D6: Quality and safety in elderly patient care

REGION ZEALAND
SLAGELSE HOSPITAL

International Forum on
QUALITY & SAFETY
in HEALTHCARE
COPENHAGEN

Adapting to a changing world: equity, sustainability and wellbeing for all

@QualityForum #Quality2023

Institute for Healthcare Improvement

BMJ

Photos: unsplash.com

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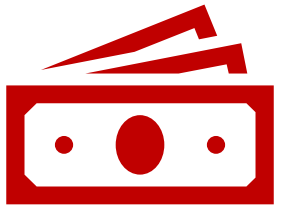
Danish Society for PatientSafety

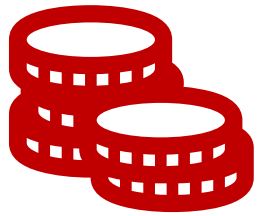
Denmark in numbers

Population: 5,813,000 (115th)

Area: 42,916 km² / 16,562 mi² (133rd)



GDP per capita: $ 63.400



Healthcare spending (% of GDP): 10.9 % (OECD average: 9.3 %)

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Organization of the Healthcare System

National Level

Ministry of Health

Regional Level

5 Regions

Local Level

98 Municipalities

Interdisciplinary geriatric team

Identification of frail elderly by an interdisciplinary geriatric team (IGT) in the acute care hospital ward reduces length of stay and supports safe discharge.

Benedikte Wanscher – Kim Mogensbæk Poulsen - Pernille Brodthagen Thomsen

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Motivation

- Many patients expirienced prolonged stay in the acute care department and was thereafter admitted to the wards
- It was difficult to arrange discharge of the patients from the acute care department
- Low patient satisfaction
- Low staff satisfaction
- Some patients experienced discharge within 48 hours despite transfer from acute care department patients to the wards
- Need for increased geriatric competencies in the acute care department.

Defining the project

- Interprofessional workgroup retreat brainstorm
- International literature; Comprehensive Geriatric Assessment (CGA)
- Shared Decision Making (SDM)
- Visit Sahlgrenska, Göteborg, Sweden

IGT Goals

- Establish an Interdisciplinary Geriatric Team – IGT
- Perform a Comprehensive Geriatric Assessment on frail patients over 65 years
- Communicate with primary health care to
    - prepare a comprehensive discharge plan
    - arrange for a transfer to relevant hospital ward.

We will present

- The team and the roles of the team
- A brief patient case
- Data collected
  - Length of stay
  - Readmission rates
  - Patient satisfaction rates
- Discussion and reflections

Defining the IGT

The team:

- 1 MD (specialist in Internal Medicine and Geriatrics)
- 1 physiotherapist
- 1 occupational therapist
- 1 nurse

Simulation training:

- 2 standardized patient actors
- 2 cases
- Debriefing of team and standardized patients

Frailty screen & Comprehensive Geriatric Assessment

- Nurse screens acute care department for candidates for IGT
- MD consults with nurse and sees patient
- Physiotherapist and occupational therapist evaluates the patient

- IGT communication continuosly throughout the day
- Common workstation

Deliniation of work in the acute care department:

- Frailty screen and CGA performed by the IGT
- Nursing care of patient by acute care dpt. staff

Patient case

86-year old Paula Lassen is admitted to the acute care department following episodes of dizziness and low blood pressure. A frailty screen flags Paula as a candidate to the IGT and she is "transferred " to such.

Nurse Nina Juul Kruse

"It is my assessment, after seeing Paula, speaking with herself and her relatives, that she is not eating or drinking well: This is to be followed during todays stay in the acute care department. We will have to arrange for her to get nutritional drinks once she is home."

On coming photos

Paula Lassen is seen walking in the acute care department ward with her wheeled walker to assess is she can walk without being dizzy. The therapist's hands behind her back indicate it was assessed that Paula was safe!

Paula Lassen

- *"I believe I will be able to take care of myself again. My daughter lives close by, which make me feel safe to go home."*

MD’s role in IGT

- Visitation to the team
- Geriatric assessment incl. review of medicatio and revision and/or prescription of new medic treatments or procedures
- Contact to primary care MD.
- In case of admission:
  - Medical plan submitted to recieving departm for use in medical rounds
- At discharge;
  - Write description of medical course during stay, plan for further treatments or referrals

Role of nurse in IGT

- Identification of patient candidates incl. a frailty screen
- Patient data collection; EWS, O_2, Bp, pulse, resp., medication list etc.
- Identification of problem areas
- Patient flow-coordinator
- Discharge coordination incl. transport, acces to home, referrals for homecare and catheter use etc.
- Contact with relatives

Role of occupational therapist in IGT

- Assesment of current function incl. some/all of the following:
  - ADL assesment (WHO's ICF)
  - Dysphagia screen with FOT or MISA test
  - Cognitive screen (standardized test??)
  - Need for assistive devises
  - Assesment of rehabilitation needs and prognosis
- Prescripe a rehabilitation plan for post-discharge care

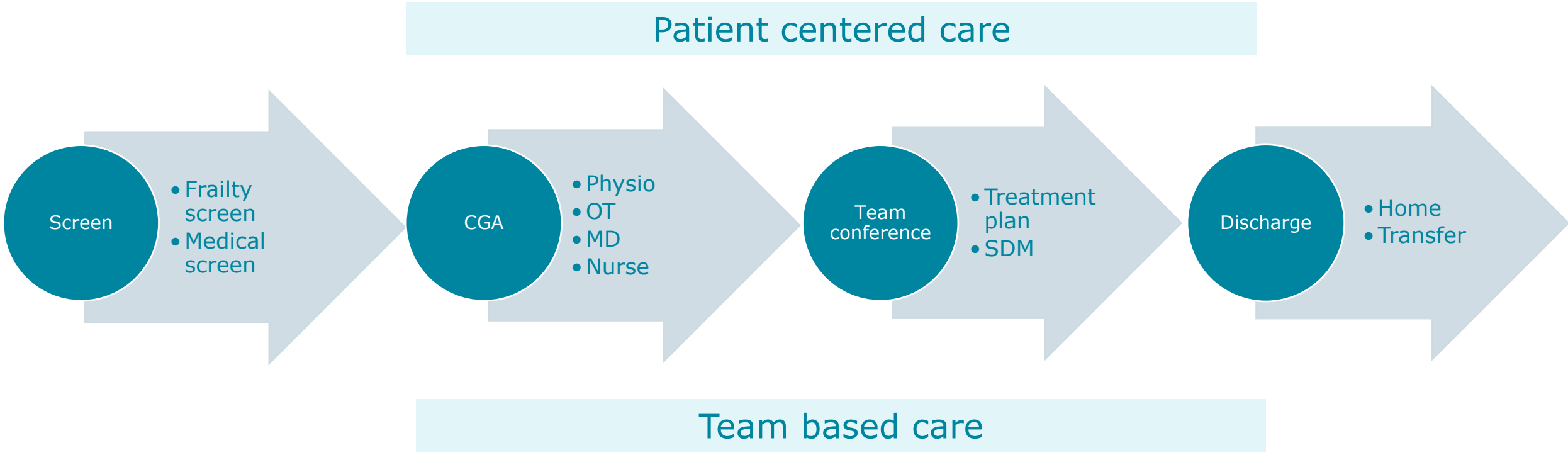
Role of physiotherapist in IGT

- Assessment of function; Walking, stair climbing, transfers, sit-to-stand
- Assesment of balance: Berg’s Balance test TUG
- Grip strength; Jamar-middle position
- Patient reported activity level
- Assesment of need for assistive device for walking
- Prescripe a rehabilitation plan for post-discharge care

Shared duties in IGT

- Preparing for discharge
  - communication with home town
  - arrange for transportation,
  - house keys etc.
- Dressing the patient
- Preparing other logistics for discharge or transfer
- 2-day follow-up phone calls

