Grúpa Ospidéal
Oirthear na hÉireann

Ireland East
HOSPITAL GROUP

UCD DUBLIN

# Building a Model Line for Frailty in IEHG

**Fiona Keogan**

**Service Improvement Lead IEHG**

**Dr. Emer Ahern**

**Consultant Geriatrician, St Luke's Hospital, Kilkenny**

# IEHG

**MODEL 4**

Mater Misericordiae University Hospital

St.Vincent's University Hospital

**MODEL 3**

Regional Hospital Mullingar

St Luke's Hospital Kilkenny

Wexford General Hospital

Our Lady's Hospital Navan

**MODEL 2**

St Columcille's Hospital, Loughlinstown

St Michael's Hospital, Dun Laoghaire

**SPECIALITY**

Cappagh National Orthopaedic Hospital

National Maternity Hospital

Royal Victoria Eye & Ear Hospital

**ACADEMIC PARTNER**

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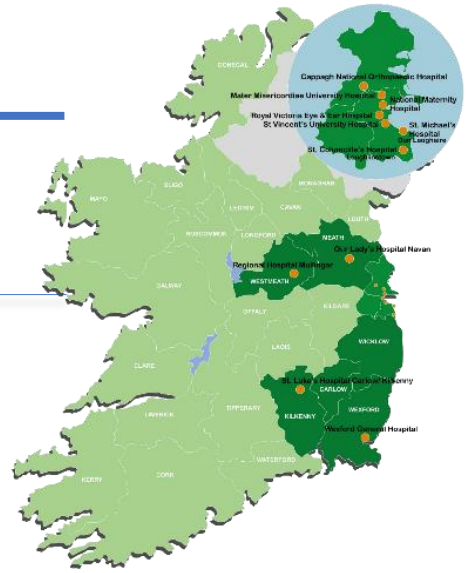


- Largest of the hospital groups
- 11 hospitals (6 voluntary and 5 HSE)
- Overlap with 5 community health organisations
- 1.3 million population and 11,000 staff
- Covering counties Dublin, Meath, Westmeath, Carlow, Kilkenny, Wicklow and Wexford

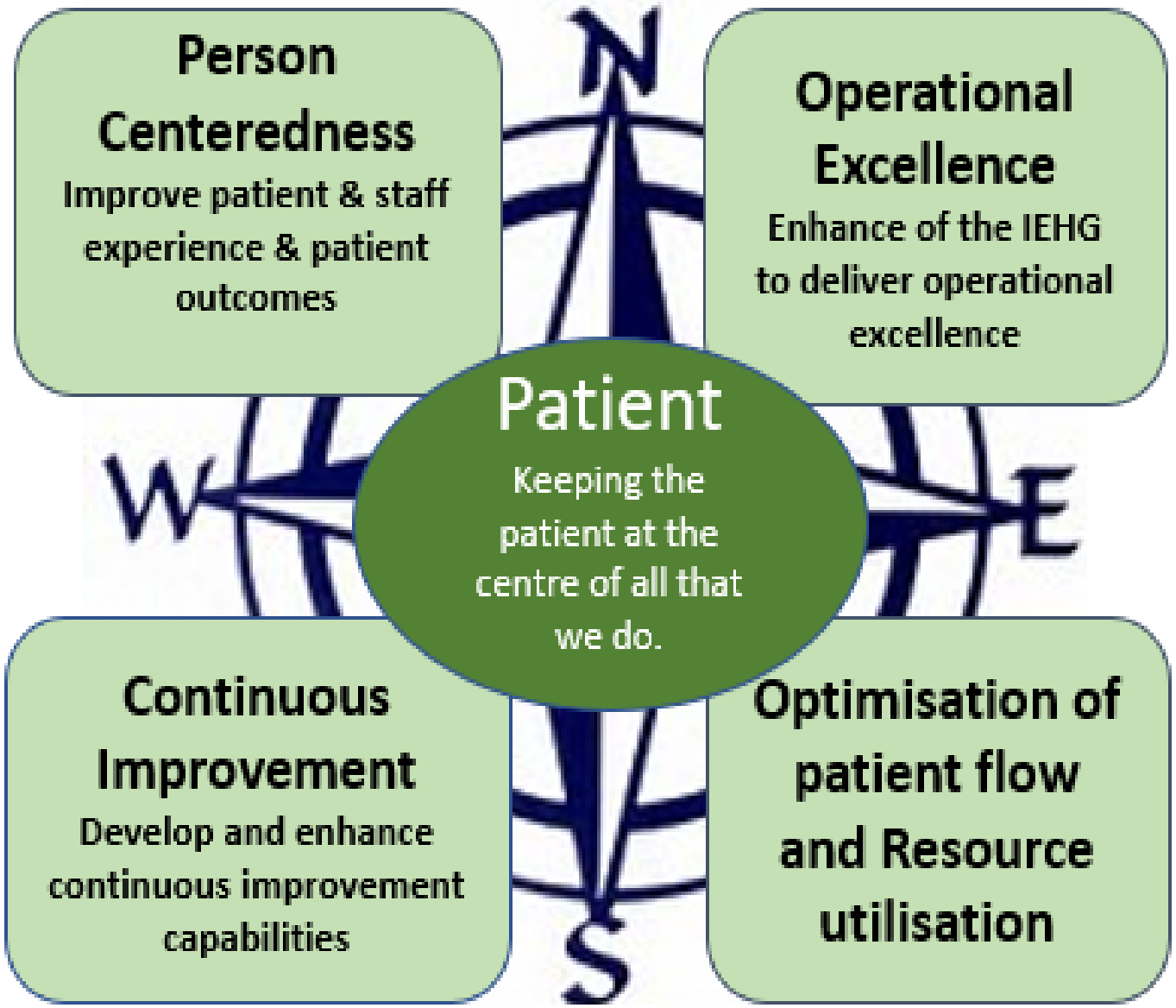
## Why Lean?

Culture of:
Respect for people
Continuous Improvement (PDSA)

Model line = integrated pathway

Adopting lean for healthcare transformation allows clinicians to spend more time caring for people and improves the quality of care these people receive

Standardised methodology required for the scale, pace and complexity of change required



**Title:** Frail Elderly 'first 72 hrs'

Facilitator: Fiona Keoganm

Sensei: Dave Jones-Lofting

**Process Owner: Kay Slevin**

**Sponsor:** Shona Schneenman

**Team Leader** Noeleen Bourke:

**Team Members:**

1 2 3 4 5 6 7 8 9

Start Date: 30 Apr 18
Current Date 4 May 18
End Date:

Simpler®

## 1. Reason for Action

Go | No Go

Context: In the unscheduled care VSA, we identified a need for development of a frail elderly pathway at RHM. RHM is currently not meeting PET targets for patients ≥ 75 years. Furthermore the principles of quality frail elderly care have not yet implemented

There is currently no agreed p identify frail / at-risk older p of care, causing increa ET and prolonged LOS cohort.

The purpos ement the Acute P ples for the first 72 hou S y (start/finish) the first 72h or ≥ 75yoa patient cohort prese RHM hospital

Therefore, improvements are req d to patient experience and entred care

se rate of Frailty Screening r 75's in RHM

b. Quality: Achieve Acute Frailty Network (AFN) Principles

c. Increase rate of completed Comprehensive Geriatric Assessment (CGA) in identified Frai patients

d. Reduce re-admission rates for fra patients over 75 years

Reflections: xxx

1. Reason for action

## 4. Gap Analysis

Go | No Go

1. No frailty screening or assessment
2. No Comprehensive Geriatric Assessment (CGA)
3. No Clinical Pharmacist in acute setting for Frail Patients
4. No early MDT assessment
5. No early ED doctor assess
6. Patient experience:
   - -Fear of coming in Very unwell
   - -Kept having t plication, re-work
   - -Reports dydration when in ED
   - -Unabl questionnaire??
   - -' re, the care was excellent'
7. to huddles/ handovers for frail patients
   - frailty beds
   - ommunication to PHN/ Community services

4. Gap Analysis

Root Cause: If true root cause not clear then review above

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

## 7. Completion Plans

Go | No Go

| Action | TT | er | Due | RAG |
|---|---|---|---|---|
| Implement Frailty Screen in ED | | | 18th June | G |
| Implement MFIT to complete CGA's | | NB | 18th June | G |
| Set up systems for alert (email ad phone, notepad) | | NB/HC | 18th July | G |
| Educate/comm | | RK/CMD/AC | 18th June | G |
| Record & analyse & i | | NB/AC | 18th July | G |

7. Completion Plans

Max 3 Actions WIP/person
30-90d break through focus.
Last Column is Status - use RAG (Red, Amber Green)
Good events have no to do list!

