

Person-centred Care through Personalised Care and Support Planning

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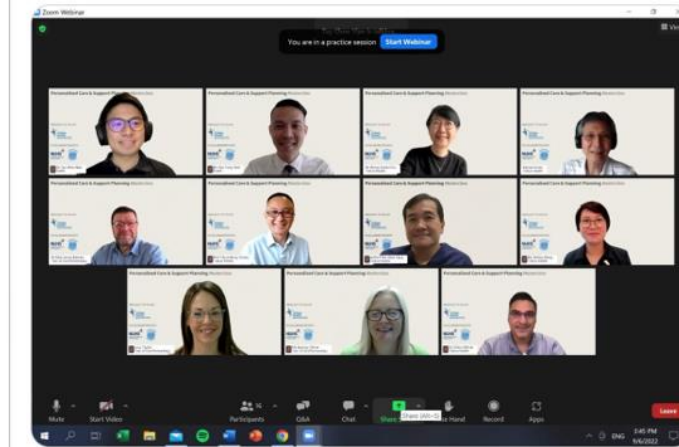


Year of Care & Personalised Care & Support Planning



Year of Care
@YearofCare

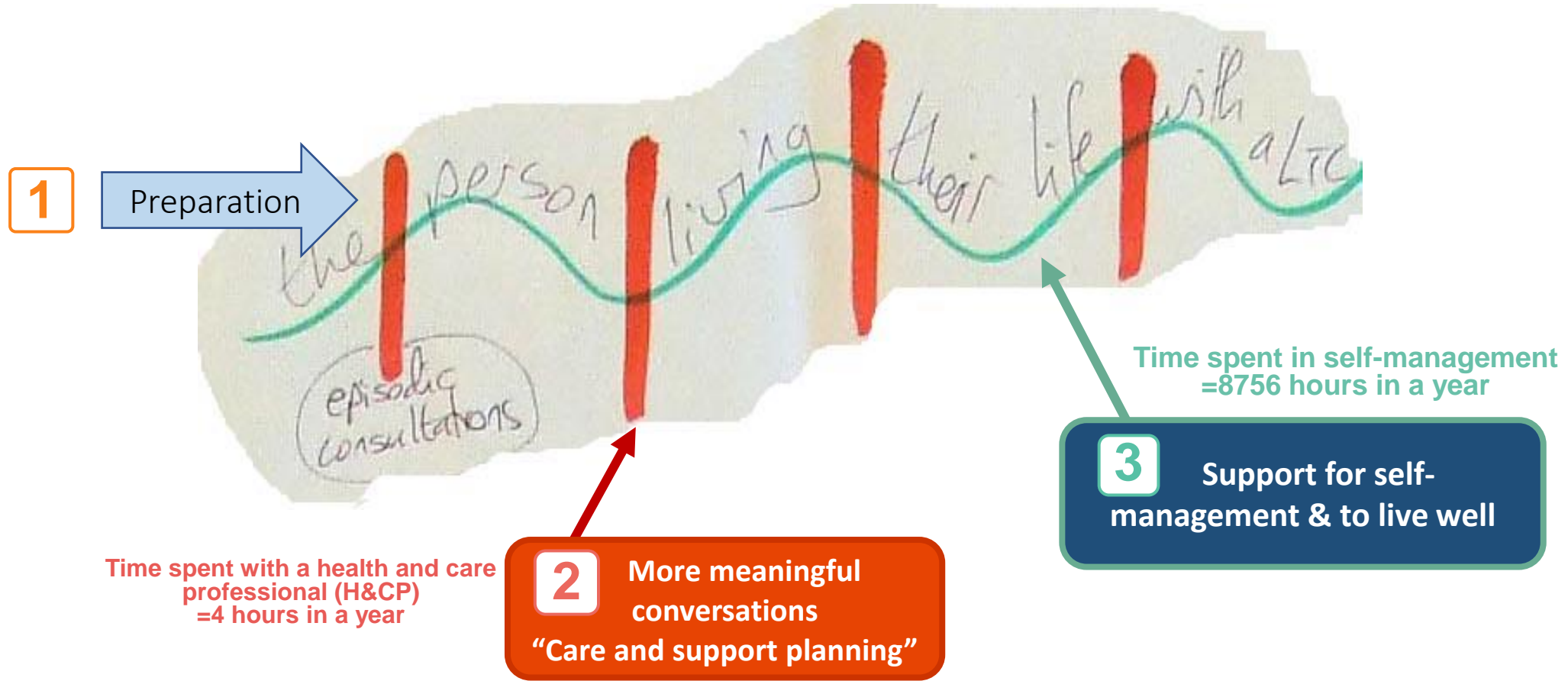
On [#WMTY22](#) we joined the wonderful teams from Yishun Health and National University Hospitals, Singapore for the second part of our [#personalisedcare](#) and support planning masterclass, well done to all 🙌. Now to finalise travel plans for [@lindsayeoliver](#) and [@NickBarned](#) 🇸🇬