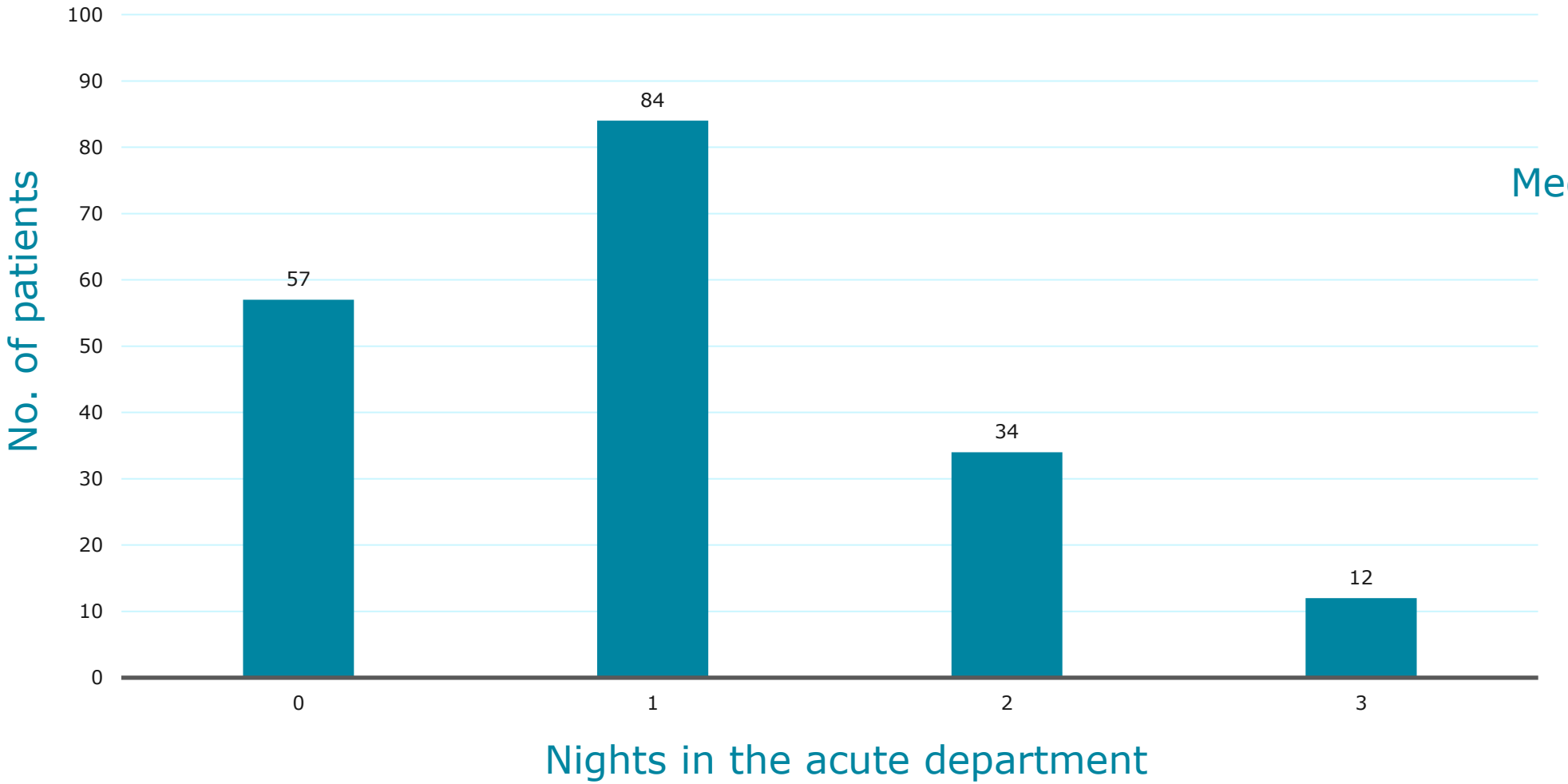
Workflow


Patient centered care
Screen
• Frailty screen
• Medical screen
CGA
• Physio
• OT
• MD
• Nurse
Team conference
• Treatment plan
• SDM
Discharge
• Home
• Transfer
Team based care

PDSA proces

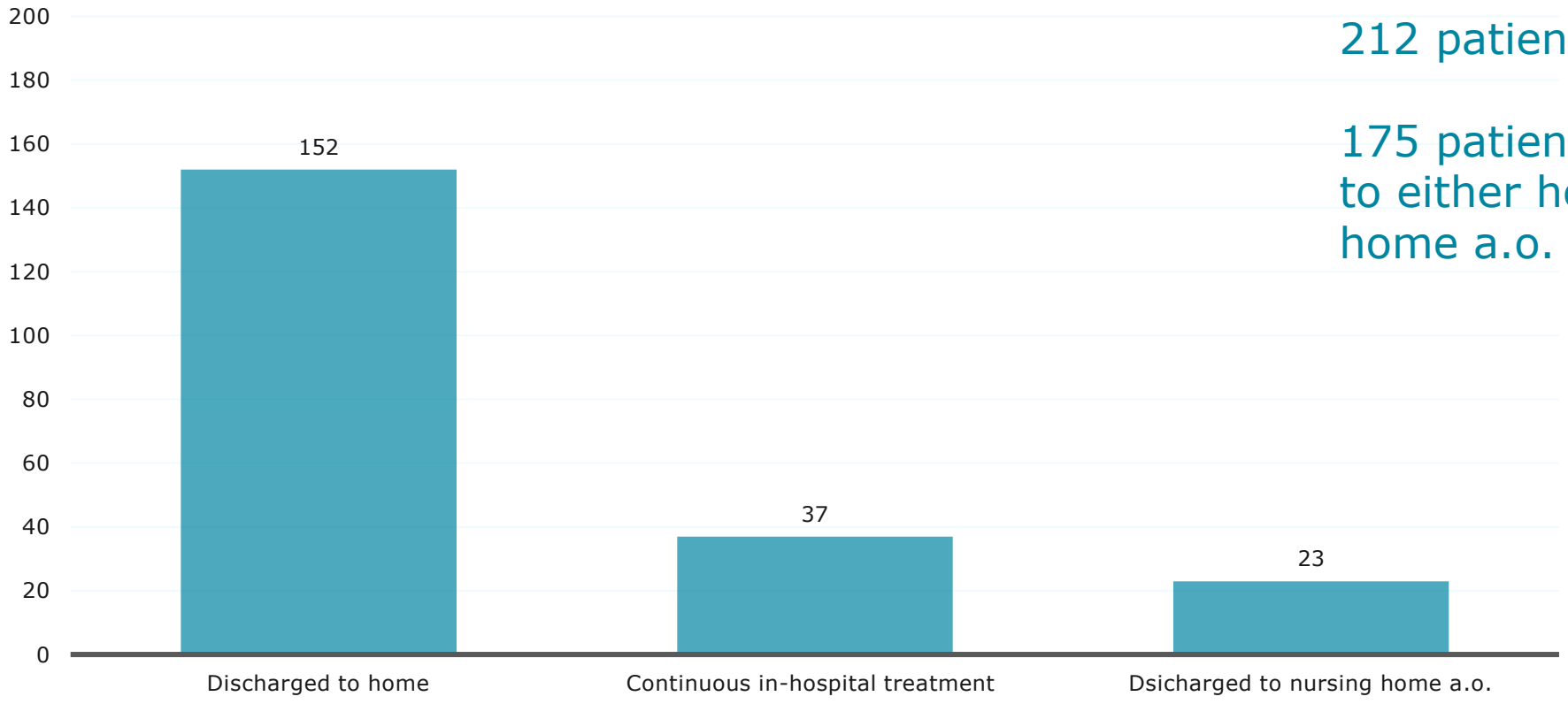
- Weekly status
- Daily check-in
- Monthly status-review
- Revision of duties

Nights in the acute department



Median: 1 night

Discharges from IGT



212 patients

175 patients were discharged to either home or nursing home a.o.

