Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

QI TALK TIME

Building an Irish Network of Quality Improvers

Building a Model Line for Frailty

1pm Thursday November 6th 2018

Connect **Improve** **Innovate**

Speaker

Fiona Keogan:

is a Service Improvement Lead with Ireland East Hospital Group (IEHG).

Fiona is a chartered physiotherapist who completed the RCPI Quality Improvement diploma in 2016. She previously worked at Beaumont Hospital where as Head of Clinical Services & Business Planning she developed services for older people including front-door multi-disciplinary assessment for frailty.

She now leads the Frailty Value-stream work across IEHG, assisting front line staff to improve processes and work together with community and voluntary partners to redesign services and improve patient and carer's experiences.

Instructions

- Interactive

- Sound:

Computer or dial in:

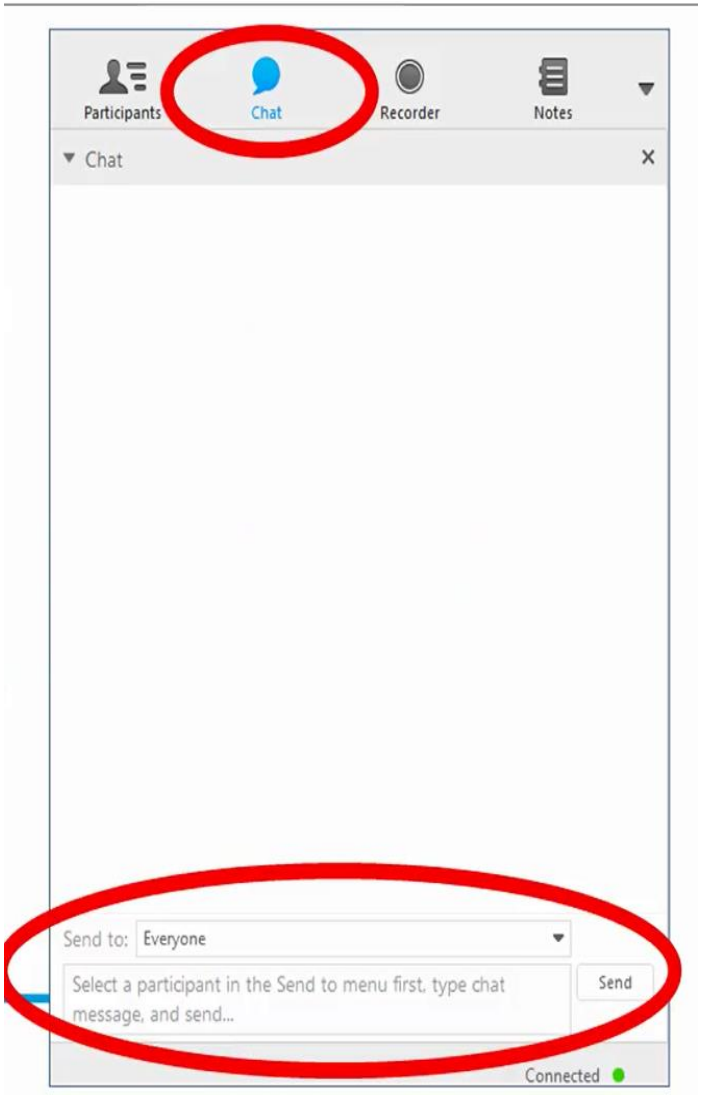
Telephone no: 01-5260058

Event number:163 654 059#

- Chat box function
  - Comments/Ideas
  - Questions

- Keep the questions coming

- **Twitter: @QITalktime**



Grúpa Ospidéal
Oirthear na hÉireann

Ireland East
HOSPITAL GROUP

UCD
DUBLIN

Developing a Model Line for Frailty in IEHG

Fiona Keogan MSc

Service Improvement Lead

Content

- Reason for Action
- Current State
- Methodology
- Measurement
- Leadership
- Insights
  - -barriers and challenges
  - -enablers
- Next steps

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

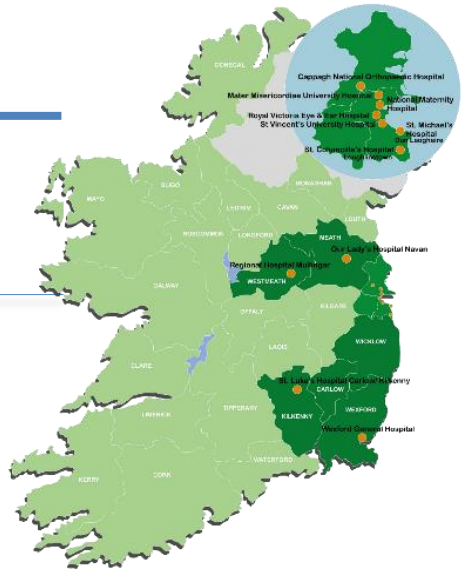
Cappagh National Orthopaedic Hospital

National Maternity Hospital

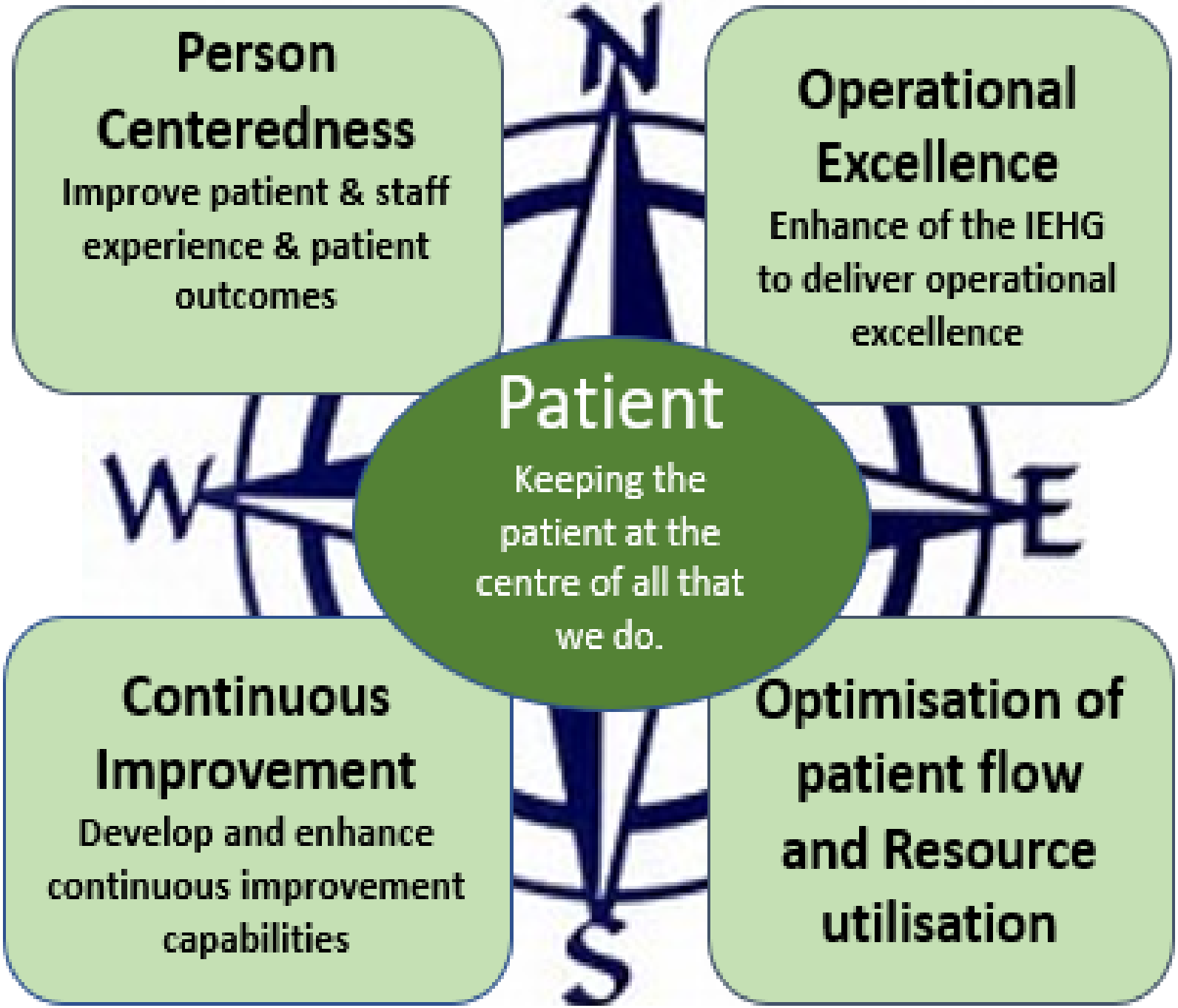
Royal Victoria Eye & Ear Hospital

ACADEMIC PARTNER

UCD DUBLIN

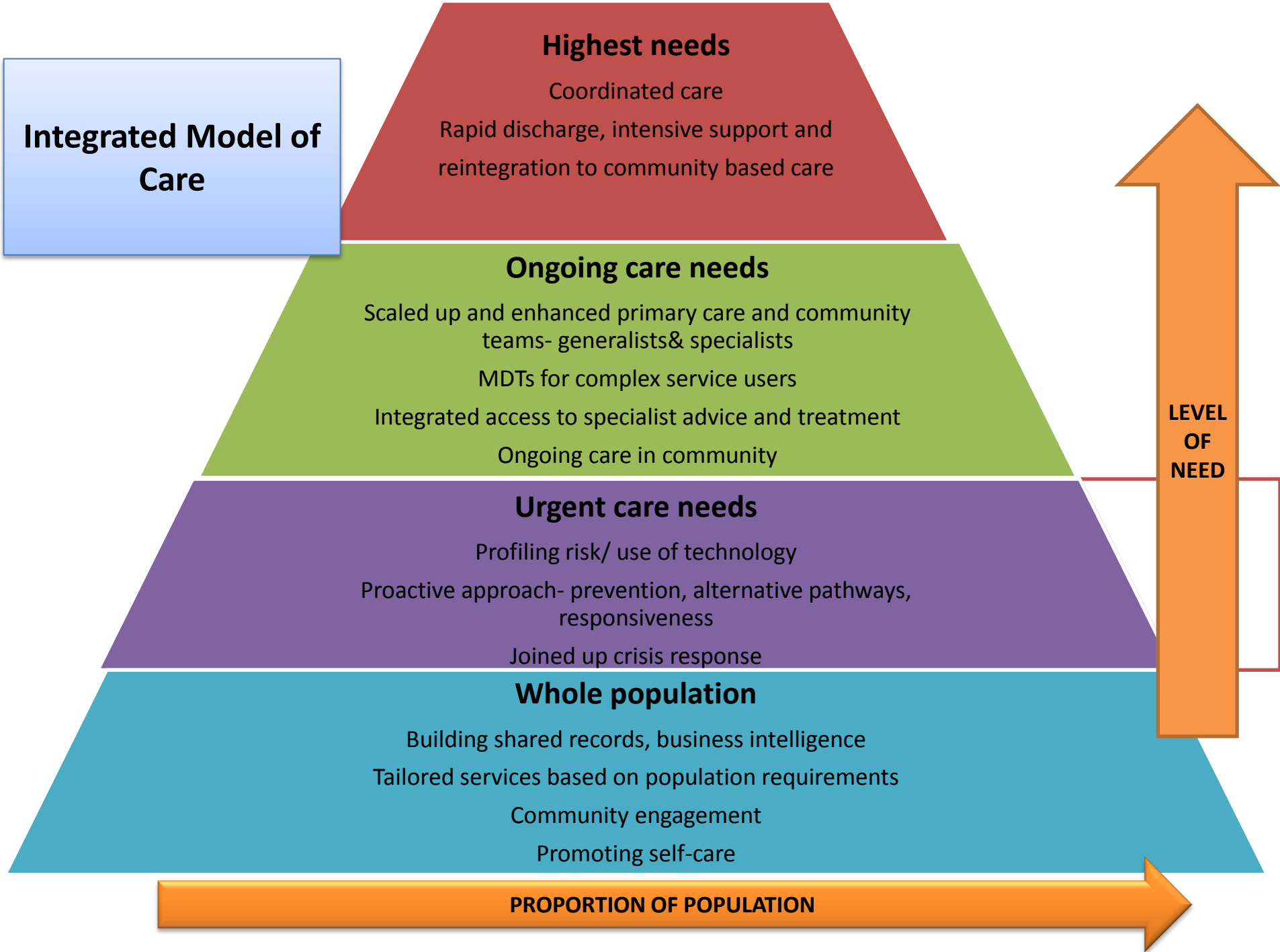


- Largest of the hospital groups
- 11 hospitals (6 voluntary and 5 HSE)
- Overlap with 5 community health organisations
- 1.3 million population and 11,000 staff
- Covering counties Dublin, Meath, Westmeath, Carlow, Kilkenny, Wicklow and Wexford


Person Centeredness
Improve patient & staff experience & patient outcomes
Operational Excellence
Enhance of the IEHG to deliver operational excellence
Patient
Keeping the patient at the centre of all that we do.
Continuous Improvement
Develop and enhance continuous improvement capabilities
Optimisation of patient flow and Resource utilisation
N
W
E
S

National Strategy
ICPOP

How do we help?


Integrated Model of Care
Highest needs
Coordinated care
Rapid discharge, intensive support and reintegration to community based care
Ongoing care needs
Scaled up and enhanced primary care and community teams- generalists& specialists
MDTs for complex service users
Integrated access to specialist advice and treatment
Ongoing care in community
Urgent care needs
Profiling risk/ use of technology
Proactive approach- prevention, alternative pathways, responsiveness
Joined up crisis response
Whole population
Building shared records, business intelligence
Tailored services based on population requirements
Community engagement
Promoting self-care
LEVEL OF NEED
PROPORTION OF POPULATION

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

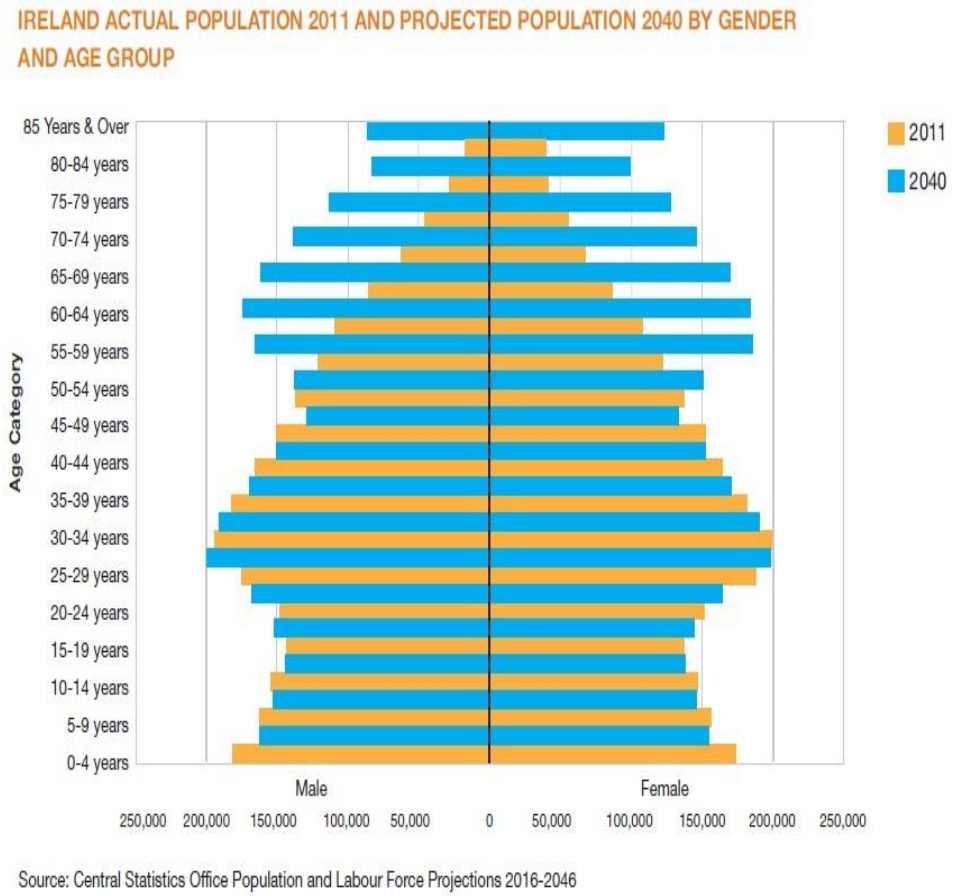
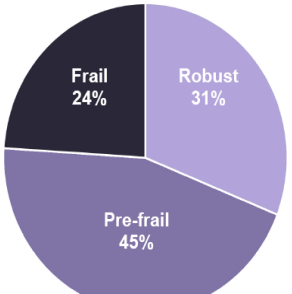


