



QI TALK TIME

Building an Irish Network of Quality Improvers

Connect

Improve

Innovate

**Quality Improvement in National Ambulance
Service –**

Refusal to travel, elderly trauma and beyond.

01/10/2019

Speakers

Eamonn Byrne has worked with the National Ambulance Service (NAS) for over 23 years.

He has a master's degree in emergency medical science, a graduate diploma in healthcare (risk management and quality) and has successfully completed the RCPI diploma in quality and leadership.

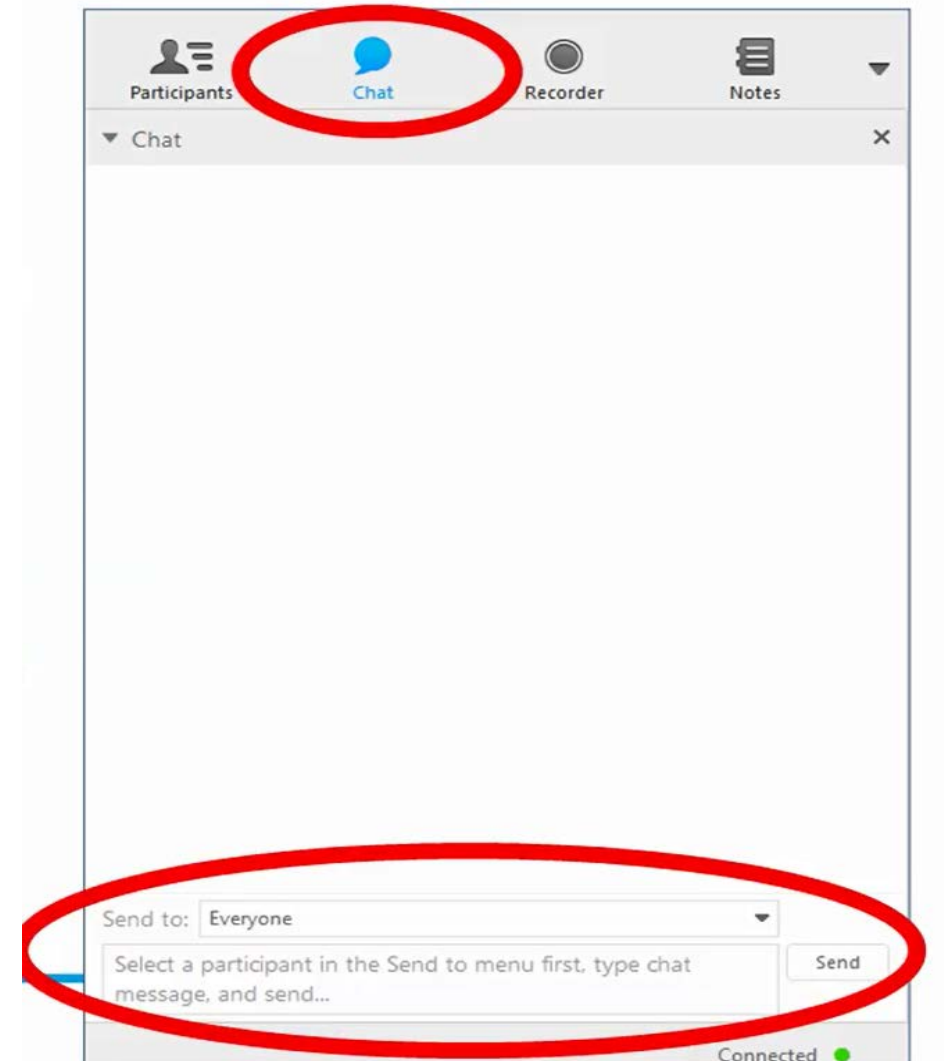
He has completed projects on medication error reporting in the NAS, refusals of care and transport to hospital and the assessment of major trauma in the elderly and has made award winning presentations at international conferences at home and abroad.

He currently works as a frontline lead advanced paramedic in Carraroe County Galway.



Instructions

- Interactive
- Sound:
Computer or dial in:
Telephone no: 01-5260058
Event number:843613936#
- Chat box function
 - Comments/Ideas
 - Questions
- Keep the questions coming
- Twitter: @QITalktime



ROYAL
COLLEGE OF
PHYSICIANS
OF IRELAND



REDS  **SPOT**

Retrieval, Emergency and Disaster Medicine
Research and Development Unit



National Ambulance Service Q. I. Project

Refusal to travel,
elderly Trauma and
beyond.

