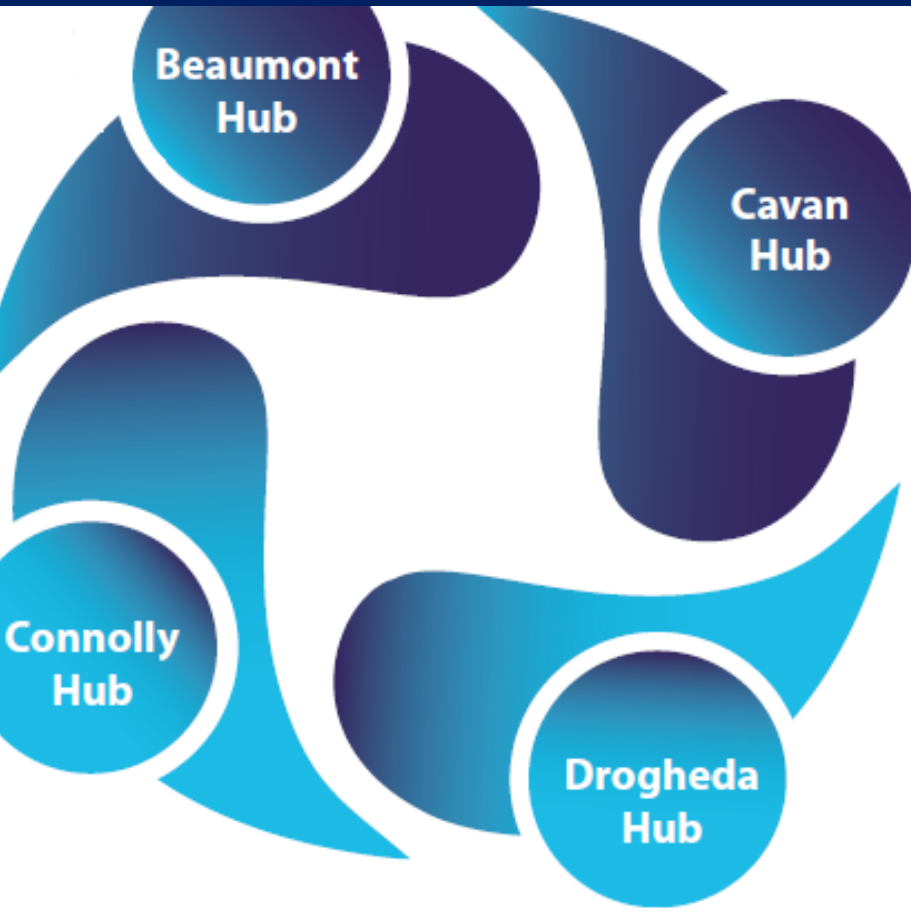
Enhancing Sustainable Quality Outcomes in Residential Care Facilities using an Integrated Care Framework