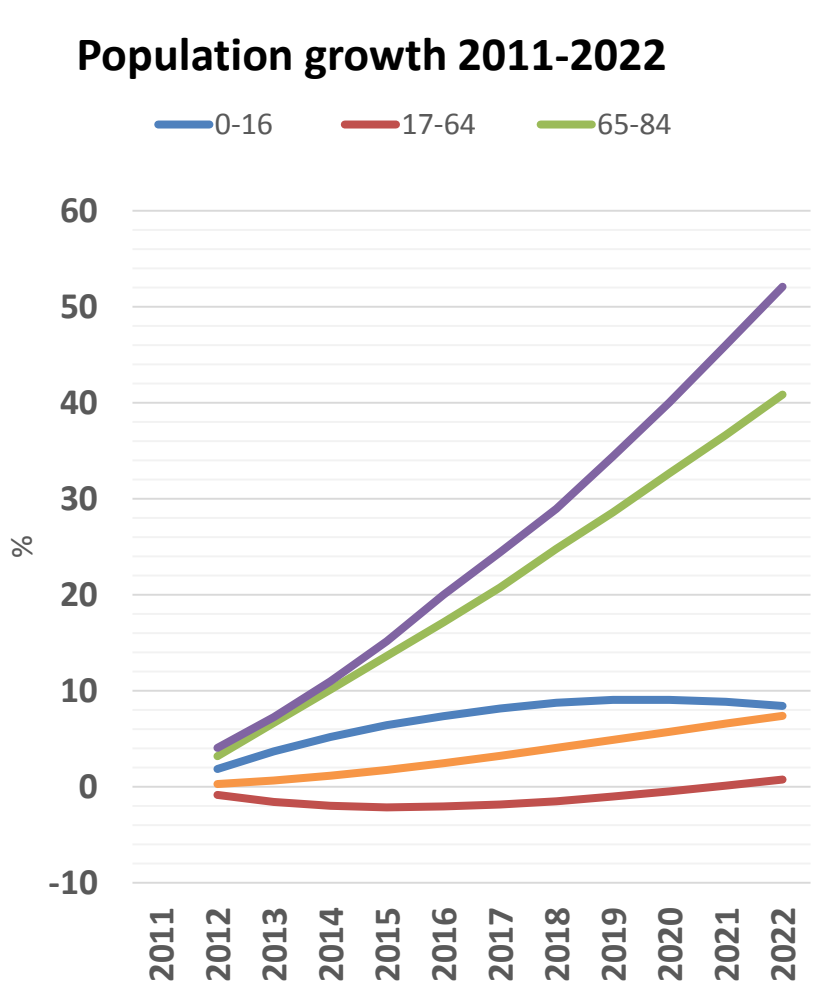
Figure 1: Weighted estimate of frailty in the community-dwelling population aged 65 years and older in Ireland (TILDA, wave 1).

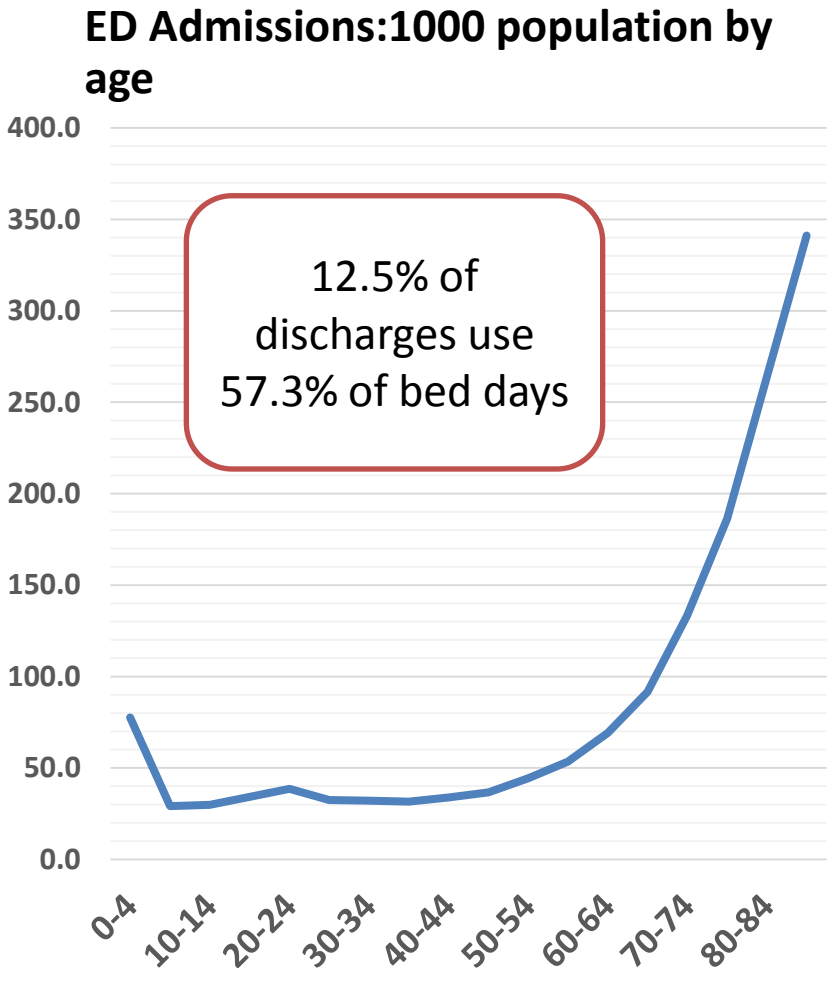


- **31% of the Irish older population aged 65 and over were robust,**
- **45% were pre-frail and**
- **24% were frail.**

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

Current State



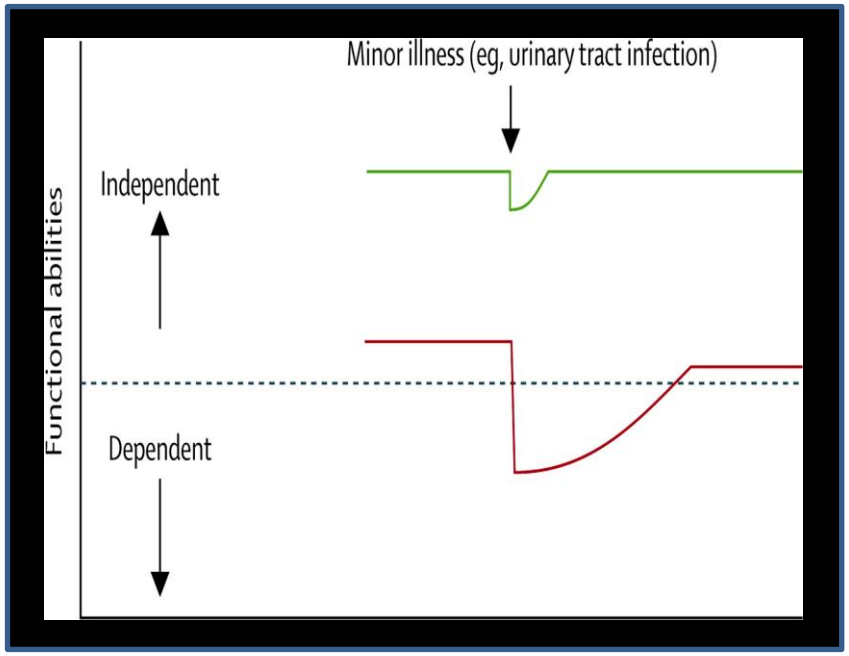


Why is frailty so relevant right now?

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

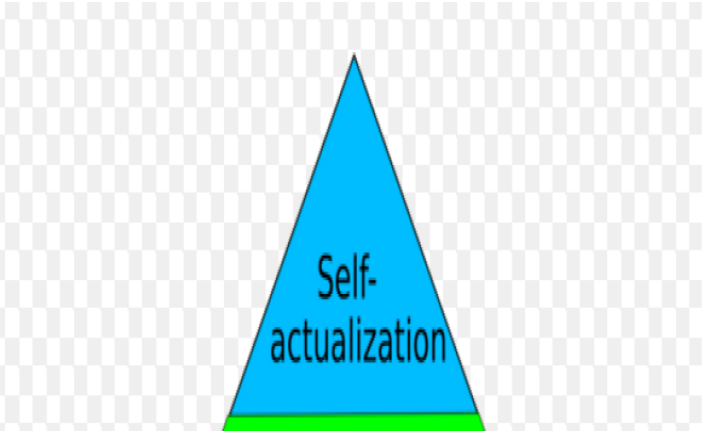
- Frailty is identifiable
- Evidence based intervention - Comprehensive Geriatric Assessment
- It crosses health and social care, so can drive integration
- Focuses on key person outcomes

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

Public policy and social norms

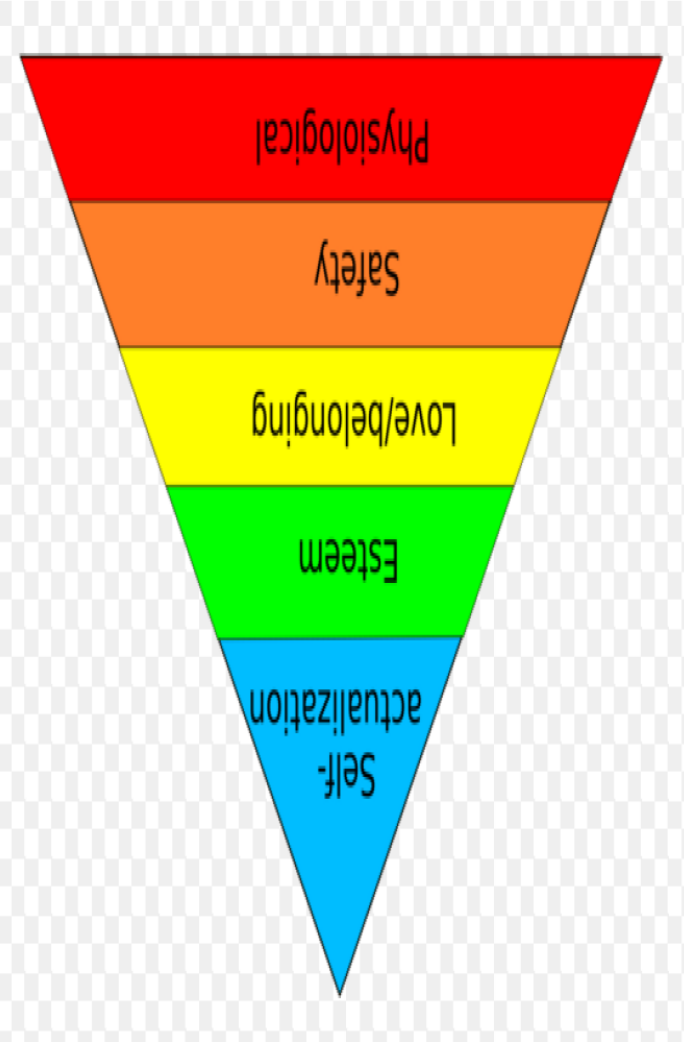


Maslow argued that safety and survival remain our primary and foundational goals- not least when our options or capacity are

Hierarchy of needs are individual and change over time

Health & Safety = manifestation of these goals

The possible new reality…



People readily demonstrate a willingness to sacrifice safety and sometimes survival for the sake of something beyond themselves… family, country, justice,

…regardless of age

What we end up with …

"Older people placed in a controlled and supervised institutional existence, a medically designed answer to unfixable problems, a life designed to be SAFE but empty of anything they care about"

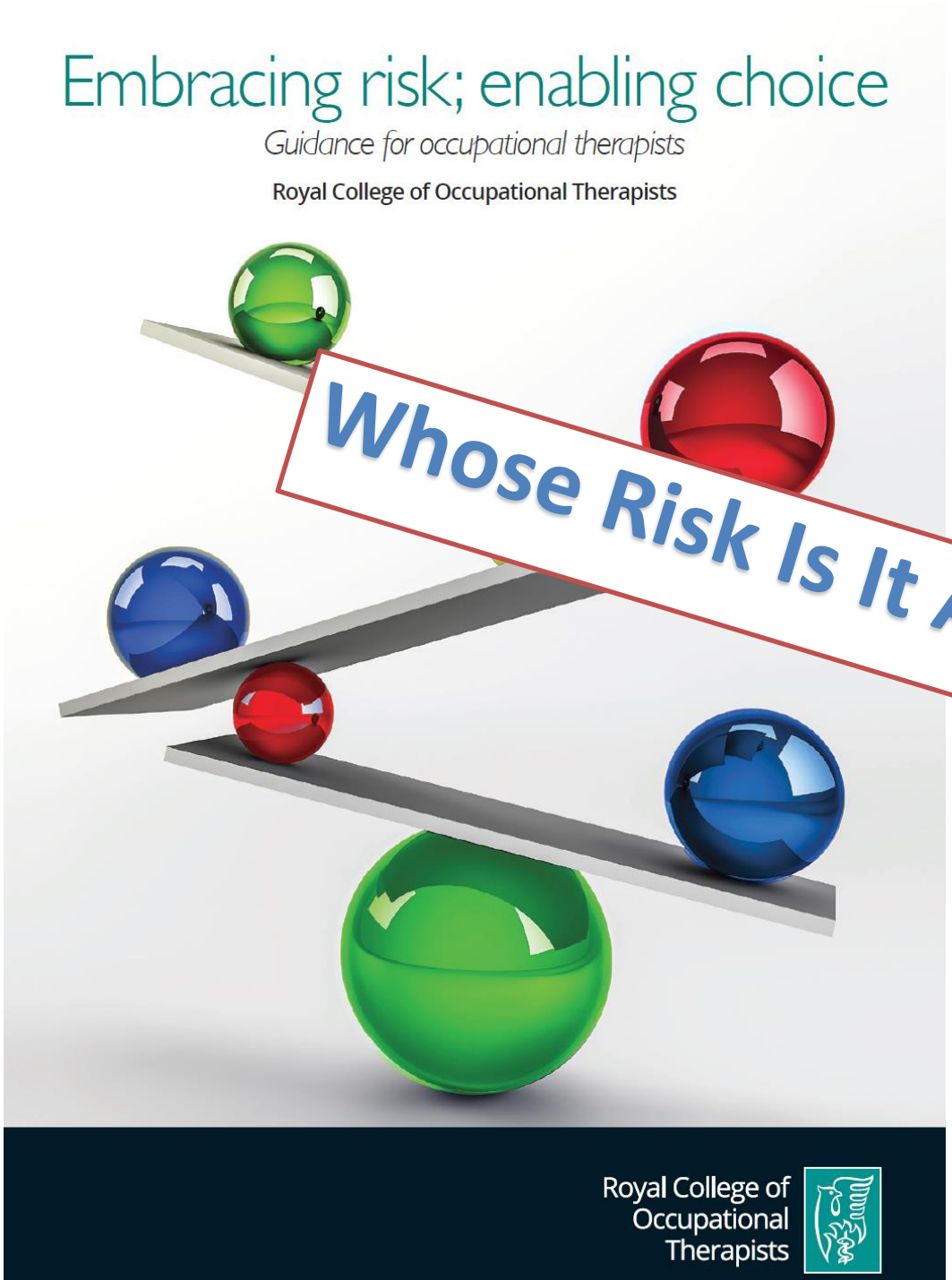
Current Language

Currently problem oriented and risk averse

- Not back to Baseline
- No Rehabilitation potential
- No capacity
- Not safe to go home
- Failed OT/PT
- Failed home visit

Goal Setting – are they really appropriate to the person?