11:14 PM · Jun 9, 2022 · Twitter Web App



Living with a Long Term Condition



A scanned drawing at a world café event by a participant living with a LTC & his relationship to contact with health services

The evidence base in *all* long-term conditions

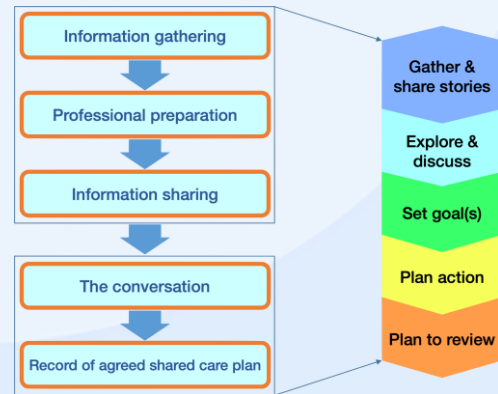


PCSP & YOC: Pulling it Together

Year of Care: *All the planned care that a person with long term condition(s) should expect to receive, usually over the course of a year, including support for self-management.*

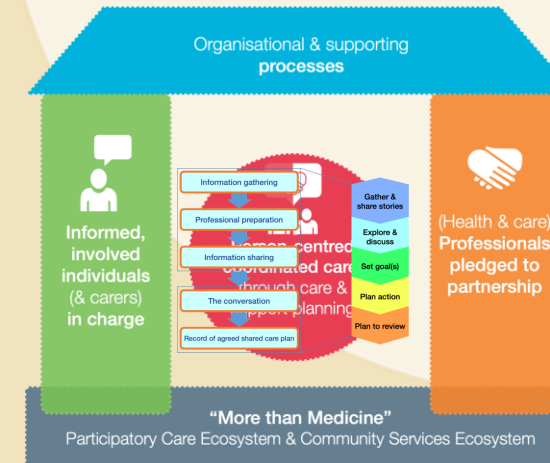
Personalised Care & Support Planning

The process of agreeing on a care plan which offers people active involvement in deciding, agreeing & owning how their long term condition(s) will be managed



- Robust reproducible 5-step model: preparation, conversation, recording, actions, review
- Solution-focused, practical, systematic approach to planned care
- Forward looking, uncluttered conversation
- Emphasis on people, not diseases

Implementation Framework: House of Care



- 4 elements for success: engaged, empowered person *working with* committed health & care professionals, *supported by* appropriate robust organisational systems & *underpinned by* responsive whole system commissioning
- Interdependent elements
- Flexible framework for localisation

Workflow for Annual PCSP at Community Health Posts

1 Preparation & Information Gathering

Connector/Nurse

- Introduces PCSP & *A Healthier Me* booklet to the resident for the 1st time
- Guides resident to access HealthHub
- Resident thinks through prompts & fills in past health readings in booklet
- The next appointment is scheduled in 1-2 weeks' time

2 PCSP Conversation

Connector/Nurse

- Conducts a PCSP conversation & reviews *A Healthier Me* with the resident
- Summarises the conversation and guides the resident to write down his/her goal(s) and action plan(s)

3 Documentation

Connector/Nurse

- Documents the conversation & the resident's goal(s) & action plan in the NGEMR documentation system.

4 Interim Follow-up (6 months)

Connector/Nurse

- Checks in with the resident on the progress of his/her action plan(s) & goal(s)
- Schedules the next annual PCSP conversation in another 6 months' time
- Repeat from 1



Name: _____
Clinic: _____
Community Health Post:
Please bring this booklet for all your appointments with your health care team.



<https://for.sg/healthierme-e>

Story of Mdm Emily



Emily (May 2022)

BP 180/113
BMI 31.1
PCSP: Improve health, find a job



Emily (Feb 2023)

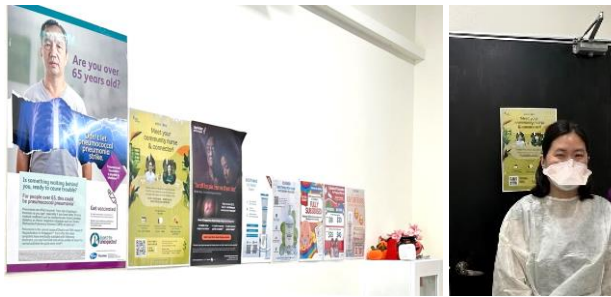
BP 126/80, anti-HPT dose reduced by GP
BMI 28.9
Works at a bakery
Active in community group "Mums with Mugs"



Emily (Feb 2023)

Entered a community beauty pageant organised by grassroots organisation, to celebrate her success and new-found confidence

Story of Mr Soon



Yishun Health 社区保健团队

Meet your regional team!

