Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

QI TALK TIME

Building an Irish Network of Quality Improvers

Living with Frailty: Take a Walk in my Shoes

1pm Tues March 19th
2019

Connect **Improve** **Innovate**

Speakers

Alison Enright: Is the HSCP Development Manager to the newly established National Health and Social Care Professions Office in the HSE. Previously OT Manager in Beaumont Hospital, Dublin. Alison pioneered and co-led the development of Beaumont Hospital's Clinical Redesign and Workload Measurement Programme (CReW) which is due to be extended to selected sites nationally. Alison has a strong track record in leading service improvement programmes.

Noleen Burke: Senior Physiotherapist graduated from UCD with a BSc Physio and an MSc in Sports Physiotherapy in 2007. Her role has evolved in recent years to focus on Falls Prevention and Frailty. She is team lead Frailty in Mullingar Hospital where they have developed a Frailty pathway, which received a commendation at the Irish Healthcare Awards 2018 and the Health Service Excellence Awards 2018.

Yvonne O Riordan: Senior Occupational Therapist, graduating from the University of Limerick. She joined Beaumont Hospital in 2014, attending to needs of the older person, from ED to acute and specialist geriatric wards. Yvonne has a keen interest in enhancing care outside of hospitals - focused on early detection of delirium and delirium awareness, frailty interdisciplinary education and integrated care. Yvonne is a facilitator on the RSCI Nursing Education Diploma on the rehabilitation of the frail older person.

Danielle Reddy: Senior Occupational Therapist in St. Luke's General Hospital, Carlow-Kilkenny. She graduated with a BscHons Degree in Occupational Therapy at Coventry University in 2007. She has been working with the Geriatric EMergency Service in Feb 2017, improving the service of geriatric interdisciplinary care for frail elderly at the front door. She successfully ran the end pj paralysis movement throughout hospital in 2018 and is spreading this concept into the community i

Instructions

- Interactive

- Sound:

Computer or dial in:

