Use of Flow Coaching Methodology in Big Room multidisciplinary team meetings to identify patients with frailty and improve outcomes in Robinson Community Hospital, Northern Ireland

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Highly Commended in 2020 CHA Innovation and Best Practice Awards

Summary:
Flow coaching methodology was introduced to the Multidisciplinary Team (MDT) meetings and a once weekly, one hour, "Big Room (BR)" was born. The BR provided an open and honest platform for all attendees on how to provide best care for inpatients with frailty. The Clinical Frailty Scale (CFS) was adopted and BR attendees agreed a process to assess and score patients at admission and discharge. All staff received classroom training and completed an online module on frailty. The BR used process mapping to determine poor, good and excellent care in recent patient journeys. A plan was developed to ensure a consistent and patient-centered approach to care whilst avoiding duplication of paperwork between disciplines.

When severe frailty CFS 8 & 9 was identified and patients had life expectancy of 3 months or less, they were referred for district nursing and palliative care services. The GP was alerted on the discharge letter to 'add name to the primary care palliative register'. GP/Advanced Nurse Practitioner (ANP) had discussions with patient/family about their priorities for end of life care and used the Macmillan booklet "My life, my choices" and advance care planning began. Goals were agreed between the patient, physiotherapist and Occupational Therapist which maximized quality of life and took account of "What matters to me?" Pharmacy reviewed medications prioritising good symptom control. End of life medicines provided at discharge. John's Campaign implemented.

For those with CFS 6 & 7, the MDT addressed six frailty syndromes to prevent or slow decline to a higher frailty score

- Polypharmacy
  Review of medication offered. Reduced medication burden, ensured safe administration, increased concordance and reduced side-effects. Matched medicine administration times to care packages. Plan to introduce self-administration of medicines on ward.
- Mobility/Falls
  PJ paralysis outlawed. Sleep hygiene promoted. Caffeine intake reduced. FRAX scoring completed. Treatment of osteoporosis or referral for DEXA scan recommended. Medicines reviewed. Referral to STEPs (Stepping Toward Enhanced Postural Stability) or physiotherapy falls class.
- Nutrition
  New links were formed with Trust dietitians. Input to carer's leaflet.
- Cognition
  The limited cover provided by mental health services to community hospitals was highlighted. Reduced anticholinergic burden. Dementia companions visited Robinson. Delirium and depression risk factors considered.
- Continence
  New links were established with Continence services and offer of telephone advice consultations to ward staff provided.
- Loneliness/social isolation
  Referral to community Navigator and service leaflets added to all discharge medication bags.

One pathway document produced for whole MDT. The Geriatrician Light Comprehensive Geriatric Assessment (CGA) Tool was developed and will be tested once Covid-19 restrictions ease.

The BR recognized the huge importance of carers and their wellbeing. Poster designed for carers to find out how to contact members of the MDT. A carers welcome pack was produced and a leaflet printed on how to prevent frailty. Carers assessments were routinely offered.

Carers and patients were surveyed by "10,000 voices" on the care provided by the Robinson Hospital MDT with very positive results.

Patients and carers living with frailty are now identified and measures put in place to improve their quality of life and reduce the risk of deterioration.

Background:
The 16-bed ward provides intermediate care to patients stepped down from acute hospital or stepped up from home.

The British Geriatric Society defines frailty as a state of increased vulnerability to poor resolution of homoeostasis after a stressor event.
Frailty is associated with increased risk of deterioration. The acute frailty syndromes result from a relatively minor insult and lead to higher risk of acute hospital admission, care home admission and death.

Most patients in CH have been exposed to some stressor event and have some level of frailty. Admission to community hospital is an appropriate time to address the risk of worsening frailty using all the MDT skills.