Follow up

- 45 patients needed special follow up from their GP shortly after discharge and this was initiated by th IGT

Follow up

Follow up on stay i Acute Department and contact to IGT

209 of 212 patients accepted follow up call 2 day after discharge

Answers were collected retrospectively form the patient record.

Satisfaction, inclusion and medication

126 patients were asked

Was you content with IGT?

100 % answered YES

108 patients were asked

Did you feel IGT included you in decisions concerning your situation?

100 % answered YES

70 patients were asked about **their medication** after discharge

100 % did not have problems

Reflections

- Defining the data we searched for

- Challenges in getting accurate data
  - Systematic interviews
  - Different interviewers
  - Patient limitations on the ability to answer the questions

- How did data collection line up with how we wanted to track outcomes as we intended to?

- Data use and our ability to show efficiency

Take home message

- No patients evaluated by IGT was readmitted to geriatric wards within 30 days
- More than half of the patients were discharged within the same day or the day after.
- Patients felts included i decisions about their plans and discharge

Thanks for your attention

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Making a difference - person centred, safe and reliable care in communities

Bodil Andersen

Vibeke Rischel

PS!

Community care in 98 local governments

- Community care focuses on rehabilitation and selfcare
- Most elderly live by themselves
- 24hr open service of nursing and social care in private homes up to 8 visits a day depending on the need of care.
- 24hr services in residential and nursing homes.

Improving care for the most vulnerable

Receiving nursing and social care at home(1)

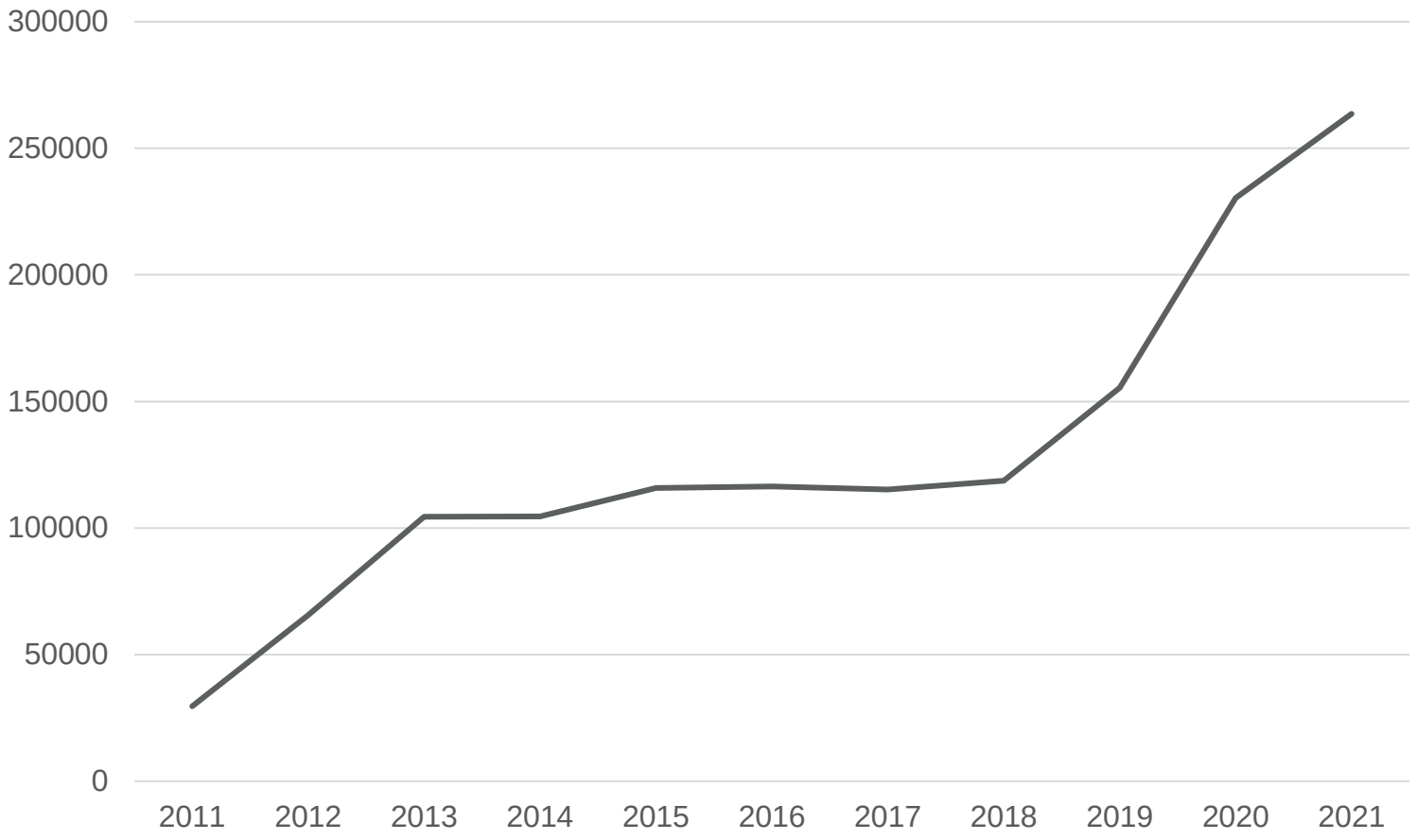
- 11,1 % > 65 years
- 29,8 % > 80 years

Living in residential homes (2)

- 16,1 % +80 years
- 32% +90 years

1.https://www.vive.dk/media/pure/15076/4308161
2. https://www.dst.dk/Site/Dst/Udgivelser/nyt/GetPdf.aspx?cid=34723

Reports of patient safety incidents in community care



The reports from 2021:

Incidents:
67,7 % medication
24,7 % falls

Severity of harm:
None 65,7 %
Low 23,5 %
Moderate 9,4 %
Severe 1,1 %

https://stps.dk/da/udgivelser/2021/aarsberetning-for-dansk-patientsikkerhedsdatabase-2020/~/media/34B5512CA00544F1B69B22918D2249DB

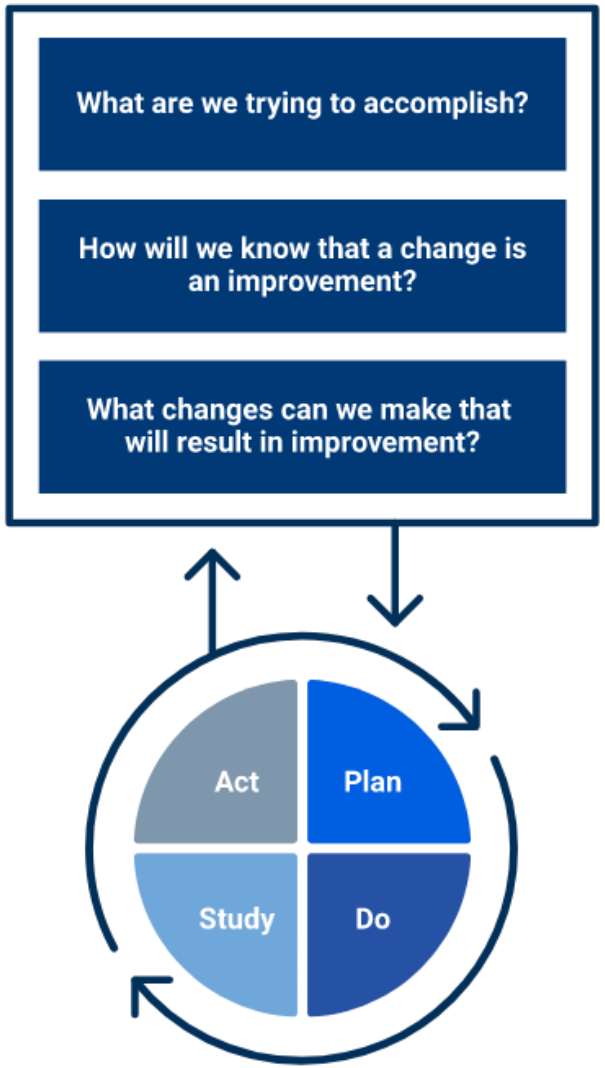
‘In Safe Hands’ 2013 – 2023 across 33 municipalities

