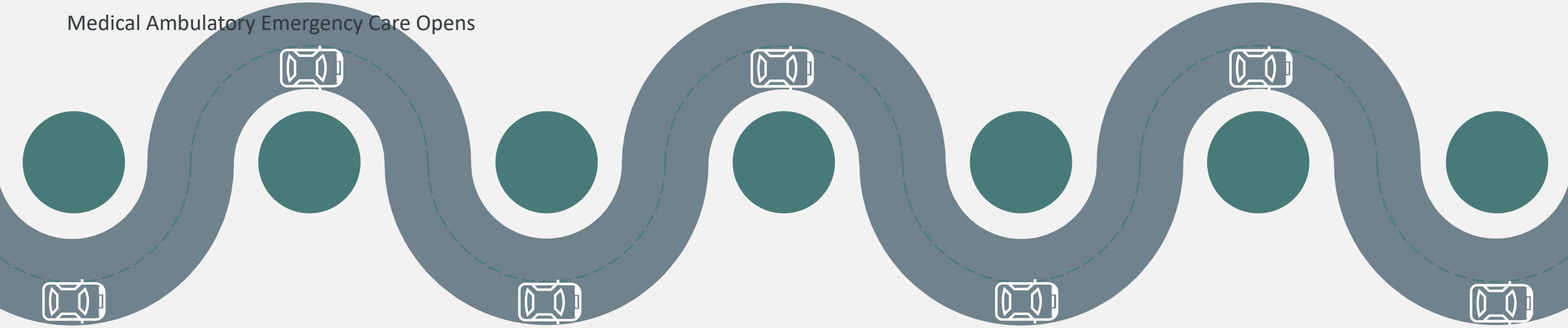
University Hospital Monklands

Developing a Culture of Improvement.

UHM Unscheduled Care Improvement Journey



2013

HIS Review & Poor HSMR

Scotland's "Worst Hospital"

SG Funding to test Scottish version of Flow, Cost & Quality Health Foundation Programme

2014

Multiple data driven process reviews

"Understanding the problem"

New Site Director

Medical Ambulatory Emergency Care Opens

2015

Introduction of Duty Manager Role

National 6 Essential Actions Programme launches

2016

Front Door Receiving Redesign – from ERU to MAU & AMRU

PIU

2017

REACT Model

Re-modelling ED space

2018

Frailty Assessment Pathway – New model

2019

Redesign of Medical and COTE wards & Surgical Assessment

2013

Despite significant changes to “Front Door” model of Acute Medical Care we experienced:

- Negative HIS Review
- Rising HSMR
- Notoriety as “Scotland’s Worst Hospital”

> *“As you know, it has been identified through several reviews that the patient flow within Monklands and specifically the flow from the ED into ERU, within the ERU, and thereafter has been and is problematic, for a range of reasons. Although work has been progressed on this over the past year it has not moved with sufficient pace, is not as radical as is needed and requires dedicated work, input and leadership from the Executive Team, Senior Clinical leaders and the Site Team”*

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Falling Performance & Poor Patient Experience

Compliance with 4hr Standard

Quality Indicators
- TTFA
- Representations

Time Critical Presentations
- Stroke Thrombolysis
- Cardiac Chest Pain
- Sepsis

Inequalities in care

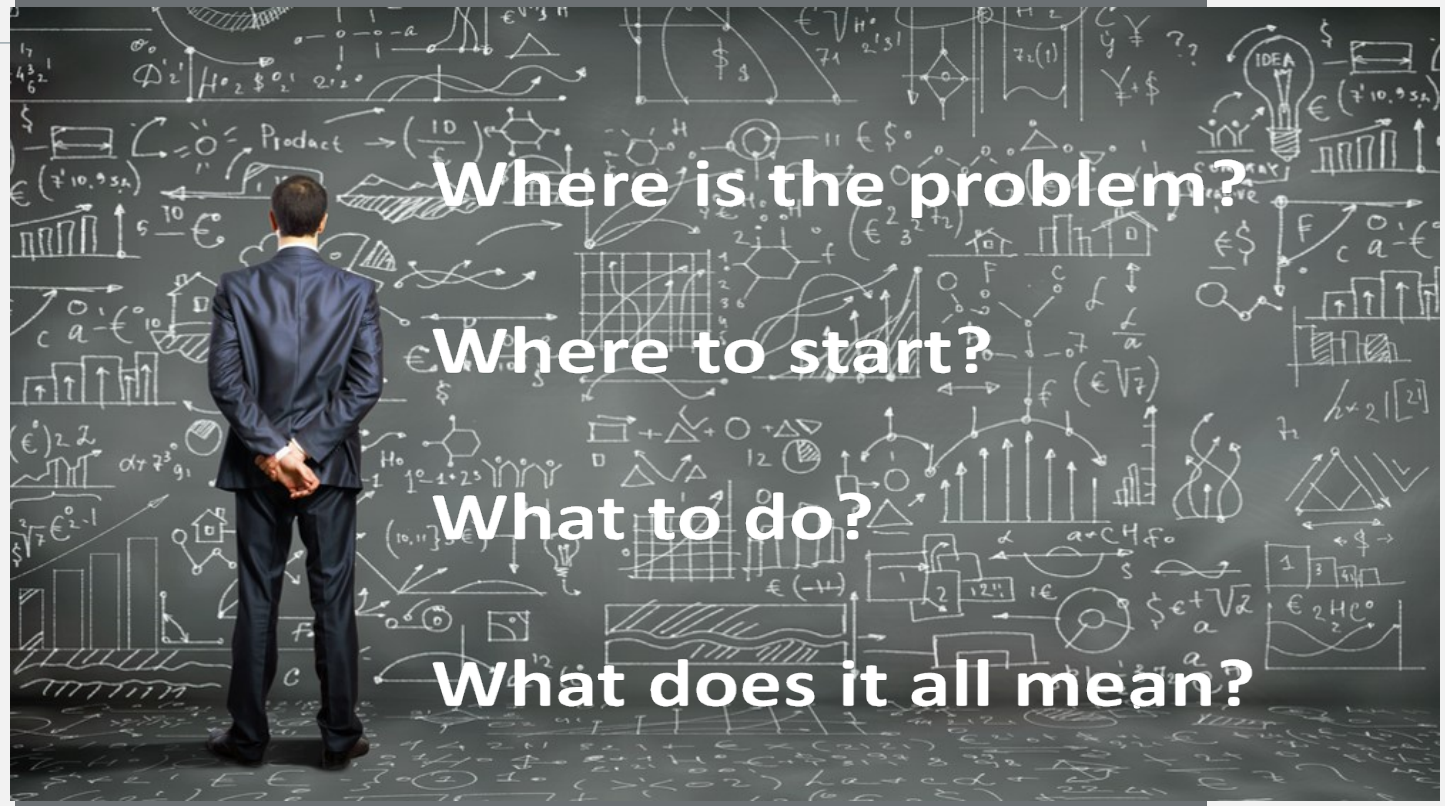
Long waits

Repetition

Poor Communication

Lack of decision makers

Don’t get sick OOH or weekends!



2013

October 13 – Agreement from Scottish Government to test Scottish version of the Flow, Cost, Quality Health Foundation Programme

Rigorous, data driven review of processes in Acute areas using QI methodology and data analysis

Adoption of “RIGHT PATIENT, RIGHT TIME, RIGHT PLACE,RIGHT TEAM, EVERY TIME” ethos

Early development of patient pathways, including “Sorting Hat” as a precursor to REACT, and Ambulatory Emergency Care

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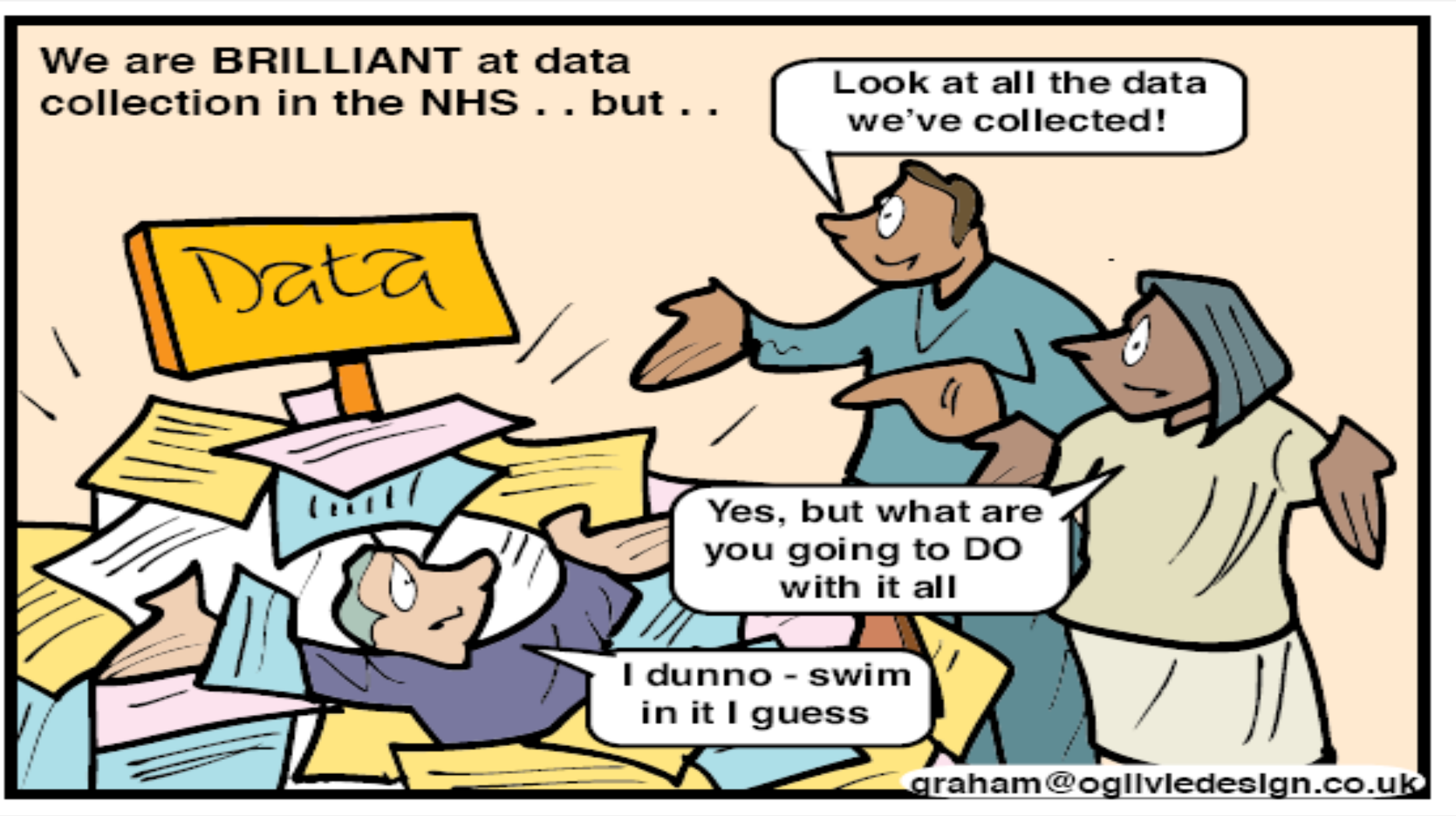

