TOCALS MIU Preventative Screening Project for the Frail Elderly Adult

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Background

The Transfer of Care, Advice Liaison Service (TOCALS) provides a discharge service in the Minor Injuries Unit (MIU) in Prince Philip Hospital, Llanelli. Historically, Front of House (FOH) professionals were dependent on MIU staff to leave patient details for urgent therapy or Integrated Care Sister follow ups. These patients are then contacted and provided with either telephone advice/signposting or an urgent home visit if necessary.

Since COVID there have been service changes, high turnover of patients and staff shortages in MIU and these referral have reduced. The project was identified to begin a more in-depth screening process where FOH staff identified and screened patients presenting to MIU, completing preventative onwards signposting and to reduce the number of admissions and community services required in the future.

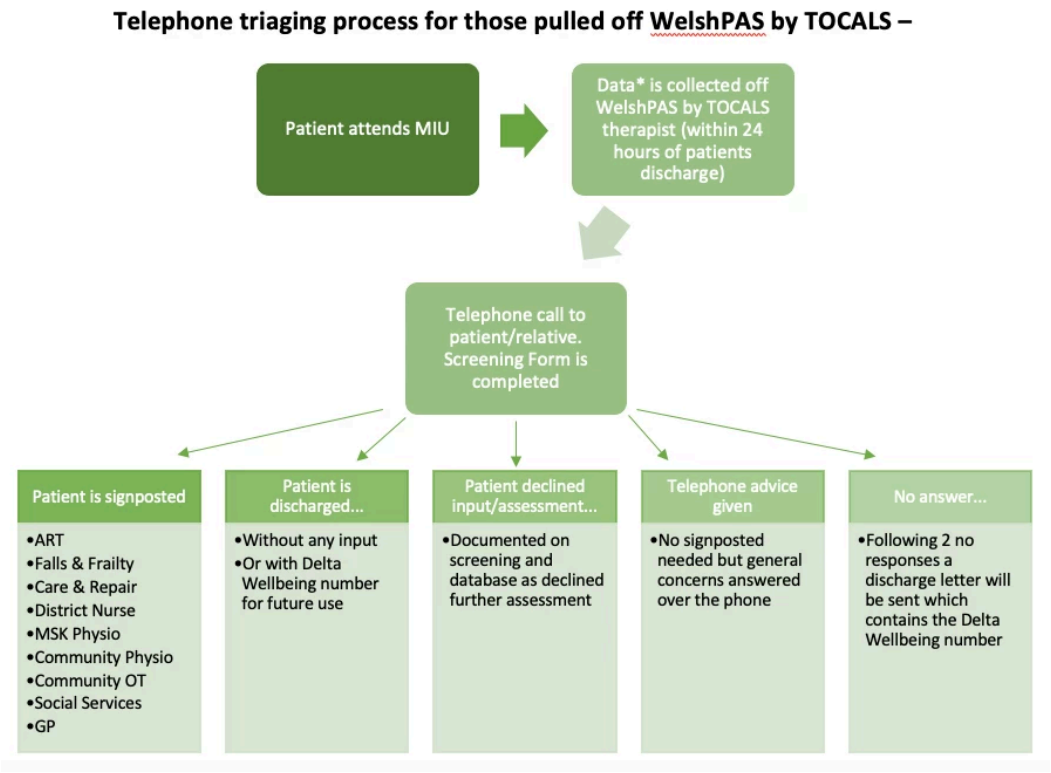

Figure 1

A flow chart titled 'Telephone triaging process for those pulled off WelshPAS by TOCALS.

- 'Patient attends MIU leads' to 'Data is collected off WelshPAS by TOCALS therapist within 24 hours of patient discharge.'

- 'Data is collected off WelshPAS by TOCALS therapist within 24 hours of patient discharge' leads to 'Telephone call to patient/relative. Screening Form completed'.

