

Understanding the Problem

Measures: How will we know a change is an improvement?

Results

- In recent times there had been nearly one hundred clinically optimised patients in a rural District General Hospital, and over thirty patients were ready to leave the acute frailty pathway.
- Clinically optimised patients receive a similar level of nursing and medical intervention as patients who are not clinically optimised.
- A traditional doctor ward round of each patient each day is probably not the most effective of resources and potentially promotes dependence and the impression that daily medical input is necessary.

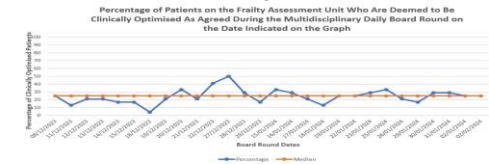
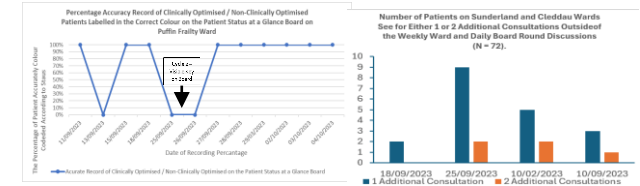
Process Measures

- Clinically optimised patients identifiable on Patient Status at a Glance (PSAG) ward board.
- Patients with a Future Care Plan.
- Patients who had polypharmacy review documented on Comprehensive Geriatric Assessment (CGA)
- Patients with completed 'What Matters to Me' Meeting
- Patients who leave the ward when family visit
- Patient who have a preventing deconditioning plan
- Patient and family feedback
- Complaints

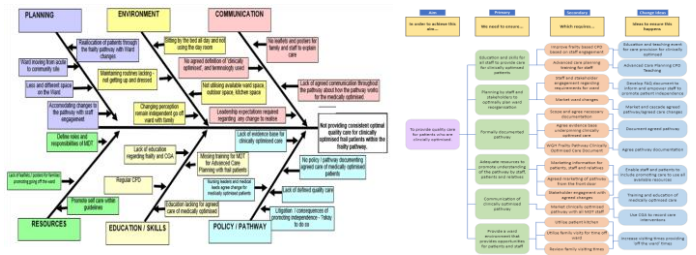
Balancing Measures

- Number of falls within the frailty pathway
- Patient mortality data within the frailty pathway
- Number of pressure area incidents within the frailty pathway

- The Frailty multidisciplinary team adopted a reliable way of identifying and recording clinically optimised patients on the Board Round.



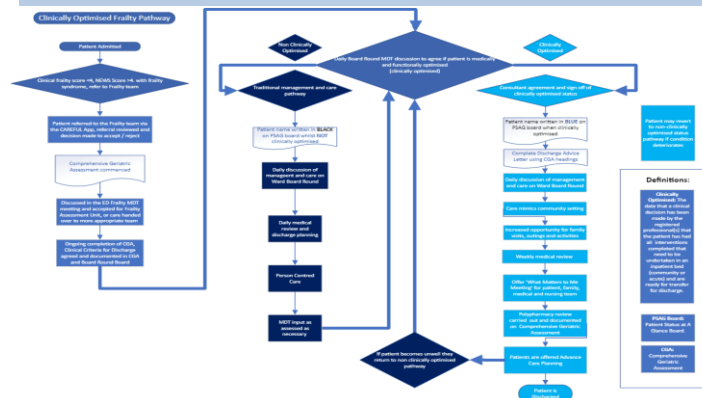
- Balancing measures, including mortality data showed no impact from reorganising care with safety netting protocols forming part of the pathway design.
- Junior doctors reported that they previously spent 5 – 15 minutes per day per clinically optimised patient. Therefore, a time saving of 16 – 48 hours per week was estimated.
- During a four week period one third (24 out of 72) patients needed review outside of the weekly planned review. Of these 79.2% required one review.
- The team piloted the introduction of 'What Matters to Me' meetings. This was used to plan next care steps and focus awareness towards promoting independence and preventing deconditioning.



Involving Others

- The project team was made up of a Consultant, Registrar, Junior Doctors, a Pharmacy ACP, and a Senior Sister all from the frailty pathway and a Coach and Buddy Coach from the Quality Improvement team.
- The team carried out a Stakeholder Analysis. Stakeholders included the Multi-disciplinary Team from the frailty pathway and the management team.
- Stakeholders were consulted throughout the project development. Patient, relatives and staff were asked for feedback regarding pathway changes.

Clinically Optimised Patient Pathway



Staff and Relatives Feedback

Staff Pathway Changes Feedback

- There is no need for medically fit patients to be reviewed daily by a doctor unless they decline medically
- Clinically optimised patients being seen once a week provides us with more time to focus on patients who need medical attention and improve quality of care
- The meeting was very useful and I got to know who was dealing with my wife.
- In the meeting we wanted to know where we stand and were able to ask questions. I was able to say that Mums aim was to go the bathroom by herself

'What Matters to Me' Meeting Feedback

Reflection and Next steps

Reflections

- Data shows the establishment of a reliable way of recognising and documenting clinically optimised patients as part the Daily Board round.
- Traditional care culture proved difficult to change although staff recognised the value of the project focus.

Next Steps

- The project continues to evolve. Spread and scale!
- Scope stakeholder group for another interested group and ward setting.
- Continue to engage with staff within the frailty pathway.

Aim: What are you trying to accomplish?

SMART AIM – TO PROVIDE OPTIMAL PERSON - CENTRED CARE FOR 30% OF CLINICALLY OPTIMISED INDIVIDUALS WITHIN THE FRAILTY PATHWAY BY AUGUST 2023.