

Healthcare management of elderly patients with complex needs in an Accident and Emergency (A&E) department, minor treatment area

Ross G. Cooper¹, Charles Mohabeersingh²

¹ Senior Lecturer, Division of Physiology, Faculty of Health, Birmingham City University, 704 Baker Building, Franchise Street, Perry Barr, Birmingham B42 2SU, UK

² Principal Lecturer, Division of Health Policy & Public Health, Department of Community Health and Social Work, Faculty of Health, 713 Baker Building, Birmingham B42 2SU, UK

Abstract: The current paper proposes a unique and novel model for the development of clinical leadership in practice in order to achieve continuous improvements in healthcare delivery. This model will enable the leader to be innovative and move from being a traditionalist by focusing on operational issues to becoming a champion of change. Using a unique and novel 9-C paradigm shift we propose the inter-twined aspects of important clinical leadership in practice of elderly patients. We suggest a personalised view of medicine that promotes for patients individualised solutions based on whole-systems thinking. A theme of clinical coordination that inspires patients' confidence, sets and maintains high standards of care, ensures consistency of care, resolves clinical issues, communicates with multi-disciplinary teams, establishes a role model for the team, ensures delivery of safe and effective care, monitors quality of care and responds to patients concerns and acts upon them. Perhaps an innovative approach to personalised patient care would also include the use of 'smart' rooms to facilitate the alleviation of stress and be connected via robot technology that suggests scenes, music or activities for patients waiting to be seen.

Key words: A&E, elderly, healthcare, management, needs

INTRODUCTION

The *Next Stage Review* proposed by Lord Darzi discusses in the context of the management of the National Health Service (NHS) innovative approaches to the management of healthcare and how to strategically meet the challenges of the 21st century [1]. The proposals can be construed as a bold opportunity for NHS managers/leaders to utilize innovative approaches in order to attain excellence in clinical care. Carlisle [2] argues that currently the NHS lacks specialist physicians trained to treat the elderly, which is a concern given the increasing ageing population.

Cooper and Mohabeersingh [3, 4] targetted the use of lean thinking strategies in medical practices, and in surgical assessment units in English hospitals, respectively. Following on from this theme, one could deduce that there are numerous issues surrounding the clinical management of the elderly patient in Britain. Indeed, redesigning care would be principally concerned with improving the flow of patients through clinical and other systems making care both safer and more accessible [5].

We propose a unique and novel model of development of clinical leadership in practice in order to achieve continuous improvements in healthcare delivery. This model will enable the leader to be innovative and move from being a traditionalist

by focusing on operational issues to becoming a champion of change. In this regard, we emphasise their development in relation in individualist *vs.* systematised conceptions of our chosen example of the care of an elderly person entering an Accident and Emergency (A&E) minor treatment area with a suspected pelvic injury. The 9-C paradigm shift is a unique and novel tool we have designed. It is created as an inverted pyramid, to emphasis the merged and equal relationships between each function and the narrowing of functionality to a point that reduces wasted time, speeds up through-put, reduces appointment times and embraces lean principles. We were motivated to create a 9-C paradigm in order to sequester the various important and relevant tasks and roles within an A&E department specialising in the care of the elderly. This is currently not clear-cut within NHS systems, the patients of whom are jumbled into a mass of waiting queues and sitting areas on a first-come-first-served basis.

Using this 9-C paradigm shift (Fig. 1) we propose the inter-twined aspects of important clinical leadership in practice of elderly patients, including financial and clinical accountability, a consistent leadership vision, preparing and training for real change in practice, establishing multiple communication channels, ensuring senior management commitment and support, strong leadership skills, creating new authority relationships, and the inclusion of physicians in all stages from diagnosis to full recovery. The 9-C model has benefits in all aspects of the care of the elderly including those functionalities designed to cope with stroke, cardiology, hepatology, diabetes, osteoporosis and osteoarthritis. We propose introducing the 9-C model into British healthcare

Corresponding author: Dr. Ross G. Cooper, Division of Physiology, Faculty of Health, Birmingham City University, 704 Baker Building, Franchise Street, Perry Barr, Birmingham B42 2SU, UK.
E-mail: rgcooperuk@yahoo.com

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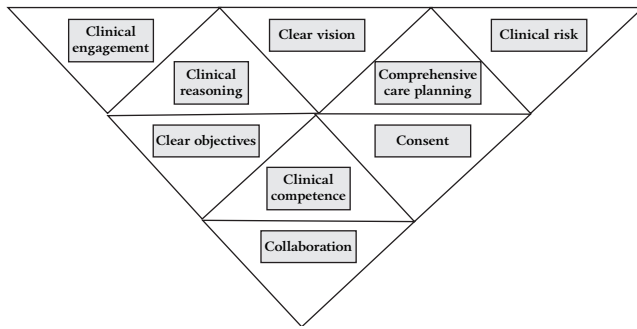