Eamonn Byrne

National Ambulance Service 2018/2019

◆ 1,900 Staff

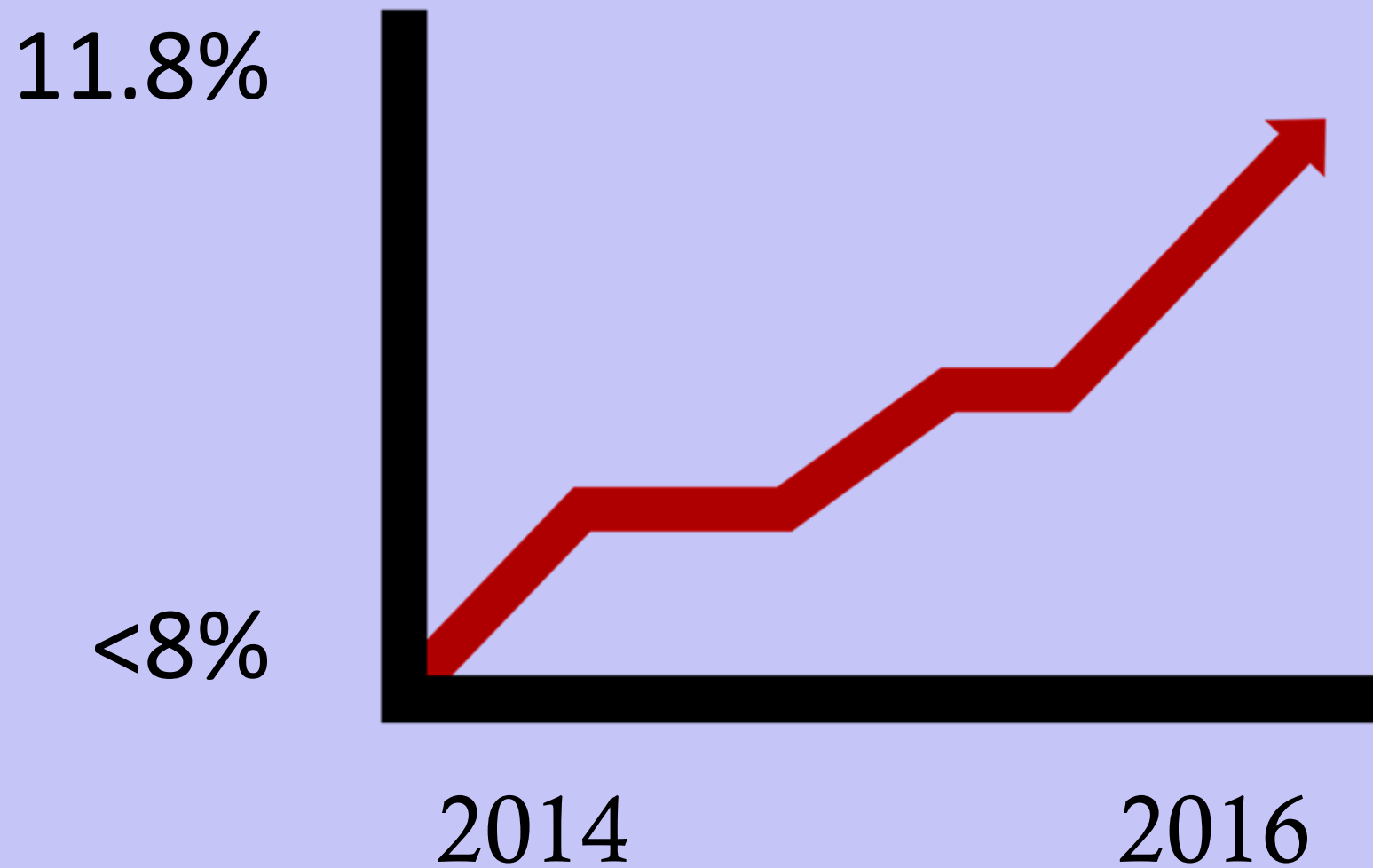
◆ 100+ Bases

◆ 334,000 Emergency and Urgent calls

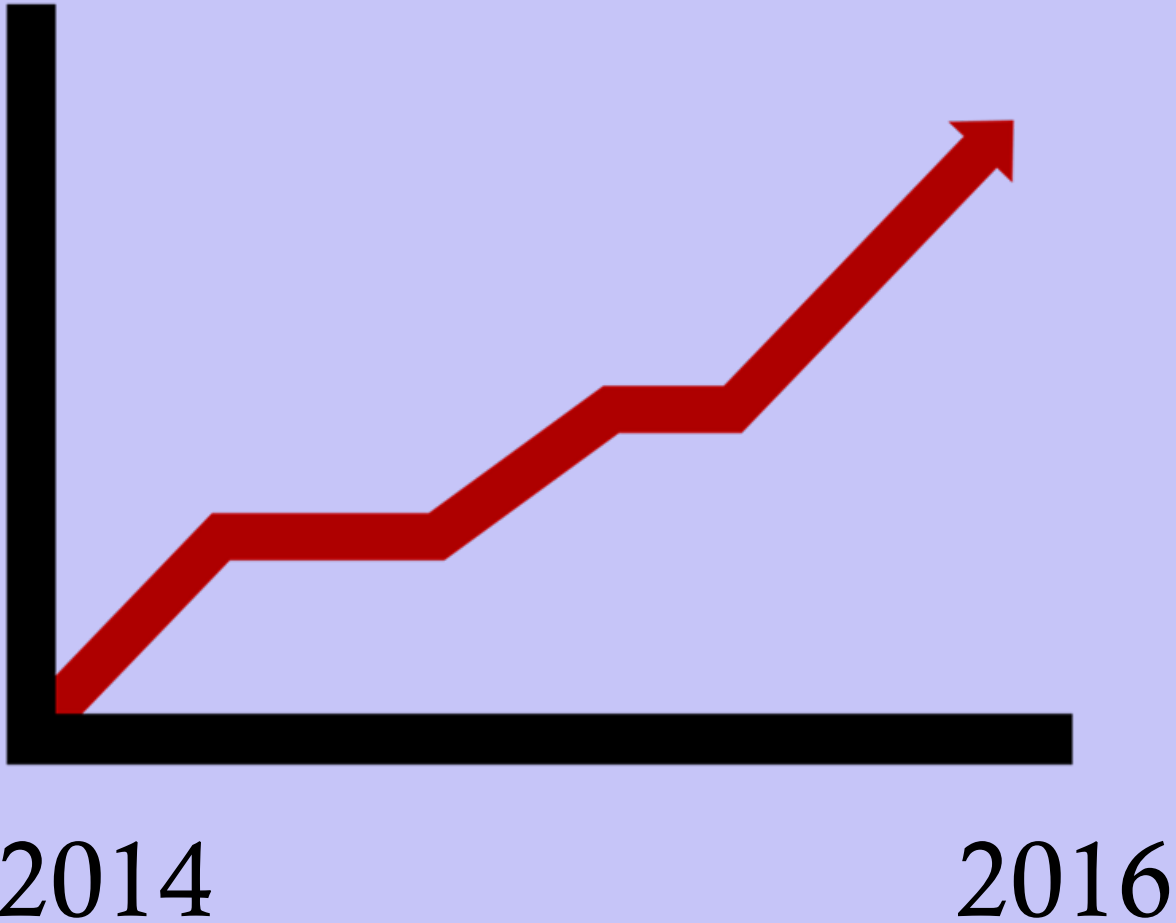
◆ 34,000 Routine transfers



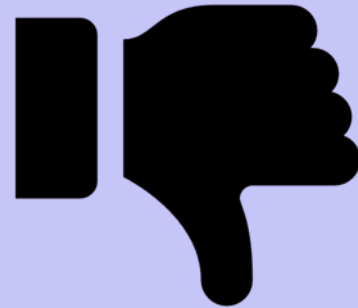
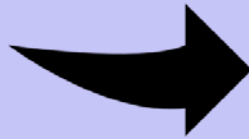
Increasing rate of Refusal to travel



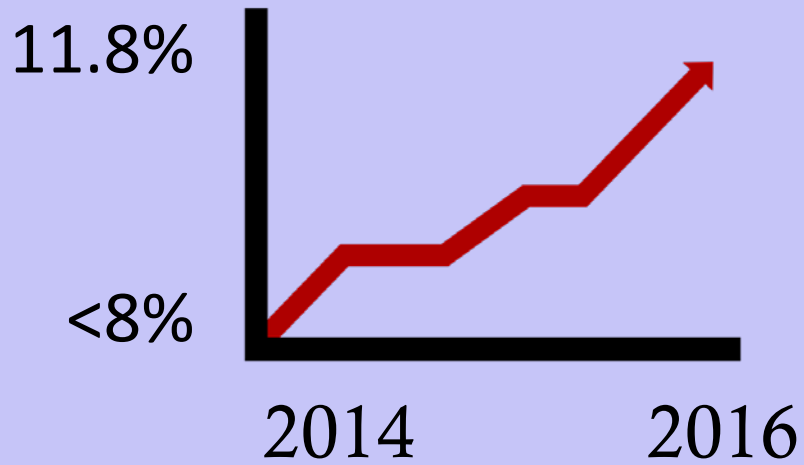
Increasing rate of Serious Incidents



Patient Care Report documentation quality



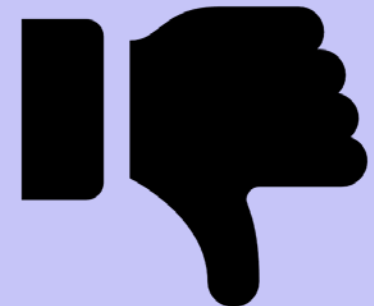
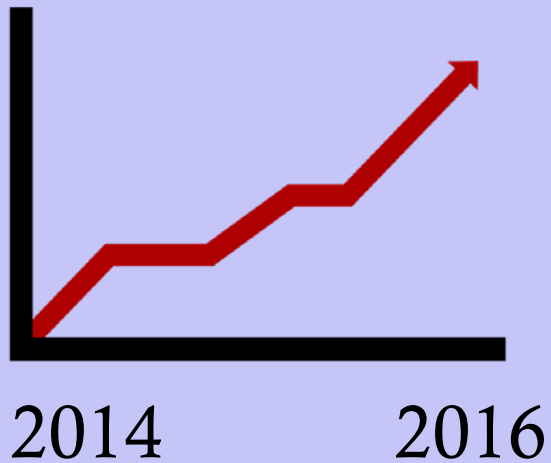
Increasing rate of Refusal to travel