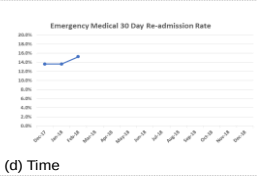
## 2. Initial State

Go | No Go

(a)

(b) Quality

(c)




(d) Time

Reflections: 2018 RHM figures. 11-16 over 75s attend ED daily, 6-9 of those were admitted. 40-50% of these identified as frail on a local study of 140 patients

2. Initial State

## 5. Solution Approach

Go | No Go

| Cause/ Priority | Solution | Affecting | C | E | C |
|---|---|---|---|---|---|
| 1 | Set up Frailty Screen in Triage | A | 100 % | Δ | O |
| 2 | Set up alert system | | 0% 100 % | Δ | O |
| 3 | Complete CGAs | C D | 0% 20% | X | Δ |
| 4 | Communic | A B C D | 1% 50% | Δ | O |

Explanation of last
- Affecting - If majo ile then use CAPITAL, if minor then lower case.
- Current State = data scribes current performance in terms used in boxes 2 & 3.
- FS = Future state pre e.g. 1 day)
- EASE O = Easy Δ = ium Ease X = Difficult.
- COST O = Low Cost Δ = Medium Cost X = High Cost

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

5. Solution Approach

## 8. Confirmed state

Go | No Go

This box is "GO" when Box 8 = Box 3
Monitor ACTUAL results against the metri d in initial and target state

(a) People

(b) Quality

(c) Time

(d) Cost

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

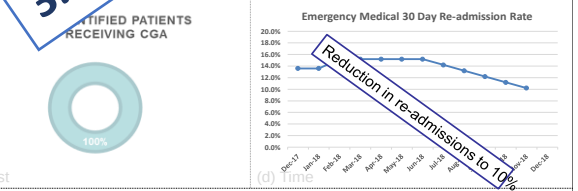
8. Confirmed State

## 3. Target State

Go | No Go


(a) Pe

(b) Quality




(c) Cost

(d) Time

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

3. Target State

## 6. Rapid Experiments

Go | No Go

| Experiment | Anticipated Effect | Actual Effect | Follow up Action |
|---|---|---|---|
| Trial VIP | Identify Frail | Frail | |
| Test iPMS | Alert syste | of Frail sitive ID'd to FIT | Make live |
| Trial CGA | Id | | |
| Education/ communi prog | awareness ailty | 50% staff educated re MFIT & Frailty | 5 min FIT education & 20 min FIT/Frailty education |

If actual effect = anticipate then proceed to box 7 if not then return to box 4:

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

6. Rapid Experiments

## 9. Reflections

What are the fundamental lessons of the event and the improvement cycle? Consider; Process Team Leader Sensei Culture & Beha

- Very good team dynamics
- Knowledge and experience in te
- Good repres from MD
- Expl

- Lack of computers and internet connection in the oom
- ing offsite

helped?

- Enthusiasm for change
- Work practices can be restructured
- Experience & expertise in the room

What hindered?
•Perceptions of nursing home residents
•Lack of medical team member on RIE team
• Doubt expressed as to whether frailty is an issue and whether it is already adequately managed

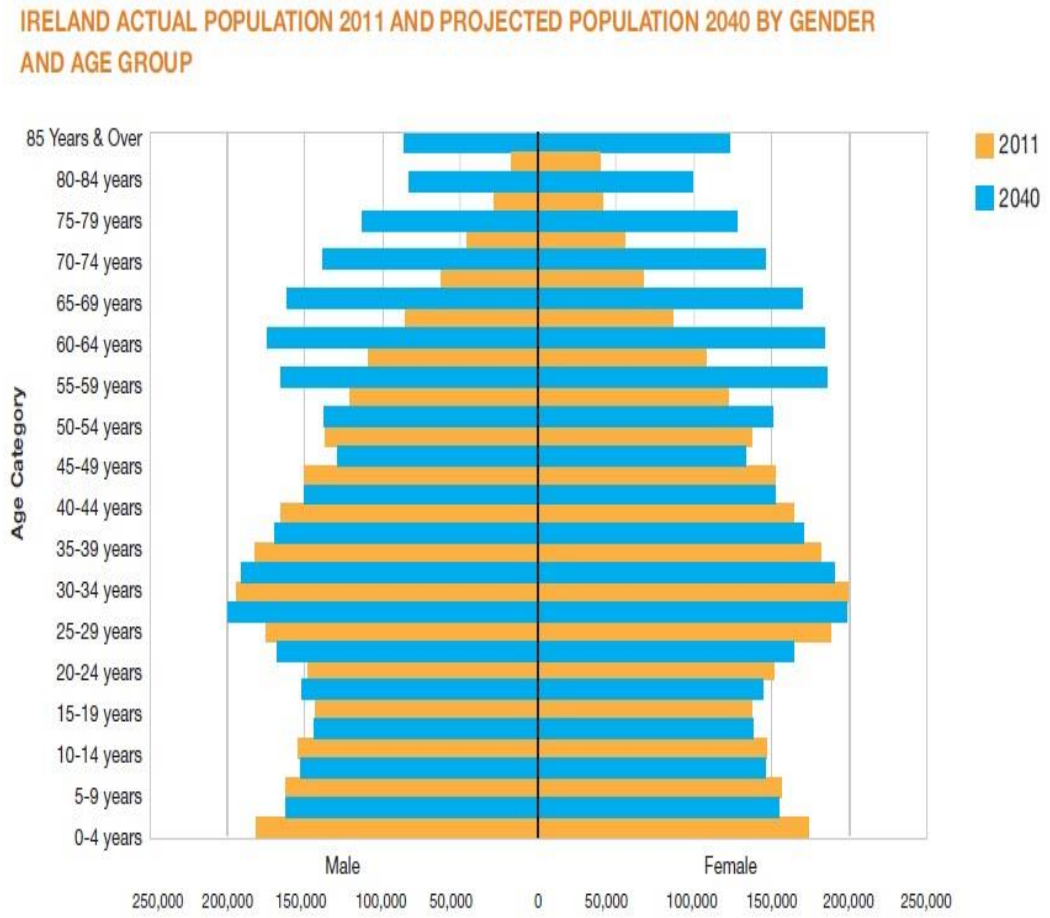
9. Reflections

# Compelling reasons for changing current model of care

- Changing demographic
- Increasing demand
- Patient, family and carer expectations
- Evidence that hospitalization causes harm- deconditioning, HAIs, falls…
- Current model not fit for purpose

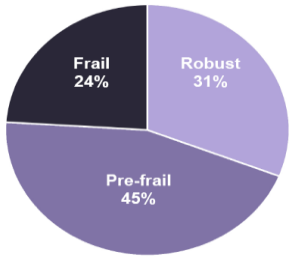
- too hospital centric/ not responsive enough

- Cost
- Over professionalisation of care- too many professions/duplication/ gaps
- Education of current graduates not in line with system requirements
- New models of care emerging




Source: Central Statistics Office Population and Labour Force Projections 2016-2046

*Figure 1: Weighted estimate of frailty in the community-dwelling population aged 65 years and older in Ireland (TILDA, wave 1).*

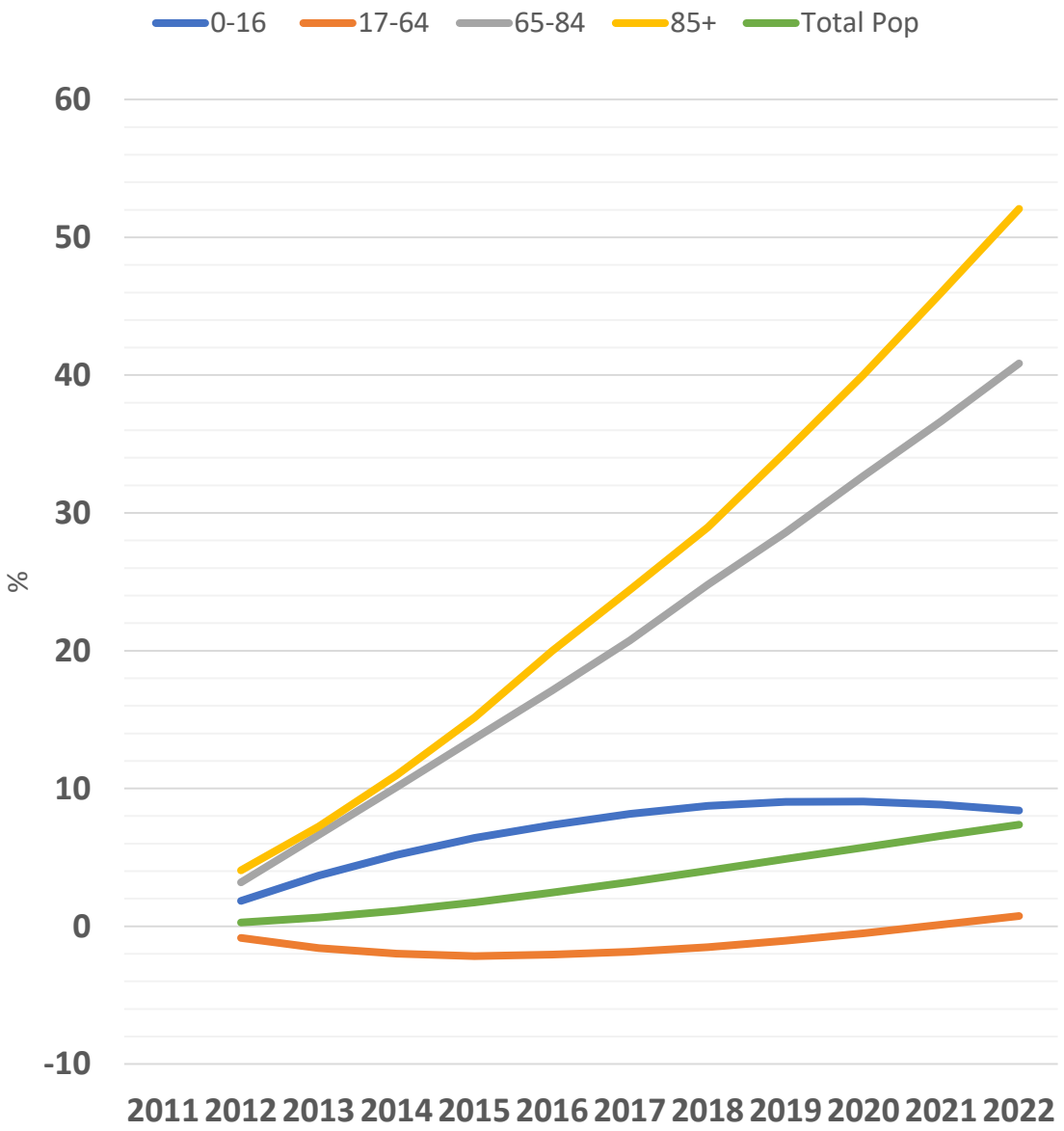



- **31% of the Irish older population aged 65 and over were robust**
- **45% were pre-frail and**
- **24% were frail.**

