Cohort 1

Flash report – SIFS Cohort 1 – Jane Carr, AHP Team Lead

QI Project Team:
Physiotherapy, Badenoch & Strathspey Community Hospital, Aviemore

QI Project Aim:
By September 2023, we will reduce the time spent on Physiotherapy admin by 50%. This will protect clinical time and contribute to the team seeing patients within the government HEAT target times i.e. 2 weeks for Urgent, 4 weeks for Routine patients. Fits with 'Releasing Time to Care' approach.

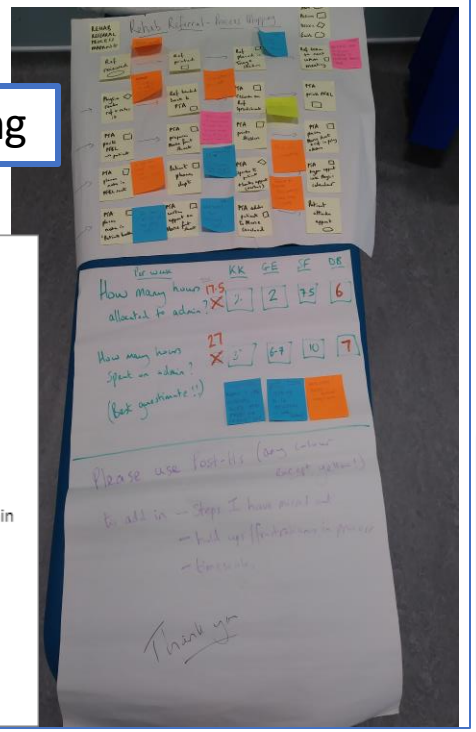
Stage of the QI Journey:

Testing Changes

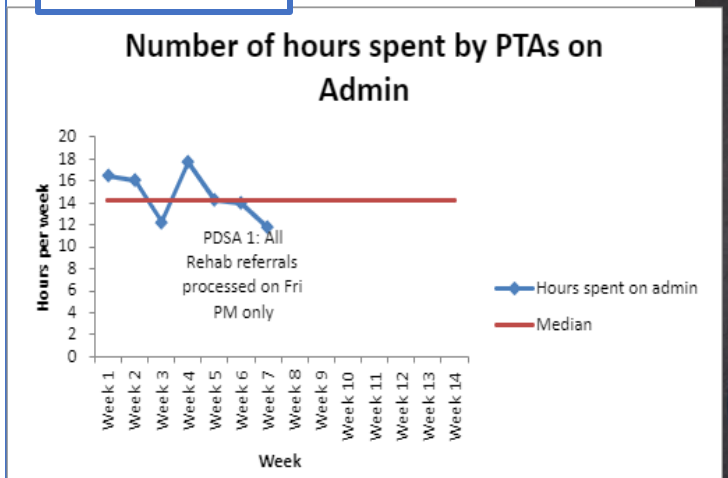
Current status:
Second PDSA cycle starts 26/6/23, and a third one planned (delegate PECOS ordering to the wider Admin team at B & S CH).
Note: Once Morse is fully functional, referrals will all be electronic and some current admin practices will be obsolete. However, the development of Morse is slow. The project started out looking at referral processing but has grown to examine our other admin processes too.

QI Tools

Process mapping



Run Chart



Act

Discussed with staff at staff meeting.
Planned the next cycle/what change do we want to test next – agreed to abolish our paper Morse front sheet and input the information onto our referral spreadsheet instead
Continue to measure admin time weekly

Plan

PTAs will record the time they spend on admin each week. Agreed what counted as admin..
First change =the way we process routine Rehab referrals. Currently processing them as they come in – change to processing on a Friday only.
Predict that total admin time will fall

Study

What happened to total admin time? Did it fall as we predicted? Admin time rose initially but now appears to be on a downward trend.
How did PTAs feel about the change? PTAs gave feedback via an online survey – positive, agreed to continue with the system. Process measure showed that the PTA processing all the referrals was able to complete them in one batch.

Do

From 2/5/23, started saving routine rehab referrals in the filing cabinet so that 1 PTA could batch process them on the Friday.
Ongoing weekly collection of admin time

Area of Learning – Successes – Challenges

Challenges – learning to use Excel for run charts – guide on Turas very helpful, difficulty sticking to allocated study time, getting all my team together at same time, asking staff to record admin time on a tick sheet – additional work

Successes – improved skills on Teams and on Excel. Trainers Laura and Jade accessible for help – Teams meetings with them made all the difference
Involved my team and got their ideas for the Process Mapping. Course run on Teams – would have been harder to attend if held at Inverness

Lightbulb Moments – you don't just measure before and after a change, measurement needs to be ongoing so that you can carry out repeat PDSA cycles (PDSA Ramp) or even Parallel PDSA ramps

- Use of Process and Balancing Measures in addition to Outcome Measures – gives a more rounded picture and provides checks/balances
- QI projects can be motivating and refreshing – great to introduce changes and refresh how we do things for benefit of patients and staff

Flash report – SIFS Cohort 1 - Susan Young, Project Manager

QI Project Team:
Mental Health & Learning Development Services

QI Project Aim:
By August 2023, there will be a 40% uplift of completion of the Learning Disability TURAS training module in NHSH in order to address the informed learning from the thematic analysis carried out in relation to the MHLD Strategy.

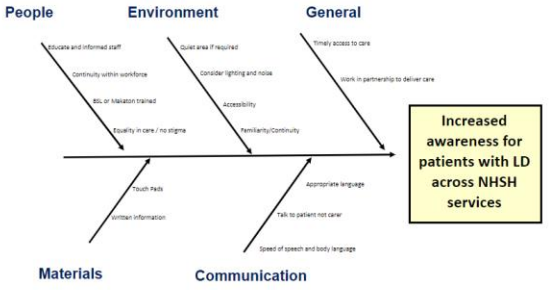
Stage of the QI Journey:

PDSA Cycle 2 (paused)

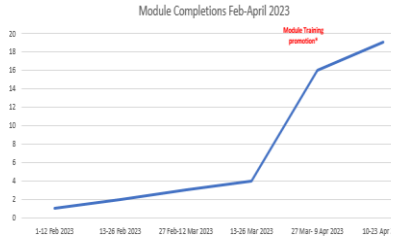
Current status:
First PDSA cycle complete. Uplift has been increased from 0-2 per month, to 16 and 18 respectively fortnight.
PDSA Cycle 2: Analysing data from TURAS to drill down and focus/drive within individual services across the organisation. Completions as expected have dropped down again.

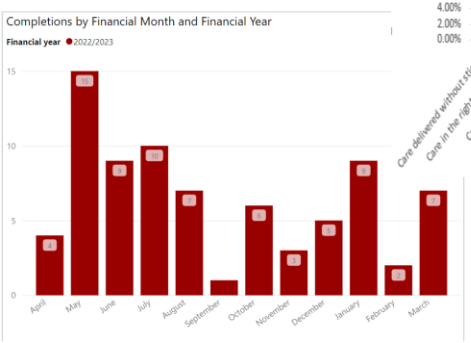
QI Tools

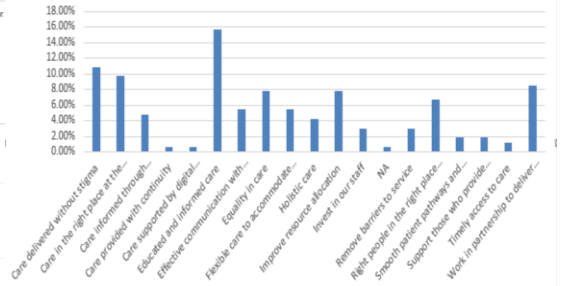
Fishbone Diagram



Data







User Feedback

Act
Thematical analysis and TURAS module ascertained. Monitor uplift of TURAS training module.
Deeper dive into services where uplift lacking.

Plan
To assess current uptake of the LD Turas module. Liaise with Comms Team to promote the module and monitor progress of uplift. Review and promote within individual services through Programme Boards.

Study
Review any uptake and further investigatory analysis around which services have completed. Seek to obtain additional feedback on improvements on training.

Do
Share findings and promote TURAS module via teams and NHS Comms.
Drill down in PDSA Cycle 2 into more specific services.