Patient Care Report documentation quality



Increasing rate of Serious Incidents



**Refusals to travel,
patient empowerment and
documentation improvement
in the
National Ambulance Service:
A Quality Improvement
Project.**

Eamonn Byrne (1,2), Paul Gallen (1,2), Sasha Selby (3), Alan Watts (2,4)

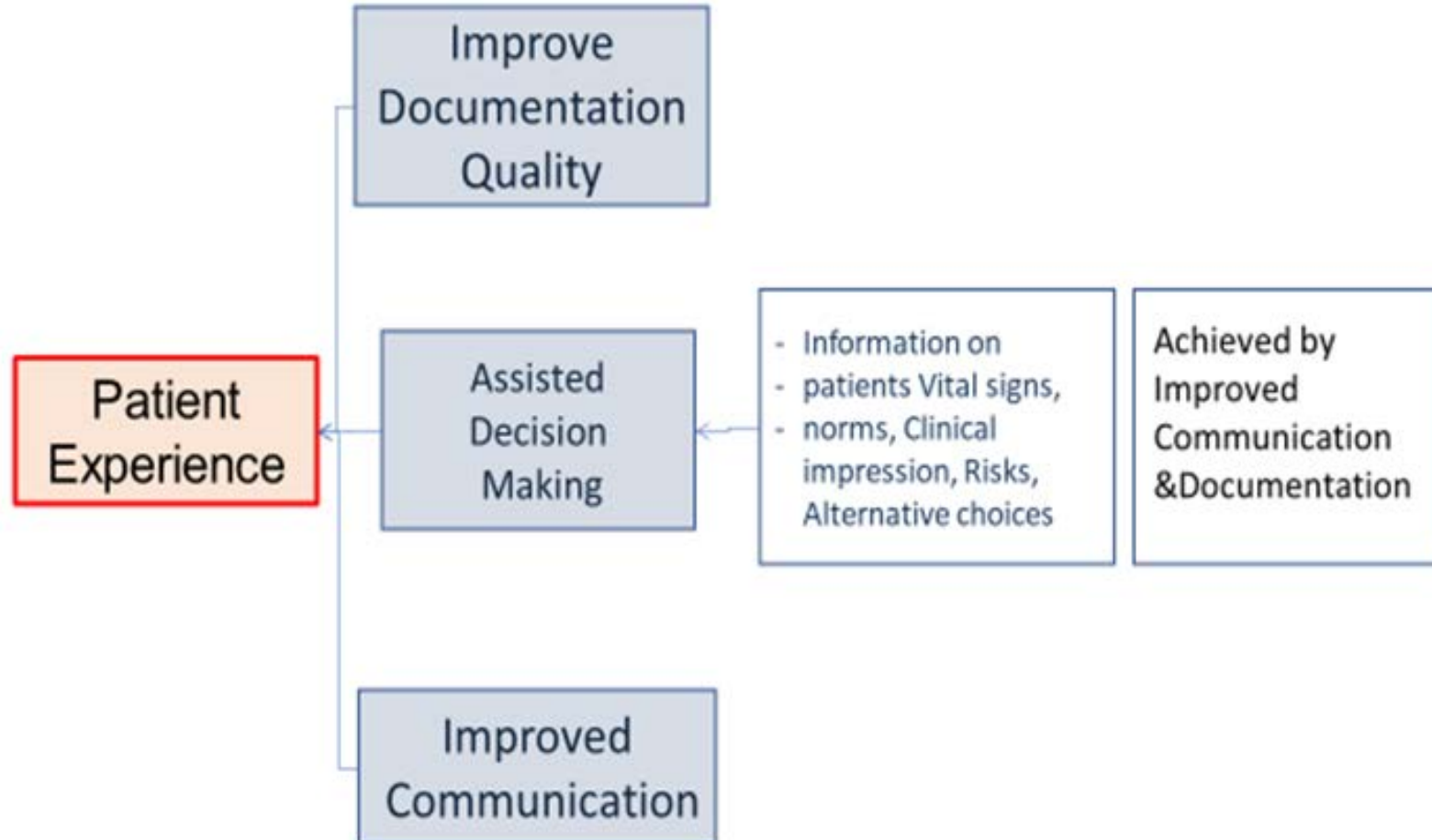
1. National Ambulance Service, 2. Royal College of Physicians of Ireland, 3. GEMS University of Limerick, 4. University Hospital Limerick.