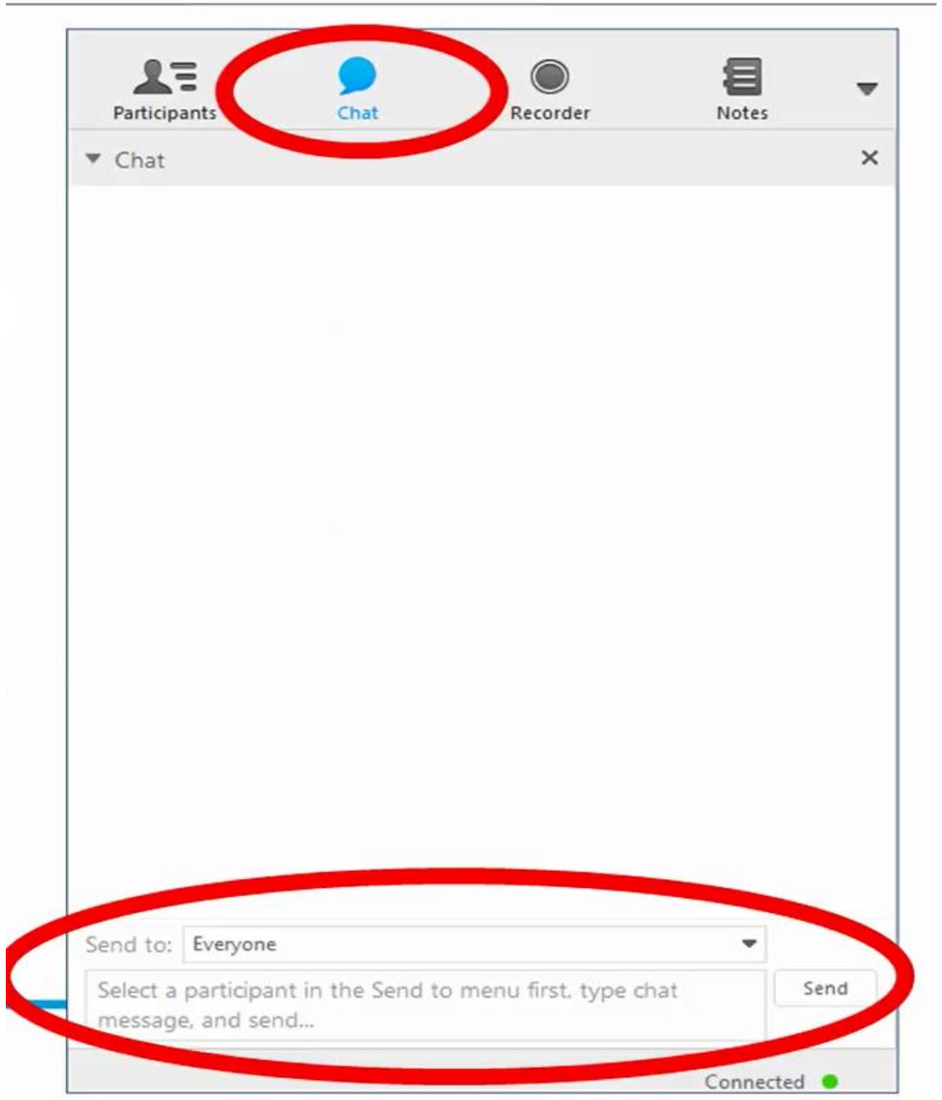
Telephone no: 01-5260058

Event number:841 079 331#

- Chat box function
  - Comments/Ideas
  - Questions

- Keep the questions coming

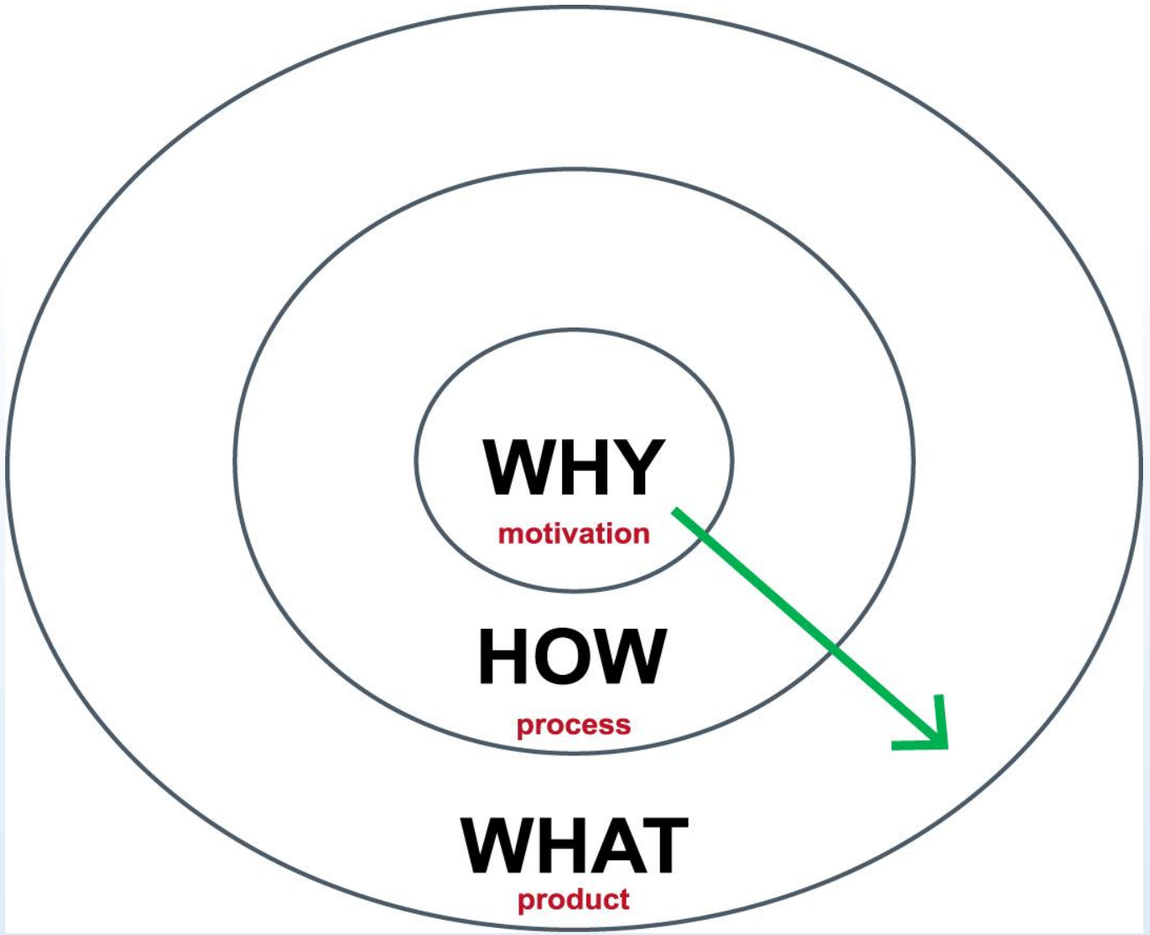
- **Twitter: @QITalktime**

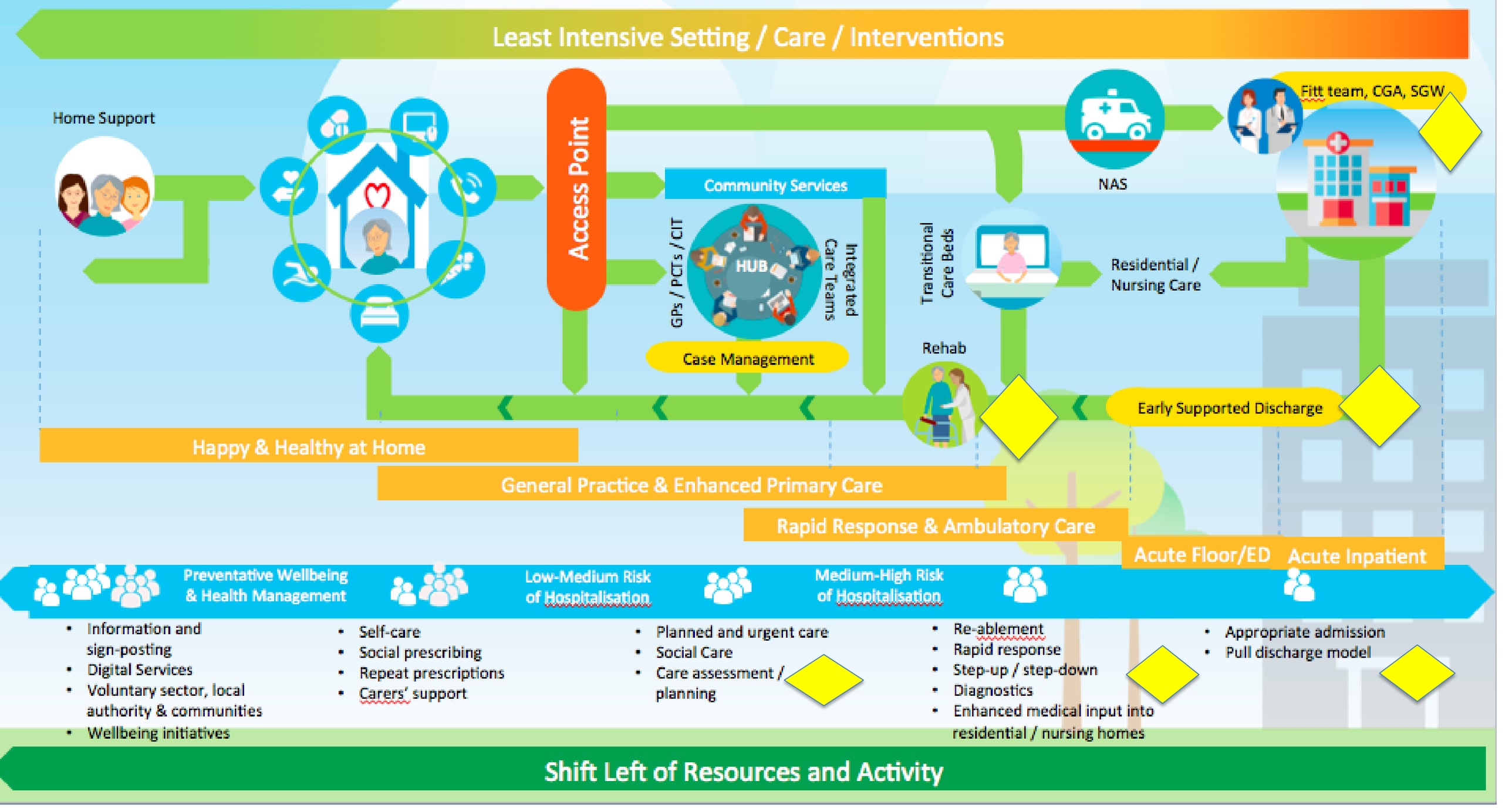


Living with Frailty:
Take a Walk in My Shoes

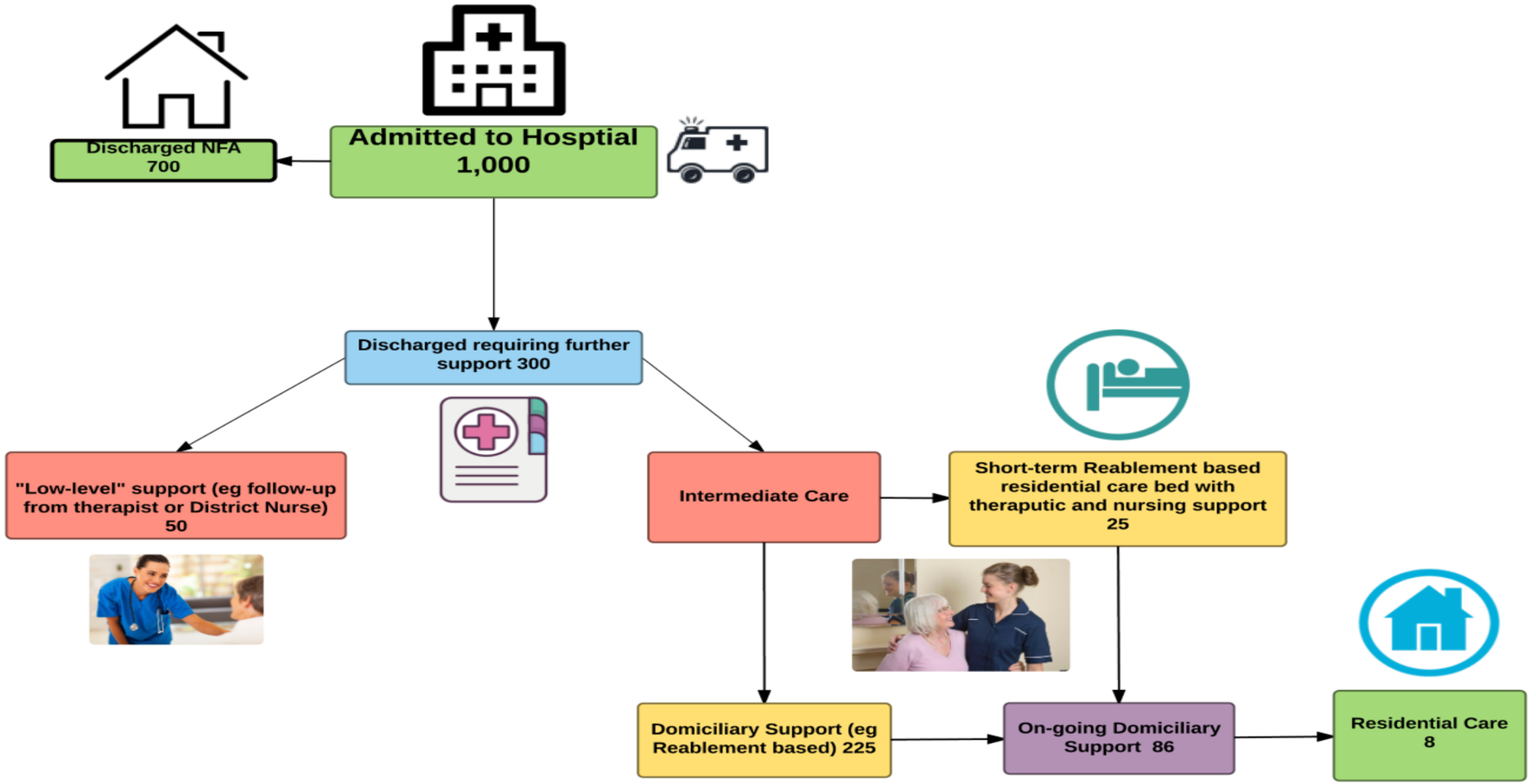
Alison Enright – National HSCP Office
Noeleen Bourke – Mullingar Frailty Intervention Team (MFIT)
Danielle Reddy – Geriatric Emergency Services (GEMS), St. Luke's Hospital
Yvonne O'Riordan – Frailty Intervention Therapy Team (FITT), Beaumont Hospital