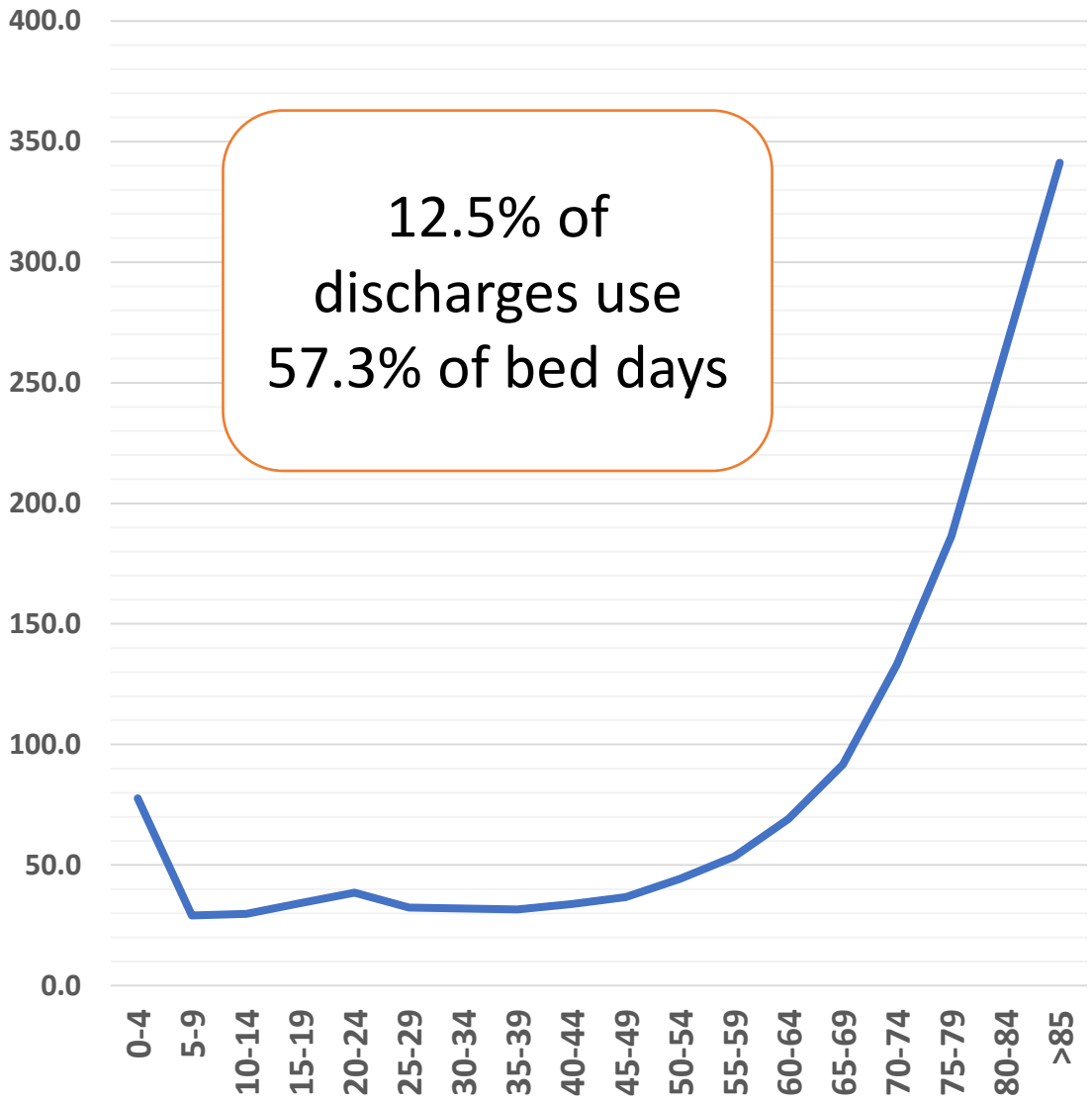
tilda
Staidéar Fadaimseartha na hÉireann um Dhul in Aois
The Irish Longitudinal Study on Ageing

Current State

## Population growth 2011-2022




## ED Admissions:1000 population by age



# National Strategy ICPOP

**How do we help?**

# Acute Frailty Network

## IEHG have engaged with the AFN to understand what good looks like

**10 principles**

1. Establish a mechanism for early identification of people with frailty
2. Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour or 14 hours if overnight
3. Set up a rapid response system for frail older people in acute care settings
4. Adopt a ‘Silver phone’ system
5. Adopt clinical professional standards to reduce unnecessary variation
6. **Strengthen links with services both inside and outside hospital**
7. Put in place appropriate education and training for key staff
8. Develop a measurement mind-set
9. Identify clinical change champions
10. Identify an Executive sponsor and underpin with a robust project management structure

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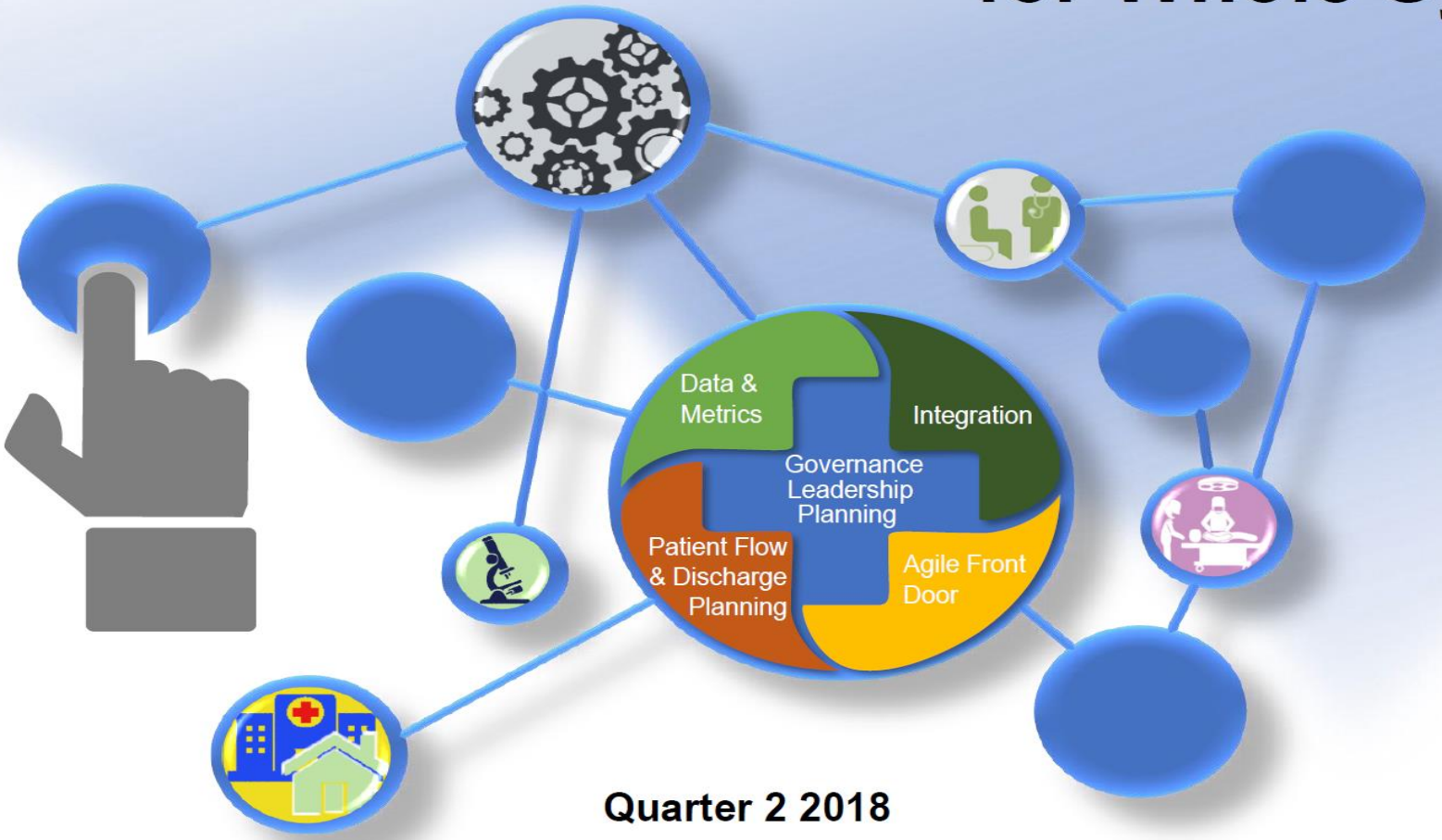
# Unscheduled Care Baseline Assessment Tool for Whole Systems




**Quarter 2 2018**

# Service Improvement Approach

## Frailty Value Stream

### Value Stream Analysis

- Value Stream Analysis
- Visioning workshop
- Rapid Improvement Event
- 30-60-90 day report outs

### Values & Visioning

### Rapid Improvement Events

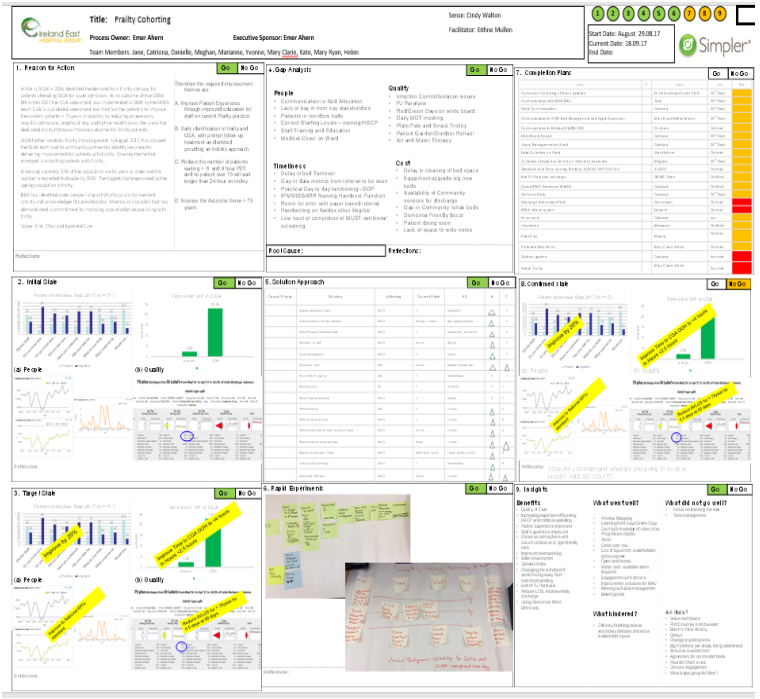
National Clinical & Integrated Care Programmes
*Person-centred, co-ordinated care*

