Beyond the Awesome

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#ihubfrailty

Improvement Hub
Enabling health and social care improvement
Overview

1. Becoming Awesome
2. Sustaining Awesome
3. Facing challenges
Geriatric Assessment Unit (GAU)

How we changed our inpatient system of CGA
Process of care

• Admissions
  – via A&E or AMIA (both have 4 hour targets)
  – Admission criteria = ‘Think Frailty’ criteria

• Assessment
  – Consultant Geriatrician, Nurses, OT, PT
  – Core team availability 8-8 weekdays, 8-1 weekends

• Daily MDT ‘huddle’
  – Patient discussed by whole MDT
  – Management plan agreed on
  – EDD set (discharge focus)

• Outlets:
  – Home; Acute inpatient bed; Rehab ward/Community Hospital
## Effect of GAU

<table>
<thead>
<tr>
<th></th>
<th>Woodend admissions 12 months to Nov 12</th>
<th>GAU admissions 12 months from Jan 13</th>
<th>% change (if p&lt;0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients</td>
<td>2,034</td>
<td>4,561</td>
<td>↑ 124%</td>
</tr>
<tr>
<td>Mean age</td>
<td>85.9</td>
<td>85.7</td>
<td>↔</td>
</tr>
<tr>
<td>Median Length of Stay</td>
<td>11 days</td>
<td>4 days</td>
<td>↓ 64%</td>
</tr>
<tr>
<td>Discharge &lt;24h</td>
<td>3%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Discharge &lt;48h</td>
<td>9%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Discharge Home</td>
<td>71%</td>
<td>74%</td>
<td>↑ 4%</td>
</tr>
<tr>
<td>Institutionalisation</td>
<td>5%</td>
<td>3.5%</td>
<td>↓ 30%</td>
</tr>
<tr>
<td>Inpatient mortality</td>
<td>12.7%</td>
<td>12.5%</td>
<td>↔</td>
</tr>
</tbody>
</table>
Monthly median length of stay in each unit

Figure 5: Monthly median LOS
Progress towards ‘front door CGA’

- **2008**
  - Woodend: Direct ward admission

- **Mar 2009**
  - Triage Unit

- **Dec 2012**
  - Rehab only

- **Aug 2017**
  - ARI: Geriatric liaison only
  - Acute beds: 152

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Progress towards ‘front door CGA’

Direct ward admission
Triage Unit
Woodend
ARI
eCGA on AMAU
Geriatric Assessment Unit

2008
Mar 2009
Dec 2012
Aug 2017

Now: 63 Acute beds

Acute beds
152
121
90
79
Generalisable principles

1. **Early Consultant review**
   Consultant review within 12 hours of admission

2. **Early MDT review**
   AHPs with sufficient seniority to take positive risk

3. **Focus on discharge**
   MDT huddle on day of admission. EDD set on day 1.

4. **Daily multidisciplinary board rounds**
   Focus on discharge plans: is EDD going to be met? What are the barriers to discharge?

5. **Consultant ownership**
   Same Consultant from admission to discharge
Jeannie has fallen in the context of delirium...

- Admitted to AMIA by GP
- Screened for delirium using 4AT
- AWI document completed
- Identified as appropriate for GAU according to ‘Think Frailty’ screening
- On transfer to GAU, FALLS bundle commenced
- MDT document findings in shared MDT notes
- PTWR sticker used to ensure essentials considered
- Proactive discussion with family re concerns and discharge
- Case discussed at GAU Huddle, where a clear plan and EDD are set
Jeannie is not mobilising well due to painful hip, and is transferred to ward 306...

- What Matters To Me and Getting To Know Me completed by nurses with Jeannie and family
- Up and dressed for every meal
- Discussed at the (no board) Board Round to ensure on track for discharge
- IDL is done on time using IDL template
- On day of discharge, ‘Pink Pause’ completed
- Information given to Jeannie for onward care on discharge
To promote health, well-being and independence amongst older people through safe, effective, person-centred care.