Reshaping Patients' Care




Least Intensive Setting / Care / Interventions
Home Support
Access Point
Community Services
GPs / PCTs / CIT
HUB
Integrated Care Teams
Case Management
NAS
Fitt team, CGA, SGW
Transitional Care Beds
Residential / Nursing Care
Rehab
Early Supported Discharge
Happy & Healthy at Home
General Practice & Enhanced Primary Care
Rapid Response & Ambulatory Care
Acute Floor/ED
Acute Inpatient
Preventative Wellbeing & Health Management
Low-Medium Risk of Hospitalisation
Medium-High Risk of Hospitalisation
Information and sign-posting
Digital Services
Voluntary sector, local authority & communities
Wellbeing initiatives
Self-care
Social prescribing
Repeat prescriptions
Carers' support
Planned and urgent care
Social Care
Care assessment / planning
Re-ablement
Rapid response
Step-up / step-down
Diagnostics
Enhanced medical input into residential / nursing homes
Appropriate admission
Pull discharge model
Shift Left of Resources and Activity

What Smart Hospitals Do



(https://ipc.brookes.ac.uk/publications.html)

Comprehensive Geriatric Assessment

Noeleen Bourke, MFIT Team Lead

Comprehensive Geriatric Assessment (CGA)

Evidence Update

- ‘Multi-disciplinary diagnostic and therapeutic process conducted to determine the medical, mental & functional problems of older people with frailty so that a co-ordinated treatment and follow up plan can be developed’ *(Ellis et al. 2017)*
- The NCPOP recommends that all older adults identified as being frail or at risk of frailty should have a timely CGA performed and documented in their permanent health record *(HSE 2012)*
- Older people who receive CGA rather than routine medical care after admission to hospital are more likely to be living at home and are less likely to be admitted to a nursing home at up to a year after hospital admission *(Cochrane Review, 2016)*

CGA Components Outlined

- History of presenting complaint
- Past medical history
- Cognitive Assessment
- Vision & Hearing
- Swallow & Speech
- Malnutrition Screen
- Pharmacology
- ADLs
- Mobility
- Falls
- Continence
- Sarcopaenia
- Depression/loneliness/isolation
- Skin Integrity
- Pt & family preferences
- Carer stress
- Safeguarding
- Any other concerns

Clinical Frailty Scale

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.

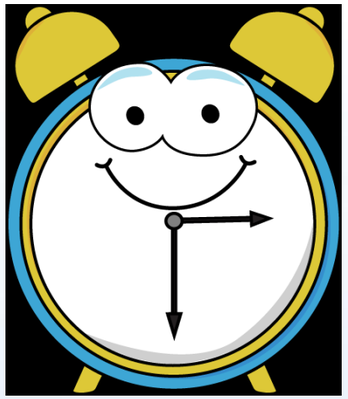
DALHOUSIE UNIVERSITY *Inspiring Minds*

Benefits for Patients…

- **Comprehensive assessment** of needs, beyond their presenting symptoms
- Identifies the patient's needs as **early** as possible
- Enables the patient to be **referred early to HSCP services** – assessment, diagnosis, rehabilitation, interventions
- Ensures the **patient is mobilised early** for best outcome
- Supports the patient journey by **ensuring timely communication of information** between hospital and community services
- **Supports patient choice** as patient's wishes are identified early in his/her journey
- Supports **an inclusive approach with family** – information is gathered from family in the Emergency Department & initial advice is given there
- Enables patients to receive the ***right treatment,*** **in the** ***right place,*** **at the** ***right time,*** **by the** ***right person***
- Supports **patients to choose 'home first'** during what is often their last 1000 days

Benefits for Staff…

- "**Clear image of patients' needs** before I go to see them."
- "I know when a CGA has been completed that my **patient's safety needs have been addressed**. I feel more confident in discharging patients home when a CGA has been completed by MFIT."
- Referrals are being received more quickly with fewer 'last minute' referrals to assess safety for discharge home. This, in turn, **aids planning and prevents discharge delays**.
- **More appropriate referrals** to hospital & community staff.
- **Improved communication, teamwork** and profile amongst HSCP group.
- CGA accepted as a referral in primary care. Completed CGAs provide more information, which **helps prevent duplication and enables primary care colleagues to prioritise patients.**
- CGA provides an **early opportunity to identify & address future risks.**
- Information from **SLT community assessments obtained at front door** & communicated to staff.
- CGA also serves as an **initial *database,* reducing duplication and staff time**.



