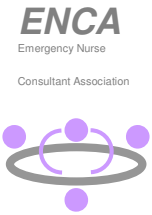
QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Clinical governance and research



Chapter 9 Clinical Governance and Research

Clinical governance

Guidelines are important for quality improvement, but will be ineffective unless supported by change management techniques and clinical champions.

Clinical audit is another key component of quality improvement. It provides a review of existing practice or performance against standards, ideally from evidence-based or expert-derived guidelines. Areas for improvement are then identified before changes are recommended and, hopefully, implemented. Further audit cycles can demonstrate both where improvements have been made and where work is still needed. There is good evidence that repeated audit, local or national, can lead to progressive and sustained improvements in clinical care and older people outcome.

Audit may be periodic or continuous, depending on the nature of the condition or process being measured, and the level of detail required. Periodic audit, i.e. audits where each cycle is separated in time from the next, are the most common type. For example, the National Sentinel Stroke Audit has competed 7 detailed cycles of audit over more than a decade and has seen the universal introduction of stroke units, amongst many improvements. Continuous audits, such as the National Hip Fracture Database, collect relatively small amounts of information on all older people, providing near-real time data, benchmarked against other hospitals. This has proved a powerful lever for change for better hip fracture services in many hospitals. Locally, a continuous audit could collect daily data on time to first analgesia, reported back to the clinical team on a weekly basis. This would rapidly lead to reductions in delays in older people receiving pain relief.

The National Clinical Audit and Patient Outcomes Programme is funded centrally by the Department of Health and administered by the Healthcare Quality Improvement Partnership (HQIP). It currently includes the following national audits relevant to the urgent care of older people:

- Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Falls and Bone Health in Older People (NAFBH)
- National Hip Fracture Database (NHFD)
- National Audit of Continence Care
- Myocardial Ischaemia National Audit Project (MINAP)

In addition, there is the Stroke Improvement National Audit Programme (SINAP), which is a continuous audit of acute stroke treatment, including thrombolysis, and outcome. From 2012, the NHFD and NAFBH will be combined in a new falls and fragility fracture audit programme. It is hoped that one or more new national audits, relevant to other aspects of emergency care of older people, will be commissioned following the publication of this report.

It is recommended that providers of urgent care introduce regular local audit of the emergency care and outcomes of older people. The key audit standards, as recommended in this report, are detailed below.

Audit standards

The key audit standards mapping to each of the main recommendations are proposed here. Some of these audit standards could be managed systematically; others will need to be assessed using spot audits.

Organisational audit standard (2.1) – There is a local policy or procedure that specifies a primary care response to an urgent request from an older person within 30 minutes.

Organisational audit standard (2.2) – There is local audit of primary care response time at least annually.

Clinical audit standard (2c.1) – Percentage of older people receiving a primary care response within 30 minutes of urgent request

Organisational audit standard (3.1) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for pain using a standardised pain score.

Clinical audit standard (3c.1.1) – Percentage of older people accessing urgent care with evidence of assessment for pain using a standardised pain score within 15 minutes of first contact.

Clinical audit standard (3c.1.2) – Percentage of older people accessing urgent care with evidence of assessment for pain using a standardised pain score within 15 minutes of first contact.

Clinical audit standard (3c.1.3) – Percentage of older people unable to express pain who have pain assessed using a standardised tool.

Organisational audit standard (3.2.1) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for cognitive impairment using a validated tool (AMT4, AMT10, MMSE).

Organisational audit standard (3.2.2) – There is a local policy or procedure that requires all older people with cognitive impairment to be assessed for delirium using a standardised tool (CAM, 4AT (http://www.the4at.com/)).

Clinical audit standard (3c.2.1) – Percentage of older people accessing urgent care with evidence of assessment for cognitive impairment using a validated tool within 4 hours of first contact.

Clinical audit standard (3c.2.2) – Percentage of older people accessing urgent care with evidence of assessment for delirium using a standardised tool within 4 hours of first contact.

Organisational audit standard (3.3) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for depression using a validated tool (e.g. GDS).

Clinical audit standard (3c.3) – Percentage of older people accessing urgent care with evidence of assessment for depression using a validated tool (e.g. GDS) within 24 hours of first contact.

Organisational audit standard (3.4) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed of nutrition using a standardised tool (e.g. MUST).

Clinical audit standard (3c.4) – Percentage of older people accessing urgent care with evidence of assessment of nutrition using a standardised tool (e.g. MUST) within 4 hours of first contact.

Organisational audit standard (3.5) – There is a local policy or procedure that requires all older people accessing urgent care to be assessed for skin integrity and risk of pressure sores using a standardised tool (e.g. Waterlow).