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Challenging The Norm

This is already the safest option.

We are always being asked to change something or other; it'll be something else tomorrow!

We've always done it this way

That's ED's issue to fix, not mine.

That's been tried before and it didn't work then, so it won't work now!

Why fix it if it's not broken?

What's the point, nothing changes!

We already do that!

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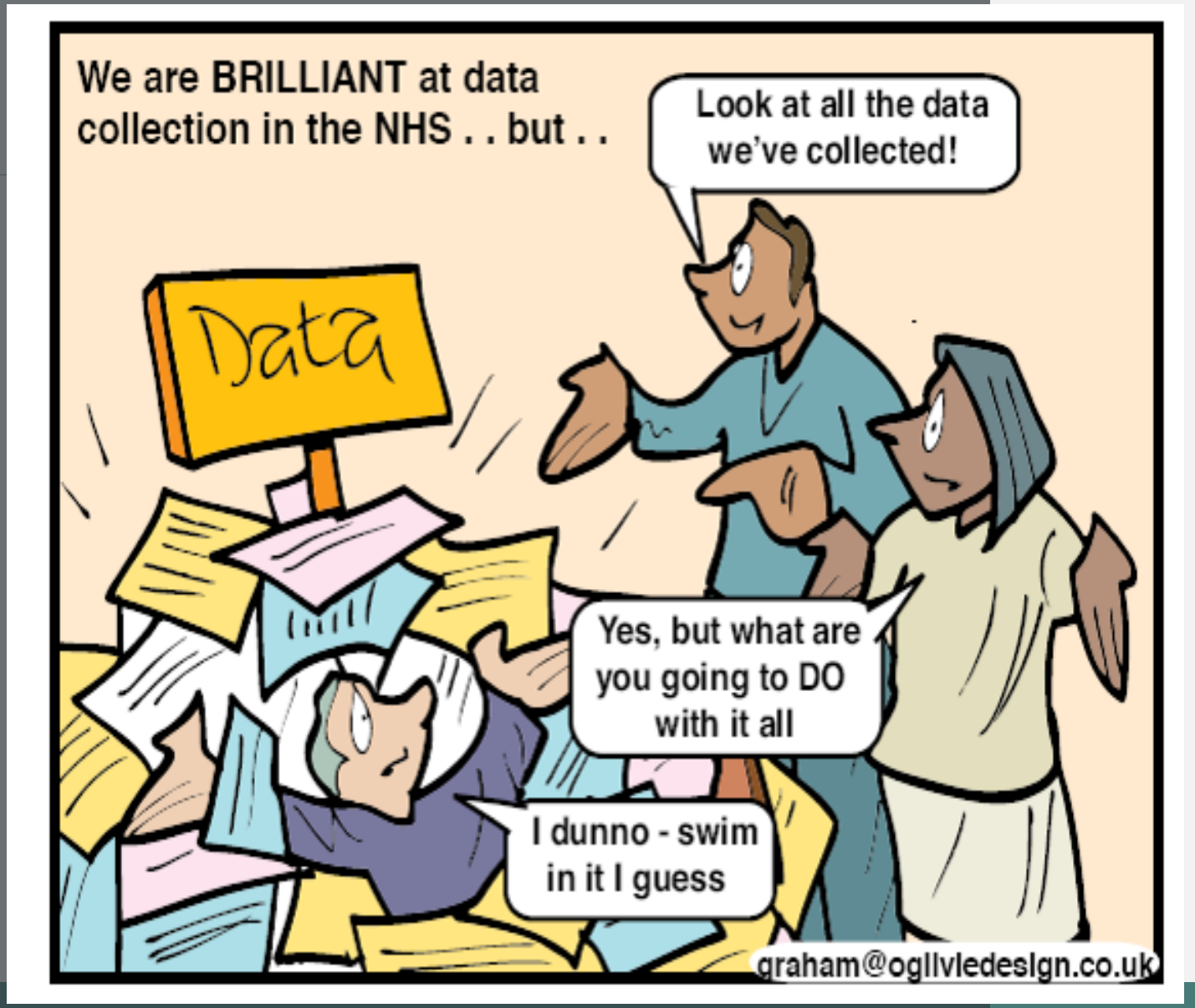
CULTURE

GROWTH
HELP!
TEAMWORK
SUCCESS


We are BRILLIANT at data collection in the NHS . . but . .
Look at all the data we've collected!
Data
Yes, but what are you going to DO with it all
I dunno - swim in it I guess
graham@ogilvledesign.co.uk

Team Working – building and developing relationships
Leadership vs Hierarchy
Learning culture
Transparency
Engaging and Empowering teams & individuals
Ownership – Sustainability / Spread
Pride / Sharing the Success

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A Culture of Leadership

New Site Director and Executive team

Development of Duty Manager, Clinical Director and Clinical Lead roles

Triumvirate Relationship

Site Presence and twice daily huddles

Streamlined escalation process via Flow Manager from Emergency Department

Later…..Investment in REACT, SDA, DSU, PIU

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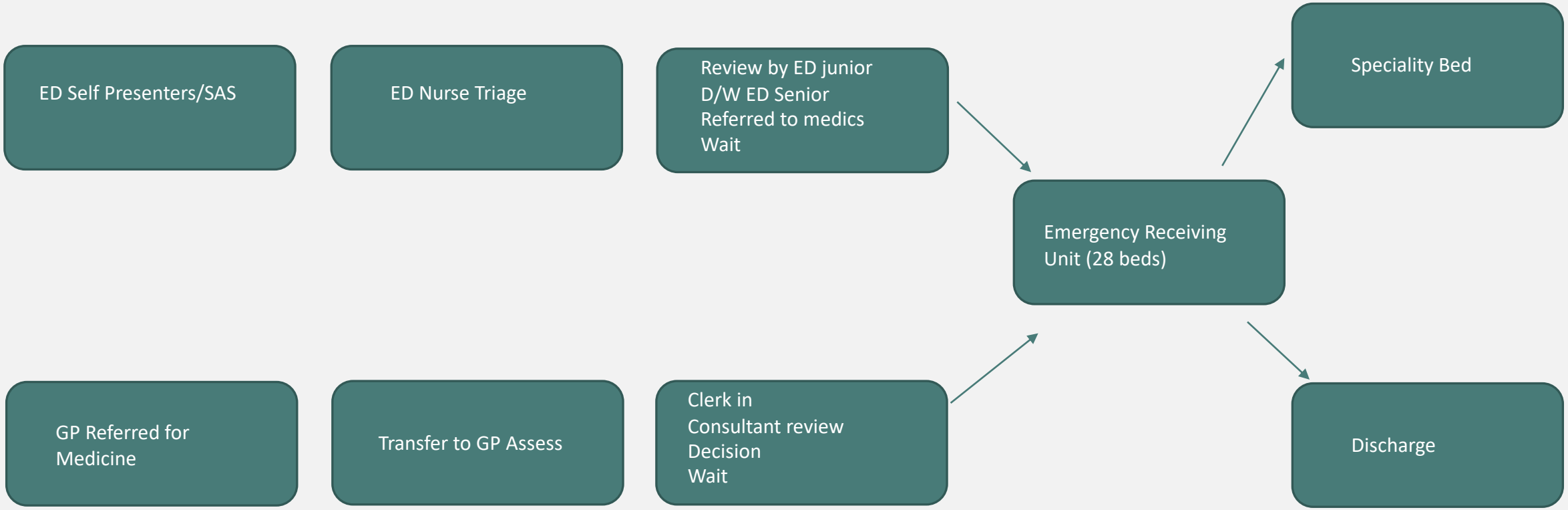
Medical Admission Pathway(S)



Priorities in Acute hospitals: Unscheduled Care

There should be early *senior review of all patients along all parts of the pathway*

Maintain the momentum of care – there should be a *senior review of every inpatient's care plan every day*

