Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

QI TALK TIME

Building an Irish Network of Quality Improvers

Understanding the 'black box' of people living with frailty: what really matters to them

1pm Tues March 5th 2019

Connect **Improve** **Innovate**

Speaker

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 has held various leadership roles in healthcare some overseas during the past sixteen years. 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.

Ciara O'Reilly:

Qualified from Physio in 2004. She is currently the Clinical Specialist Physiotherapist in Care of the Elderly in Beaumont based in the Emergency Department. Ciara completed her Masters by Research Degree in the School of Physiotherapy, RCSI in 2013. The research was on falls risk factors and healthcare use in patients with a low trauma wrist fracture attending a physiotherapy clinic.

Siobhan Julian:

qualified as a Dietician from DIT/TCD in 1995. Siobhan is a Dietician Manager in Wexford General Hospital with both a managerial and clinical portfolio. Siobhan has held numerous roles in Dietetic professional body. She has completed a MSc in Healthcare Leadership and Management RCSI (2009) and a Certificate in Healthcare Leadership (2014). She has recently completed Bronze Lean Certification has revitalised thinking in a multidisciplinary solutions approach to ongoing quality improvement for service users.

Instructions

- Interactive

- Sound:

Computer or dial in:

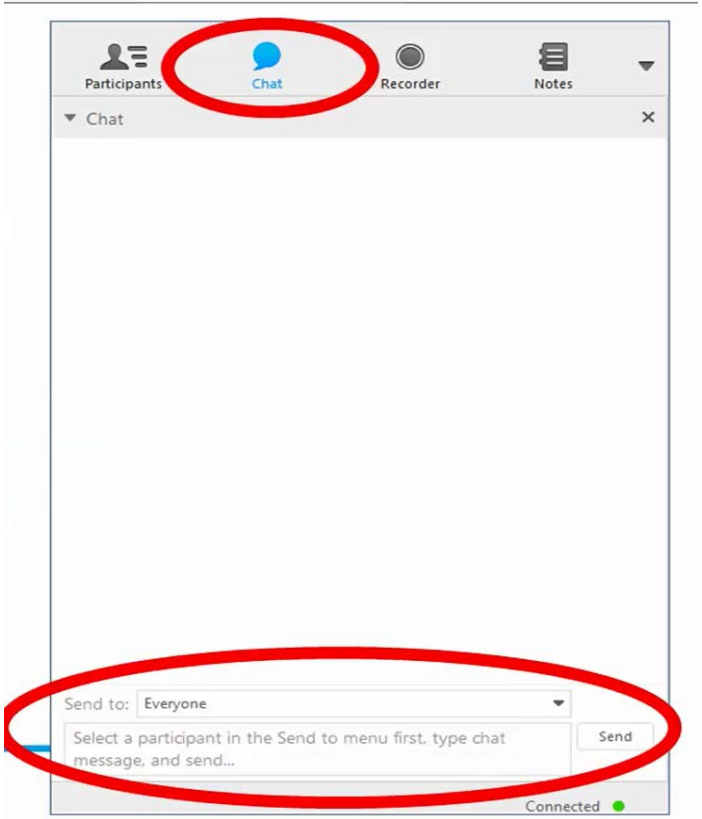
Telephone no: 01-5260058

Event number:840 097 842#

- Chat box function
  - Comments/Ideas
  - Questions

- Keep the questions coming

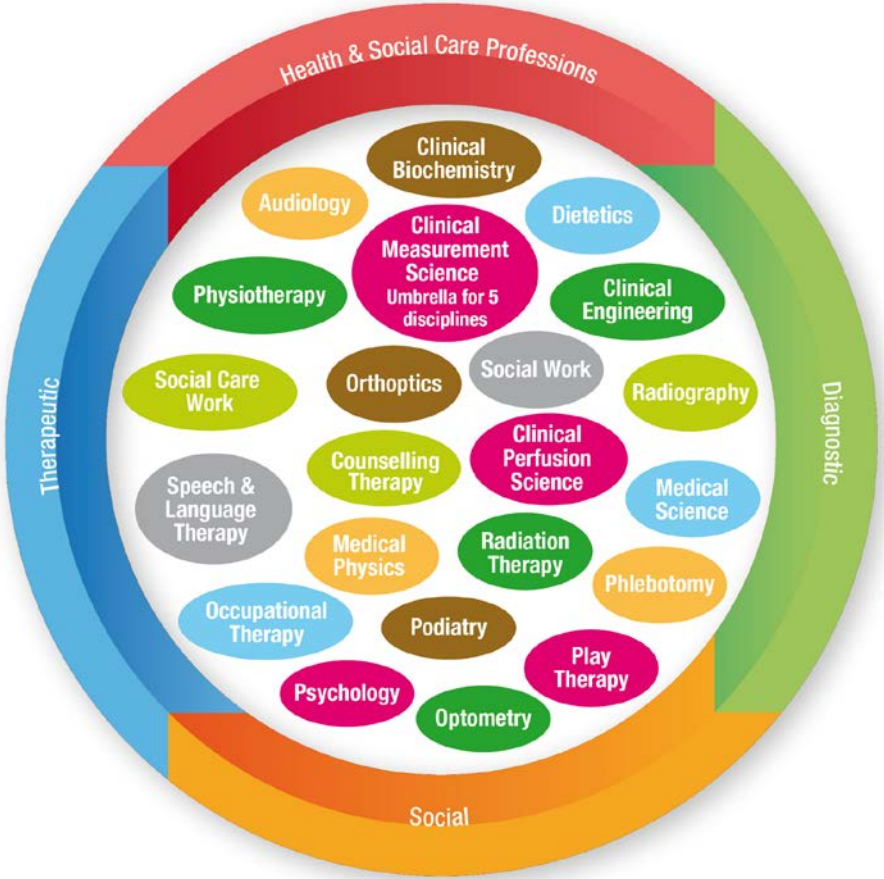
- **Twitter: @QITalktime**



Understanding the 'black box' of people living with frailty: what really matters to them

Alison Enright, Ciara O'Reilly and Siobhan Julian

5th March, 2019


Health & Social Care Professions
Therapeutic
Diagnostic
Social
Clinical Biochemistry
Audiology
Dietetics
Clinical Measurement Science
Umbrella for 5 disciplines
Physiotherapy
Clinical Engineering
Social Care Work
Orthoptics
Social Work
Radiography
Clinical Perfusion Science
Counselling Therapy
Speech & Language Therapy
Medical Science
Medical Physics
Radiation Therapy
Phlebotomy
Occupational Therapy
Podiatry
Play Therapy
Psychology
Optometry

Doctors & Dentists

- 10,065 people
- 16% of staff
- €450.6M 2018 pay budget YTD (29%)

Health & Social Care Professions
26 Disciplines

- 15,974 people
- 25% of staff
- €299.4M 2018 pay budget YTD (19%)

Nurses & Midwives

- 37,297 people
- 59% of staff
- €805M 2018 pay budget YTD (52%)

HSE Clinical Workforce Groups

National HSCP Office

Launched 2017

Strategically lead and support HSCP to **maximise their potential** and **achieve the greatest impact** for the design, planning, management and delivery of **people centred, integrated care.**

Builds and expands on original HSCP Education & Development Unit 2006 – 2016

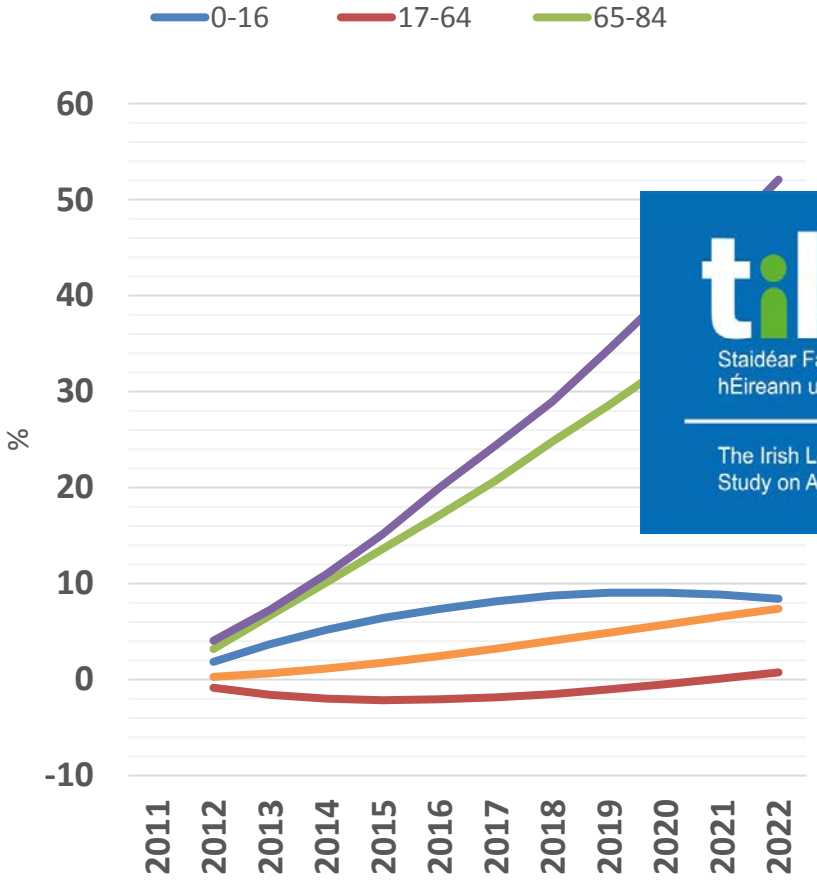
The HSCP Office is a stand alone function reporting to the Chief Clinical Officer

Why Change Our Unscheduled Care System?