Our Hypothesis

Primary Drivers

Secondary Drivers

Target Areas of
Improvement



Patient
Experience

Improve
Documentation
Quality

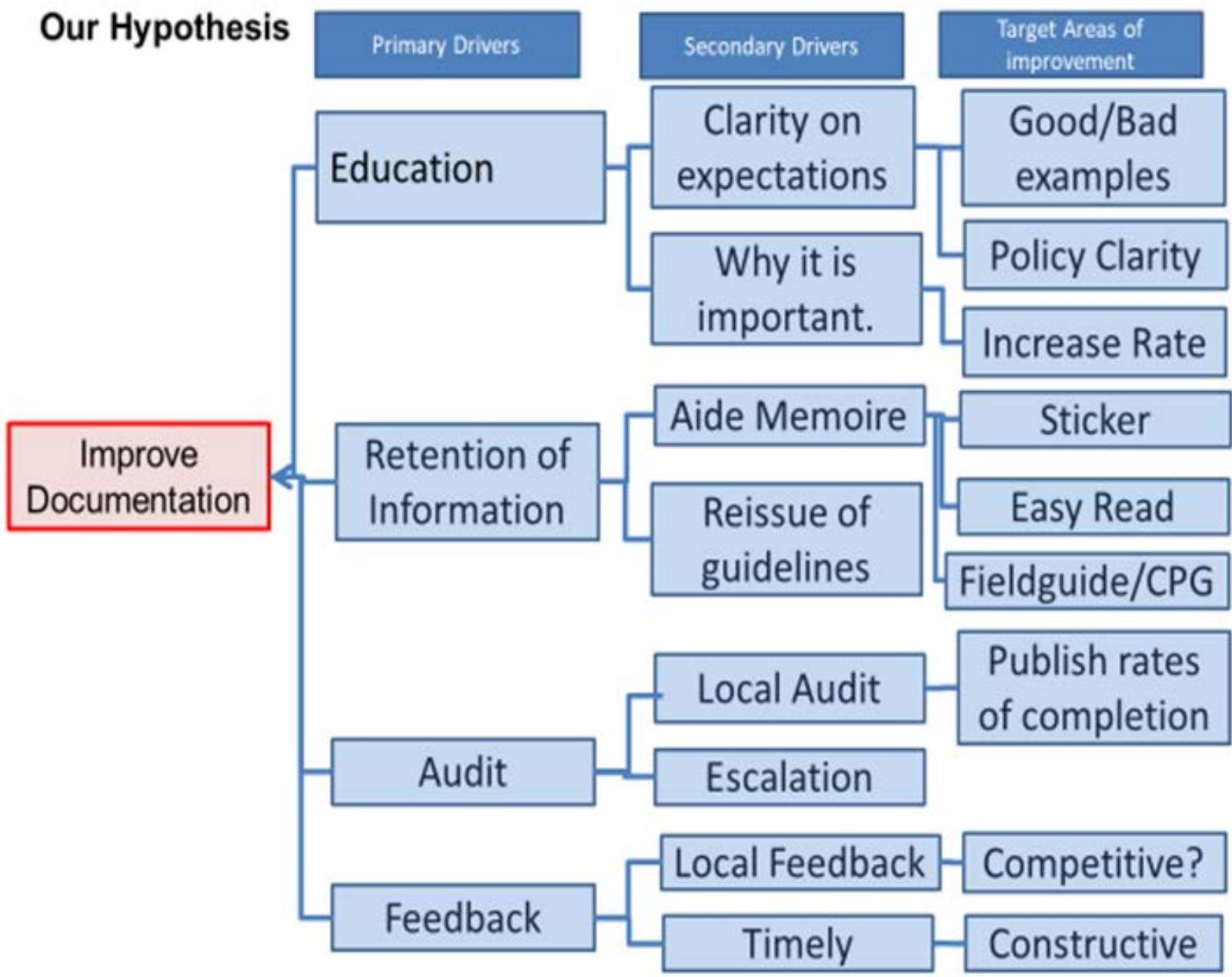
Assisted
Decision
Making

Improved
Communication

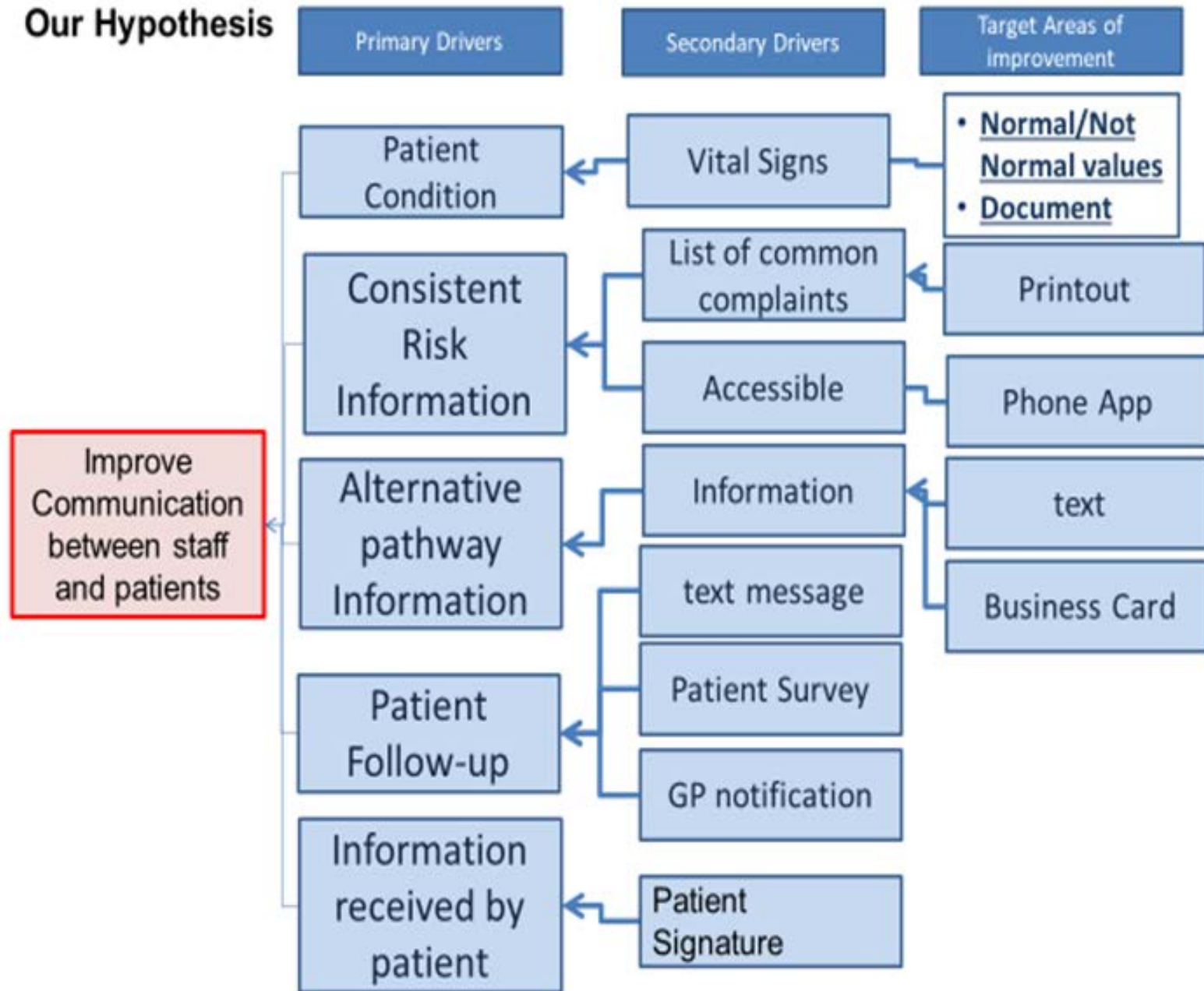
- Information on patients Vital signs, norms, Clinical impression, Risks, Alternative choices