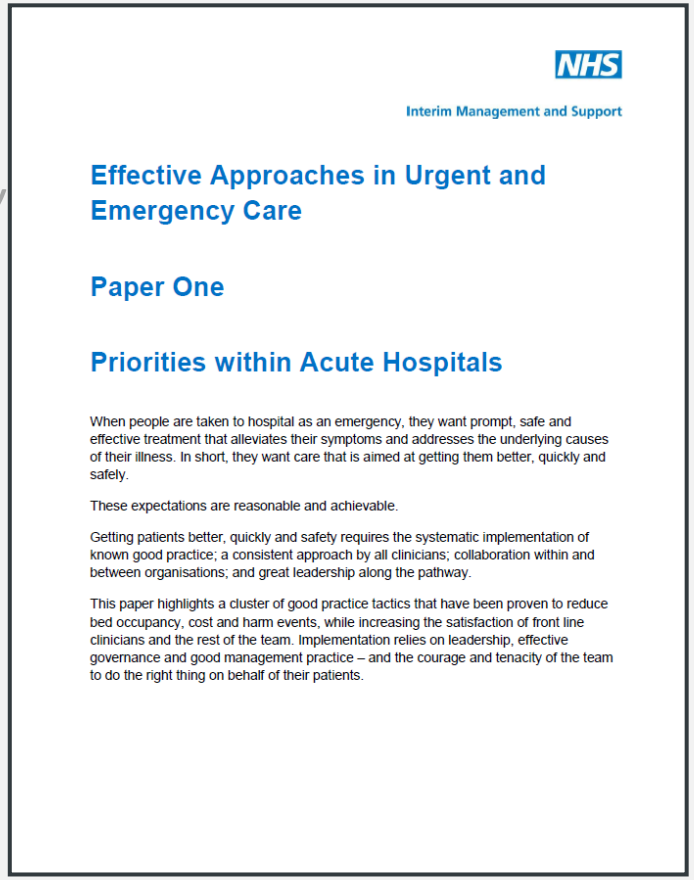
Get patients on the right pathways - manage patients in 'flow streams'

Work together systematically and predictably – implement internal professional standards

Plan and manage capacity to meet demand

Manage variation in discharge planning

Avoid unnecessary overnight stays – implement ambulatory emergency care



NHS

Interim Management and Support

Effective Approaches in Urgent and Emergency Care

Paper One

Priorities within Acute Hospitals

When people are taken to hospital as an emergency, they want prompt, safe and effective treatment that alleviates their symptoms and addresses the underlying causes of their illness. In short, they want care that is aimed at getting them better, quickly and safely.

These expectations are reasonable and achievable.

Getting patients better, quickly and safety requires the systematic implementation of known good practice; a consistent approach by all clinicians; collaboration within and between organisations; and great leadership along the pathway.

This paper highlights a cluster of good practice tactics that have been proven to reduce bed occupancy, cost and harm events, while increasing the satisfaction of front line clinicians and the rest of the team. Implementation relies on leadership, effective governance and good management practice – and the courage and tenacity of the team to do the right thing on behalf of their patients.

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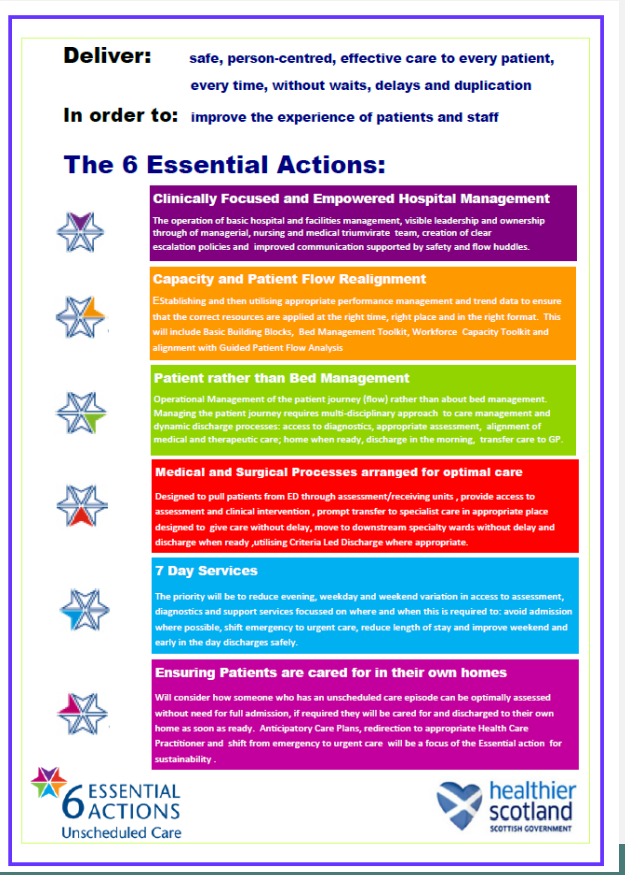
The 6 Essential Actions:
Medical and Surgical Processes arranged for optimal care

‘Designed to pull patients from ED through assessment/receiving units, provide access to assessment and clinical intervention, prompt transfer to specialist care in appropriate place designed to give care without delay, move to downstream specialty wards without delay and discharge when ready, utilising Criteria Led Discharge where appropriate.’



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REACT

Front loading of appropriate investigations
- Bloods, ECG, Imaging

Early initiation of treatment
- Analgesia, fluids, IVAB

Signposting/streaming patient care
- AEC, MAU, SAU
- Aspiration to add Frailty Assessment Unit

Identifying time-critical illness

Early patient redirection

Reducing inequalities in patient care

Improving patient experience

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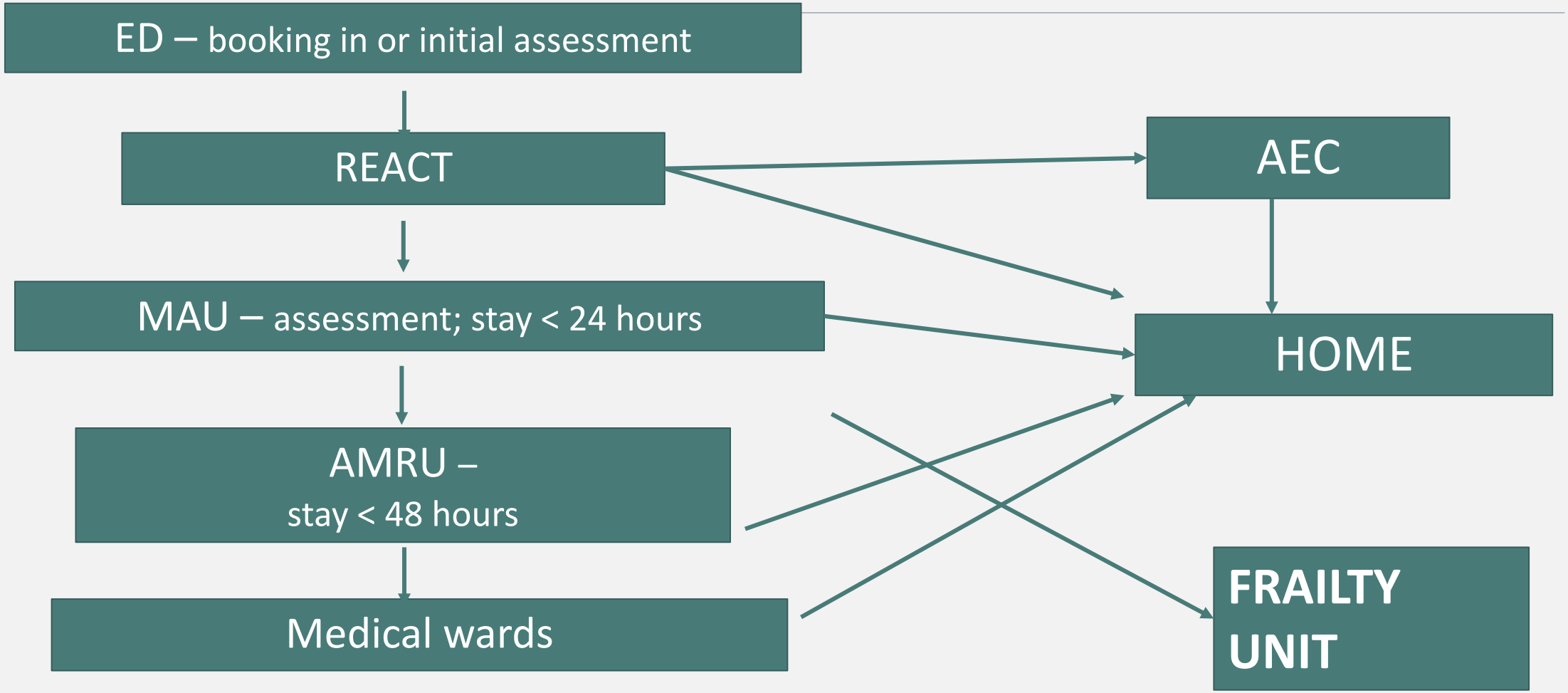
Separate Assessment from Receiving Beds



