Welcome to the RGP of Toronto network webinar!

The presentation will begin in a few moments. Here are some tips:

• To ask a question during the webinar, type into the “Chat” box

• A fast, wired internet connection is best – slow connections might cause poor reception and gaps in audio or video

• Please use the background music to adjust the volume of your audio. If you cannot hear sound, try the following:

  1) Check the “Hardware and Sound” folder in your computer’s “Control Panel” – check if you are muted, if the volume is set at a good level, and if your playback device is set to be the system’s “default”

  2) Close and restart the webinar

  3) Close and restart the webinar in a different browser (Internet Explorer vs. Google Chrome vs. Mozilla Firefox)

  4) Let us know if you need additional help by typing into the “Chat” box

To ask a question during the webinar, please type into the “Chat” box
RGP of Toronto Network Webinar

*Emergency Departments in the UK: Designing Care and Meeting the Needs of Older Adults*

September 25 2017

Suzie Southey, Emergency Nurse Consultant
Queen Elizabeth Hospital, Norfolk UK
CONSULTANT NURSE CLINICAL
LEADERSHIP, SERVICE DESIGN, RESEARCH, EDUCATION

- Older persons project
- Identify the gaps
- Utilize resources
- Creative Solutions

- EMERGENCY / COMMUNITY INTERFACE
- FOCUS ON DESIGN OF SERVICES THAT RESPOND TO THE OLDER PERSON IN HOSPITAL
- OLDER PEOPLE & TRAUMA CARE
ELDERLY FRAILTY IS ED THE RIGHT PLACE?
OR WE COULD MAKE AN ONLINE RESERVATION 2 DAYS BEFORE AN ACCIDENT!
KEY STREAMS OF WORK FOR OLDER PEOPLE IN ED

- UNDERSTANDING THE CHALLENGES
- PREVENTING AVOIDABLE ADMISSION GP/AMBULANCE
- EARLY ASSESSMENT IN ED
- INTERVENTIONAL TURNAROUND FROM ED
- THE HOSPITAL FRAILTY TEAMS
- ENVIRONMENT
- EARLY DIAGNOSIS OF DEMENTIA
- TRAUMA CARE IN OLDER PEOPLE
- LOCAL DEMOGRAPHIC NEED
CHALLENGES

• LONG DELAYS IN ED
• ED OVERCROWDING LONG TROLLEY WAITS
• INCREASING AMBULANCE PATIENTS
• INCREASED ADMISSIONS
• DELAYS IN DISCHARGE TO HOME
• FRIALTY AND OLDER POPULATION
DRIVERS

• ROYAL COLLEGES
• GP/PSYCHIATRY/EM/RCN/GERIATIRIC/ACUTE MEDICINE/NMC/
• DEMENTIA STRATEGY
• ADVANCING ROLES
• 5 YEAR FORWARD CARE IN THE COMMUNITY
• CHANGES IN FUNDING STREAMS
• OLDER PEOPLE DEMOGRAPHICS
EVERY CONTACT COUNTS

Every contact counts – while they identified few easy answers, participants pointed to a potentially large number of contacts with the NHS which could have been used to resolve the older person’s underlying health problems once and for all. Sometimes, the older people had not felt listened to, with underlying health problems left to culminate in a subsequent admission.

GPs and paramedics have a key role to play – many older people contacted their GP or were brought to hospital by a paramedic, so any potential for prevention must surely start with these two professionals.

Don’t neglect adult social care – none of the older people in our study said they were in current contact with a social worker, and few reported receiving social care services in the run-up to admission. Health professionals felt that adult social care was too under-funded at national level to be able to play a key role in prevention.

IMPROVING URGENT & EMERGENCY CARE NEEDS FOR OLDER PEOPLE? RIGHT PLACE - RIGHT PERSON
FOCUS FOR CHANGE

• DEMENTIA DIAGNOSIS
• PREHOSPITAL TEAM AVOIDANCE
• CARE HOME SUPPORT - DELERIUM
• ED + INTEGRATION OF SPECIALIST TEAMS
• ACT DON’T DELAY - ASSESSMENT
• TURNAROUND
• TRANSPORT HOME
• HOSPITAL ENVIRONMENTAL DEVELOPMENTS
AGIS
ACUTE GERIATRIC INTERVENTION SERVICE