Achieved by
Improved
Communication
& Documentation

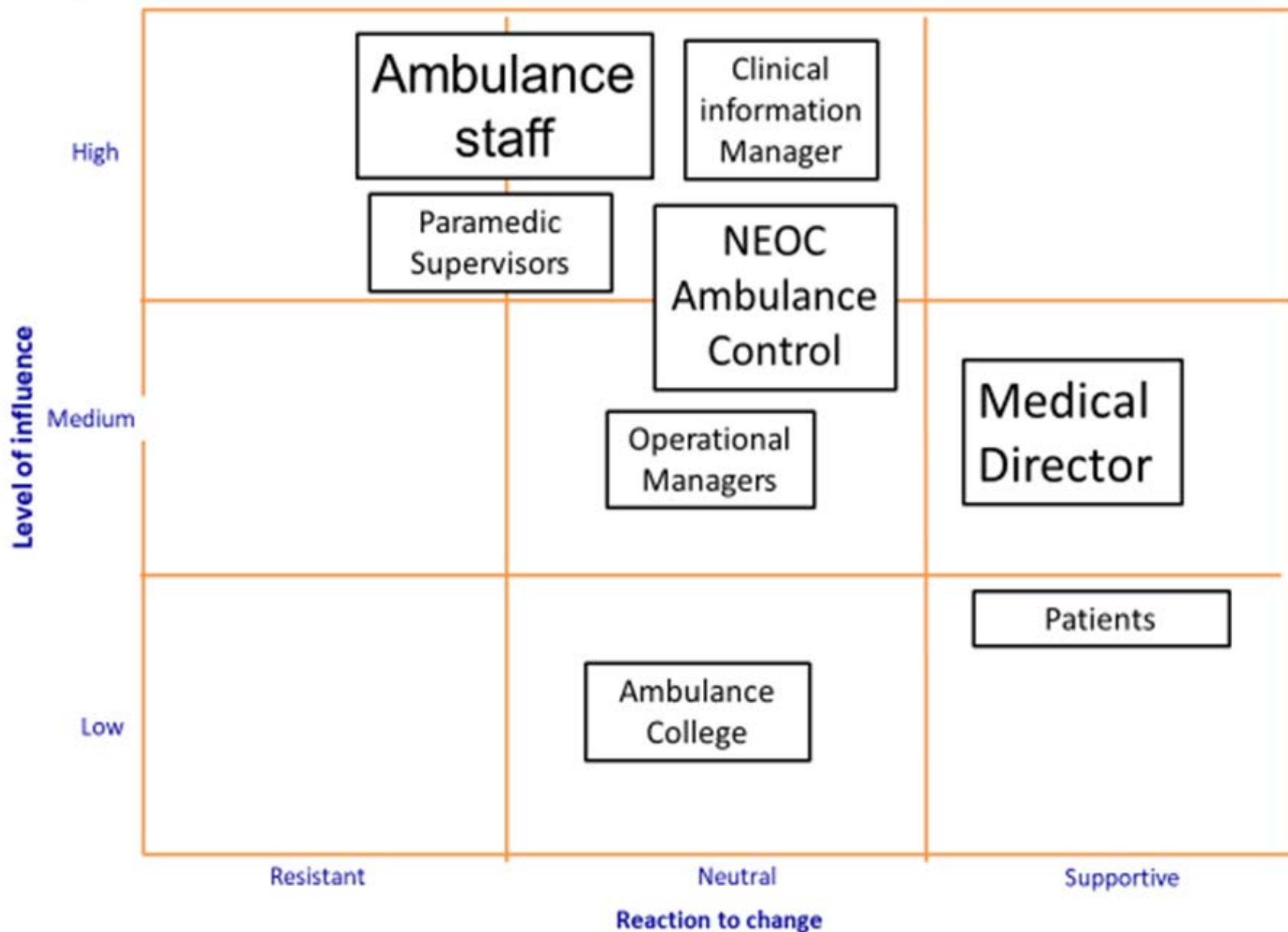
Our Hypothesis



Our Hypothesis



The people/teams we need to communicate with are:



Staff engagement

- ◆ Focus group type of interactions
- ◆ Semi structured interviews
- ◆ An electronic survey

◆ ‘I can bring a heart Attack to a Cath. Lab., but I can't bring a cut finger to a Local Injury Unit’.

◆ ‘Drunks can be intimidating; they will tell you, “I didn’t call the ambulance” ’

‘Too long to read.’

‘...overly wordy and
complex.’

‘Too long winded.’

- ◆ A patient after eye surgery that day.
- ◆ We tried to find him someone sober, a taxi or a family member to take him to the private hospital.
- ◆ That went down as a refusal to transport.'

‘Sometimes it’s easier to bend the rules!’

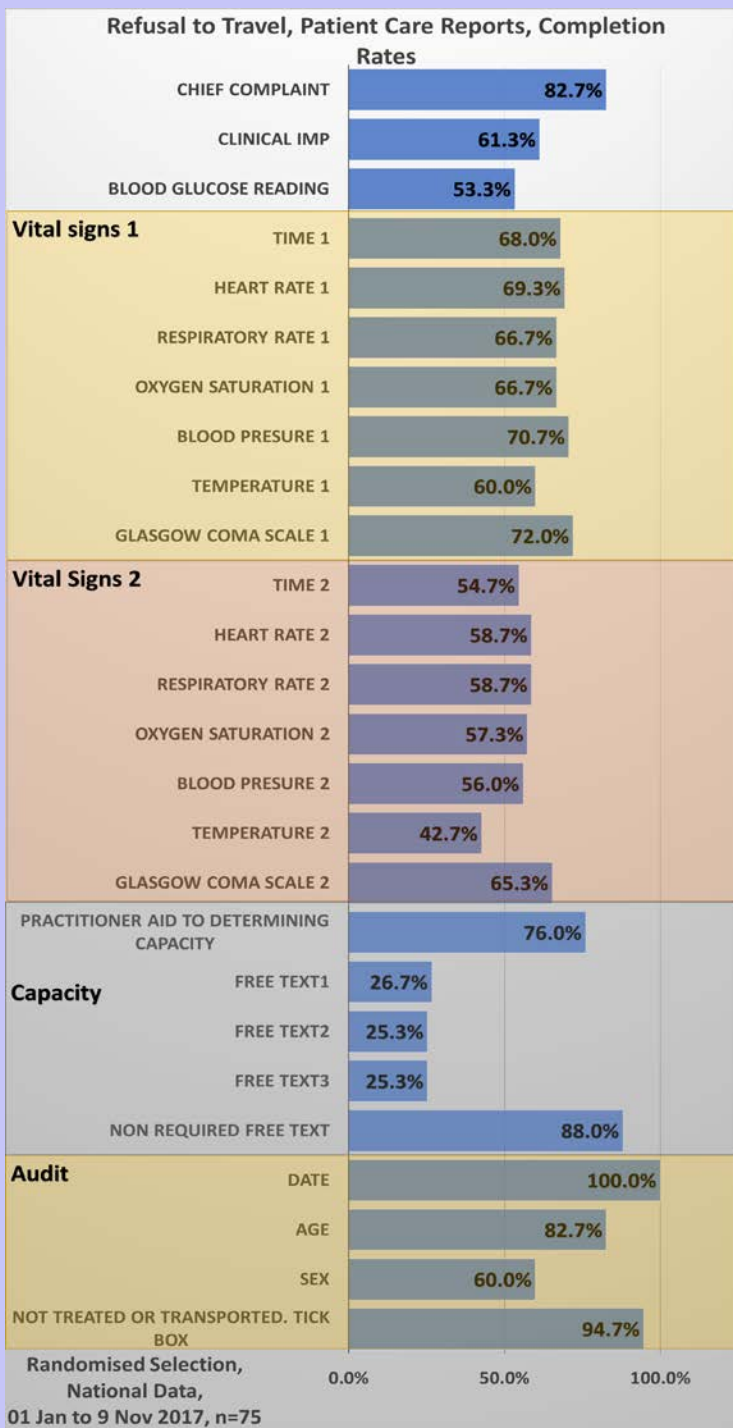
Process Mapped
refusal to travel pathway

**Refusals to travel,
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Project.**

**Refusal to Travel in the NAS.
A Patient Care Report
examination.**

Eamonn Byrne (1,2), Paul Gallen (1,2), Sasha Selby (3), Alan Watts (2,4)

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Mean paper PCR completion rate was 59.1%

(n=52, median 71.2%, range of 15.4% to 88.5%)

Mean e-PCR completion rate was 72.4%

(n=23, Median 92.3%, range from 7.7% to 100%)

Electronic Patient Care Reports (E-PCR)

80 of 102 Ambulance Bases

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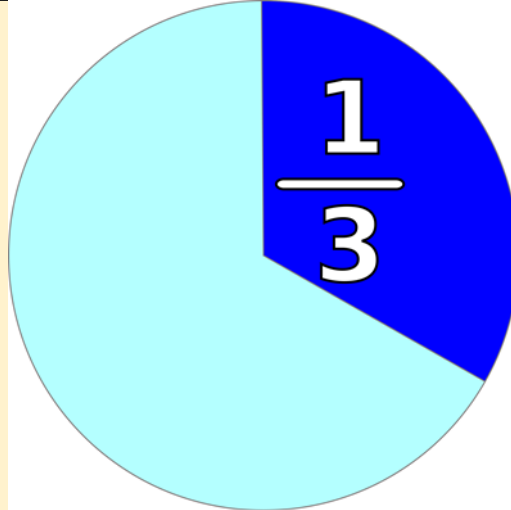
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**Refusal to Travel in the NAS.
A Patient Care Report
examination.**

**A Retrospective Examination of
'Refusal To Travel' Calls
in the National Ambulance
Service From 2017.**



1. Falls,
2. Unconsciousness / near fainting,
3. Generally unwell patients.



Delta Calls

2nd Highest Response

Advanced Life Support

Blue Light Response



**Peaked nationally between
2000 and 2059h.**

**Southern area between
2000-2059h and 0000-0100h.**

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**Refusal to Travel in the NAS.
A Patient Care Report
examination.**

**A Retrospective Examination of
'Refusal To Travel' Calls
in the National Ambulance
Service From 2017.**

**Is it worth spending time on
patients who don't want our
help? A risk analysis of
National Ambulance Service
refusals of treatment and or
transport.**

National Ambulance Service (NAS) in Ireland is rarely the subject of litigation (Slattery et al., 2017).

