

Macmillan Anticipatory Care Planning Programme **ACP Skills Practice Case Study – Morag Smith**

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Morag Smith: Known as 'Mo' / Age: 77

Medical History: COPD, Glaucoma.

2 hospital admission over the last 4 months with increased shortness of breath and chest infections.

Morag **threatened to irregular discharge** as her original discharge date came and went due to her physical condition still being problematic. Morag was discharged 4 days later (with support from a ward nurse) but made Sarah aware that **she was not keen to go through** the same situation again.

'I know my breathing's getting worse, some days I'm lucky if I can make to the toilet and back. It's exhausting - not being able to breathe is frightening and I start to panic. I want to be at home with my family and my things, if I go back in there I'll no come out again'

New management plan includes nebuliser and increased input from **District Nursing Team** to monitor her COPD and compliance with the nebuliser: *'the nurses are great, so kind and always helpful if I don't understand anything'*

DNACPR not in place.

Social Circumstances:

Lives alone and has good support from her daughter, Sarah: *'she takes care of things, thank goodness for Sarah'.*

Her son Paul, lives some distance away and is kept busy with his work. He visits when he can: *'he does not always agree with Sarah, they fall out, usually about what happens to me - I know when it's your time to go, it's time to go – as long as I'm no in pain or struggling for breath'*

Mo has 3 'lovely' grandchildren Chloe, Kerry and Paul. **Family are important to Morag.**

'Sarah is getting married again next year, I know I'll no be whizzing round the dance floor with these lungs, just as long as I see her big day – god willing, Kevin's a keeper and I just want to see her and the kids happy and settled'

Alfie, Morag's **husband passed away 4 years ago** in hospital. It was a **traumatic**, Alfie in was in hospital for months: *'hooked up to all those machines, just waiting, I felt helpless – I just wanted to bring him home'*.

Morag added *'I don't want any fuss if I'm too sick and don't have any fight left in meI don't want my family to see me like that.'*

She misses Alfie very much, they did everything together – dancing and days out *'I know he's up there, I still talk to him'*

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Clinical Frailty Scale: 5 – declining at home due to breathlessness. Morag manages some personal care but her daughter assists with showering and housework. This takes its toll on Sarah - she finds that now she has to do more and more for Mo.

Morag is a **practising Roman Catholic**, this is comforting to her, especially after Alfie died.

Occasionally, when Morag is well enough she enjoys going to her wee **lunch club**, her pal, Meena is very supportive: '*we share our aches and pains and talk about the good life we've had, we know we are just in the big waiting room **biding our time**'*

Based on prior contact with Morag, Morag has agreed to engage in an ACP conversation:

1. What key areas you would wish to cover with Morag?
2. Who else would you involve in the conversation?
3. Suggest questions you could ask or statements from Morag to explore more, for example, what is important to Morag?
4. What do you see as the main barriers or challenges of having an ACP conversation with Morag?

Think about -

- Preferred place of long term care
- Views on hospital admissions
- Preferred treatments and interventions
- Views on DNACPR