• CARE AT POINT OF CRISIS AT HOME  GP/HUB CALL /INTERCEPTION OF 999
• SEND
• PRE-HOSPITAL STAFF SKILLED in ASSESSMENTS
• ACCESS TO COMMUNITY SUPPORT MDT (MOBILITY AIDS ETC)
• GP DOES NOT NEED TO VISIT unless clinical need
• HOME BASED DIAGNOSTICS-POINT of CARE TESTING
• ACUTE INTERVENTIONS
• INSTRUMENTAL IN INITIATING PERSONAL SOCIAL AND MEDICAL INTERVENTIONS STAY AT HOME SUPPORT
• PARAMEDICAL/NURSING/MEDICAL/
• THERAPIES
FRAILTY ASSESSMENT PROJECTS IN ED

• SUFFOLK
• NORFOLK
ED ASSESSMENT OF FRAILTY

- TOOLS OF ASSESSMENT AT TRIAGE
- BOURN MOUTH
- ISAR
- ROCKWOOD
- TRIGGER FRAILTY TEAM AND INTERVENTIONS
- SEATED AREA
- ENVIRONMENT FOR FURTHER ASSESSMENT
- STAFF TRAINING
- DELIRIUM PATHWAY
‘Think Frailty’ Triage Tool

Step 1
Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

<table>
<thead>
<tr>
<th>Over 65 and ....</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex multiple conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls in the last 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident in a care home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute or chronic confusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired mobility or self care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely to need complex support for discharge</td>
<td></td>
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</tbody>
</table>

Are any of the above criteria met?

If YES to any of the above move to Step 2
Improving Care for Older People in Acute Care: Think Frailty Driver Diagram

**Primary Drivers**

**Aim**
- To improve the early identification of frailty and ensure that older people who are identified as frail have access to comprehensive geriatric assessment or are admitted to a specialist unit within a day of admission to hospital, by March 2014.

**Identification of Frailty**
- Screening of admission to identify frailty
  - Apply the ‘Think Frailty Triage Tool’ or equivalent screening tool on all older inpatients in acute care to identify those who are frail.
  - Promote the use of patient, family, carer feedback to improve care
  - Ensure patient requirements are accurately reflected in the care plan

**Care Pathway**
- Care Pathways
  - Ensure inpatients identified as frail receive early specialist comprehensive geriatric assessment
  - Optimise efficiencies in flow, handovers and discharge
  - Create a culture that involves patients and family in care

**Secondary Drivers**

**Education, Leadership and Culture**
- Develop an infrastructure to support local testing of the ‘frailty triage tool’ using improvement approaches
- Align work with other relevant work streams including wider older people’s improvement work, person centred health and care, patient flow
- Optimise opportunities for spread and sustainability
- Optmise opportunities to learn from and share good practice
- Clinical Leadership
- Develop measurement framework to guide improvement
- Ensure reliable communication across clinical teams of at risk patients
**Affix Patient Label Here**

**Concise Care Bundle for the Management of Acute Delirium**
This does not replace your clinical judgement

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Clinical Area</th>
<th>Referred From</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr’s Name</td>
<td>Grade</td>
<td>Bleep</td>
<td>Signature</td>
</tr>
</tbody>
</table>

**Clinical Assessment** Use ABCDE approach,

**Definition and Diagnosis**
Delirium is characterised by a disturbance of consciousness and a change in cognition that develops over a short period of time.

Confusion Assessment Method (CAM)
- Presence of an acute onset and fluctuating course
- Inattention / easily distractible
- Disorganised thinking in time / place or person
- Altered level of consciousness

Diagnosis of delirium requires presence of 1 and 2 plus 3 or 4 Types:
- Hyperactive – agitated / hallucinations
- Hypoactive – Lethargic, withdrawn

**Precipitating Factors:**
- D- “Drugs”: Hypnotics, opiates, anticholinergic, general anaesthetics, steroids
- E- “Electrolytes”: Glucose, Calcium, Sodium, Urea, Ammonia
- L- Lacking medications (Withdrawal) – Alcohol, Benzodiazepines
- I- Infection: Chest, Urine, Skin, CNS
- R- Reduced sensory input: Sleep, hearing, vision
- T- Intracranial – tumours, infarcts, bleeds, infections, seizures
- U- Urinary / Faecal: Incontinence or Retention/Constipation
- M- “Myocardial”/Pulmonary: Hypoxia

