Family Meeting

Social Worker - Sharnia: So, I'll introduce everyone. So, my name is Sharnia, you've spoken to me on the phone Sonya. I'm the social worker who has been involved with Ken and the family. To my right we have Dr. Ranasinghe, you would have met her last week, she is our specialist geriatrician that has been working with Ken. And then just along here I have Michael, he is our occupational therapist, so he would be able to talk about dad's function and cognition and those sort of things. So, we will just start the meeting with another medical update about how dad's been going throughout his whole admission, but specifically in the last week since we last spoke with you.

Geriatrician – Dr. Ranasinghe: We also have Bonnie.

Social Worker - Sharnia: Oh sorry. And we do have Bonnie, who's just off to the side. She's the Registrar. She's just going to be doing some scribing for us.

Consumer – Sonya: Okay.

Social Worker - Sharnia: Okay. Perfect. So, I'll hand over to Dr. Ranasinghe now.

Geriatrician – Dr. Ranasinghe: So, Ken came, I think, on 18th of February following another fall at home. He tripped over his wheelie walker and then fell. And I noted that is in the setting of progressive decline in function and likely cognition and also had multiple falls in the past. Have you got any questions so far?

Consumer – Cheryl: I think…

Consumer - Sonya: Yep. You go Cheryl.

Consumer - Cheryl: I mean, Sonya spoke to Dad the other day and he wasn't with it really. So, we didn't know if the medication he's on is affecting… Umm what

Consumer - Sonya: Yeah, is affecting his whole body. Mind…

Consumer - Cheryl: Mind, yeah.

Social Worker - Sharnia: Hi Cheryl. Yep.

Occupational Therapist - Michael: Question.

Consumer - Cheryl: Can I just put something in there? Would that include the fact that the other day, when he was talking to Fah, that he actually confused her with Sonya when speaking to her.

Geriatrician – Dr. Ranasinghe: It could be, yeah. I might get Michael to talk more about it because he has done some assessment in that area.

Occupational Therapist - Michael: Yeah. And I think it's always very difficult for us to kind of tease it out when there actually is so much going on with the medications. But I think having known Ken probably over a month now, I think we first got involved on the 19th of February between our occupational therapy team. We have a pretty good idea of kind of where he's at and what he's probably going to be functionally and cognitively over the next good few months at least.

Carly, one of the OTs, touched base with one of you earlier and Mary, one of the CHIP nurses as well, and got a big history from you guys about all of these things are going on at home. And so going into the assessment, I really had a good picture from you guys that actually over a long period of time this hasn't been easy at home, and these have been some long-standing concerns. And it sounds like a big incentive for him is the medications and then without that incentive, we're identifying a lot of things here about his inability to initiate his own self-cares or just become really apathetic because he's not motivated to look after himself. And that's consistent with what you have been seeing.

From there I can determine he, definitely, even getting him into the shower, needs a moderate level of assistance, hands-on assistance, to shower adequately. Otherwise, it would be suboptimal hygiene and I've explained that to him at length. The recommendation from that and it has been a long-standing thing, was to get some help in the shower and he's since declined that many times.

Consumer - Sonya: It doesn't surprise me because we've been knowing this has been escalating pretty badly for quite a while now. So, the fact that you's guys are starting to realise and go, "Hang on a minute. Something isn't right. You's aren't going crazy." is like a fresh breath of air.

Geriatrician – Dr. Ranasinghe: So, in this type of situation, next step is to have an objective assessment of his decision-making ability. So, at the last meeting we had, he was kind of giving you permission to look at the nursing homes but not also consenting fully to go ahead and make decisions on behalf of him. So, in this type of situation, next step is to have an objective assessment of his decision-making ability, which we call Capacity Assessment.

Social Worker - Sharnia: And after Dr. Ranasinghe's done that assessment then I can refer to the Aged Care Assessment Team for the ACAT. But as I told you yesterday Sonya, in the interim we can still have discussions with the aged care facilities about his current nursing care information. It's just that support plan that they'll require from ACAT.

Consumer - Cheryl: Sorry, with our last meeting, I was under the impression that you were going to try and get that ACAT done by today's meeting.

