ACI NSW Agency for Clinical Innovation

LEADING BETTER VALUE CARE

CLINICAL EXCELLENCE COMMISSION

Leading Better Value Care

The next phase

Malcolm Green
Senior Manager
Adult Patient Safety Program

From volume to value

LEADING BETTER VALUE CARE

NSW GOVERNMENT Health

Why?

LEADING BETTER VALUE CARE

- Key focus of the NSW health system is to provide **effective**, **efficient**, **evidence based**, **safe** and **high quality** health services.
- Need to act now to position the NSW public health system to deal with future fiscal and demand pressures – declining growth funding, increasing demand…..
- Establishment of **Leading Better Value Care** initiative – major activity being reported to the Health Funding Steering Committee, chaired by Secretary with NSW Treasury, DPC attendees

NSW GOVERNMENT Health

Value

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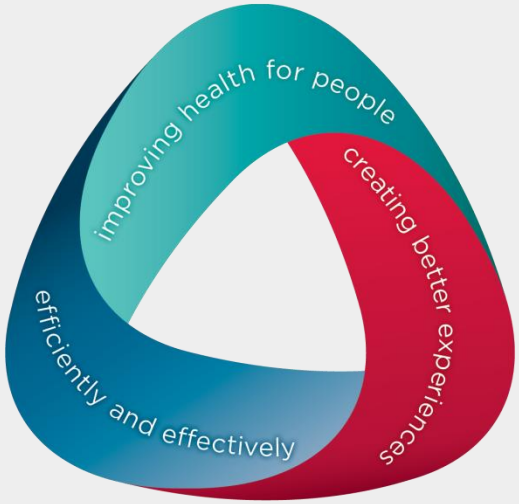
Comprehensive approach includes the triple aim of improving:

- the health of the public
  (eg: a change in outcomes)
- the experience of receiving and providing care
  (eg: patient/carer/clinician)
- efficiency and effectiveness of care provision



Initiatives

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- Management of Osteoarthritis – OACCP | ACI
- Osteoporotic Refracture Prevention – ORP | ACI
- (Local Musculoskeletal Service | ACI)
- Diabetes High Risk Foot Services – HRFS | ACI
- Diabetes Mellitus | ACI
- Chronic Heart Failure – CHF | ACI
- Chronic Obstructive Pulmonary Disease – COPD | ACI
- Renal Supportive Care: End Stage Kidney Disease – Palliative and End of Life Care | ACI
- Falls in Hospitals | CEC

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Better Value Health Care

Musculoskeletal Initiatives

2017

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Why did we develop these models of care?

Osteoporotic Refracture Prevention

- Evidence internally, nationally & locally tells us we:
  - Don't identify *minimal trauma fractures* no matter who or where we are
  - Thus people are denied care that the evidence suggests can prevent the next fracture in 50% of cases
  - NSW hospital data concerning repeated admissions for fracture confirm this

Why did we develop these models of care?

Osteoarthritis Chronic Care Program

- International and national guidelines advise that ‘conservative care’ be available to all people with osteoarthritis & certainly before surgical measures are considered

- ACI data confirms almost 70% of people accessing OACCP while on the waitlist for elective hip or knee replacement joint had not accessed ‘conservative care’ prior to referral to the surgeon

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Diabetes Projects

Inpatient Management of Diabetes Mellitus

High Risk Foot Services

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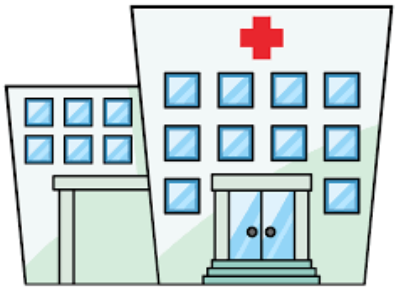
Why change?