Geriatric Emergency Services (GEMS)

St. Luke’s Hospital, Kilkenny

Danielle Reddy, GEMS Senior Occupational Therapist

Streaming from the Acute Floor

Senior decision making at the front door is vital to stream patients to the right place to receive the best care and outcomes.

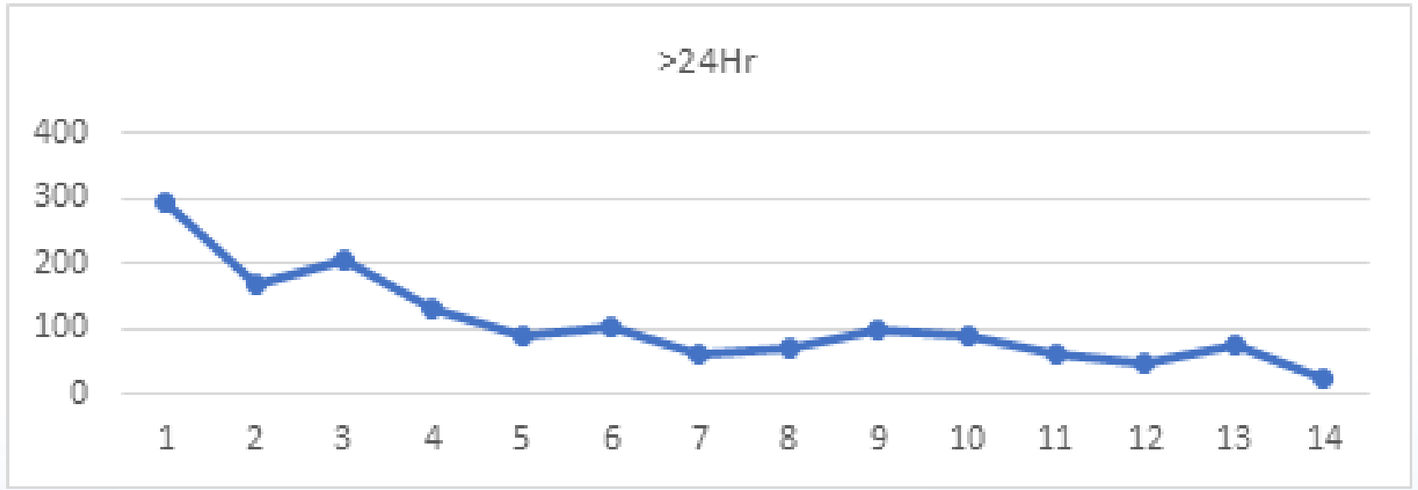
In 2018:

- ✓ 20% patients admitted went to specialised geriatric ward
- ✓ 86% of those returned to their own residence
- ✓ 5% newly listed for long term care

Right Place, Right Time, Right Care

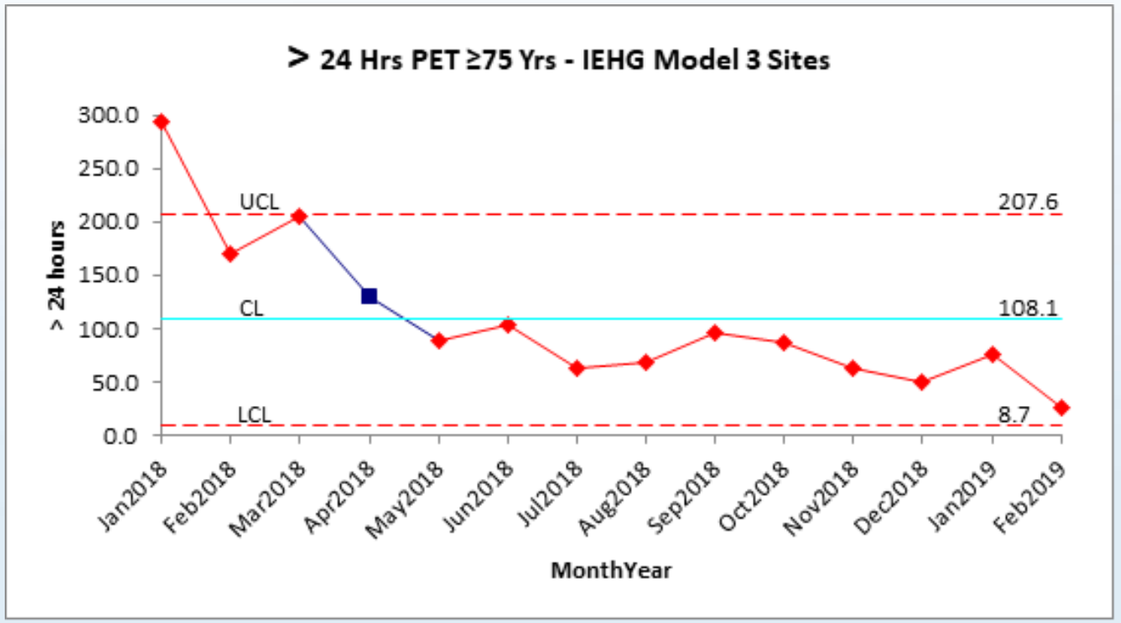
2017		2018		Improvement Outcomes
LOS		LOS		
Median	8 Days	Median	7 Days	↓ 1 day
Same Day D/C	86	Same Day D/C	157	↑ 83%
		Potential Turn Around 156		Actual front door turn arounds 56%
Readmission (178)	Av: 14.3 Med: 14	Readmission (232)	Av: 12.4 Med: 11	↓13% ↓21%
7 day	Av: 4.3 Med: 5	7 day (86)	Av: 3.8 Med: 4	↓12% ↓20%
Rehab / Other Hospital	88	Rehab / Other Hospital	130	↑48%

PET Time >24hrs over 75 year olds



Reduction of 76% (n:492)

Below the control limit since May 2018
(4) IEHG Model 3 Hospitals



Where GEMS are … Good Practice?