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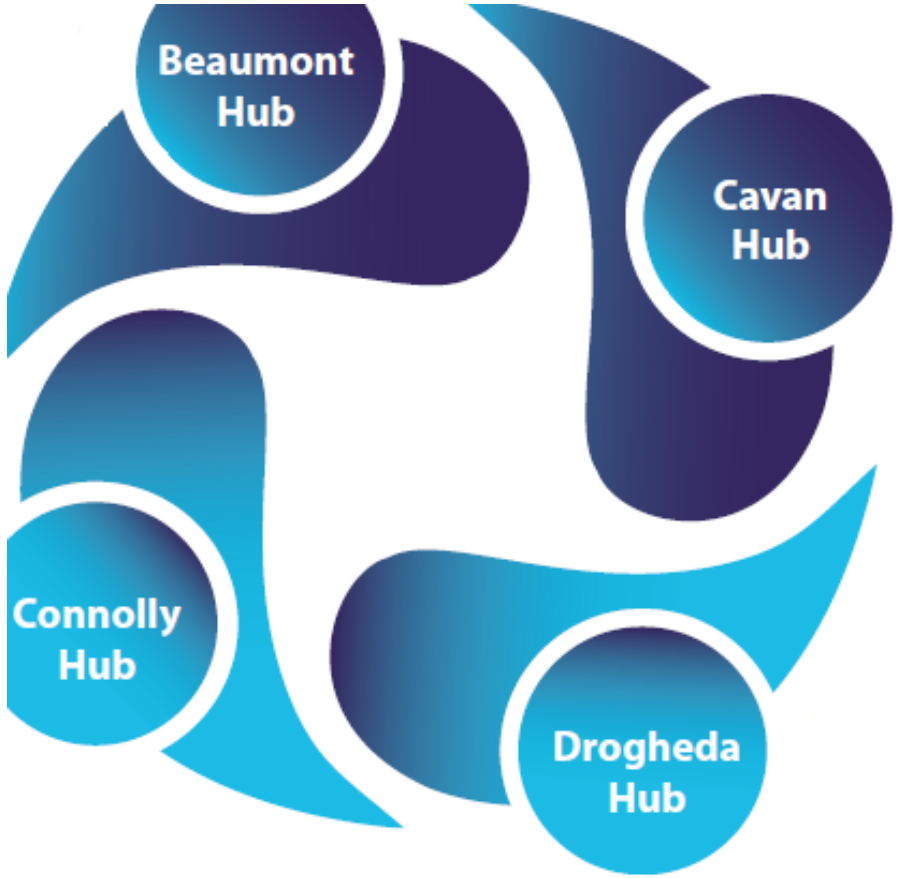
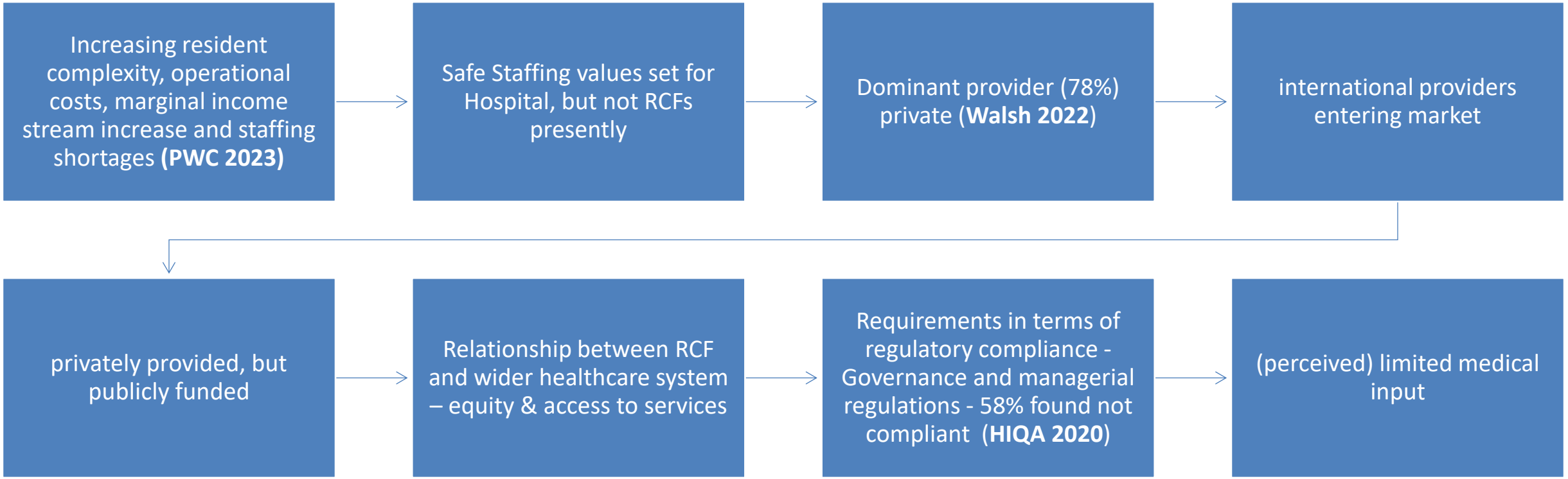
PURPOSE

To provide a structured and proactive integrated model of care that will create sustainable, robust and enhanced clinical interfaces between the acute services and Residential Care Facilities. The Integrated Care Framework (ICF) is designed to enhance quality of care for RCF residents in their home, and develop clinical pathways outside of the requirement for transfer to a hospital's Emergency Department (ED).



CONTEXT

Challenges for Residential Care Facilities (RCFs), Hospitals and Residents



Background

It is expected that by 2030, 24% of the European population will be over 65 years.[1]

Approximately 5% of all older people need residential or nursing home care in Ireland.[2]

Compared with the community dwelling population, those in residential care facilities are more likely to have multi-morbidities and increased risk of frailty.[3]

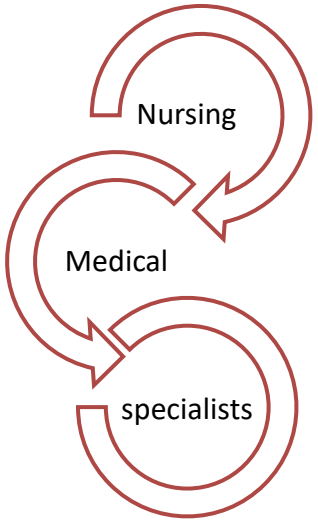
Currently there are approximately 30 transfers from RCFs to Eds per 100 RCF bed days annually.[4]