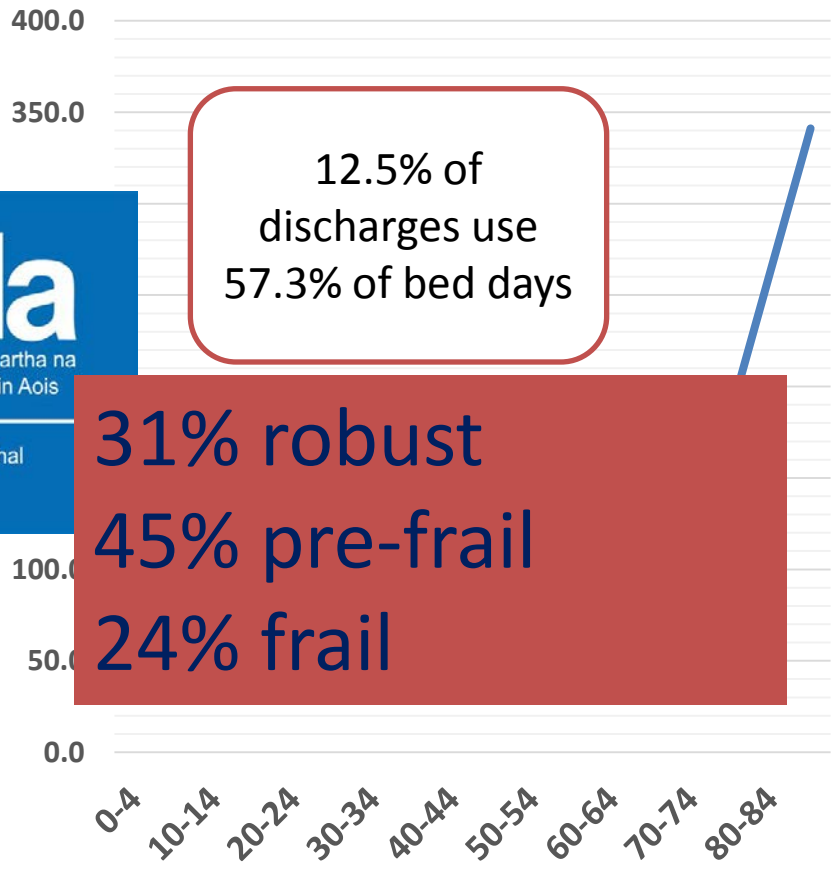
- Current model is not working
- Causing harm
- Need to enable patient choice
- Need to increase patient trust and satisfaction
- Need to provide safe and timely discharge of patients with complex needs, with no increase in readmissions
- Need to reduce cost
- Need to improve flow and reduce LOS
- Need to improve employee satisfaction

Current State

Population growth 2011-2022



ED Admissions:1000 population by age



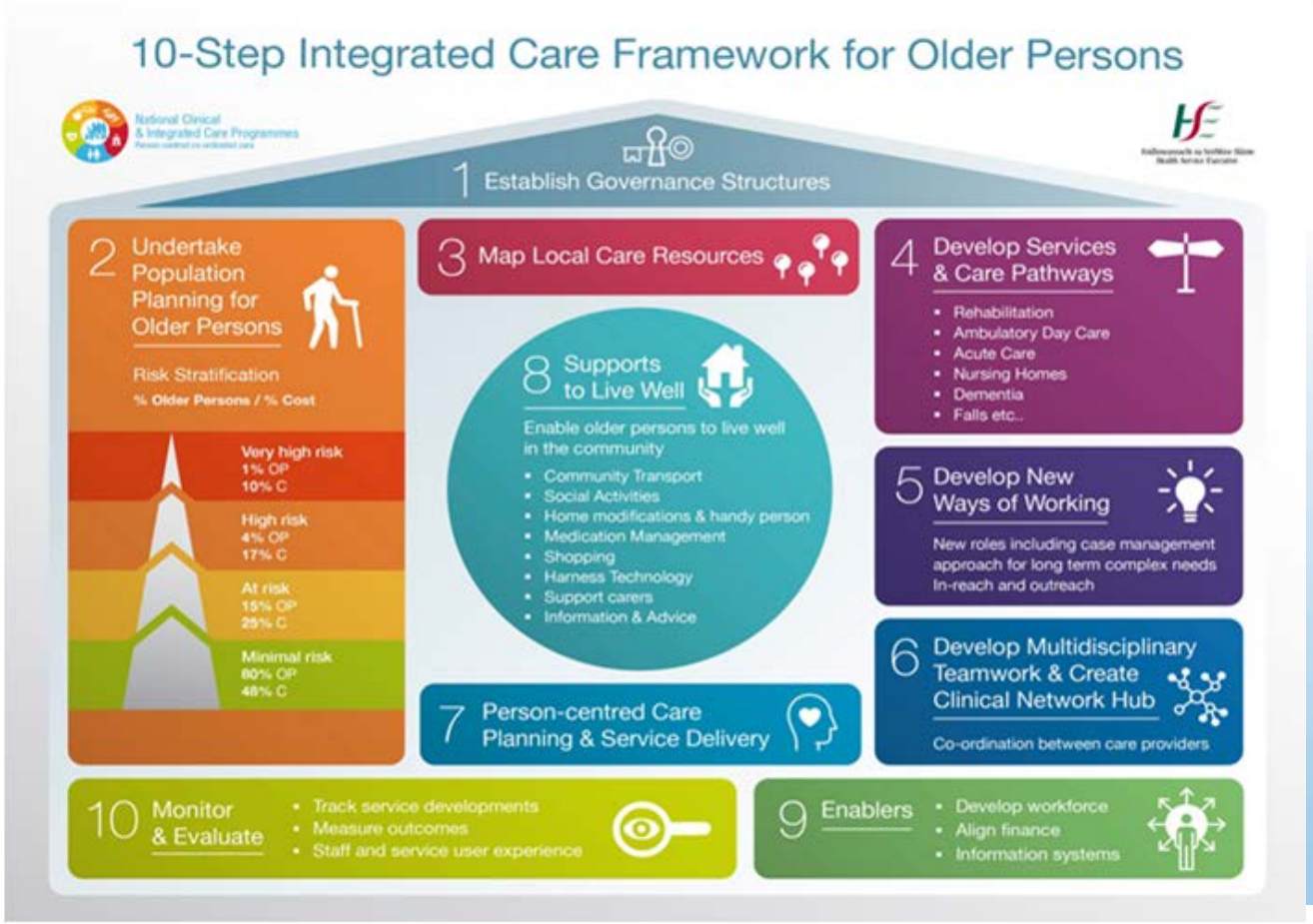
12.5% of discharges use 57.3% of bed days

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

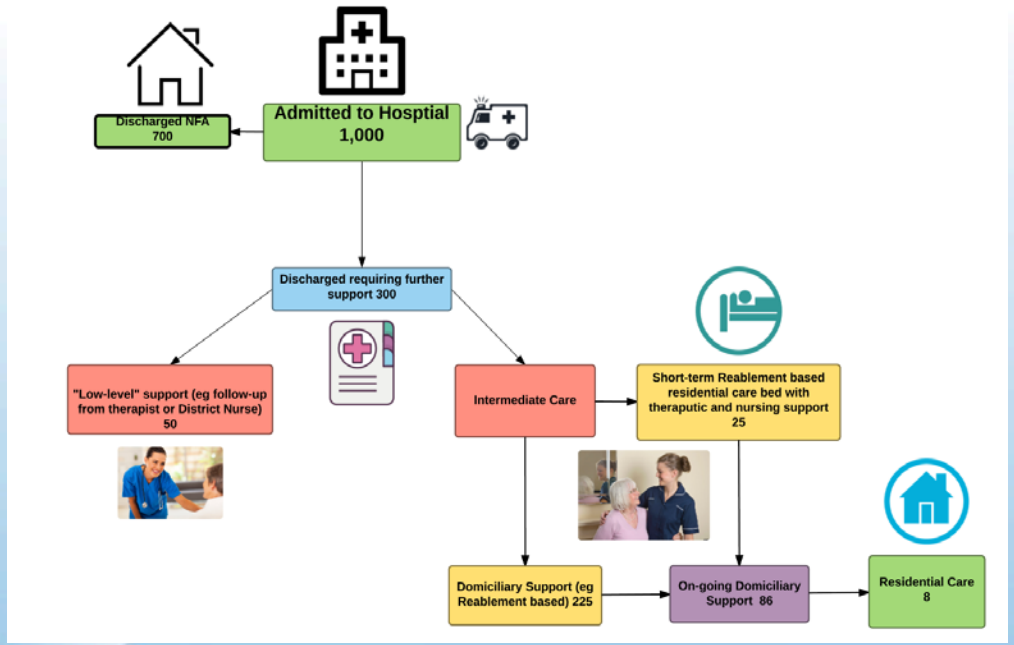
31% robust
45% pre-frail
24% frail

Patrick's Story

10-Step Integrated Care Framework for Older Persons



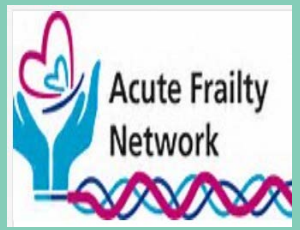
What Smart Hospitals Do



- Focus on the admission pathway (early assess 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

