
Quality Focused Interventions for the Relief of Symptoms Team (QFIRST)

Initiative Type

Model of Care

Status

Deliver

Added

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URL

<https://cnxp3cuvtvrn68yjaibaht5ywrxspj7m.clinicalexcellence.qld.gov.au/improvement-exchange/quality-focused-interventions-relief-symptoms-team-qfirst>

Summary

(QFIRST) is a multidisciplinary model of care that involves the establishment of a multidisciplinary working group to explore the development of mechanisms to ensure the full range of options

available to high risk patients are investigated prior to undergoing procedures and facilitate agreement regarding treatment that aligns with the patient's wishes. QFIRST targets high risk patients undergoing procedures in Queensland public hospitals. High risk is defined as:

- ASA Physical Status 4
- ASA Physical Status 3 and Age>70
- Clinical grounds to suspect at risk of poor outcome on basis of frailty or comorbidities
- Demonstrable limited cardiorespiratory reserve from testing (e.g. Anaerobic threshold <11ml/kg/min)
- Predicted mortality >5 per cent or double baseline
- Predicted morbidity >20 per cent

The QFirst Nurse in consultation with the patient undertakes an assessment to determine risk, frailty, disability, goals and promote understanding. The patient is provided with an information package including a 'statement of choice' which sets goals / identifies substitute decision maker / advanced care planning. The QFIRST Nurse then meets with the multidisciplinary team to plan meetings, present the case and the collation of assessment, investigations, goals/values etc. The QFIRST Nurse then meets with the patient and clinician to undertake pathway planning and discuss support and follow up (refer to the attached workflow diagram). QFIRST trial outcomes will be provided in a report to the SWAPNET Steering Committee and will guide decision making in relation to the future direction of the project. This body of work follows on from the SWAPNet Pre-anaesthetic Evaluation Framework Project (to ensure appropriate and effective triage and assessment of patients undergoing procedures requiring anaesthetic) and specifically focusses on the management of high risk patients.

Key dates

Feb 2018

Jan 2019

Implementation sites

Trial at the Sunshine Coast University Hospital

Key Contacts

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Aim

QFIRST aims to improve the delivery of healthcare for high risk patients through shared decision making and patient engagement by providing a seamless continuity of care from decision to intervention that aligns with the patient's goals to recovery (providing the right care in the right place at the right time).

Benefits

QFIRST aligns with Statewide Clinical Networks Vision Statement and Guiding Principles in that it aims to drive clinical practice improvement; reduce clinical risk; improve quality of care and patient outcomes and embed evidence based practice. Benefits of QFIRST include:

- decreased length of stay
- ICU avoidance
- decreased complication rates
- decreased mortality and morbidity
- patient focused care resulting in better outcomes for patients and increased patient satisfaction.

Background

QFIRST is an initiative of the Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNET). In 2017, a Queensland Clinical Senate report highlighted the need for value based

healthcare to ensure a sustainable healthcare system and suggested that clinicians and consumers must question existing models of care to ensure there is real benefit to the patient for the investment of resources. In addition, a Queensland Audit of Surgical Mortality (QASM) report identified the need to establish systems that protect the elderly in surgical care (Goal 4) and provide funding for research into reducing incidence of avoidable clinical incidents (Goal 5) and the Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee (QPPAMRC), Mortality Review Report, Volume 1 identified that 62 per cent of the first 800 reviewed cases as Category 5 (inevitable death that would have occurred irrespective of anaesthetic or surgery procedures).

Solutions Implemented

- accept referrals and meet and interview new patients
- follow up QFIRST patients
- engage multidisciplinary team members and stakeholders
- data collection through clinical audit
- mapping the process and project to inform the sustainability report

Evaluation and Results

Key performance indicators include patient centred (qualitative, PROMs), Quantitative (functional outcome measures (WHODAS 2.0); disability free survival, morbidity, mortality, PRECALL/MET last 48 hours and discharge destination) and HHS centred (resource utilisation (LOS, throughput) and complication rates).

Lessons Learnt

- Having realistic timeframes.
- Continuous engagement of staff.
- Understanding limitations and where to seek help.
- Seeking feedback.
- Test and trial.

References

Dodds C, et al. **Peri-operative care of elderly patients – an urgent need for change: a consensus statement to provide guidance for specialist and non-specialist anaesthetists.** *Perioperative Medicine* 2013, 2:6 *The elderly surgical patient demands the highest level of care throughout their pathway from consideration of a surgical opinion to returning to their home. This can only be delivered if significant changes are made as a matter of urgency. These changes include: * The development of ‘fitness to referral’ pathways in primary care * Effective individualised pre-operative assessment and optimization * Tailored surgical management to the overall clinical and functional state of the patient * Discharge planning, across teams, which begins on referral and is reviewed during the entire pathway including return to home.* Harari D, et al. **Proactive care of older people undergoing surgery (‘POPS’): Designing, embedding, evaluating and funding a comprehensive geriatric assessment service for older elective surgical patients.** *Age and Ageing* 2007; 36: 190–196 *Pre/post comparison in elective orthopaedic patients showed improved post-operative outcomes indicative of better clinical effectiveness and efficiency, and contributed to the service obtaining mainstream funding.* Epstein N. **Multidisciplinary in-hospital teams improve patient outcomes: A review.** *SNI: Spine* 2014; 5(S7):195-303. *Acting like “well-oiled machines,” multidisciplinary in-hospital teams include “staff” from different levels of the treatment pyramid (e.g. staff including nurses’ aids, surgical technicians, nurses, anesthesiologists, attending physicians, and others). Their enhanced teamwork counters the “silo effect” by enhancing communication between the different levels of healthcare workers and thus reduces AE (e.g. morbidity/mortality) while improving patient and healthcare worker satisfaction.* Story D, et al. **Complications and mortality in older surgical patients in Australia and New Zealand (the REASON study): a multicentre, prospective, observational study.** *Anaesthesia*, 2010, 65, pages 1022–1030. *20% patients aged over 70 years had postoperative complications within 5 days of surgery, with an increased odds ratio for mortality with implications on length of stay (mean 30 days in non-survivors vs 6 days in survivors)* Shulman M, et al. **Measurement of Disability-free Survival after Surgery.** *Anesthesiology* 2015; 122(3):524-536. *Development of new disability (WHODAS>25 or increased by 8) postoperatively resulted in a higher complication rate (20% vs 11%) and increased hospital stay (mean 6.9 vs 5.3 day*

Further Reading

[QFIRST crowned top innovation at the Health Roundtable](#)

Resources

[QFIRST Presentation](#)

[QFIRST Clinical Workflow](#)