Group level values and visioning events

### Masterclasses

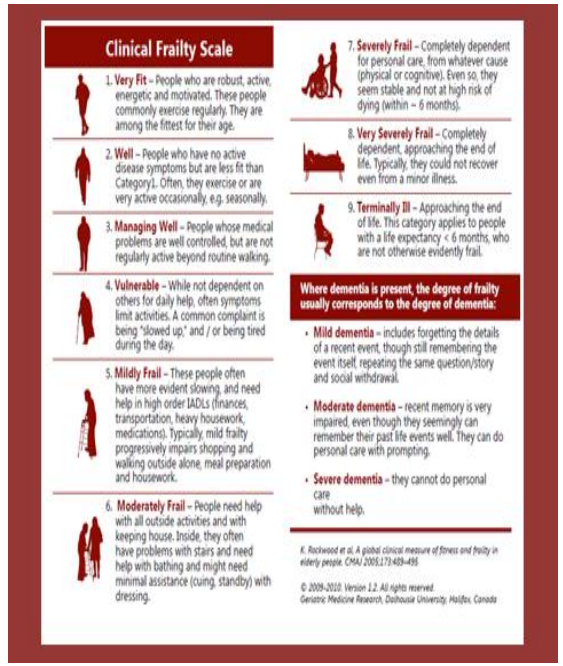
Acute Frailty Network

### A3



### Clinical Leadership


### What Good Looks Like



# Regional Hospital Mullingar – Frail Elderly Management- First 72 hours

RAPID IMPROVEMENT EVENT

**Reason for action:To improve care, outcomes and patient experiences for all older people living with frailty**

## What we did

- We collected patient experiences and mapped the process
- We compared current patient experience against what good care looks life and completed a gap analysis
- We developed the ideal state and mapped the future process.
- We developed a RHM screening and assessment tool.
- We commenced the process of creating an IT mechanism to ensure screening need highlighted.
- We tested the process in ED and on a medical ward.

## Patient stories


## Patient stories

Mullingar FIT

**Benefits**
Patients √
Staff √

**Next Steps:**
**Testing new way of working**
**Measuring for improvement**
**Embedding change**
**Sustaining improvements**

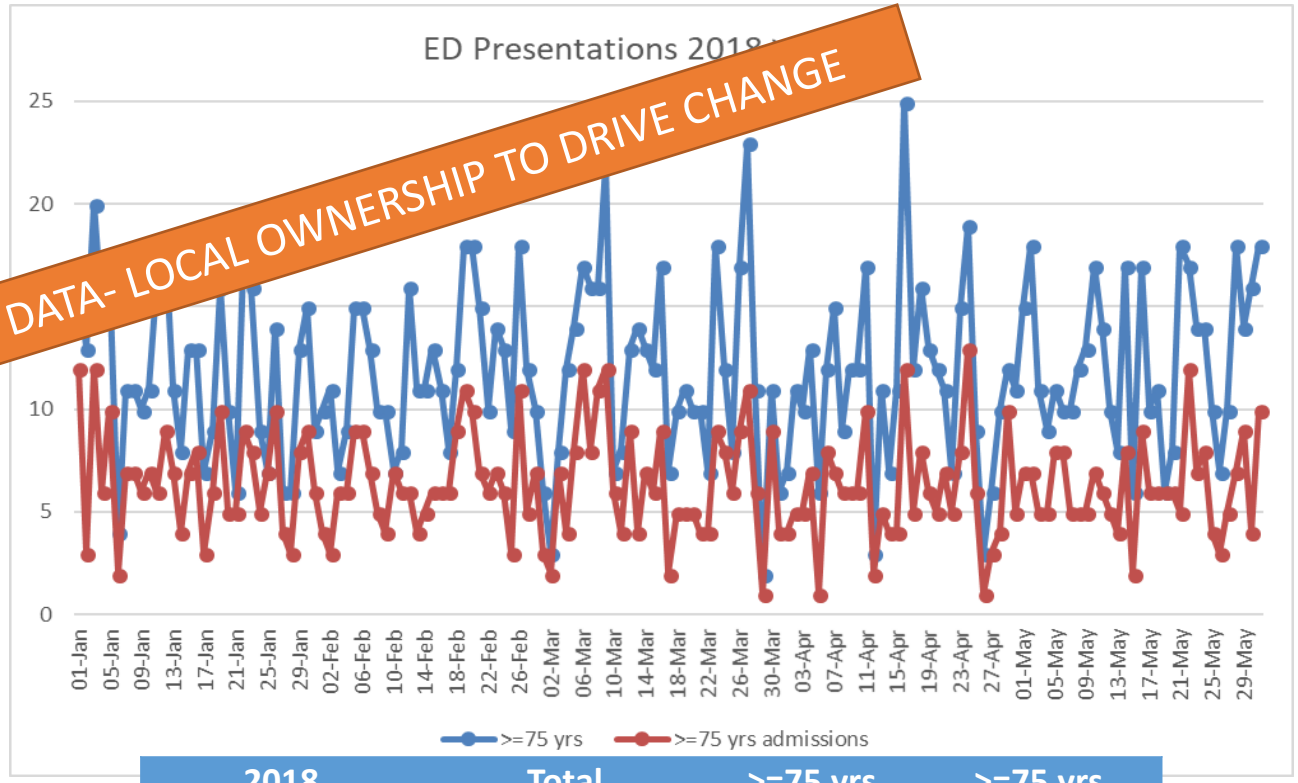
## Process 7 Flow Map

| 10 Key Principles | ? | Progress |
|---|---|---|
| Establish a mechanism for early identification of people with frailty | √ | VIP, CFS Testing commencing June 18th |
| Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour or 14 hours if overnight | √ | Testing commencing June 18th |
| Set up a rapid response system for frail older people in acute care settings | √ | Testing medical ward June 18th |
| Adopt a 'Silver phone' system | x | |
| Adopt clinical professional standards to reduce unnecessary variation | √ | Links with Clinical Senate/ Network |
| Strengthen links with services both inside and outside hospital | √ | Representation from community nursing |
| Put in place appropriate education and training for key staff | √ | Local plan, TILDA, Masterclasses, ICPOP |
| Develop a measurement mind-set | √ | Database, AFN tools, support from SILs |
| Identify clinical change champions | √ | Via engagement , planning for events and connecting to senate/ network |
| Identify an Executive sponsor and underpin with a robust project management structure | √ | Via engagement , planning for events, links to IEHG transformation, CHO engagement, ICPOP, NCPOP |

Right **Patient** in the Right **Place** at the Right **Time,** seen by the **Right Staff** !

# Context for Regional Hospital Mullingar

USING DATA- LOCAL OWNERSHIP TO DRIVE CHANGE



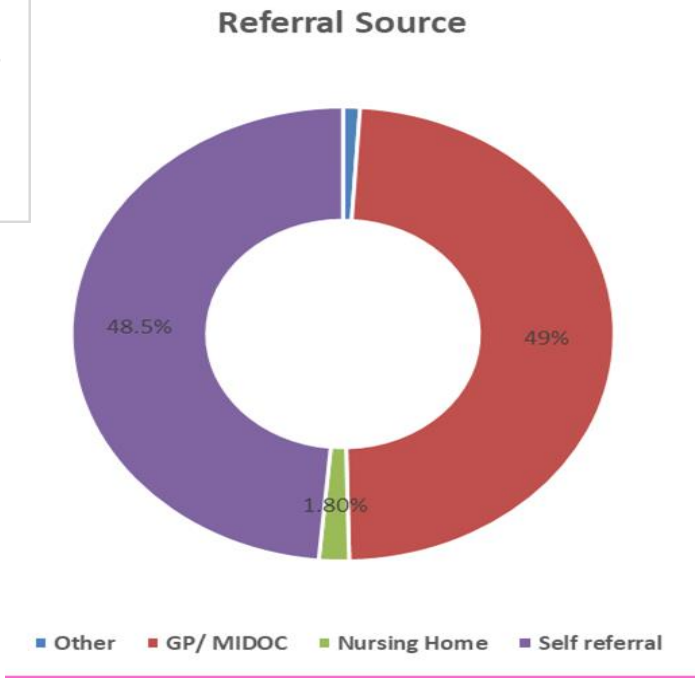

| 2018 | Total Presentations | >=75 yrs | >=75 yrs admissions |
|---|---|---|---|
| **median** | 104 | 11 | 6 |
| **80th centile** | 118 | 16 | 9 |
| **Average** | 101.8 | 11.8 | 6.4 |

60% of presentations ≥ 75 years are > 6 hours in ED compared with 35% % of all presentations