Winnie Nurse, Ruiyi Nurse, Pan Pan Nurse, Jannah Connector, Leonard Connector, See Khée Connector, Cheryl Connector

Connect with us to... 与我们联系:

- Manage & improve your health (e.g. eat well, monitor blood pressure) 管理、改善您的健康 (例如: 吃得健康、检查血压)
- Try out activities you might enjoy 尝试您喜欢的活动
- Get to know people in your neighbourhood 认识邻里的新朋友
- Find out how you can play a part in your community 了解您能为社区做什么
- Find support in difficult times (eg. health challenges, stress) 遇到困难时寻求支持 (例如: 健康挑战和压力)

Scan to get in touch with us! 扫二维码, 与我们联系!

You may also meet us at the nearby Community Health Post: 您也可以到社区保健站与我们联系:
 Blossom Seeds, 105 Canberra Street, #02-01/06, S750105
 Tuesday (星期二), 9:00am - 12:00pm

Information accurate as of February 2023

Open Access Poster (Sep 2022)

MY LIVING WELL PLAN STARTS HERE!

Meet your health & care team. You are here to work with you to create your health plan and achieve your goals.

Zhang Ruiyi
xxxx8455

- PREPARE**
 - Write down what is important to you and your areas of concern on Page 3.
 - Fill up your health measurements on Page 4 to 5 (when applicable). Bring the latest health screening results that you have.
 - Think about what you want to achieve and what you can do to achieve them.
- DISCUSS**
 - Say what is important to you.
 - Ask questions and share the concerns that you have.
- MAKE A PLAN**
 - Agree on your care goals and action plan together.
- REVIEW**
 - Review the plan with your health & care team to see how you are doing and the support you may need along the way.

SELF-PREPARATION

Complete this before your visit. This will allow us to understand you better.

What are the most important things to you at the moment?
 Circle those that you are concerned with.

These are some things that people want to talk about. Circle those that you are concerned with.

Sleep	Contraception (Family Planning)	Menopause
Medication	Monitoring my health	Relationship
Memory	Dental/Oral Health	Alcohol
Work/Benefits/Finance	Pain	Give up smoking
Independence	Eye Sight	Healthier eating
Keeping Active	Hearing	Weight
Feeling down/stressed	Pregnancy	Driving/travel
Loneliness/isolation	Breastfeeding	Future care plan

Other areas of concern

GOAL SETTING

What do you want to work on?

Full recovery from my sickness

What do you want to achieve?

Stop taking my medicine

How important is it to you? (Circle it)

Not important 1 2 3 4 5 6 7 8 9 10 Very important

ACTION PLANNING

What exactly are you going to do?

- What is the diagnosis I have?
- Can I stop my medicine?
- Can I start work?

What might stop you and what can you do about it?

If doctor said that I can't stop my medicine or if I can't work

To stay positive & continue physical activity

How confident do you feel? (Circle it)

Not confident 1 2 3 4 5 6 7 8 9 10 Very confident

Regional Team@CHP

Mr Soon visited the Community Health Post at Blossom Seeds on 4 Oct 2022. A community nurse explained his condition & treatment to him, a connector engaged with him in PCSP.



Mr Soon contributing back to the Community

Mr Soon is now a Medical Escort with Blossom Seeds, volunteers his free time at the rooftop garden and is back to doing the thing he enjoys most – cycling with his friends.

“ More meaningful conversations

With PCSP, I listened more to residents on what mattered to them. I am able to engage them in a more meaningful conversation.

*PCSP has taught me to **reserve my judgement** and **hold back from making assessment** without first listening to resident's full story.*

*PCSP has **changed my practice** at CHP, now I focus more on what is **the most important things**/what **motivate** the resident to live well with their long term conditions.*



Resident-led goal setting

*Sometimes we just need to **slow down** and **take a step back**, to **allows resident to do self-reflection** and **set goal by themselves**.*

*The **preparation** process allows the residents to have time to **think and prepare** for the PCSP conversation. A **realistic goal** and **specific action** can be set by residents.*

*It has made a difference to **the way I speak with residents**, and how I can support the resident to set specific goal and **what the residents want to achieve**.* ”