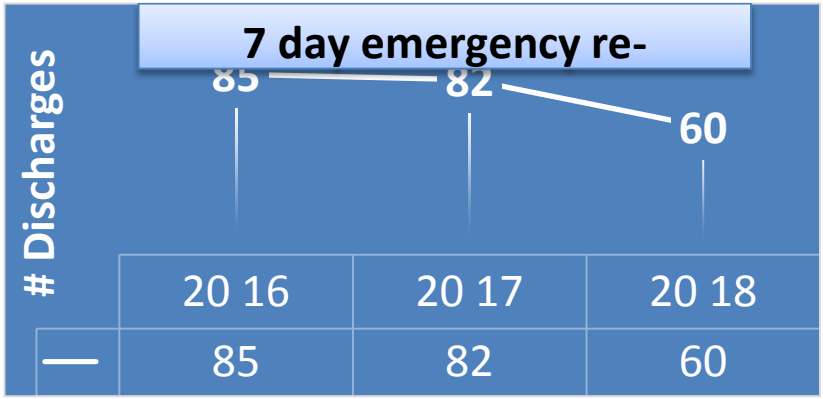
Acute Frailty Network – 10 Principles

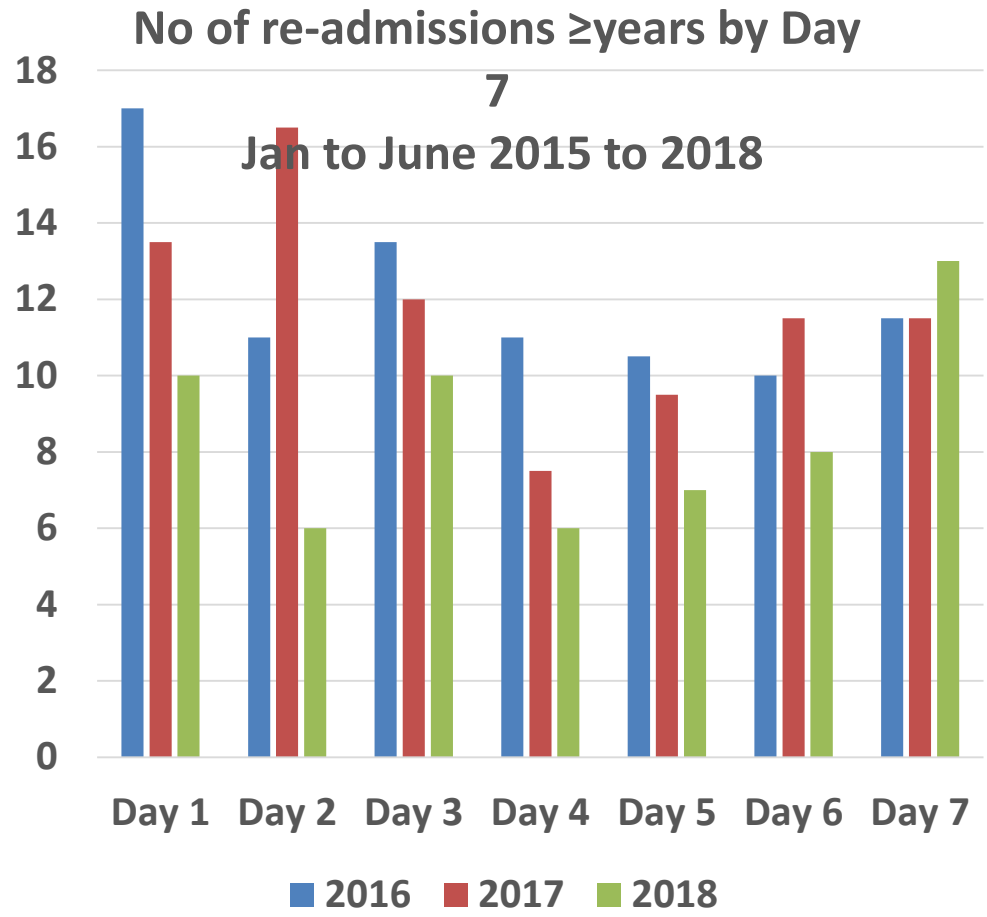
1. Establish a mechanism for early identification of people with frailty
2. Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour or 14 hours if overnight
3. Set up a rapid response system for frail older people in acute care settings
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

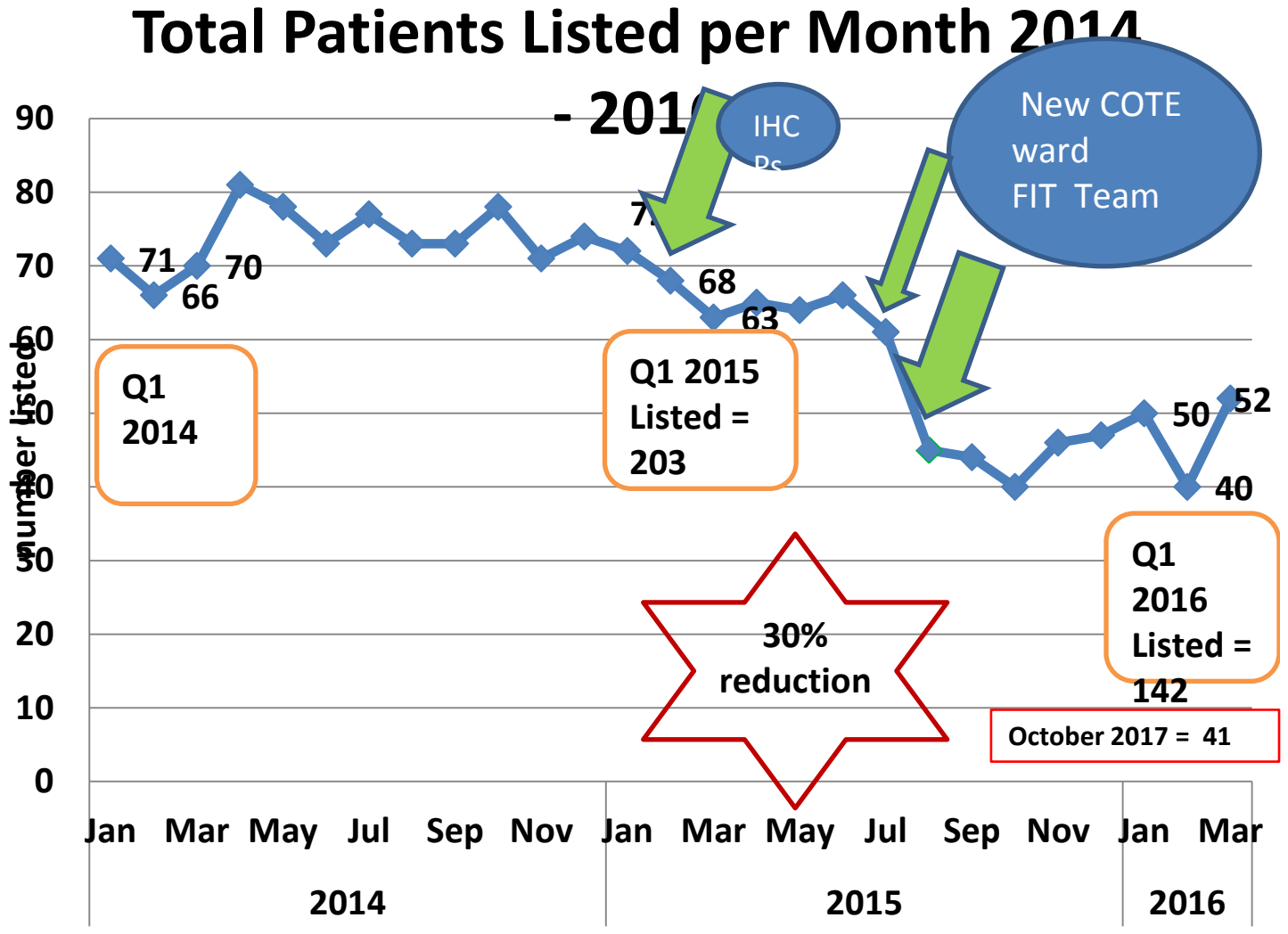


7 day re-admission Rate

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






Total Patients Listed per Month 2014 - 201
IHC
New COTE ward FIT Team
number listed
90
80
70
60
50
40
30
20
10
0
71
66
70
68
63
50
52
40
Q1 2014
Q1 2015 Listed = 203
30% reduction
Q1 2016 Listed = 142
October 2017 = 41
Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar
2014
2015
2016

‘Black Box’ Insights

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 acute services is to be admitted**
- **Lack of prevention services** – immobile, in pain, malnourished, undiagnosed cognitive impairment, incontinence
- **Families unable to cope**
- **Easier to admit patient than discharge**
- **Lack of same day responsive services** – rapid intensive support for short term needed
- **Lack of alternative care pathways/options** for emergency services