*Unpublished MSc RHM 2018

54% ≥ 75 years are admitted

* 50% of admitted patients are frail



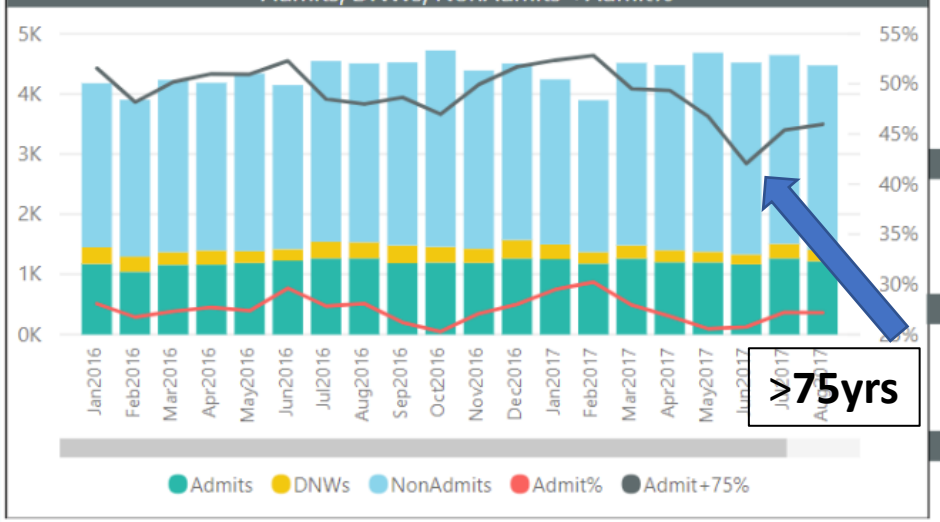
# Data & Analytics Driving Performance and Improvement

HOSPITAL
- Kilkenny
- Mater
- Mullingar
- Vincent's
- Wexford

MODEL
- 4

YEAR
- 2015
- 2016
- 2017

## Admits, DNWs, NonAdmits +Admit%




| Year | Attends | Admits | DNWs |
|---|---|---|---|
| 2016 | 52,174 | 14,307 | 3,023 |
| 2017 | 44,723 | 12,247 | 2,190 |

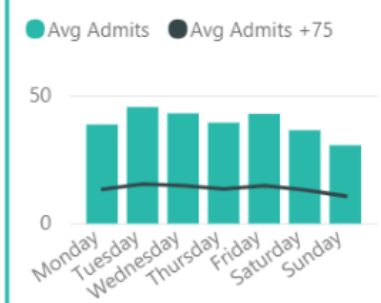
## YTD (Green) v LYTD (Pink) Attends


## YTD (Green) v LYTD (Pink) Admits


## YTD (Green) v LYTD (Pink) DNW's

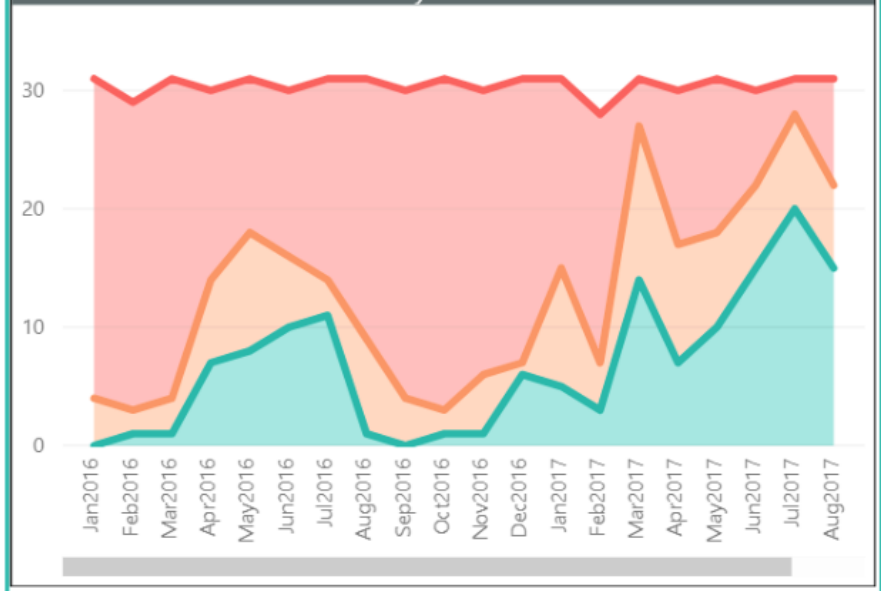

≥75yrs

## Average Admits by Day

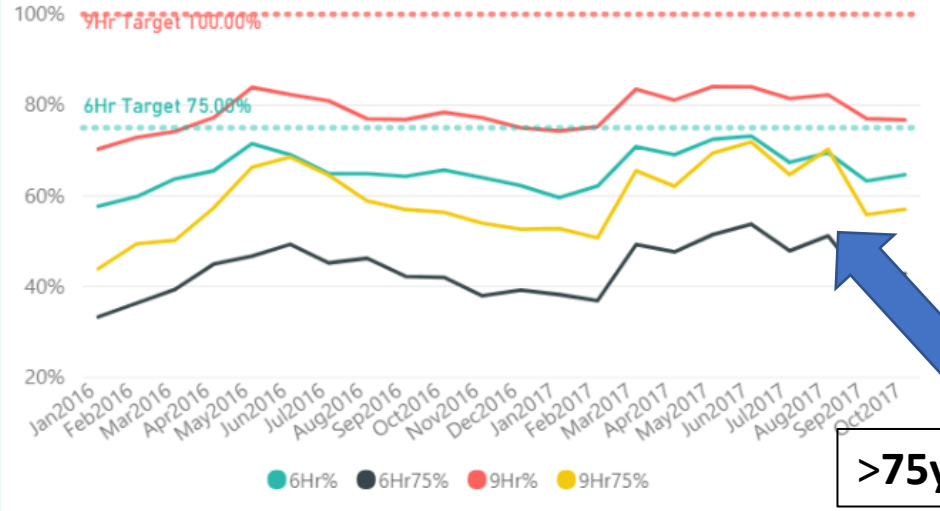



| Day | AvgAdm | StdDev | AvgAdm+75 |
|---|---|---|---|
| Monday | 38.81 | 7.15 | 13.43 |
| Tuesday | 45.65 | 6.69 | 15.48 |
| Wedne... | 43.19 | 6.80 | 14.83 |
| Thursday | 39.55 | 5.92 | 13.54 |
| Friday | 42.98 | 5.88 | 14.85 |
| Saturday | 36.56 | 6.20 | 13.19 |
| Sunday | 30.73 | 6.29 | 10.75 |

## TrolleyGAR 8am




## Wait Time Percentages




| Year | 6Hr% | 6Hr75% | 9Hr% | 9Hr75% |
|---|---|---|---|---|
| 2016 | 64.49% | 41.92% | 77.23% | 56.61% |
| 2017 | 67.33% | 45.99% | 80.07% | 62.09% |

| YTD 24Hr | LYTD 24Hr |
|---|---|
| 1,325 | 2,353 |

| YTD 24Hr75 | LYTD 24Hr75 |
|---|---|
| 554 | 995 |

## Ambulance TAT

| Year | 60 Min % |
|---|---|
| 2016 | 96.50% |
| 2017 | 96.20% |
| Total | 96.37% |

>75yrs

## TrolleyGAR

| YTD 8am | LYTD 8am |
|---|---|
| 2,517 | 4,274 |

## Trolley/Attend Ratio

| YTD | LYTD |
|---|---|
| 0.06 | 0.10 |

## 8am YTD v LYTD

Unscheduled Care Summary

**Title:** Frail Elderly 'first 72 hrs'

Facilitator: Fiona Keoganm

Sensei: Dave Jones-Lofting

**Process Owner: Kay Slevin**

**Sponsor:** Shona Schneenman

**Team Leader** Noeleen Bourke:

**Team Members:**

1 2 3 4 5 6 7 8 9

Start Date: 30 Apr 18
Current Date 4 May 18
End Date:

Simpler®

## 1. Reason for Action — Go / No Go

Context: In the unscheduled care VSA, we identified a need for development of a frail elderly pathway at RHM. RHM is currently not meeting PET targets for patients ≥ 75 years. Furthermore the principles of quality frail elderly care have not yet implemented at RHM

There is currently no agreed process to identify frail / at-risk older patients at first point of care, causing increased risk, increased PET and prolonged LOS for the ≥ 75 patient cohort.

The purpose of this RIE is implement the Acute Frailty Network principles for the first 72 hours of care in RHM.
Scope and boundary (start/finish) the first 72hours of care for ≥ 75yoa patient cohort presenting to RHM hospital

Therefore, improvements are required to patient experience and patient-centred care

a. Increase rate of Frailty Screening in over 75's in RHM

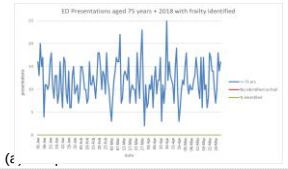
b. Quality: Achieve Acute Frailty Network (AFN) Principles

c. Increase rate of completed Comprehensive Geriatric Assessment (CGA) in identified Fra patients

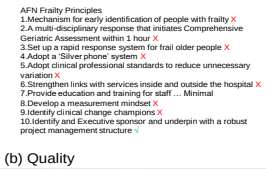
d. Reduce re-admission rates for frail patients over 75 years

Reflections: xxx

## 2. Initial State — Go / No Go

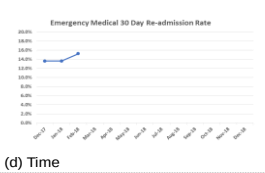



(a)




(b) Quality

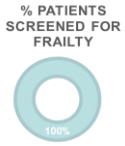

(c)



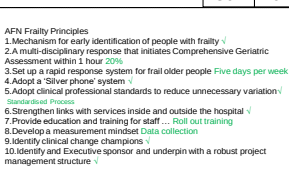

(d) Time

Reflections: 2018 RHM figures. 11-16 over 75s attend ED daily, 6-9 of those were admitted. 40-50% of these identified as frail on a local study of 140 patients

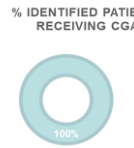
## 3. Target State — Go / No Go



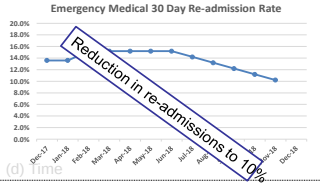

(a) People




(b) Quality




(c) Cost




(d) Time

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

## 4. Gap Analysis — Go / No Go

1. No frailty screening or assessment
2. No Comprehensive Geriatric Assessment (CGA)
3. No Clinical Pharmacist in acute setting for Frail Patients
4. No early MDT assessment
5. No early ED doctor assessment
6. Patient experience:
   - -Fear of coming into ED, waiting until very unwell
   - -Kept having to repeat history, duplication, re-work
   - -Reports of poor meals and hydration when in ED
   - -Unable to answer AFN questionnaire??