If I have diabetes I stay 6 days

Other acute hospitalisations have a 4 day stay

By 2025-26

all diabetes hospitalisations in NSW will cost

$2.1 billion

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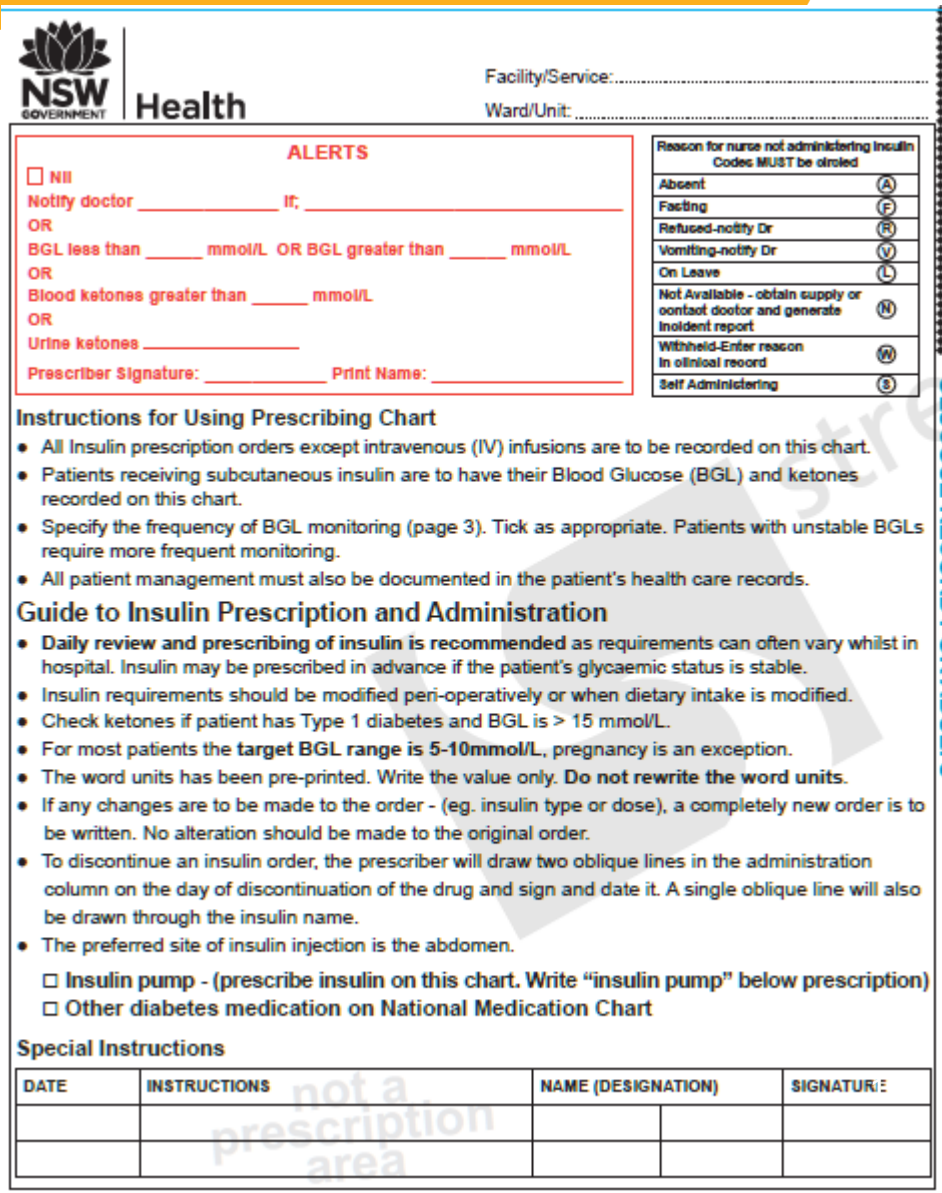

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Facility/Service:.....

Ward/Unit:.....

ALERTS

☐ Nil

Notify doctor _____ If; _____

OR

BGL less than _____ mmol/L OR BGL greater than _____ mmol/L

OR

Blood ketones greater than _____ mmol/L

OR

Urine ketones _____

Prescriber Signature: _____ Print Name: _____

Reason for nurse not administering insulin Codes MUST be circled	
Absent	A
Fasting	F
Refused-notify Dr	R
Vomiting-notify Dr	V
On Leave	L
Not Available - obtain supply or contact doctor and generate Incident report	N
Withheld-Enter reason in clinical record	W
Self Administering	S

Instructions for Using Prescribing Chart

- All Insulin prescription orders except intravenous (IV) infusions are to be recorded on this chart.
- Patients receiving subcutaneous insulin are to have their Blood Glucose (BGL) and ketones recorded on this chart.
- Specify the frequency of BGL monitoring (page 3). Tick as appropriate. Patients with unstable BGLs require more frequent monitoring.
- All patient management must also be documented in the patient's health care records.