**Primary Driver**

- Immobility and Falls
- Delirium and Dementia
- Person-centred Care Processes
- Discharge Processes and Flow
- Leadership
- Quality Improvement

**Secondary Driver**

- SPSI – Falls, Falls screening, Care planning
- Enablement
- Telecare
- Consistent bed rail assessments
- Preventing and managing pressure ulcers
- Assessment/reassessment for risk of developing pressure ulcers
- Documentation
- Maintaining mobility

- Assessment for Cognitive Impairment on admission
- Identification and management of delirium
- Compliance with Adults with Incapacity legislation
- Ensure patients identified as having cognitive impairment have a personalised care plan in place
- Ensure systems to record key personal information about people with cognitive impairment
- GTKM, WMTM.

- Compliance with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR)
- Documentation
- All patients treated in accordance Clinical Standards for Older People in Acute care
- Nutritional Care and Hydration Assessment for under-nutrition within 24 hours of admission to hospital and on an ongoing basis
- Personalised nutritional care plans
- Food and fluid intake accurately monitored and necessary action if intake is inadequate.
- Person-centred mealtimes managed in a manner that ensures that the patients are prepared for meals and get assistance in a timely manner
- Hello my name is

**Acute Geriatric Medicine 2014/15 Goals:**

- 25% reduction Falls
- 90% of people asked report a positive experience of care
- No complaints re discharge process
- No patients boarded from Acute Geri Med

**Leadership Quality Improvement**

- Raise profile of Care of Older People within hospital
- Demonstrate that NHSG values its staff and invests in time dedicated to Quality Improvement
- Provide leadership around implementation and development of ongoing QI
- Empower wards and departments to find their own solutions
- Empower staff to raise concerns over care processes or systems
- Staff education on QI methodology

**Acute Geriatric Medicine 2014/15**

- Effective discharge planning begins on, or shortly after admission, and is a continual process
- eDl standard in place re early completion and forward to pharmacy
- Management of patient flow in the hospital is fit for purpose, and maintains patient safety, care and dignity
- Reduce inflow to Unscheduled Care

**Raise profile of Care of Older People within hospital**

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Friday QI meetings

Workstreams based on Primary Drivers

Nursing/Medical/AHP lead for each group

#FridayisQIday

QI meeting topic rotates weekly through each workstream
Improving Older People's Acute Care

Learning from a Blended Local Collaborative Approach 2015-2016
Identifying critical success factors for improved outcomes for people with dementia and their carers in acute care
A focus on NHS Grampian
3 preconditions for radical change...

- Vision
- Engaged, facilitating management
- Boots on the ground
So what happened next?
Emergency and delayed discharge bed days per 1000: aged 75+, ye January 2014

Source: ISD
Chart by PK/AR JIT
Silver City project
reducing admissions from Northfield/Mastrick GP practice
Improvements in Orthogeriatric care
Older People’s Care Collaborative
So what was happening on GAU/Acute Geriatrics?
Challenges...
• Staffing
• Workload
Monthly admissions to medical wards
Change in mean admissions over time since ECC opened

<table>
<thead>
<tr>
<th></th>
<th>102</th>
<th>104</th>
<th>GIM</th>
<th>107</th>
<th>108</th>
<th>109</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions/Month ECC open</td>
<td>319</td>
<td>159</td>
<td>308</td>
<td>169</td>
<td>79</td>
<td>165</td>
<td>1199</td>
</tr>
<tr>
<td>Admissions/Month now</td>
<td>396</td>
<td>124</td>
<td>334</td>
<td>158</td>
<td>87</td>
<td>145</td>
<td>1244</td>
</tr>
<tr>
<td>% change in admissions</td>
<td>24%</td>
<td>-22%</td>
<td>8%</td>
<td>-6%</td>
<td>10%</td>
<td>-12%</td>
<td>4%</td>
</tr>
<tr>
<td>Extra patients per month now</td>
<td>77</td>
<td>-35</td>
<td>26</td>
<td>-11</td>
<td>8</td>
<td>-20</td>
<td>45</td>
</tr>
<tr>
<td>Extra patients per year now</td>
<td>928</td>
<td>-420</td>
<td>307</td>
<td>-126</td>
<td>97</td>
<td>-243</td>
<td>542</td>
</tr>
</tbody>
</table>
Mean length of stay