Figure 1 Inverted pyramid illustrating a 9-C paradigm shift in clinical leadership in practice of an elderly patient.

facilities, a system that will make the units more efficient and eliminate waste. It may not be appropriate in other countries, such as the USA, which has an endemic medical insurance service facility that is difficult to break given their huge financial resources and wielding power. The tool is unlikely to be of use in most developing countries simply because of the lack and shortage of resources, where wastage thereof is extremely unlikely. Clearly, money is the only guarantee of treatment, and in Zimbabwe, for example, it is said that one has to pay a deposit of an extortionate US \$2,000 before any treatment is forthcoming.

Proposal of a 9-C paradigm shift. Clinical competence is the team-focused strategic application by which an accurate patient assessment is made, followed by a reliable diagnosis verified by other specialists, and instigation of reliable and appropriate treatment regimes. Clinical competence can be gauged by the care of patients suffering from osteoarthritis with debilitating loss of physical function and severe pain [6]. Indeed, while a patient is on a waiting list for joint replacement, case managers and/or community matrons should coordinate and assess their needs to alleviate pain and improve service provision [6]. Clinical engagement and collaboration is the clinical facilitation and support of the treatment regime by use of other units that ease patient pain, loosen the joints and assist the dynamics of – in the case of skeletal problems – movement. They may extend into outpatient physiotherapy departments designed to treat patients with musculoskeletal conditions necessitating excellent lines of communication between therapist and patient, with improvements in psychosocially-motivated roles in patient experience [7]. Different professionals may become involved at different points in the transition process. Certainly there should be an emphasis on good communication, structured planning meetings, and action planning with clarification of roles and responsibilities. Comprehensive care planning is a precisely detailed schedule of treatment protocols involving initiating, ensuring, facilitating and recording treatment progression. It may involve improvements in health promotion provision necessitating confidence development among nursing staff in undertaking tasks and evaluating clinical risk particularly with increases in patients aged over 65 [8]. Clinical risk involves failure of treatment, adverse reactions to medications, including side effects, depression due to isolation from family, and susceptibility to super-bug infections, e.g. Methicillin-resistant *Staphylococcus aureus* (MRSA). In patients suffering from mental health disorders, multidisciplinary clinical teams need to explore ways of integrating with spiritual and

pastoral care services [9]. Management should operate with *clear objectives* and a *clear vision* to promote lean strategy in the operations of A&E departments and training of staff to enhance their *clinical reasoning* and ensure patient *consent* to treatment and clinical or community procedures. In spite of the protocols of treatment and care regimes differing between the NHS trusts, an efficient unit will always operate in line with its mission to seek patient approval for procedures, photographs and treatment. A precisely controlled operational facility will minimise exposure to injury of both staff and patients, and deal with vulnerable patients in the appropriate manner. In essence, a patient-centred planning approach is used in a way that allows a holistic assessment of patient needs, including health and social care needs mobility, communication, etc. Indeed, patients' perspectives on medication-related problems necessitate a comprehensive management approach that spans patient education to the systems of care delivery [10]. However, more research is needed to evaluate the professional practices and operations designed to assist self-medicating patients [10]. Can an elderly patient self-manage their prescribed medications and comply with a dose? Or is it essential for a carer or family member to assist them?

The 9-C paradigm, which allows interactions between all elements, will permit the creation of a novel, personalised approach to the care of elderly patients who expect nothing less. Ultimately, holistically the model will recognise how vulnerability in the elderly serves autonomy and seeks to allow health and social care professionals to interact for the provision of effective treatment, support and care regimes. As the elderly are potentially vulnerable, the 9-C paradigm allows an increased awareness of health and social needs of these patients. The interaction between the different elements will certainly help the way in which service users enhance health and social care delivery, based on empowered professional roles within the team. This is based on appointments, scheduled into the future, in the event that patients with chronic ailments need to be seen [11]. This traditional view of medicine management controls the care of the patient, rather than engaging the patient. We suggest that personalised medicine will promote individualised solutions for patients that are based on whole-systems thinking. Some systems are offered where patients go on-line and book their appointment without speaking to a receptionist. Indeed, telemedicine, telehealth and at the point care testing [11] will allow patients to manage themselves in a productive and added value manner, and reduce hidden costs in the clinic and travel costs for the patients.