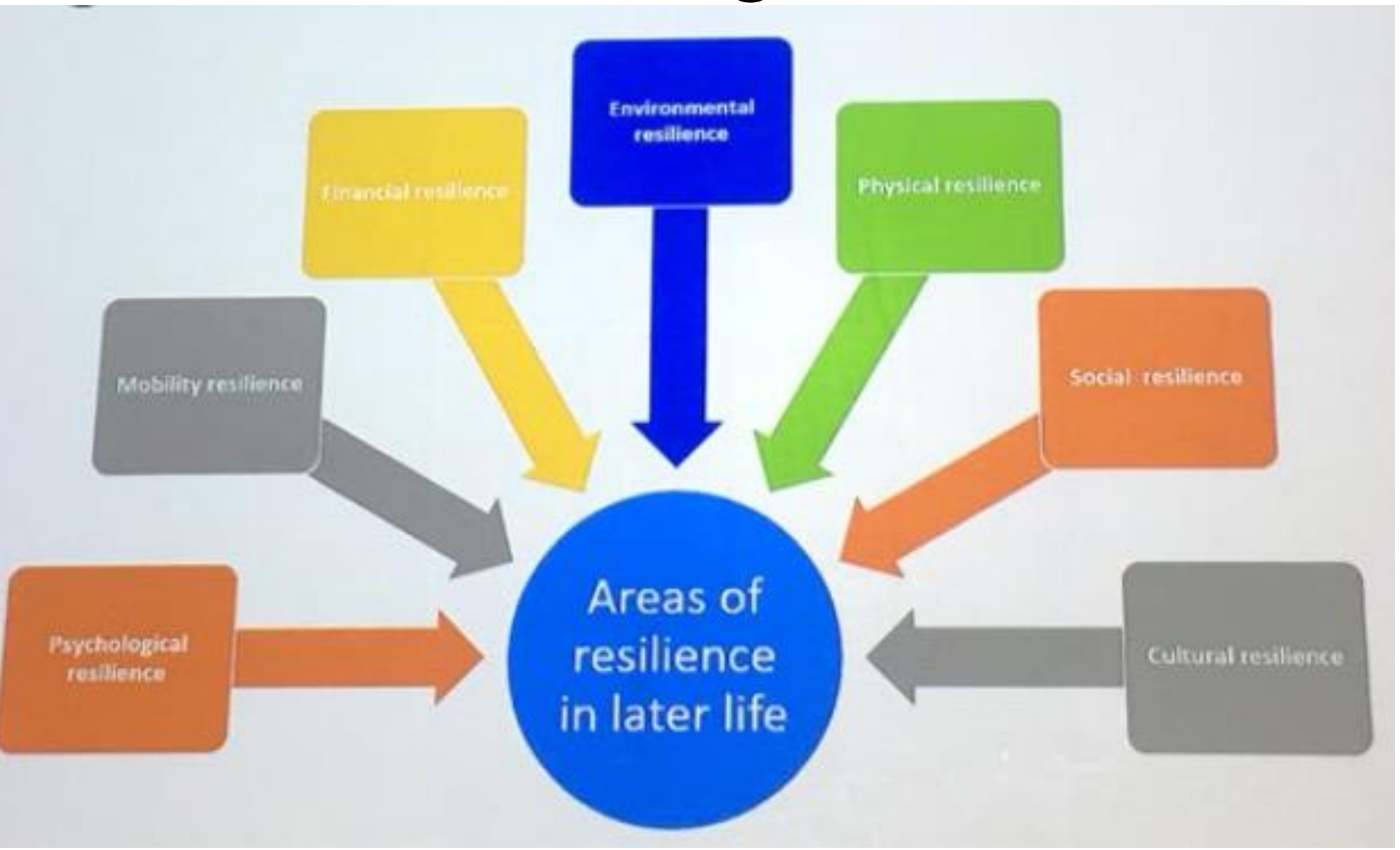
- Goals do not sound as if the person said them
  - I/Need to be able to walk 10 metres
- Base goals on how the person lived before admission



Whose Risk Is It Anyway?

Older People don’t see themselves this way

Resilience- resisting challenges and bouncing back



What matters to me?

- What is your understanding of the situation and your potential outcomes?
- What are your fears and what are your hopes?
- What are you willing to sacrifice and what are you not willing to sacrifice?
- What is the best course of actions that would meet all of this for you?
- What would make you feel 'SAFE' to go home

What People Want To Know

- What is wrong with them?
- What is being done to fix it and when will that happen?
- How the team judge when they can to home and how will they hear what the person thinks and when appropriate their carer
- When is it that likely to be?

Acute Frailty Network

IEHG have engaged with the AFN to develop a 'model line' 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

UNSCHEDULED CARE GATEWAYS

Transformation not possible without considering continuum of care

Assess/ CIT etc

complex cases

Service Improvement Approach

Frailty Value Stream

Values & Visioning

Rapid Improvement Events

Masterclasses

Value Stream Analysis

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

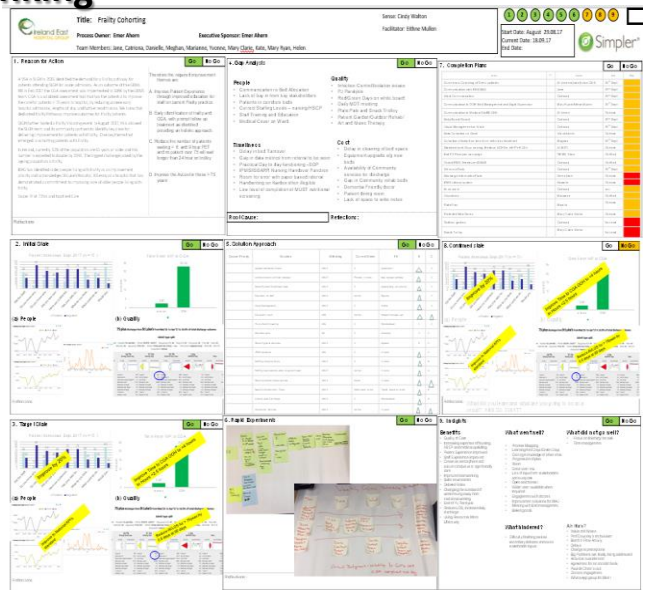
Group level values and visioning events

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

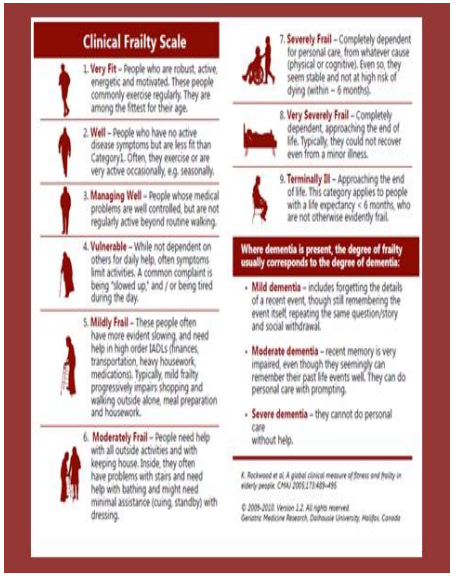
Acute Frailty Network

What Good Looks Like

A3 Thinking



Clinical Leadership



Lean Healthcare Management System

More than a box of tools

A lean management system is not a box of tools leaders can cherry pick from to make quick, organisational change. It is part of an integrated operating system where Leadership Vision and Strategies are connected to daily continuous improvement to sustain and steadily improve the organisation.

There are eight key elements, or tools, of a lean management system:

LEAN MANAGEMENT SYSTEM

Each of these tools are linked to create a system, not just a series of discrete tasks.

These elements work together and become interlocking

Simpler CONSULTING
IBM Watson Health

Grúpa Ospidéal Oirthear na hÉireann
Ireland East HOSPITAL GROUP
UCD DUBLIN

Ireland East Hospital Group

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 implemente

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

The purp ment the Acute es for the first 72 h

(start/finish) the first 7 ≥ 75yoa patient cohort pres RHM hospital

Therefore, improvements are re o patient experience and tred care

rate of Frailty Screening 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

4. Gap Analysis — Go / No Go

1. No frailty screening or assessment
2. No Comprehensive Geriatric Assessment (CGA)
3. No Clinical Pharmacist in acute s ng for Frail Patients
4. No early MDT assessment
5. No early ED doctor asses
6. Patient experience:
   - -Fear of comin very unwell
   - -Kept having ication, re-work
   - -Reports uration when in ED
   - -Una estionnaire??
   - the care was excellent'
7. huddles/ handovers for frail patients
   - ilty beds
   - mmunication to PHN/ Community services

Root Cause: If true root cause not clear [illegible] above

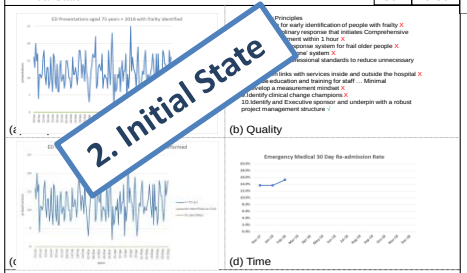
Reflections: What did you learn and what are you going to do as a result? AND SO WHAT?

7. Completion Plans — Go / No Go

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

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

2. Initial State — Go / No Go



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

5. Solution Approach — Go / No Go

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

Explanation of las
- Affecting - If ma then use CAPITAL, if minor then lower case.
- Current State = d mbes current performance in terms used in boxes 2 & 3.
- FS = Future state p g. 1 day)
- EASE O = Easy Δ im Ease X = Difficult.
- COST O = Low Cost = Medium Cost X = High Cost

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

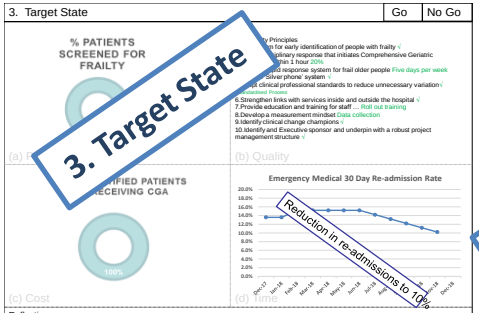
8. Confirmed state — Go / No Go

This box is "GO" when Box 8 = Box 3
Monitor ACTUAL results against the mp 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?

3. Target State — Go / No Go



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	rail	
Test iPMS	Alert sys	Frail ive ID'd to FIT	Make live
Trial CGA			
Education/ commu pro		wareness ity	50% staff educated re MFIT & Frailty	5 min FIT education & 20 min FIT/Frailty education

tual 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?

9. Reflections

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

- Very good team dynamics
- Knowledge and experience in
- Good repr from M
- Ex

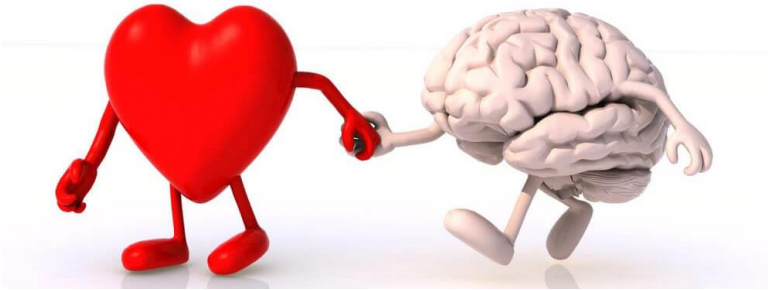
- Lack of computers and internet connection in the om
- g offsite

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

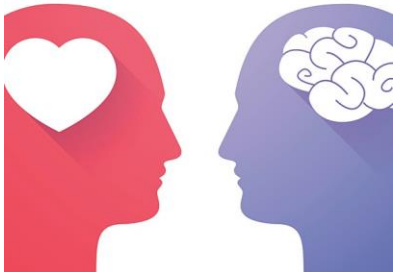
What hindered?
- Perceptions of nursing home residents
- Lack of medical team member on RIE team
- Doubt expressed as to whether frailty is an issue and whether it is already adequately managed

1. Reason for action
2. Initial State
3. Target State
4. Gap Analysis
5. Solution Approach
6. Rapid Experiments
7. Completion Plans
8. Confirmed State
9. Reflections

Why ?



Simple definition:	The way we do things around here		
Culture change	Takes Time	Can be difficult to measure	
Key notions:	Behavioural statement	Leaders must find ways to change behaviours	Behaviour changes lead to changes in beliefs which changes the culture



A Compelling Reason

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

- **48% of people over 85 die within one year of hospital admission**

Imminence of death among hospital inpatients: Prevalent cohort study
David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*

- **10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80**

Gill et al (2004) studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.
Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

Crowded emergency departments

- Dangerous
- Correlates with increased length of stay

1: Means (95% CIs) of inpatient length of stay and excess* inpatient length of stay

	Emergency department length of stay			
	≤4 hours	4–8 hours	8–12 hours	>12 hours
IPLOS (days)†	3.73 (3.53–3.93)	5.65 (5.48–5.82)	6.60 (6.31–6.89)	7.20 (6.91–7.49)
IPLOS – SALOS* (days)†	0.39 (0.21–0.57)	1.30 (1.15–1.45)	1.96 (1.71–2.21)	2.35 (2.08–2.62)

* Excess inpatient length of stay is defined as inpatient length of stay exceeding the state average length of stay for the diagnosis-related group (IPLOS – SALOS). IPLOS = Inpatient length of stay. SALOS = State average inpatient length of stay (for specific diagnosis-related group). †$P < 0.001$ for difference, on analyses of variance (ANOVA).

- Retrospective analysis of 694 patients with community acquired pneumonia
- Delayed delivery of antibiotics in 4 hours
- ED not crowded – 31%
- ED overcrowded – 72%

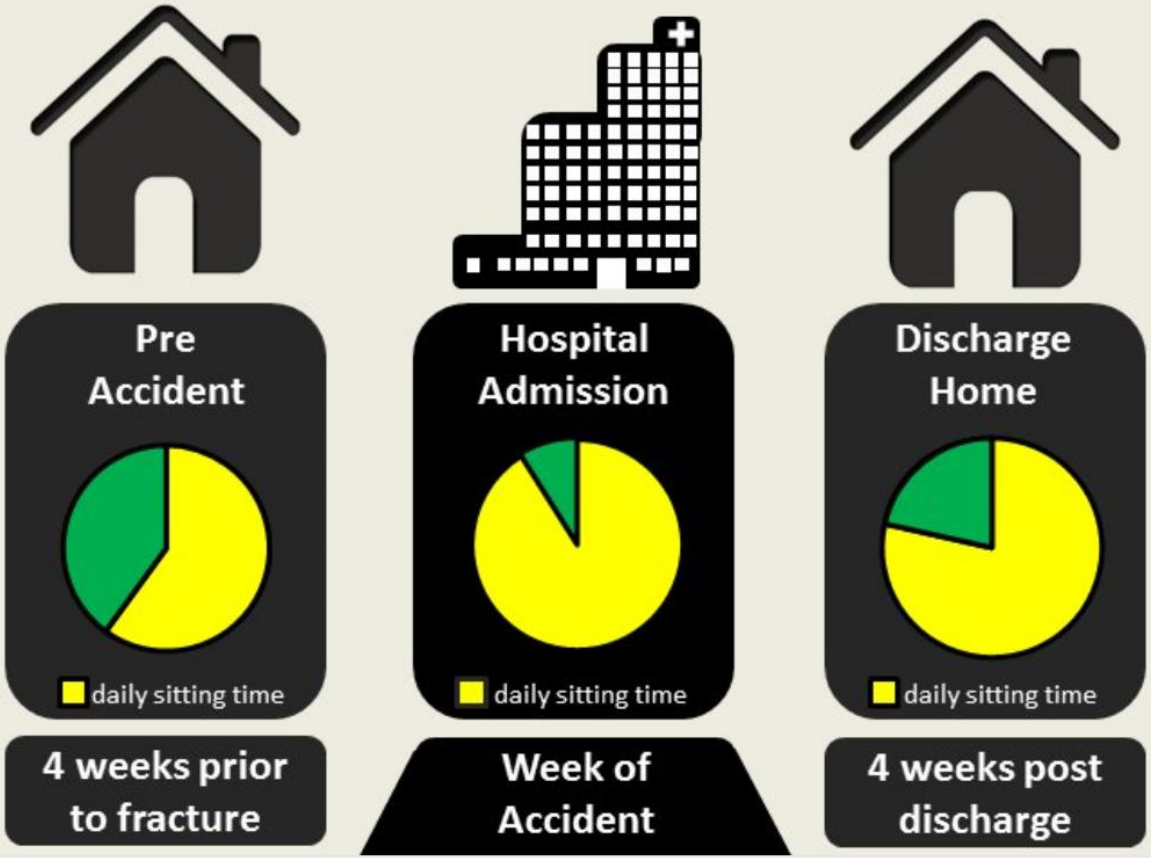
Pines JM et al. The impact of emergency department crowding measures on time to antibiotics for patients with community acquired pneumonia. Annals of Emergency Medicine, 2005, 50(5):510-516

Patients waiting over 12 hours for a bed have a 2.35 increase in their hospital length of stay.