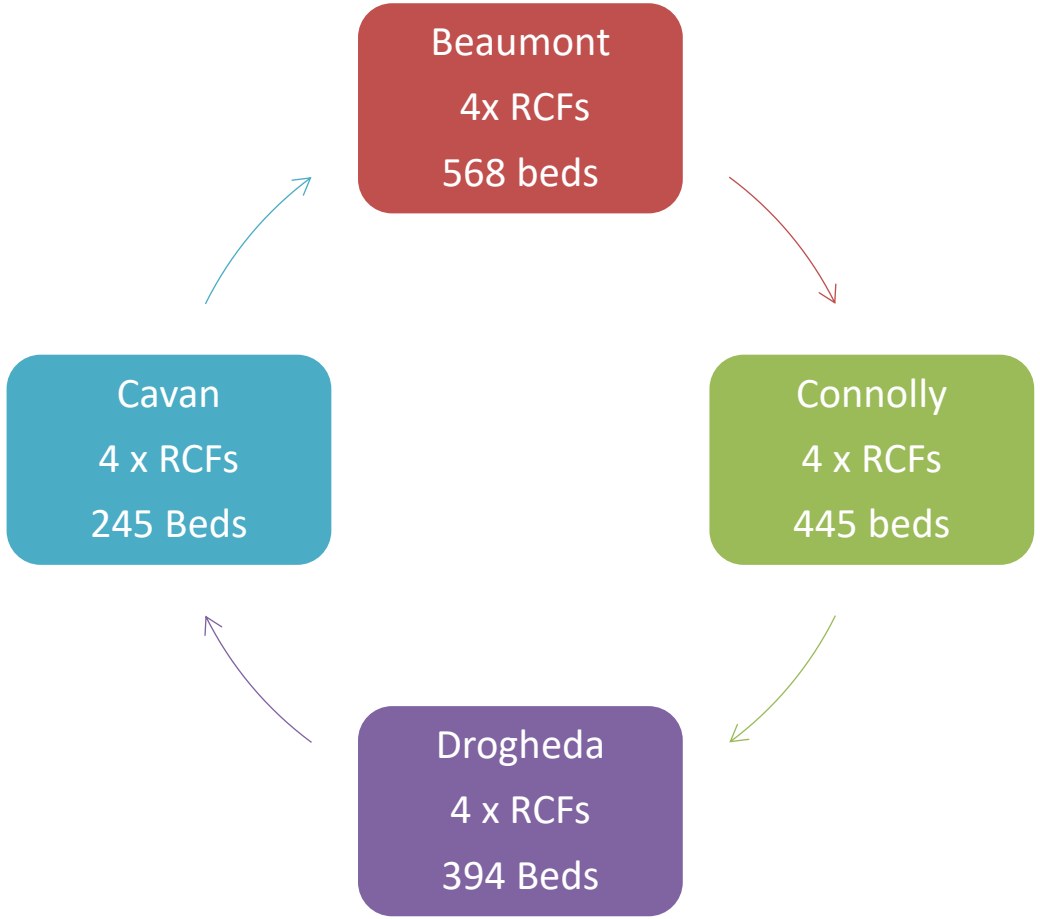
ED admissions can be avoided by 55% with appropriate alternative care.[5]

Transfers are associated with adverse outcomes for residents, longer lengths of stays, with 1-5% of presentations dying in the ED.[3]

ICF Framework Participants

Creation of an Integrated Care and Support Framework





➔ voluntary participation - private ownership prevails

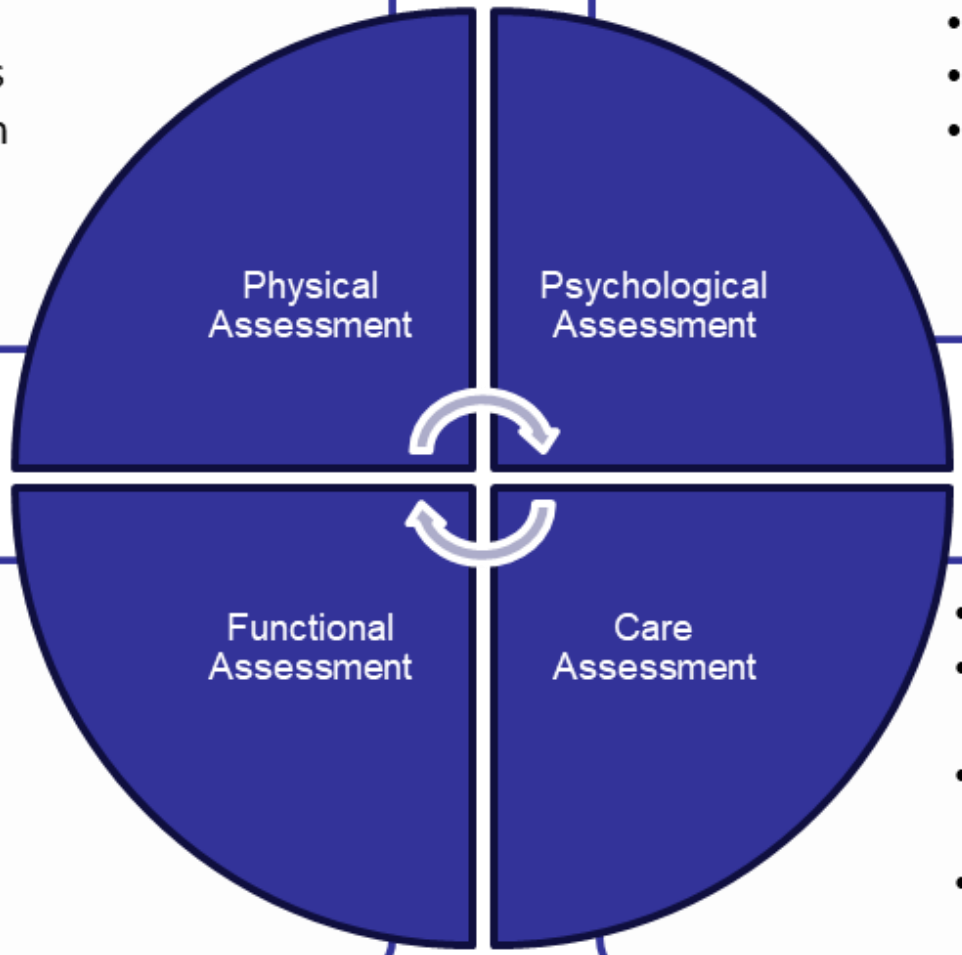
Key Dimensions of the Integrated Framework

