Improving the Quality and Experience of Care for Older People in Hospital

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Introduction

- High-quality care:
  - clinical effectiveness,
  - safety
  - and patient experience.

- NSF for Older People introduced in 2001 in response to concerns about standards of acute hospital care
- Many initiatives (Dignity campaign, Dignity on the Wards, New Ambition for Old Age)
The problem

- Patient UK, Care Quality Commission, NCEPOD and the Health Service Ombudsman all highlighted major deficiencies in the care of older people in acute hospitals ranging from issues around privacy and dignity to peri-operative care.

- Age independent risk factor for experiencing an adverse event.
- Falls, pressure ulcers, medication errors, HCAI.
- How do we measure harm?
  - Routine reporting systems detect only 5% of incidents that resulted in patient harm.
- Do we have tools to improve?

Features of the Culture in an Organisation Providing High Quality Care

- Patient focussed and clinically driven seeking to deliver *excellence rather than simply satisfactory care.*
- Creates an empowering and enabling culture for staff that encourages innovation and promotes a *can do attitude*, *underpinned by a clear and agreed philosophy of care.*
- Considerable and sustained investment in staff development.
- The culture is seen as *relational, with an appreciation of the* central role played by interpersonal dynamics *(Patterson,M et al, 2011)*
What does high quality care look like?

- How do we identify the frail older people in hospital?
- Low Mortality? Low Length of stay?
- Low Readmissions? High patient satisfaction?

- Can we compare? Or...
Can we measure Compassionate Care?

#hello my name is...
What does high quality care look like?

- Low Mortality?
- Low Length of stay?
- Low Readmissions?
- High patient satisfaction?
- Or... Harm Free Care?

Reduce your chances of developing four common avoidable conditions:

Falling
Pressure ulcers
Blood clots
Catheter infection

Inside you will find some information and simple steps you can take to help yourself or someone you care for...
What’s the role of CQC?

- “we monitor, inspect and regulate services”
- ..”want hospitals to learn from each other to improve their services”
- Examples of good practice highlighted

- “Latest hospital inspections find good care, but still too much variation”

- (May 2014)
Using local data for Improvement

- Reducing Inpatient Falls on the Acute Medical Wards using improvement methods
- The work of the Multi-Professional frontline staff in collaboration with Yorkshire and Humber Improvement Academy
Interventions:

- Daily multi-professional **falls safety briefing**
- **Toileting prompts** pre meals
- High risk of falling signage for patients bed side and on patient board
- Sharing results and lessons through newsletters, run charts and visual displays of “**days since last fall**”
- Certificates awarded for going 10days, 20days and 30days without a fall
- Education of staff
- Equipment availability (including falls sensors)
- Dedicated leaders for improvement on each ward
Wider benefits...

- Culture change
  - Engendering a team culture of patient safety
- Multidisciplinary working is more successful
- Falls safety thermometer
Patient Safety in the Emergency Department: far reaching implications

• 43% increase in mortality at ten days after admission through an overcrowded emergency department (ED) (Richardson 2006)

• Length of stay in an ED is a predictor of inpatient length of stay (Liew et al 2003)
  • An ED stay of 4-8 hours increases inpatient length of stay by 1.3 days and an ED stay of more than 12 hours increases length of stay by 2.35 days

• For patients who are seen and discharged from ED, the longer they have waited to be seen, the higher the chance that they will die during the following seven days (Guttmann et al 2011)
The Silver Book

- British Geriatric Society have published “The Silver Book”
- Comprehensive advice on quality care for older people with urgent and emergency care needs
- Endorsed by RCP, RCGPs, Ambulance services, ADASS, RCN, RCPsych, SAM etc etc
Patient Experience

- Starts at Front Door (Emergency Department)
  - CGA + decision-making
  - Facilitating discharge direct from ED
  - Rapid access outpatient reviews
  - Starting outpatient investigation
  - Liaising with Care Homes, GPs and community services
  - Advance care planning
  - Developing links with ED
Impact

Patients seen in ED by IG

- Admitted Medical Need: 3%
- Admitted No Medical Need: 7%
- Admitted no ICT / CIC: 5%
- Admitted CDU Protocol: 27%
- Discharged From ED: 58%
- Discharged From CDU: 8%

The Leeds Teaching Hospitals
NHS Trust
Case Study 1

- 85 year old man been visiting his wife in a care home and had collapsed on leaving.
- 3rd attendance to ED with “collapse”- via 999, several short stay admissions
  - Medications reviewed previously-postural hypotension
  - appeared low in mood, tearful
- Referred to the community matron from ED
  - arranged for him to have a hot meal at the care home joint visit with social worker, subsequent telephone F/U
- better quality of life, improved mood and health, not presented again to the ED.
Case Study 2

- 91 year old female in Residential Home.
- End of life approaching
  - Community DNACPR in situ
  - Advance care planning being considered
- Presented to ED following a seizure
  - Excluded reversible causes
- Spoke to NOK, care home manager, GP, S/W
  - Identified ongoing care needs + concerns seizures, pain
- Discharged from ED with increased Anti-epileptics, analgesia, PRN rectal diazepam, advanced care plan
Conclusion

The evidence base for effective care of older people indicates that we should offer Comprehensive Geriatric Assessment to Older People at their first point of contact with the acute hospital

- We need to define and measure quality indicators
- Use local data for action and improvement
- Use the available evidence to drive a change culture
- “Turn patients into people again”