QFIRST PROJECT

Quality Focused Interventions for the Relief of Symptoms Team

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Background

Reports relating to High risk patients undergoing procedures in Queensland public hospitals

- Recent Queensland Clinical Senate report
- Recently published Queensland Audit of Surgical Mortality (QASM) report
- The Queensland Perioperative and Peri-procedural Anaesthetic Mortality Review Committee (QPPAMRC), Mortality Review Report

How do we know this is a problem?

- Planning documentation is unclear
- Discussion of cases rarely involve more than 2 parties
- Advanced Care Planning is often insufficient
- Documented ceilings of care is low
- Number of futile/inevitable deaths following/during surgery occurring at a state and national level

How do we know this is a problem?

Local data collected indicating the need

Level of need (2/2016 – 2/2017)

77yo home O2 >ureteric stent+EVAR+hemicolectomy > died^{D32}

85yo critical AS+COPD > EVAR > died^{D1}

76yo cognition+Cspine > nephrectomy > HCNH^{8M}

92yo NH+CKD+IHD > cystoscopy q1-2 monthly

72yo NH+IHD+COPD+ > girdlestones+reintubation > died^{D15}

61yo met BRCA > Roux-en-Y failed > died^{D20}

87yo IHD+AS+PulmHT+Cog > #NOF NHFS 7 > died^{D2}

85yo COPD+IHD > EVAR 5.1cm Carlisle 12-22% > died^{D1}

83yo CKD+AAAR > Asymp RIAA repair > amputation+NH^{M7}

What is currently working well and where are areas for improvement

What's working Well,

- ✓ MDT framework for ortho-geriatric patients is working well
- ✓ MDT discussion focused on oncological management has been successfully done through many Q/H and national facilities

Areas for improvement

- ? No MDT/co-ordinated approach
- ? Very little patient and primary healthcare provider engagement in planning and shared decision making
- ? No decision making through expert clinical consensus
- ? No support and follow-up for non-operative pathway decision for non-cancer patients

QFIRST Project Brief

To develop a multidisciplinary model of care which will involve 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 Project Brief

- This will be achieved by:
  - Employment of the QFIRST nurse who is responsible for
    - Developing, implementing and revising the project plan
  - Trial the multidisciplinary model of care
    - QFIRST CNC role
    - Multidisciplinary team meetings (MDT)
    - Data collection and analysis
  - Ensuring QFIRST aligns with State wide Clinical Networks Vision Statement and Guiding Principles.
  - Realising savings in terms of reduced LOS, ICU avoidance and result in better outcomes for patients and increased patient satisfaction.

Project Plan

- Establish a working group
- Identify communication methods
- Develop a governance structure
- Develop relevant guidelines and procedures
- Identify data requirements
- Develop and refine a clear clinical flow process
- Develop and refine documentation inline with HHS
- Trial QFIRST
    - Pt meeting
    - MDT
    - Pt Follow up

Project Framework

Identify who are important stakeholders and who makes the final decision?

- Key is collaboration, it is a joint decision
- The team is led by perioperative medicine with the support of surgery, anaesthetic, ICU, GP and other specialist input

How and where should that decision be made?

- Decision is made during the meeting so that it can be documented
- A plan is made to follow-up the patient 1, 3 and 6 months

Project Framework

What are the immediate next steps after a decision

- Informing the patient/carer and GP of decision and providing management plan determined at the meeting
  - Proceed with planned surgery or modify booking
  - Make appropriate referrals as per treatment plan
  - Document advanced care planning choices

Project Framework

How is the patient optimised for surgery or managed appropriately without operative intervention?

- Referral to existing services (Allied health, Medical Subspecialist groups)

What are the most important issues that need to addressed?

- Focus discussion on the patient, orient goals of care with the patient's values and own goals of treatment

Where are we at

- QFIRST working group formed
- Key stakeholders – Identification and engaging
- Outcomes to be achieved - Primary and Secondary
- Developed, tested and refined patient cohort criteria
- Data collection - what and how to report
- Identified the risks & issues

Where are we at

CONT:

- Developed project guidelines and procedures
- Ongoing communication - multiple forms to a broad group (consumers, Stakeholders, staff)
- Implemented pre trial medical survey
- Documentation – Developed and refined Patient assessment form, MDT outcomes & summary
- Reporting timelines
- Branding – Development of a unique look on a screensaver, fact sheets and spotlight

Lessons learnt so far

- Having realistic timeframes
- Constantly engaging all staff
- Know your limitations and where to seek help
- Seeking feedback
- Test and trial

Where to from here?

- Begin referring QFIRST patients
- Conduct fortnightly MDT's
- Analyse Pre data against trial data
- Conduct patient experience survey
- Measure and report on outcomes
- Follow up QFIRST patients
- Conduct 3 month survey on patients QOL
- Evidence the sustainability need

To recap?

Choosing Wisely Australia
An initiative of NPS MedicineWise

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

Aim: To improve the management of high risk patients presenting for elective or planned surgery at SCUH

Why is this important?

- High risk patients are at greater risk of poor outcomes from major surgery
- They are likely to experience greater dependence post-discharge
- If patients are informed of the risks and likely outcomes, they may elect a non-surgical pathway to achieve or maintain better quality of life

Who is championing this?

- QFIRST CNC & Project Officer - **Ailsa Mckitterick-Gillett**
- Anaesthetist - **Alex Grosso**
- General Medicine Physician - **Nick New**
- D/Director DA&PM - **Owain Evans**
- NUM Pre-Anaesthetic Evaluation Unit - **Linda McCardell**
- CNC Pre-Anaesthetic Evaluation Unit - **Julie Osgood**
- Princ. Advisor, Redesign - **Megan Giles**

Providing a coordinated pathway to meet our patient's wishes

What changes can we make to lead to an improvement?

- Reliable process for referring high risk patients to QFIRST
- QFIRST CNC meeting to discuss patient life and health goals and aligning with care plan
- MDTs to review high risk patients
- Dialogue between hospital clinicians and GPs

How will we know a change is an improvement?

- For high risk elective/planned surgery patients:
  - % referred to QFIRST
  - % with an ACP in place
  - % discussed during an MDT
  - Post-op complication rates
  - Health and disability assessment
  - Patient satisfaction
- Clinician satisfaction

References

- QH Clinical Senate 2016: Value Based Healthcare
- National Standard requirement for advanced care planning initiatives Health Round Table
- CICM/ANZCA/ASA Perioperative Medicine SIG
- RCoA Perioperative Medicine: the pathway to better surgical care
- ASA Perioperative Surgical Home
- RACS QASM (Goals 4,5)
- QPPAMRC: ~496pts(62%) Cat5="inevitable death"