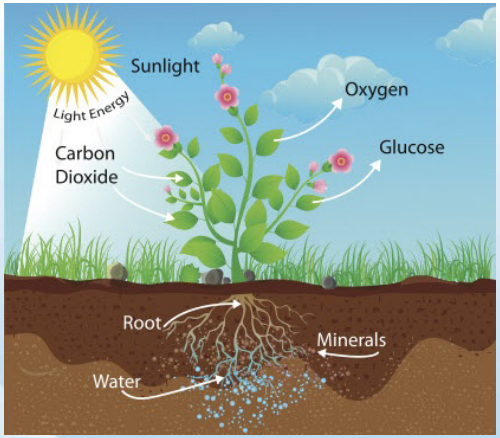
IEHG 2019

What good older persons care looks like

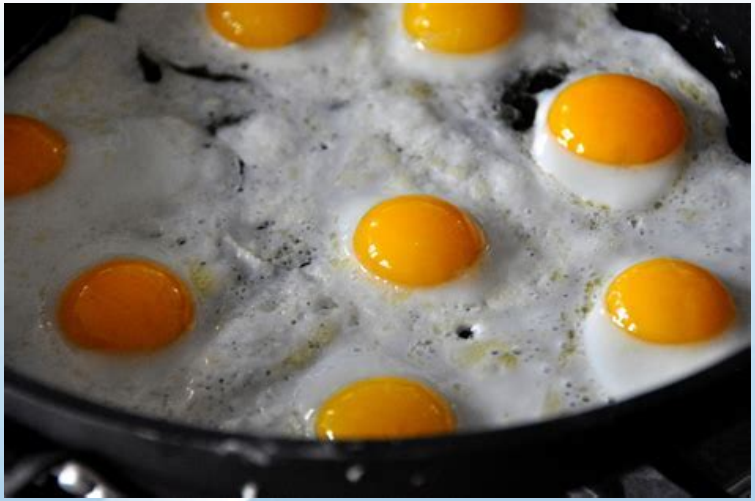
- **Age well and stay well**
- **Live well with one or more long-term condition**
- **Support for complex co-morbidities**
- **Accessible, effective support in crisis**
- **High quality, person-centred acute care**
- **Good discharge planning and post discharge support**
- **Effective rehabilitation and re-ablement**
- **Person-centred, dignified, long-term care**
- **Support, control and choice at end of life**

The King’s Fund

Seed of Change



Workforce to Manage Demand



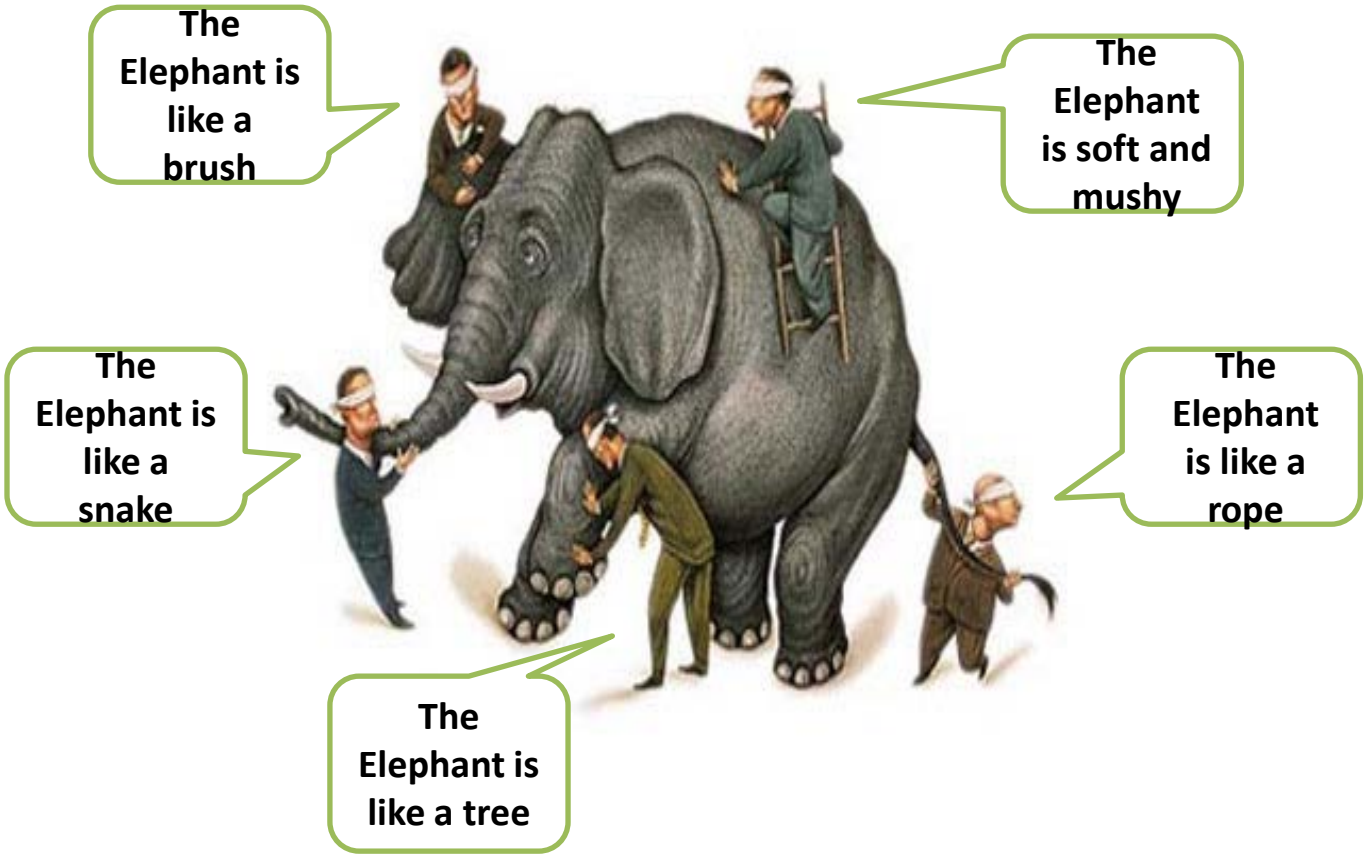
Leadership – executive management
Leadership - senior clinical decision-making
Roles/responsibilities aligned to current need
Capacity
Skill mix
Flexibility
Frontline ownership

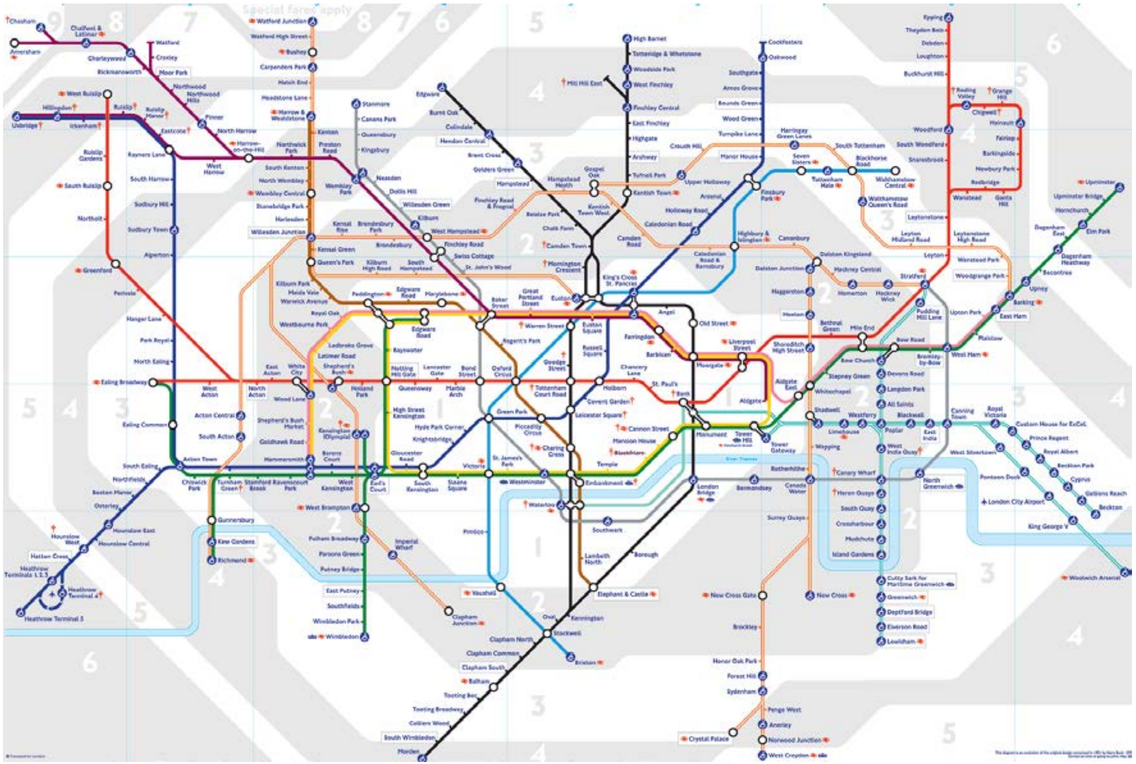
FITT Beaumont Hospital

Ciara O’Reilly

Life before FITT

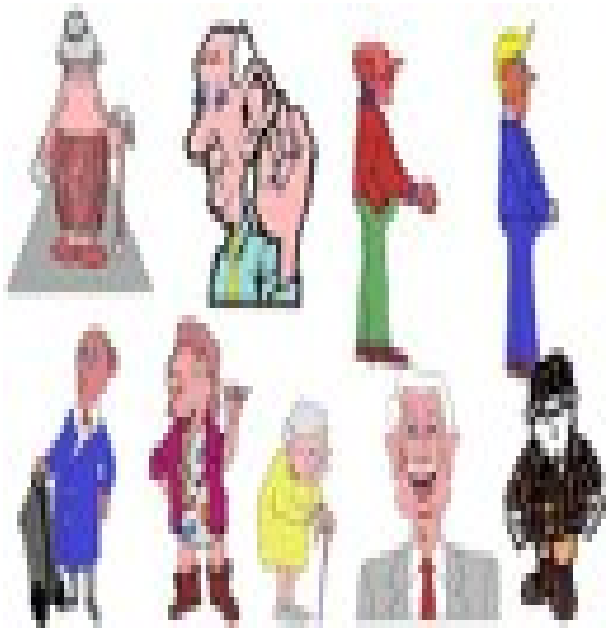
Understanding the WHOLE Elephant!