- 'Telephone call to patient/relative. Screening Form completed' leads to five outcomes;

    - 1: Patient is signposted; ART, falls and frailty, care and repair, district nurse, MSK physio, Community Physio, Community OT, Social services, GP
    - 2: Patient is discharged: Without any input or with Delta Wellbeing number for future use

    - 3: Patient declined input/assessment: Documented on screening and database as declined further assessment.
    - 4: Telephone advice given: No signposting needed but general concerns answered over the phone
    - 5: No answer: Following two no responses a discharge letter will be sent which contains the Delta Wellbeing number

End of description.

Project Aims

The main aim of the project is to identify key areas of patient needs to reduce the risk of that patient hitting crisis point and re-attending hospital.

Other aims included:

- Setting up a database to capture the screening information gathered and those contacted.
- Forming pathways to ensure consistency with the screening.
- Creating a screening tool to document the information gathered.
- Targeting those over the age of 60 attending MIU with falls, MSK injuries, reduced mobility & head injuries.
- Creating additional links with community services to maintain patients function at home.
- Evaluating data collected to establish the quality and the benefit of the project.
- Obtaining patient feedback comments to ensure benefit from the service user perspective.

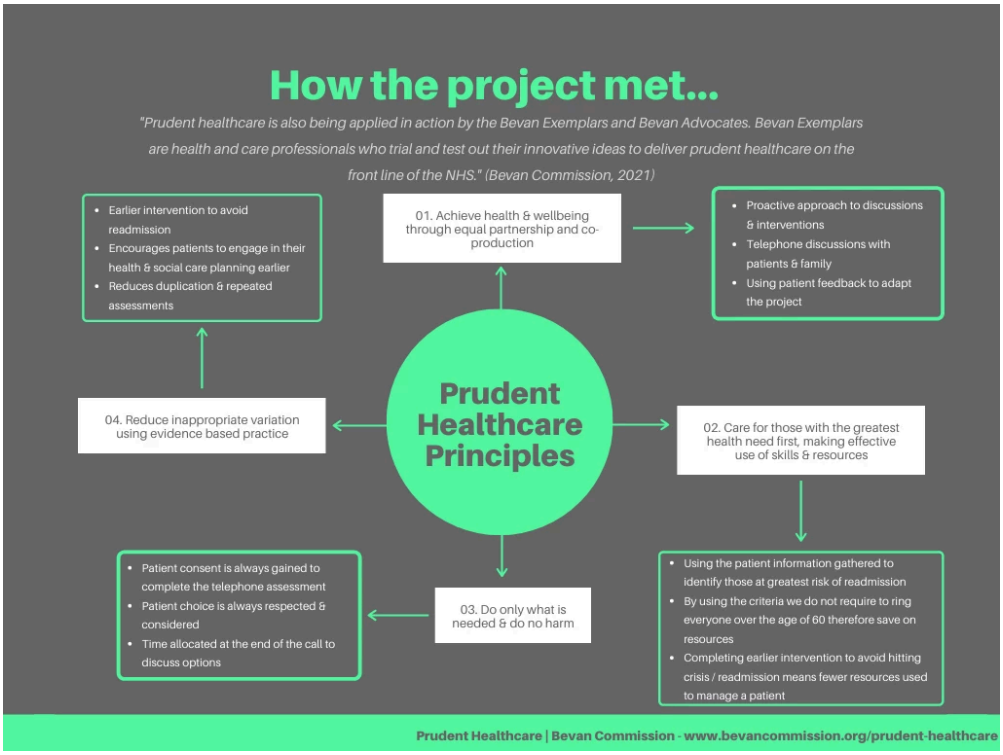

Figure 2

A diagram depicting four ways in which the project met the prudent healthcare principles:

1. Achieve health and wellbeing through partnerships and coproduction
- Proactive approach to discussions and interventions
- Telephone discussions with patients and family
- Using patient feedback to adapt the project
2. Care for those with the greatest health need first, making effective use of skills and resources
- Using the patient information gathered to identify those at greatest risk of readmission
- By using the criteria we do not require to ring everyone over the age of 60 therefore save on resources
- Completing earlier intervention to avoid hitting crisis/readmission means fewer resources used to manage a patient
3. Do only what is needed and do no harm
- Patient consent is always gained to complete the telephone assessment

- Patient choice is always respected and considered
- Time allocated at the ned of the call to discuss options

4. Reduce inappropriate variation using evidence based practice

- Earlier intervention to avoid readmission
- Encouraging patients to engage in their health and social care planning earlier
- Reduces duplication and repeated assessments

End of description.

