Management of Complex Housebound Patients

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Quality issue / initial problem

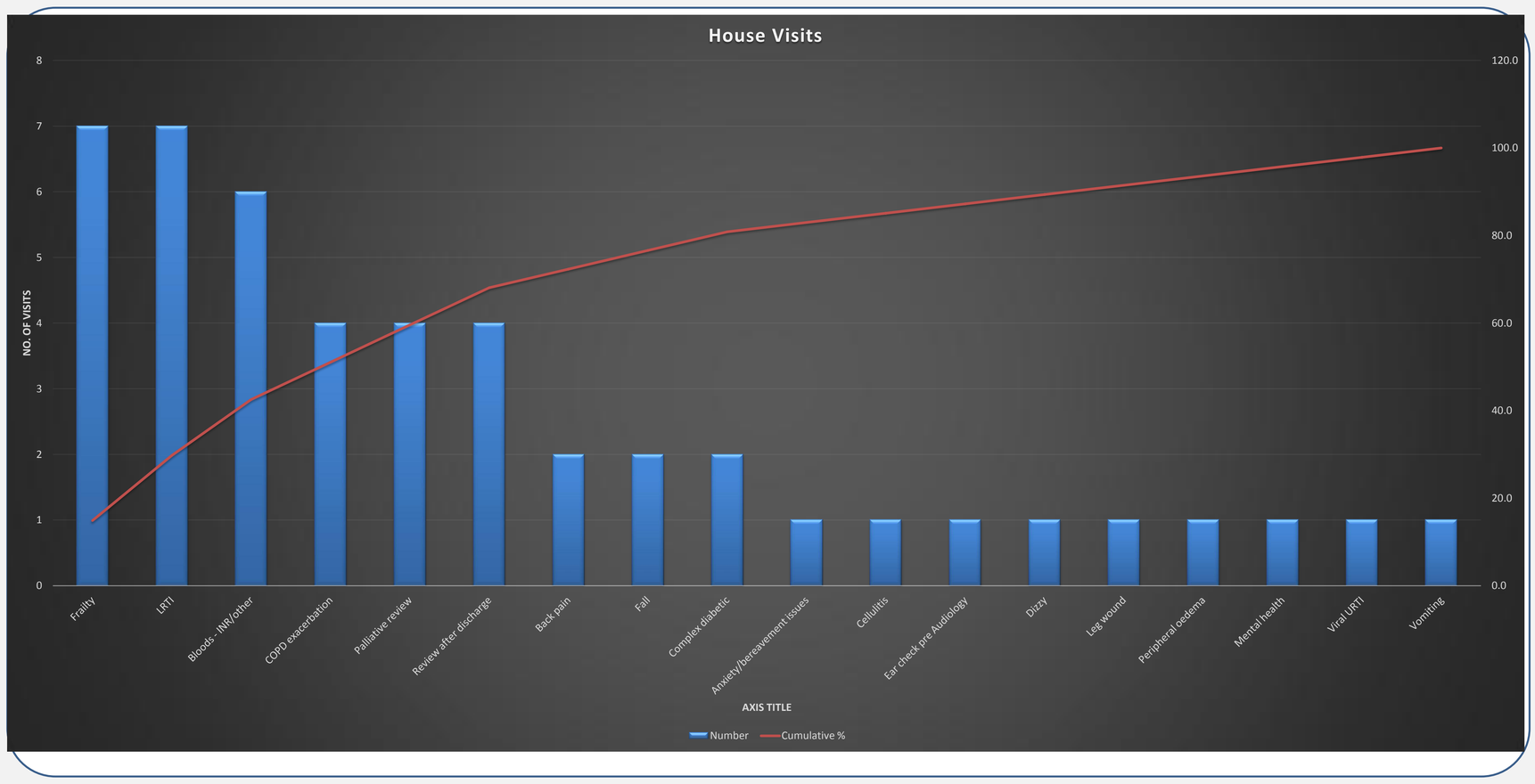
I am a GP in a 7500 patient practice in SE Edinburgh.
We have a mixed demographic, with some elderly residents across a broad demographic. We often see elderly, frail, complex patients on house calls.
My aim was to improve the care of these patient through improving ACPs and linkages within the multidisciplinary team (MDT) through data sharing

Aim

Appropriate management of housebound (HB)patient through improved ACPs

Measurement of improvement

We looked at reasons for admission, and those with ACP/KIS. We will revisit this to see if improving ACP/KIS will reduce admission rates



Priorities for improvement

- Improve identification HB patient
- Improve communication with patients/families and other parts of MDT
- Reduce admission rates

Tools

- Process Map
- Driver diagram
- Pareto charts

Effects of change

More comprehensive ACP and KIS for those in the identified group. Better communication with patient and families, with lower admission rates.

Lessons learned and message for others

Willingness of other MDTs to share information
Lack of IT infrastructure to allow full sharing of housebound registers
General improvement in family support.

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