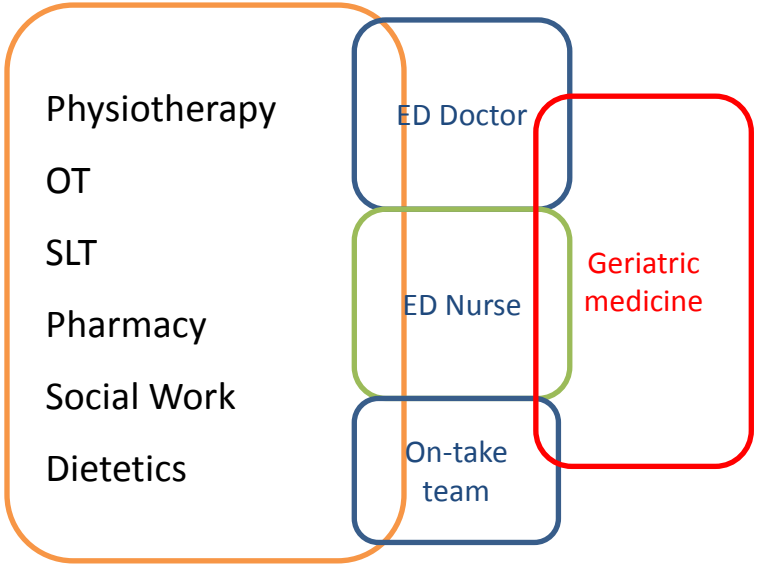



Special fares apply

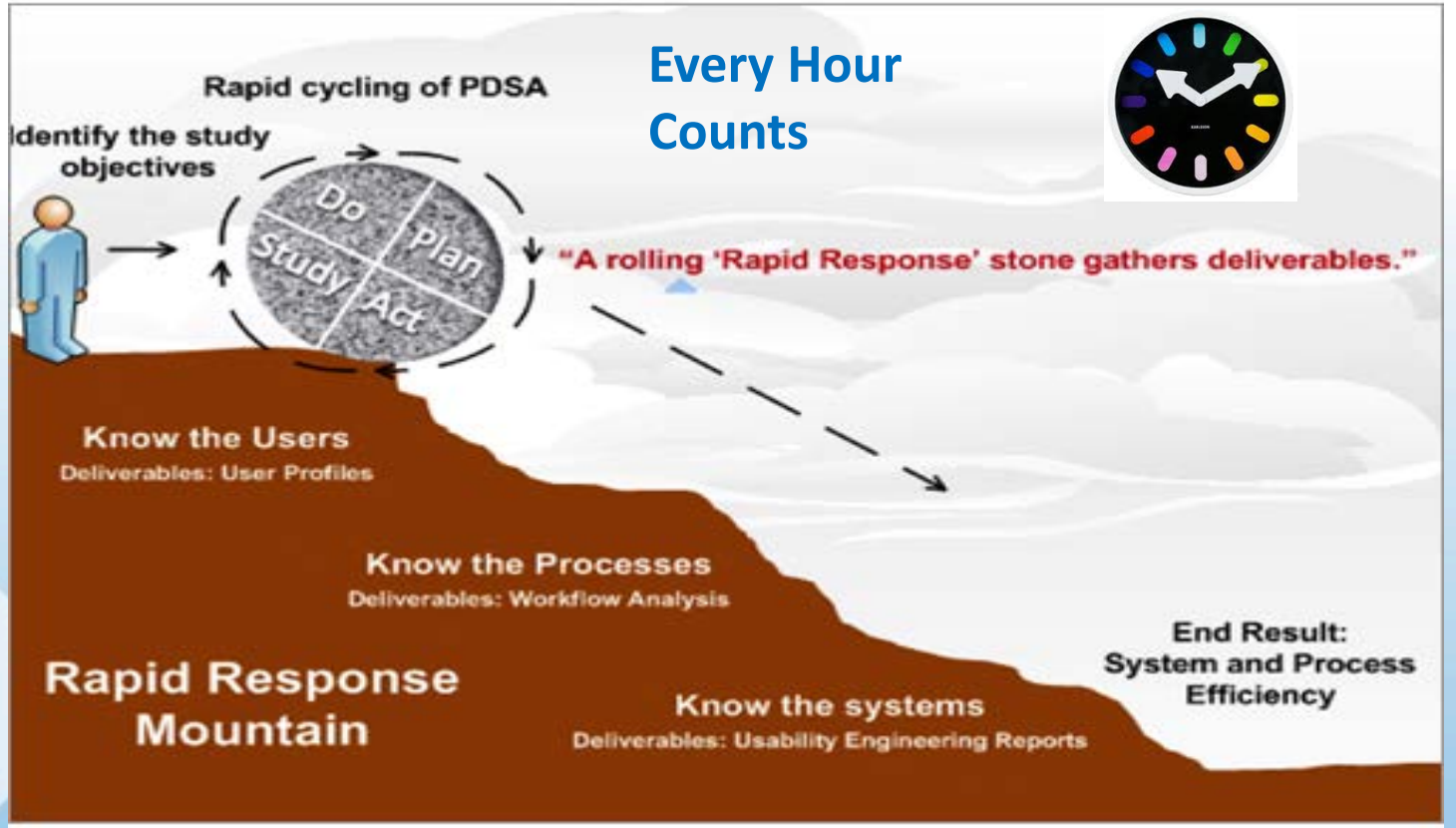
FIT Team Growth

‘Frailty Intervention Therapy Team’





How We Did It.....


Rapid cycling of PDSA
Identify the study objectives
Do
Plan
Study
Act
Every Hour Counts
"A rolling 'Rapid Response' stone gathers deliverables."
Know the Users
Deliverables: User Profiles
Know the Processes
Deliverables: Workflow Analysis
Know the systems
Deliverables: Usability Engineering Reports
End Result: System and Process Efficiency
Rapid Response Mountain

Make the Status Quo uncomfortable

Fostering a Home First Ethos

Is Hospital Always the Most Appropriate Option?

Ann…

How do we know we are making a difference?

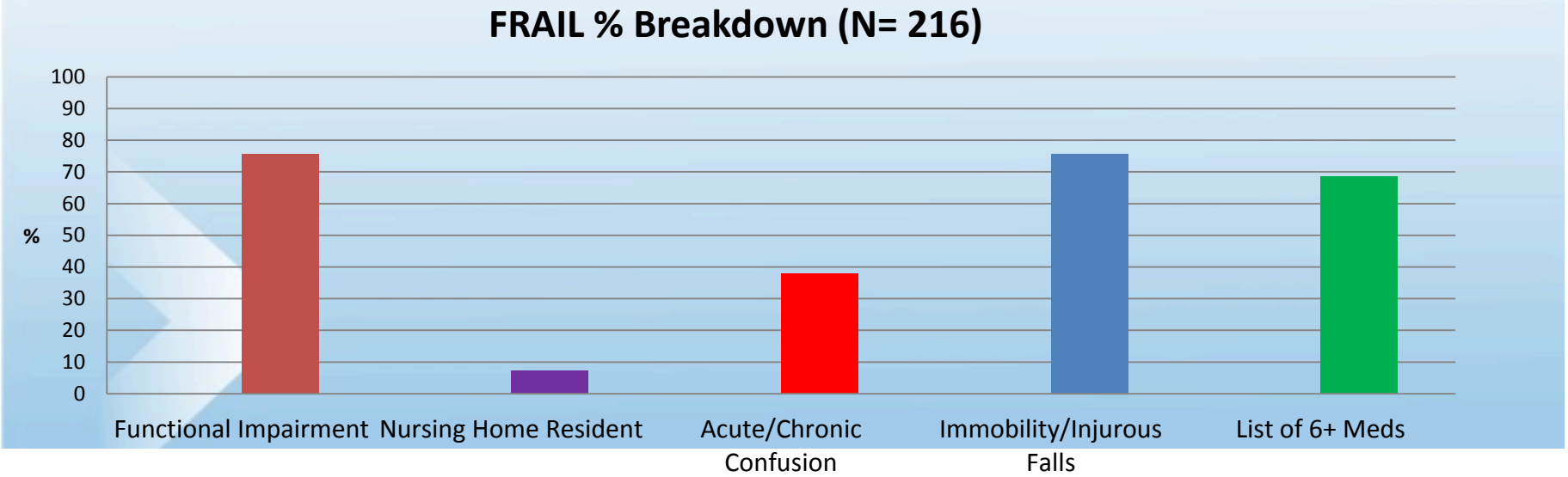
We felt pressure to deliver!

