Developing a FAU – The MEHT QI journey

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Overview

- MEHT, the SR and Essex
- The QI journey
  - Pre-FAU
  - Pilot
  - Intervention - the FAU
  - Outcome measures / results
  - Effect of change and lessons learnt
- The Future
‘What has been will be again, what has been done will be done again; there is nothing new under the sun.’

Ecclesiastes 1 verse 9, The Bible
We care. We excel.
We innovate. Always
The QI journey begins...
The Background
• Emergency floor - ED / EAU / ESS
• Unselected medical take (4/15 Geriatricians)
• Two 26 bedded wards + 20 beds run by Geriatricians
• No FAU / Frailty assessment team
• Pressure to create Frailty Unit
The Problem
The Problem

- No FAU / Frailty Assessment Team
- No MDT joined up working on the Emergency floor
- No frailty scoring or assessment
- ED Consultant recruitment issues
- No ED shop floor frailty presence
- No CGA focus
- No division between short stay and long stay frailty
- Poor access to community information
The Pilot
Introducing

Frailty at the Front Door

The Frailty team consists of a Consultant Geriatrician, OT, PT and ESDAAR nurse specialist.

Hours available 1pm-6pm Monday to Friday.

This in-reach team can offer support to emergency / acute teams in managing frail older people. We can perform a Comprehensive Geriatric Assessment (frailty assessment), aid with discharge planning, signpost to relevant support services, and support management of common geriatric medicine syndromes.

If you may have a suitable patient please contact the Frailty Consultant (bleep 1475),
The QI Story

Model for Improvement

- What are we trying to accomplish?
- How do we know that a change is an improvement?
- What changes can we make that will result in the improvements we seek?

Act    Plan    Study    Do


Changes that result in improvement

Hunches, theories, and ideas

We care. We excel. We innovate. Always
WORKSHEET FOR A SMALL TEST OF CHANGE

TEAM: Acute Frailty Team

Date: 03rd July 2015

AIM:

Question you want answered with this test:

<table>
<thead>
<tr>
<th>Describe your first (or next) test of change</th>
<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consultant geriatrician on the Acute Floor</td>
<td>Matt Sweeting</td>
<td>03/07/15 12:30-17:00</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>2. Involve ESDAAR in Discharge planning</td>
<td>Michelle Frostick</td>
<td>03/07/15 12:30-17:00</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>3. Complete all EDLs on ExtraMed (same day).</td>
<td>Junior Doctors</td>
<td>03/07/15 12:30-17:00</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>4. Early setting of case management plan, including Expected date of discharge. (EDD)</td>
<td>Matt Sweeting</td>
<td>03/07/15 12:30-17:00</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>5. Admitted attempts with frailty have a Clinical Criteria for Discharge (CCD).</td>
<td>Matt Sweeting</td>
<td>03/07/15 12:30-17:00</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>6. Work without the input from therapists.</td>
<td>Matt Sweeting</td>
<td>03/07/15 12:30-17:00</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>7. Trial follow up appointments to be arranged via email</td>
<td>Matt Sweeting / DOME Sec.</td>
<td>03/07/15 12:30-17:00</td>
<td>Emergency Floor</td>
</tr>
</tbody>
</table>

Plan

List the tasks needed to set up this test of change

<table>
<thead>
<tr>
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<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Matt will make himself available (#6555 4016)</td>
<td>Matt Sweeting</td>
<td>03/07/15</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>- Agree and plan with ESDAAR on how they will be contacted. (#6555 4003)</td>
<td>Matt Sweeting</td>
<td>03/07/15</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>- Arrange for Junior Doctor to support service</td>
<td>Deepika Chhabra</td>
<td>03/07/15</td>
<td>Emergency Floor</td>
</tr>
<tr>
<td>- Ensure the list of patients requiring follow up appointments is sent to DOME sec. (Clare Steward x4670)</td>
<td>Ogechi Iko</td>
<td>03/07/15</td>
<td>Emergency Floor</td>
</tr>
</tbody>
</table>
Predict what will happen as a result of this test | What measures will help evaluate results compared to prediction
---|---
- Rapid delivery of CGA – ED/MAZ/EAU < 4 hrs.
- Safe and Timely discharge of patients with the support of ESDAAR.
- All patients to be admitted will have an EDD & CCD in notes and on ExtraMed. | Time patient is seen – arrival time
# of Patients discharged appropriately and destinations.
# of patients admitted with EDD & CCD on file.

... at this point. You have planned your test and will not be able to complete the Do-Study-Act portion until you run the test.