- The right (and safe) care, for the right person, at the right time.
- Reduce the number of ‘harms’ and improve outcomes
- Promote safety culture
- Promote learning systems
- Create sustainability & strategy for scale-up

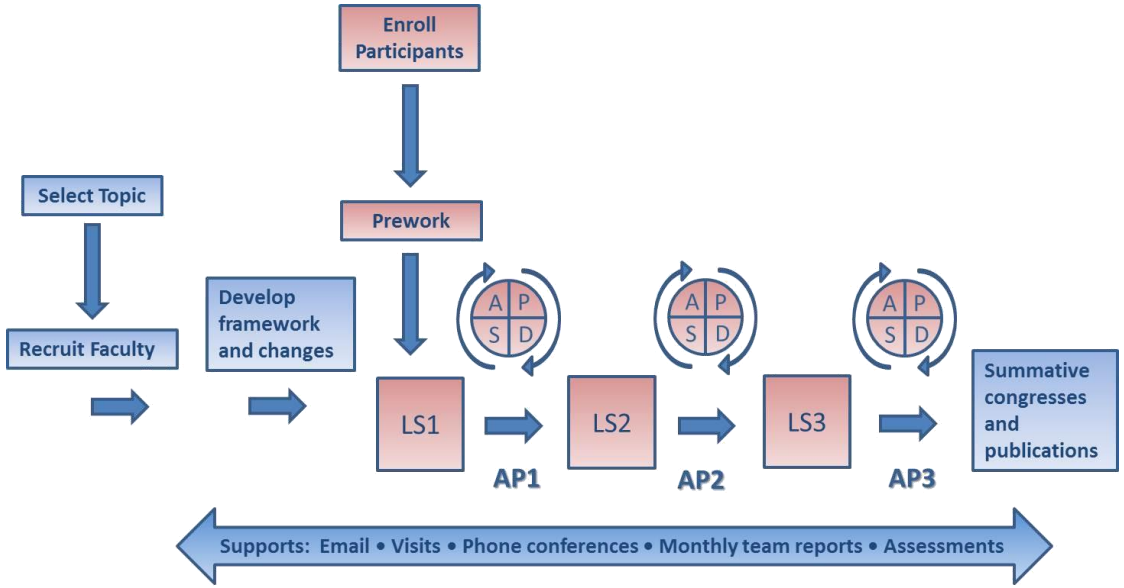
Evidence-based bundles of care

- Elimination of **Pressure ulcers**
- Reduction of **Falls**
- Safe and reliable **Medication processes**
- Reduction of **Infections**
- Early recognition of **Deterioration (EWS)**
- Improvement of **Nutritional status**
- Partnering with patients and families
- Leadership

Methods used in the ‘In Safe Hands’ program



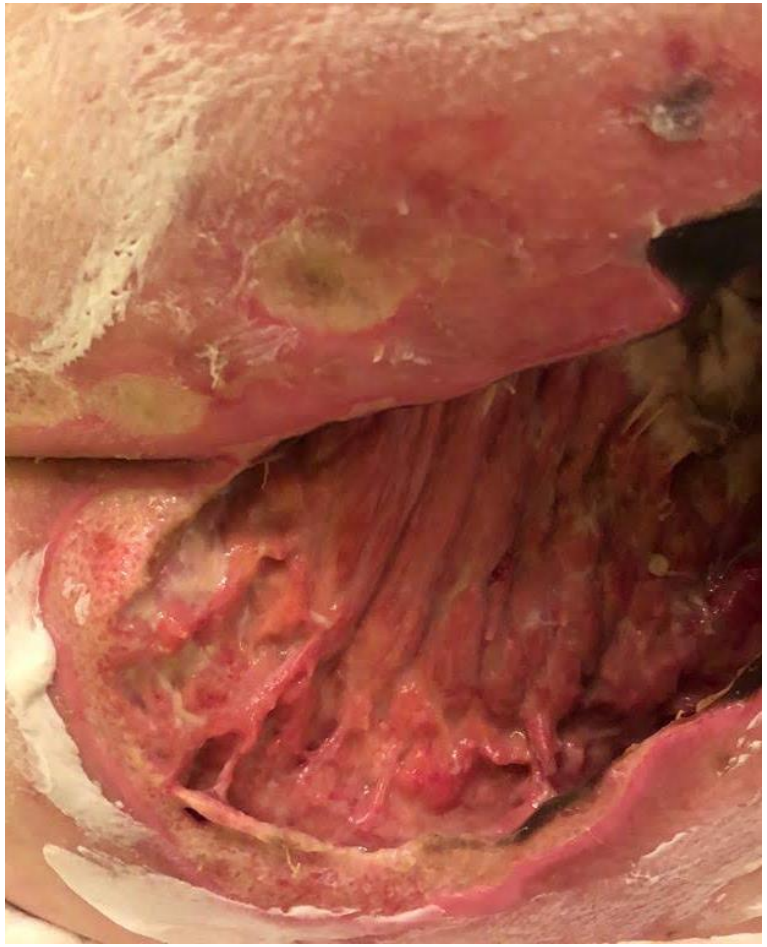
Reference: IHI.org



AP: Action Period
LS: Learning Session
PDSA: Plan, Do Study, Act (Testing Cycle)

Elimination of Pressure Ulcers – PU Bundle

- 2009: a Danish review: 10% of patients had hospital acquired PU(1)
- 2012: PU in top 5 of patient harm in 3 out of 5 hospitals (2)
- 2017: PUB led to a 63% reduction in the incidence of pressure injury in the municipality of Sønderborg(3).



1. Experiences with global trigger tool reviews in five Danish hospitals: an implementation study Plessen et al 2012

2. Are labour-intensive efforts to prevent pressure ulcers cost-effective? Mathiesen et al. Journal of medical economis, Oct 2013. https://www.ncbi.nlm.nih.gov/pubmed/23926909

3. Cost-effectiveness analysis of the Pressure Ulcer Bundle in the municipality of Sønderborg, Aalborg University, Student Report, Autumn 2017.

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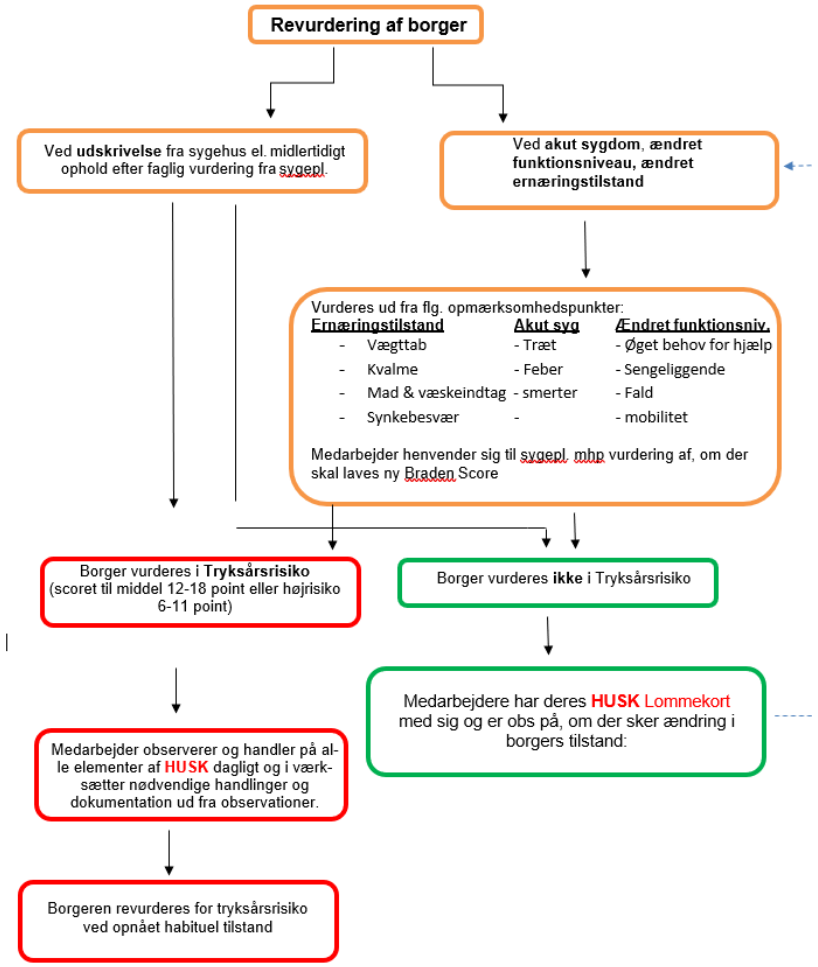
Pressure Ulcer Bundle



