Improving frailty care at the front door

Jay Banerjee
Front door challenges
An adaptation of a Hindi proverb

Five visually impaired people touch an elephant to learn what it is like. Each one feels a different part.

"Hey, the elephant is like a tree trunk," said the first man who touched the elephant’s leg.

"Oh, no! The elephant is like a snake" said the second man who felt the trunk.

"Oh, no! It is like a rope," said the third man who touched the tail.

"It is like a brush" said the fourth man who rubbed the elephant ear.

And the fifth man said "It’s soft and mushy..."

They began to argue about the elephant and they all insisted they were right. They all were right in what they were saying as they had all developed an understanding based on their own experiences and perspective. However, they did not have an understanding of the whole elephant.

Imagine the elephant to be a patient. Different clinicians and health care staff see the patient in different ways, all of them correct, but by not seeing the whole patient pathway, their understanding is limited. Make sure you understand the entire process/patient pathway before starting any improvement project.
Characteristics of Complex Systems

- Across types of systems, across scales, and thus across disciplines
- Which exhibit common behaviors
- Giving rise to a number of hierarchical levels
- Dynamically interacting
- Many components

Complex Systems Involve

A 'complex' system

Emergent behavior that cannot be simply inferred from the behavior of the components

- Emergence
- Hierarchies
- Control Structures
- Self-Organization
- Decomposability
  - Into Subsystems

Kinds of (Sub)Systems
Implementation - ?traditional

A “GOOD” Standard Operating Procedure

- Should provide all the information necessary to perform a task
- Is usually specific to the equipment used for the procedure
- Should be detailed
- Should “stand alone”
- Should provide quality control information
- Should provide references

Steps:
1. Name Method.
2. Mainly necessary control or label. Views.
17. Pick Mainly necessary. Mes.
34. Pick Mainly necessary. Mes.
41. Pick Mainly necessary. Mes.
42. Pick Mainly necessary. Mes.
43. Pick Mainly necessary. Mes.
44. Pick Mainly necessary. Mes.
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84. Pick Mainly necessary. Mes.
86. Pick Mainly necessary. Mes.
89. Pick Mainly necessary. Mes.
90. Pick Mainly necessary. Mes.
100. Pick Mainly necessary. Mes.

Memo

To: [Recipient name]
From: [Your name]
Date: 04/03/2023

Re: Death of Staff Member

The purpose of this email is to share information regarding the unfortunate passing of our friend and colleague, ________. We are writing to inform you of the tragic news and to extend our deepest condolences to the family. Our hearts go out to them during this difficult time.

We hope that you have been notified of the passing of ________, and we want to assure you that our thoughts are with the family and everyone affected by this loss.

The funeral arrangements are as follows:

[Include details about the funeral arrangements here]

We appreciate your understanding and support during this time. If you have any questions or need assistance, please don’t hesitate to reach out.

Sincerely,

[Your name]
QA or QI

"QA" Approach

Source: Joint Commission on Accreditation of Healthcare Organizations, 1990.

Focus
ANALYTIC: UNDERSTAND THE PROCESS THAT CREATED THE RESULT. STUDY PROCESS OVER TIME.

ENUMERATIVE: EXPLAIN, EVALUATE, DESCRIBE. GREAT FOR STUDYING UNCHANGING SITUATION OR A SNAPSHOT OVER TIME
A QI ‘rapid-cycle’ change model of clinical audit

An audit with one cycle of action and repeat measurement

An audit with several cycles of action and repeat measurement
Given 2 different numbers, one will always be bigger than the other!

What action is appropriate?

Last month

This month

Something very important!
My trip to work

Consecutive trips
Min.
My trip to work
Mean
Upper process limit
Lower process limit
TARGET

Courtesy of Dr Richard Lendon – Modernisation Agency
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act  Plan  Do  Study

Building Knowledge with PDSA Tests

Evidence and Data

Test under new condition

Very small scale

Follow up test

Very small scale

Test under new condition

Wide scale tests of change

Breakthrough Results

Theories And Best Practices
An example!

• Opportunistic - quiet Saturday; 3 hour test
• Staffing and permissions - alignment....
• Outcomes - patient centred; staff reported
• Processes - assessment, management, discharge planning
• Measures - satisfaction of patient and staff; times; discharges
• Will - Ideas - Execution = WILL - IDEAS - EXECUTION
What matters to you?

• What is the matter with you???

• Trop I/ D-Dimer/ ECG/ sepsis “markers”

• Pain/ autonomy/ carer involvement/ shared decision making/ loneliness & isolation/ polypharmacy/ sandwich and tea
PICOS

• Who are you trying to improve it for?
• What are you trying to improve?
• How will you know the change will be an improvement?
• How will you improve?
• How will you know your actions resulted in that improvement?
• How will you share the learning?
TTO

• Go and test

• Set your outcomes - patient, staff

• Measure what matters

• Scale and spread

• NEVER LOOSE FAITH