**Preventative Measures:**
1. Identify early (<24 hours) patients at risk of delirium and establish a multicomponent intervention package tailored to the patient’s needs
2. This is often best achieved by liaising with nursing / MHLN / Dementia support professionals and asking nursing colleagues to start a “Confused / Disorientated Patient Care Plan”

**Predisposing Factors:**
1. Age >75 Elderly patient
2. Known cognitive impairment
3. Surgery especially NOF fracture
4. Polypharmacy
5. Intercurrent severe illness
6. Wounds and IV lines

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**Concise Care Bundle for the Management of Acute Delirium**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>K number</th>
</tr>
</thead>
</table>

**Initial Management**
1. AMT10 – baseline for patient and CQUIN target
2. Consider: FBC, LFTS, U/Es, CRP, Calcium, TFTs, B12, Folate, Glucose, Blood culture in sepsis
3. Urine Dip (+MSU / CSU) CXR
4. ABG
5. CXR
6. ECG (will guide medication choices later)
7. CT Head (Very low threshold – essential if concerns about new dementia diagnosis)
8. Consider DRE/ Digital Rectal Examination
9. Further IX may be indicated such as EEG (to differentiate from non-convulsive status epilepticus, focal intracranial lesions or encephalitis) along with more advanced cognitive screening (MOCA, TYM ACER etc)
10. Consider LP (e.g. if concerns about encephalitis / meningitis)

**Further Management**
1. Treat the cause of delirium if known
2. Collateral History from family care home etc
3. Full Medication Review
4. Ask nursing staff to start a “Confused / Disorientated Patient Care Plan”
5. Consider involvement of MHLN (and Psychiatric input) and Dementia Support Team and others...
Scene setting Ipswich Hospital

- Ipswich Hospital catchment approx. 330,500
- In comparison to England average:
  - Older population
  - Longer life expectancy
  - 13.6% increase in over 60 year olds by 2021
  - Higher rate of disease prevalence.

- Recent change in community health provider
- Winter pressure initiatives an opportunity for change.
Integrated Admission Prevention Service

- Commenced October 2015
- 6 month pilot
- Winter scheme
- Proactive
- Direct Access
- Successful
Frailty Assessment Base (FAB)
Service Description

Comprehensive Geriatric Assessment with focus on acute issues.

- Multidisciplinary rapid assessment service
- Assessment within 48 hours
- 8am - 6pm Monday to Friday
- Referrals from GP, Community teams, ED. Phone direct to consultant or email.
Frailty Assessment Base (FAB)
Team personnel and dynamics

To promote patient independence and return home or arrange alternative discharge destination. Shared Care Plan provided to patient.

- Consultant geriatrician
- 2 Nurses
- 2 Physiotherapist
- 2 Occupational therapist
- 1 Therapy Assistant Practitioner
- 1 Healthcare assistant
- Suffolk Family Carers
- 1 Administrator
- 1 Pharmacist
Crisis Action Team (CAT)

Service Description

Admission prevention service, with 24/7 multi-agency team (health, social care and voluntary care)

Outcomes are:

1. Support of adults experiencing a “crisis”, to remain in their own home, or

2. A rapid discharge from the emergency department to prevent an emergency admission.
Crisis Action Team (CAT)
Team personnel and dynamics

Each team member contributes an individual skill set to the CAT team, enabling a holistic team approach to each individual patient.

2 Physiotherapists
2 Occupational therapists
3 Nurses
13 Generic Workers
1 Social Worker
1 Suffolk Family Carer
7 British Red Cross staff
Geriatrician support
Service Challenges led to the need for a new integrated approach

Service Challenges

Growing legacy Issues:

1. Limited integration of services
2. Missed opportunities in A&E for admission avoidance

New integrated approach

- A&E
- CAT
- FAB
Service Challenges led to the need for a new integrated approach

**Growing legacy Issues:**

1. Limited integration of services
2. Missed opportunities in A&E for admission avoidance

New integrated approach

- A&E
- CAT
- FAB
- Geriatric Interface Nurse
Geriatric Interface Nurse

Role description: Establishing the Geriatric Interface Nurse was critical to achieving a truly integrated approach.

Role commenced: September 2016
Specialist geriatric input
Proactive case finding
Supporting safe appropriate discharges and/or admissions from the department
CAT and FAB liaison
Assessing the impact

1. Positive patient experience
2. Good stakeholder engagement and feedback
3. Admission avoidance
Impact 1: Positive patient experience

“Friendly and helpful, nothing was too much trouble and answered everything clearly - you would be hard pushed to improve the service.”