Key Dimensions of Integrated Care Framework

- Clinical Leadership
- Quality Assurance
- Training and upskilling
- Staff Provision

- Skin integrity assessment & management of pressure ulcers
- Otimising Nutrition & Hydration
- Infection Prevention & Control
- Dependency Levels

- responsive behavior support
- safeguarding vulnerable adults
- Dementia Management



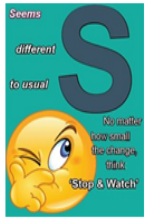
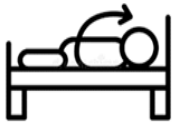
- falls risk & assessment
- continence assessment, promotion & management
- frailty nursing assessment
- EOL & Palliative care

- person experience
- number of resident transfers to emergency department
- number of residents reviewed onsite in RCF by acute MDT staff
- safe staffing and skill mix

Quality Assurance Key Performance Metrics

Necessary Assessment Framework and related specific RCF metrics

Training Provided

Falls Prevention 	Dementia 	Deteriorating Resident 
Infection Prevention & Control 	Pressure Prevention & Management 	Complaints Training 
Catheterisation Management 	End of Life 	RCSI Leadership Programmes 

Produced by: North Cumbria Health & Care System

Learning Disabilities Mortality Review (LeDeR) Programme

North East and Cumbria learning disability network

Recognising Deterioration

Early Warning Tool

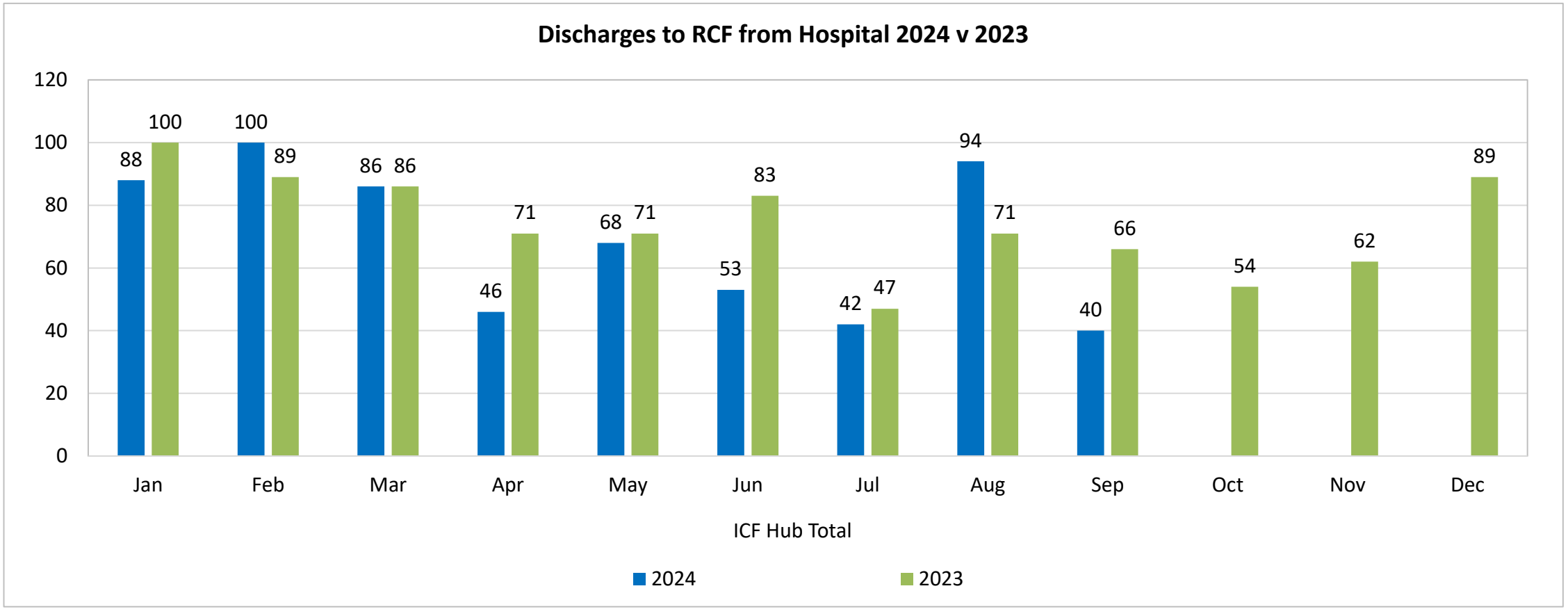
Everyone can spot the signs

S T O P

A N D

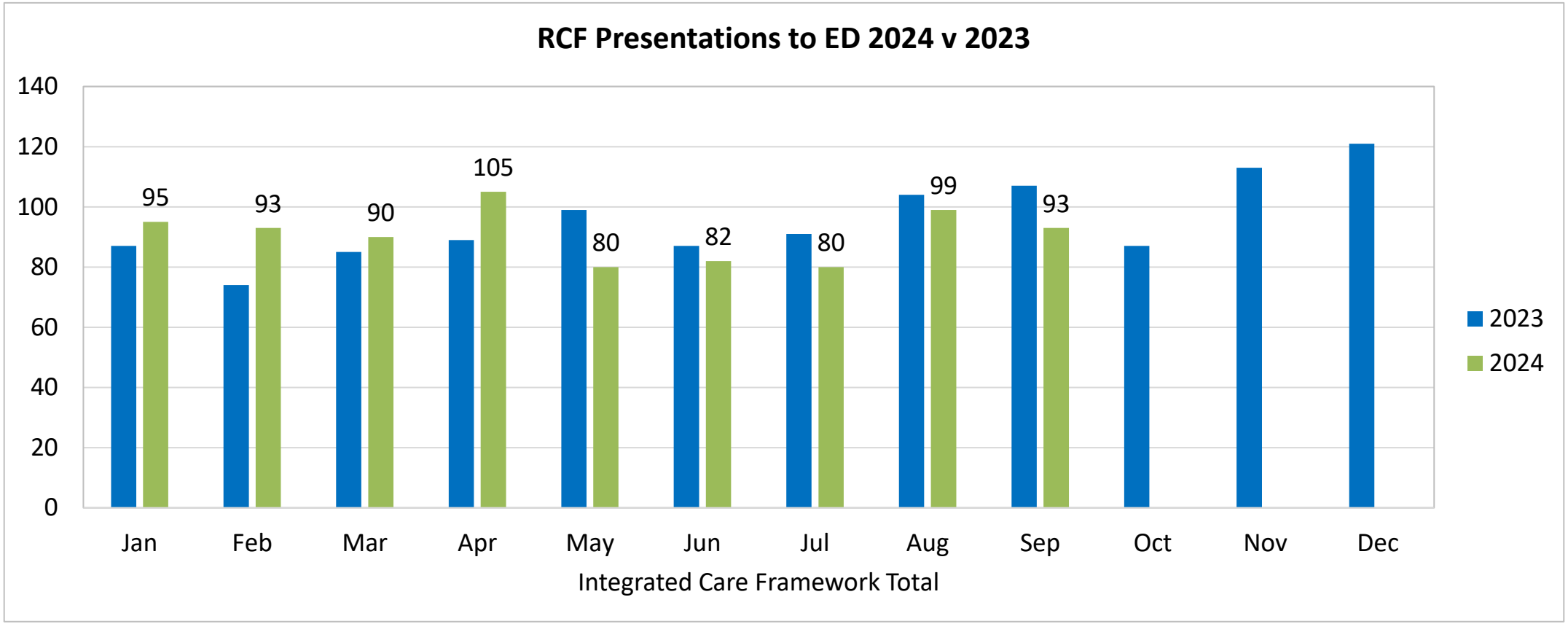
W A T C H

What is the Data Telling Us?