Guide to Insulin Prescription and Administration

- **Daily review and prescribing of insulin is recommended** as requirements can often vary whilst in hospital. Insulin may be prescribed in advance if the patient's glycaemic status is stable.
- Insulin requirements should be modified peri-operatively or when dietary intake is modified.
- Check ketones if patient has Type 1 diabetes and BGL is > 15 mmol/L.
- For most patients the **target BGL range is 5-10mmol/L**, pregnancy is an exception.
- The word units has been pre-printed. Write the value only. **Do not rewrite the word units.**
- If any changes are to be made to the order - (eg. insulin type or dose), a completely new order is to be written. No alteration should be made to the original order.
- To discontinue an insulin order, the prescriber will draw two oblique lines in the administration column on the day of discontinuation of the drug and sign and date it. A single oblique line will also be drawn through the insulin name.
- The preferred site of insulin injection is the abdomen.

☐ **Insulin pump - (prescribe insulin on this chart. Write "insulin pump" below prescription)**

☐ **Other diabetes medication on National Medication Chart**

Special Instructions

DATE	INSTRUCTIONS	NAME (DESIGNATION)		SIGNATURE

not a prescription area

SUBCUTANEOUS INSULIN CHART AND BLOOD GLUCOSE RECORD FOR ADULTS

SMR130.035

What needs to change?

1. **Continuous improvement** in inpatient diabetes care
2. Investment to **enhance the capability and/or capacity of general ward staff** in the care of patients with diabetes
3. **Timely and appropriate access** to inpatient diabetes management teams
4. Implementation of procedures for the **safe and effective transfers of care** for people with diabetes within hospital wards and across settings, which may include criteria-led discharge
5. Standardised **identification and screening processes** for patients with diabetes on presentation to hospital

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What needs to change?

Improved access to multidisciplinary High Risk Foot Services across NSW

1. Investment in additional HRFS in Local Health Districts, including telehealth

2. A blended approach to caring for patients across primary, specialist and community-based care

3. Redesign of the existing workforce to meet the *Standards for HRFS in NSW*

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Investigating (unwarranted) clinical variation in the inpatient setting

Chronic Heart Failure / Chronic Obstructive Pulmonary Disease

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CHF: NSW INPATIENT CARE BUNDLE

INVESTIGATIONS		INDICATOR
• Review of history • ECG • Chest x-ray • Blood biochemistry • Accurate assessment of fluid balance		Investigations performed? In what time frame? Are actions taken in response to test results?
SYMPTOM MANAGEMENT		**INDICATOR**

• Identification of cause of exacerbation
• Evidence-based medicines
• Dyspnoea
  ○ Oxygen therapy
  ○ Non-invasive ventilation, where appropriate
	Pulmonary congestion and load on the heart: administration of:
	• loop diuretics
	• vasodilators
	• inotropic agents
		Evidence in the clinical notes of best practice, including medicines management

PATIENT FLOW, DISCHARGE AND CEILING OF CARE		**INDICATOR**
• Access to specialist support and allied health • Access to advance care planning and palliative care services • Access to disease management services • Provision of individualised management plans • Appropriate medicines management on discharge		Evidence of : • key referrals • appropriate transfer and discharge • medicines on discharge best practice • community support services arranged in hospital

COPD: NSW INPATIENT CARE BUNDLE

CONFIRM (DIAGNOSIS), EXACERBATION AND SEVERITY	INDICATOR
• Focused review of history and physical examination • **Spirometry** unless the patient is confused or comatose • **Arterial blood gas** measurements for appropriate patients • **Chest X-ray and ECG**	Investigations performed? In what time frame? Are actions taken in response to test results?
OPTIMISE TREATMENT	INDICATOR
Oral corticosteroids – IV corticosteroids show no additional benefit	Timing of administration
Antibiotics – for patients with clinical signs consistent with bacterial infection	Type and timing
Controlled **oxygen therapy**	Compliance with TSANZ oxygen prescription guidelines
PATIENT FLOW, DISCHARGE AND CEILING OF CARE	INDICATOR
• Access to allied and specialist services in hospital including nutritional support and smoking cessation services. • Access to pulmonary rehabilitation services	Key referrals
Ceiling of care discussions and access to palliative care services	Evidence of advanced care directives and acute resuscitation plans