Ageing and senescence face all of us. As osteoblasts become less active, the quality of bone is reduced resulting in the loss of bone (osteopaenia) which may progress to osteoporosis. Joints become stiffer and degenerate, particularly in patients over 75 years of age. Thinner cartilage and the loss of synovial fluid results in the bone surfaces becoming exposed, less joint lubrication, leading to osteoarthritis. The sternal joint may be adversely affected, precipitating painful breathing. The useful outcomes of the 9-C paradigm therefore are enhanced clinical competence, utilisation of appropriate technology and medication, and the prioritisation of patient treatment by severity of condition. If necessary, a system should be in place to make allowances for the more critical cases, rather than a rigid time-slot mechanism of patient appointment. The 9-C model will also allow a more efficient means of pain management alleviation and treatment. Detailed follow-up of

patients will be achieved by home visits, or virtual links via the internet whereby the specialist doctor discusses the patient's progress after discharge, without the patients having to return to hospital. Reduced waiting times for an appointment will be available to those with access to radio communication. The massive paperwork endemic in the NHS will be considerably reduced. The system, though, will require a trained, good leader to ensure its successful application, IT professionals and service technicians, and therefore may require the creation of new job roles.

RECOMMENDATIONS

Patients are likely to provide support for attendance of clinics outside normal working hours, although an assessment will be needed to estimate the number of patients likely to attend [12]. District nurses need to liaise with patients in the community to evaluate and determine complex needs, including mobility, access to transport, assistance from family members, medication and financial matters [13]. Management of A&E departments should be devoid of informal, non-transparent systems of promotion that may act in a subjective manner and open discriminatory windows [14], as ex-patriot and foreign-born nurses may be able to assist with the treatment of patients more efficiently from their home countries. They may have a better understanding of cultural differences and needs, and thus promote respect and dignity at all stages of their care management.

For implementation, lean managers will need to undergo training that will address tact time, material flow, information flow, role and types of kanban (material handling system), principles of single-piece flow, level of production schedule, and concept of lead time [15]. Such details are described in detail in this paper. We wish to emphasise the importance of the introduction of kaizen and visual management systems in a healthcare setting which signal whenever an abnormal condition occurs. It also suggests – possibly through 'smart'-room technology [3] – a more personalised patient care encompassing system that provide the right care, for the right patient, at the right time, and in the right place, using the right technology [11]. Kaizen Workshops, if correctly managed, will facilitate the creation of continuous flow and will assist the development and implementation of a lean thinking but difficult system which will take time and patience to implement [15]. An effective training programme modelled after systems in Toyota manufacturing, will assist in sustaining, increasing and continuously improving this newly established healthcare system [15].

Additionally we suggest a theme of clinical coordination that inspires patients' confidence, sets and maintains high standards of care, ensures consistency of care, resolves clinical issues, communicates with multi-disciplinary teams, establishes a role model for the team, ensures delivery of safe and effective care, monitors quality of care, and responds to patients concerns and acts upon them.

Clinical engagement will encompass the visible embodiment of leadership in an NHS setting, marshalling and inspiring the team through coaching; engage more explicitly with efforts to meet strategic objectives at team and organisational level, enjoy professional growth, and recognise the vital contribution of the team. More detail about this is provided by Flinchbaugh and Carlino [16].

CONCLUSION

Accident and Emergency departments, and indeed hospitals as a whole, need to be constructed in a supportive way that allows personal space, a caring atmosphere, easy access to external areas and provision of facilities (recreation and leisure) [17]. For patients requiring assistance with movement, exercise programmes may greatly enhance improvements in balance and mobility in patients suffering from balance problems, and possibly improve confidence and the quality of life [18]. Despite advances in technology that assist doctors to prolong life and an increasingly aged population in Britain, management needs to finance change adequately so that the NHS copes with increasing demands on its limited resources [19]. Indeed, the increasing older population is a global phenomenon and nursing homes should strategically position themselves to achieve measured outcomes, enhance open and accurate communication lines, and upgrade technological applications [20]. Other methods of treatment, such as homeopathy [21], complementary and alternative medicine [22], may have added benefits for patients not responding well to medication. Nurses should be more involved in independent and supplementary prescribing, which will necessitate training them in how to provide appropriate information about the medication, and knowledge of side effects [23]. Clinicians and other healthcare professions (e.g. physiotherapists) will require more training in database software and the use of health information topics [24].

Perhaps an innovative approach to personalised patient care would also include the use of 'smart' rooms to facilitate the alleviation of stress, and be connected via robot technology that suggests scenes, music or activities for patients waiting to be seen. The principles of such technology have been reported in institutes of higher learning and could be easily adapted to healthcare requirements [25-27].

CONFLICT OF INTEREST

None recorded.

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