HUSK

Hud

Underlag

Stilling

Kost

Skin

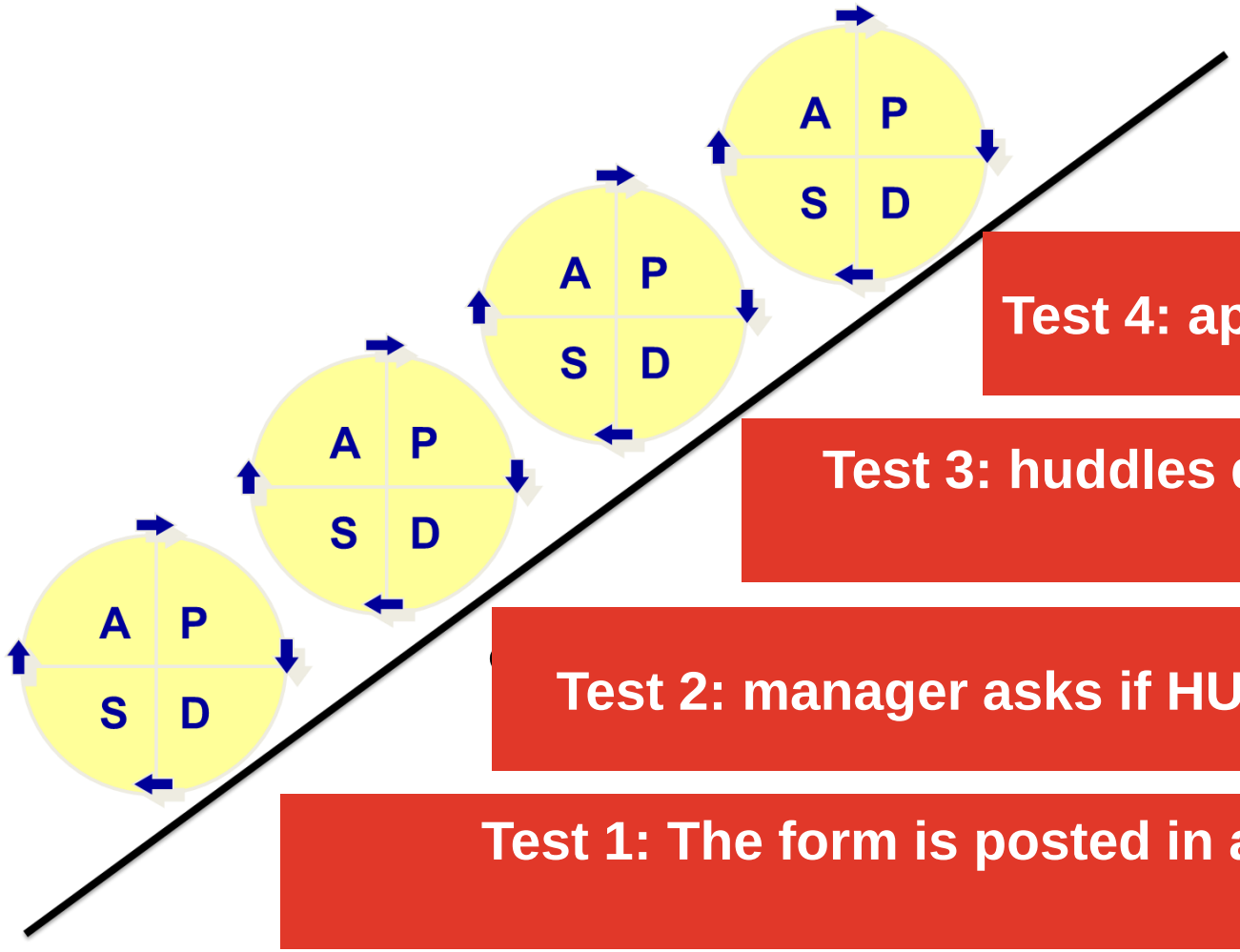
Surface

Keep moving

Incontinens

Nutrition

Small scale testing daily use of HUSK



Test 4: appointing a daily coordinator

Test 3: huddles during the day to remind staff about HUSK

Test 2: manager asks if HUSK was used

Test 1: The form is posted in a meeting room

Documentation

Tjekskema: HUSK Måned:

Beboer	Bolig	Risiko	Dato	1	2	3	4	5	6	7	8	9	10	11	12	13
			H													
			U													
			S													
			K													
			H													
			U													
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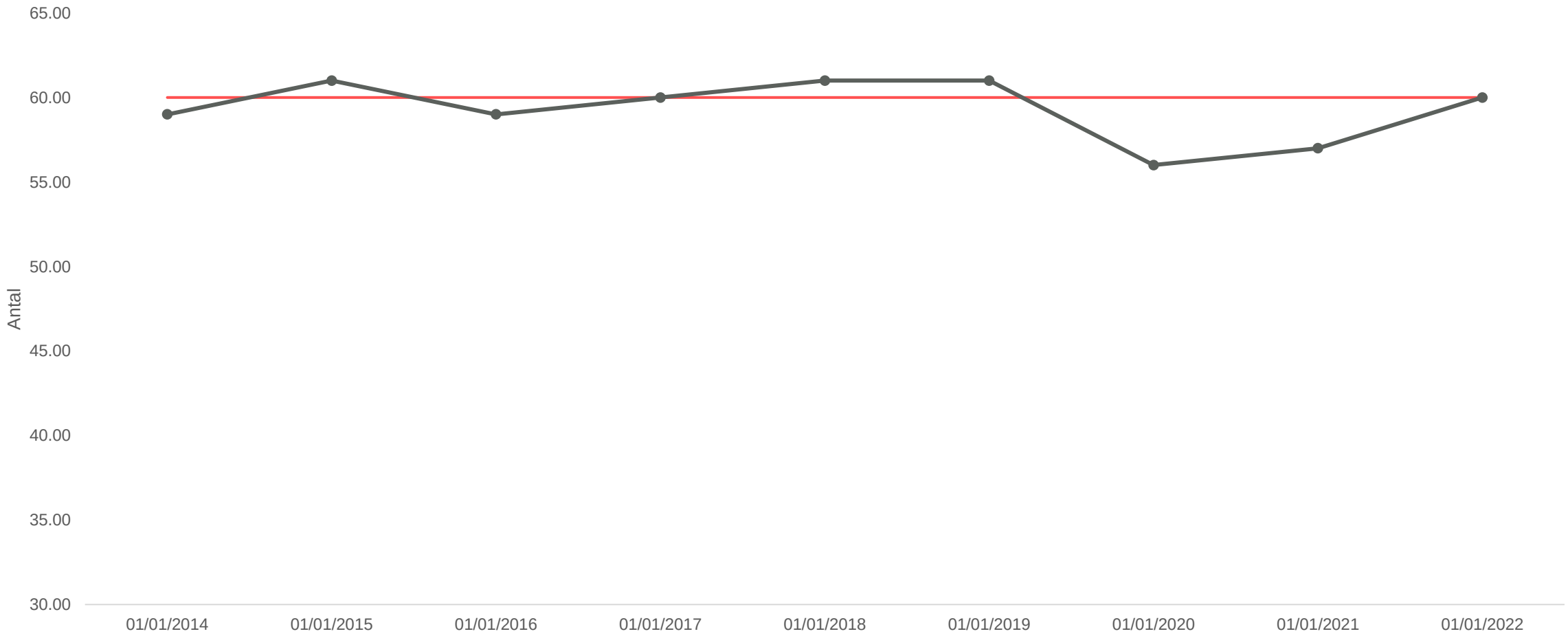
- Daily documentation of the HUSK for each citizen at the Home Care Team