Clinical audit standard (3c.5) – Percentage of older people accessing urgent care with evidence of assessment for skin integrity and risk of pressure sores using a standardised tool (e.g. Waterlow) within 4 hours of first contact.

Organisational audit standard (3.6.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for hearing impairment.

Organisational audit standard (3.6.2) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for vision impairment.

Clinical audit standard (3c.6.1) – Percentage of older people accessing urgent care with evidence of assessment for hearing impairment within 4 hours of first contact.

Clinical audit standard (3c.6.2) – Percentage of older people accessing urgent care with evidence of assessment for vision impairment within 4 hours of first contact.

Organisational audit standard (3.7) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for falls risk, including a minimum of asking about a history of falls in the previous 12 months and basic assessment of gait and balance (e.g. Timed Up and Go test).

Clinical audit standard (3c.7.1) – Percentage of older people accessing urgent care with evidence of assessment for a history of falls within 4 hours of first contact.

Clinical audit standard (3c.7.2) – Percentage of older people accessing urgent care with evidence of assessment of mobility (either by a standardised tool such as Timed Up and Go test, or documented observation of patient walking) within 4 hours of first contact.

Organisational audit standard (3.8) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for problems with activities of daily living.

Clinical audit standard (3c.8) - Percentage of older people accessing urgent care with evidence of assessment of activities of daily living using a standardised tool (e.g. Barthel) within 4 hours of first contact.

Organisational audit standard (3.9.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for urinary problems.

Organisational audit standard (3.9.2) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for bowel problems.

Clinical audit standard (3c.9.1) – Percentage of older people accessing urgent care with evidence of assessment for urinary problems within 4 hours of first contact.

Clinical audit standard (3c.9.2) – Percentage of older people accessing urgent care with evidence of assessment for bowel problems within 4 hours of first contact.

Organisational audit standard (3.10) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for vital signs (level of consciousness, temperature, pulse, blood pressure, respiratory rate).

Clinical audit standard (3c.10) – Percentage of older people accessing urgent care with evidence of assessment of vital signs (level of consciousness, temperature, pulse, blood pressure and respiratory rate within 15 minutes of first contact.

Clinical audit standard (3c.11) Percentage of older people, identified as requiring end of life care, with a documented preferred place of care.

Clinical audit standard (3c.12) Percentage of older people, identified as requiring end of life care, that die in their preferred place of care, or at home if no place of care identified.

Organisational audit standard (4.1) - There is a local policy or procedure that requires all older people accessing urgent care to be assessed for the presence of frailty syndromes (falls, immobility, incontinence, confusion).

Organisational audit standard (4.2) - There is a local policy or procedure that requires comprehensive geriatric assessment of all older people accessing urgent care that have been identified as presenting with one or more frailty syndromes (falls, immobility, incontinence, confusion).

Organisational audit standard (4.3) – there is evidence of local commissioning of multidisciplinary geriatric services that can contribute towards early CGA across primary and secondary care.

Clinical audit standard (4c.1) – Percentage of older people accessing urgent care with evidence of assessment for the presence of frailty syndromes within 4 hours of first contact.

Clinical audit standard (4c.2) – Percentage of older people accessing urgent care and presenting with evidence of any frailty syndromes (from standard 4c.1) that receive comprehensive geriatric assessment commencing within 4 hours of first contact.

Clinical audit standard (5c.1) – Percentage of older people accessing urgent care and presenting with evidence of any frailty syndromes (from standard 4c.1) that receive comprehensive geriatric assessment commencing within 4 hours if admitted to hospital.

Organisational audit standard (8.1) – There is a local policy or procedure that recommends assessment for falls risk factors of all older people presenting to healthcare services following a fall.

Organisational audit standard (8.2) – There is a local falls service that includes multifactorial falls risk factor assessment and management, including medication review, and access to therapeutic falls prevention exercise (Otago and/or FaME programmes).

Organisational audit standard (8.3) – There is a pathway for older people presenting to urgent care following a fall to be referred to the local falls service.

Clinical audit standard (8c.1) – Percentage of older people presenting to urgent care following a fall that have a record of further assessment of reversible causes for falls including, as a minimum, assessment of gait and balance, lying and standing blood pressure, medication review – within 4 hours of presentation.

Clinical audit standard (8c.2) – Percentage of older people presenting to urgent care with a history of 2 or more falls in the last 12 months, or a single injurious fall, that are referred to a local fall service.

Organisational audit standard (9.1) – There is a local fracture liaison service.