“For the complete care and professionalism they show. They are cheerful and help you come to terms with the difficulties being suffered. Anyone relying on the service can’t go far wrong. I would recommend them to anyone”

<table>
<thead>
<tr>
<th></th>
<th>Recommend</th>
<th>Not Recommend</th>
<th>Total Responses</th>
<th>Extremely Likely</th>
<th>Likely</th>
<th>Neither Likely or Unlikely</th>
<th>Unlikely</th>
<th>Extremely Unlikely</th>
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<tbody>
<tr>
<td>FAB</td>
<td>99.6%</td>
<td>0%</td>
<td>246</td>
<td>228</td>
<td>17</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAT</td>
<td>100%</td>
<td>0%</td>
<td>74</td>
<td>68</td>
<td>6</td>
<td>0</td>
<td>0</td>
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</table>
Impact 2: Good stakeholder engagement and feedback

I didn’t think you would add anything to what I already knew, but you did and have really helped manage my patient (GP)

Thank you and the team for the fantastic level of support you provided. This maintained her independence and reduced risk of muscle bulk loss hospitalisation is at risk of causing (GP)

This service has been invaluable to MAU (consultant)
Impact 3: Admission avoidance

931 patients assessed
90% returned home
31% home with change
3% stepped-up to ICB
7% admitted to acute hospital

All had CGA

81% admission prevention at 30 days
Integrated service, fully operational from end Sept. 2016, showing clear reduction in ED Attendance to Medical Admission conversion rate
Against a backdrop of 9% greater ED attendance, the integrated service yields 5.5% greater ED discharge rate, and 7.9% lower admission rate.
### Integrated admission avoidance service benefits delivered

<table>
<thead>
<tr>
<th>Monthly</th>
<th>CAT</th>
<th>FAB</th>
<th>GIN</th>
<th>Total</th>
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<tbody>
<tr>
<td>Cost</td>
<td>(£117k)</td>
<td>(£42k)</td>
<td>(£12.5k)</td>
<td>(£171.5k)</td>
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<tr>
<td>Prevented Admissions</td>
<td>75</td>
<td>82</td>
<td>40</td>
<td>197</td>
</tr>
<tr>
<td>CCG(^1) Savings</td>
<td>£107k</td>
<td>£131k</td>
<td>£22k</td>
<td>£260k</td>
</tr>
<tr>
<td>Trust Savings</td>
<td>£75k(^2)</td>
<td>£82k(^2)</td>
<td>£20k(^3)</td>
<td>£177k</td>
</tr>
</tbody>
</table>

(1) CCG savings based on QUIPP
(2) CAT & FAB savings based on 80% admission avoidance of 5-day length of stay
(3) GIN savings based on 2-day length of stay
Staying ahead of emerging challenges

Initiatives delivered
• Already expanded FAB to 6 assessment areas
• Proactive ED case finding implemented

Initiatives in progress
• FAB to move to 7 day working
• To implement telephone patient follow-up
• Further staff training required

Remaining challenges to overcome
• Match capacity with volatile demand
• IT interface
Conclusions

Services recommissioned
Norfolk Service 400 BED DGH

- 65000 ED attendance
- 40% age 75 or over
- 60 ambulances a day mainly older people
- Conversion to admission 28% higher than average 20% from ED to hospital bed
- Rural location transport challenges
Rapid Assessment Team In ED

Integrated, co-located, generically trained, MDT

We aim to provide admission diversion & early supported discharge support to patients in emergency care and outpatients settings.
How do we work?

- Direct referrals and pro active sourcing of patients.
- Daily co-ordinator.
- Welfare triage calls post discharge.
- Emergency falls pathway.
- Outreach as appropriate.
- Named discharge co-ordinator role per patient.
- Close interface with community services.
- Access to the stakeholder IT systems to assist in decision making
  - Carefirst, System One, EDIS, Patient Centre etc.
Demand on Service

- Increased numbers attending A&E
- Change in Acuity & complexity of patients
- More input/services required
- Boundaries for D/C loosened
- Increased risk taking
## What does it look like?