2022 V 2023 ⇧ 52%

DISCHARGES FROM HOSPITAL TO RCF



2022 V 2023 **Increase 11%**

2023 V 2024 **YTD 1% reduction**

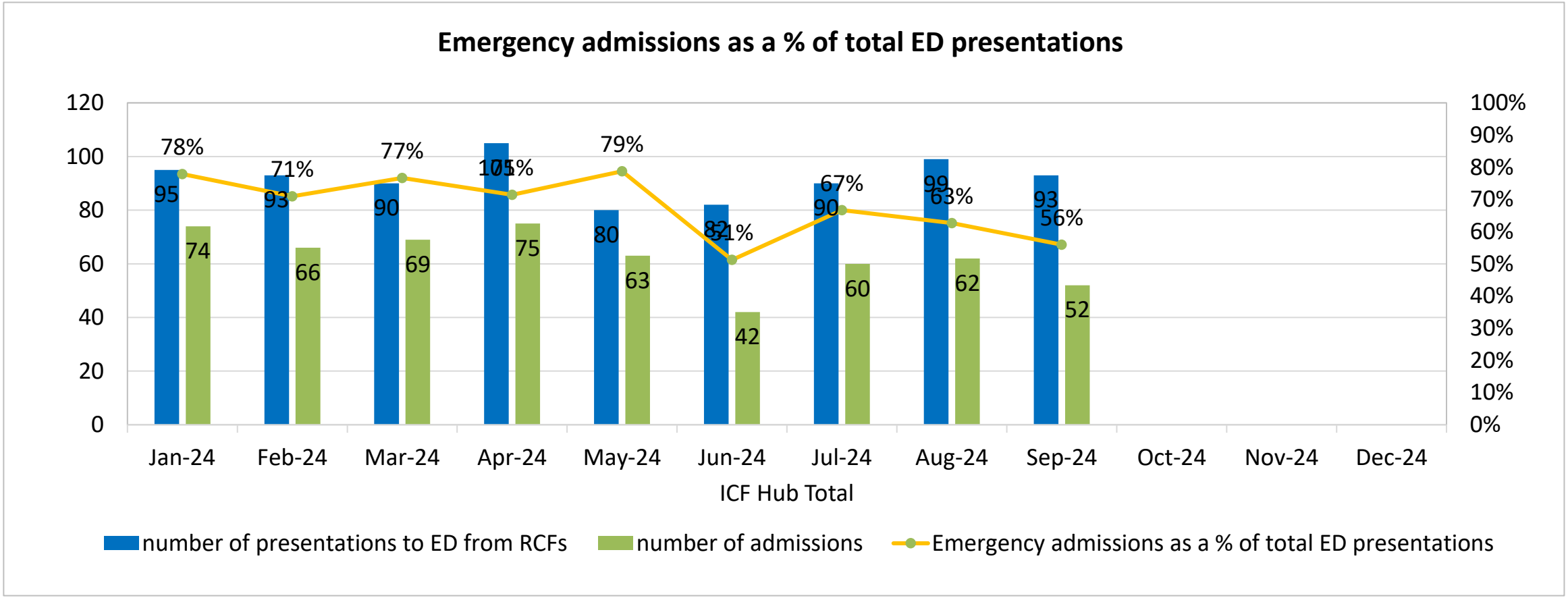
RCF Presentations to ED

Top 5 Reasons for Presentations

1. Disease of Respiratory System (30%)
2. Injury (95% caused by falls)
3. Kidney & Urinary Tract
4. Digestive System
5. Circulatory System