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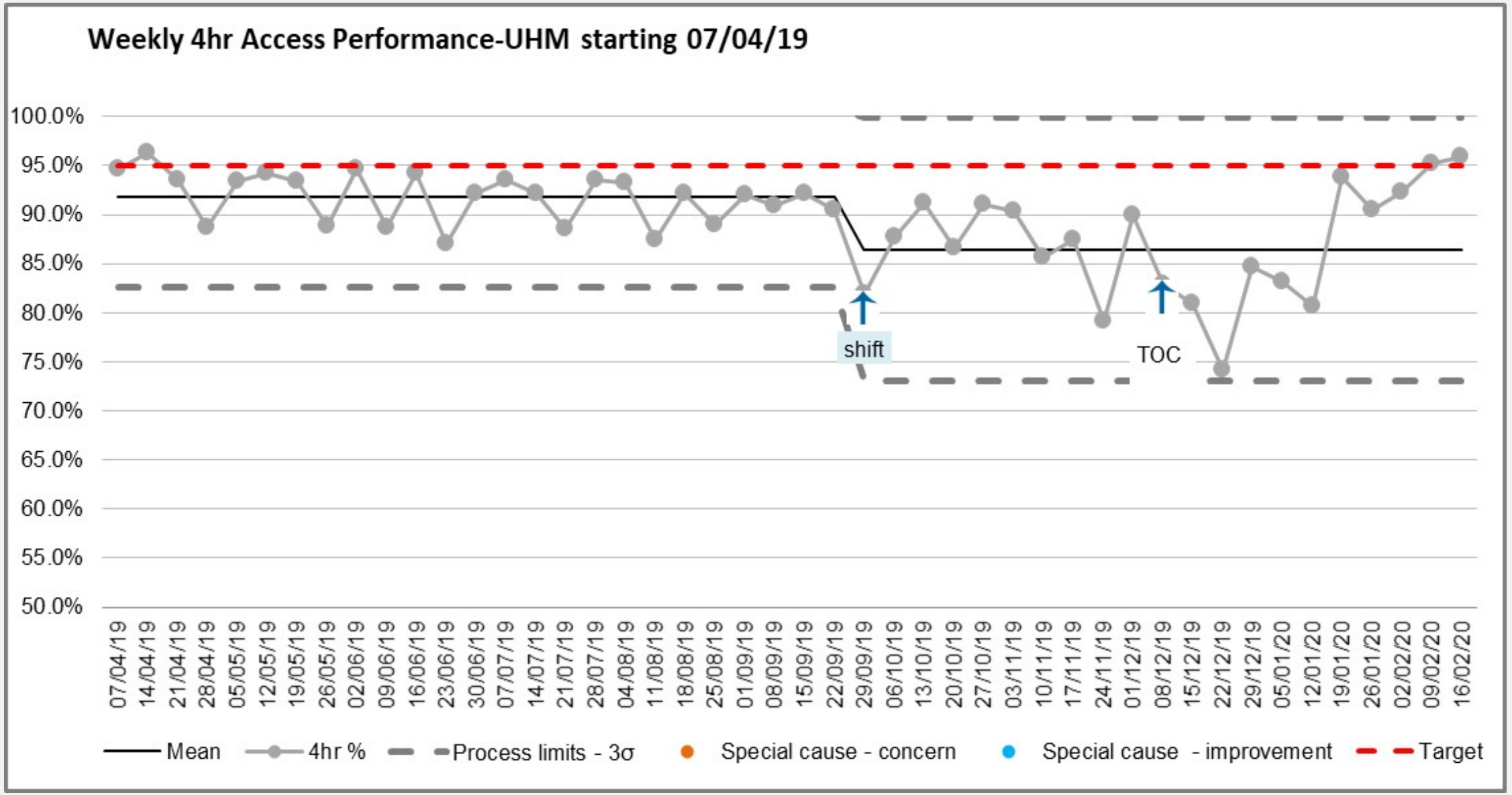
Weekly 4hr Access Performance-UHM starting 07/04/19
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
shift
TOC
07/04/19
14/04/19
21/04/19
28/04/19
05/05/19
12/05/19
19/05/19
26/05/19
02/06/19
09/06/19
16/06/19
23/06/19
30/06/19
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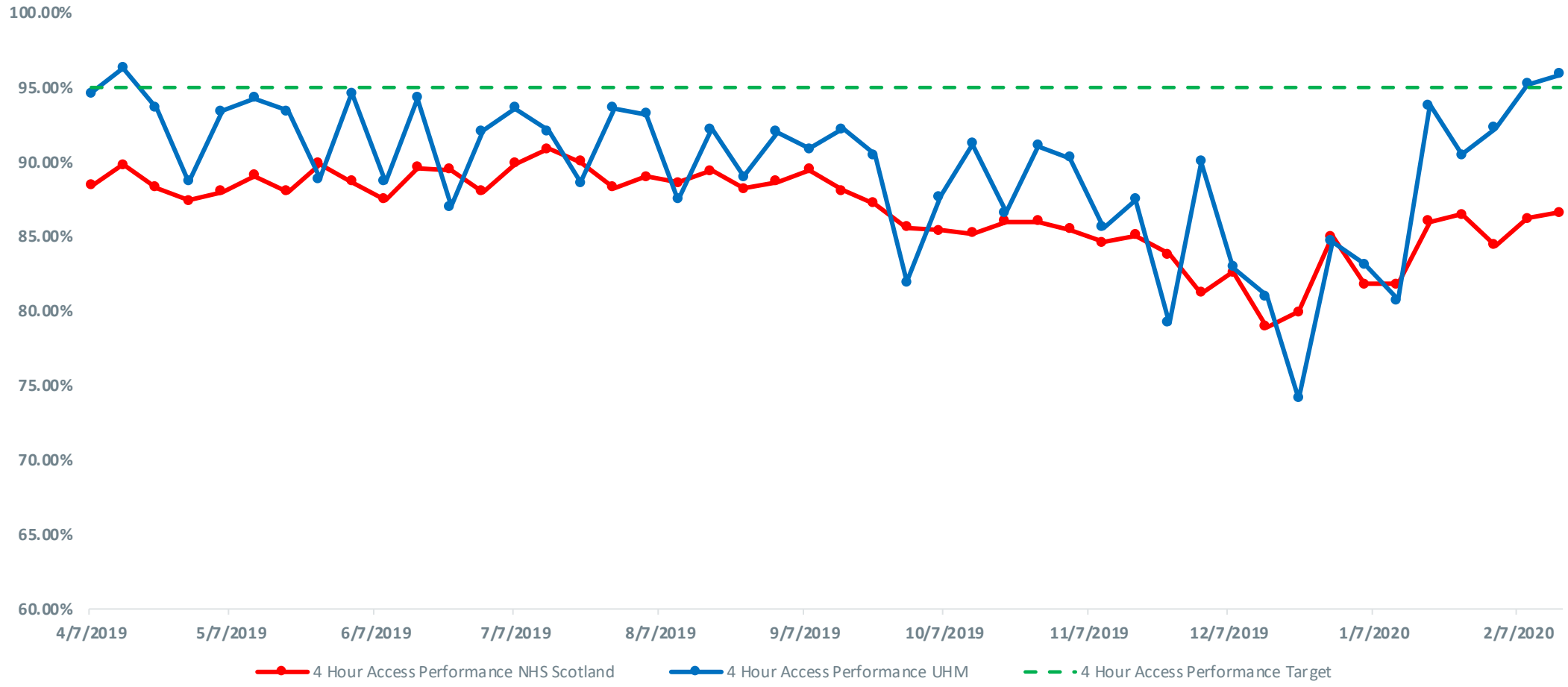
03/11/19
10/11/19
17/11/19
24/11/19
01/12/19
08/12/19
15/12/19
22/12/19
29/12/19
05/01/20
12/01/20
19/01/20
26/01/20
02/02/20
09/02/20
16/02/20
Mean
4hr %
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

UHM 4 Hour Access Performance



Measuring Success (not just KPIs)

Staff & Patient/Carer Experience

Social Media

Safety Huddle

External Interest

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What Worked?

Reviewing success as well as failures

Didn’t Give up!

Continuously monitoring outcomes against demand

Sharing the learning (good and bad)

An awareness & understanding of our culture combined with the use of improvement methodology & technical tools, enables us to overcome the do nothing approach to change.

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NHS
Lanarkshire

Caring for the Elderly

Our Journey

High falls rate

High degree of enhanced observations

High level of complaints

Communication between nursing staff and medics was poor

Negative attitudes

Ward closed on several occasions for IPC issues

About Us

Why the Facility was Needed

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Change was Required

Improve Communication

Give identity to the ward

Create a structure

Establish routine

Improve outcomes

Essential Qualities of Leadership

- Clarity
  - Clear and concise
- Decisiveness
  - No hesitation in commitment
- Courage
  - Belief in the outcome
- Passion
  - Doing it because you care
- Humility
  - Strength to admit when you don't get it right

Beginning of Change

What I Observed	What I Saw	Changes Made
How the team worked What strengths the team had Ward routines Staff knowledge and practical skills	Disjointed routines Well established, but lack of direction Didn’t meet the needs of the patients Lack of understanding of their role	Created a three team structure. Teams created ensured more direction Developed B.I.N.G.O Created ‘Safety Pauses’ throughout the shift.

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Challenges of Change

Behaviours	Observations	The Fix
Disengagement from staff Resistance to change Increase in staff absence	Lack of understanding about the model ‘We’ve always did it like this’ Didn’t like change so opted out	Worked on staff moral and sense of worth Baby steps in implementation as not to overwhelm Followed Organisational protocol in back to work measures in a supportive manner.

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Understanding Demand

Older Peoples Report				
	Prev 24hrs New	Prev 24hrs Ongoing	Admitte	Discharged
AMRU	0	0	0	0
MAU	0	0	0	0
Frailty Unit	7	11	14	4
Total on Site	7	11	18	7
	New Today	Ongoing Today		
AMRU	0	0		
MAU	0	0		
Frailty Unit	13	10		
Total On Site	13	10		
Hospital at Home	2	19		
Total H @ H	21			

Benefits for all Involved

Decreased falls rate – last fall with harm

Enhanced observations utilised within the team as little or no supplementary staff required.

Lower level of complaints, early resolutions are now made at ward level.

Communication at all levels has greatly improved.

Staff now see benefit of working in a different way and the role of this type of ward.

Ward running more optimally, with minimal disruptions from Norovirus and Flu.