Mean Length of Stay

Average Length of Stay (days)


Mean Length of Stay

102 104 107 108 109
Trends in mean length of stay

Trend in Mean Length of Stay

Mean Length of Stay (days)

Jan-13 to Jan-18

Linear (102)  Linear (104)  Linear (GIM)  Linear (107)  Linear (108)  Linear (109)
Mortality Trends by Wards


- Linear (102)
- Linear (104)
- Linear (GIM)
- Linear (107)
- Linear (108)
- Linear (109)
• Organisational change
How did we (try to) manage with these challenges?

• Shared MDT vision

• Clinical leadership

• Improvement focus
Tipping point...

- Rising workload (and variability of workload)
- 25-30% reduction in Consultant sessional input over 9 months
- Middle and Senior management changes, and organisational change (HSCP; Acute Sector)
- Loss of MDT cohesion and Improvement vision
Team discussion

How do you sustain improvement?

How do you adapt to challenges?
Things we did...

• Reduced bed base within Acute

• Reorganised Consultant service delivery

• Reduced rehab bed base; changed vision for Acute Care at Home team; slowed growth in GP linkages
Generalisable principles

1. **Early Consultant review**
   Consultant review within 12 hours of admission

2. **Early MDT review**
   AHPs with sufficient seniority to take positive risk

3. **Focus on discharge**
   MDT huddle on day of admission. EDD set on day 1.

4. **Daily multidisciplinary board rounds**
   Focus on discharge plans: is EDD going to be met? What are the barriers to discharge?

5. **Consultant ownership**
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Data...
‘Anyone can be cool, but AWESOME takes practice!’

Laura Hay
Highly Specialist Physiotherapist
Improvement Adviser
NHS Grampian
AIM: All patients will be screened for frailty on admission to ED using a screening tool

ED/AMIA
Screen for frailty

Discharge
OPAL
Acute care @ home
Consider early discussion with geriatrician

Needs CGA
Refer to GAU

Needs OLOGY/SURGERY
INITIATE
FRAILTY care plan
to reduce Hospital Acquired Frailty Syndromes
Patient attends ED

Majors: Triage – Complete CFS
Minors: ENP Complete CFS

CFS Score documented

CFS score ≤3
No further action required

Direct to Health Point if required
e.g. for advice on strength and balance classes, health options etc

CFS score ≥5
AHP review in ED

Patient highlighted to admitting ward
Frailty care plan initiated <12 hrs

?? Completes CFS

Consider ‘Acute Care at Home’
105 FRAILTY CARE PLAN

• PT/OT Ax within 24hrs of admission (mon-fri)

• Medication review
  - Optimise medication
  - Minimise unnecessary polypharmacy

• Document patient goals

• Set EDD (Reminder: REVIEW DAILY)

• Consider early discussion with geriatrician
Frailty AHP Assessment

- Date/time adm to ward: 25/11/18
- 14:30
- Clinical Frailty Score: 5
- Care Provision: BD, am for washing/dressing and night settling
- Normal level of Mobility: Normally IND mob with 1 x w/s
- EDD: 27/11/18

PLAN

Physiotherapy

Occupational Therapy
So what now?

- Testing/developing front door frailty identification
- Testing/developing the ‘so what?’
- Ongoing QI support
- AHP’s embedded in ED
AWESOME STORY

- last 1000 days...