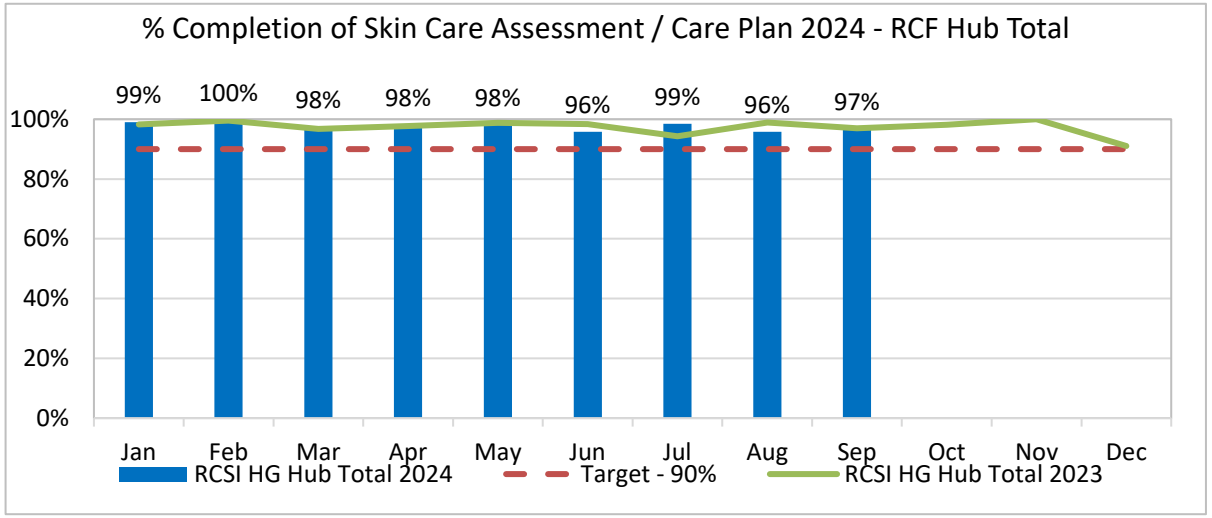
Operational Issues

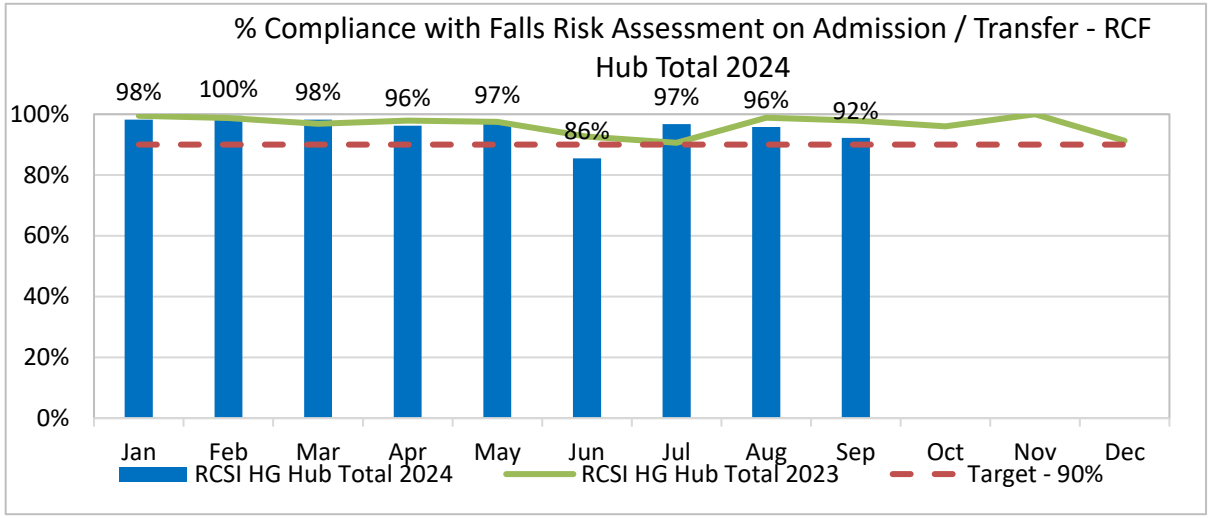
Admission Conversion of RCF Presentation ➔ Hospital on an Emergency Basis