Overcoming Challenges

The main challenge of implementing this project has been continuously adapting the service as the demands of the hospital changed due to the pandemic progressing and altering. At the beginning of the project there was ample time to set aside time to gather data and complete telephone calls.

By November 2020, with the second wave hitting the country, workload within the hospital increased and there was less time to complete the screening. Due to lockdown, the patients that are now presenting to hospital are more complex in regards to their functional and social needs and are therefore taking up more clinical time. We have developed strategies to overcome time restraints and these include…

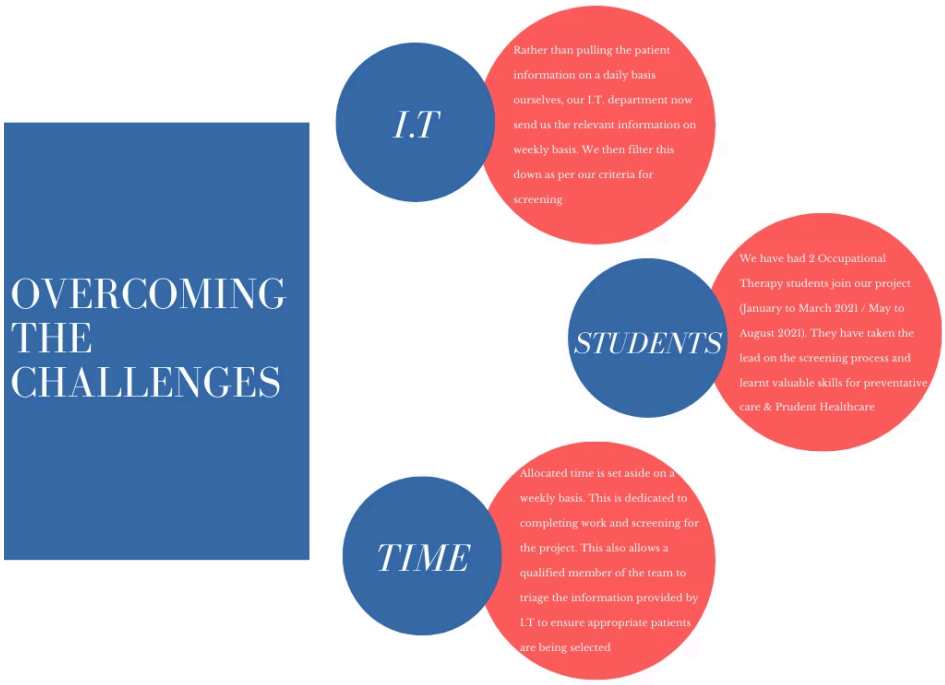

Figure 3

A diagram titled 'Overcoming the challenges'. Three headers each accompanied by text.

Header 1: I.T

- Rather than pulling the patient information on a daily basis ourselves, our I.T department now send us the relevant information on a weekly basis. We then filter this down as per our criteria for screening.

Header 2: Students

- We have had 2 occupational therapy students join our project (January to March 2021/May to August 2021). They have taken the lead on the screening process and learnt the valuable skills for preventative care and Prudent healthcare.

Header 2: Time

- Allocated time is set aside on a weekly basis. This is dedicated to completing work and screening for the project. This also allows a qualified member of the team to triage the information provided by I.T to ensure appropriate patients are being selected.

End of description.