24,735 refuse to travel (NEOC, NAS, 2018)

Mortality rate of non-conveyed patients. (0.2% and 6.1%) 49 to 1508 people (Ebben et al., 2017).

Patients not transported **twice** the death rate (Tohira et al., 2016).

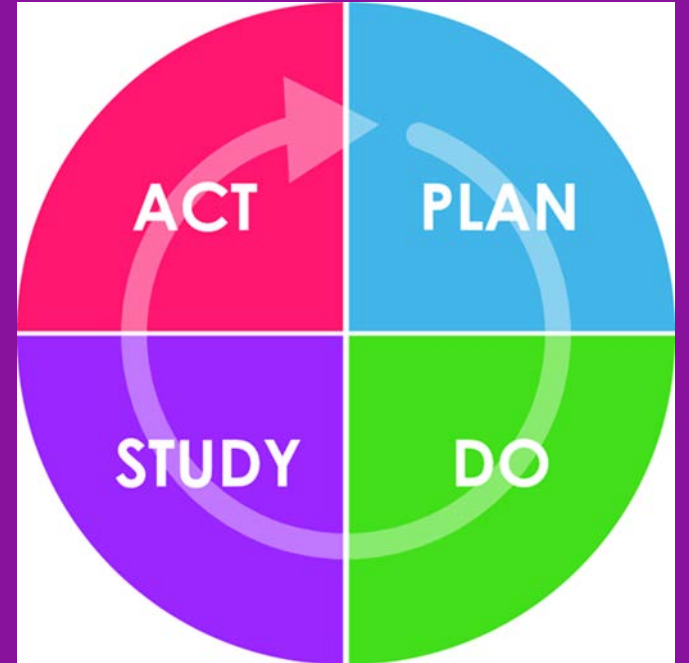
10% of families are dissatisfied with a non-conveyance decision. (Zachariah et al., 1992).

Average cost per claim to the State Claims Agency in 2014 of €141,813 (Slattery et al., 2017)

2 and 75 litigants our projected annual risk is between €283,626 and €10,635,975.

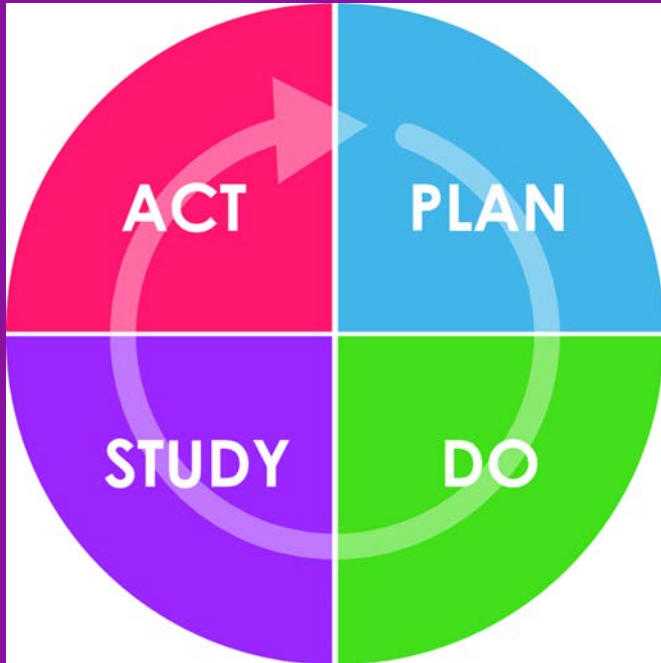


Anecdotal staff stepping outside of protocols to make alternative treatment arrangements for patients.





Education Piece



Education Piece



Aide Memoire



REFUSAL TO TRAVEL

HAVE YOU DOCUMENTED...

The Presenting complaint?

What is the patients current issue?

Two sets of vital signs?

Including Times. HR, RR ,BP, and Temp and GCS. Is the Patients GCS 15 both times?

A BGL measurement and time?

A Clinical impression?

What do you think is wrong with the patient?

Completion of the Patient 'Decision Making Capacity' Aid.

In free text?

"The consequences of refusal of care have been explained to the patient; including (List risks stated to the patient.....)"

"The patient understands these consequences."

The patient, in the opinion of the staff member, has decision making capacity. The patient has been advised of the following options should they require further assistance (List options mentioned...)

If a GP has organised transport for a patient who subsequently refuses to travel, GP must be informed. **Document who was informed & when.**

Control must be informed of all patients that refuse to travel.

Request help if required Gardai, Officer, Doctor, AP

Any further relevant details that you might rely on at a later stage eg Assistance requested, drink, drugs, abusive/threatening behaviour, reason for non- completion of vital signs or examination.

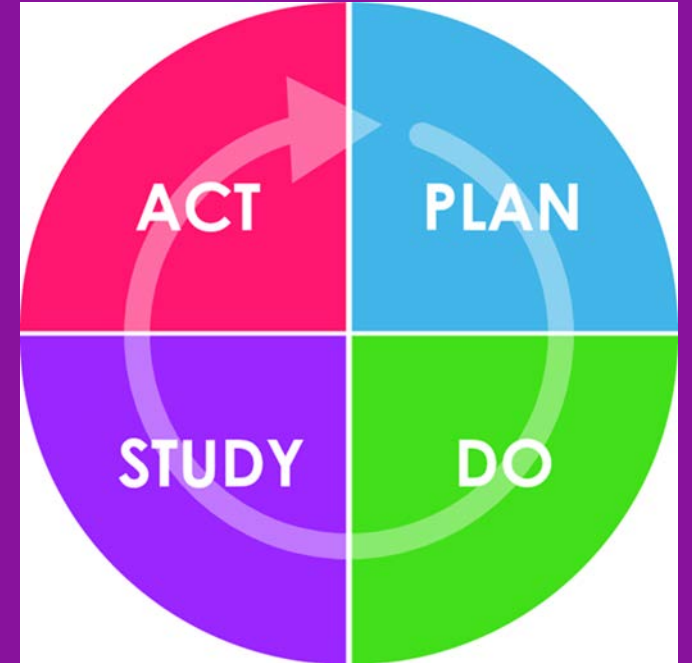
NAS STAFF HAVE NO AUTHORITY TO ADVISE A PATIENT NOT TO TRAVEL TO HOSPITAL.