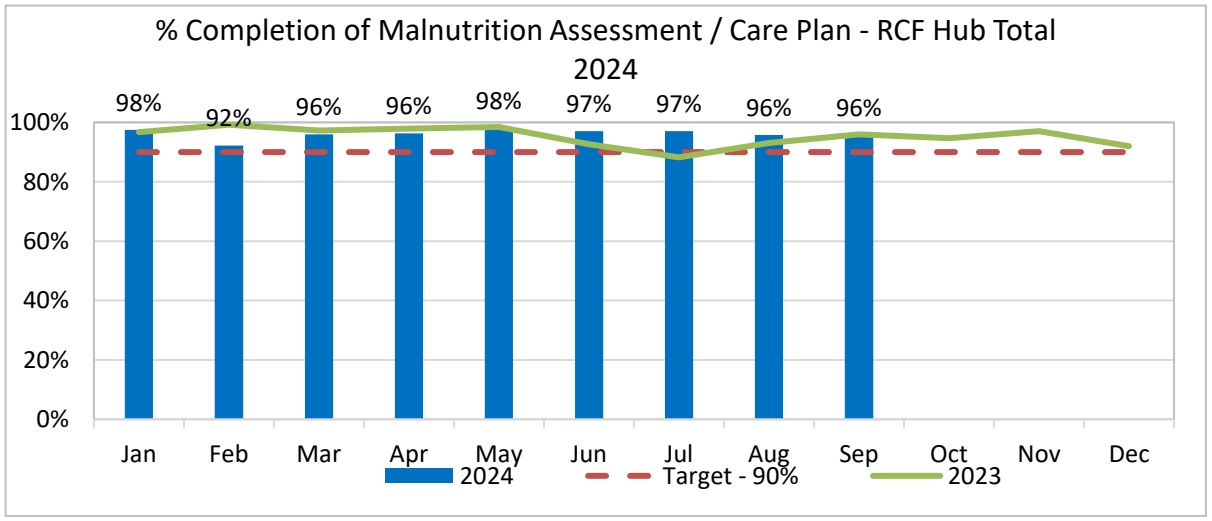


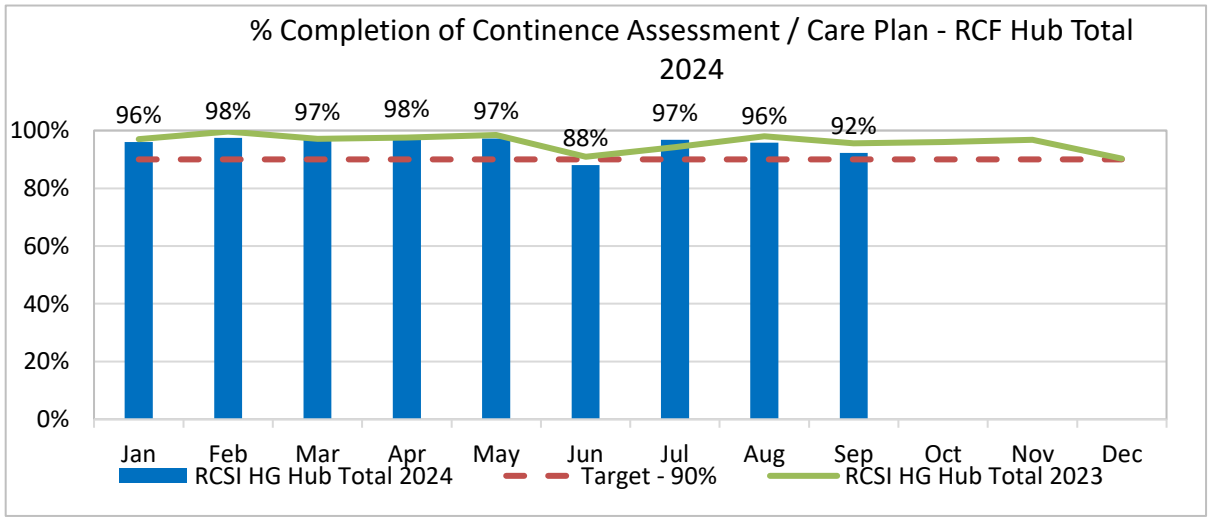
- Average 68% admission conversion compared to 55 % initially