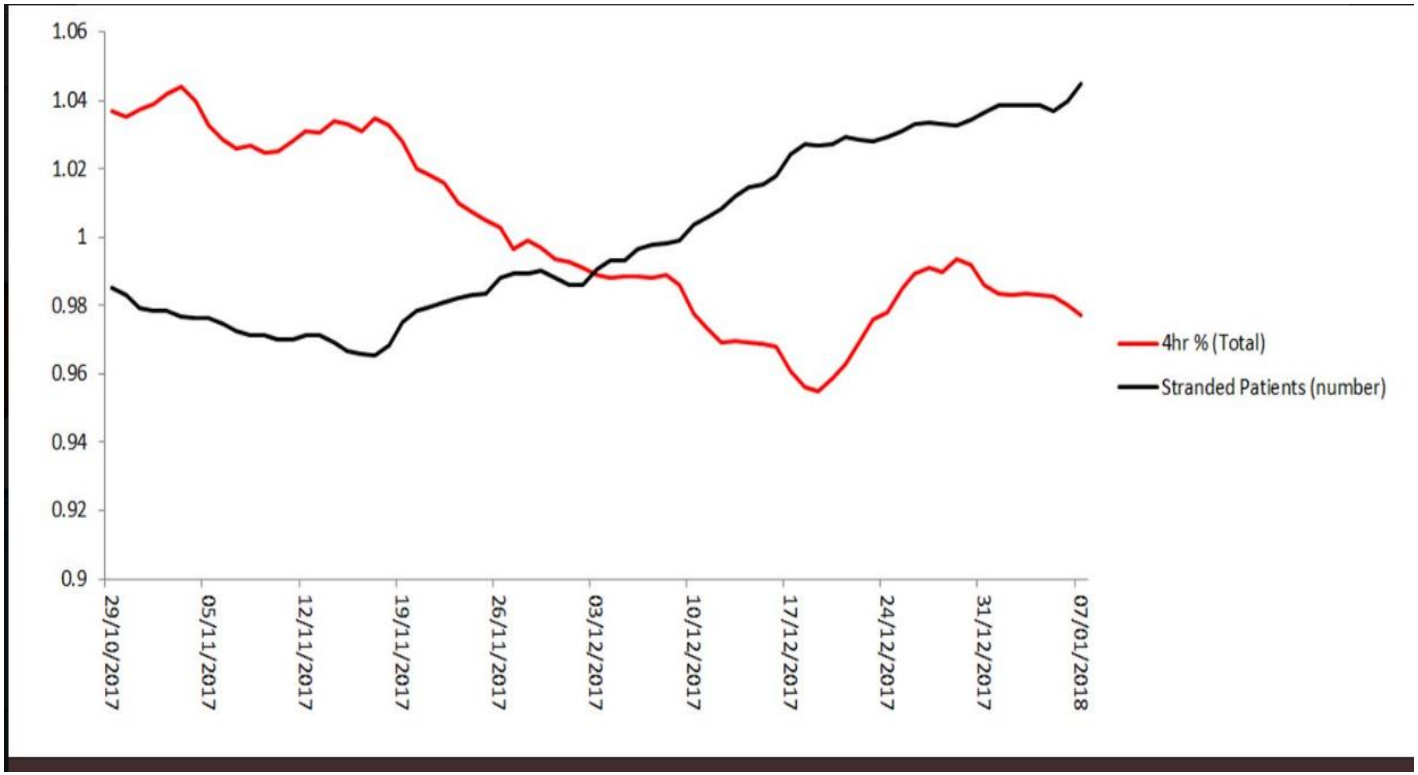
Essential drugs are delayed when an emergency department is crowded

Harvey et al. (2018) AIMS Medical Science, 5(3): 255 http://www.aimspress.com/journal/medicalScience @DrJulietHarvey

What happened to my legs when I broke my arm?



The ‘Stranded Patient’ Metric



Impact of poor access to emergency admission:

↑ LOS

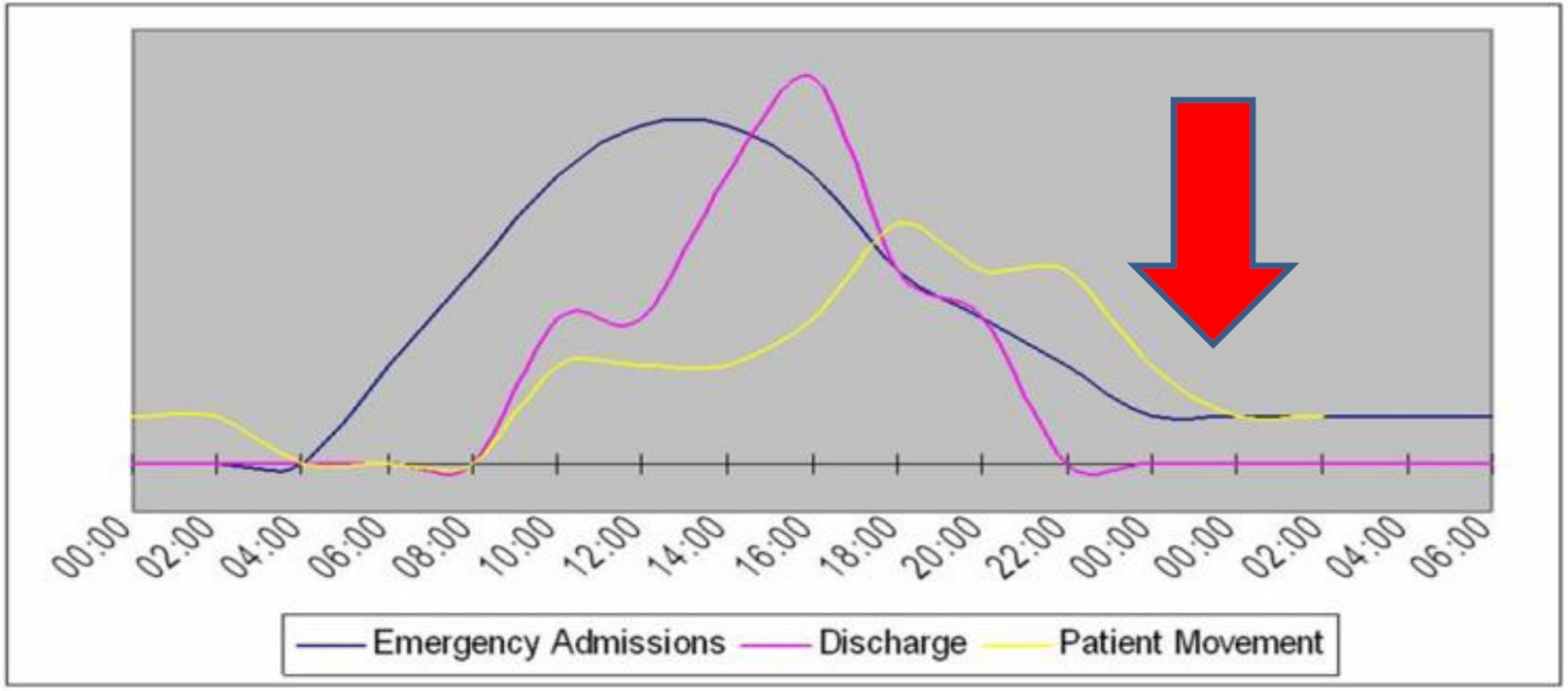
↑ Care needs

↑ Cost

↓ Quality of patient experience

Patient harm

The consequences of late transfers and discharges batched late afternoon



Vital Signs for Frailty

Abnormal is Normal
Atypical is Typical

Gait is a vital sign
Altered mental state is a vital sign
Talking is a vital sign

Is it safe to admit/ stay in hospital?
Dyspnoea/ acute confusion/ weakness

Hidden signs- feet/ inappropriate clothing, hygiene…

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

Clinical Frailty Scale

The Clinical Frailty Scale (CFS) is a quick and simple tool describing degrees of frailty based on symptoms and functional status.

- Patients scoring 1 are very fit, active and independent – during a hospital admission their aggregated risk of death is 2%.
- Patients scoring 4 – 6 are vulnerable but with a mortality risk of less than 6%.
- Patients scoring 8 are very severely frail and completely dependent, with an aggregated risk of death of 24% during that hospital admission.
- Patients scoring 9 are terminally ill with a life expectancy of less than six months.

Uses of CFS in Clinical and Disposition Decision Making

Category	CFS score	Clinical considerations	Disposition considerations
Robust	1-3	Usual care pathway, including specialist care referrals if indicated	Driven primarily by primary presenting problem
Mild frailty	4-6	Screen for presence of geriatric syndromes, refer onwards if identified (usually as outpatient)	Consider case management in discharge planning to reduce the risk of readmission
Moderate to severe frailty	7-9	Geriatric syndromes highly prevalent, ensure holistic care available, end-of-life scenarios common	Services able to deliver Comprehensive Geriatric Assessment (in hospital or at home)

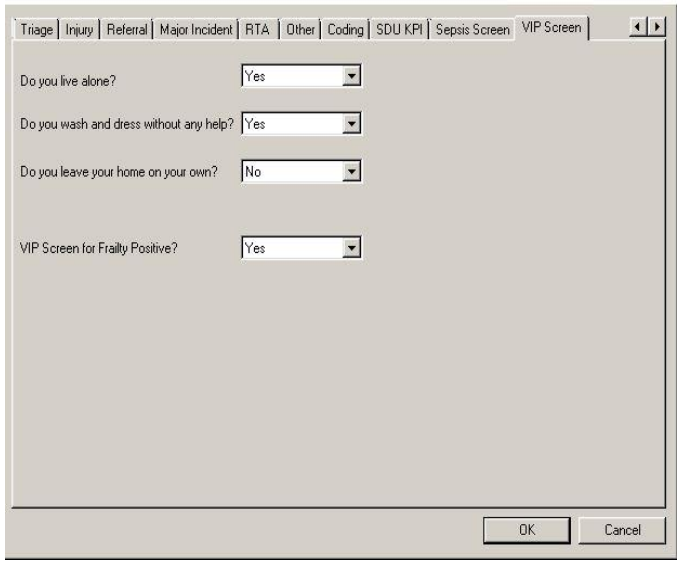
Ambulatory emergency care guide

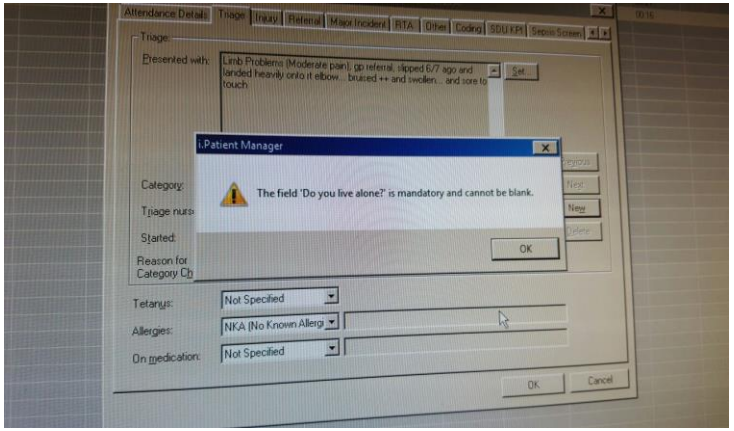
Same day acute frailty services

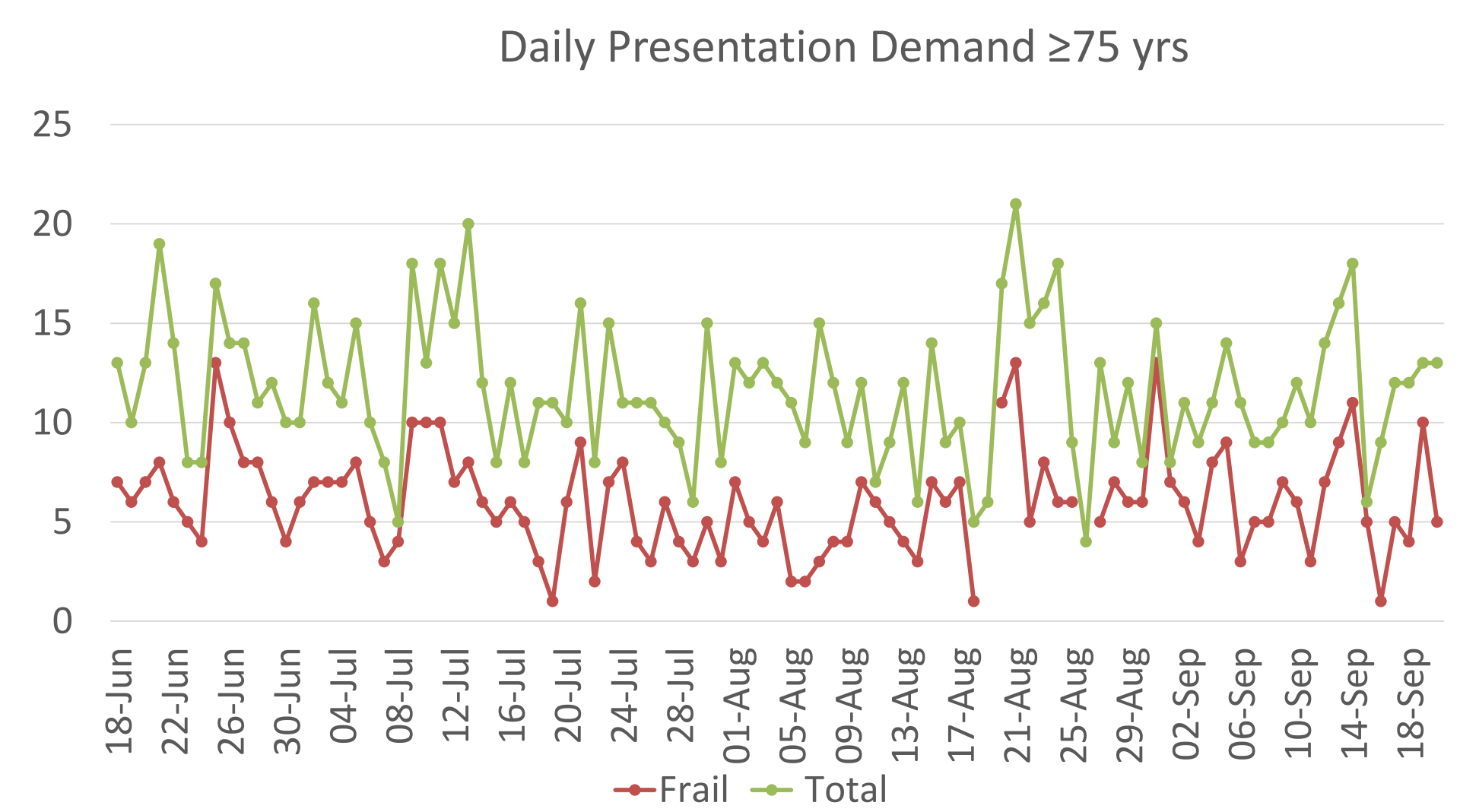
Published by NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network