Geriatrician – Dr. Ranasinghe: It's a little bit convoluted and complex. So that is why I need to do this Capacity Assessment and then assess his decision-making ability and then enact the Power of Attorneys to make decisions. So, then only we can refer him to the ACAT. So, all the steps are to preserve the dignity and decision-making ability for adults. This is to safeguard their rights but at the same time sometimes it can be a little bit convoluted and complex when we actually need that process. So, sorry, that is why the ACAT hasn't happened and that is why it took another week to come to this point. So, I know it is very complex and tricky situation knowing Ken and the way of behaviour and the way of decision making but unfortunately, we have to go through this process.

Consumer - Cheryl: Yeah, you have to go through the process. Absolutely.

Consumer - Sonya: Yeah, okay. Alright. So, the sooner it's done, the better.

Geriatrician – Dr. Ranasinghe: I think I can guarantee by end of this week, we have movement and definite plans but that is how the system works and that is how we need to go through the process.

Consumer - Cheryl: Yeah. Yep. So yeah.

Social Worker - Sharnia: Thank you so much for taking the time guys to have another meeting with us. And Sonya, I'll catch up with you a bit later over the phone once I can send through that ACAT. Okay?

Consumer - Sonya: Okay.

Consumer - Cheryl: Alright. Thank you everyone.

Occupational Therapist - Michael: Bye.

Social Worker - Sharnia: Thanks guys.

Social Worker - Sharnia: My name's Sharnia. I've been a social worker for the Ipswich Hospital for about four months now and today was my first family meeting using the Queensland Health telehealth software.

Today we had two family members who wanted to participate in the meeting. One of them is a stay-at-home mum who has dependent children, and the other is a fulltime working person. So, to be able to avoid them both having to take time out of their day, organise care for their children or wrangle their children into the hospital, it was a much easier option for them to be able to use telehealth. They didn't have to take time off work. They didn't have to muck around with parking and getting to the hospital. They could just do it at their workspace or at the comfort of their own home and still participate in the conversations about their loved one.

Director of Social Work - Fiona: Telehealth in the hospital here started during COVID. It was an initiative by the clinicians who sought this as a solution for families to continue to be engaged in the care that we were delivering. We - allied health have a business telehealth coordinator, who helped us establish the service here in the hospital for family to be able to be involved in the care of patients in the hospital.

Social Worker - Vicki: So, when I use telehealth, there's not a lot that I do differently to how I would normally deliver our service. For example, in a family meeting, which is the primary reason that we would use telehealth, it's still done in the same way. It's still introducing the meeting in the same way. It's still involvement of all the allied health. I think there's a few things that we do have to do differently. We have done a combination of telehealth, where we'll have people in person, and family members who are offsite.

Social Worker - Sharnia: Face to face is always preferable, right? Like just even as human beings, being able to meet someone face to face is always preferable. But I think in this time we need to be adaptable and be able to build our skills as workers and practitioners to be able to comfortably have those conversations with people on telehealth. For example, the family meeting I just conducted, it's unlikely I'm going to meet those people in person. So, we've been able to establish those relationships across the two telehealth meetings that we've had. It is a little bit different, you know, in terms of building rapport. You do have to work a little bit harder, but that's just how you adapt your skills as a worker to a new technology.

Social Worker - Vicki: You've got to be really careful that the computer doesn't become the centre of the meeting and it's only a small part of the meeting. So, I guess that's different in terms of our practice that we're not addressing the computer. We have to treat them as a person, but you've also

got to be mindful that they need to hear what's going on. And so, without them becoming the centre of attention, make sure you're orienting the computer in a way that they're able to see the person who is talking at the time.

Occupational Therapist – Michael: Troubleshoot prior. Allow time to troubleshoot. Speak clearly. Speak concisely. Frequently check that the people on the other end can hear you. And consistently ask for feedback - perhaps a little bit more so than what you would do in a face-to-face meeting.

Social Worker - Vicki: If telehealth is something that you're wanting to implement, suggest you talk to your manager. Really worthwhile process to get involved with because we're able to engage so many more people in the care of our patients. It's patient centred. It's family centred.

Director of Social Work - Fiona: As a manager, what I've observed is that all of our workforce have become upskilled in telehealth. Even our more experienced clinicians who've worked for a long time in the health service have come on board with the technology. And that's been a great point for us to leverage to make sure that we can build the service ongoing.