Key Outcomes

The main key outcome established from the data collected within the project demonstrates a significant increase in number of people assessed. This results in an increase of those in which the service is reaching. The total number of patients screened to date is 441.

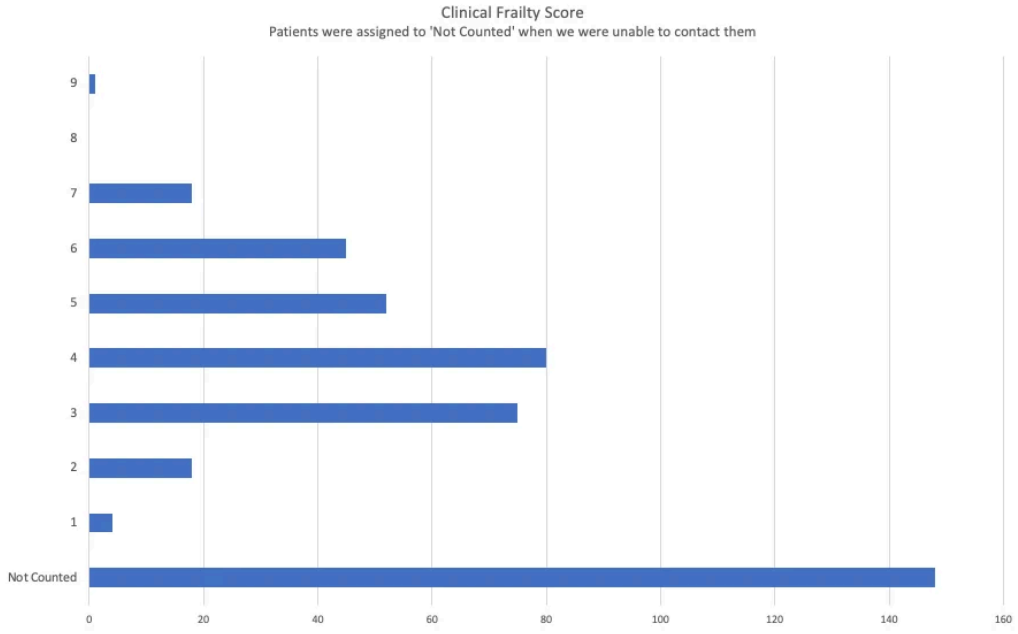

Figure 4

A bar graph titled ‘Clinical Frailty Score’. A sub header reads ‘Patients were assigned to ‘No Counted’ when we were unable to contact them. The horizontal axis measures the frailty score and the vertical axis measures nine individual patients. The data reads:

- Patient 1 has frailty score of 5

- Patient 2 has frailty score of 15
- Patient 3 has frailty score of 75
- Patient 4 has frailty score of 80
- Patient 5 has frailty score of 50
- Patient 6 has frailty score of 45
- Patient 7 has frailty score of 15
- Patient 8 has frailty score of 0
- Patient 9 has frailty score of 5

These numbers have been rounded to the nearest 5.

End of description.

**Although this states "not counted", these patients were still sent a letter containing the Delta Wellbeing number should they need support in the community.*

Within 9 months of beginning the project there was an average of 49 patients screened and saw an average increase of 43 referrals per month, ranging from an additional 25 to 59 referrals compared to our standard service.

From the data collected we were able to demonstrate that 204 of the patient's being screened required at least a referral onwards, telephone advice or needs were identified but the patient declined a referral.