The PL and trainee ANP posts were funded for one year by Public Health Agency (PHA). Frailty is primary focus due to a growing and ageing population. PHA aim that 'all older adults are enabled to live healthier and more fulfilling lives.' The project objectives included frailty identification and stratification, Comprehensive Geriatric Assessment, MDT Interventions to improve frailty syndromes and carer/service user involvement.

Prior to commencement of project, frailty was not routinely assessed and rehab goals were not adjusted depending on level of frailty. The results from a baseline questionnaire on frailty showed that majority of staff were not aware of the terminology associated with frailty, the link with frailty syndromes and few had received formal training in frailty or its assessment.

10,000 more voices, a patient survey system was utilized to provide valuable insight into patient experience at the CH. Qualitative feedback was overwhelmingly positive and highlighted the excellent care provided in keeping with the Trust quality and safety plan. The results provided focus for driving further and sustained improvement in quality and safety for all service users.

Other PHA work in NI had recommended the CFS as the best tool for easily assessing frailty in individual patients. All staff were offered classroom training and completed online frailty module. It was also recognized that it would be important to communicate information on frailty back to patients own GP and community services. A team was tasked with exploring the best way to do this.

Flow coaching methodology was adopted in the BR to enable a co-production and co-design approach to redesign of services using quality improvement and coaching methodology combined. BR attendees were Robinson hospital staff (GP, Sister, Nurses, Assistants, physiotherapists, OTs, pharmacists, technicians, catering staff, cleaning staff) patient/carer representative, invited outside agencies, acute hospital staff, community discharge coordinators, palliative care team, mental health liaison, district nursing, community navigator, carer coordinator, community dietitian, falls and continence nurses.

It was evident early in the project from process mapping exercises that there was much duplication of paper work between the different members of the MDT and many long-established patient documents/tools were not designed with the frail patient in mind. This also became a focus for the MDT to enable streamlining of services and make more effective use of each MDT member's time.
It was also apparent that the community hospital beds were not always used for those patients who would benefit most from a period of rehabilitation or assessment. The acute hospital did not realise the full scope of the services provided. This led to an invitation at BR being extended to patient flow managers to work out how best to ensure appropriate patients were transferred.

The project ran from 1/11/ 2018 to 15/3/2020.

Description:
The PL completed fact finding mission to establish current practice with patients admitted with underlying frailty to the CH.

Frailty was not recognized, not assessed, and no standard method for identification and stratification of frailty was used. CH staff were not familiar with how frail patients present and did not recognize frailty syndromes. Staff had not received frailty specific training.

However, staff expressed their love for working with older people and had a particular pride in working within their local CH.

There was evidence of good MDT relations within the hospital. Morning handover meetings and weekly discharge planning meetings already occurred. PL discovered MDT willingness to engage and embrace a new way of working to improve outcomes for older people living with frailty. Baseline questionnaire on frailty given to all staff members. 10,000 more voices surveyed patient and carer insight into their experience within the CH. This provided focus for driving sustained improvements in quality and safety for users. It highlighted that more patient/carer involvement in decisions was required and sleep environment needed improved.

A group was established to bring together all stakeholders inputting to patients care in the CH. Process mapping of patient journeys from pre-admission, admission, inpatient stay and discharge highlighted what was working well and other areas that needed improvement. Areas for improvement included: lack of activity therapy, carer engagement too late in the patient journey, MDT meeting too focused on discharge planning rather than improving quality of care, poor use of community navigator, carers assessment not routinely offered, no frailty screening tool, CGA not completed, no consistent approach to advanced Care Planning, No John's campaign and limited implementation of #endPJ paralysis. No continence assessments undertaken, dietitian not integrated into MDT, limited referrals for STEPs post discharge. Short time set aside for physio, none at weekend.

Good practice noted included pharmacist medicines reviews in line with Beers Criteria and STOPP/START, provision of medicine record sheet at discharge, senior nurse screening of suitable admissions, GPs immediately informed of their patients admission, patients given information pack about their stay on the day of their admission, physio and OT on site, falls bundle completed, 9am-6pm GP cover and out of hours at evenings and weekends.