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

ED & AMAU

Teams

- **A(cute Floor) GEMS**
- **H(ome) Team**
- **i(ntegrated) GEMS**

Same day GEMS (A) → Home

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

GEMS Inpatient Unit <72 hours> #Red2Green #SAFER #HomeFirst #WhatMattersToYou → D2A / Rehab

Stranded patients (H) *'Manage the back door as aggressively as the front door'* → NH

The Digital Age

Dynamic 365 CRM System

- Communication – integration with community partners, thorough seamless service across sectors
- Time – live data, onsite changes
- Data security/ access – professional and secure data collection & efficient measurement tool
- Cost saving, too!

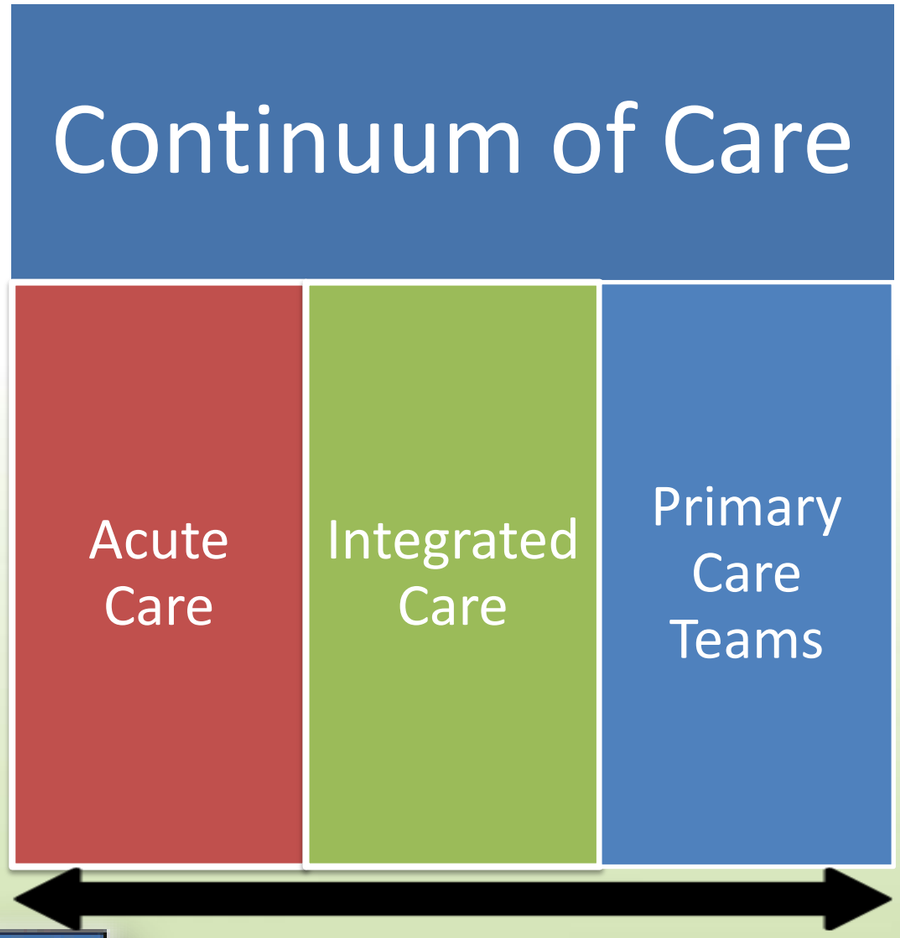
Bringing Healthcare Home

(Discharge to Assess)

Yvonne O'Riordan, Senior Occupational Therapist

Beaumont Hospital

Missed Opportunity!



Partnership between Beaumont Hospital and Dublin North CHO 9

Progressed with **available** staffing:

1 WTE BH Occupational Therapist (additional post)
BH and PCCC Physiotherapy
BH Medical Social Worker
GP
PHN
Case Manager
Day Hospital Geriatrician

Referral Sources

- Emergency Dept
- FIT Team

64%

- Virtual Ward

17%

- COE
- In-patients – Early Supported Discharge

16%

Discharge to Assess TEST highlights

41% Scored **4/5** on the THINK FRAILTY TOOL

50% of patients DID NOT have a HCP

44% had a cognitive impairment

>€740,000
savings for cost of 1WTE OT for 5 months

96% improved or maintained their FIM pre/post intervention

TUG – 49% Improvement

81% safely maintained at home ≥ 30 days

53 people in their own beds
(70 -101 years)