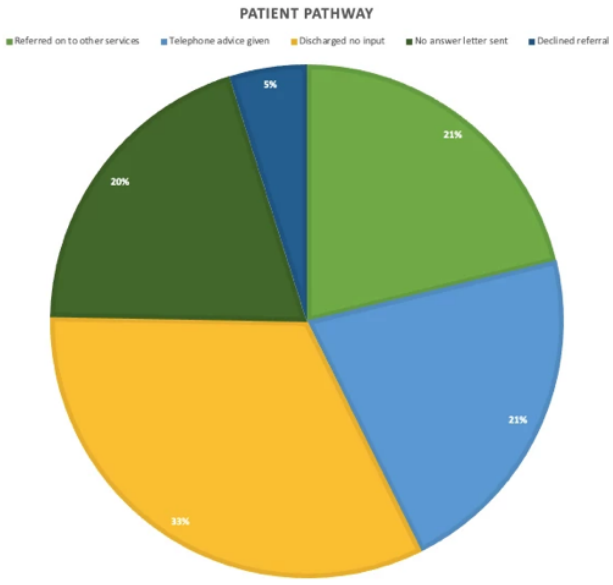

Figure 5

A pie chart titles ‘Patient Pathway’. The data reads:

- Referred on to the other services: 21%
- Telephone advice given: 21%
- Discharged no input: 33%
- No answer letter was sent: 20%
- Declined referral: 5%

End of description.
The top three community services that patients were directed back to was Delta Wellbeing, General Practitioners and the Carmarthenshire Community Falls & Frailty team.

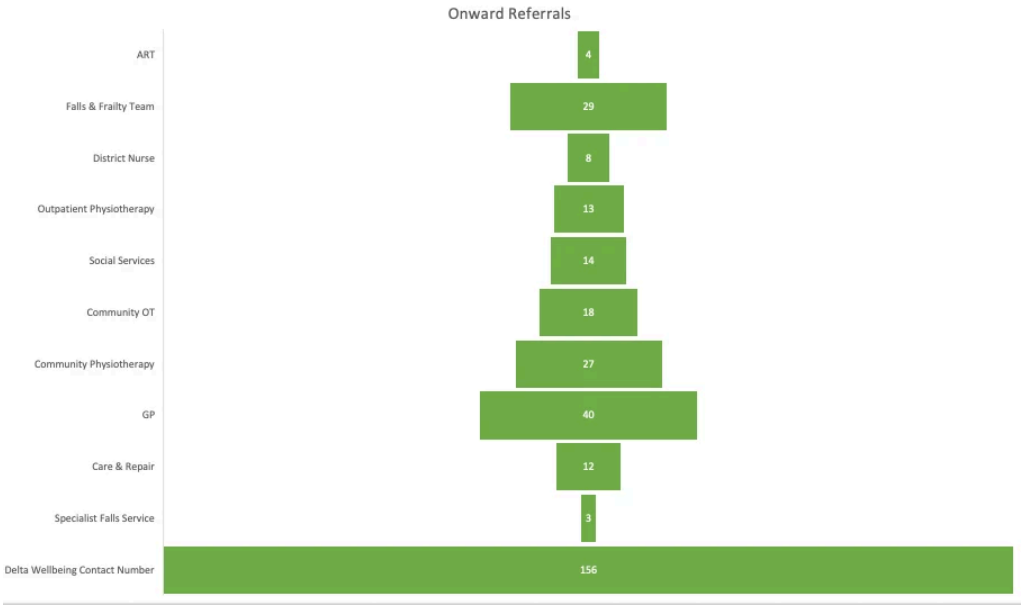

Figure 6

A graph titled ‘Onward Referrals’ depicting the data:

- ART: 4
- Falls and frailty team: 29
- District nurse: 8
- Outpatient physiotherapy: 13
- Social services: 14

- Community OT: 18
- Community Physiotherapy: 27
- GP: 40
- Care and repair: 12
- Specialty Falls Service: 3
- Delta Wellbeing Contact Number: 156

End of description.

Prior to the screening project patients we identified were also at times frequently attending MIU. We have begun to collect data to demonstrate the impact of the screening on readmission rates 6 months following the initial MIU attendance.

Figure 7

Patient feedback 1:’ Thank you so much for the phone call. It is lovely to know there are people that care.’

Patient feedback 2:’ Access to social care at the right point was exactly what I needed’

Patient feedback 3:’The telephone advice was really helpful to keep me independent at home’

End of description.