**Do:** Describe what actually happened when you ran the test

- Pre-meeting attended by Dr. Matthew Sweeting (Clinical Lead), Diane Perkins (ESDAAR- Provide Clinical Lead), Michelle Frostick (ESDAAR-Provide) and Ogechi Ilko (Project Manager).
- ESDAAR had a patient’s details to hand Matt.
- Today’s objectives and plans were discussed.
- Constraints were also discussed such as Pharmacy support, transport and completing Discharge summaries particularly over the weekends.
- Project Manager communicated the presence of the team in ED to nurse coordinator.
- Junior Doctor (FY2) from ESS supported Dr. Sweeting.
- ESDAAR provided access to SystmOne to view patients on frailty register
- ESDAAR assisted in the prompt discharge of two patients to IMC beds.
- Dr. Sweeting provided senior decision to expedite the discharge of a patient identified by the therapies team.
- A patient’s discharged was delayed because his medication was unavailable till the next day. TTOs’ to be ready by 4/5pm for IMC bed.
- For patients not already on the frailty register, a note was included by the Consultant advising GP to add patient on the frailty register on the TTO.
The Pilot - PDSA

- June – July 2015 9 -10 cycles
- 57 patients seen over weekdays
- Mean LoS 8 days (median LoS 7 days)
- 39% 0-1 days LoS
- LoS ≥ 10 = 14/57 (24.5%)
- Admission avoidance 10%
Other Data

- CFS ≥ 5 80%
- All had rapid CGA / CCD / EDD set
- 30 day Readmissions = 30%
- Mortality (IP) = 7%
- Main diagnoses fit with ‘frailty syndromes’. Falls, cognitive concerns, continence.
The Intervention
Frailty Assessment Unit (1)

12 ring-fenced beds on ESS ward (+/- 3)
Commenced 19th September 2016
Geriatrician led MDT FAU plus ED in-reach
MDT meeting twice daily
Push / pull model

Admission criteria:
• Emergency admission
• >75 years old
• A frailty syndrome
• Not critically ill
• Care home resident
• Expected LOS ≤ 72 hrs
Frailty Assessment Unit (2)

- Dedicated Geriatrician, OT, PT, SW, Frailty nurse, and ward senior nurse
- 1-2 junior doctors (locums, now funded)
- 20 back door beds given to Gen Med
- Funded business case approved
- New Consultant Rota – 7 day working Nov 2016
- Full 7 day working (MDT) January 2017
- Monthly business meetings
The results
FAU Admissions – 1st month

Destination from FAU:

- Deep ward: 69%
- Discharged to usual residence: 13%
- Discharged to intermediate care: 13%
- Discharged to new residence: 5%
1st Oct – Nov 15th data

346% Increase
## LoS Data

<table>
<thead>
<tr>
<th>Ward</th>
<th>FAU</th>
<th>ESS Acute</th>
<th>CoE wards</th>
<th>≥75 year old through EAU</th>
<th>ESS same time period in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>LoS</td>
<td>3.5</td>
<td>3.4</td>
<td>10</td>
<td>7.5</td>
<td>5.5</td>
</tr>
</tbody>
</table>
KPIs / outcome measures

Data over 6 months (25/9/17 – 30/4/17)
Results on FAU

- 776 admissions
- 539 discharges (30.5% transfer to another ward*)
- Mortality 5%
- Average age 85 years
- Bed capacity at 00:00: 91%
- All had MDT Frailty approach
LoS (days)

Mean = 3.8  Median = 3
FAU admissions source

47% admitted directly from ED
Readmissions at 30 days

- 17% readmission rates
Day of week discharges

- 20% discharges are over the weekend in FAU
- Weds – Fri most popular discharge days
ED 4 hour performance

Steady improvement in ED performance since change
Q1. Was a frailty assessment completed and was the score recorded in the EDL?

- No: 97%
- Yes: 3%

All patient data:

- CFS 1: 0
- CFS 2: 5
- CFS 3: 10
- CFS 4: 15
- CFS 5: 20
- CFS 6: 25
- CFS 7: 30
- CFS 8: 35
- CFS 9: 40
- Not done: 45
- No letter: 50
- N/A: 55

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### Backdoor impact?

<table>
<thead>
<tr>
<th>Dates</th>
<th>Total Patients</th>
<th>LoS (mean) Days</th>
<th>LoS (median) Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2015 – April 2016 (inclusive)</td>
<td>1026</td>
<td>10.81</td>
<td>7</td>
</tr>
<tr>
<td>Oct 2016 – April 2017 (inclusive)</td>
<td>948</td>
<td>11.65</td>
<td>8</td>
</tr>
</tbody>
</table>

Patients on Baddow and Braxted (52 beds)
Effect of changes
• Functional 7 day fully operational FAU
• Consultant led 7 days a week
• MDT approach – ‘no paperwork’ – social care and intermediate care assessment
• LoS consistent with short stay ward
• Real joined up working with acute, social and community services
• Business meeting with KPIs built in
Lessons Learnt
Lessons Learnt

• Change takes time and much patience! *(Whoever is patient has great understanding, but one who is quick-tempered displays folly, Proverbs 14.29)*

• Clinical leadership and engagement essential

• IT involvement early in discussions

• Control expectations of stakeholders

• Data, data, data

• Pilots useful and build up to project plans
Where next?
• Same day rapid assessment in FAU from GP or community referrals
• Silver phone – GP access line to Frailty Consultants
• Standardised CGA proforma
• Essex Success Regime – FAUs across the region
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We innovate. Always
Thank you!

Any questions / comments?

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