Education Piece



Aide Memoire

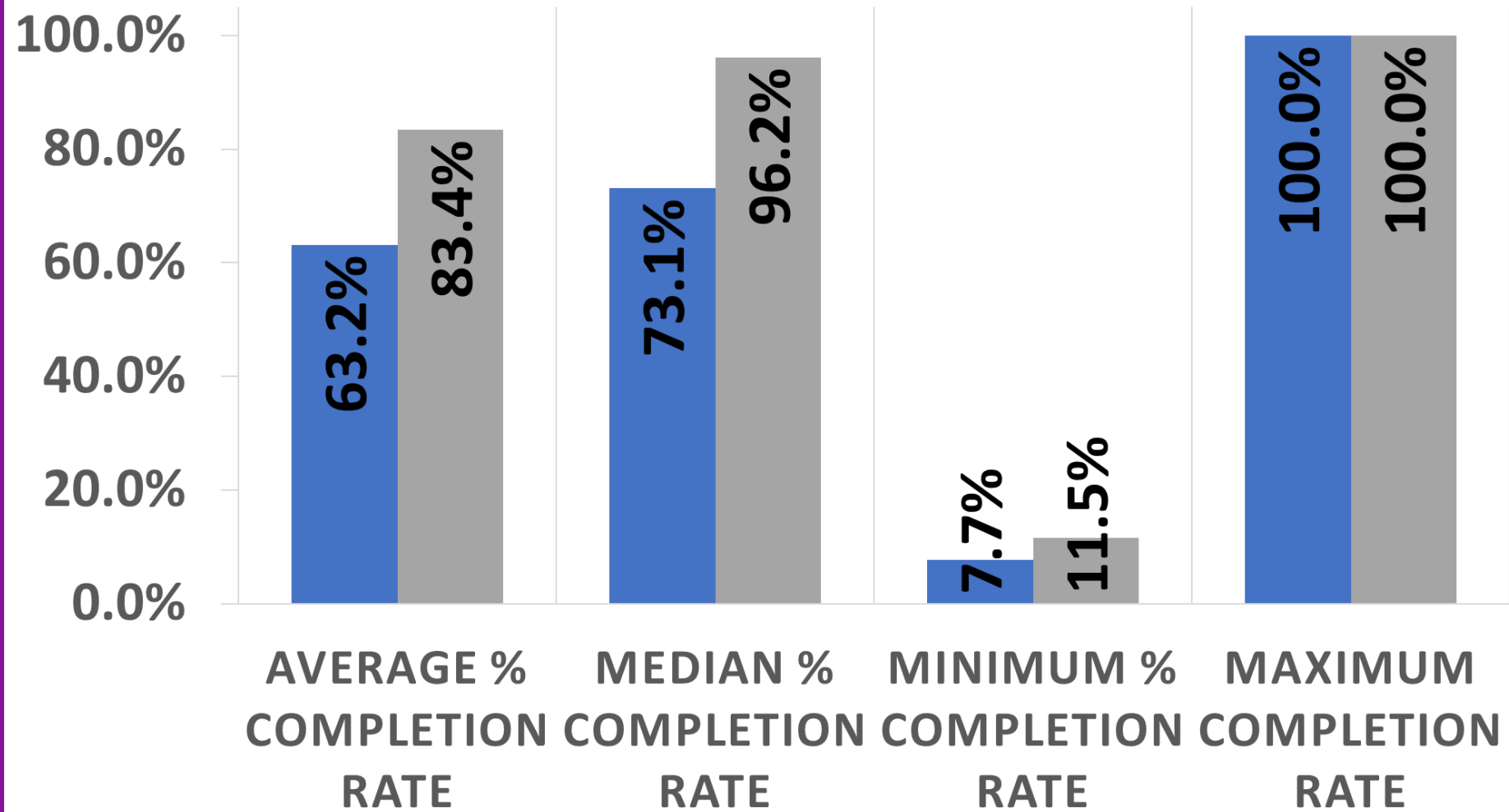


Trial Refusal to
Travel Form



BASELINE TO FINAL COMBINED PCR COMPLETION RATE

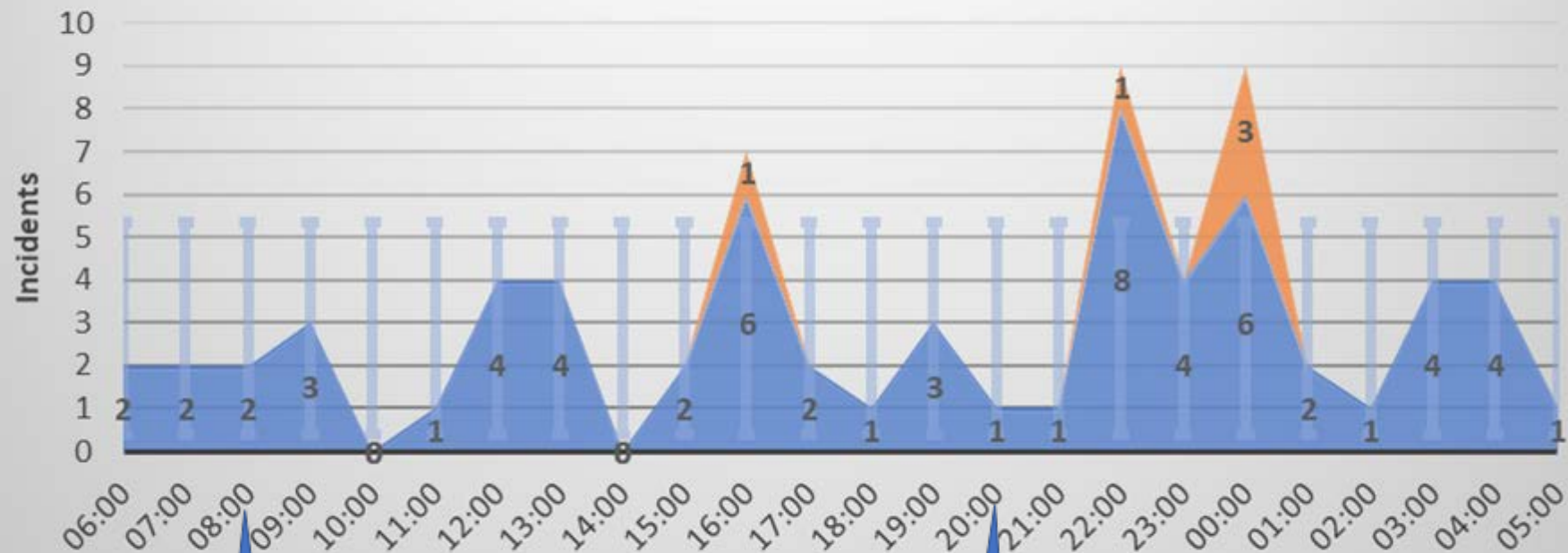
■ BaseLine Combined ■ Final Combined



N=70, SEQUENTIAL SAMPLE, 29 APRIL TO 29 JULY 2018

Analysis of RTT per Hour Call Stopped, Mallow 29 April 2018-29 July 2018

incidents Extra Patients



Hour Call Stopped,
Includes Multi-Casualties incidents

64 incidents

70 patients

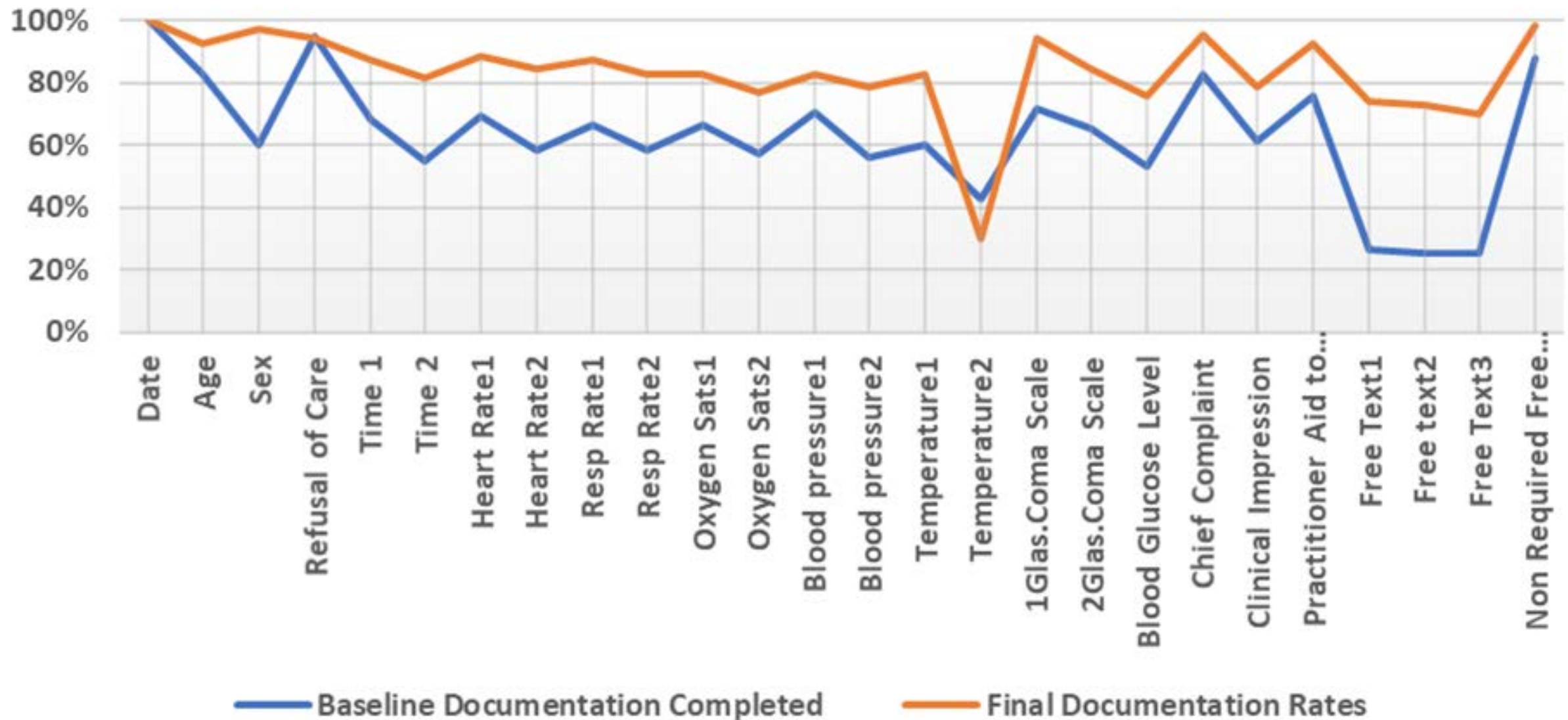
1 Std Dev Shown

Shift
change
0800h

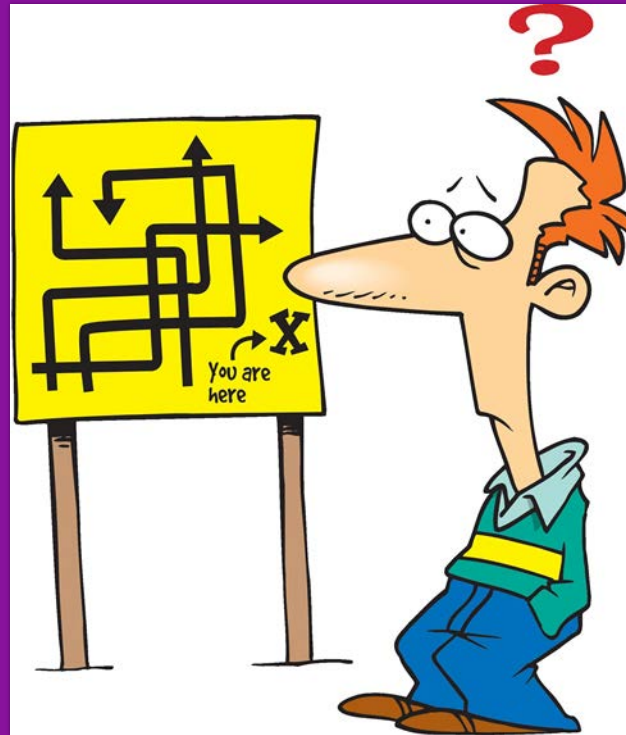
Shift
change
2000h



Comparative Baseline vs Final Rates of Documentation Completion







Difficult to determine what information is given to a patient to facilitate a shared decision-making model.



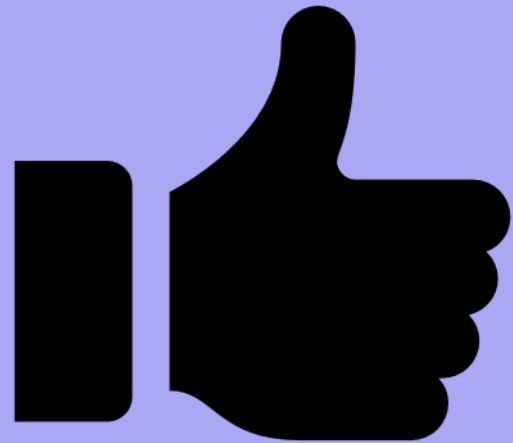
Development of
alternate treatment
pathways

Patient Account

A 92-year-old patient whose daughter
given enough information to make an informed decision

They were both part of the decision-making process and were
'100% confident that it was the correct decision not to go to CUH.'

the paramedics were extremely professional and very caring, and we
did not feel as though they were 'doing just a job'
they wanted to ensure that, 'the best was being done for the patient.'



Assessment of Major Trauma in the Elderly

Major Trauma?

Serious, life-threatening and often multi-system traumatic injuries.

Where??? & How???

At home with falls of less than 2 metres.



That's not very dramatic!