Patient Pathways

Rapid Assessment & Intervention

2 – 2.5 hours

1 Encounter

Rehabilitation

8 hours

6 Encounters

Physical Compensatory

6 hours

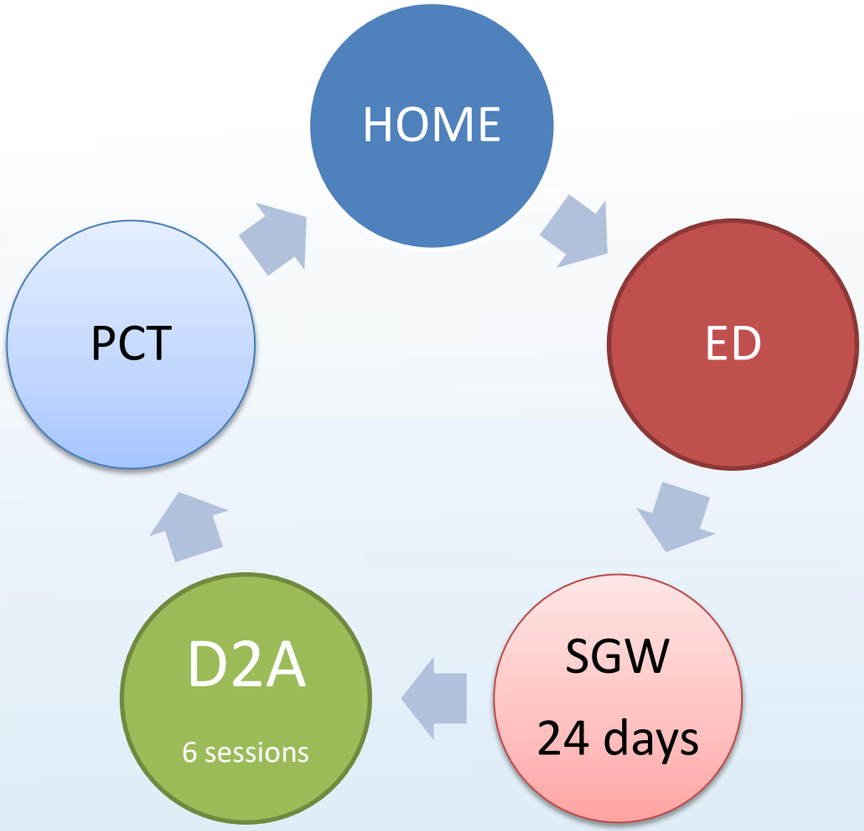
2- 3 encounters

Cognitive Compensatory

13.5 hours

6 Encounters

Mary's Story....



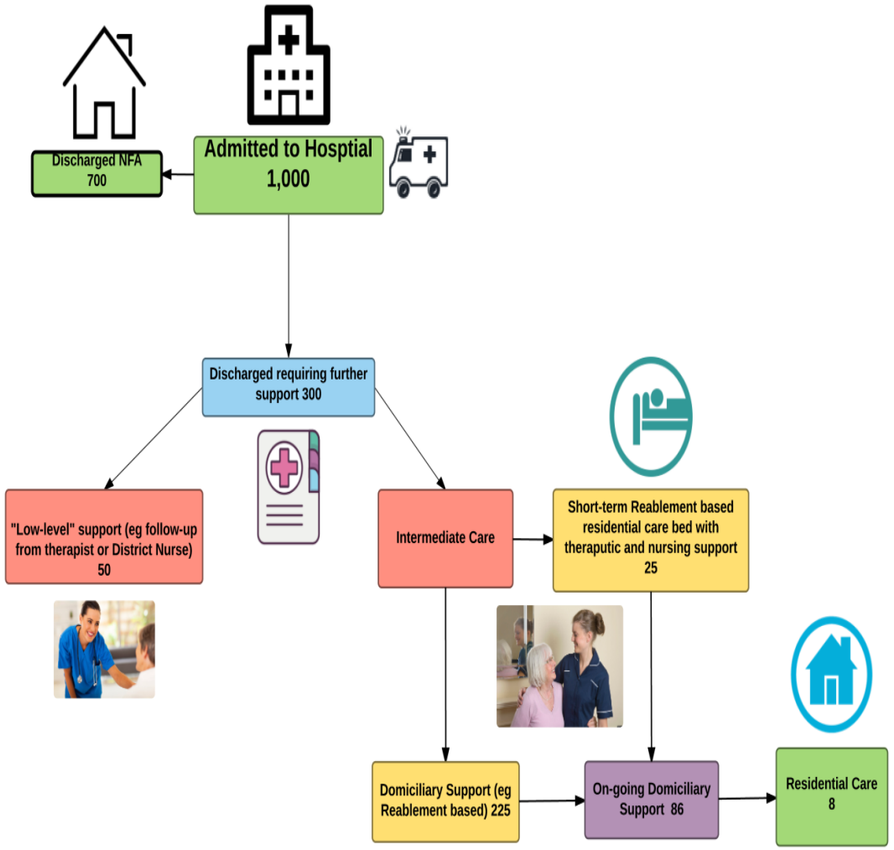
Therapist Experience

Key Reflections

1. Difficult Challenging the status quo
2. Time & perseverance required in building trust & openness for effective team work

1. Empowering to design a service which is right for patients
2. Proud to work in partnership on what matters to them
3. Grateful for the opportunity to develop leadership skills