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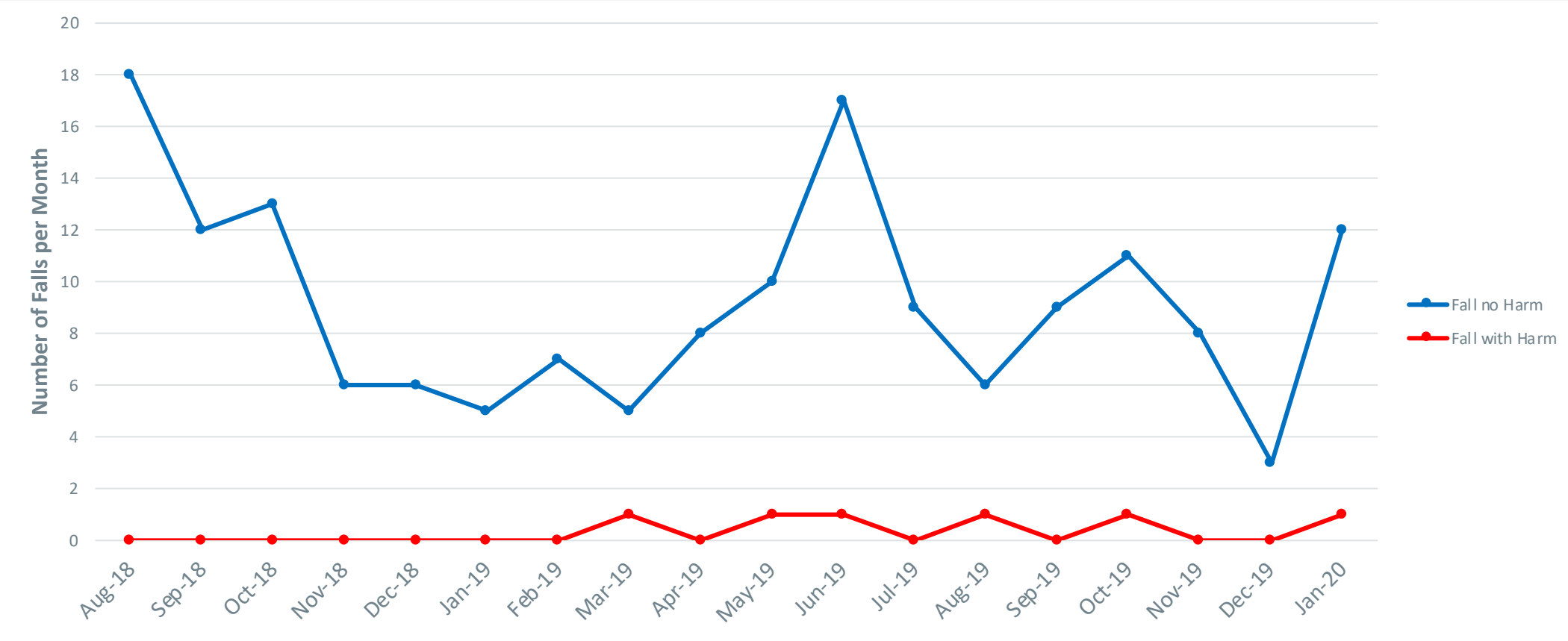
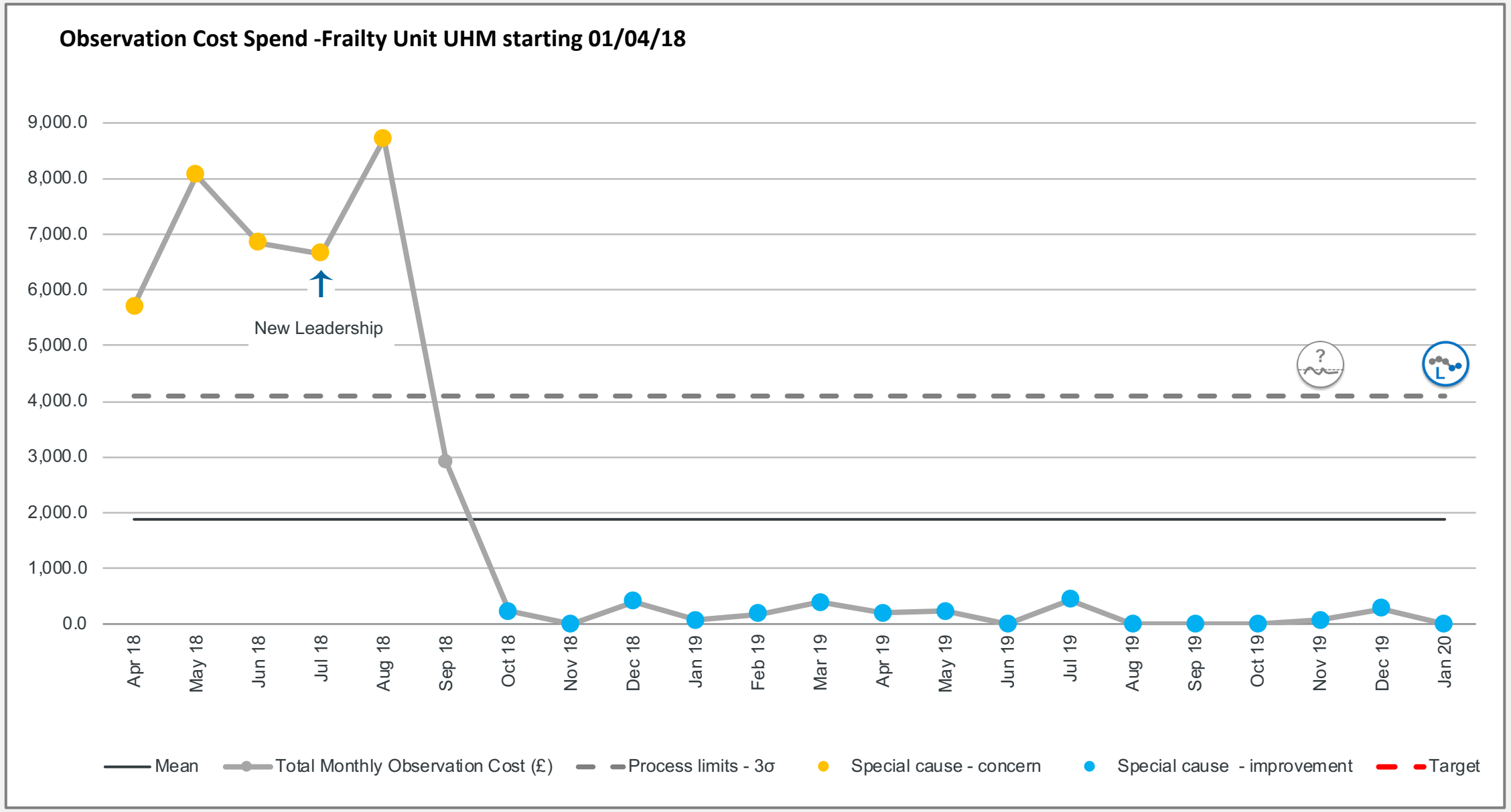
Falls and Falls with Harm in Frailty Assessment Unit




Observation Cost Spend -Frailty Unit UHM starting 01/04/18
9,000.0
8,000.0
7,000.0
6,000.0
5,000.0
4,000.0
3,000.0
2,000.0
1,000.0
0.0
New Leadership
Apr 18
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18
Nov 18
Dec 18
Jan 19
Feb 19
Mar 19
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Mean
Total Monthly Observation Cost (£)
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Development of a Frailty Assessment Unit in University Hospital Monklands to provide a Safe, Person Centred Pathway for Older People

Yvonne Fielder, Service Manager / Susan Wilson, Senior Nurse / Alistair McVean, Consultant / Jennifer Allan, Service Improvement Manager / Agnes Wells, ACE Team Lead / Sharon McGrady, SCN / Sarah McInally, OT / Sekhar Santapur, Physio

Introduction

The recognition and management of the frail older patient is vital to help ensure the patient has timely access to Comprehensive Geriatric Assessment (CGA). Historically this patient group were identified following admission to the medical receiving areas by the ACE Nursing team, and often had already been transferred to a Specialist COTE bed prior to review by the COTE team, leading to missed opportunities and delays to CGA and subsequent delays to discharge and increased Length of Stay for some.

UHM Team were part of the HIS Frailty Collaborative and recognised the support this would provide in establishing a new Frailty Model

Methodology

Regular steering group established with new Service Manager as Chair, and representation from full MDT, as well as data and improvement support colleagues.

An initial Process Mapping session confirmed the view that the existing admission pathway for Frail Older people was convoluted and repetitive and did not support the aims of timely CGA.

Aims / objectives

Deliver a Safe, Effective and Person-Centred Frailty pathway throughout University Hospital Monklands

Embed a robust Frailty detection process for all patients over 65 years

Deliver timely CGA for Frailty positive patients identified at initial assessment

Ensure a 'Home First' approach for Frailty positive patients where appropriate, following CGA. i.e. Avoid admission to hospital if possible

Work with H&SCP to develop a Discharge to Assess Model

Challenges

18/19 Winter pressures impacted on the new model

To begin with …. manual data collection, now discontinued, new dataset in development with Information Services Team, testing new movement functionality in TRAK

Ongoing delay in introduction of electronic frailty screening in ED (impact on data collection and frailty processes)

Ward and site wide knowledge of frailty

Lack of engagement with frailty work, culture, resistance to change, benefit from additional nurse staffing not realised initially due to sickness

Additional nursing resource for frailty remains temporary and unfunded

Additional ACE nurse resource remains temporary and unfunded

MAU and ERC frailty screening not embedded

Identified key areas for focus which included, reconfiguration of the bed base across one COTE specialist ward to create Frailty Assessment Beds, cease manual data collection by ACE nurses which was felt to onerous on them and not robust.

Development of a measurement plan with electronically available information to inform improvement aims.

Education and training sessions for Nursing, AHP and medical staff within Medical Receiving Unit to allow Frailty Assessment to be carried out a point of admission

Results / Outcomes

Development and expansion of Frailty unit 24 beds since August 2018

Review and change in very wide remit of ACE nurses (the pioneers!) which had included (but was not restricted to)

- All frailty screening
- Offsite bed capacity
- Flow management to Acute CotE beds
- Manual data collection…..