June 2018

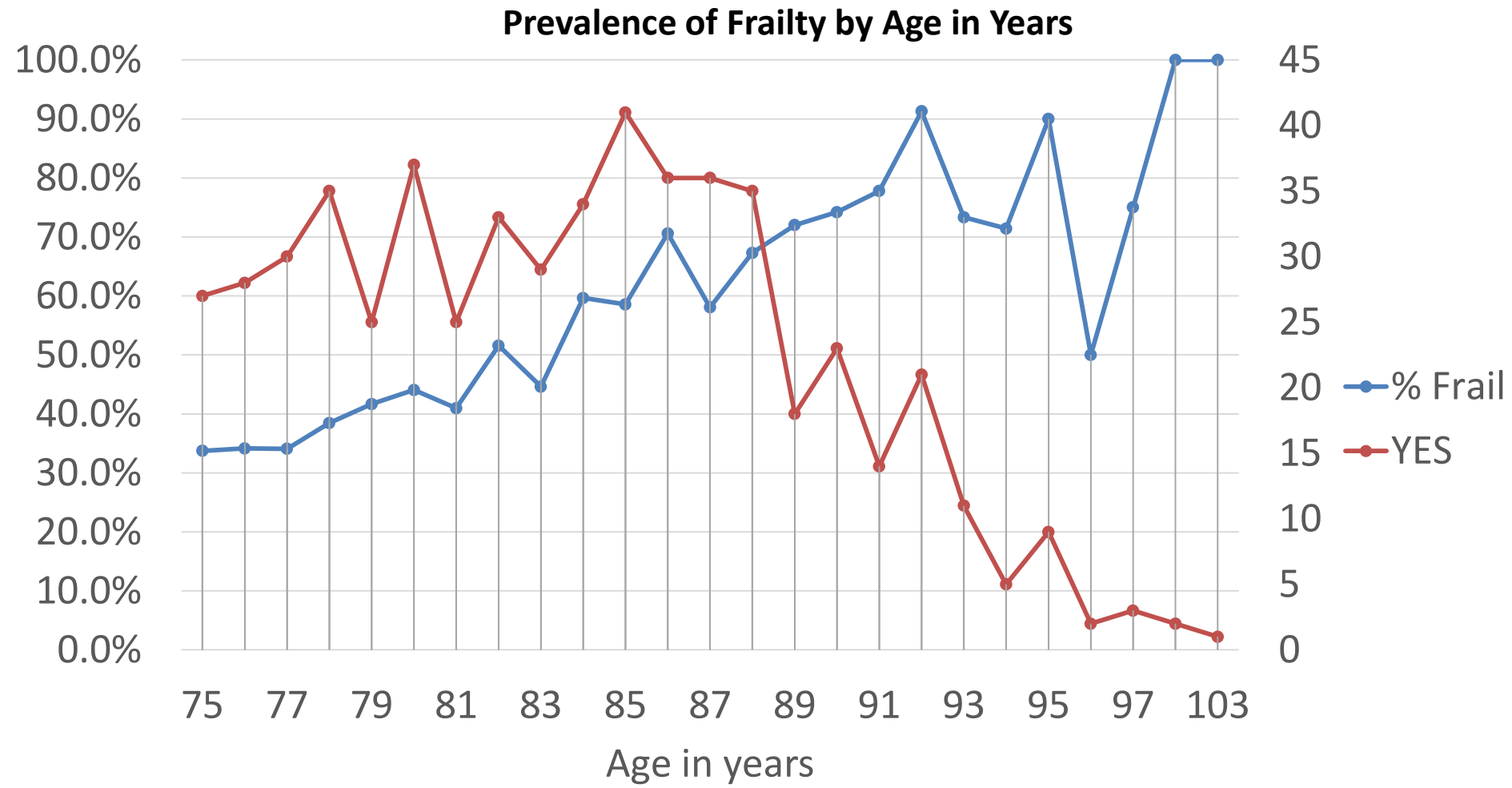
Screening on the Acute Floor







11 Presentations per Day
6 Frail
51.2% of total are frail
54.5% are admitted

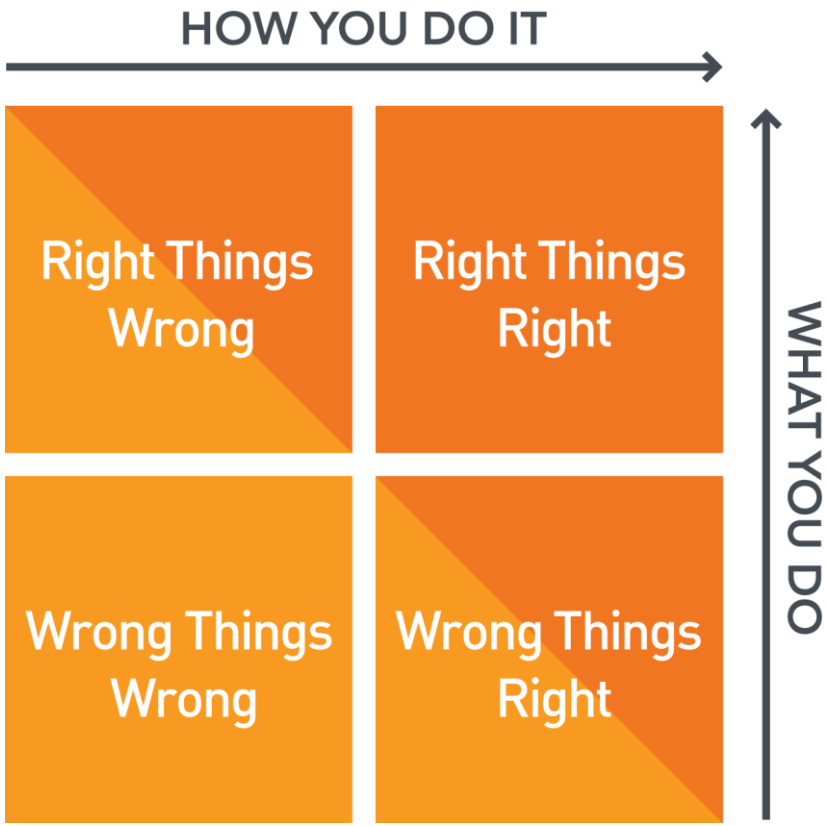

Prevalence of Frailty by Age in Years
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
45
40
35
30
25
20
15
10
5
0
75
77
79
81
83
85
87
89
91
93
95
97
103
Age in years
% Frail
YES

We need to know what good looks like

Are we ‘Finding the Frail’?
What are we doing about it?
What should we be doing about it?

Ask

‘Is it safe to admit?’



What smart Hospitals do

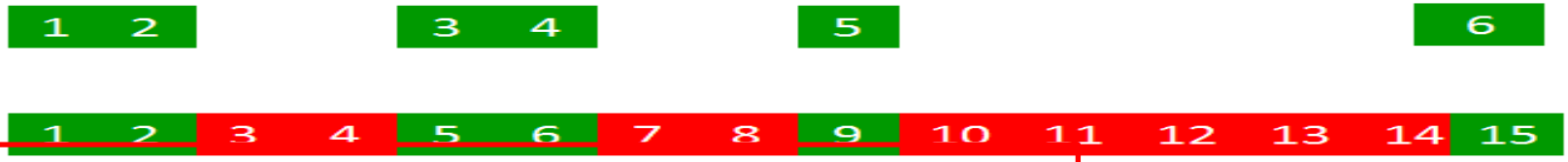
- Focus on the admission pathway (assess early and short stay)
- Maximise emergency day care (ambulatory emergency care)
- Focus on the admission pathway (assess early and short stay)
- Maximise emergency day care (ambulatory emergency care)
- Assertively manage frailty and tackle deconditioning
- Focus on down-stream flow
- Have processes to reduce delays
- Focus on simple discharges….case manage and not over assess in hospital
- Work as a system – as a team of teams

Beds are not capacity

Beds are where patients wait for the next thing to happen

Why not home – Why not home today?

Red and Green bed days



A **Red** day is when the patient no longer requires an 'acute level of care'

- Could the current interventions be feasibly (not constrained by current service provision) delivered at home?
- **If I saw this patient in out-patients, would their current 'physiological status' require immediate emergency admission?**

If the answers are 1. Yes and 2. No, then this is a '**Red** bed day'.

Examples of what constitutes a **Red** Day:

- A planned diagnostics is not undertaken as requested
- A planned therapy intervention does not occur
- Medical management plans are not reflective of interventions and required outcomes to progress the patient's pathway of care
- The patient no longer requires an acute level of care

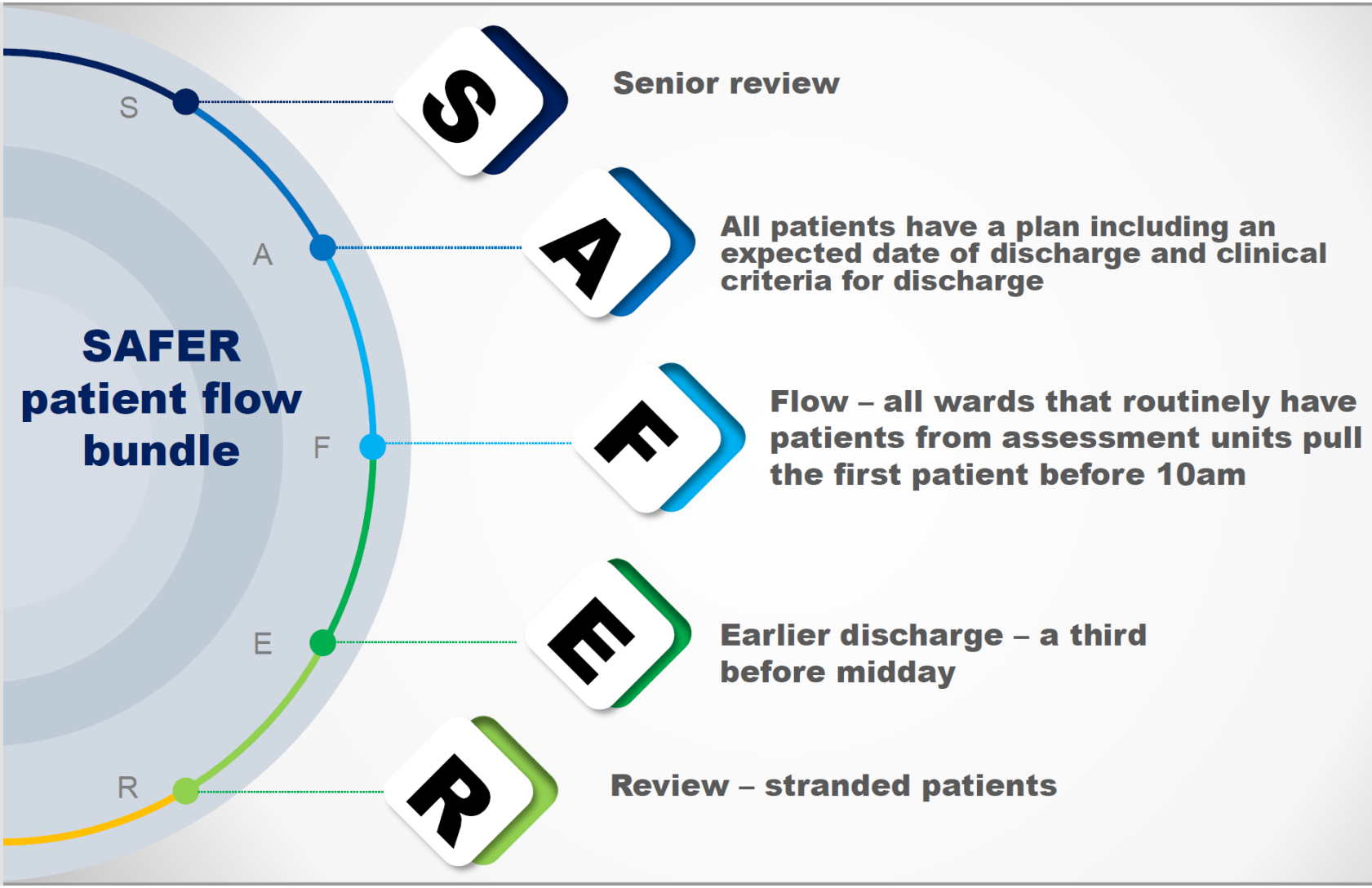
A RED day is a day of no value for a patient

A **Green** day is when a patient receives an intervention that supports their pathway of care through to discharge

A **Green** day is a day when all that is planned or requested happened on the day it is requested, equalling a positive experience for the patient

A **Green** day is a day when the patient requires an acute level of care

A GREEN day is a day of value for a patient


SAFER patient flow bundle
S
A
F
E
R
S
Senior review
A
All patients have a plan including an expected date of discharge and clinical criteria for discharge
F
Flow – all wards that routinely have patients from assessment units pull the first patient before 10am
E
Earlier discharge – a third before midday
R
Review – stranded patients

R Review all patients in hospital

7 days or more

- Escalate to MDT/ Family meetings
- Ask whether care needs to be delivered in acute setting
- What needs to be done to ensure early recovery
- What are the patient's wishes?
- Who do you need to help resolve issues?
- Develop a process to discuss and problem solve weekly with all key people in the room
- Seek same day access to community supports, using simple referral processes

4 Questions ….

patients (and families/ carers) should know the answer to:

1. Do I know what is wrong with me?
(or what is being excluded?)

This requires a competent senior assessment and discussion.

2. What is going to happen now, later today and tomorrow to get me sorted out?

The ‘inputs’ needed (diagnostic tests, therapeutic interventions etc.) with specified timelines.

3. *What do I need to achieve to get home?*

The ‘clinical criteria for discharge’ (CCD), a combination of all factors.

4. when should I expect to go home?
(if my recovery is ideal and there is no unnecessary waiting)

This is the ‘predicted date of discharge’ (PDD) which should be set at the point of admission.

An informed patient is an empowered patient

PATIENT EXPERIENCE

Name Of Ward And Hospital :
Date :

YOUR EXPERIENCE

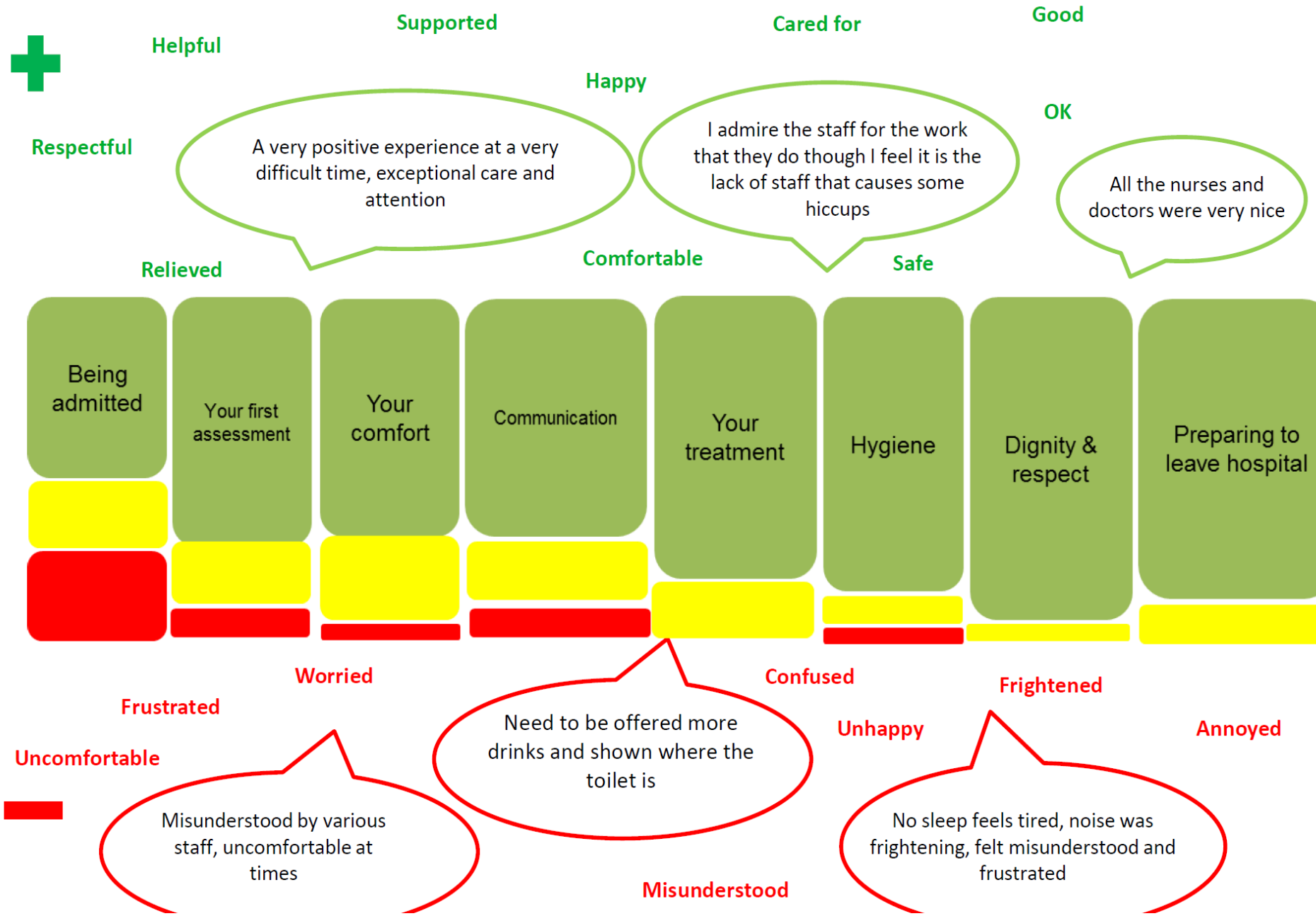
Being Admitted	Your First Assessment	Your Comfort	Communications	Your Treatment	Hygiene	Dignity & Respect	Preparing to Leave Hospital
							
Select How You Felt							

Using The List Below, What Emotion(s) Describes Your Experience?