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Renal Supportive Care

BETTER VALUE HEALTHCARE

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Renal Supportive Care is…

- About patient choice
- Interdisciplinary: renal and palliative care teams working collaboratively
- For people on a conservative OR dialysis pathway
- Focussed on symptom management and quality of life
- Available from diagnosis to end of life
- Patient-centred

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Support and tools

- Standards of care
- Pre-planning checklist
- Factsheets
- Audit tool (partnership audit)
- Data analysis (triangulation) and feedback sessions
- Capability program
- Site visits as required
- Sharing lessons learnt
- Tailored implementation support

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Clinical Excellence Commission

Older Persons Patient Safety Program reducing falls and harm from falls

Lorraine Lovitt

Lead NSW Falls Prevention Program

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NSW FALLS PREVENTION PROGRAM

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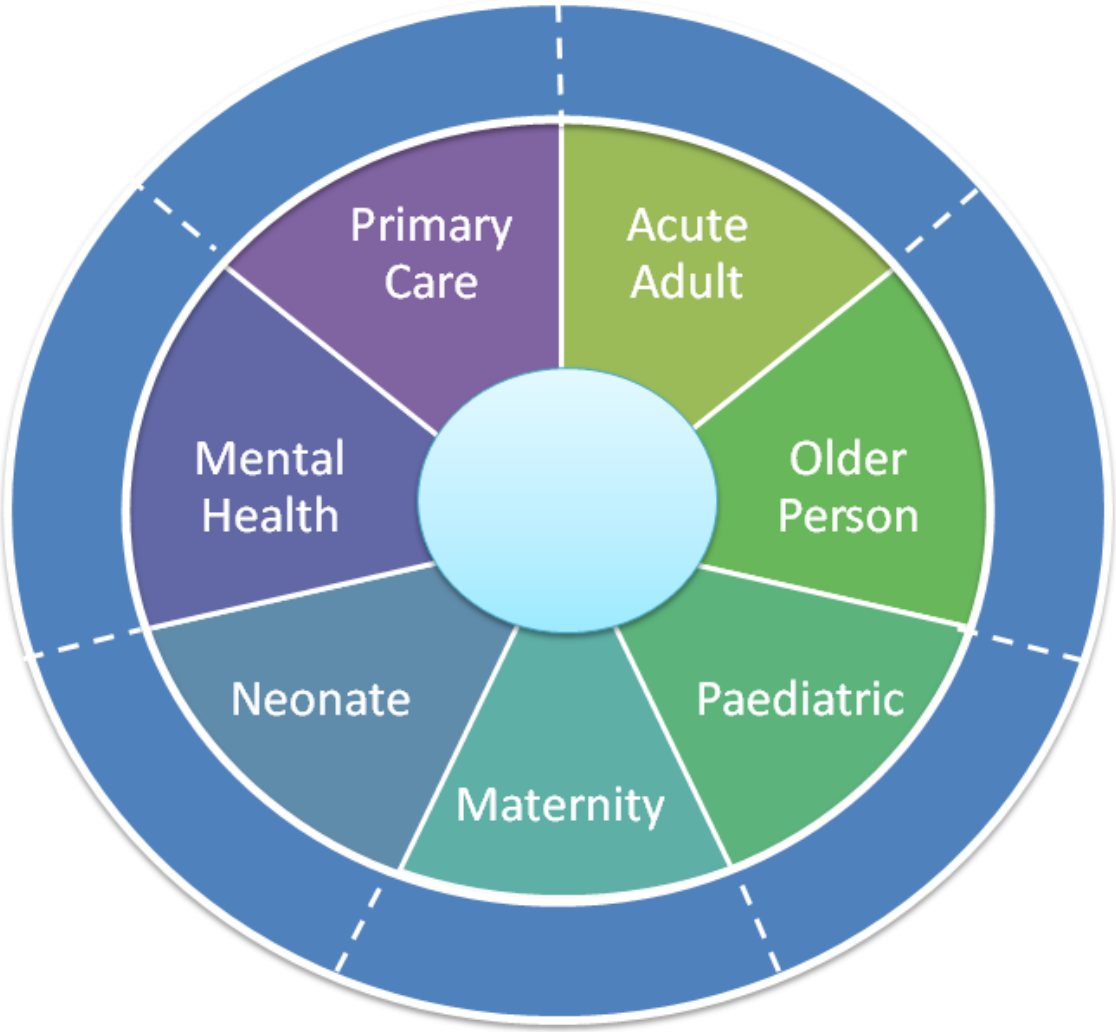
Patient Safety Program



