eczema with recurrent cellulitis. Due to the recurrent infections and decreased function, her husband who was also her caregiver requested for her to be institutionalised. The family physician (FP) is well-placed to provide patient education and correct misperceptions in our patients. We can also collaborate with our specialist colleagues to manage common conditions such as asteatotic eczema, which can result in high morbidity. The multi-disciplinary team is also essential in ensuring that all concerns from different stakeholders are addressed adequately for patients to be discharged and remain well in the community.

Keywords: family physician; multi-disciplinary team; home assessment; behaviour modification

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INTRODUCTION

Family physicians (FP) are often the first port of call for patients, resulting in frequent encounters with patients and thus in a privileged position of being the ones who can empower patients to gain control over and improve their health.[1] FPs are also important when it comes to patient education and in correcting misperceptions when it comes to medical conditions. We are also advocates for our patients, often having to take into consideration the social circumstances and different family dynamics at play that surround our patients and the challenges they may face in remaining well in the community.

Working in a multi-disciplinary team (MDT) with input from our allied health colleagues is also invaluable in ensuring that patients are able to remain well in the community. They can give advice regarding home modifications and environmental set-up to optimise living conditions and conduct appropriate training to allow caregivers to cope better with the care needs of patients.

DR QUEK SI MIN GINNY
Consultant, SingHealth Community Hospitals

WHAT HAPPENED?

Madam L is a 75-year-old Chinese female who was pre-morbidly ADL-independent and community ambulant with a walking stick and lives in a 3-storey terrace house with her husband.

She was admitted to tertiary hospital with issues of:

1. Recurrent cellulitis with osteomyelitis and abscess formation of the left second toe requiring a left second toe ray amputation
2. Functional decline

She stepped down to the community hospital (CH) for rehabilitation and subacute wound care. On arrival, she had severe generalised asteatotic eczema, worst over bilateral lower limbs, and was scratching herself uncontrollably, resulting in excoriations that had started bleeding. She also required minimal to moderate assistance in her bADLs and ambulation.

Significant Background:

1. Right intertrochanteric fracture status post right Proximal Femoral Nail Antirotation (PFNA) in 2015
2. Asteatotic eczema, with element of irritant dermatitis complicated by recurrent cellulitis

Patient's Revelation

When exploring with her the reasons for the recurrent cellulitis, I discovered that she would wash her lower limbs repeatedly with scalding hot water to ameliorate the itch. She did not apply her emollients as she was certain that her itch was caused by her diet. She also expressed her desire to return home despite repeated requests from her husband to send her to a nursing home (NH). She mental capacity and felt that she would be able to care for herself once her wound was fully healed and able to ambulate independently again.

Gaining Insights: What are the Issues?

1. How do we change and modify behaviour that is due to fixed ideas and misperceptions?
2. How can we reconcile the differences between the patient and her husband in terms of her placement?
3. How do we enable the couple to return home safely and minimise the risks of falls?

Study the Management – how do we apply this in clinical practice?

1. How do we change and modify behaviour that is due to fixed ideas and misperceptions?

Madam L appeared to have good insight into her condition. She understood her medical conditions and was aware of the reason for her admission to the CH. She also had clear goals to regain her independence. However, on further exploration, it became evident that she had certain ideas and perceptions that were incorrect especially pertaining to her underlying eczema and her recurrent cellulitis. She also had certain behaviours that led to worsening of her eczema. She would bathe in scalding hot water to relieve her itch instead of using emollients and oral anti-histamines that were prescribed to her. She was not aware that bathing in hot water would worsen the itch. As the FP, understanding what drives certain behaviours and understanding the thought process of our patients provides us the ability to modify behaviour.

Patient education can help to increase awareness and it is critical to provide patients with an understanding of the personal relevance of the information. General knowledge will not be sufficient for behavioural change.[2] In addition, education on how and why a change needs to be made will go a long way in increasing patients' self-efficacy in achieving the desirable health outcome.[2]

To help increase awareness in the understanding of eczema as a condition, I educated her on the cause of eczema, which is dry skin and a damaged skin barrier. I then subsequently linked it back to her situation by asking her to recall the instances of when her eczema would flare up. She was able to share that her eczema would usually flare up after she had bathed herself in scalding hot water and when she neglected to apply her emollients. She was also able to recall instances of where her eczema would flare up even without seafood consumption, which led her to conclude that seafood was not the cause of her eczema. After increasing awareness, I then focused on what interventions she could apply to control her condition to increase her self-efficacy. She was willing to stop bathing with scalding hot water once she understood that it would only serve to strip her skin of moisture. We also assessed her ability to apply emollients on herself. She was able to apply the emollients over both lower limbs, thus increasing her confidence in managing her eczema.

Therefore, with tailored patient education, we were able to modify her behaviour. By increasing personal awareness of change, why the change needed to be made, and providing training to make the change, patient education can be delivered effectively.[2] The FP can be an advocate for patients in behavioural change by tailoring the education to the patients' needs and unique circumstances.