Please Add Other Thoughts Or Feedback On Your Experience

EMOTIONS

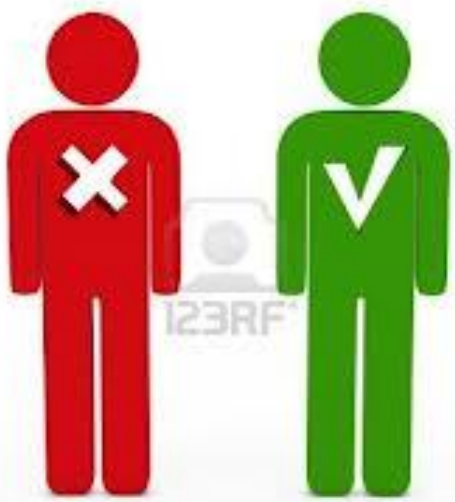
Supported	OK	Safe	Misunderstood	Uncomfortable	
Relieved	Cared for	Worried	Confused	Annoyed	Frightened
Comfortable	Good	Happy	Unhappy	+ Additional Emotion	

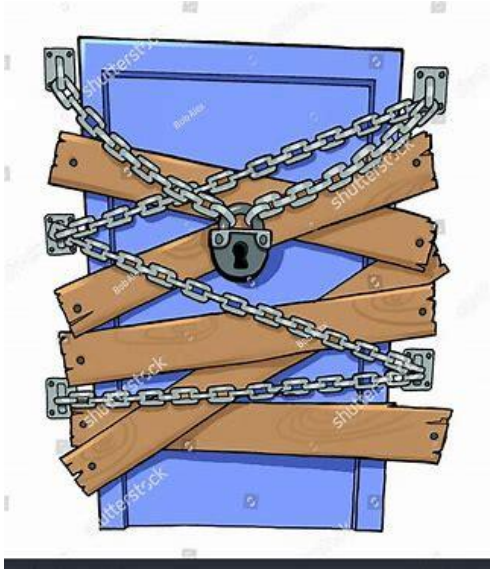

Helpful
Supported
Cared for
Good
Happy
OK
Respectful
A very positive experience at a very difficult time, exceptional care and attention
I admire the staff for the work that they do though I feel it is the lack of staff that causes some hiccups
All the nurses and doctors were very nice
Relieved
Comfortable
Safe
Being admitted
Your first assessment
Your comfort
Communication
Your treatment
Hygiene
Dignity & respect
Preparing to leave hospital
Worried
Confused
Frightened
Frustrated
Unhappy
Annoyed
Uncomfortable
Need to be offered more drinks and shown where the toilet is
Misunderstood by various staff, uncomfortable at times
No sleep feels tired, noise was frightening, felt misunderstood and frustrated
Misunderstood

HOW CAN WE CONTRIBUTE?

UNDERSTAND DEMAND TO GET OUT

- 25 to 35% of beds are filled with patients who are medically fit for a safe discharge or transfer to their next planned destination.



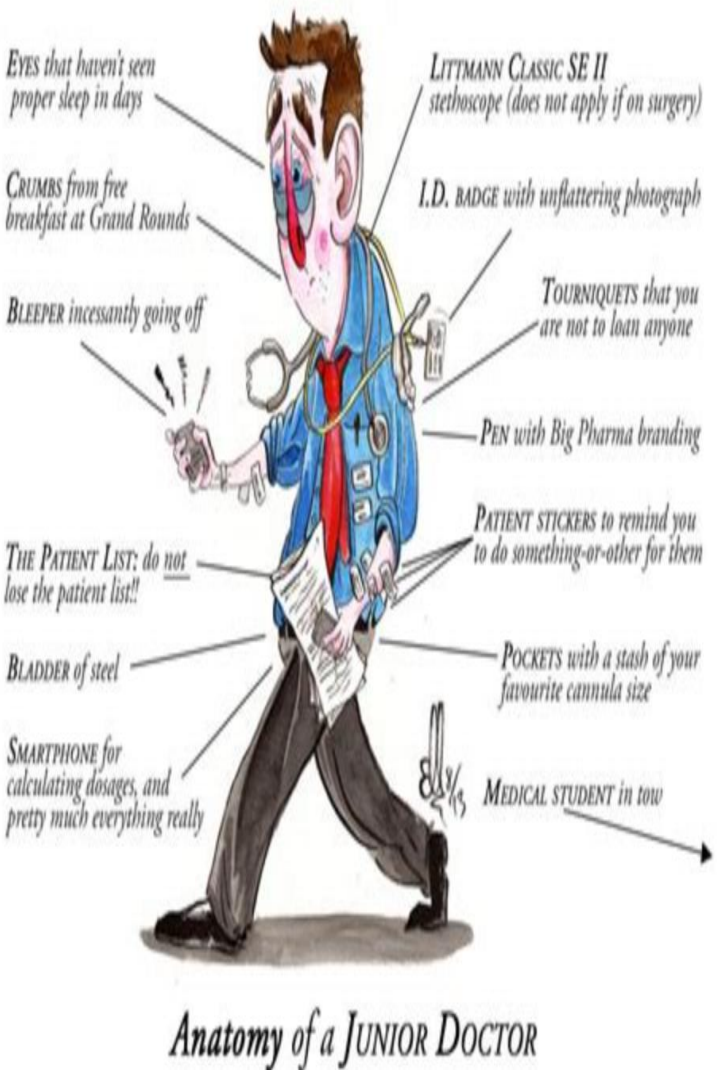


The Stranded Patient Metric

(LOS > 14 days)

Reviews of 100s of Long Stay Patients show…

- Care often delivered by Junior Doctors
  - relatively inexperienced
  - poor continuity of care
- Patients with multiple chronic problems
- Lots of symptoms/signs/abnormal test results
- More tests and referral (bloods, scans, echos, endoscopy et
- Reports
  - delays pending (further) investigations & referrals
  - complications (NBM, contrast, biopsies, infections…)
  - false (or irrelevant) positive results = **cycle repeats…**



After ≥ 21 days in hospital…

Original reason for admission is often forgotten – no longer in main stream

- Records are too large to read
- Clinical team disconnect due to ward/staff changes

Complications are common

- many iatrogenic or due to hazards of hospitalisation

Discharge planning is on hold

- Clinical management is day to day = focused on latest symptoms, signs or abnormal results
- **MDT bypass** – patient labelled "not stable" or "not ready for discharge"

Reducing the Stranded Patient Metric

- Increase visibility of Stranded Patients
- Prevention of those at risk
- Rescue those already stranded

Prevention Actions

Identify problems early
- Plan discharge before admission
- Set expectations and goals
- "Why is this patient here?" an early question
- Structured assessment - Acute InterRAI

Prevent Delirium and Sarcopaenia
- Activity
- Volunteers
- Exercise prescription

Review medications continuously

Frequent flyers – same team every time

Rescue Actions

Review by Care Team at 14 Days
- Risks of discharge overestimated
- Can the risk be changed?
- There is always a bed at home

Expert Review at Bedside of Sample at 21 Days
- Senior Executive
- Senior Clinician
- Project Nurse
- Senior Allied Health
- **Review 4 patients per week**

Guide to reducing long hospital stays

June 2018

https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf

Creating the system

=

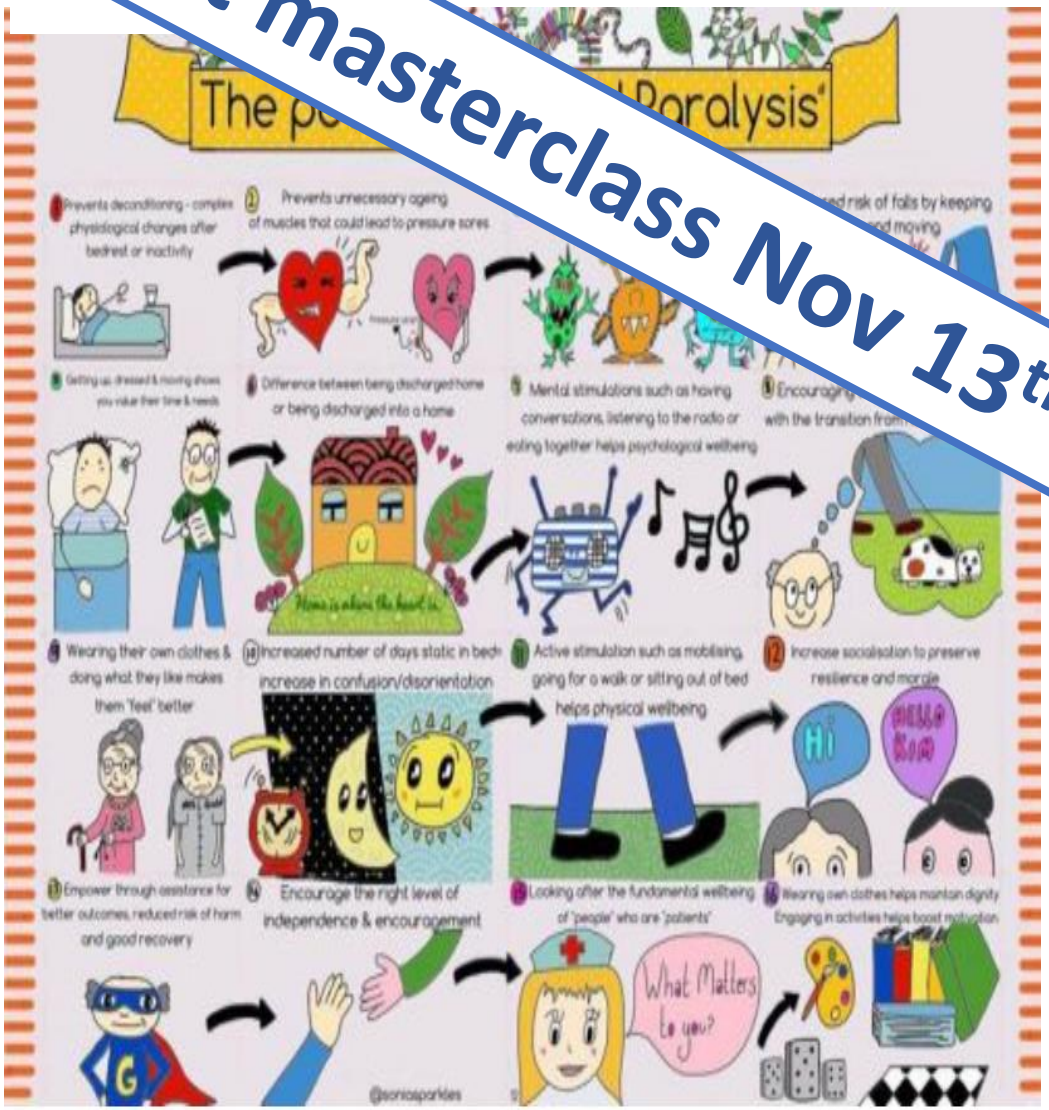
Right Patient

Right Environment

Right Time

Winning the Hearts and Minds

Next masterclass Nov 13th



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

#endPJparalysis
#homefirst
#last1000days
#redtogreen

What we will need to get the service 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

Learning from outside of Ireland

Integrated primary and Acute Care Models (PACs) in UK

-Population based accountable care model

-Aims to improve physical, mental and social health and wellbeing of local population and reduce inequalities.

-General Practice at its core

-greater focus on prevention and integrated community based care and less reliance on hospital care

-those with ongoing needs need coordinated care through integrated MDTs

- partnership working
- Data driven care model
- Integrated neighbourhood teams for populations of 30 to 50k
- Flexible workforce and technology- need to disrupt existing ways of working

Relationships and trust across system critical to success

Are we using our competencies, skills and experience to their potential?

- Waiting to be asked to see patients?
- Working 5/7?
- Working in silos- whose job is it anyway?
- Not challenging decision making
- Not advocating for our patients
- Not seeing those at risk as priorities?
- Discharging from treatment too soon
- Not challenging our culture…….our society…

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, incontinence 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

Essential components of successful implementation

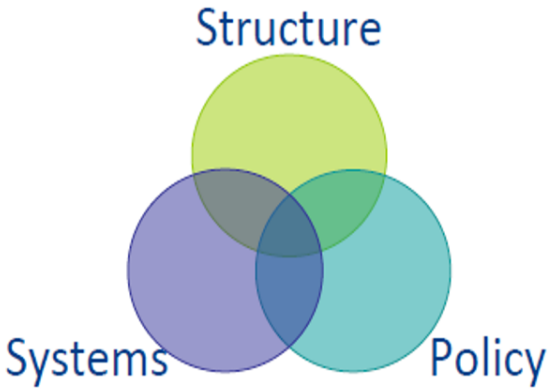
- Communication and education
- **Clinical leadership**
- Senior management support and engagement
- Measurement- simple, meaningful data
- Social momentum- win hearts and minds, share stories, identify and link with like-minded people
- Local ownership of improvement work
- **Frontline staff 'safety'**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

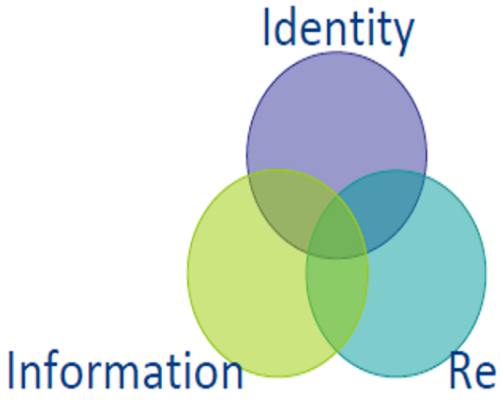
Measurement

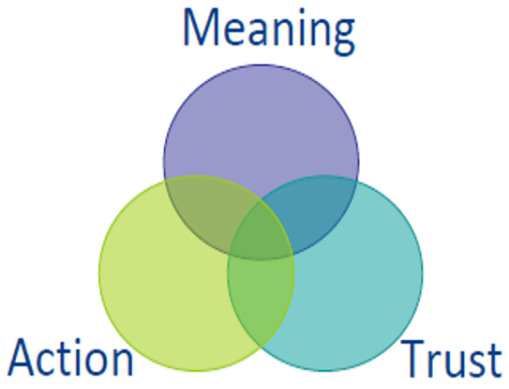
Integrated patient centric metrics

- % 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







Myron's Maxims:

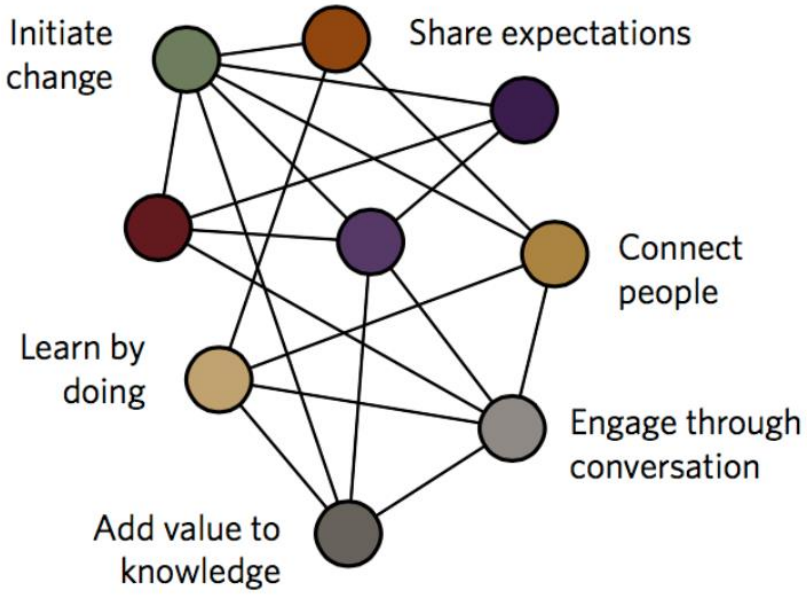
- People own what they create
- Real change takes place in real work
- The people that do the work do the change
- Start anywhere but follow it everywhere
- Keep connecting the system to itself

Key Lessons

- Focus on what matters to patients and staff
- Small projects can change the world
- Be braver
- Be kinder
- Be patient and impatient at the same time
- Be collaborative
- Be tenacious and resilient

Together we need to create an IEHG network

- Collaborate
- Co-operate



This is not a project!