Greve municipality

It worked - the first celebration of 100 days without pressure ulcers

Greve municipality

Preventable admission per. 1000 >65 years 2014 - 2022



https://www.esundhed.dk/Emner/Patienter-og-sygehuse/Forebyggelige-ophold

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Early recognition of deterioration (EWS) and timely intervention

Daily assesment of:

- Mental and social status
- The home setting
- Daily activities
- Nutritional status
- Physical status

Sæt kryds ved de svar, der passer bedst til den habituelle tilstand			
Navn		CPR-nummer	
Psykisk og socialt			
Humør	Glad/positiv	Svingende	Trist/negativ
Hukommelse	God	Svingende	Glemsom
Social aktivitet	Aktiv	Svingende	Passiv
Søvnproblemer	Sjældent	Svingende	Ofte
Hjemmet			
Hvordan ser hjemmet ud	Ryddeligt/rent	Visne blomster	Ophobet affald/lugt
		Snavs/rod	Gammelt mad
Behov for hjælp	Stabilt	Øgede hjælpemidler	Øget behov for hjælp
Hverdagsaktiviteter			
Borgerens initiativ	Meget	Lidt	Passiv
Graden af hygiejne	Velsoigneret	Pletter på tøjet	Usoigneret
Fysisk aktivitet	Meget aktiv	Aktiv	Passiv
Fald	Ingen	Et fald det sidste år	Flere fald det sidste år
Spise og drikke			
Appetit	Spiser vanlig mængde	Småt spisende	Appetitløshed/kvalme
Tørst	Fin væskeindtag	Drikker sparsomt	Skal nødes
Vægt	Holder vægten		Vægttab > 3 kg
Mundstatus	Ren og hel	Synlig plak/blødning	Tyggeproblemer
Fysiske klager			
Afføringsmønster	Normalt	Af og til forstoppelse	Klager
Vandladning	Normal	Hyppig vandladning	Koncentreret/ildelugtende
Vejrtrækning	Normal	Åndenød bevægelse	Åndenød i hvile
Hoste	Ingen	Ofte	Hoste med slim
Træthed	Sjælden	Sløvhed	Afkræftet/slap/mat
Smerter	Sjælden	Ofte	Kronisk
Svimmelhed	Sjælden	Ofte	Kronisk
Slimhinder	Normal	Svingende	Røde, blege, tørre
Hudfarver	Normal	Blussende/varm	Bleg/grå/kold
Hud	Normal	Hudturgor nedsat	Ødemer
Medicinindtag	Selvadministrerer	Skal mindes om	Skal hjælpes

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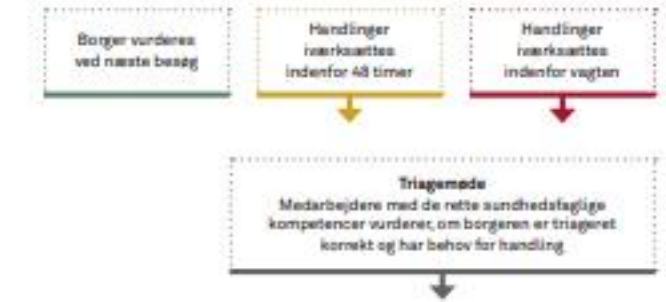
Triage at huddle and timely intervention

Trin 2: Vurdering og observation: Triage og triagemøde



Selve vurderingen af borgernes ændringer i forhold til habitueltilstanden kaldes triagering og udløser en farve. Fig. 3 viser Sundhedsstyrelsens definitioner af grøn, gul og rød, hvor farverne udtrykker alvorlighedsgraden af tilstanden.

	Borgere, der er triageret grønne, vurderes at være i deres sædvanlige helbredstilstand, men kan godt have en kompleks helbredstilstand. Borger vurderes igen ved næste besøg.
	Borgere, der er triageret gule, har vist tegn på svækkelse. Ved brug af Ændringsskemaet triageres en borger oftest gul, når der er observeret én til tre ændringer i forhold til habitueltilstanden. Ved brug af Hjulet foretager social- og sundhedshjælperen eller social- og sundhedsassistenten en vurdering af graden af svækkelse. Når en borger triageres gul, bør der være dialog mellem social- og sundhedshjælpere og social- og sundhedsassistenter eller eventuelt sygeplejerske. Sammen sparrer de om det observerede, og der udarbejdes og igangsættes handleanvisninger efter en individuel vurdering, men senest inden for 48 timer.
	Borgere i den røde farvekategori er i risiko for en alvorlig helbredstilstand og/eller tab af funktionsevne med mange eller markante ændringer. Når en borger triageres rød, skal der være dialog mellem social- og sundhedshjælpere og sygeplejerske eller eventuelt social- og sundhedsassistenter, som hurtigst muligt og senest inden for 24 timer udarbejder og igangsætter handleanvisninger.

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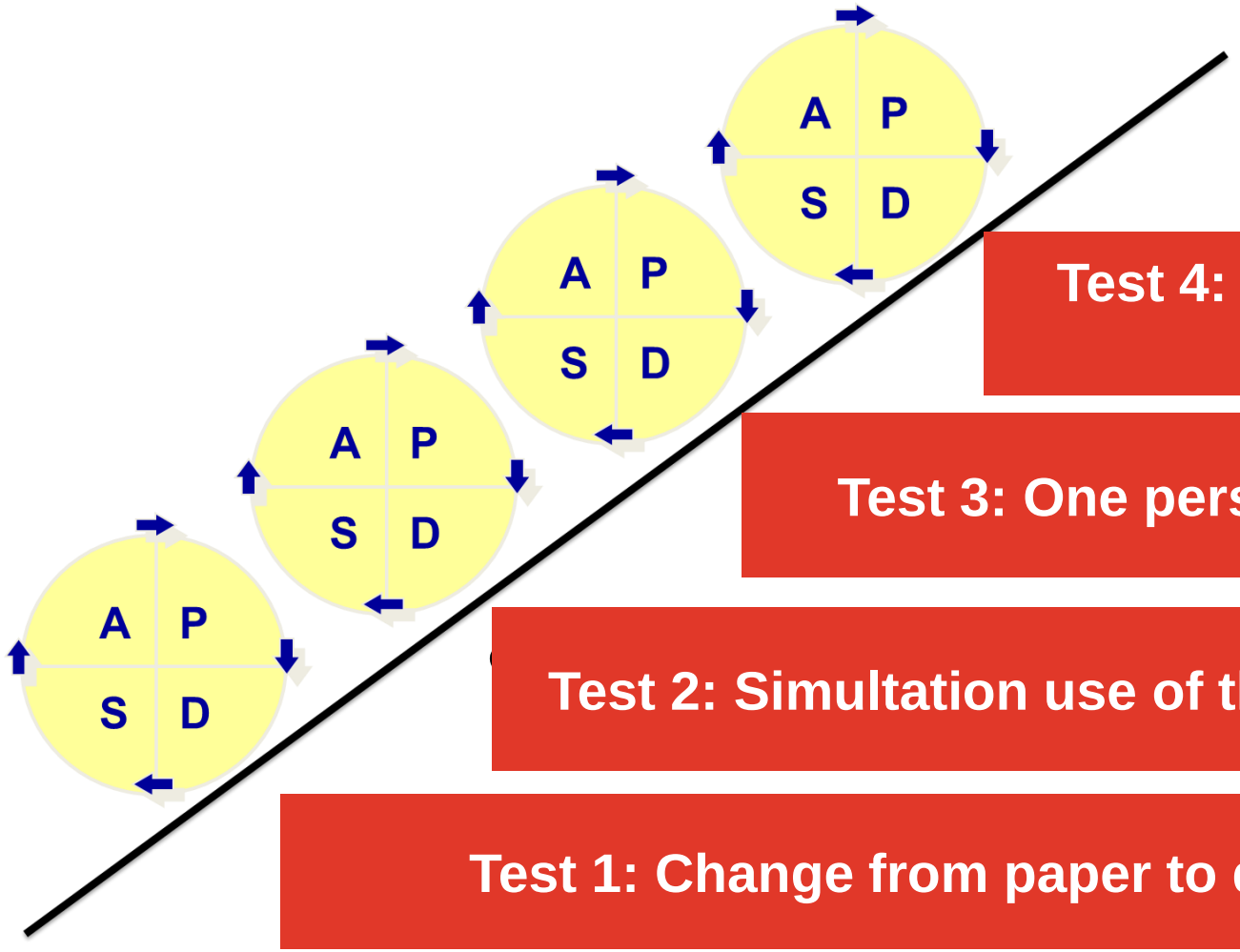
Small scale testing of digital tool for assesment