Frailty screening by nursing team in MAU from April 2019

Additional temporary ACE Nurse resource (enabling dedicated ACE nurse resource for frailty beds) from April 2019

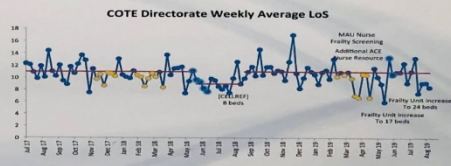
Additional temporary nursing resource for Frailty Unit at 12 beds from November 2018

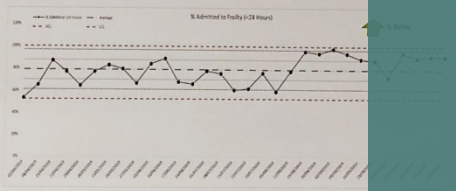
Rolling site wide education by ACE Nurses (frailty, delirium, 4AT etc)

Reduced number of moves for frail older patients through MAU and AMRU

Impact on LOS

Role of D2A – 77% of referrals (46 patients) to D2A originated from CotE with positive feedback from patients/family/carers





Feedback from the Team

You need the right team from the beginning, more than doctors and nurses, the full MDT

The project needed dedicated leadership with no conflicting priorities

Don't continue to manually collect data if you are not undertaking improvement work

Summary

The introduction of the Frailty Assessment Unit and revised pathway has provided so far:

- Improved recognition and identification of Frail Older People 24/7 at point of admission through training and education
- Timely access to CGA and Specialist COtE bed
- Reduced Length of Stay for Frail Older Patients – embracing NHSL Home First approach
- Reduced Length of Stay in CotE

Future Plans

Relocation of 24 bedded Frailty Unit to mirror MRRP plans for Frailty Assessment Unit within ECV
Ongoing development of models of care which suppo planning assumptions for new build
Support OT/PT colleagues to review workforce for frailty model
Embed frailty screening in MAU
Increase number of patients transferring directly from ED/React/MAU to Frailty Unit
Patient and staff experience
Electronic frailty screening in ED
Advanced Nursing Practice Model for CotE
Support identification and management of frailty in the community (efrailty index) to optimize quality of life and prevent unnecessary hospital admission

University Hospital Monklands

Developing the Frailty Pathway

Aims

Deliver a Safe, Effective and Person-Centred Frailty pathway throughout University Hospital Monklands

Embed a robust Frailty detection process for all patients over 65 years

Deliver timely CGA for Frailty positive patients identified at initial assessment

Ensure a ‘Home First’ approach for Frailty positive patients where appropriate, following CGA. i.e. Avoid admission to hospital if possible

Work with H&SCP to develop a Discharge to Assess Model (D2A)

Recognition of Frailty Assessment as a Front Door service

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The Before Model – Pre 2018

Well established frailty pathway including screening and prompt access to CGA.

Short length of stay, do not move frail elderly out of speciality

Early discharge and admission avoidance through established Hospital at Home service.

BUT…..

Variability in access to non-medical members of MDT depending on point of access to specialty bed.

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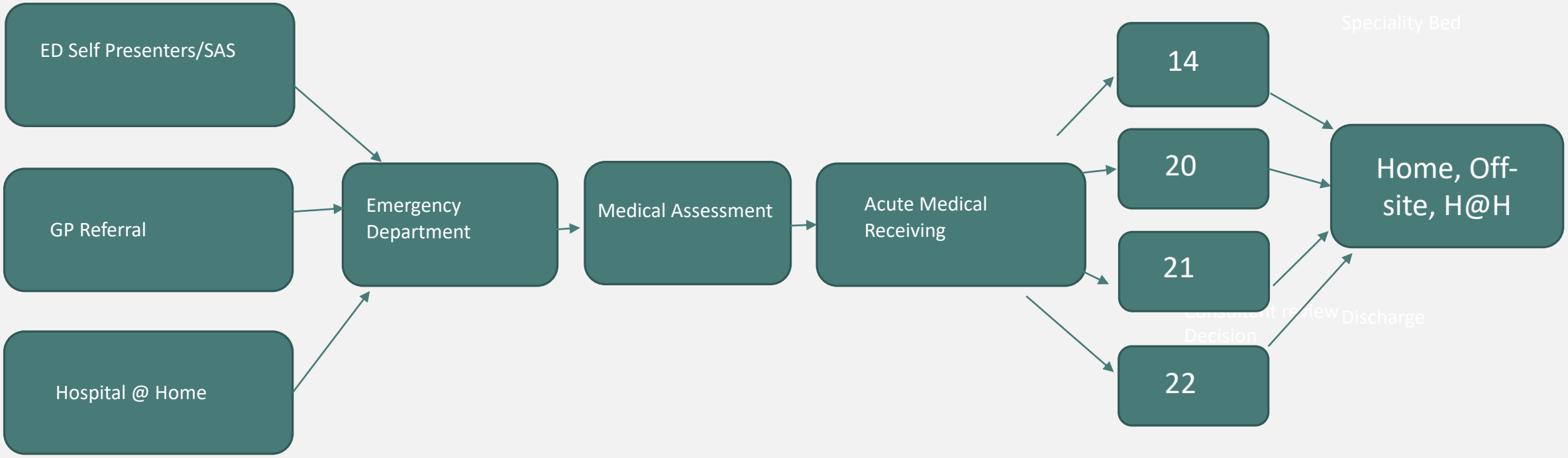
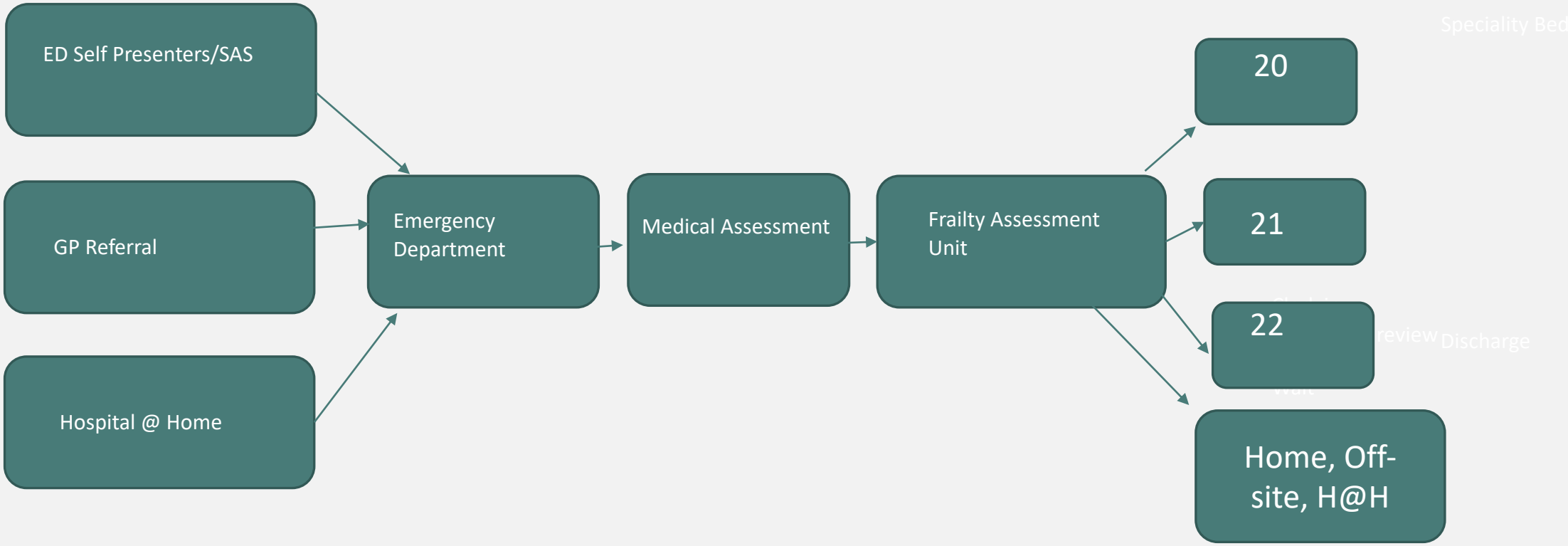
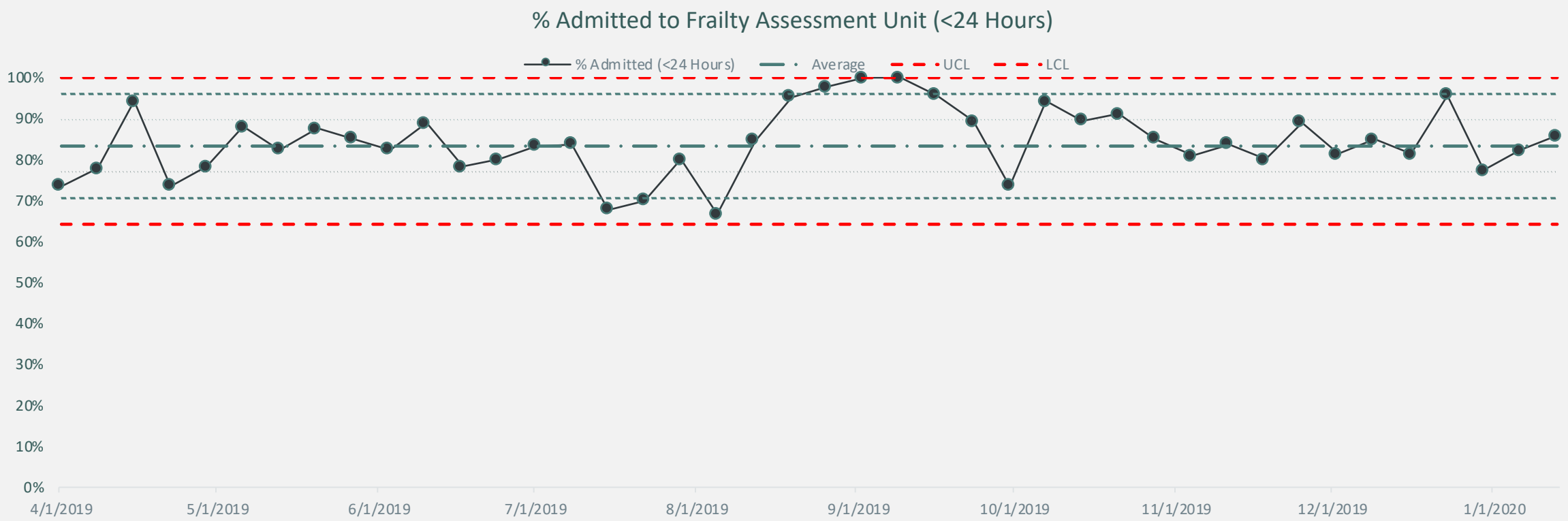
Frail Elderly Admission Pathway Pre 2018