PDSA Cycle 2:

Due to anomalies within the TURAS data, it is not possible to ascertain fully which services are undertaking the training. Additionally, it has been identified that the TURAS Module is out of date and requires some work. On completion of the upgraded module, I will run PDSA cycle 2 to increase uplift again, however will market on the basis of a new module.

Area of Learning – Successes – Challenges

Success within engagement in learning about how we can improve services for those with Learning Disabilities. Challenge around this was language and different methods of communication. Analysis of data from TURAS learning module reflects this need to educate on a wider NHSH scale showing on average 0-2 per month workforce carrying out the learning module. Promoted via S&D team, Project Management Teams and NHS Weekly Comms. Excellent uptake over fortnightly period lifted to 16 and 18 completions over the two-week period. Drawing PDSA Cycle One to a close, require to focus on services where training is not being encouraged and gain buy in via Programme Boards to encourage teams to undertake the training. This will be the commencement of PDSA Cycle 2. The TURAS reports do not offer a deeper dive into the service areas sufficiently and therefore need to rethink how we focus on this for PDSA Cycle Two

Flash report – SIFS Cohort 1 – Adrienne Swan, REP

QI Project Team:

Belford ED Medical Team

QI Project Aim:

Improve the written record-keeping by the junior doctors in the ED in the Belford hospital for patients being transferred out for specialist care to be in line with GMC guidance to 75% by August 2023

Stage of the QI Journey:

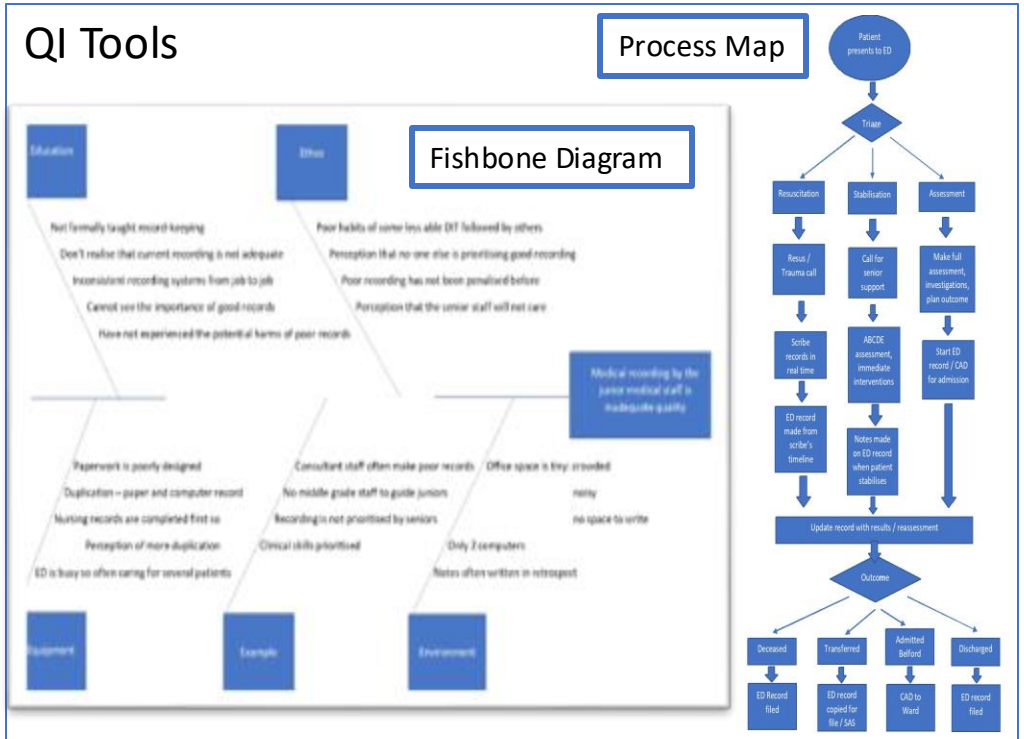
Testing changes

Current status:

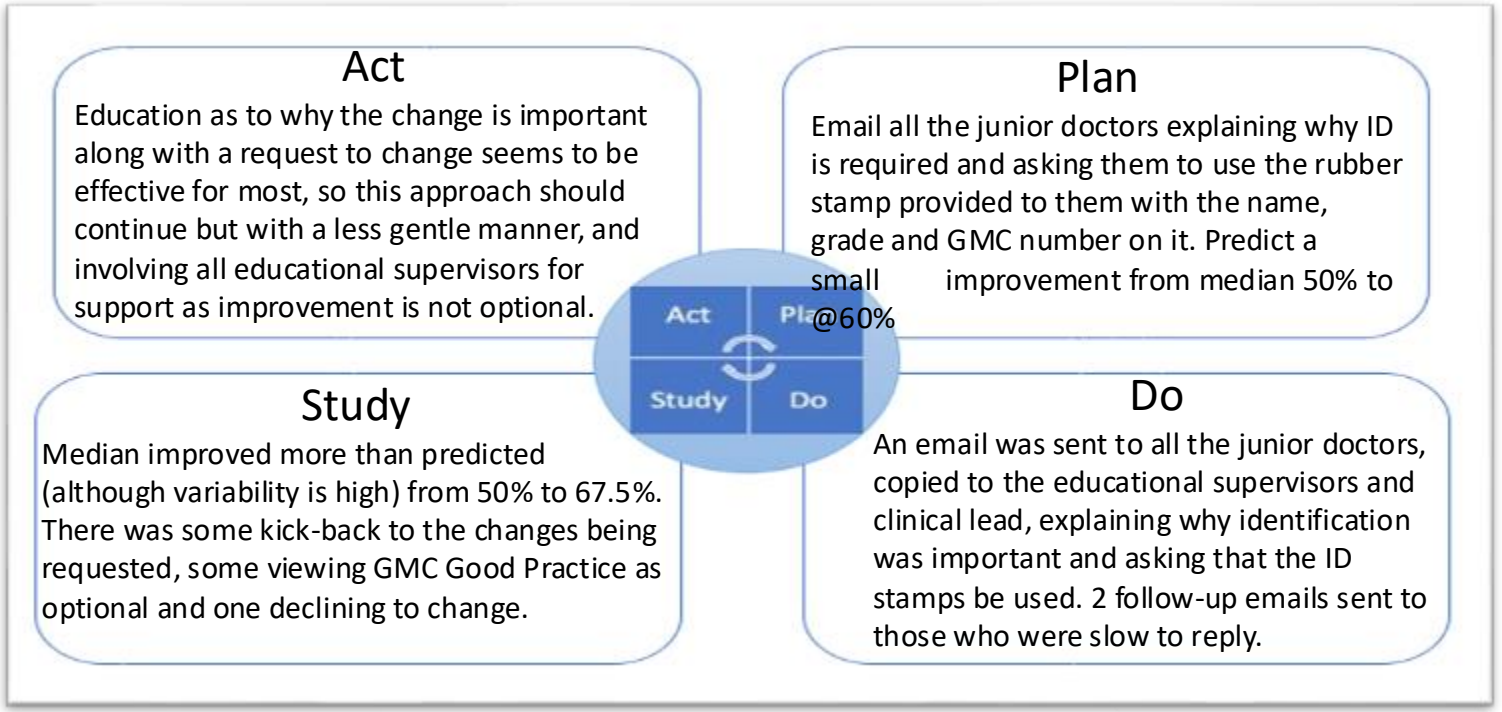
Testing different methods of changing how well written medical records are made in the ED and reinforcing the importance of this task

QI Tools

Process Map



Fishbone Diagram



Area of Learning – Successes – Challenges

It is always challenging to change an established pattern of behaviour, particularly in a group of people. Using the QI tools helped to break the process down into manageable chunks and highlighted ways to involve the junior doctors in improving recording. The first PDSA chain continued to concentrate on teaching what is required and therefore expected of record keeping as this was raised as a contributor to the original issue. Going forwards this education will be added into induction at the start of all the junior doctor rotations. A second chain will be to look at the design of the admission pro-forma which was another issue seen in the fishbone diagram. One of the juniors is keen to help with this process as an innovator which should be helpful in moving improvement forwards.