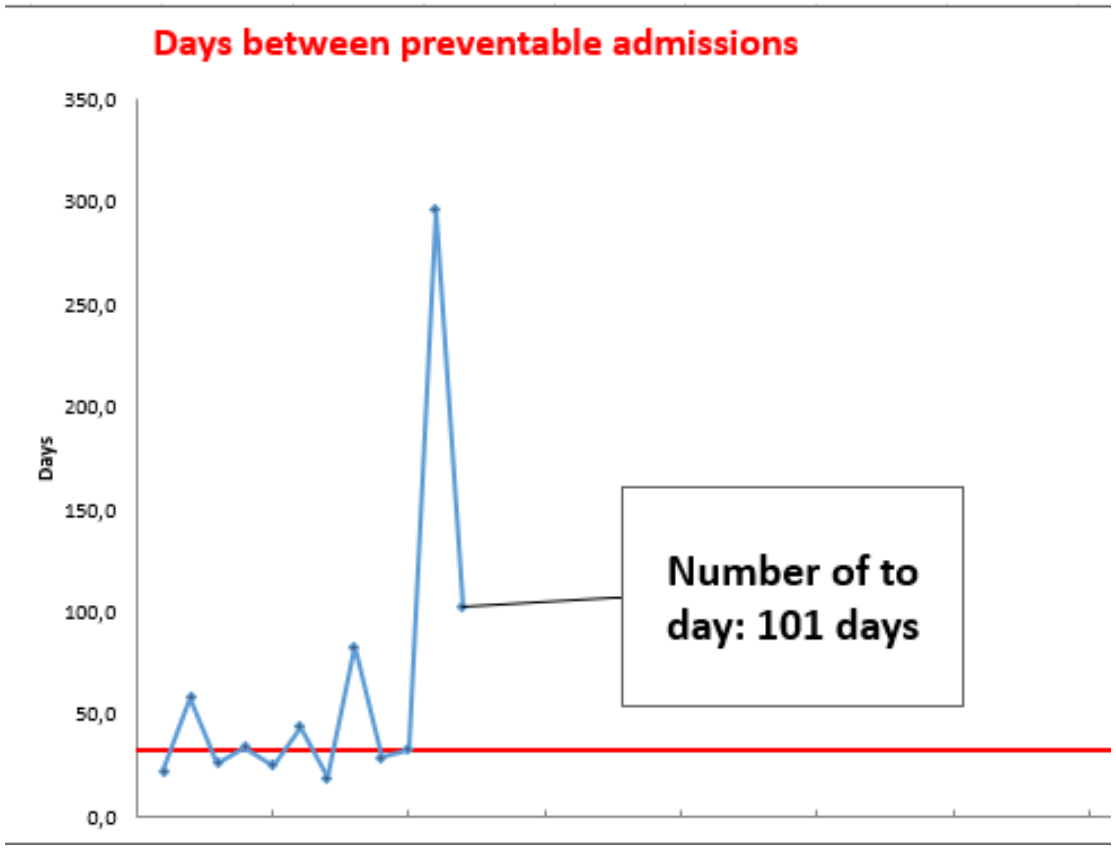
Test 4: One person use digital tool in evening-shift

Test 3: One person use digital tool in day-shift

Test 2: Simultation use of the digital tool

Test 1: Change from paper to digital

Reduction in preventable admissions at Grønsund community



Preventable admissions:

- 2021: 7
- 2022: 3
- 2023: 1

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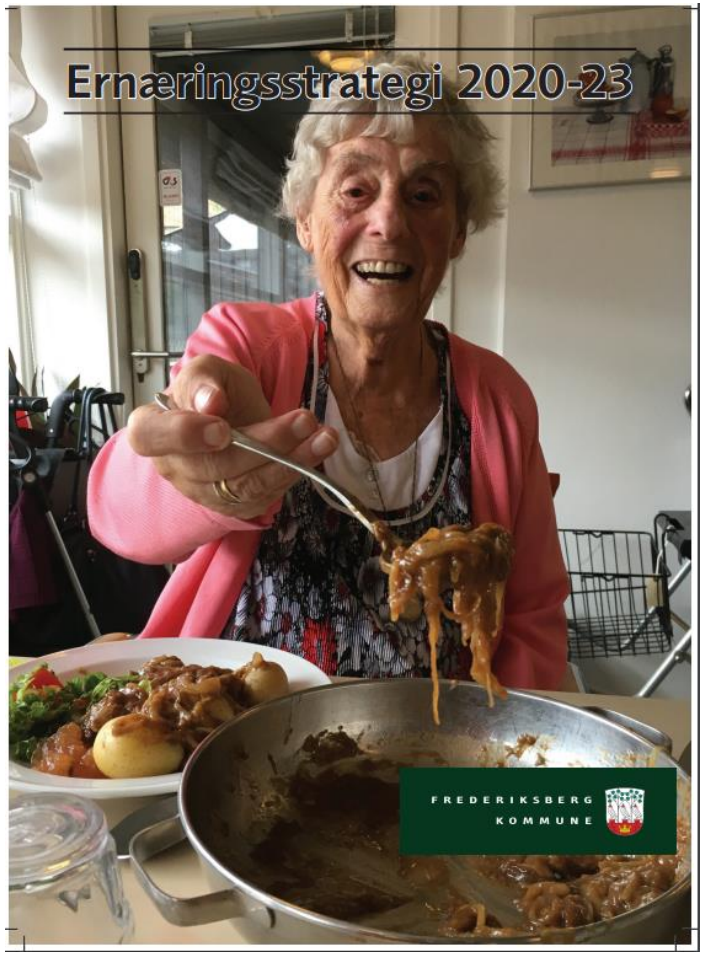
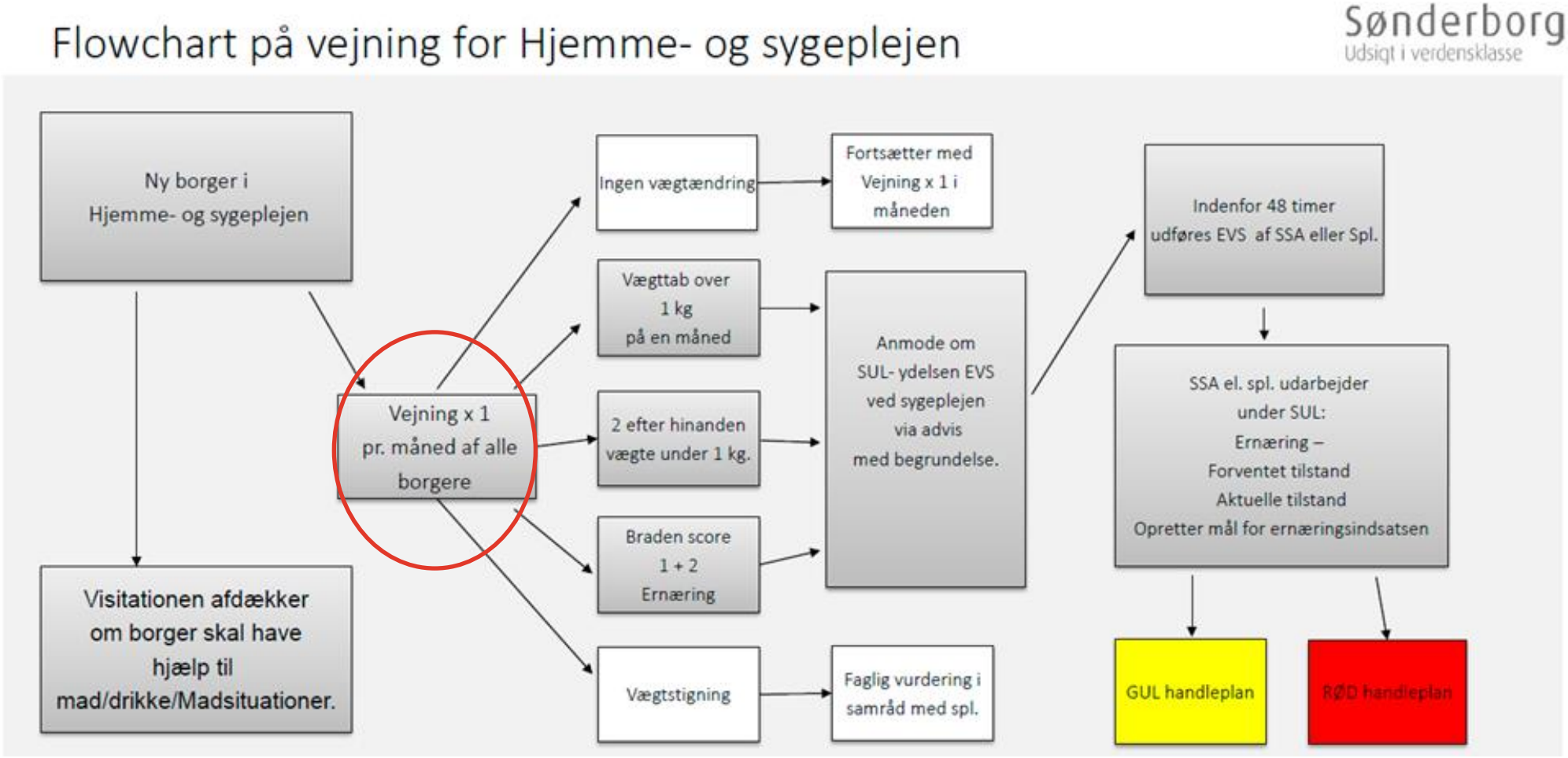
Improvement of Nutritional status