This low energy mechanism of injury may not trigger existing major trauma protocols.



Is that bad?

Delayed recognition of Major Trauma by practitioners can delay definitive treatment.



Who is affected?

44% are older than 65 years.



Is that significant?

Pre-hospital triage systems may not account for the older patient.

	Priority 1 Critical Time: <input type="text"/>																
Dead Time: <input type="text"/>	<small>Patient Name:</small> VITAL SIGNS <table border="1"><thead><tr><th>Time</th><th>Pulse</th><th>Resp</th><th>BP</th><th>AVV</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></tbody></table> <small>Drugs given: Name: Dose:</small> BY:	Time	Pulse	Resp	BP	AVV											Priority 2 Serious Time: <input type="text"/>
Time	Pulse	Resp	BP	AVV													
	Priority 3 Minor Injuries Time: <input type="text"/>																

Who are PHECC?

All pre-hospital staff are required to be PHECC registered.



What do PHECC do?

They set the clinical standards for all pre-hospital care in Ireland.



Next?

Any queries related to presentation please contact:

eamonn.byrne@hse.ie

FALLS & SYNCOPES UNIT
(AONAD TITIMÍ & SIONCÓIPÉ)
Welcome to the Falls and Syncope
Unit (FASU) at Mercer's Institute for
Successful Ageing.



IRISH ASSOCIATION FOR
EMERGENCY
MEDICINE



1989-2019



Stay tuned and Spread the word

Keep an eye on www.Qualityimprovement.ie

Next talktime:

Friday 4th October: 8.30-9am – Thinking up
Heather Shearer, PHD

Thank you from all the team @QITalktime

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