Metrics that Matter



- Re-admission rate – 7, 30, 60, 90 days
- % pts, with services in situ, within 48 hrs of DC
- % pts awaiting an agreed service in any week
- % pts delayed DC who are fit for DC from Medical/HSCP perspective
- Proportion pts DC to LTC without opportunity for short-term recovery
- Proportion of pts who return home from transitional care (should be 75%)
- Proportion of pts requiring LTC after short-term home-based rehab (should be 25%)
- Proportion of pts DC who have no formal supports at 2 wks and 6 wks (should be 40%/66%)

(https://ipc.brookes.ac.uk/publications.html)

National HSCP Office
Harnessing Full HSCP Value and Impact

Phase 1

- Identification of innovation/best practice; new models of care
- Build leadership capability
- Foster frontline staff engagement
- Education and development

Phase 2

- Standardised improvement methodology & supporting data
- Co-design approach for scale up and spread
- Workforce planning for optimal skill mix
- Moving to communities and networks of practice

The process we use to get to the future determines the future we get

Myron's Maxims

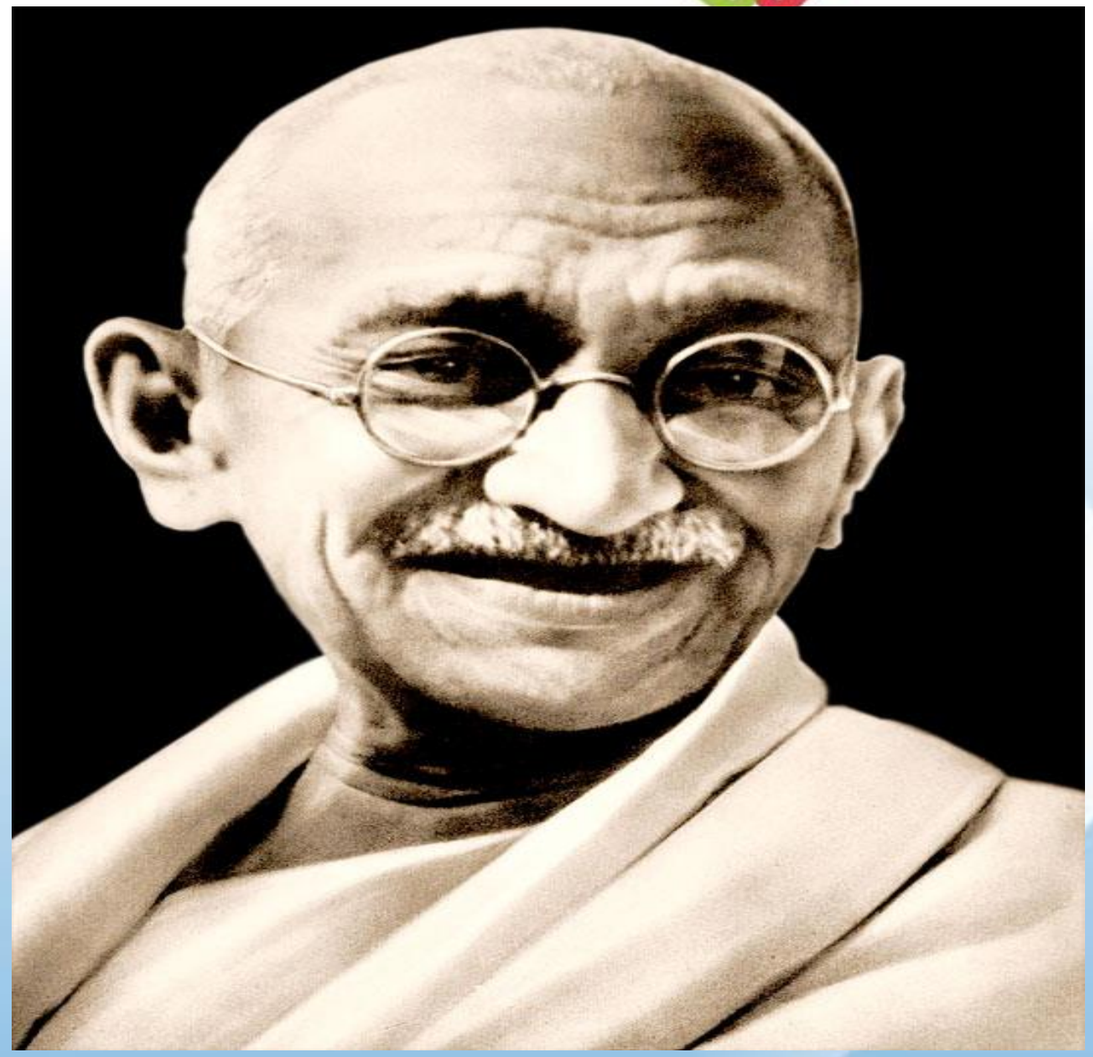
- People own what they create
- Real change takes place in real work
- The people that do the work do the change
- Start anywhere but follow it everywhere
- Keep connecting the system to itself
- The process we use to get to the future determines the future we get

HSCP Shaping a Better Future

- demonstrating leadership
- providing first contact services
- embracing risk, supporting choice
- delivering integrated care
- developing communities of practice

“You must be the change you wish to see”

Gandhi



We would value your feedback please have a look on the link provided

https://www.hse.ie/eng/about/who/qid/aboutqid/strategic-plan-2019-2021.pdf

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Next QI Talktime:

Tuesday April 2nd 1pm

Person Centredness – Making a difference in practice

Thank you from all the team @QITalktime

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Noemi.palacios@hse.ie

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