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Support for LHD

- Commit to support LHD as required
- Can range from one off, light touch to ongoing, sustained intense and detailed support
- Our approach is individualised and proportionate to the local issue for simple or more complex problems

Falls in Hospital

Keeping Older People Safe in Our Care

- Patients >70 in hospital
- Older patients are vulnerable to a range of harms including falls
- Safe reliable comprehensive, individualised systematic risk screening and intervention for every patient every day
- **Falls Prevention is *everyone's* business** ® - everyone has a role to play

NSW FALLS PREVENTION PROGRAM

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Keeping Older People Safe in Our Care

Leadership and culture

- **Boards**: leading through strategic direction, governance, risk management, financial and quality and safety
- **Executive**: building capability and supporting frontline teams in improvement
- **Expert clinical/improvement leads and teams:** nursing, medical and allied health improve clinical processes
- **All ward staff:** practice reliable falls prevention/care

NSW FALLS PREVENTION PROGRAM

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Falls in Hospital

Support for improved clinical practice

- identification and risk management
- reliable implementation of multidisciplinary interventions that address personal fall risk factors
- engagement with patients/families/carers.
- continued support for implementation of National Standard: 10 Falls
- ongoing work to improve eMR documentation

CEC support

- CEC has communicated to all CEs outlining our support

- **Evidenced based change package**

  Cognitive impairment

  Mobility

  Medication review, reconciliation and reduction

  Multi-disciplinary rounding

  Huddles/team talks and clinical handover

NSW FALLS PREVENTION PROGRAM

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Strategies

- *Delirium/Dementia:* systems in place to identify patients. Promoting resources from the ACI networks, and the ACSQHC.
- *Mobility:* Systems in place to mobilise patients safely. CEC safe mobilisation resources.
- *Medications* – review, reconciliation and reduce, where feasible: antipsychotics, antidepressants, sedatives/hypnotics, opioids and others. CEC Medication reconciliation toolkit.
- *Intentional and interdisciplinary rounding:* CEC In Safe Hands and team effectiveness assistance.
- *Huddles and clinical handover:* proactive, regular ward/hospital huddles as well as post fall huddles. CEC safety and post fall huddle knowledge and tools.

CEC support

- Link LHD/SHN clinical leads/teams with the NSW Falls Co-ordinators and network
- Provide LHD/SHN access to quality improvement data system platform
- Learning from triangulated data (IIMS, HIE, improvement) - support LHD/SHN teams with web access to collaborate on key strategies

CEC support

- Workshops for clinical teams - information and further resources including state-wide falls forums; workshop in September 2017, specialist Mental Health Services workshop in August 2017 and two rural falls forums later in 2017

- Conduct webinars and quality improvement education sessions to build capability across the LHD/SHN

- Conduct LHD/SHN site visits to work with clinical teams on their implementation of improvement initiatives

CEC support

- **Leadership support for quality and safety**
  - Executive leadership in quality and safety
  - Clinical leadership programs
  - Building safe and effective teams at all levels
  - Partnering with Patients/families/carers – Patient Based care

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CEC support

- **Quality and Safety Improvement Capability through QI Academy**

  - Clinical practice improvement, basic and advanced measurement techniques and tools

  - Includes training for staff on screening and assessment for falls risk, clinical team communication and teamwork and medication safety and reconciliation

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Evaluation of Falls in Hospital - KPI

- Triple aim - improved patient and staff experience, outcomes (health of the public) and efficiency & effectiveness of care

- LHD performance meetings – aim 5% reduction in hospital falls leading to intracranial injury, fractured neck of femur or other fracture per 1000 occupied bed days.