Frailty Screening Profile

224 patients audited retrospectively (random selection)

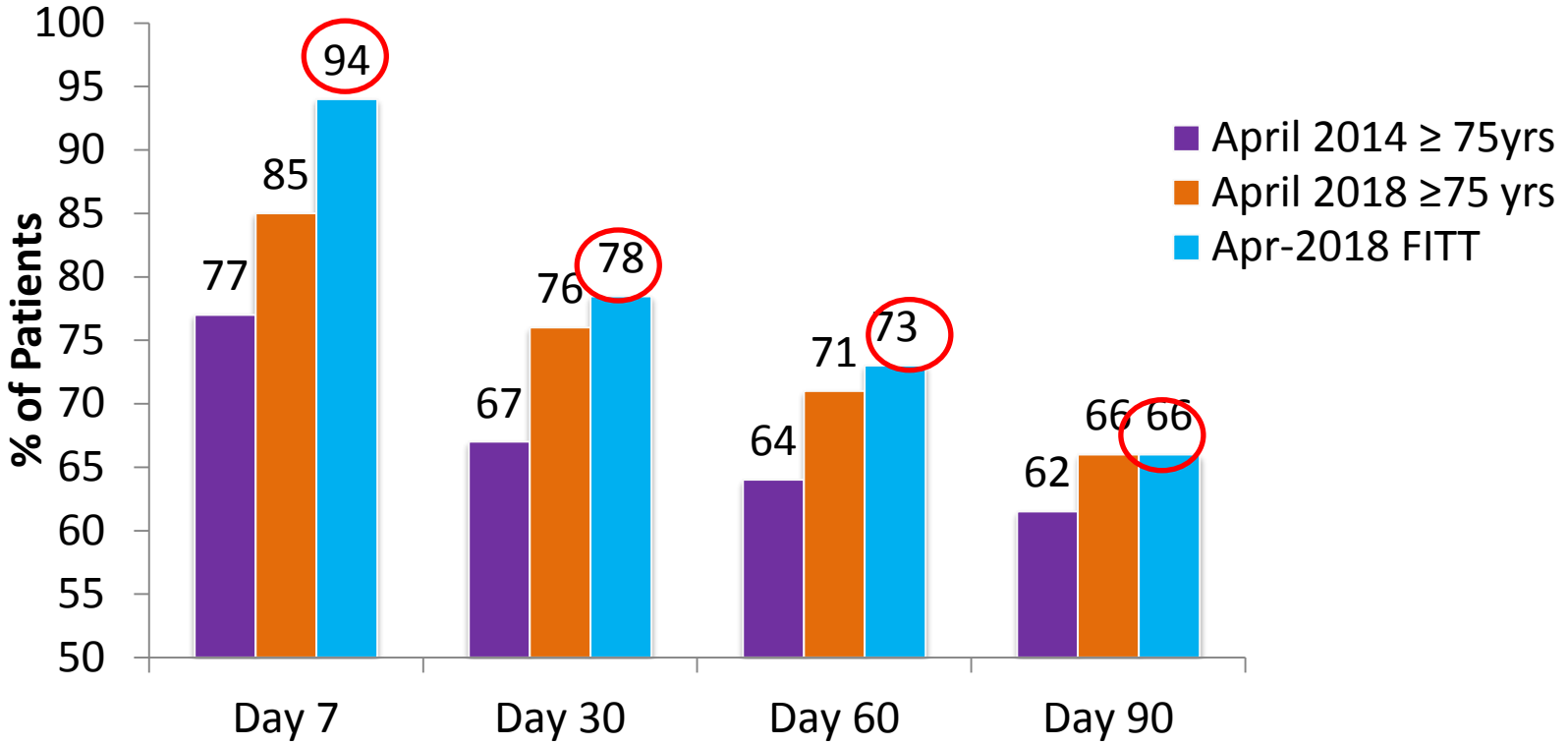
- 75% Frail
- Age range 75 to 97 yrs , Mean 84 YRS
- 35% live alone
- 52% have no formal community supports
- 17% had no informal support
- 5.6% are primary carer for other person

Approx. 17,500 patients screened since FITT started

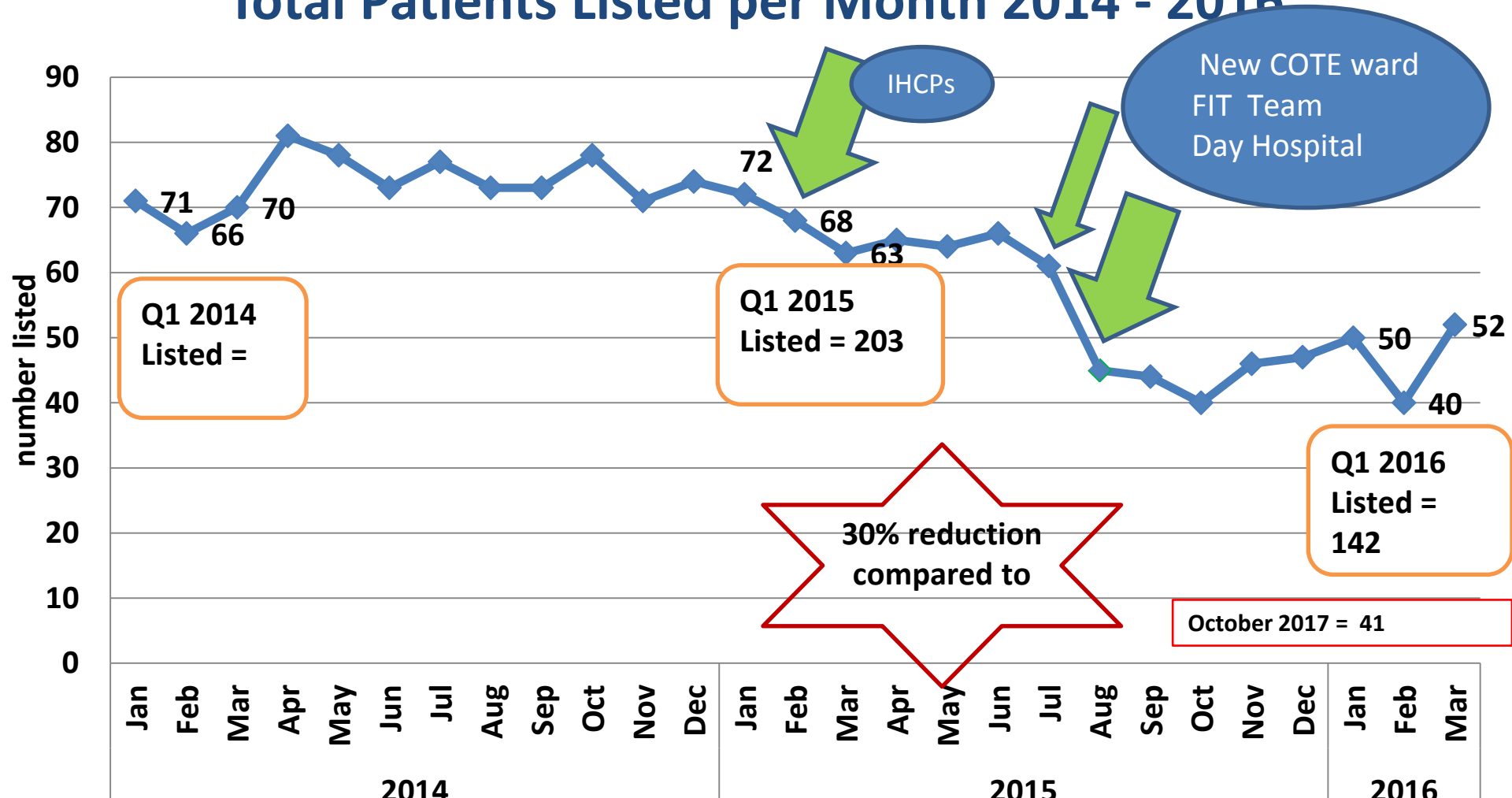


≥ 75 years: % of ED Patients Remaining at Home

(1st Representation to ED)



Total Patients Listed per Month 2014 - 2016



Our experience of FITT

- Greatest challenge of my career
- Challenge my own beliefs and admit what I was doing before was not the right thing!!
- Most rewarding thing any of us have done in our careers.
- Be Brave
- When you do all this amazing things can be achieved….

Supporting Front-line Engagement

FITT Beaumont @FITTBeaumont · 5h

'The team who won't take NO for an answer &have driven Prof Ciaran Donegan describes @FITTBeaumont.

7 13

@FITTBeaumont

A Dietitian manager's perspective in opening the 'black box' of people living with frailty……

Siobhan Julian
Dietitian Manager
Wexford General Hospital

Risk of hospital based deconditioning..

Rapid Improvement Event – Remodelling thinking!

- Reason for Action
- Initial State
- Target State
- Gap Analysis
- Solution Approach
- Rapid Experiments
- Completion Plan
- Confirmed State
- Insights

Title: Frail Elderly Pathway 'first 72 hrs'

Facilitator: Emma Smyth/ Fiona Keogan | **Sensei:** Steve Hurren

Process Owner: Dr. Eithne Harkin | **Sponsor:** Lily Byrnes | **Team Leader:** Orla Fahy/Deirdre Wickham

Team Members: Margaret Bolger, Olivia Cadogan, Crona Carew, Claire Donnelly, Veronica Gallagher, Patricia Hackett, Siobhan Julian, Deirdre Lambert, Maria Randles, Karina Somers, Aine Teevan, Marie Whelan

Start Date: 10.09.2018
Current Date: 13.09.2018
End Date:

1. Reason for Action

Go | No Go

Context: The Unscheduled Care VSA identified the need for the development of a frail elderly pathway in WGH. WGH is currently not meeting PET targets for Patients ≥ 75 years. Furthermore the Acute Frailty Network principles of quality care have not yet implemented at WGH.