Flash report – SIFS cohort 1 – Emma Zineldin

QI Project Team:
Highland Urology Clinic, Raigmore Hospital

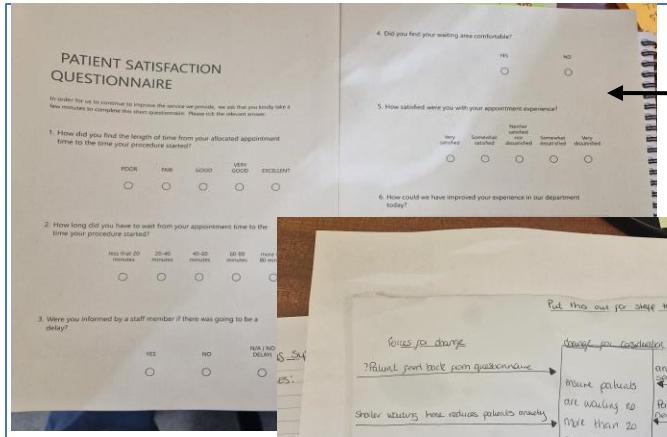
QI Project Aim:
By 1st July 2023, patients attending the Highland Urology Clinic for a cystoscopy, will wait no longer than 20 minutes from the time of their appointment, till the time the procedure starts.

Stage of the QI Journey:

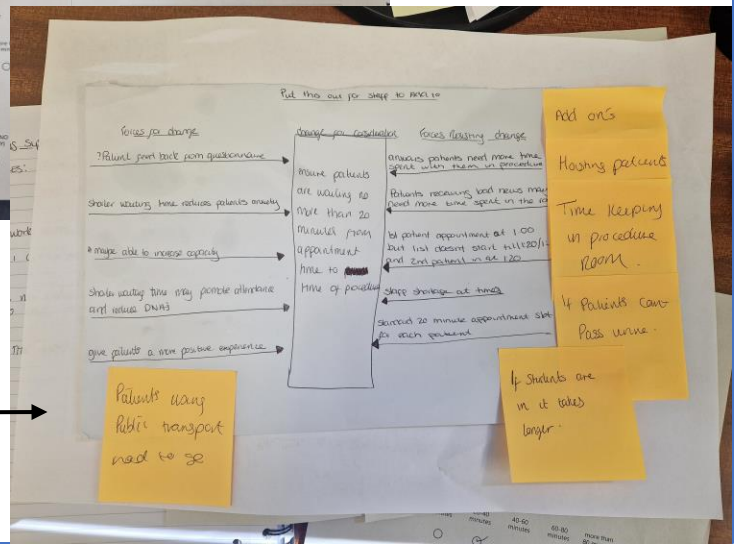

Testing Change

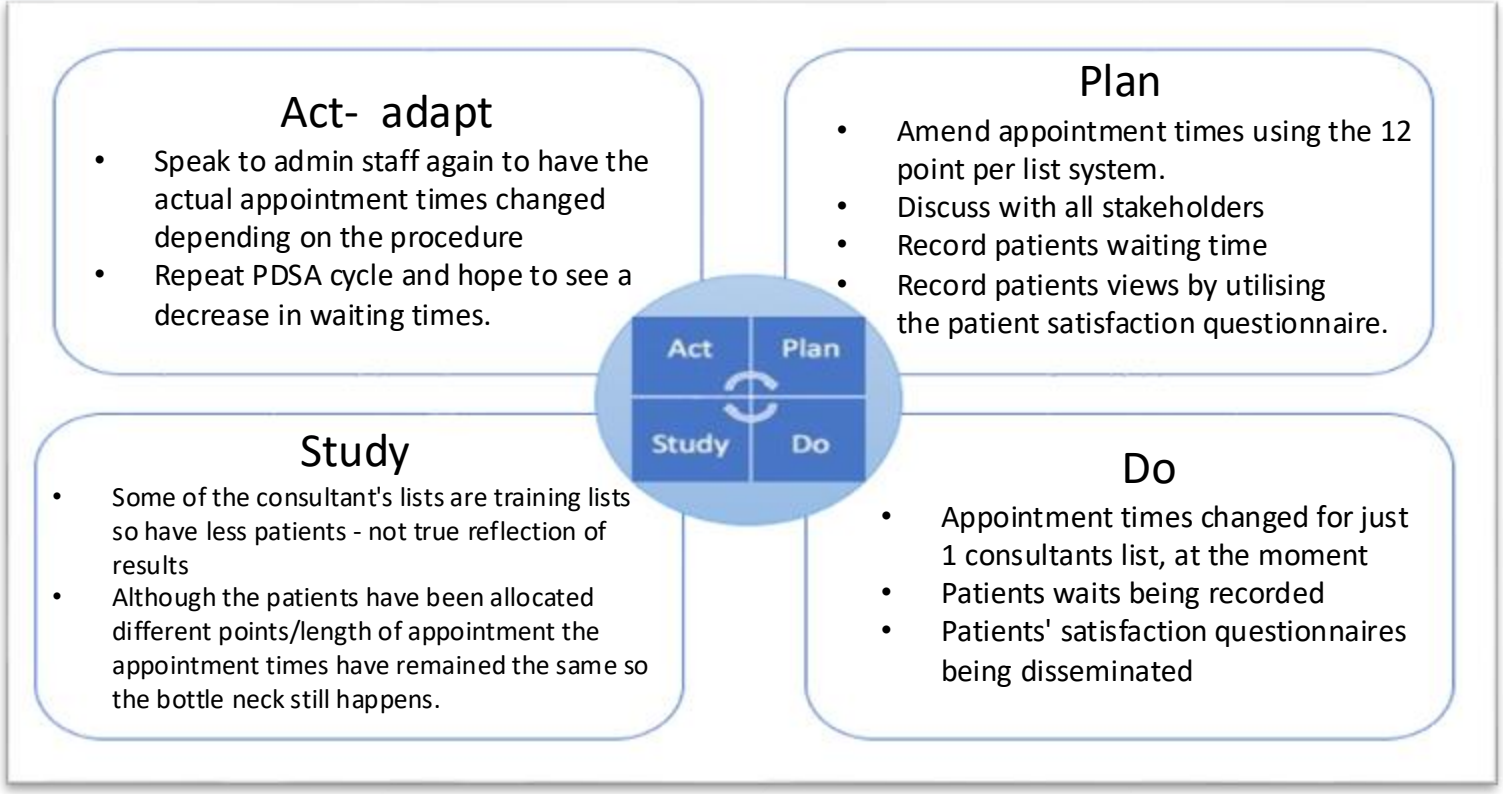
Current status:
PDSAs – 1st PDSA cycle - collecting date to assess if the implemented change had improved patients waiting times.

QI Tools - User feedback



QI Tools - Forcefield Analysis





Area of Learning – Successes – Challenges.
I have learnt that this project is going to take me a lot longer to complete than I first anticipated due to the length of time it had taken me to collect the relevant data. I found the QI tools a good way of getting staffs constructive feedback/ideas/thoughts and encourages them to get involved and feel valued. When collecting the data, I realised that the problem was not as big as I had first thought however there is still lots of room for improvement.

Flash report – SIFS Cohort 1 – Fiona MacDonald, Health Visitor

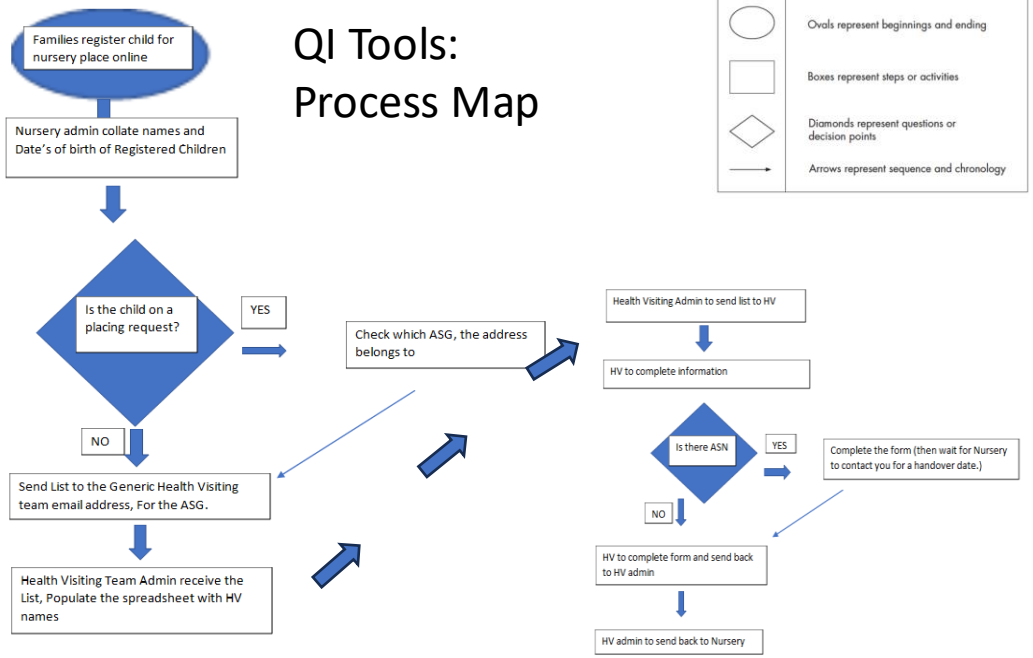
QI Project Team:
Inverness East and Nairnshire Team