ASSESSMENTS

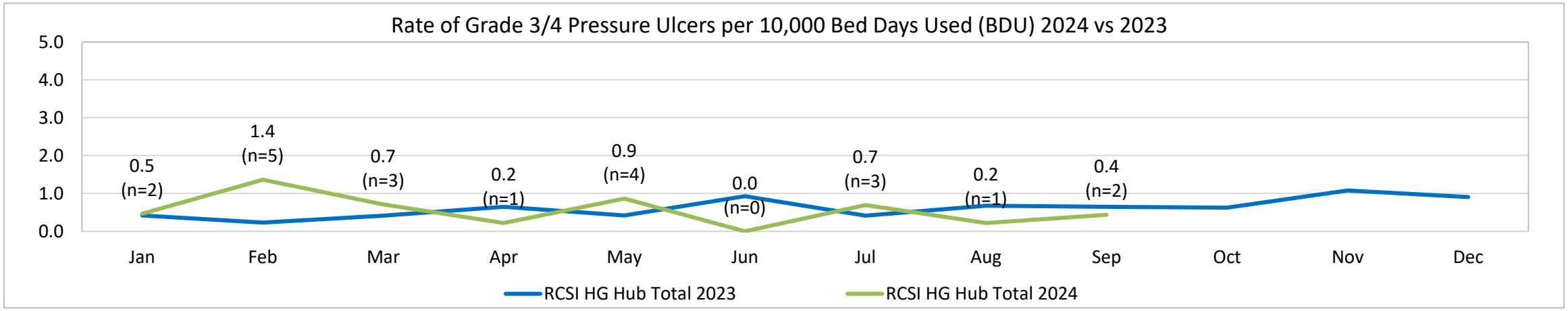


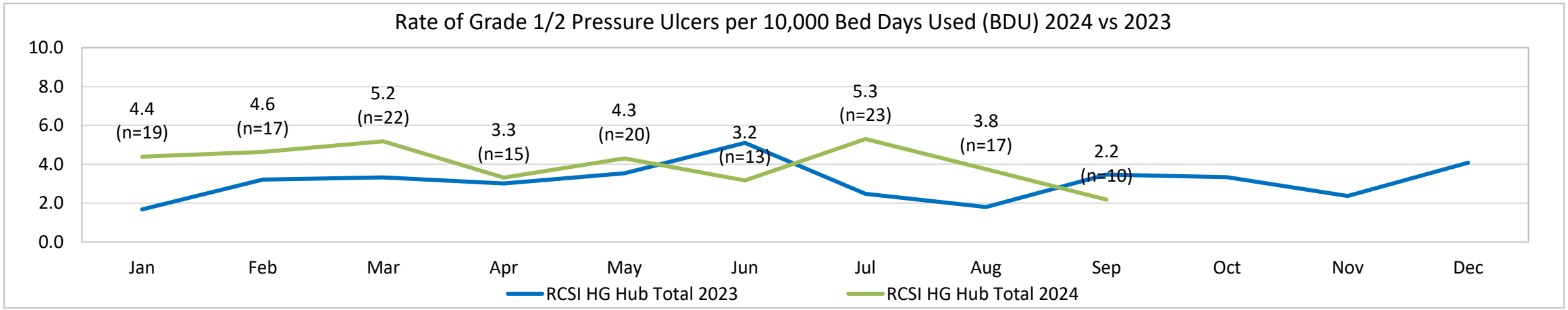






Pressure Ulcers





2023 v 2022 73 % reduction in Grade 3 & 4 and a further 5 % reduction 2023 V 2024 YTD

CURRENT STATUS – IMPROVEMENTS

➔ 2 . 5 years full data

- full establishment of MDT across each Hub
- Improvements in terms of ability to maintain patients in RCFs
- reduction of pressure sore incidents Grade 3 & 4
- compliance & standards maintained across QCMs
- Reduction of ED presentations 10% over 2 years
- increase of Hospital ➔ RCF discharges 52% year one and maintained
- Strong working relationships across boundaries ➔ person centred care
- Direct relationship between Hospitals and RCF
- Ease of transfer Hospitals ➔ RCF move to Hospital referral/ rather than out of hours ED attendance
- Understanding key causal problems RCF ➔ Hospital transfers ➔ which provides focus for bespoke training/assessment /pathway development

Thank You