The Improved Pathway



Admission to Frailty Unit (<24hrs)



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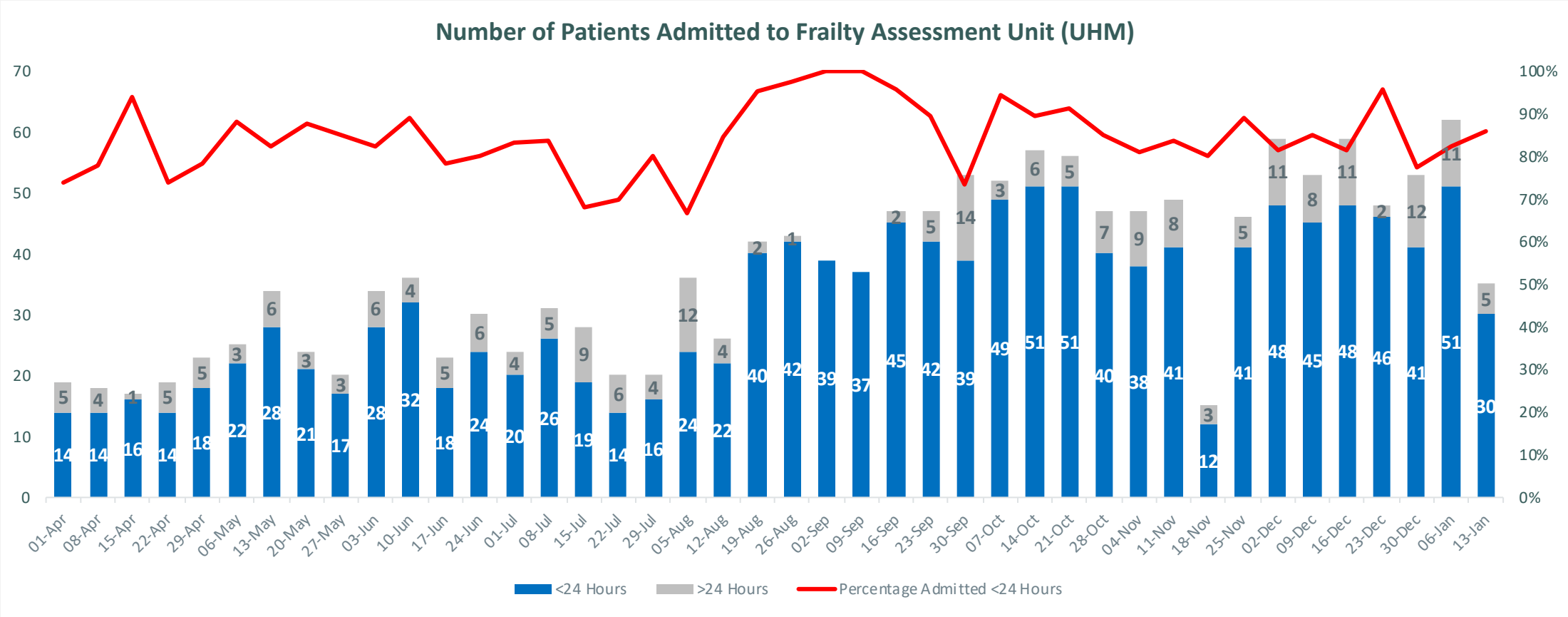
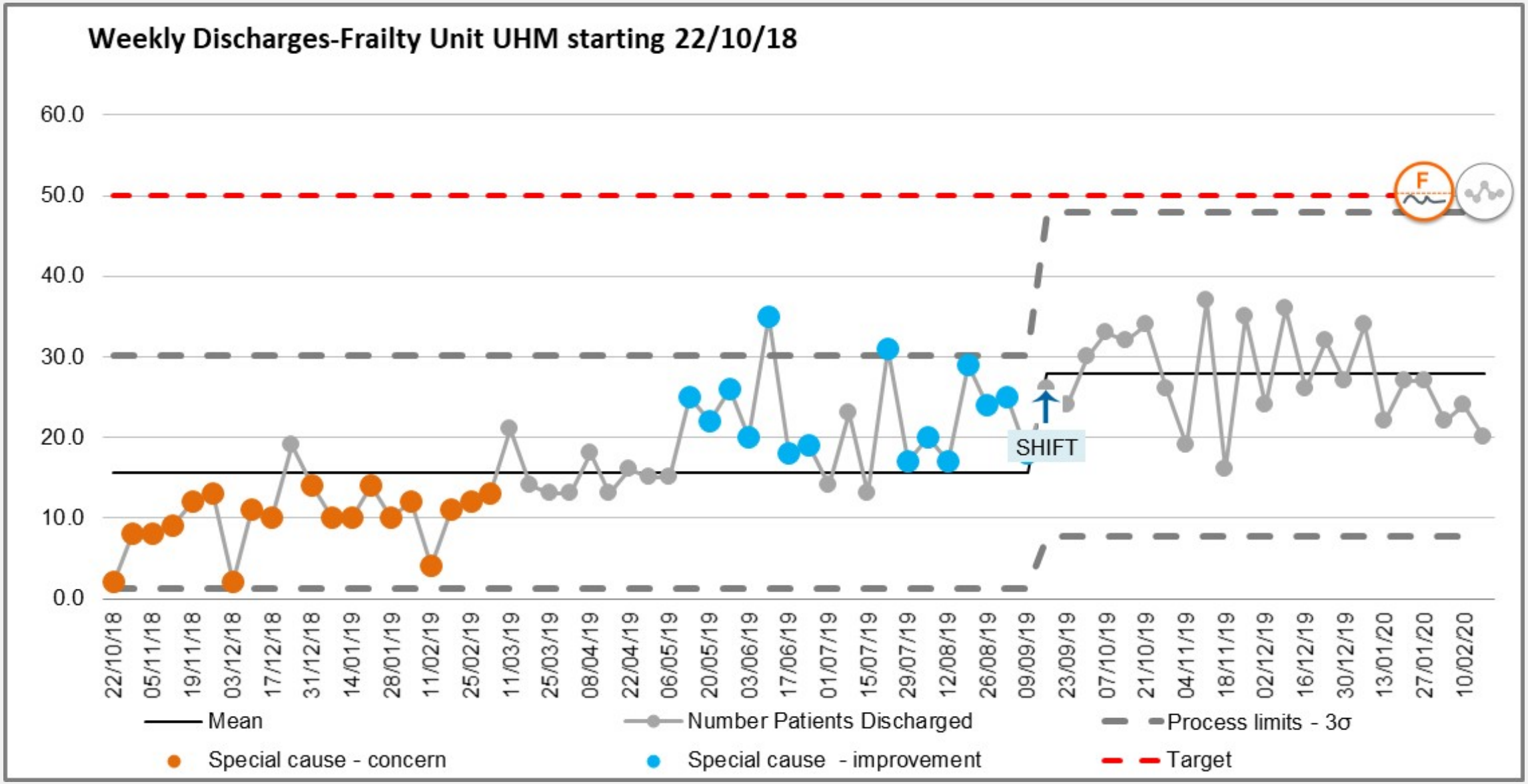
Admission to Frailty Unit (<24hrs)