Clinical audit standard (9c.1) – Percentage of older people presenting to urgent care with a fragility fracture who are referred to a fracture liaison service.

Organisational audit standard (10.1) – There is a local policy that older people are discharged to their normal residence within 24 hours unless continuing hospital treatment in necessary.

Organisational audit standard (10.2) – There is a local service specification that enables older people to be discharged to their normal residence within 24 hours, 7 days a week, with increased care or support at home if required.

Clinical audit standard (10c.1) – Percentage of older people discharged to their normal residence within 24 hours of acute presentation to hospital. (Note – the target for this cannot be 100%, but will allow benchmarking within sites over time, or between comparable sites)

Local services are also encouraged to audit periodically a random sample of case notes of older patients who were admitted or readmitted for between 24 hours and 7 days to identify where improvements in rapid safe discharge can be made.

Organisational audit standard (11.1) – There is a locally commissioned single point of access (SPA) and directory of services (DOS) linked to consistent clinical content (e.g. NHS Pathways, Map of Medicine).

Organisational audit standard (11.2) – There is a quarterly audit of SPA response times and referral accuracy.

Organisational audit standard (12.1) – There is a locally commissioned rapid response team, or equivalent, that includes nursing, occupational therapy, physiotherapy, mental health and social services. The team should provide 24 hour access 7 days/week and respond within 12 hours of referral via SPA.

Organisational audit standard (12.2) – There is a quarterly audit of the team's response times.

Clinical audit standard (12c.1) – Percentage of SPA referrals that are triaged to a rapid response team, or equivalent, and assessment by a team member commences within 2 hours (14 hours overnight) of contact with SPA.

Organisational audit standard (13.1) – There is a local policy or procedure whereby all older people who present with self-harm are assessed for on-going risk of further self-harm during transportation, whilst in ED and whilst in hospital. (Note - Not all settings will apply to all services, and older adults should be considered to have suicidal intent until assessed and proved otherwise)

Clinical audit standard (13c.1) – Percentage of older adults presenting acutely with self-harm that are assessed by senior decision maker of the mental health team.

Organisational audit standard (13.1) – There is a local policy or procedure whereby all older people who present with unintentional self-harm are assessed for on-going risk of further self-harm prior to discharge.

Whole system metrics

Health and social care systems may wish to analyse the following metrics, which should describe the system's performance about older peoples' care:

- Proportion of urgent care encounters in primary care leading to a hospital attendance and separately hospital admission in people aged 65+/75+/85+
- ED attendance and re-attendance rate per 1000 population of 65+/75+/85+
- Emergency department conversion rate for people aged 65+/75+/85+ per 1000
- Hospital readmission rates for people aged 65+/75+/85+ and ED re-attendance rate for same group
- Rates of long term care use at 90 days post-discharge following ED attendance and discharge from hospital for people aged 65+/75+/85+
- Mortality rate per 1000 in the 65+/75+ and 85+
- Patient and/or carer satisfaction survey

Research in geriatric emergency care

There is an embarrassing paucity of research into the needs of frail older people in general, and hardly any directly relevant research addressing urgent care. The reasons for this mismatch in research versus population needs are partly historical, but also related to some of the difficulties in recruiting frail older people into research studies. Possible barriers include individual reluctance, and fears of being a 'guinea pig', difficulties recruiting people without capacity and the challenges of loss to follow up in a population with inherently high rates of mortality. There is the additional complexity and challenge of conducting service related research (e.g. testing a new unit or multidisciplinary team) in contrast to condition specific research (e.g. aspirin in stroke) where human factors may be multiple and funding bodies are generally more cautious. None of these barriers are insurmountable – for example, greater public awareness about research can change perceptions, recent developments in ethical regulations and the Mental Capacity Act have clarified the procedures to recruit people without capacity[1], and newer outcome measures are being developed that address the issues of loss to follow up[2].

Changes in national research funding mechanism, specifically the introduction of research funding streams such as the National Institute of Health Research (NIHR) 'Research for Patient Benefit' and 'Programme Grants for Applied Research' have increased the amount of funding available to deliver high quality research that has direct relevance to the needs of the NHS. Notably, recent NIHR calls have focussed on dementia, a hitherto much neglected are of research. The challenge for the research community interested in frail older people is to develop sufficient expertise, quality and critical mass to take advantage of the research infrastructure now in place. Given the dearth of research on the urgent care needs of frail older people, there is considerable scope to develop a substantial body of work addressing this issue. This is likely to need to start with developing an in-depth understanding of the issues, from the person, carer, professional and system perspective. Once this is achieved, then there is a need for high quality randomised studies that test different models and systems of care, which must also include measures of cost-effectiveness.