Our PCSP Journey in Yishun Health

Training

- Level 1 Practitioners Training: 271 trained (Yishun Health, NHG and other partners)
- Level 2 Train-the-Trainers: 9 accredited trainers
- Embedded as one of the multidisciplinary programmes within Yishun Health (YH)

Implementation Sites in YH

- 20 Community Health Posts (CHPs) in Yishun & Sembawang
- Geriatric Clinic and Diabetes Clinic
- Plans to systematise PCSP as a Person-Centred Care practice to the rest of YH

PCSP in NGEMR (Epic) Documentation System

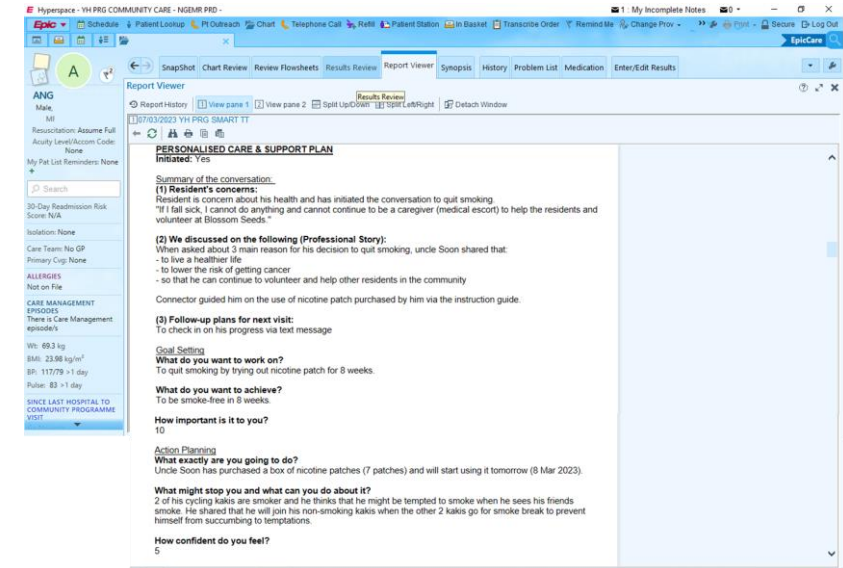
- Launched in YH from Feb 2023
- Integrated PCSP care plan across care settings



Accreditation of Yishun Health's PCSP trainers at a Level 1 Practitioners Training by NUHS' PCSP Master Trainers



Visit by Dr Nick Lewis-Barned and Ms Lindsay Oliver from Year of Care Partnership UK to a CHP in Sep 2022



Residents' care plan jointly developed with their care team is linked to a PCSP Episode of Care in Epic

Key Challenges

1. Health & Care Professional's mindset

“How is this different from what we are already doing?”

Preparation as a key component of PCSP;
two-way conversation to co-develop the care
plan with the person

2. Patient's/ Resident's mindset

“Can't you just tell me what to do?”

Takes time to practise self-management

3. Implementation

“Who is missing from the table?”

Systemic approach to build the House of Care
(e.g. process, IT, manpower, community
resources)

Tips & Recommendations

1. Engage key stakeholders as key drivers

Clinical champions (e.g. doctors, nurses,
allied health) supported by a strong
implementation team (e.g. HRD, Ops and IT)

2. Train the whole care team

For an impactful rollout and consistent care
experience for the patients/ residents

3. Conduct regular monitoring and improvements to the implementation

e.g. Community of Practice, learning
sessions, feedback from practitioners and
patients/ residents



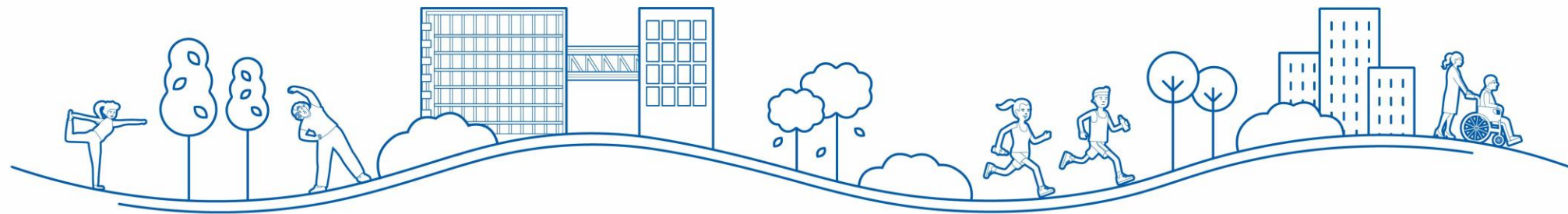
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Caring for patients • staff • community • environment