The current process to identify frail / at-risk older patients at first point of care is not standardised with limited performance of the Comprehensive Geriatric Assessment, 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 WGH.

Scope and boundary: The first 72 hours of care for ≥ 75yoa Patient cohort presenting to WGH

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

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

b. Achieve Acute Frailty Network (AFN) Principles

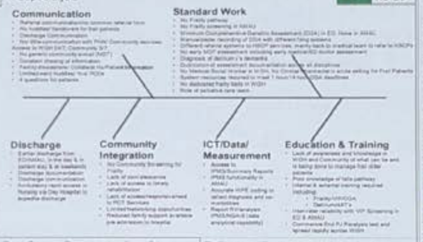
c. Increase rate of completed Comprehensive Geriatric Assessment (CGA) in identified Frail patients within one hour.

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

Reflections: Improvement work required to implement a high quality frailty pathway in WGH, commencing with the first 72 hours (ED / AMAU +/- admission or discharge)

4. Gap Analysis

Go | No Go



Root Cause: Gaps arising from 6 key domains, principally gaps in

Reflections: Frailty pathway required across spectrum of health & social care

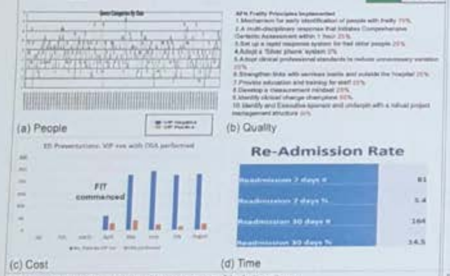
7. Completion Plans

Go | No Go

Action	TT	Owner	Due	RAG
1. Implement alert to WaxFIT (ED/AMAU)		MW/SJ/PMS		
2. Implement flipped VIP Screen (ED/AMAU)		MW		
3. Implement VIP screening in AMAU (Think Research)		DW/AT		
4. Finalise & implement revised CGA form		MB/SJ		
4. Agree & implement CGA for admitted patients (St. Aiden's) for weekdays and weekends		VG/HSCPs		
Implement electronic CGA using tablet		PH/KS		
6. Finalise & implement HSCP common referral form for frail older Patients		SJ/OF/MR/ HSCPs		
7. WaxFIT to commence attending ED Huddles		MW/AT	17/09/18	
8. Implement End PJ Paralysis (St. Aiden's)			31/10/18	
9. Design WaxFIT logo		OF/MR		
10. Reg clinic in Day Hospital ??Ambulatory care in Day Hospital ??Satellite Consultant led clinics??? What [illegible]		OC		
11. Implement revised Community OT prioritisation for frail older patients		CD		
12. Finalise and implement education campaign for WGH, Community and Public		PH/CC/MB		
13. Finalise and implement communication campaign for WaxFIT and Frailty in WGH, Community and Public		PH/CC/MB		

2. Initial State

Go | No Go



Reflections: Limited implementation of key components of the frailty pathway

5. Solution Approach

Go | No Go

Cause/ Priority	Solution	Affecting	Current State	FS	E	C
1	Design and implement frailty pathway in ED/AMAU through to admission/discharge (first 72 hours)	ABCD	Limited components of frailty pathway	In place	Δ	
2	Design and implement Frailty screening in AMAU (for direct GP referred patients)	ABCD	No screening in AMAU	In place	Δ	O
3	Revise CGA documentation	B		In place	O	O
4	Commence process to enable electronic CGA including tablet procurement		Paper record	Electronic	O	Δ
5	Revise HSCP referral guidelines & develop common HSCP referral form		Referrals requested by FIT via medical team	Direct referral	Δ	O
6	Revise WGH Discharge documentation and PHN discharge form		Limited and done per discipline			O
7	Design and implement visual management		None for frailty	In place	O	O
8	Develop & implement training/education campaign for WGH/Community/GPs/Public		Limited training in WGH	Active	O	
9	Develop and implement communication campaign re: WaxFIT, Frailty		Limited awareness	Active	O	

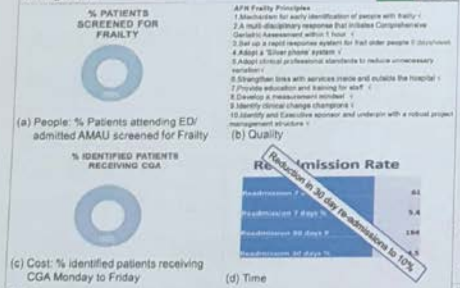
Reflections: - EASE: O = Easy Δ = Medium Ease X = Difficult.
- COST: O = Low Cost Δ = Medium Cost X = High Cost

8. Confirmed state

Go | No Go

3. Target State

Go | No Go



(a) People: % Patients attending ED/ admitted AMAU screened for Frailty

(b) Quality

(c) Cost: % identified patients receiving CGA Monday to Friday

(d) Time

Reflections

6. Rapid Experiments

Go | No Go

Experiment	Anticipated Effect	Actual Effect	Follow up Action
1. Test VIP screening in AMAU	Enable completion of VIP screen for Patients referred directly to AMAU	Manual completion until Think Research implemented	Agree interim method of screening until Think Research active
2. Perform staff survey to ascertain Frailty knowledge across WGH	Establish baseline of frailty knowledge in WGH to inform frailty education campaign	Baseline established	Develop education campaign
3. Test common HSCP referral for frail older Patients	Timely access to required HSCPs for frail older Patients	More responsive intervention from required HSCPs	Agree common referral system across all HSCPs
4. Create & test visual management for Frail older Patients: 'Frailty' sticker on ED & AMAU chart; 'F' on wardboards (PSAG)	Improved awareness of VIP screen and outcome	Patient status/VIP screen awareness raised	Agree system to place stickers on chart

Reflections

9. Insights

Go | No Go

Actions:

Appreciation for the transformation that frontline staff from across organisations can effect when they come together to undertake lean improvement work with their 'hearts and minds' in synch.

What went well?
- Lean Methodology
- Preparation especially Patient Journeys
- Current State Analysis
- Theming concerns/issues to develop solutions
- Discussion/Openness
- Community Engagement
- 'Fresh'/External perspectives
- Sharing and learning with Discharge team(WGH & Comm. on Tuesday)
- Staff Frailty knowledge survey
- Support to procure Tablet

What did not go well?
- Not having key stakeholders in the room for the RIE i.e. Medical and PHNs

What helped?
- Preparation incl. process maps/ surveys/ data
- External team members
- 'GEMBA' walks
- Face-to-face conversations
- IEHG wide sharing and learning
- Testing & implementation during RIE

What hindered?
- Notice & information re:RIE beneficial to team members
- Medical Staff & Public Health Nursing key stakeholders - representation essential

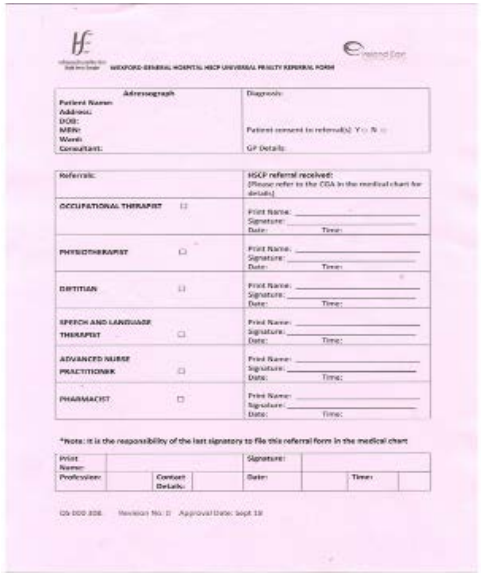
tilda
Staidéar Fadaimseartha na hÉireann um Dhul in Aois

The Irish Longitudinal Study on Ageing

Frailty Hospital Community Support

WexFIT

Acute Frailty Network



WEXFORD GENERAL HOSPITAL HSCP UNIVERSAL FRAILTY REFERRAL FORM

Addressograph	Diagnosis:
Patient Name: Address: DOB: MRN: Ward: Consultant:	Patient consent to referral(s) Y ☐ N ☐ GP Details:

Referrals:	HSCP referral received: (Please refer to the CGA in the medical chart for details)
OCCUPATIONAL THERAPIST ☐	Print Name: Signature: Date: Time:
PHYSIOTHERAPIST ☐	Print Name: Signature: Date: Time:
DIETITIAN ☐	Print Name: Signature: Date: Time:
SPEECH AND LANGUAGE THERAPIST ☐	Print Name: Signature: Date: Time:
ADVANCED NURSE PRACTITIONER ☐	Print Name: Signature: Date: Time:
PHARMACIST ☐	Print Name: Signature: Date: Time:

*Note: it is the responsibility of the last signatory to file this referral form in the medical chart

Print Name:			Signature:		
Profession:		Contact Details:	Date:	Time:	

QS 000 808 Revision No: 0 Approval Date: Sept 19

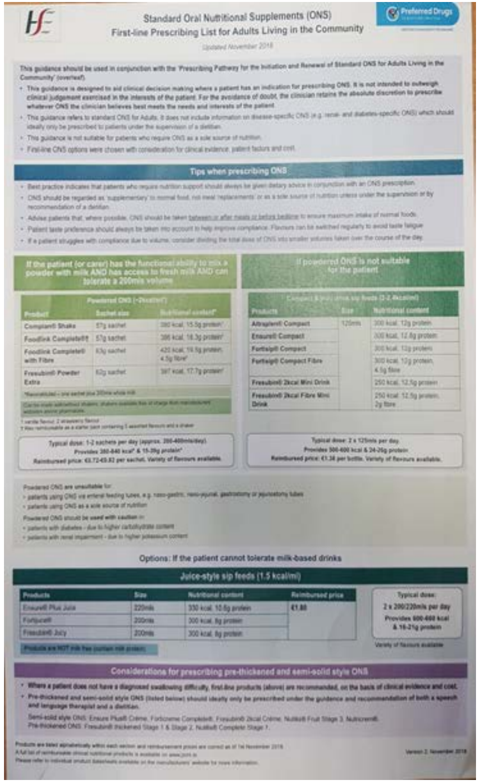
UCD DUBLIN

30/60/90 Days

Student Project Objectives

- ‘To assess patients’ access to food shopping, cooking ability, cooking skills and social support regarding meal preparation for patients over 60 years who are admitted to Wexford General Hospital.’