QI Project Aim:
By Dec'23 85% of ELC report that they have received all information they require to plan a child's transition into nursery in a timely way. In line with current processes and guidelines

Stage of the QI Journey:
Testing Changes

Current status:
PDSA 1

QI Tools: Process Map



Act
Further discussion with Education stakeholders on how best to get the data.
Ask parents barriers of registering for nursery

Plan
To determine if all families are asked for their consent at their 27-30mth review and nursery registration

Study
20% parents had not been asked – significantly less than predicted - 10% of parents had not decided on which nursery they would be enrolling their child too. **Did not think that this would be an issue** 60% of parents keeping children at private nursery until p1 enrolment with 30% doing a split placement between school and private nursery. **Hadn't considered the split placements**

Do
10 Records audited weekly
Requested information from education on numbers of families giving consent on education enrolment

Area of Learning – Successes – Challenges
It was challenging to get my aim right to fit, but once that was achieved it meant that the outcome measure and PDSA's became clearer. It has also been challenging to fit in some of the learning due to workload pressures, so a lot has been done in my own time. This project is still in it's infancy and will form part of a bigger project as it is adapted and rolled out. All the stakeholders remain on board and they can really see the benefit this is going to bring. I am also devising a way to get feedback from children as is in line with "The promise".

Flash report – SIFS Cohort 1 – Vicki Cowan, Staff Nurse BSCH

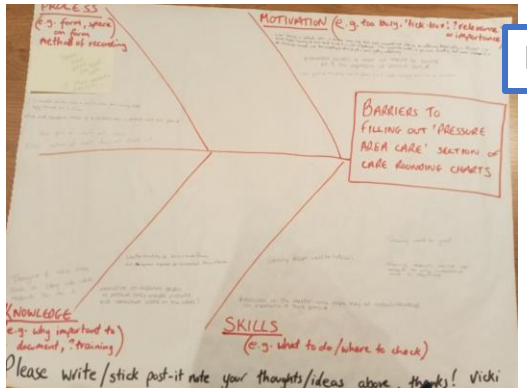
QI Team:
Badenoch & Strathspey Community Hospital
March-June 2023

QI Project Aim Statement:
To improve the recording of pressure area care by 100% by June 2023 in line with HIS Prevention & Management of Pressure Ulcers:Standards(Oct 2020) and NMC Code of Conduct 2018 (Section 10).

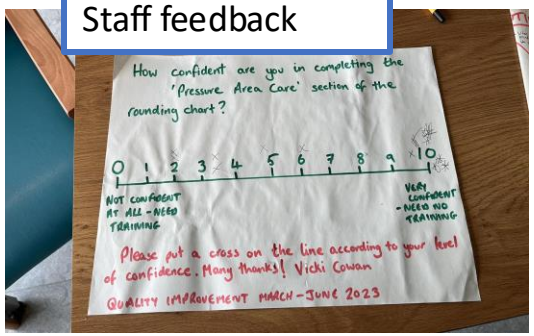
Stage of the QI Journey:

Testing Changes

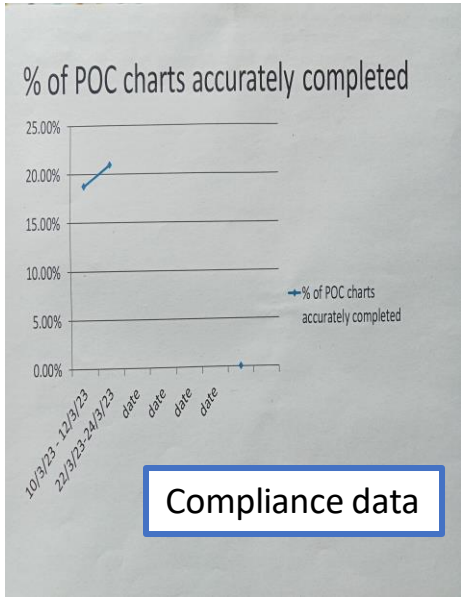
Current status: PDSAs – As lack of staff confidence was main issue identified from QI tools, PDSA 1 will test the introduction of mini training sessions on the ward around pressure area care. These will be done on an ad-hoc basis by myself and 2 other Band 5s to try and capture as many shift patterns as possible.



Fishbone diagram



Staff feedback



Compliance data

Act

Results of QI initiative reported to staff via meeting and on staff noticeboard. Plan to continue with opportunistic training to maintain the improved recording of PAC, aiming to carry this compliance forward to new DCP.

Plan

2 Band 5s and 1 band 2 identified to roll out mini ad-hoc training sessions on ward around importance of PAC and how to fill out charts. Staff will initial their name on list to confirm they have had mini training session to ensure no-one is missed.

Study

All staff reported an increase in confidence following training sessions. A sample taken over 3 days in the week beginning 12/6/23 showed an increase in correctly completed PAC charts from 20% to 45%.

Do

Mini training sessions conducted over a three-week period from 15/5/23-05/06/23 to ensure all staff and shift patterns covered.

Area of Learning – Successes – Challenges: Area of Learning:

Learning: The initial data from the QI tool Fishbone diagram identified that lack of knowledge around the charts was the main barrier, which was an unexpected result. I thought about changing the aim statement at this point , but realised that my aim remained the same, but I had identified a major potential for change. It was really valuable to learn how to use the QI tools to explore the topic and gather relevant data. The knowledge I have gained will make future QI projects conducted on the ward more structured, focused and relevant.

Successes: The idea of opportunistic training was well received, and initial results show that the project aim was met. This will need ongoing monitoring to ensure improvement is maintained, with results plotted on a run chart to establish if change has been made.

Challenges: The main challenge has been reaching staff due to different shift patterns and levels of engagement with online communication. Face to face seems to get the best levels of engagement currently.

Flash report – SIFS Cohort 1 – Anthony Powell, SCN

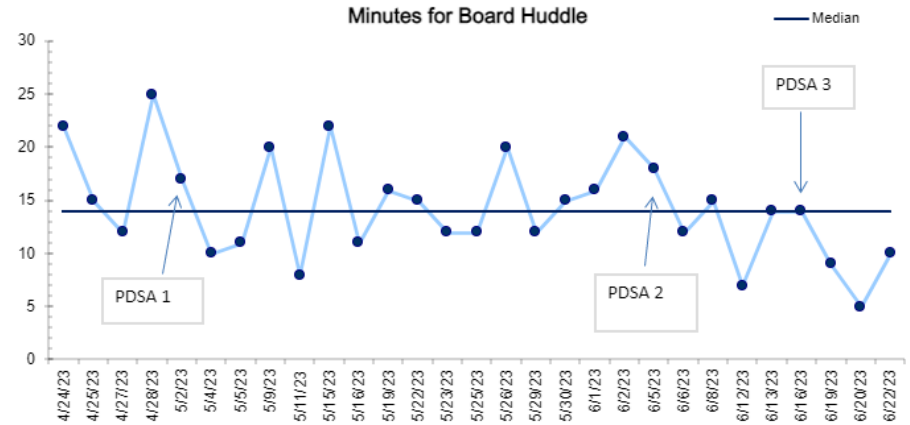
QI Project Team:
B&S Community Hospital Inpatient Ward

QI Project Aim:
To reduce the time of the inpatient board round to 10 minutes by the end of August 2023 while ensuring it remains relevant and in line with the NMC Code

Stage of the QI Journey:
Testing Changes

Current status:
Reviewing PDSA2 and implementing PDSA3

Run Chart



Act

Some progress made in using discharge planning summary to focus BR.
Changes to remain and introduce change where SCN decides on which patients to be reported on based on DHD status and use GP book for routine communication.