  (ACSQHC Hospital Acquired Complication data set)

- Supporting LHDs and Board in its commitment to exercising governance role including monitoring of clinical outcomes

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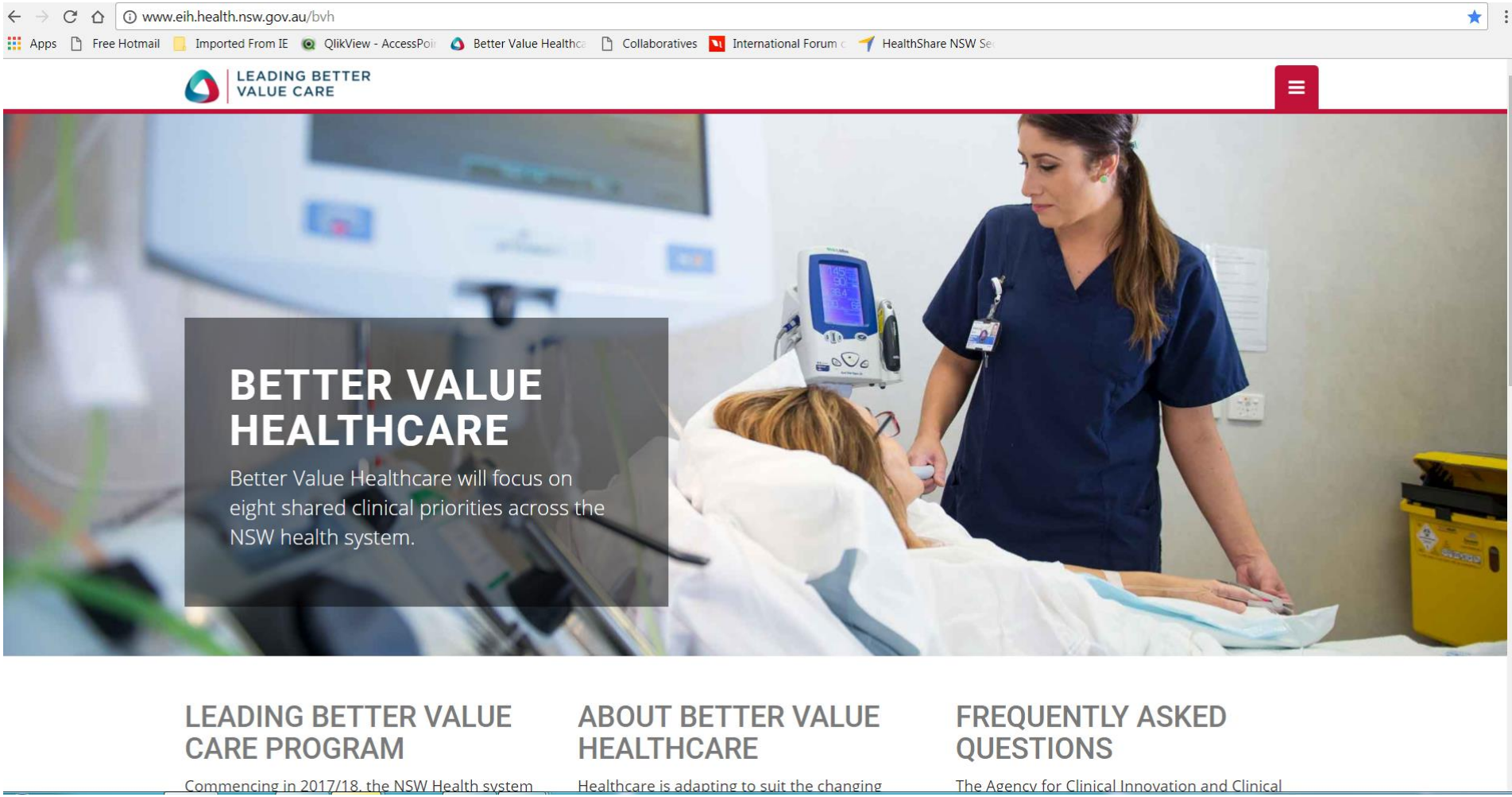
More information.....



Thank you and Questions

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