Next Steps

To conclude I feel this project has demonstrated a need to switch focus to preventative care rather than the current model of reactive interventions. The COVID pandemic has created a significant increase in loneliness within the community and those attending emergency departments are now presenting with increased social care needs.

We have already targeted a significant amount of patients in our local area and provided them with not only advice and support but a friendly phone call to let them know that there are people in their community who can help them. By continuing the screening we hope to reach more of those that require support, to complete low level interventions and sign posting to continue to prevent crisis’ in the community and future admissions.

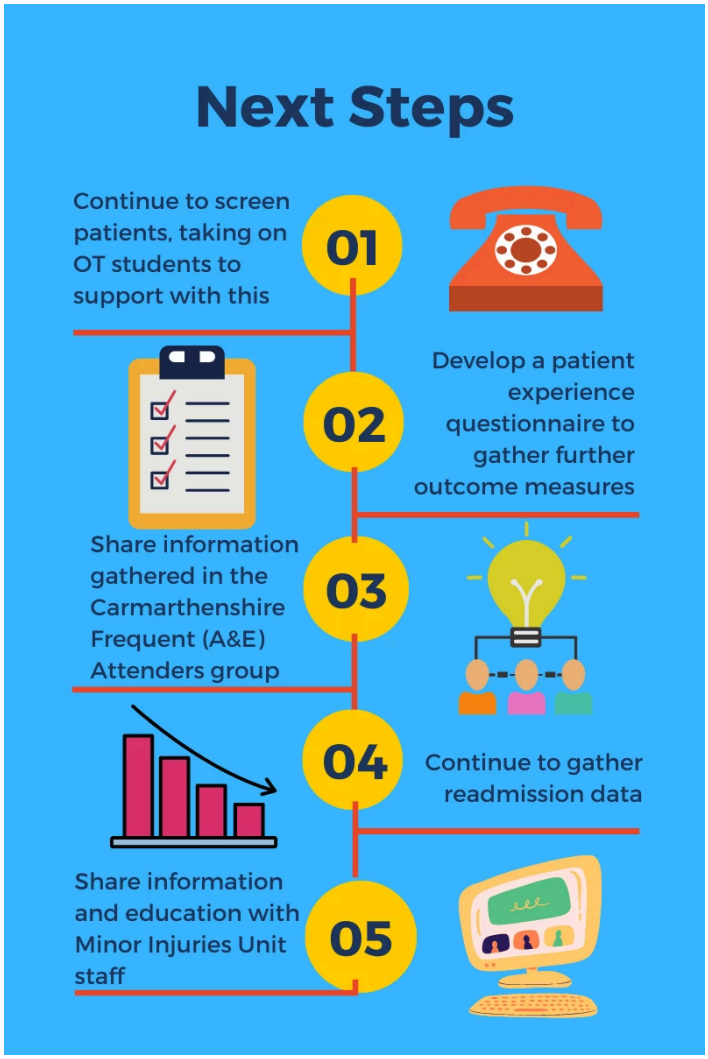

Figure 8

Next steps:

1- Continue to screen patients, taking on OT students to support with this.
2- Develop a patient experience questionnaire to gather further outcome measures
3- Share information gathered in Carmanthenshire Frequent (A&E) Attenders group
4- Continue to gather readmission data
5- Share information and education with Minor Injuries Unit staff

End of description.

My Exemplar Experience

Although initially I was a little apprehensive, my Bevan Exemplar experience has been an incredibly positive and beneficial journey in developing my skills as a clinician. I feel fortunate to have been given the opportunity to explore the service development side of this project through the Exemplar project and I feel that I have taken something new away from every session I have attended. It has been a great experience to network with others who are developing other projects within Wales and I hope to maintain these links into the future. I would recommend anyone considering this path to take the leap and become part of the Bevan Exemplar family.

With thanks to:

Carol-Anne Davies (Service Lead for Acute Occupational Therapists in Carmarthenshire) Aysha Davies (Senior Nurse Manager for Hospital Flow)

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