Weekly Discharges-Frailty Unit UHM starting 22/10/18
60.0
50.0
40.0
30.0
20.0
10.0
0.0
SHIFT
22/10/18
05/11/18
19/11/18
03/12/18
17/12/18
31/12/18
14/01/19
28/01/19
11/02/19
25/02/19
11/03/19
25/03/19
08/04/19
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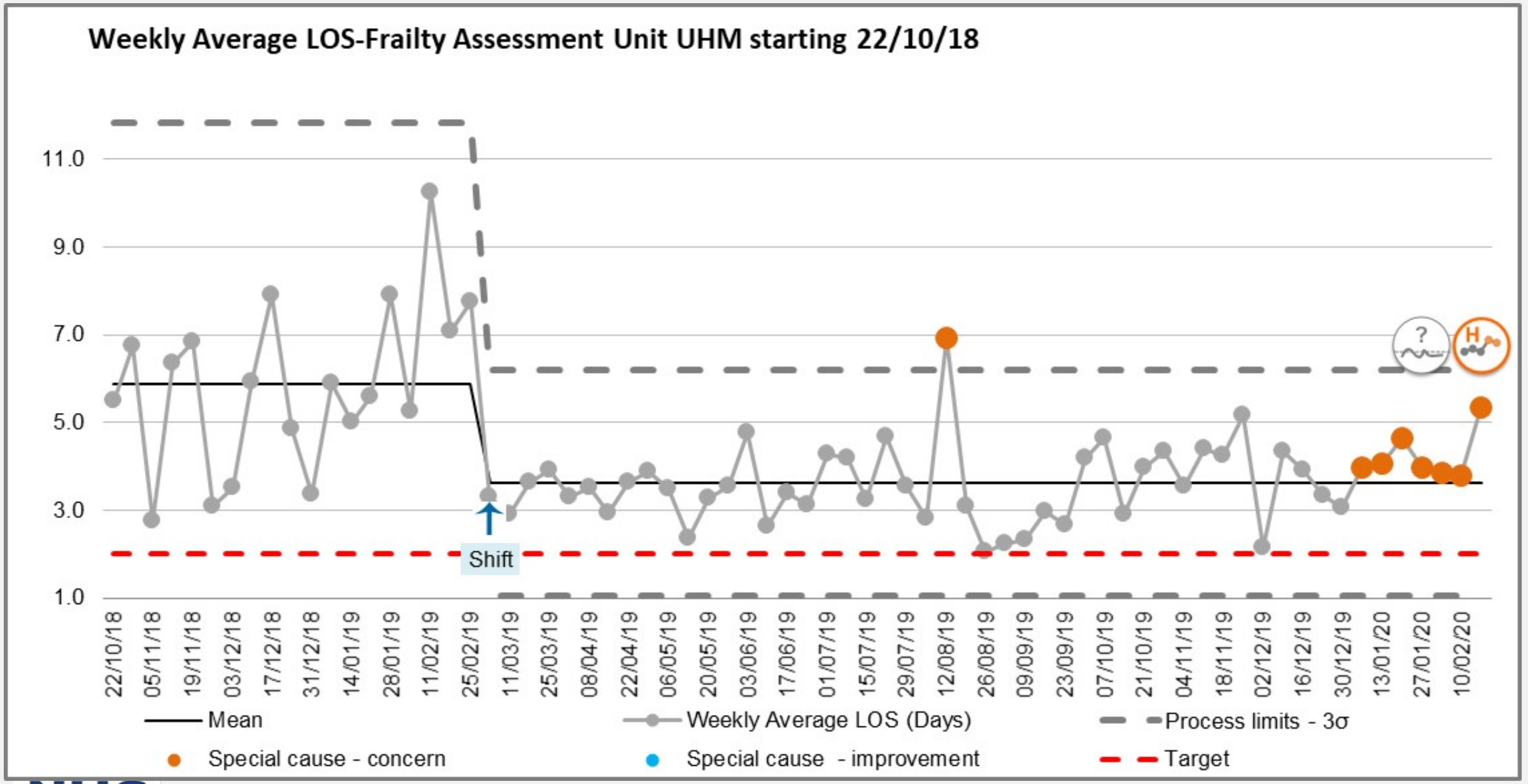
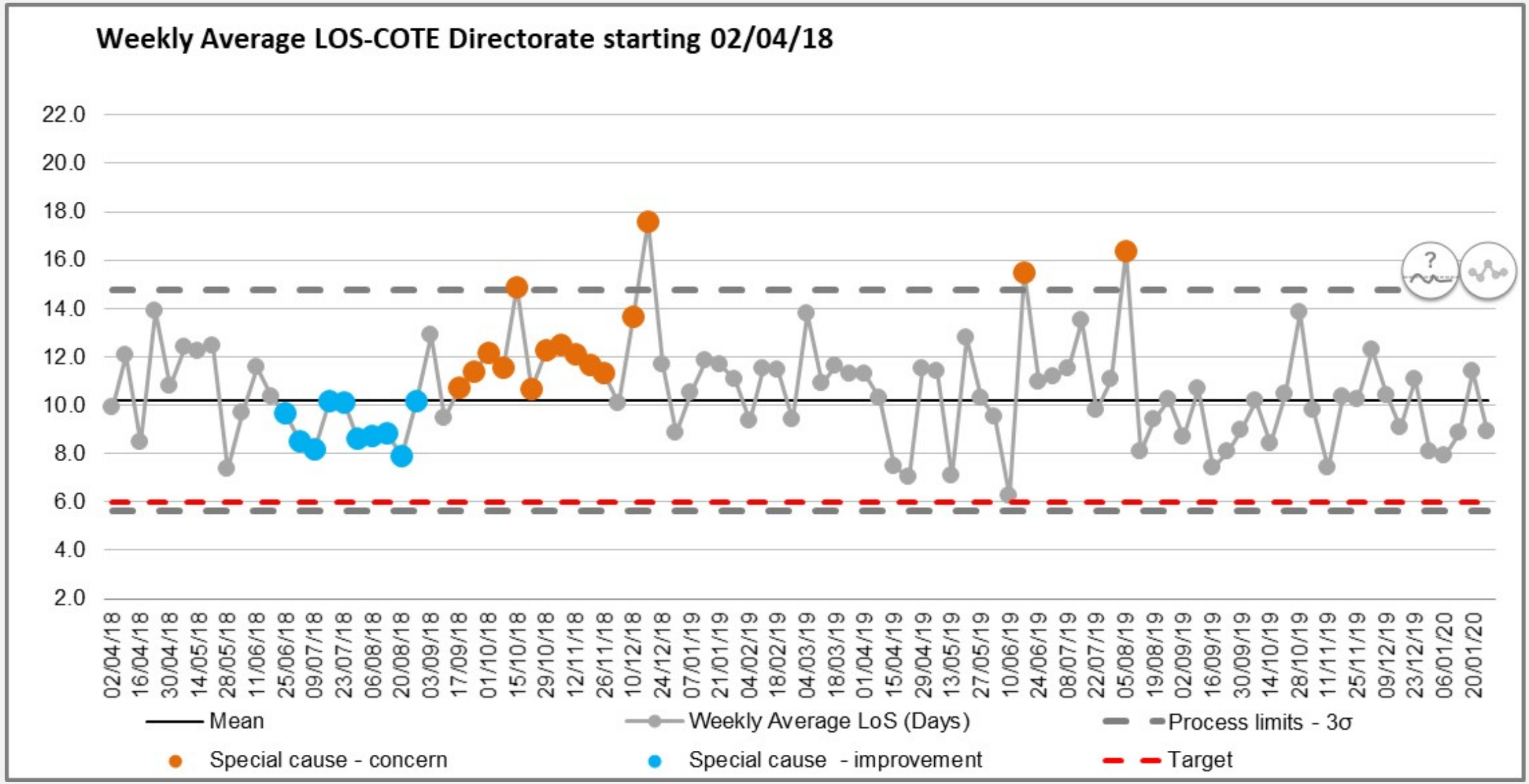
29/07/19
12/08/19
26/08/19
09/09/19
23/09/19
07/10/19
21/10/19
04/11/19
18/11/19
02/12/19
16/12/19
30/12/19
13/01/20
27/01/20
10/02/20
Mean
Number Patients Discharged
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target



NHS Lanarkshire


Weekly Average LOS-COTE Directorate starting 02/04/18
22.0
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
02/04/18
16/04/18
30/04/18
14/05/18
28/05/18
11/06/18
25/06/18
09/07/18
23/07/18
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22/07/19
05/08/19
19/08/19
02/09/19
16/09/19
30/09/19
14/10/19
28/10/19
11/11/19
25/11/19
09/12/19
23/12/19
06/01/20
20/01/20
Mean
Weekly Average LoS (Days)
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Future for Frailty

MRP an opportunity to plan a future service – 48hr unit

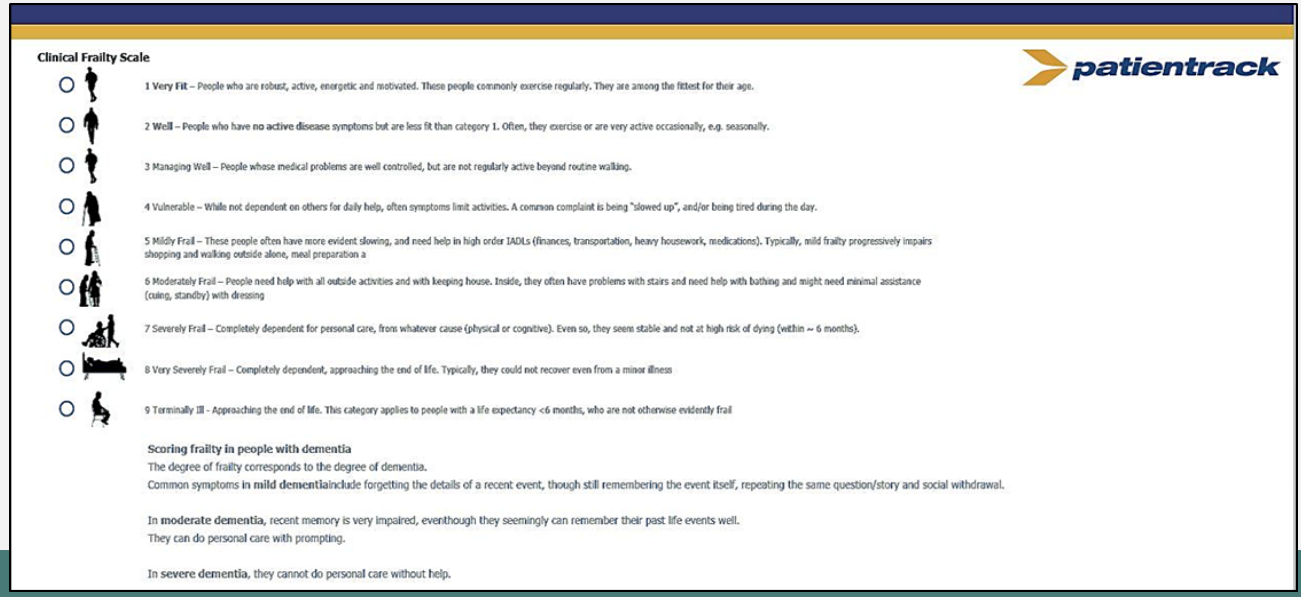
Right patient, right place, right time

Electronic Frailty Screening via Patienttrak at Triage/REACT

Direct to Frailty Unit streaming from Emergency Department

Development of Advanced Practice Model

Expansion of Discharge to Assess with H&SCP



Clinical Frailty Scale

patientrack

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active** disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation a

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness

9 Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia.

Common symptoms **in mild dementia**include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, eventhough they seemingly can remember their past life events well.
They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

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Thank You

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