2. How can we reconcile the differences between the patient and her husband in terms of her placement?

Madam L wanted to go home once she was able to achieve independence in self-care. Despite amputation, Madam L was confident that with adequate rehabilitation, she would be able to self-care at home. She stays in a 3-storey private property with her husband who is also elderly. We were concerned that she would not be able to manage at home with just her husband as she was at moderate to high risk of fall. This concern was also surfaced by her husband, who did not feel confident in being able to ensure her safety at home. He was deeply concerned that both of them might end up falling, leading to poor outcomes. Thus he requested for Madam L to be placed in a nursing home (NH). When this was brought up to Madam L, she made it clear that she did not want to go to a NH. The option of hiring a helper was explored but rejected by the couple due to previous bad experiences. On further assessment, she was deemed to have full mental capacity to decide on her placement. She understood that there were risks of falls and her husband would not be able to provide much in terms of assistance. Nevertheless, she still desired to return home. As such, we had to help the couple reach a resolution in terms of the discharge destination.

A family conference was held with Madam L, her husband, and the MDT. By communicating and facilitating the conference empathetically, this allowed both parties to be involved in the decision-making process. Empathy is crucial in the development of the therapeutic relationship. Displaying empathy in the therapeutic relationship can help achieve certain aims such as:

a. Initiating supportive, interpersonal communication in order to understand the perceptions and needs of the patient.[3]

Through open and empathetic communication with Madam L and her husband, we were able to help them understand the perceptions and concerns that they each had with regards to her eventual discharge destination. Madam L understood that her husband was concerned about the risks of falls and the resulting consequences, and he understood that she valued her independence and was motivated in doing rehabilitation to ensure that she could be competent in self-care. This then led to the second aim, which is:

b. Empowering the patient to learn, or cope, more effectively with his or her environment.[3]

With that in mind, both Madam L and her husband listed down some of the potential challenges they would face on her return home and to work together with the team for a solution. This then resulted in achievement of the third aim of empathetic communication, which was:

c. Reduction or resolution of the patient's problems.[3]

The use of empathetic communication via a family conference with the healthcare team, which included inputs

from the physiotherapist (PT) and occupational therapist (OT) in updating her rehabilitation progress and the medical social worker (MSW) who informed them about the various community resources available, helped the couple to resolve their differences in terms of the discharge destination. It also created harmony within the relationship as the couple then started to seek solutions together to ensure the best possible outcome.

3. How do we enable the couple to return home safely and minimise the risks of falls?

At the conclusion of the family conference, there were several issues that were highlighted by the couple that needed to be resolved. First, they lived in a 3-storey private property and Madam L's bedroom was on the third floor. However, Madam L recognised that it would not be possible for her to navigate steps with her walking frame on discharge. She shared her intention of moving to a small room on the first floor, which was close to the common toilet. There were also steps into her home, which would be challenging for her to navigate. In addition, she had a habit of carrying boiling water into the bathroom as there was no heater installed.

The occupational therapist (OT) and I decided to carry out a home assessment (this was before the COVID pandemic). Extrinsic risk factors, such as home environment, is an important factor in the fall risk assessment. The prevalence of environmental hazards in the home of elderlies is high.[4] Home assessments also evaluate the degree to which the patient is able to function in their home environment post-discharge.[5]

Following the home assessment, recommendations made by the OT included:

- The cabinets in her bedroom be removed to allow greater space for manoeuvring
- Grab bar installation at the entrance to assist her in climbing the steps to her home
- Installation of a water heater so that she would not need to carry hot water into the bathroom
- Anti-slip mats to be installed in the bathroom

Madam L and her husband were greatly reassured by the home assessment that was conducted. This also increased the confidence level of the couple as to staying at home after discharge. Madam L was also referred to community services to help ease the burden of care. The services included home help services to aid in performing simple household chores and medical escort transport to ensure that Madam L would be able to attend her follow-up appointments. She was also referred to the day rehabilitation centre to maintain her functions. The couple was appreciative of all the community services that enabled them to continue to remain in their own home.

CONCLUSION

Understanding the motivation and perceptions of our patients will go a long way in addressing many health issues that may have been labelled as "non-compliant". After identifying the misperceptions, it is important to educate and correct these perceptions, which can lead to better health outcomes. It is also important to collaborate and work together with our patients' loved ones to achieve the desired outcome. This requires us to respect the autonomy of our patients and to advocate for them even though it might be contrary to the expectations of their loved ones. Working together in a multi-disciplinary team also enables us to tap on the skillset and resources of our allied health colleagues, which are equally important in ensuring that our patients can continue to live well in the community.

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LEARNING POINTS

- **Patient education can be tailored to the patient's needs and unique circumstances.**
- **Open and emphatic communication is essential in conflict resolution and managing differing expectations between various stakeholders.**
- **Working in a multi-disciplinary team enables one to tap on different skill sets and resources to achieve desired outcomes.**