The Golden Age: Improving care of the older patient through ED

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Trust Board paper E

Executive Summary

Context

The over 65 population of Leicestershire is predicted to grow by 72.7% while the 85 and over population is predicted to grow by 186.8%

In 2010 there were 35,700 residents aged 65 years or older in Leicester. This number is predicted to rise to 51,300 by 2030.
The 65-plus age group places the heaviest demand on health and social care services, accounting for 37% of emergency inpatient admissions.

Over 20% of the patients treated in the UHL Emergency Department are frail and older.

This is the first time that medical students from Leicester Medical School and nursing students from De Montfort University have worked together with the ED and Care of the Older People team to make changes in the way we manage these patients.

These projects that the students have worked on form part of a wider program of improvements in the care of the older patient being carried out at UHL.

Questions

4 projects were carried out by 20 medical and 5 nursing students over a period of 10 sessions.
These were projects at various stages of design and implementation in the ED, which the students have helped to implement.

1.Implementation of the Clinical Frailty Scale on Nerve Centre to improve the care of older patients.

Initial data collection demonstrated a gross underreporting of Clinical Frailty Scale (CFS) scoring. The CFS helps clinicians to determine holistic management strategies avoiding unnecessary investigations and treatments in patients with significant physical and cognitive comorbidities. Upon questioning, healthcare professionals (HCPs) highlighted several causes of poor CFS reporting:

1. An unawareness of the importance of the CFS.
2. Uncertainty regarding which HCP was responsible for CFS scoring.
3. Limited understanding of the score criteria.

2. Improving the Older Falls Patient Experience in the Emergency Department

Initial data collection showed patients waiting long periods of time for transfer into the emergency department and for decision making to admit or discharge. Decision making was not standardised, leading to wide variation in timings and quality of assessment.

To reduce waiting times the team proposed the reintroduction of a falls assessment pathway. The pathway is intended to aid health professionals in assessing a patient over the age of 65 who presents with a fall. It gives indications for stepping down care to minor injuries; where to admit and how to safely discharge the patient.

3. Lost in handover: improving handover from Acute Frailty Unit

The handover process is a critical part of patient care and has been shown to improve the patient experience and prevent clinical teams from making errors in care. To implement change, it is important to motivate the staff involved and disseminate the information in an effective way.

During handovers, base wards were not using the AFU patient transfer information document adequately. Additionally, the transfer notes lacked detail and had no way of indicating task completion. Doctors were not being made aware when patients arrived on their ward. These issues posed problems to patient safety due to their primary carers not being fully aware of their situation.

The team worked with the staff on the wards to redesign the AFU handover document. Adding the presenting complaint, current management plan and the latest Early Warning Score (EWS).

- Adding tick boxes to indicate job completion.
- Educating the staff on how to effectively complete the jobs list, in a 'What? Why? When?' format.

4. To dip or not to dip: improving management of suspected UTI in patients over 65

SIGN guidelines state that "in elderly patients (over 65 years of age) diagnosis should be based on full clinical assessment including vital signs" (1). Thus, urine dipsticks (UD) should not be used for diagnostic purposes in this patient group. Despite this, retrospective data collected in the ED between July – September 2017 shows an over reliance on UD results for diagnosis of UTI. Based on these results, older patients are frequently receiving unnecessary antibiotic treatment despite evidence indicating increased risk of *Clostridium difficile*, MRSA and multi-drug resistant gram-negative infections with no compensating clinical benefit.

Retrospective data collection of 70 patients without long term catherisation were analysed based on the NICE guidelines. This showed that 44.3% of patients in this group were inappropriately investigated with a UD, resulting in unnecessary interventions (i.e. MSU, antibiotic use).

As per NICE guidelines, no patients with long term catheterisation should have a UD; however, in our study sample 46.2% of such patients had an unnecessary UD.

Evaluation and discussion with the team lead the team to run PDSA cycles focussing on developing a flowchart, individualised feedback letters and flashcard intervention. Following these PDSA cycles the final actions focussed on the development of the flashcard which summarised the current NICE/SIGN guidelines. These were piloted, modified and then distributed among staff members.

Conclusion

Key findings from each of the projects are highlighted below:

1. Addressing the systemically poor healthcare professionals understanding of the CFS, they hosted "Frailty Week", in addition to initiating regular teaching sessions in ED. To improve the ease of scoring and referral for escalations in care, CFS scoring was introduced to the ED electronic database: Nerve Centre.
Repeat data collection following implementation of the interventions demonstrated an increase in CFS reporting from 12% (from 52 applicable patients) to 82% (from 78 applicable patients).

2. The falls pathway has the potential to help healthcare professionals and therefore benefit patients that are older and present to the Emergency Department with a fall. The intervention has resulted in an increased utilisation of the existing pathway; the impact on patients however is yet to be determined. Concurrent qualitative data on staff opinions has helped to develop a new pathway in the future.

3. Post implementation results showed that the jobs list was being filled out more comprehensively using the formatted structure. There was an increase in overall detail of the sticker with the additional domains. However, no stickers had been signed off by the nurses or doctors on the base wards, highlighting an issue with the new handover process. This appears to be due to a lack of awareness from consultants and matrons, leading to minimal top-down promotion of the changes. The insights gained here will inform the next cycle.

4. Post implementation of the flash cards data showed prior to intervention there was a mean of 59 UD per day and post intervention this reduced to a mean of 57 UD per day. This showed a 3.4% reduction in the six days. The intervention has also initiated discussions to challenge the prevalent attitudes within the department and promote awareness of the NICE/SIGN guidelines.

These projects have highlighted the impact students both nursing and medical can make in the implementation of quality improvement care in a short period of time.

Longitudinal themes arising from all the projects were: the need to address culture and behaviour to implement change and the importance of multidisciplinary team approach for its success; pathways need to be simplified and made relevant to ensure adherence. Burdening staff with increasing checklist, protocols and guidelines does not necessarily improve patient safety and care; patients' journey and experience should form the basis of any pathway that is developed in patient care.

In addition to these 4 projects, a nursing student has led on the development of a learning video which highlights the patients' journey and experience of coming into the ED with fall. This has been developed with the media students from De Montfort University and support from our own patient partner Rosemary Stokes whom we are grateful for her input and time.

This is a valuable resource for students to understand the impact of hospitalisation, unnecessary investigations and the need for good communication to alleviate anxiety in these patients.

Link to view the video is https://youtu.be/wEonxszen44

Input Sought

We would welcome the board's input in acknowledging the students' contribution to the ED improvement program and continuing to support this across other areas in the Trust.

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Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare [Yes x /No /Not applicable]
Effective, integrated emergency care [Yes /No /Not applicable]
Consistently meeting national access standards [Yes /No /Not applicable]
Integrated care in partnership with others [Yes /No /Not applicable]
Enhanced delivery in research, innovation &ed' [Yes x /No /Not applicable]
A caring, professional, engaged workforce [Yes /No /Not applicable]
Clinically sustainable services with excellent facilities [Yes /No /Not applicable]
Financially sustainable NHS organisation [Yes /No /Not applicable]
Enabled by excellent IM&T [Yes /No /Not applicable]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes /No /Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Yes /No /Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Insert here]

4. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]

5. Scheduled date for the **next paper** on this topic: [XX/XX/XX] or [TBC]

6. Executive Summaries should not exceed 4**sides** [My paper does / does not comply]

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