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
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

11.8%

<8%

2014 2016

Increasing rate of Serious Incidents

2014 2016

Patient Care Report documentation quality
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)
Our Hypothesis

Primary Drivers

- Improved Documentation Quality

Secondary Drivers

- Assisted Decision Making
  - Information on patients' Vital signs, norms, Clinical impression, Risks, Alternative choices
  - Achieved by Improved Communication & Documentation

Target Areas of Improvement

Patient Experience

- Improved Communication
Our Hypothesis

Primary Drivers

Education

Retention of Information

Secondary Drivers

Clarity on expectations

Why it is important.

Aide Memoire

Reissue of guidelines

Audit

Feedback

Target Areas of improvement

Good/Bad examples

Policy Clarity

Increase Rate

Sticker

Easy Read

Fieldguide/CPG

Local Audit

Publish rates of completion

Local Feedback

Competitive?

Timely

Constructive
Our Hypothesis

**Primary Drivers**
- Patient Condition
- Consistent Risk Information
- Patient Follow-up
- Information received by patient

**Secondary Drivers**
- Vital Signs
- List of common complaints
- Accessible Information
- Patient Survey
- GP notification
- Patient Signature

**Target Areas of improvement**
- Normal/Not Normal values
- Document
  - Normal/Not Normal values
  - Printout
  - Phone App
  - Text
  - Business Card
The people/teams we need to communicate with are:

- Ambulance staff
- Clinical information Manager
- Paramedic Supervisors
- NEOC Ambulance Control
- Operational Managers
- Medical Director
- Patients
- Ambulance College
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, 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)
Mean paper PCRs 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
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. 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.
Refusals to travel, patient empowerment and documentation improvement in the National Ambulance Service: A Quality Improvement Project.

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.

Eamonn Byrne (1,2), Paul Gallen (1,2), Sasha Selby (3), Alan Watts (2,4)
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.
Anecdotally 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 patient's current issue?
Two sets of vital signs?
Including Times, HR, RR, BP, and Temp and GCS. Is the patient's 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 e.g. 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**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline Combined</th>
<th>Final Combined</th>
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</thead>
<tbody>
<tr>
<td>Average Completion Rate</td>
<td>63.2%</td>
<td>83.4%</td>
</tr>
<tr>
<td>Median Completion Rate</td>
<td>73.1%</td>
<td>96.2%</td>
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<tr>
<td>Minimum Completion Rate</td>
<td>7.7%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Maximum Completion Rate</td>
<td>100.0%</td>
<td>100.0%</td>
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N=70, Sequential Sample, 29 April to 29 July 2018
Analysis of RTT per Hour Call Stopped, Mallow
29 April 2018-29 July 2018

Shift change 0800h

Hour Call Stopped,
Includes Multi-Casualties incidents
64 incidents
70 patients
1 Std Dev Shown

Shift change 2000h
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.
How is that a problem?

An older patient’s condition may be wrongly classed as stable.
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 & SYNCOPE UNIT (AONAD TITIMÍ & SIONCÓIPÉ) Welcome to the Falls and Syncope Unit (FASU) at Mercer’s Institute for Successful Ageing.
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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