Plan

Following implementation of changes made in PDSA2 discussion was had within MDT on SCN/NIC being the one to identify patients to be discussed and then going back to any who have not been mentioned but need review. This was felt to hamper flow of BR.

Study

Use of MDT spreadsheet on screen has given focus to BR however difficult to navigate.
Standing during BR has also helped staff focus however some staff feel this is unnecessary and have refused to stand.

Do

Collective decision to have each nurses decide which patients from their base require to be discussed at each BR. There will continue to be no distinction made between which patients are due for ward round that day.

Area of Learning – Successes – Challenges

Challenges

Initiating changes proved to be challenging

- nursing staff feeling changes unnecessary, in particular being asked to stand which resulted in the need to remove chairs. No change is ever easy, but I have been surprised at the resistance to change and the difficulties in communicating changes and reasons for them to the wider nursing team.
- technological - attempts to display Discharge Planning summary on ward view screen were initially unsuccessful due to being unable to log onto screen – delaying this change being fully implemented until 25th May 2023.

Learning

- Data collected for period has been used to create run chart above. The median is calculated as 14.5 minutes. This represents a reduction in the Median of 0.5 minutes since the start of the data collection.
- While the data collected for the period since implementing changes in PDSA 3 has been limited it does show an encouraging red uction. On a Friday as we head into the weekend there is more lengthy discussion of patients knowing that the only medical support over that period would be from OOH.

Success

- The compiling development of the process mapping and the run charts are two of the areas I have found most useful. Developing the process map including all the team involved in the board round was useful as a collective approach and benefited all future discussions around what changes could be of benefit.
- The run chart has in some ways changed the focus of the projects aim of the board round lasting no more than 10 minutes. Given that the median point is 15 minutes and that times where the Board Round has exceeded this it would be reasonable to consider a target time of 15 minutes which would still represent an efficient time while meeting the aim of being relevant and in line with the NMC Code. I have found using the data in this way and being able to illustrate trends a very useful tool and one which helps me to demonstrate the progress of the projects in relation to the aim statement and makes the changes more relevant for those who have been sceptical.

Cohort 2

Flash report – SIFS Cohort 2 – Andrew Kyle, Health Development Officer

QI Project Team:

Child Health.

QI Project Aim:

To increase the number of parents attending the Planet Youth parent group by 75%, in line with the Planet Youth 10 steps implementation guidance, by the end of September 2023.

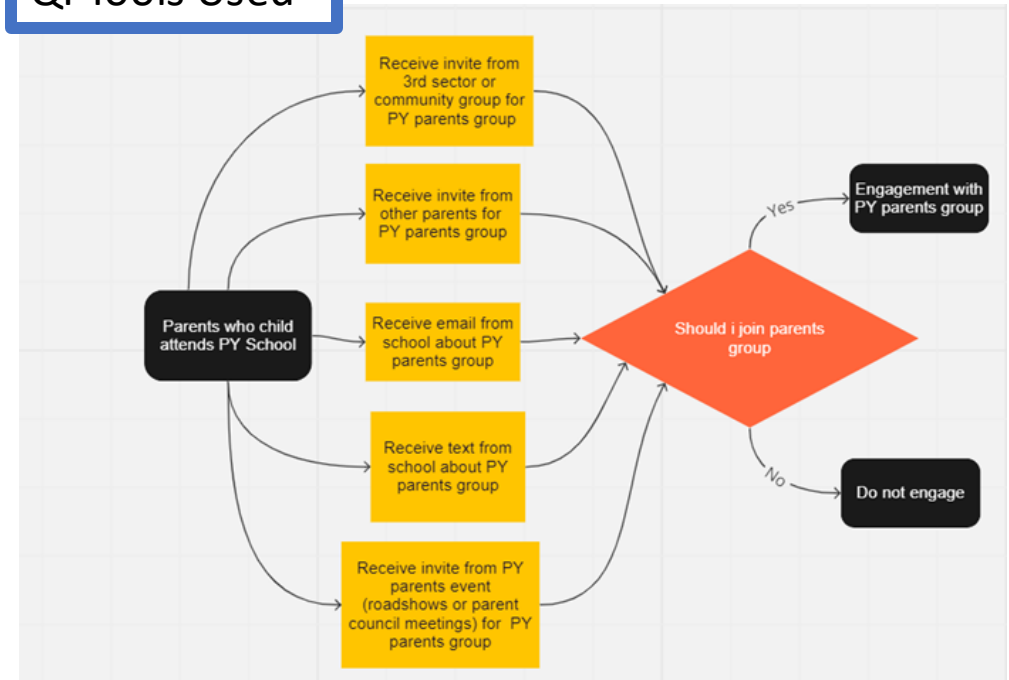
Stage of the QI Journey:

Testing Changes

Current status:

PDSAs – Testing whether sharing Planet Youth information at transition events increases the number of parents attending the parent group

QI Tools Used



Act

Small changes in how you approach parents can make a difference in sign up rates. The same approach will be used with future change ideas such as in-person meetings, flyers in public spaces and flyers sent home to parents.

Plan

Plan to new change ideas that increase the number of parents attending parents' group. The number of sign up and the number of interactions with 3rd sector groups will be measured.

Study

Slightly more parents than expected signed up to join the parents group. More parents signed up in areas where we had existing connections with the community councils and groups.

Do

Meetings with community councils were set up and they shared information on the parents group. 7 parents signed up to join future parent's meetings.

Area of Learning – Successes – Challenges

Area of Learning – The QI process provides structure and tangible steps for implementing change which are useful. The project charter was also helpful in ensuring the whole project was well thought out before I begun.

Successes – A small increase in parents signing up for the parent's group was achieved.

Challenges – Working in a system that relies on other organisations to communicate key messaging is challenging

Flash report – SIFS Cohort 2 – Anna Frankowska, Workforce System Specialist (Turas Appraisal & Turas Learn)

QI Project Team:

Turas Learn

QI Project Aim:

By end of August 2023, 95% Agenda for Change employees will have a single Turas Learn account linked with workforce information in line with NHSH Policy for Mandatory Learning. This will also link Together We Care Strategy (22-27) – Strategic Objectives 2: Our People , Ambition 8 – Plan Well – and Annual Delivery Plan 23/24 which focuses on data quality and accuracy improvement.

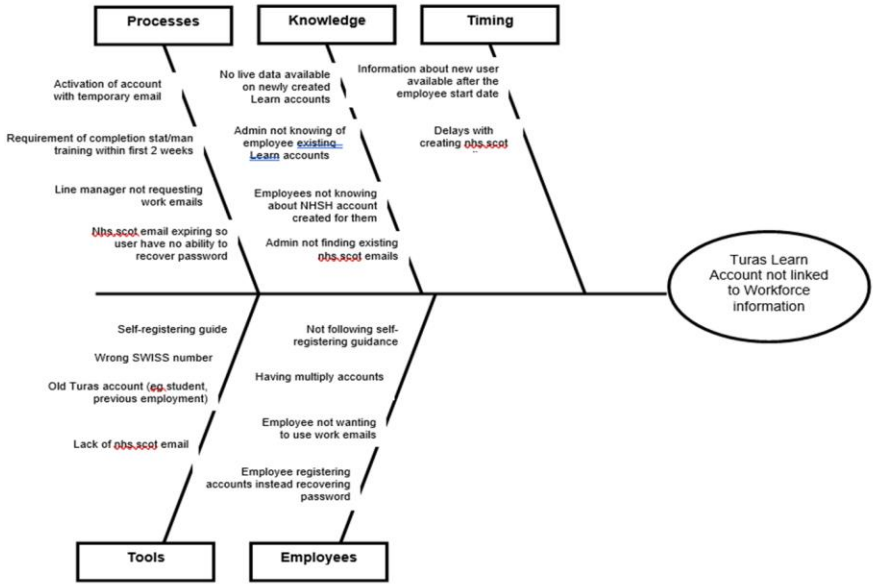
Stage of the QI Journey:

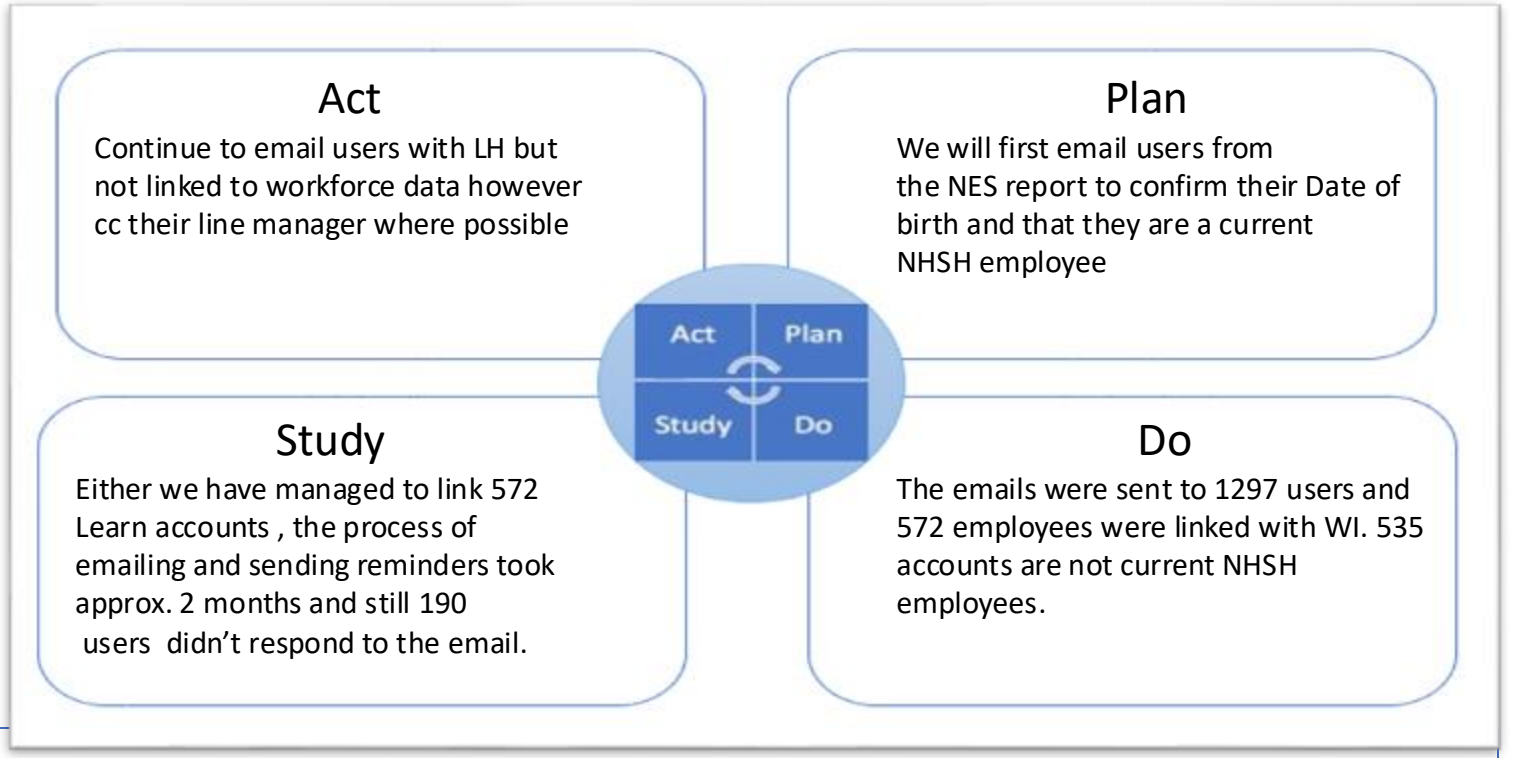
Implementing Changes

Current status:

PDSAs – Use NES report for those having learning history but no workforce data to directly email users to ensure they are NHS Highland employee and link their Learn accounts with Workforce information (WI)
Email Line Managers of those individuals who have temporary or old nhs.net emails and request to supply a valid employee email.
Replace current guidance for new starts in NHS for creating Turas Account.

QI Tools





Area of Learning – Successes – Challenges

I think this project made positive changes to our data quality. The number of Turas accounts with temporary email or old nhs.net, reduced to approximately 3% across the NHSH workforce. We will continue to contact users on a quarterly basis. The challenge is to fit this within the current workload and to get responses from the users. By including line managers in these emails will also encourage users to respond. Line managers can also let us know if the person is not currently at work for any reason.
The second PDSA brought positive changes as the new users are contacting us before creating an account. This change is not affecting the Turas support team as those employees are linked with workforce information and are using their personal email address.

Flash report – SIFS Cohort 2- Karen Thurgo

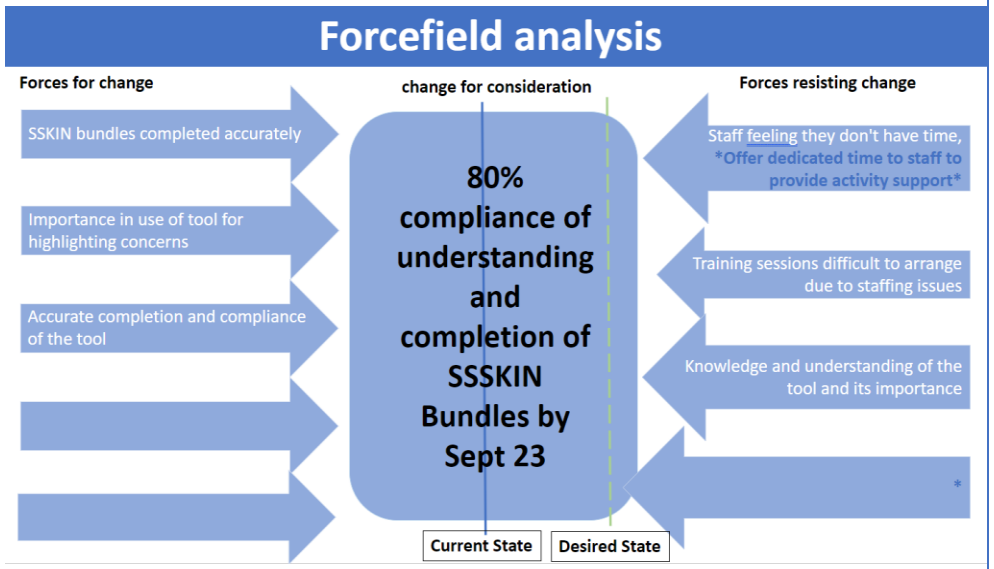
QI Project Team:
Mains House

QI Project Aim:
To improve the compliance in use of the SSKIN Bundle Tool to 80% by September 2023 in line with NiCE Quality Standard 89

Stage of the QI Journey:
Testing Changes

Current status:
PDSAs –1ST CYCLE Dedicated training meeting

QI Tool



Act
Format of session was ideal using scenario based concept on how to complete TOOL.
Smaller groups/individual sessions to test on next PDSA

Plan
To educate all care staff in the use of the tool and to audit the completion and actions from tool
Set up team to discuss project

Study
Poor attendance due to staffing levels
Reduce care provision
Poor concentration due to listening for call bells
Feed-back from participants was that the format was easy to follow

Do
Arrange dedicated session on Wednesday afternoons meeting with project team
Discuss current data and compliance
Set out aim of project
Arrange questionnaires to be distributed and collated.
Arrange training sessions for staff

Area of Learning – Successes – Challenges
Mains house is understaffed and freeing up Care staff to train and undertake the project has been difficult. Due to the importance in compliance with this document it was decided to train the Senior Carers on a 1- 1 basis to get them started . Prior to change idea we sent out questionnaires to all staff to determine their understanding of the tool but only 40% responded. We decided we need to start with 1-1 training to ensure staff are competent and confident to complete. This is taking longer than expected so our target of completion may have to be reduced to 50% by September ,Success wise the format we used achieved the result

Flash report – SIFS Cohort 2 – Kari Magee, Project Manager

QI Project Team:
Armed Forces and Veterans Project

QI Project Aim: By 30 September 2023, 100% of existing patients registered with CMP will have been asked whether they are members of the AF&V community and status recorded using READ codes in line with the Armed Forces Covenant Duty.