<table>
<thead>
<tr>
<th></th>
<th>2013-2014</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>RAT</td>
<td>Discharged</td>
<td>Discharged %</td>
<td>Admitted</td>
<td>Admitted %</td>
<td>FALLS</td>
<td>All contact</td>
</tr>
<tr>
<td>Apr-14</td>
<td>230</td>
<td>157</td>
<td>68.3</td>
<td>73</td>
<td>31.7</td>
<td>121</td>
<td>351</td>
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<tr>
<td>May-14</td>
<td>235</td>
<td>173</td>
<td>73.6</td>
<td>62</td>
<td>26.4</td>
<td>129</td>
<td>364</td>
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<tr>
<td>Jun-14</td>
<td>230</td>
<td>165</td>
<td>71.7</td>
<td>65</td>
<td>28.3</td>
<td>118</td>
<td>348</td>
</tr>
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<td></td>
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<tr>
<td></td>
<td>2016/2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr-17</td>
<td>398</td>
<td>250</td>
<td>63%</td>
<td>148</td>
<td>37%</td>
<td>213</td>
<td>611</td>
</tr>
<tr>
<td>May-17</td>
<td>355</td>
<td>245</td>
<td>72%</td>
<td>110</td>
<td>28%</td>
<td>201</td>
<td>556</td>
</tr>
<tr>
<td>June 17</td>
<td>387</td>
<td>251</td>
<td>65%</td>
<td>136</td>
<td>35</td>
<td>211</td>
<td>598</td>
</tr>
</tbody>
</table>

Looking after you locally
Comparison of Activity by 2014 & 2017

Looking after you locally
More numbers!

• Average length of assessment time is 115 minutes (2014 = 93)
• Re-admission rate currently just over 1% (2014 = 0.5%)
• 7% D/C patients go to alternative venue of care
• 28% require some form of formal care
• 61% return home with some form of referral
• 4% decline or do not require any ‘on-referrals’
• Average number of ‘On-referrals’ per person is 6 (2014 = 3)
What are we providing to patients?

• Multi-factoral comprehensive assessments.

• Informed decision making.

• Referrals onwards.

• Safe discharges and appropriate admissions from emergency care and outpatients areas.
Why CGA?

• Gold Standard Care
• It’s a PROCESS not a tool!
• Alive & At Home
• Not just for frailty wards!

Twitter; @MDTea_podcast
Facebook.com/MDTeapodcast
**Lightning Learning: CGA**

**WHAT?**
CGA (Comprehensive Geriatric Assessment) is a single assessment process for the older person.

It looks at several aspects of the person's life using the multidisciplinary team.

- Medical
- Mental health (including cognition)
- Social and home environment
- Functional capacity

Can be completed in the ED area by the PCCs with input from a MOE consultant, as well as therapy staff.

**WHY?**
CGA aims to promote independence in the individual, while also reducing admission/length of stay.

Older patients who don't require a prolonged stay in hospital (less than 24 hours) can be admitted to EDU on the EFU pathway.

They should be a medically stable non cardiac patient with a NEWS <2 and investigations should be around patients baseline.

They will get comparable care to AFU, but allows AFU beds to be utilised by the more complex older patient.

**HOW?**
- Paper on the benefits of the EFU (Oxford University Press)
- Comprehensive Assessment of the Frail Older Person (British Geriatrics Society)
- CGA course module (#LeicGEM)
Things to consider..

- Prior attendances
- Social History
- Mechanism of attendance
- CGA
- Who knows them?
- Changes
- Available support

Looking after you locally
What’s next?

• Extended weekends- recruiting now!
• Exploration of collaborative opportunities with QEH Frailty team- exploring rapid access frailty clinics and silver phone support
• Networking- with other teams in the region- attendance to East of England Therapy Network
• Publication- invited to write for nursing/therapy journals.
• Additional training- exploring opportunities for enhanced practitioner roles.
Questions and Discussion......
Thank you for attending this webinar!

You will receive a quick evaluation survey by email – please share your suggestions and topics for future sessions.

A link to presentation slides and a recording will be provided after completing the evaluation.

Please join us at our next webinar Tuesday October 3 2017 at 2–3pm

**Why Patient Time is the Most Important Currency in Healthcare: A Perspective from the UK**

**Brian Dolan**, Visiting Professor of Nursing
Oxford Institute of Nursing, Midwifery and Allied Health Research

Next Webinars: (details to follow)
- *The Senior Friendly Care Framework* (Dr. Barbara Liu), Nov 9 2017, 12-1pm
- *Patient and Family Engagement in the Design of Care*, Nov/Dec 2017

If you have additional questions, contact ken.wong@sunnybrook.ca

www.rgp.toronto.on.ca
www.seniorfriendlyhospitals.ca