A3

Root Cause: If true root cause not clear then review above

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

## 5. Solution Approach — Go / No Go

| Cause/ Priority | Solution | Affecting | Current State | FS | E | C |
|---|---|---|---|---|---|---|
| **1** | Set up Frailty Screen in Triage | A B c d | 0% | 100 % | Δ | **O** |
| 2 | Set up alert system | a B C d | 0% | 100 % | Δ | O |
| 3 | Complete CGAs | a B C D | 0% | 20% | **X** | Δ |
| 4 | Communication/Education | A B C D | 1% | 50% | Δ | O |

Explanation of last 5 columns:
- Affecting - If major affect on deliverable then use CAPITAL, if minor then lower case.
- Current State = data point that describes current performance in terms used in boxes 2 & 3.
- FS = Future state prediction (e.g. 1 day)
- EASE O = Easy Δ = Medium Ease X = Difficult.
- COST O = Low Cost Δ = Medium Cost X = High Cost

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

## 6. Rapid Experiments — Go / No Go

| Experiment | Anticipated Effect | Actual Effect | Follow up Action |
|---|---|---|---|
| Trial VIP | Identify Frail | Identify Frail | |
| Test iPMS | Alert system | 100% of Frail positive ID'd to FIT | Make live |
| Trial CGA | Identify patients for DC and HSCP referral | | |
| Education/ communication programme | Increase awareness of Frailty | 50% staff educated re MFIT & Frailty | 5 min FIT education & 20 min FIT/Frailty education |

If actual effect = anticipate then proceed to box 7 if not then return to box 4:

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

## 7. Completion Plans — Go / No Go

| Action | TT | Owner | Due | RAG |
|---|---|---|---|---|
| Implement Frailty Screen in ED | | PT/ NB | 18th June | G |
| Implement MFIT to complete CGA's | | RG/NB | 18th June | G |
| Set up systems for alert (email address, phone, notepad) | | NB/HC | 18th July | G |
| Educate/communicate | | RK/CMD/AC | 18th June | G |
| Record & analyse data (set up database & iPMS reports) | | NB/AC | 18th July | G |

Max 3 Actions WIP/person
30-90d break through focus.
Last Column is Status - use RAG (Red, Amber Green)
Good events have no to do list!

## 8. Confirmed state — Go / No Go

This box is "GO" when Box 8 = Box 3
Monitor ACTUAL results against the metrics defined in initial and target state

(a) People

(b) Quality

(c) Time

(d) Cost

Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

What are the fundamental lessons of the event and the improvement cycle?
Consider;
Process
Team
Leader
Sensei
Culture & Behaviour

What helped?

- Very good team dynamics
- Knowledge and experience in team
- Good representation from MD
- Exploring fresh ideas and options
- Testing ideas by 'doing'

What hindered?

- Lack of computers and internet connection in the room
- Being offsite

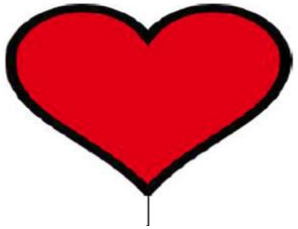
What helped?

- Enthusiasm for change
- Work practices can be restructured
- Experience & expertise in the room

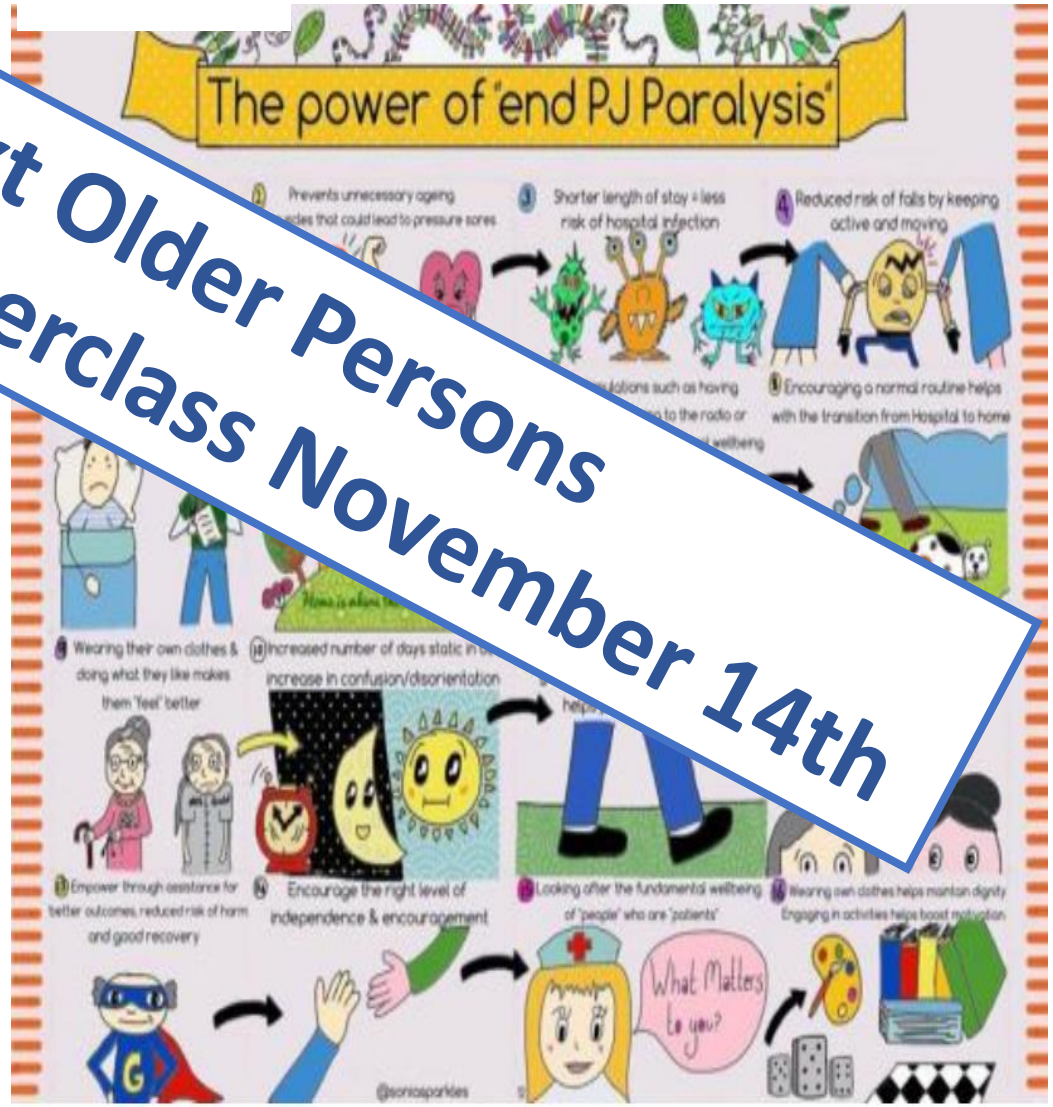
What hindered?

- Perceptions of nursing home residents
- Lack of medical team member on RIE team
- Doubt expressed as to whether frailty is an issue and whether it is already adequately managed

# Winning the Hearts and Minds



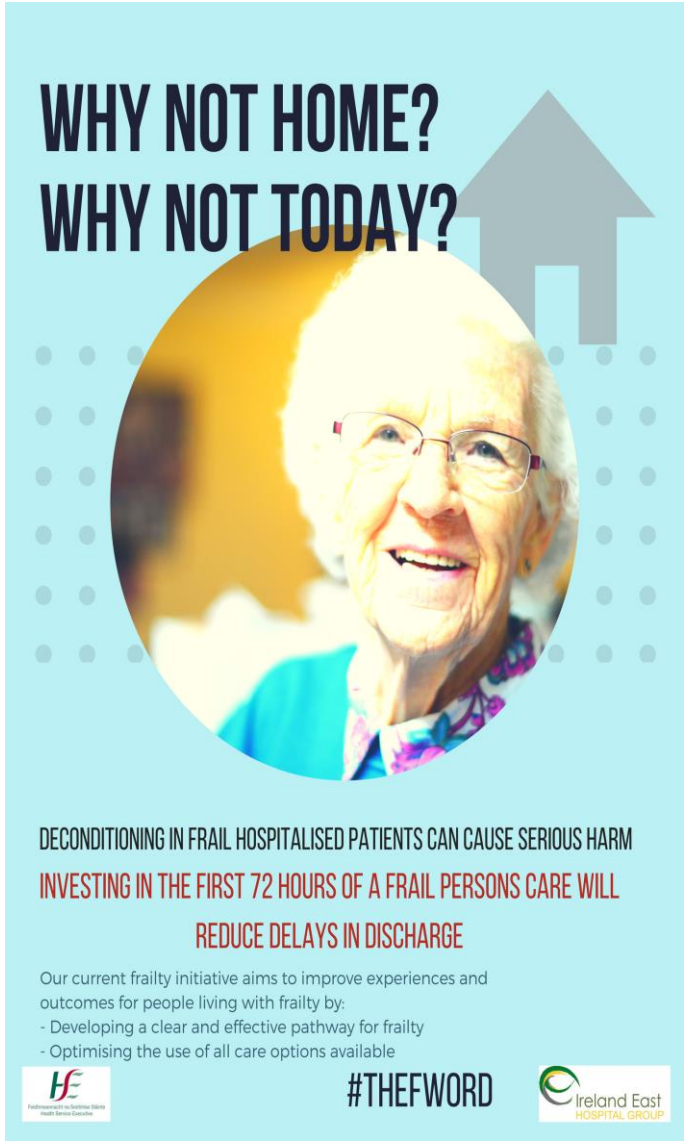
## Next Older Persons Masterclass November 14th




If you had 1000 days left to live how many would you choose to spend in hospital?