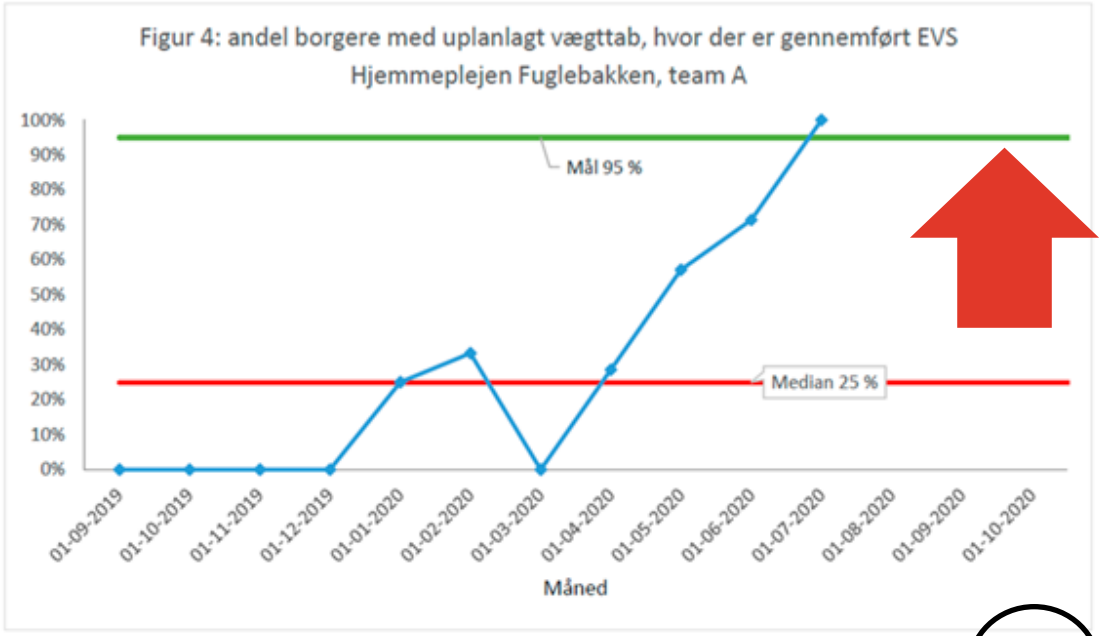


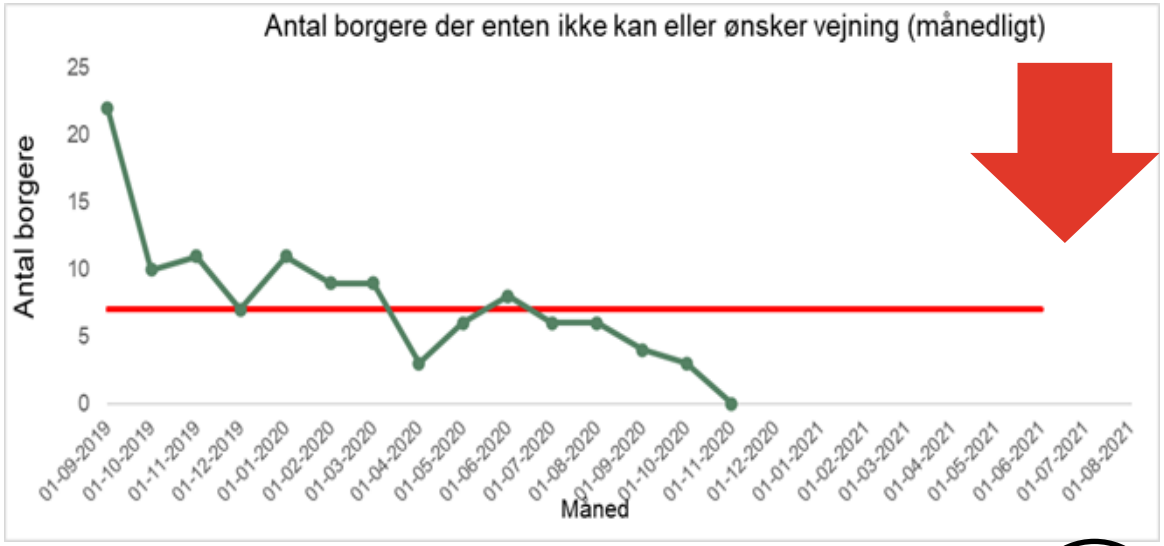
Monthly assesment of weight



Monthly assesment of weight

Figur 4 viser for hjemmeplejen andel borgere med et uplanlagt vægttab, hvor der er gennemført en EVS. Over det seneste år er der typisk identificeret 6 uplanlagte vægttab pr. måned for dette hjemmeplejeteam.





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Take home message – making a difference

- Safe care depends on the application of evidence-based interventions testing using PDSA methodology
- Reliable care depends on making it easy to do the right thing
- Person-centred care depends on partnerships

Photo: unsplash.com