Weekly Frailty BR established using skills PL gained from Flow Coaching Academy. Effective meeting skills adopted. Patient/Carer representative attended. Bottom up approach to service improvement. Process Mapping and "Love and nuts" exercise undertaken to identify key themes which were voted on by staff to determine areas for improvement and ensured quick wins.

Training needs were identified and then facilitated from specialists in frailty and associated syndromes, dementia, falls, continence, carer coordinator, medicines optimization & dietetics. Rockwood CFS was introduced and tested. CGA was designed and initial testing started. Carer leaflet and poster designed. Discharge planning meeting moved its focus to improving inpatient quality of care.

Outcome and Impact

Once project up and running
45 staff completed baseline frailty questionnaire
18 patients and carers completed 10,000 more voices survey
71 people attended the big room on 1 or more occasion
5 patients had their journey process mapped
100% patients had frailty assessed on admission and discharge.
66% of patients had CFS ≤ 6
44% of patients had CFS ≥ 7
10 carers had their frailty assessed and signposted for intervention
100% of patients had CFS communicated to GP at discharge
100% of patients had polypharmacy reviewed and medication adjusted
100% patients who needed falls assessment had it completed
100% of those who needed referred at discharge for palliative care services/palliative care register had this documented on discharge letter
3 patients had CGA completed leading to a continence referral, treatment for geriatric depression, community navigator referral,
All patients discharging home given leaflets on how to access community navigator.
24 referrals to Community Navigator, a 30% increase on previous 12 months.
108 staff attended training sessions provided either through BR or by PL over 12-month period
60% patients participated in PJ paralysis campaign, compared to 10% initially
100% patients with dementia were able to avail of John's Campaign
All patients given access to eye masks, ear plugs and sleep hygiene information.
CGA format developed to capture carer engagement and "what matters to me".
Poster for MDT contact numbers displayed.

Change of culture around the care of frail patient. Recognition of the frail patient, the routine use of the CFS and improved knowledge of all staff on the syndromes of frailty and their best management.

More synergistic MDT working with respect for the roles carried out by different staff, less overlapping and duplication of roles.

Embedding the # endPJ Paralysis approach with a 'move more' ethos on the ward and encouraging every professional to take on a responsibility to encourage.

Proactive palliative care approach for those identified to be nearing the end of life. Better communication with patients and their families about priorities of care and advance care planning. Better and safer discharge planning with wrap- around support for patient and family. Provision of "just in case" end of life medicines at discharge to those identified to be in last weeks of life.

Recognition of huge importance of carers, enabling carers to access MDT staff more easily and encouraging them to be present during therapy sessions where possible. Recognising the burden of caring and the need for assessment of carers health needs in addition to the patient being cared for. Embedding John's Campaign, with staff understanding the benefit to patients with dementia of their family and carers having unrestricted visiting.

Four-page, patient centred, CGA designed to capture “what matters to me?” and carer engagement. Resulting management plan in CH designed around the wishes of patient and carer. Tool avoids duplication and provides consistency in approach to care of the frail patient taking account of all frailty syndromes. This in turn will lead to increased quality of life, better symptom management, better management of incontinence, better nutrition, better social engagement, less falls, better mobility, reduction in polypharmacy and better care for those with cognition problems and dementia.

In turn patients will remain independent and in their own homes for longer. They will avoid hospital and nursing home admission. They will have a less rapid decline into more severe levels of frailty.

The Big Room approach encouraged the inclusion of multiple staff disciplines and input from the voluntary sector and from our carer representative. Process mapping of patient journeys tried to include patients with diverse social backgrounds, diagnoses and outcomes. We considered the impact of a palliative diagnosis on those from different ethnicities who may wish for care to be carried out in differing ways. Spiritual needs were highlighted within the CGA. Newer versions of CGA will also include flagging any barriers to communication.

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