#endPJparalysis
#homefirst
#last1000days
#redtogreen

# Communication & Education





# What we are learning from our patient stories……

- Older people afraid to come to ED- Leave it until very unwell/ in crisis
- Only way to access appropriate services is to be admitted and in an acute bed
- Lack of preventative services- immobile, in pain, malnourished, undiagnosed cognitive impairment, incontience etc - families and carers unable to cope
- Only option in crisis is ED
- Easier to admit patient than to discharge
- Lack of same day responsive services- rapid intensive support for short duration needed
- Lack of options for alternative to conveyance for emergency services

# Learning as we lead…..

## Essential components of successful implementation

- Communication and education
- **Clinical leadership**
- Senior management support and engagement
- Measurement- simple, meaningful data
- Social momentum- win hearts and minds, share stories, identify and link with like-minded people
- Local ownership of improvement work
- **Frontline staff ‘safety’**
- Patient feedback and participation
- Gemba coaches and sensai expertise

# Learning as we lead….. Measurement

## Integrated patient centric metrics

- % of population with unplanned emergency admissions
- % remaining at home post acute admission at 90 days
- % returning to baseline or better
- % of emergency admissions ≥75 years converting to long term care
- % of home care funding spent on complex care (intensive HCPs etc)

The future – less money, less small specific services, more responsiveness, more emphasis on outcomes and collaboration

# IEHG Clinical Senate 2017 – 2020

***Connecting clinicians to improve care***

## Our Guiding Principles

- Value service user perspectives and focus on quality patient outcomes and experiences
- Connect clinicians from all disciplines across the IEHG
- Create capacity and build the capability of clinicians to build a culture of transformation, innovation, quality and improvement
- Provide constructive advice that is inclusive, transparent and evidence-based and contributes to setting the health reform agenda.

## Our Vision

The IEHG will have a sustainable, thriving, efficient and progressive approach to clinical engagement
Clinicians will actively contribute to decision making around the design, delivery and evaluation of quality health services across the IEHG.

## Our Purpose

Represent clinicians in providing independent strategic knowledge, advice and leadership on system-wide issues that affect quality, safe and efficient patient care.

## Focus Areas

### Clinician Leadership

1.1 Model a high standard of professional excellence
1.2 Collaborate with stakeholders to develop a fit-for-purpose clinician engagement and leadership framework that focuses on outcomes and promotes accountability
1.3 Advocate for active clinician representation on senior leadership, strategy, planning, policy and performance committees
1.4 Promote the development and nurturing of clinical leadership capabilities

### Effective Partnerships and Collaborations

2.1 Embed effective connections and real collaboration with clinicians, service users, carers and executives across the health service
2.2 Work with our partners within the community and primary care sectors to improve the patient experience and health outcomes
2.3 Be responsive to challenges, opportunities and communicate successes

### Championing System Improvement

3.1 Promote a culture of transformation and innovation in health service delivery
3.2 Showcase high value clinical excellence that results in measurement changes in health outcomes
3.3 Identify opportunities to challenge historical health care practice and champion evidence-based disinvestment in low-value health care

The IEHG Clinical Senate has a broad view of health care and operates at a strategic system-wide level.
The IEHG Clinical Senate does not participate in local operational issues or specific patient group or condition issues that fall within the domain of national clinical networks.

# System Leadership

## What we will need to get the system we require….

- Patient focus with emphasis on quality
- Use of improvement methodology and supporting data
- Leadership, vision, empathy, courage
- Frontline staff engagement
- Professionalism & pride in work
- Teamwork, collaboration, networking and influencing

**Willingness to challenge the status quo: basis of demand rather than any historical inheritance**

**Courage to change the culture of professional and institutional domination to patient first**

OLDER PEOPLE

National Clinical & Integrated Care Programmes
*Person-centred, co-ordinated care*

# Geriatric EMergency Services (GEMS)
# St Luke's Hospital, Kilkenny, 2018

GEMS


Ireland East HOSPITAL GROUP

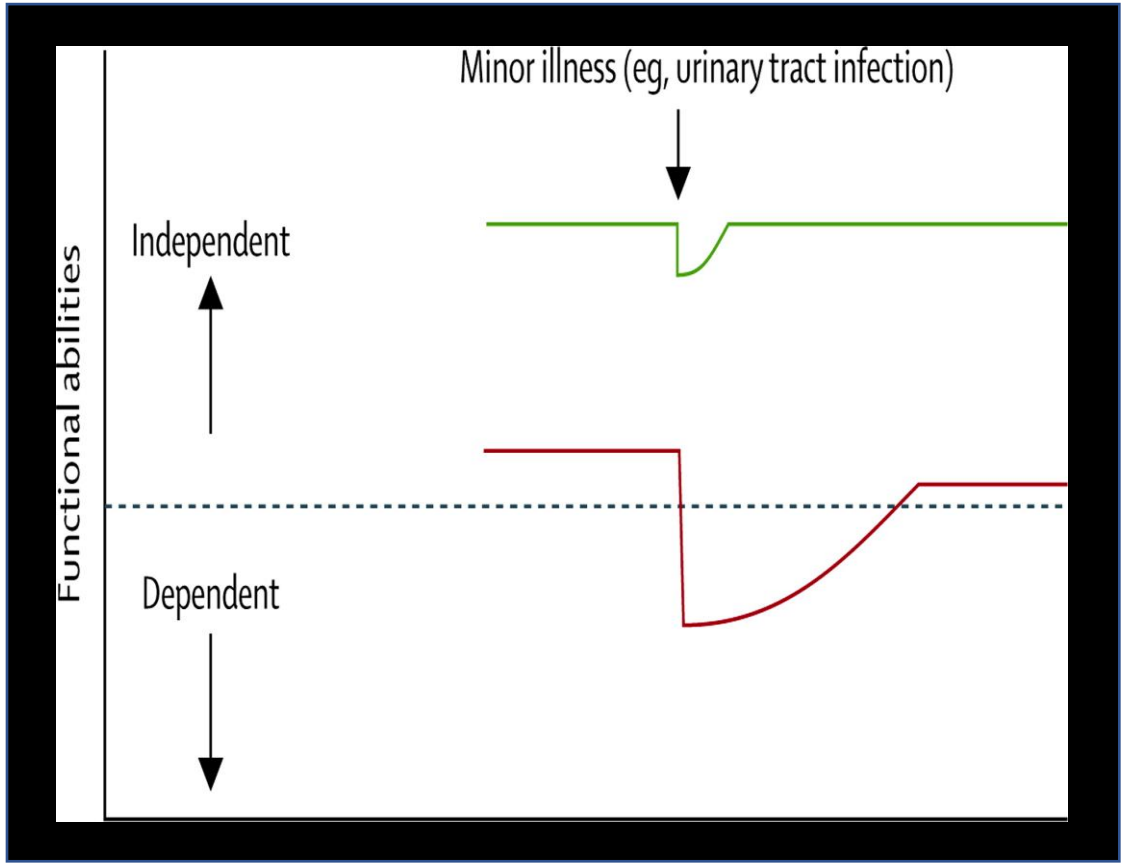
Acute Frailty Network

# Why is frailty so relevant right now?

- Frailty is common
- Complex cohort at high risk of adverse outcomes
- Costly

- Frailty is identifiable
- Evidence based intervention - Comprehensive Geriatric Assessment
- It crosses health and social care, so can drive integration
- Focuses on key person outcomes

**Vulnerability of frail older people to a sudden change in health status after an illness**




*Clegg, Young, Iliffe, Rikkert, Rockwood*
*Frailty in elderly people*
*Lancet 2013; 381: 752 - 762*

# Principle 1. Early, routine identification of frailty (Median = 27 minutes)

**'To improve outcomes and the patient experience for all older people living with frailty'**

OLDER PEOPLE

## POP Model of Care

- Each ED/AMAU in conjunction with the Specialist Geriatric Service will have in place an agreed process for identifying/triaging the older adult.

GEMS


## 24/7 identification of frailty on triage on Acute Floor

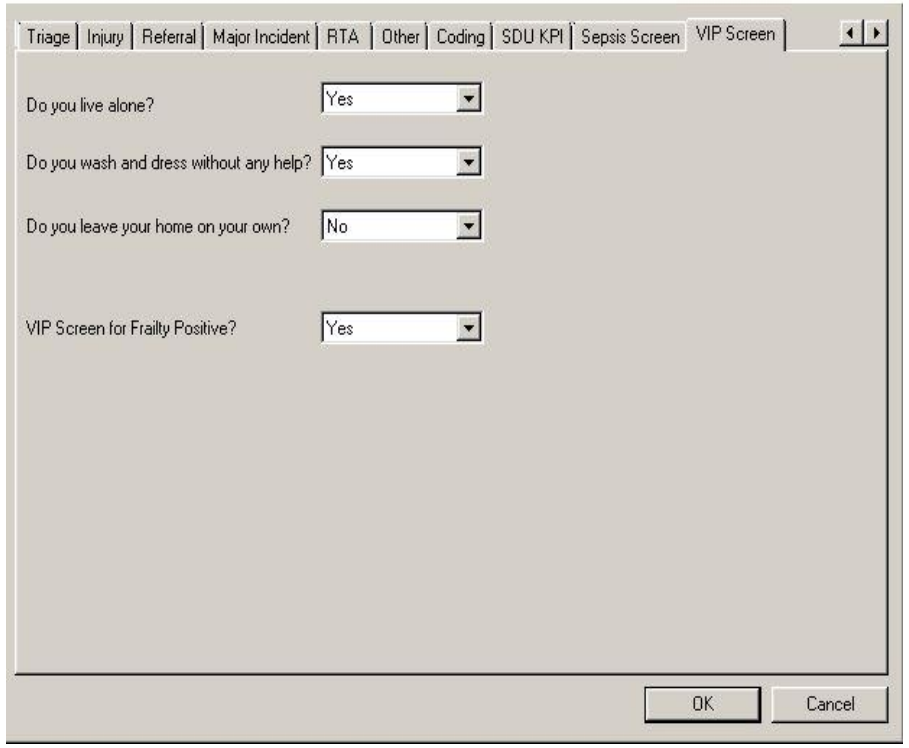
- All patients 75yrs and over who attend the Acute Floor are screened for frailty by the triage nurses using the VIP screening tool.
- This is a mandatory field on the iPiMS and 100% of our patients are captured at triage.