Healthcare- A Complex Adaptive System

- Collection of parts
- Parts are interconnected
- Parts can act independently
- Action by any part may affect the whole

“Complex and orderly outcomes can emerge from a few simple rules, even without central control” - Paul Plesk

It is complex so keep it simple!

Thinking like a farmer

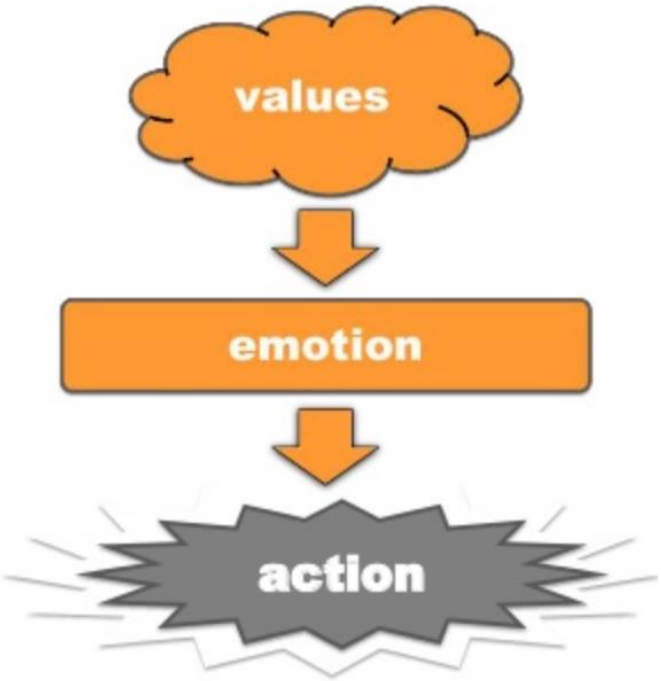
- Don’t shout at the crops
- Don’t blame the crop for not growing fast enough
- Don’t uproot crops before they haven’t had a chance to grow
- Choose the best plants (processes/people) for the soil
- Irrigate, fertilise (provide motivation)
- Remove weeds (obstacles)
- Realise outcomes are not predictable – sacking the farmer won’t help the crops grow

GOOD LEADERSHIP

- Deal with uncertainty
- Achieve shared purpose
- Create Conditions
- Enable others

Values into Action

- Values inspire action through emotion
- Emotions inform us of what we value
- Decisions to act follow emotional judgements about values



Leaders accept responsibility not only for their individual ‘part’ of the work, but also for the collective ‘whole’

Marshall Ganz

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

RAPID IMPROVEMENT EVENT

Regional Hospital Mullingar – Frail Elderly Management- First 72 hours

Grúpa Ospidéal Oirthear na hÉireann
Ireland East HOSPITAL GROUP

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 √

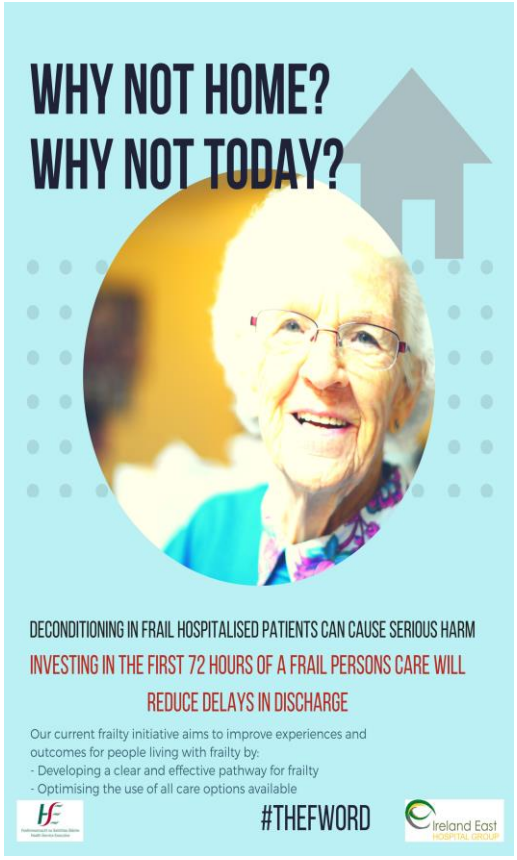
Next Steps:
Testing new way of working
Measuring for improvement
Embedding change
Sustaining improvements

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** !

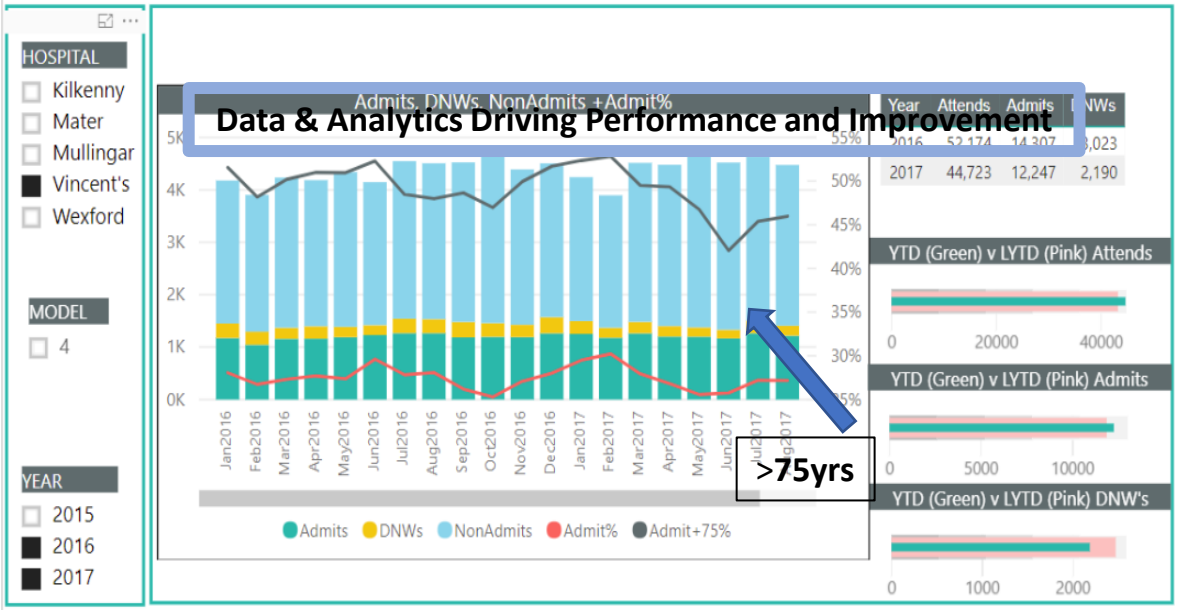
Communication & Education

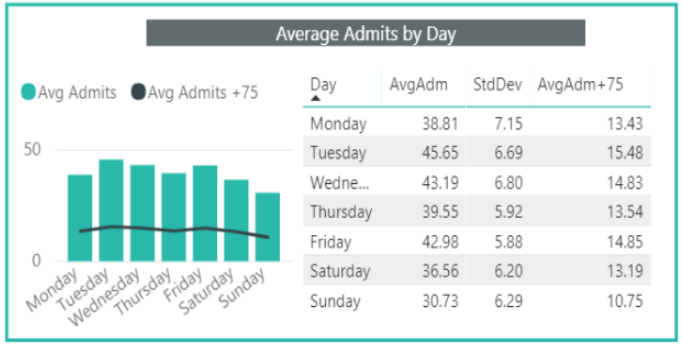


Measurement for Improvement

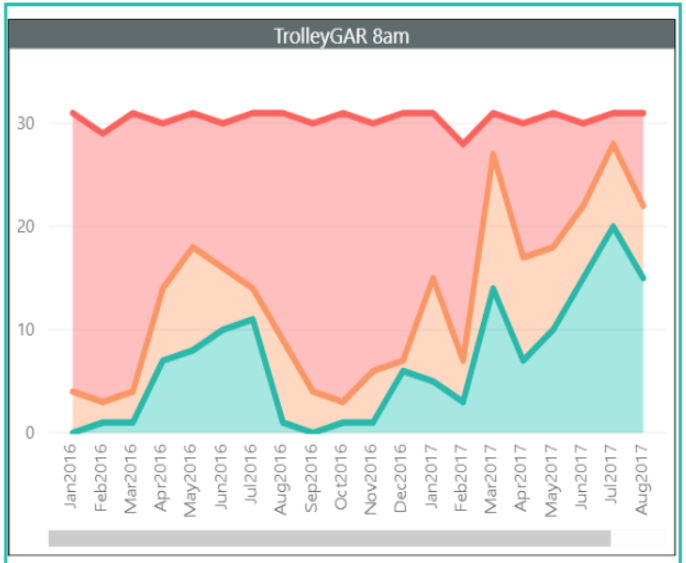
1. **Are you clear on your aim?**
2. **Have you selected the right measures to quantify the benefits?**
3. **Are you tracking the right patient groups - how do you identify these?**
4. **Can you map and quantify the flow of acutely frail patients through your system?**
5. **Will you be able to demonstrate the impact of implementing your improvements?**

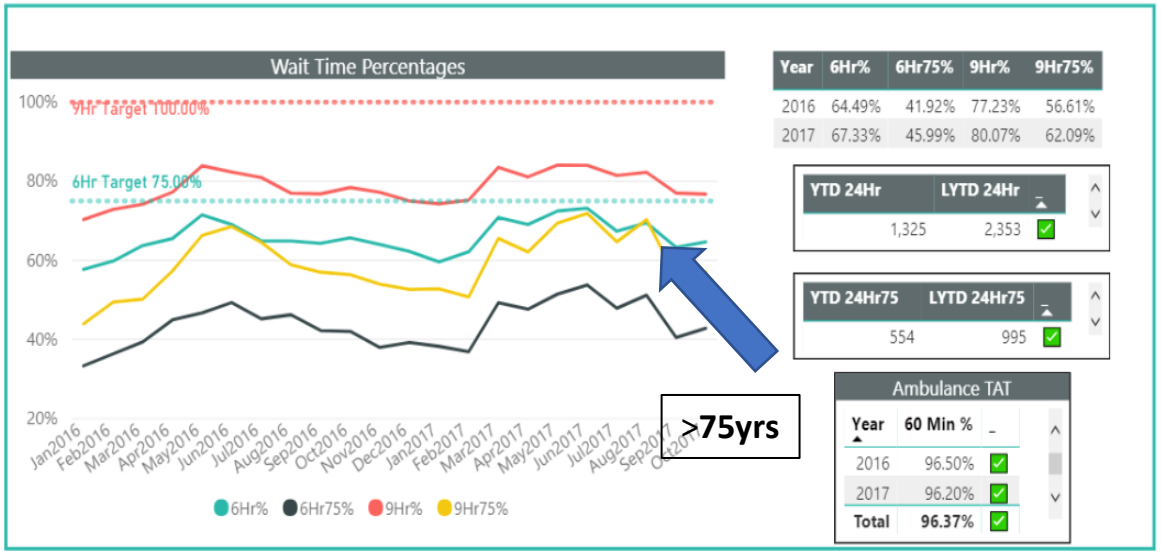
Data & Analytics Driving Performance and Improvement





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





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

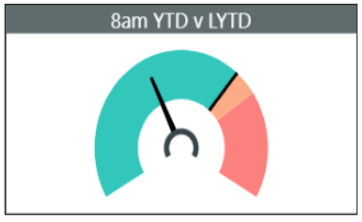
Year	60 Min %
2016	96.50%
2017	96.20%
Total	96.37%

