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

1pm Tues March 5th 2019
**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
26 Disciplines

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

Doctors & Dentists

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

HSE Clinical Workforce Groups

Nurses & Midwives

- 37,297 people
- 59% of staff
- €805M 2018 pay budget YTD
  (52%)
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 provide safe and timely discharge of patients with complex needs, with no increase in readmissions
- Need to enable patient choice
- Need to reduce cost
- Need to improve flow and reduce LOS
- Need to increase patient trust and satisfaction
- Need to improve employee satisfaction
Current State

Population growth 2011-2022

0-16 17-64 65-84

ED Admissions: 1000 population by age

- 12.5% of discharges use 57.3% of bed days
- 31% robust
- 45% pre-frail
- 24% frail
Patrick’s Story
10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons
   - Risk Stratification
     - Very high risk (1% OP, 10% C)
     - High risk (4% OP, 17% C)
     - At risk (19% OP, 29% C)
     - Minimal risk (60% OP, 49% C)

3. Map Local Care Resources

4. Develop Services & Care Pathways
   - Rehabilitation
   - Ambulatory Day Care
   - Acute Care
   - Nursing Homes
   - Dementia
   - Falls etc...

5. Develop New Ways of Working
   - New roles including case management approach for long term complex needs
   - In-reach and outreach

6. Develop Multidisciplinary Teamwork & Create Clinical Network Hub
   - Co-ordination between care providers

7. Person-centred Care Planning & Service Delivery

8. Supports to Live Well
   - Enable older persons to live well in the community
     - Community Transport
     - Social Activities
     - Home modifications & handy person
     - Medication Management
     - Shopping
     - Harness Technology
     - Support services
     - Information & Advice

9. Enablers
   - Develop workforce
   - Align finance
   - Information systems

10. Monitor & Evaluate
    - Track service developments
    - Measure outcomes
    - Staff and service user experience
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%

7 day emergency re-admissions

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<th>Day 1</th>
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<td>85</td>
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No of re-admissions ≥years by Day

Jan to June 2015 to 2018

7 day re-admission Rate

- 2016
- 2017
- 2018

Reduction in 7 day re-admissions of 29.4%
Total Patients Listed per Month 2014 - 2016

- New COTE ward FIT Team
- Q1 2015 Listed = 203
- Q1 2016 Listed = 142
- 30% reduction
- October 2017 = 41
‘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

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

IEHG 2019

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
Life before FITT
Understanding the WHOLE Elephant!

The Elephant is like a snake

The Elephant is like a brush

The Elephant is soft and mushy

The Elephant is like a tree

The Elephant is like a rope
A major challenge in the ED, is that older people do not fit neatly into a clinical pathway. Clinical expertise in Geriatric medicine is essential as you need to be able to see the whole picture even through the muddy waters. Senior Clinical Roles enabled this process.
FIT Team Growth

‘Frailty Intervention Therapy Team’

Physiotherapy
OT
SLT
Pharmacy
Social Work
Dietetics

ED Doctor
ED Nurse
On-take team

Geriatric medicine
How We Did It.....

Every Hour Counts

Rapid cycling of PDSA
Identify the study objectives
Do plan Study Act
“A rolling ‘Rapid Response’ stone gathers deliverables.”

Know the Users
Deliverables: User Profiles

Know the Processes
Deliverables: Workflow Analysis

Rapid Response Mountain
End Result: System and Process Efficiency

Know the systems
Deliverables: Usability Engineering Reports
Fostering a Home First Ethos

Make the Status Quo uncomfortable
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

FRAIL % Breakdown (N= 216)
≥ 75 years: % of ED Patients Remaining at Home
(1st Representation to ED)

Day 7 | Day 30 | Day 60 | Day 90
--- | --- | --- | ---
77% | 76% | 71% | 64%
85% | 78% | 73% | 66%
94% | 67% | 62% | 66%

April 2014 ≥ 75yrs
April 2018 ≥75 yrs
Apr-2018 FITT
Total Patients Listed per Month 2014 - 2016

Q1 2014 Listed = 71
Q1 2015 Listed = 203
Q1 2016 Listed = 142

30% reduction compared to October 2017 = 41

New COTE ward
FIT Team
Day Hospital

IHCPs
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 @FITTB Beaumont · 5h

'The team who won't take NO for an answer & have driven Prof Ciara Donegan describes @FITTB Beaumont.
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 hours

Facilitator: Emma Smyth Fiona Keegan

Team Leader: Ola Fatoyinbo

Team Members: Margaret Boger, Olivia Castong, Connor Cowen, Claire Donnelly, Veronica Castong, Patricia Hackert, Susan Julian, Debra Lambert, Randy Randles, Karina Schnee, Anne Taylor, Marine Sivonen

Start Date: 10.09.2018

Current Date: 13.09.2018

End Date: 

1. Reason for Action
Context: The Unhurried Care VBP identified the need for the development of a Frail Elderly Pathway for patients currently not meeting M1 goals for Patients 65+ years. Furthermore, the Acute Frailty Network principles of quality care have not been implemented at WJH.

The current process to identify frail older patients at the point of care is not standardized with limited performance of the Comprehensive Geriatric Assessment, causing increased risk. Increased P&T and antimicrobial LGO for the 75+ Patient cohort.

The purpose of the RIE is to implement the Acute Frailty Network principles for the first 72 hours of care in WJH.

Screen and Sustain: First 72 hours care for a 75+ Patient cohort ensuring prescribing, improving over the next 3-5 days.

Impact: Improvement in care and quality of care leading to a reduction in hospital readmissions.

2. Initial State

(a) People

(b) Quality

3. Target State

4. Gap Analysis

5. Standard Work

6. 7s Completion Plan

7. Problem Description

- Patient: 65+ (M1)
- Frailty
- Antimicrobial LGO for 75+ Patient cohort
- No comprehensive Geriatric Assessment

8. Root Cause

Gaps arising from 6 key areas:

1. Frailty
2. Antimicrobial LGO
3. No comprehensive Geriatric Assessment
4. No M1 direction for 75+
5. Antimicrobial LGO

9. Solution Approach

10. Rapid Experiments

11. Intrinsic Actions

12. What went well?

- Improved care and outcomes
- Reduced antimicrobial use
- Improved quality of care

13. What did not go well?

- Initial implementation challenges
- Resistance to change
- Resource limitations

14. What helped?

- Leadership support
- Staff engagement
- Continuous improvement initiatives

15. What hindered?

- External factors
- Limited resources
- Resistance to change
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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.’
Malnutrition Universal Screening Tool (MUST)

Cognitive Global Assessment (CGA)
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:

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

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

Next QI Talktime:

Tuesday 19th March 1pm

Continuing the Frailty Conversation

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