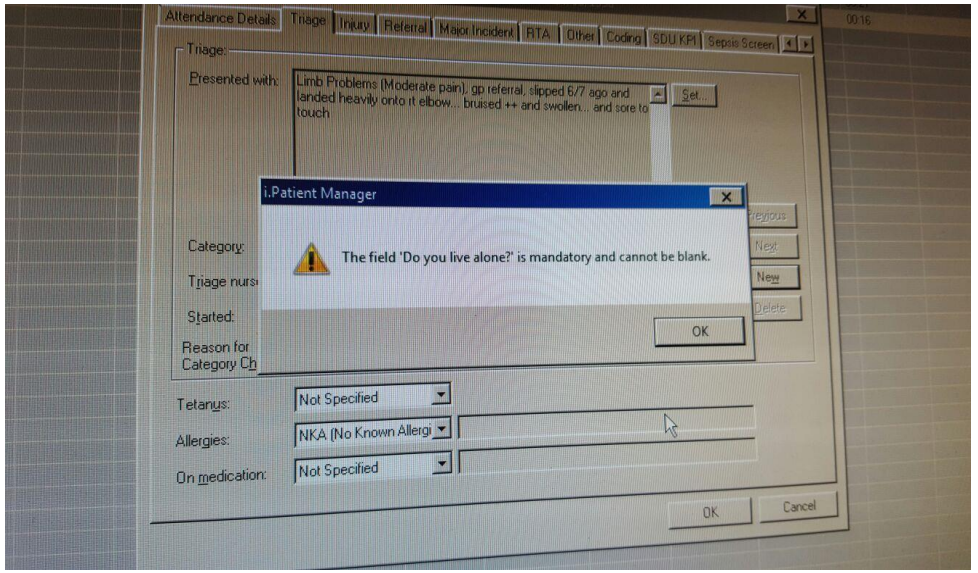
Over 75s screened using Variable Indicative of Placement (VIP)

1. **Do you live alone? Yes = 1**
2. **Do you wash and dress yourself without assistance? No = 1**
3. **Do you leave your neighbourhood on your own? No = 1**

Score > 1 activates the GEMS pathway

# Screening on the Acute Floor



## Principle 2. Early Comprehensive Geriatric Assessment (CGA)

***To improve outcomes and the patient experience for all older people with Frailty***

OLDER PEOPLE OP

- The SGS will link with the ED/AMAU when an older person is identified as having frailty and requires referral to the SGS for CGA/admission to the SGW

- Each SGS will have defined and agreed criteria with their ED/AMAU and community that determines whether an older person should be referred to the SGT

GEMS

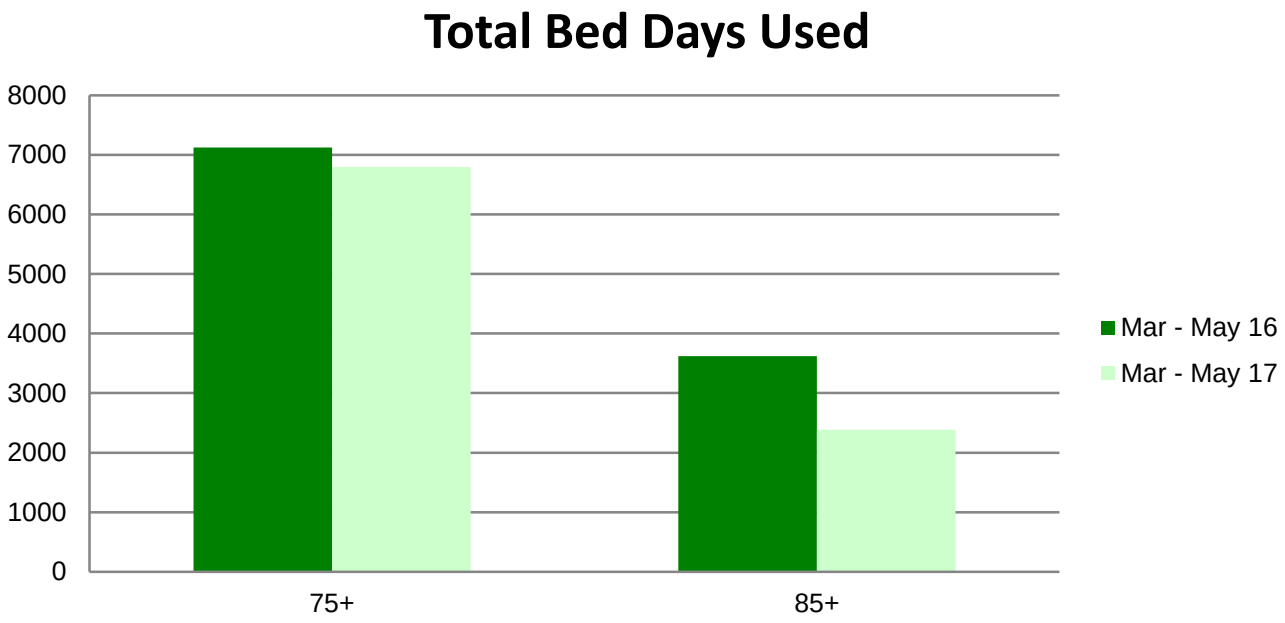
- Initiates early interdisciplinary Comprehensive Geriatric Assessment within 1 hour
- Agreed clinical professional standards of care and work

# GEMS Summary Data

- 7,570 patients aged 75 years and older were triaged in SLGH
- 43% (3,237) screened positive for frailty
- Median time to identification of frailty = 27 minutes
- Mean and median age was 85 years
- 36% (1,167) triaged as Unwell Adult
- 75% (2,426) triaged as Immediate, urgent or Very Urgent

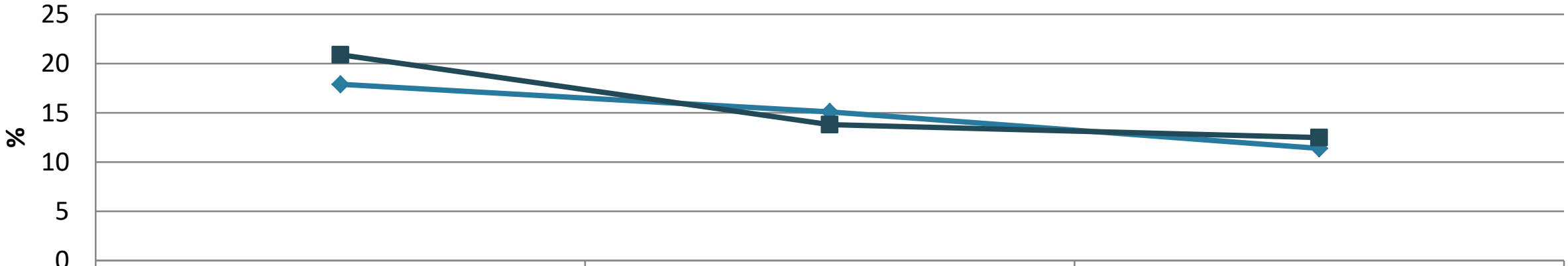
# Terence’s Story

| Bed Days Used Pre and Post GEMS (NQAIS) | | | | |
|---|---|---|---|---|
| | No of Discharges 75+ | 75+ BDU | No of Discharges 85+ | 85+ BDU |
| Mar - May 16 | 845 | 7127 | 330 | 3621 |
| Mar - May 17 | 848 | 6797 | 283 | 2385 |
| Bed Days Saved | +3 | 330 | -47 | 1236 |
| % change since 2016 | 0.4% | -4.6% | -14.2% | -34.1% |




| iPiMS | 75+ Yrs Total | VIP+ | Median LOS |
|---|---|---|---|
| March- May 2017 | 1,265 | 502 | 6 Days |
| March- May 2018 | 1,287 | 563 | 5 Days |

## 30 Day Re-admission Rate




| | Mar - May 16 | Mar - May 17 | Jan - Mar 18 |
|---|---|---|---|
| 75+ | 17.9 | 15.1 | 11.4 |
| 85+ | 20.9 | 13.8 | 12.5 |

# And in the end, GEMS 2017-2022

**GEMS Teams**

- Front Door GEMS
- GEMS Inpatient Unit
- Back Door GEMS
- DTA GEMS
- Ambulatory GEMS

**ED & AMAU**
(100 attendance/week > 75 years)

**Front Door GEMS**

- *Frailty screen at triage*
- *Early identification of frailty within 30 min*
- *CGA within 1 hour*

**Home or DTA**

**Ambulatory GEMS**
(EWS < 2) within 72 hours
'Patients in the community are just as complex'

**GEMS Inpatient Unit**
<72 hours,<7days
#Red2Green #SAFER
#HomeFirst
#WhatMattersToYou
#endpjparalysis

**Back door GEMS**
'Manage the back door as aggressively as the front door'

**Home**

**DTA**

**Rehab**

**NH**