WIN **WIN** **WIN**



Standard Oral Nutritional Supplements (ONS)
First-line Prescribing List for Adults Living in the Community

Preferred Drugs

Updated November 2018

This guidance should be used in conjunction with the 'Prescribing Pathway for the Initiation and Renewal of Standard ONS for Adults Living in the Community' (overleaf).

- This guidance is designed to aid clinical decision making where a patient has an indication for prescribing ONS. It is not intended to outweigh clinical judgement exercised in the interests of the patient. For the avoidance of doubt, the clinician retains the absolute discretion to prescribe whatever ONS the clinician believes best meets the needs and interests of the patient.
- This guidance refers to standard ONS for Adults. It does not include information on disease-specific ONS (e.g. renal- and diabetes-specific ONS) which should ideally only be prescribed to patients under the supervision of a dietitian.
- This guidance is not suitable for patients who require ONS as a sole source of nutrition.
- First-line ONS options were chosen with consideration for clinical evidence, patient factors and cost.

Tips when prescribing ONS

- Best practice indicates that patients who require nutrition support should always be given dietary advice in conjunction with an ONS prescription.
- ONS should be regarded as 'supplementary' to normal food, not meal 'replacements' or as a sole source of nutrition unless under the supervision of or by recommendation of a dietitian.
- Advise patients that, where possible, ONS should be taken between or after meals or before bedtime to ensure maximum intake of normal foods.
- Patient taste preference should always be taken into account to help improve compliance. Flavours can be switched regularly to avoid taste fatigue.
- If a patient struggles with compliance due to volume, consider dividing the total dose of ONS into smaller volumes taken over the course of the day.

If the patient (or carer) has the functional ability to mix a powder with milk AND has access to fresh milk AND can tolerate a 200mls volume

Powdered ONS (~2kcal/ml*)

Product	Sachet size	Nutritional content*
Complan® Shake	57g sachet	380 kcal, 15.5g protein¹
Foodlink Complete®†	57g sachet	386 kcal, 18.3g protein¹
Foodlink Complete® with Fibre	63g sachet	420 kcal, 19.9g protein, 4.5g fibre¹
Fresubin® Powder Extra	62g sachet	397 kcal, 17.7g protein¹

*Reconstituted – one sachet plus 200mls whole milk

Typical dose: 1-2 sachets per day (approx. 200-400mls/day)
Provides 380-840 kcal* & 15-39g protein*
Reimbursed price: €0.72-€0.82 per sachet. Variety of flavours available.

If powdered ONS is not suitable for the patient

Compact & mini drink sip feeds (2-2.4kcal/ml)

Products	Size	Nutritional content
Altraplen® Compact	125mls	300 kcal, 12g protein
Ensure® Compact		300 kcal, 12.8g protein
Fortisip® Compact		300 kcal, 12g protein
Fortisip® Compact Fibre		300 kcal, 12g protein, 4.5g fibre
Fresubin® 2kcal Mini Drink		250 kcal, 12.5g protein
Fresubin® 2kcal Fibre Mini Drink		250 kcal, 12.5g protein, 2g fibre

Typical dose: 2 x 125mls per day.
Provides 500-600 kcal & 24-26g protein
Reimbursed price: €1.38 per bottle. Variety of flavours available.

Powdered ONS are unsuitable for:
- patients using ONS via enteral feeding tubes, e.g. naso-gastric, naso-jejunal, gastrostomy or jejunostomy tubes
- patients using ONS as a sole source of nutrition

Powdered ONS should be used with caution in:
- patients with diabetes - due to higher carbohydrate content
- patients with renal impairment - due to higher potassium content

Options: If the patient cannot tolerate milk-based drinks

Juice-style sip feeds (1.5 kcal/ml)

Products	Size	Nutritional content	Reimbursed price
Ensure® Plus Juice	220mls	330 kcal, 10.6g protein	€1.80
Fortijuce®	200mls	300 kcal, 8g protein	
Fresubin® Jucy	200mls	300 kcal, 8g protein	

Products are NOT milk free (contain milk protein)

Typical dose:
2 x 200/220mls per day
Provides 600-660 kcal & 16-21g protein
Variety of flavours available

Considerations for prescribing pre-thickened and semi-solid style ONS

- Where a patient does not have a diagnosed swallowing difficulty, first-line products (above) are recommended, on the basis of clinical evidence and cost.
- Pre-thickened and semi-solid style ONS (listed below) should ideally only be prescribed under the guidance and recommendation of both a speech and language therapist and a dietitian.

Semi-solid style ONS: Ensure Plus® Crème, Forticreme Complete®, Fresubin® 2kcal Crème, Nutilis® Fruit Stage 3, Nutricrem®.
Pre-thickened ONS: Fresubin® thickened Stage 1 & Stage 2, Nutilis® Complete Stage 1.

Products are listed alphabetically within each section and reimbursement prices are correct as of 1st November 2018.
A full list of reimbursable clinical nutritional products is available on www.[illegible]
Please refer to individual product datasheets available on the manufacturers' website for more information.

Version 2, November 2018

Malnutrition
Universal **S**creening
Tool
(**MUST**)

Cognitive **G**lobal
Assessment
(**CGA**)

Meals on Wheels

Ongoing Cycle ...

- Challenge your thinking
- Multidisciplinary approach - powerful and inspiring
- Solutions approach
- Keep it Simple and Straight forward
- Celebrate and share your success
- Never forget what it is all about
- Right Treatment, Right Place, Right Time

Thank you

- Colleagues in WGH & IEHG
- Look forward to next RIE in Admitted Care

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

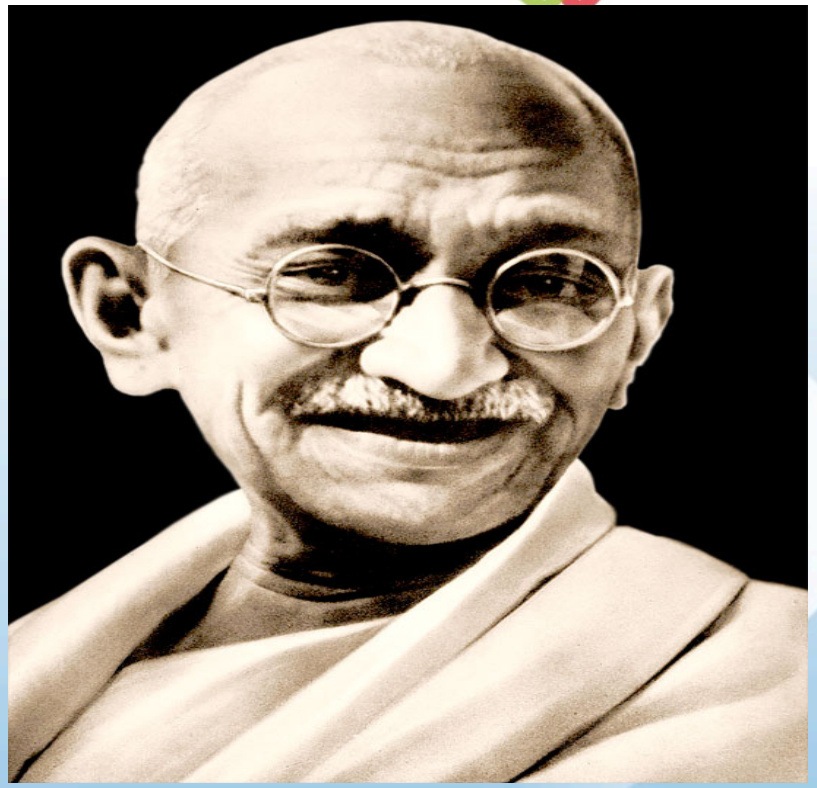
- People own what they create
- Real change takes place in real work
- The people that do the work do the change
- Start anywhere but follow it everywhere
- Keep connecting the system to itself
- The process we use to get to the future determines the future we get

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



Here is a link to the Healthcare Improvement Scotland Ax tool comparator, it is useful for people to find what is validated for work in their clinical area:

- https://ihub.scot/media/1742/frailty-screening-and-assessment-tools-comparator.pdf

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 19th March 1pm

Continuing the Frailty Conversation

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