TrolleyGAR

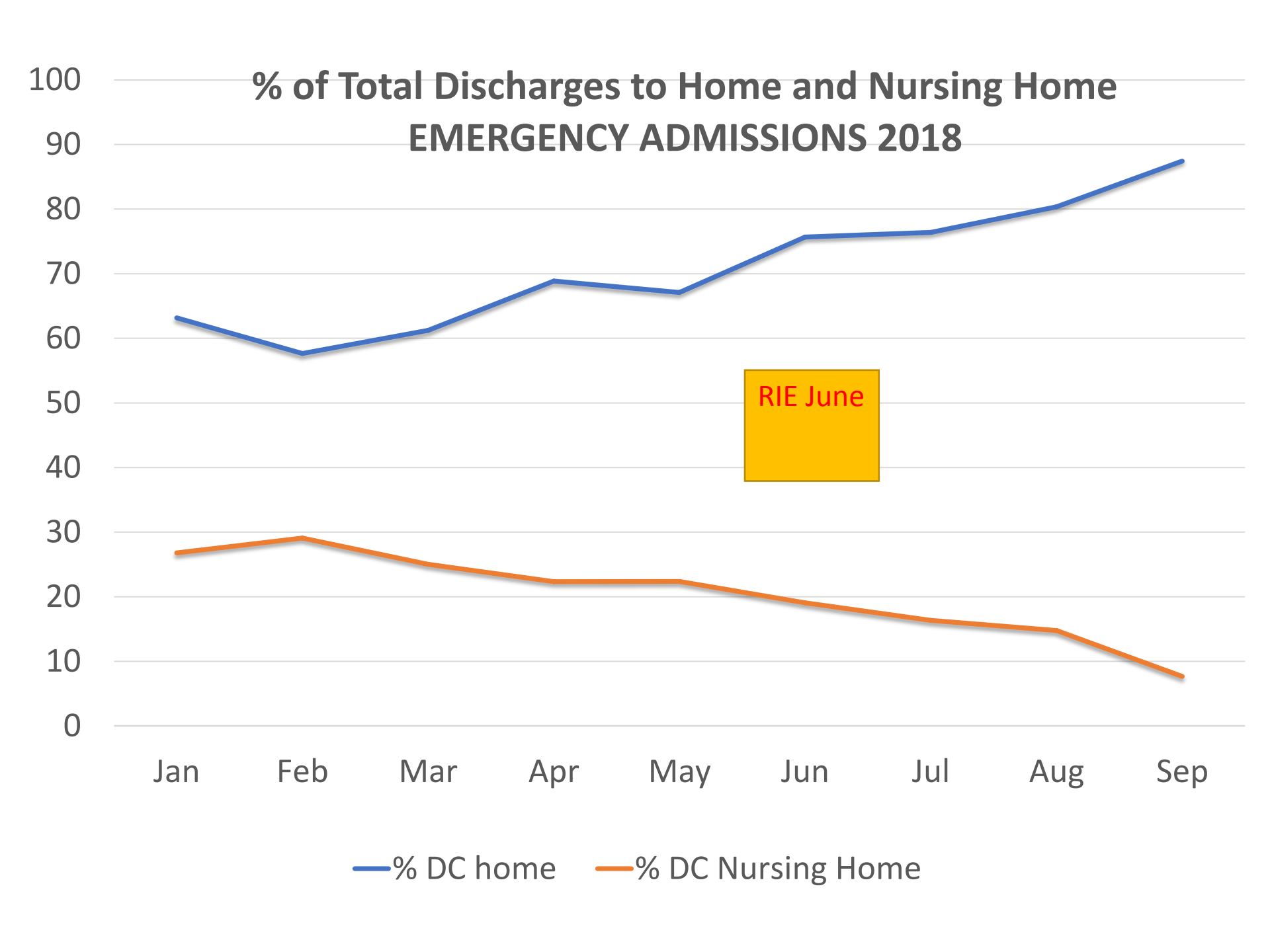
YTD 8am	LYTD 8am
2,517	4,274

Trolley/Attend Ratio

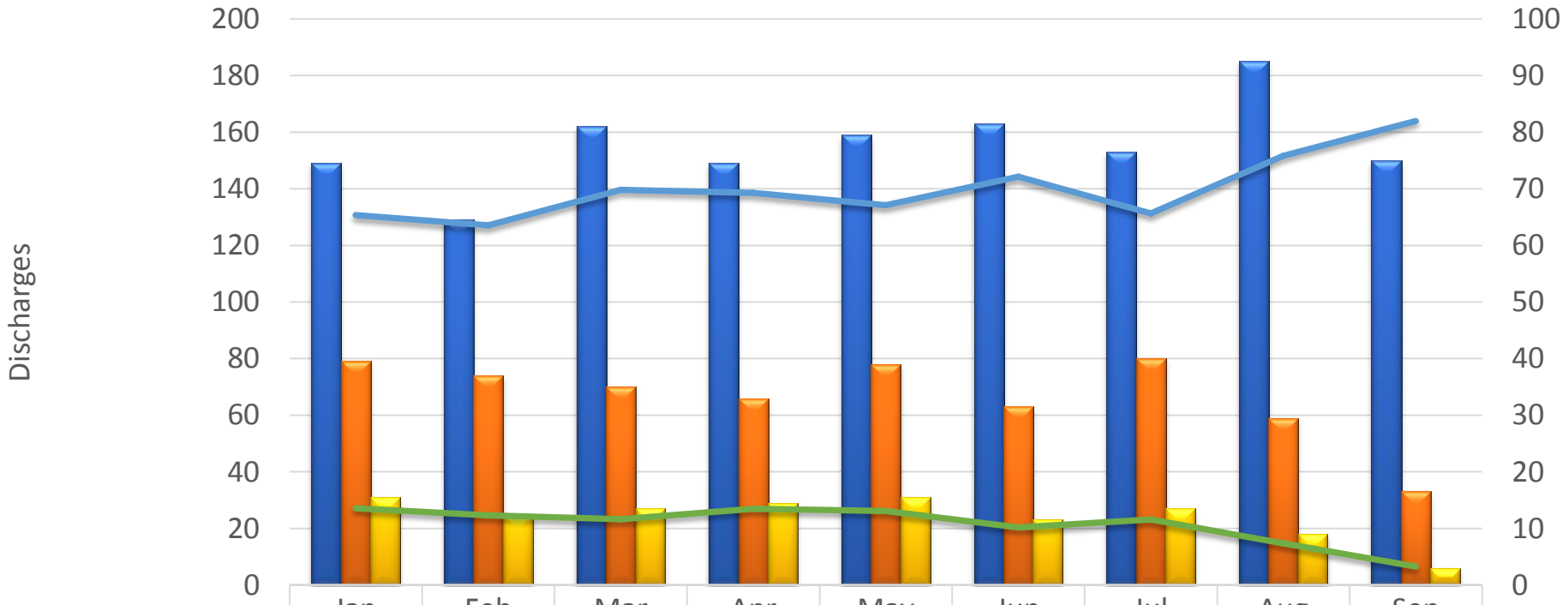
YTD	LYTD
0.06	0.10



Unscheduled Care Summary

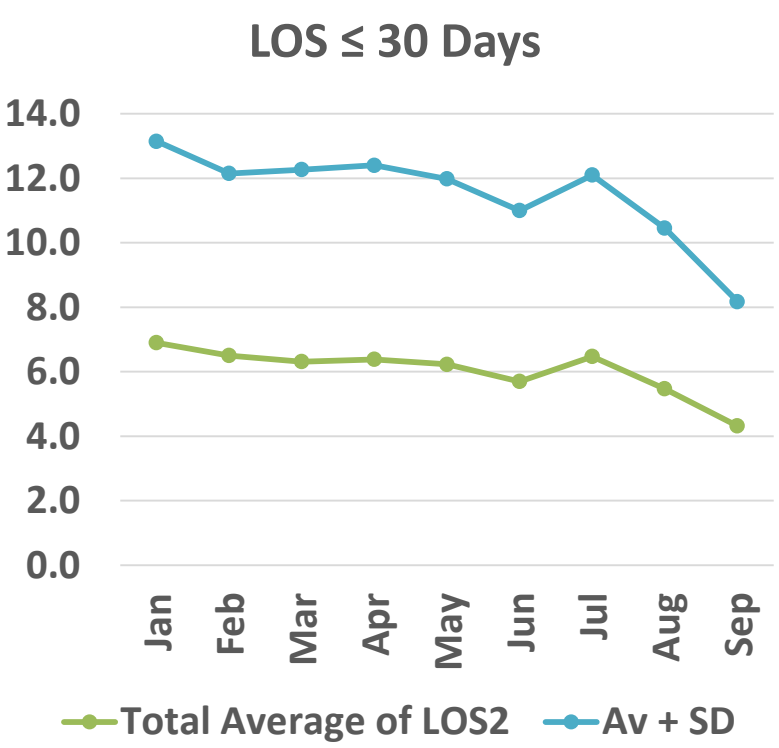

% of Total Discharges to Home and Nursing Home
EMERGENCY ADMISSIONS 2018
100
90
80
70
60
50
40
30
20
10
0
RIE June
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
% DC home
% DC Nursing Home

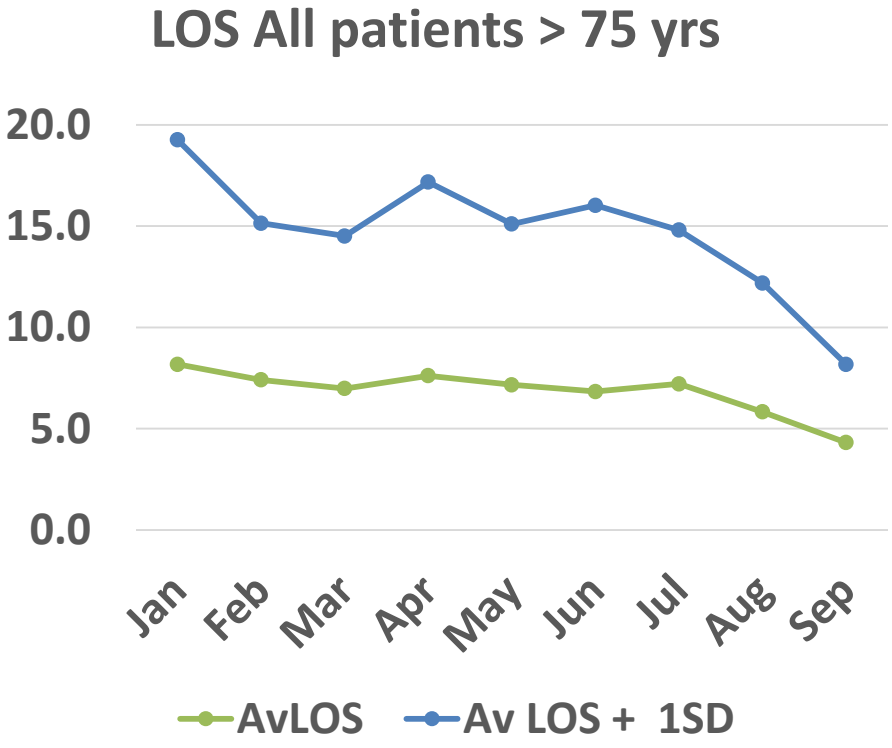
Discharge Categories



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
<=7	149	129	162	149	159	163	153	185	150
>7	79	74	70	66	78	63	80	59	33
>14 Days	31	25	27	29	31	23	27	18	6
% DC in 7 days	65.4	63.5	69.8	69.3	67.1	72.1	65.7	75.8	82.0
% DC in >14 days	13.6	12.3	11.6	13.5	13.1	10.2	11.6	7.4	3.3

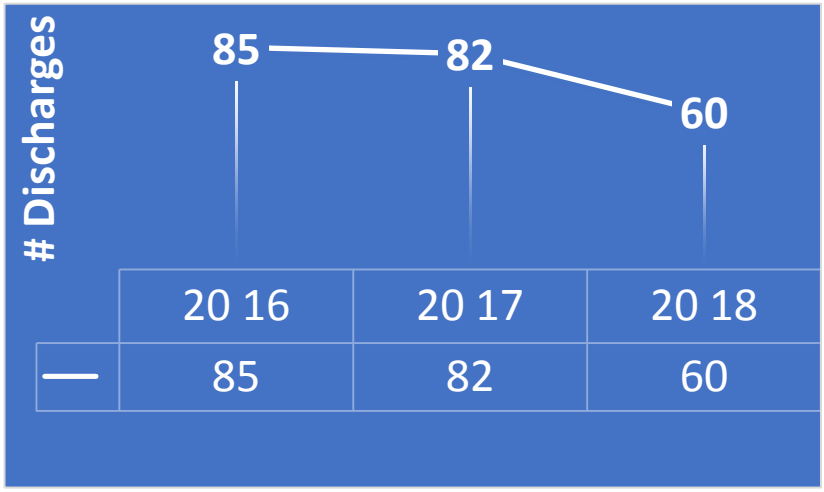
Av LOS

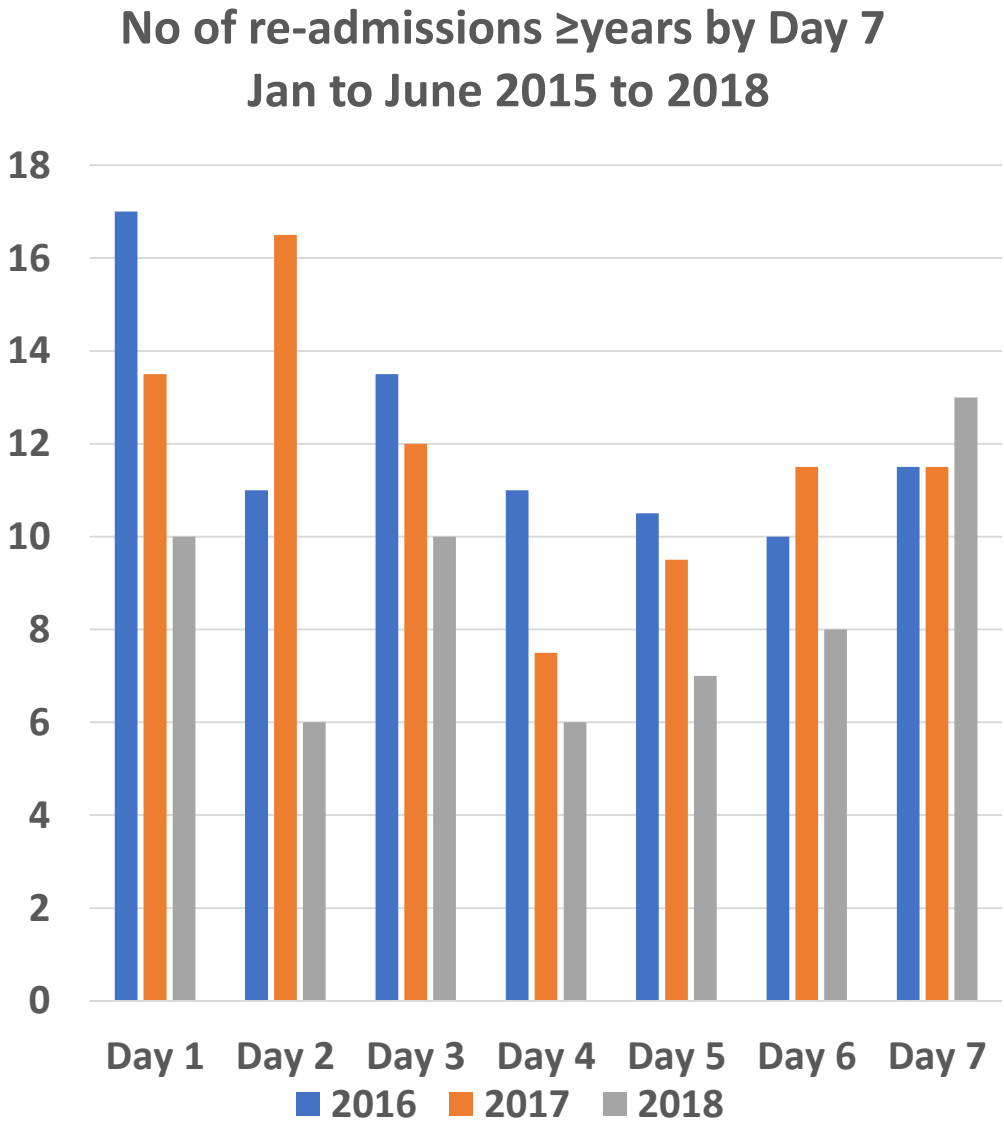

LOS ≤ 30 Days
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Total Average of LOS2
Av + SD


LOS All patients > 75 yrs
20.0
15.0
10.0
5.0
0.0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
AvLOS
Av LOS + 1SD

7 day re-admission Rate

Reduction in 7 day re-admissions of **29.4%**



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IEHG Service Improvement Team are hosting:

Shifting the Curve in Frailty

Integrating Services for Older People

When: November 13th, 9am – 4pm

Where: Freeman Auditorium, Mater Hospital

Grúpa Ospidéal Oirthear na hÉireann

Ireland East HOSPITAL GROUP

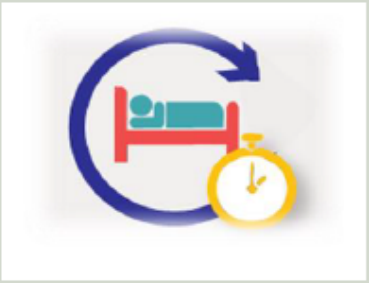
UCD DUBLIN

An opportunity for IEHG sites actively engaged in the Frailty Value Stream improvement journey to come together to celebrate and share success to date:

Risk stratification and streamline

Development of Frailty Intervention Teams

Integration at the Front Door



Thank You

In the final analysis, change sticks when it becomes the way we do things around here

John P Kotter

Helpful links

Framework for Improving quality

www.qualityimprovement.ie

Improvement Knowledge and Skills Guide

http://www.hse.ie/eng/about/Who/QID/aboutQID/

Follow us on Twitter **@QITalktime**

Missed a webinar – Don't worry you can watch recorded webinars on HSEQID QITalktime page

Next QI Talktime: Tuesday 27th November

PlayDecide: Patient Safety - a new "serious game" learning tool for health professionals to discuss patient safety and error reporting

Speakers: Members of the Health Systems Team, UCD

Thank you from all the team @QITalktime
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Noemi.palacios@hse.ie

QI TALK TIME
Building an Irish Network of Quality Improvers