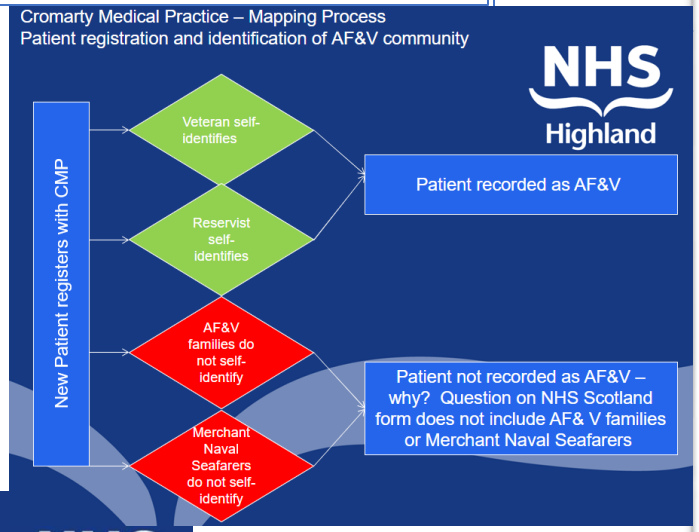
Stage of the QI Journey:

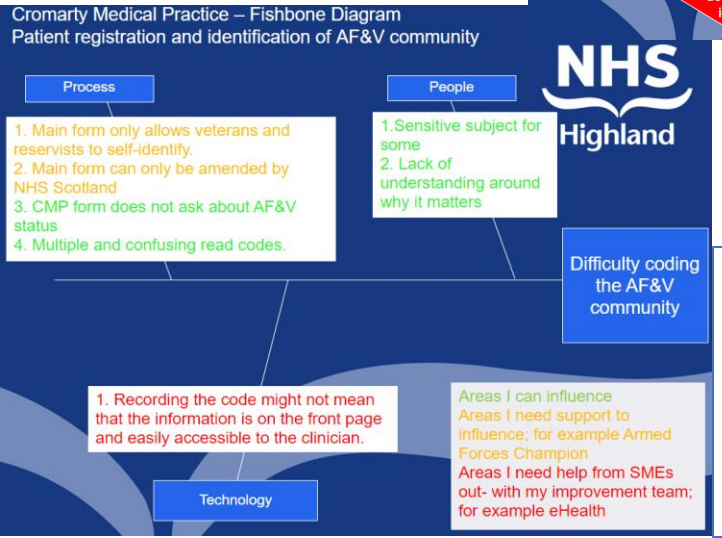
Adopting Changes

Current status:
PDSAs – adopt and identify an urban surgery to test in a different environment with a view to creating a toolkit for surgeries and rolling out the changes across NHSH's area.

QI Tools Understanding my system:

Process mapping
&
Fish Bone Diagram





Adopt – use of HCA and texts has proven very effective. CMP have shared their progress with their cluster for further consideration. I will identify an urban surgery to see whether similar results can be yielded in an urban environment or whether adaptation is necessary.

Cycle 1 – use of texts and healthcare assistant to ask the question. Seeking veteran, military family and reservist status. Positive responses recorded using Read coding.

Testing has exceeded predictions. 50% of patients asked. AF&V patients recorded has risen to 50. Balancing and mitigation – some older patients worried about scam text's but they were called and it was an opportunity to use the HCA script.

HCA starts 14 June/ Texts start 28 June – need to generate interest first. Prediction: 50% of patients asked by 14 July 23. Number of AF&V patients recorded up from 4 to 15. First run of data 14 July 23. Second run of data 12 August 23.

Area of Learning – Successes – Challenges

I spent a lot of time with the practice manager before considering changes. This was particularly useful because she highlighted a number of barriers to the test that I hadn't considered, including the need to run tests in quick succession to maximise on community interest and to minimise impact on staff time. This threw up the challenge of separating out the data – what would be more successful – the easy text message that minimised effort for both patients and staff or the more personal conversation that would take more time but would allow patients to engage more.

Flash report – SIFS Cohort 2 – Louise Henderson

QI Project Team:

ANP Team, East Highland Out of Hours

QI Project Aim:

Aim to reduce the ANP workload by 20% and promote staff-well-being and satisfaction by August 2023, in line with 'Together We Care' NHSH Strategy 2022-2027

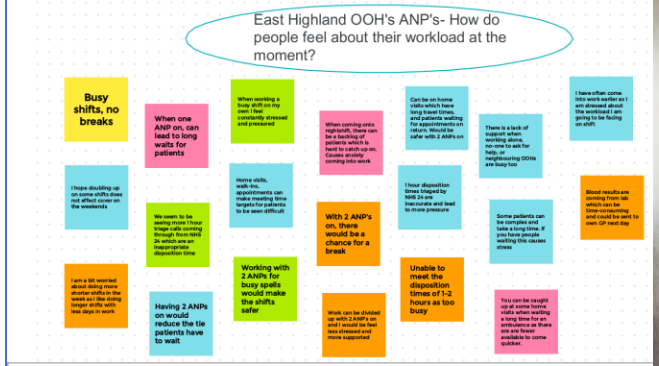
Stage of the QI Journey:

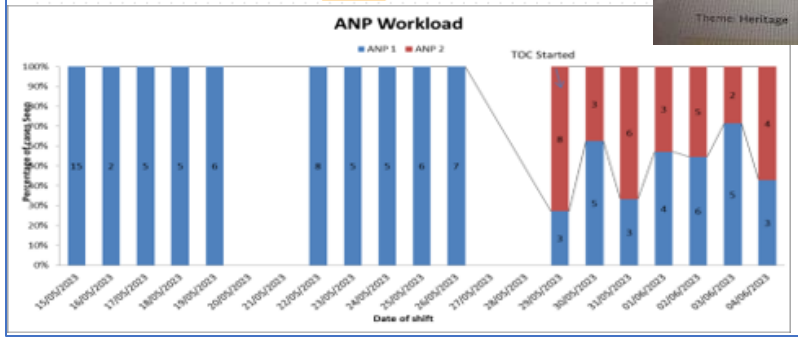
Testing Changes

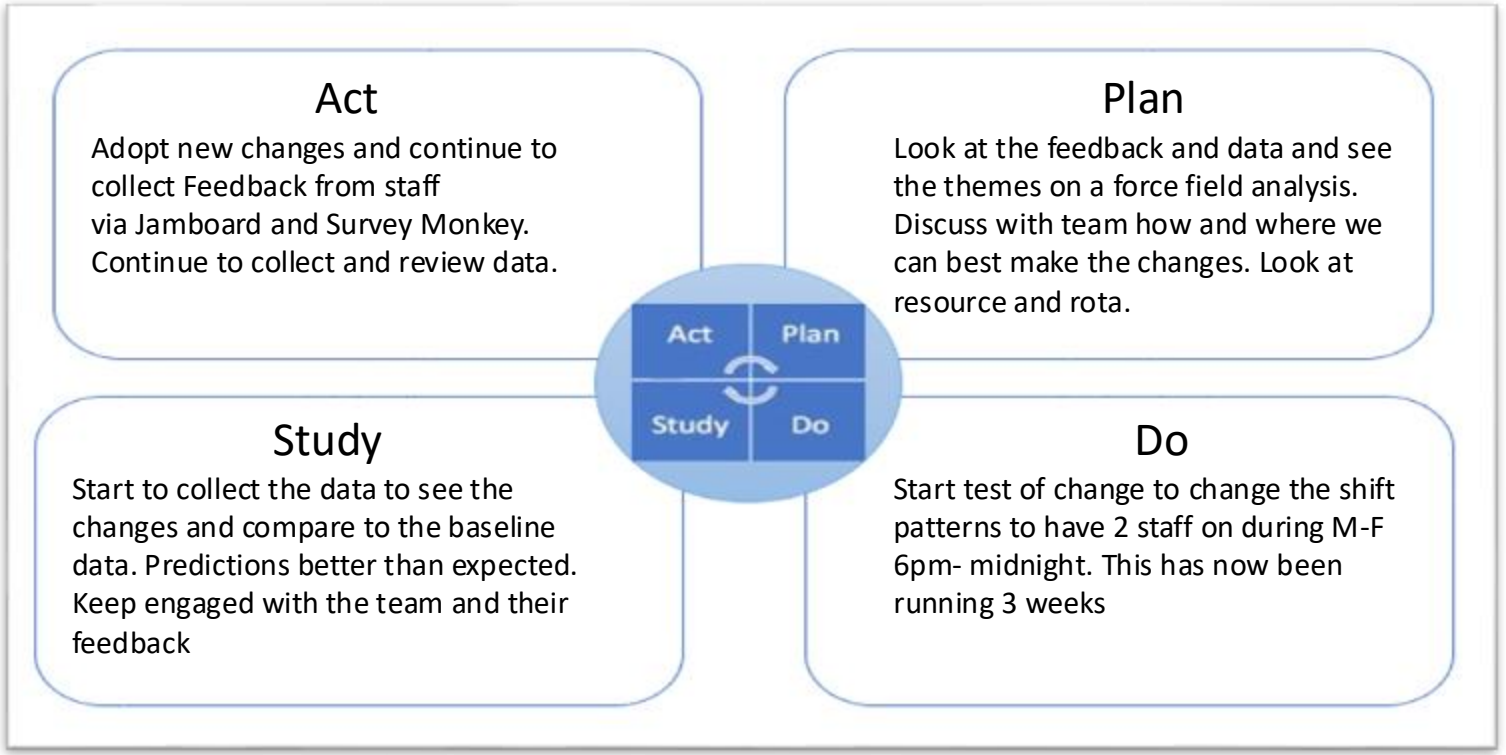
Current status:

Measurement- testing changes with shift patterns. Already taking learning from this to implement and expand.

QI Tools Used







Area of Learning – Successes – Challenges

Really good engagement and team working , communication and a feeling of being listened to is key. Our predictions in terms of data collected to date appear to better than our expectations of 20%. Challenges- some sickness so gaps in shifts where there is not always 2 people on, so need to sift through data to add annotations when this occurs.
Using PDSA cycles was really good, adpoted, abandoned and adapted a few original ideas from this.

Flash report – SIFS Cohort 2 – Rachel Ware – Project Manager

QI Project Team:
SC leadership and care home registered managers

Aim: By Dec 2023, all new social care staff will have followed the role-based induction workbook to the point of assessment within 6 months of employment as per NHSH and SSSC induction requirements.

Stage of the QI Journey:

Testing Changes

Current status: 1st PDSA cycle – To compile comprehensive list of SCA work based practices.

QI Tools

FORCE FIELD ANALYSIS

DRIVING FORCES	PROPOSED CHANGE	RESTRAINING FORCE
Evidence that all areas/ work based responsibilities are demonstrated and assessed during induction	INTRODUCE SCA ROLE BASED INDUCTION WORKBOOK (including competence sign off)	Staff in service used to working in a certain way
Knowledge that all staff are assessed as competent in their role		Current lack of understanding and consistence of SCA role across Care home area.
All SCA staff in the 16 NHS Highland Care homes working to the same standards		Appropriate supernumerary time set aside for new staff
Mentors aware of what tasks/ responsibilities need to be demonstrated during shadowing period		Lack of role based theory workshops provided during induction
Identifies ongoing training needs		
Increased confidence of inductees starting their role		

Act

Adapt – collection method to a direct observation and questioning of SCA carrying out role in 2 in-house care homes.
Adopt – current draft of work practices as initial template
Abandon – Email circulation to managers as collection method

Plan

Information gained from questionnaire identified a lack of consistency in relation to competencies that are assessed at induction. Following completion of a draft SCA work practices document, require consultation with work bases to obtain confirmation if the document is comprehensive.

Study

Only a 25% response rate was achieved.
Returns simply confirmed if practices were carried out, no additional information added.

Do

We will circulate the draft work practices list to managers of the care homes to discover if all work practices have been captured.

Area of Learning – Successes – Challenges:

Following on from my MSc dissertation and examining a number of exit interviews it was clear that a large number of staff felt that they were not adequately inducted into their role before expected to undertake it independently. An initial questionnaire was used to ascertain information on the current role-based inductions processes that are in place, in relation to competencies, supernumerary status and mentor support. Force field analysis undertaken surrounding the potential of a role-based workbook. Number of tests of change discussed : allocation of mentor, introduction of comprehensive work practices list, number of supernumerary hours allocated.

Flash report – SIFS Cohort 2 – Lauren Baird, Beverley Green, Dorota Piotrowicz - Project Managers

QI Project Team:
Project Managers within Strategy and Transformation Team

QI Project Aim:

To create a "Project Initiation Checklist" which will provide assurance of a consistent approach to project management, for projects aligned with the Together We Care Strategy in NHSH. This checklist will be used by 100% of Project Managers within the Strategy and Transformation team by 30th July 2023.

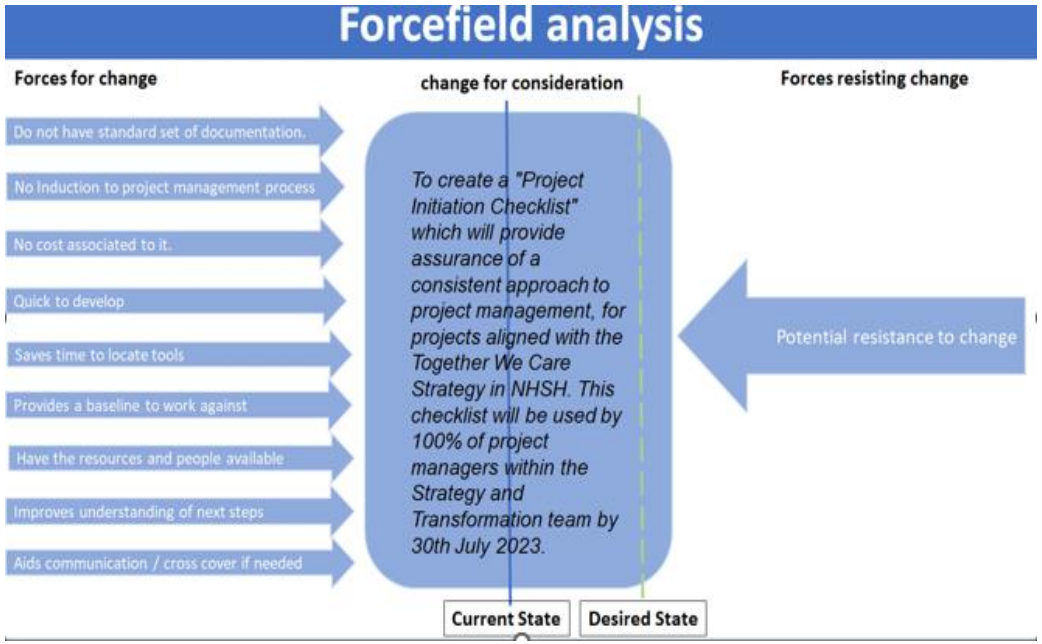
Stage of the QI Journey:

Testing Changes

Current status:

PDSA cycle 1
Define best practice and capture any lessons learnt.
Compile a list of all project documentation needed to monitor and control the project throughout its lifecycle.
To develop a checklist. Test the checklist created.

QI Tool



With the comments and feedback received, we will now amend the checklist as per below (PDSA 2)

- Add in the individual document names under each stage
- Include fields for the Programme Manager, Programme Board and ADP objective
- Differentiate between essential documents and desirable documents

Will test updated checklist against measurement plan

- Capture previous lessons learnt.
- Develop checklist
- Evaluate checklist against measurement plan through discussion and survey

Feedback received:-

- 71% of respondents said checklist did not make them feel more confident however could see the benefit with further iterations
- Collated qualitative data

- Collated information from a previous survey regarding project documentation
- Created first draft of Project Checklist using above information and shared with Project Management team
- Created a survey poll and asked for feedback/comments

Area of Learning – Successes – Challenges

1. It has been a challenge at times to do this project as a team due to conflicting demands – annual leave etc
2. We have had good engagement from the Project Management team, and everyone has been receptive into this new way of working which has helped massively with this test of change
3. We have successfully used more than one QI tool and developed our knowledge more in using these.
4. We have learnt that the current checklist we developed in the first PDSA cycle is not fit for purpose however the concept of a checklist is desirable amongst the team so we will further develop this in the next PDSA cycle.
5. We have learnt that the timeline of our project aim did not take into consideration other demands – longer timeline needed for PDSA cycle 2

Flash report – SIFS Cohort 2 – Jillian Schurei, SCN Ward 3C

QI Project Team:
Ward 3c,- Elective Orthopaedics, Raigmore

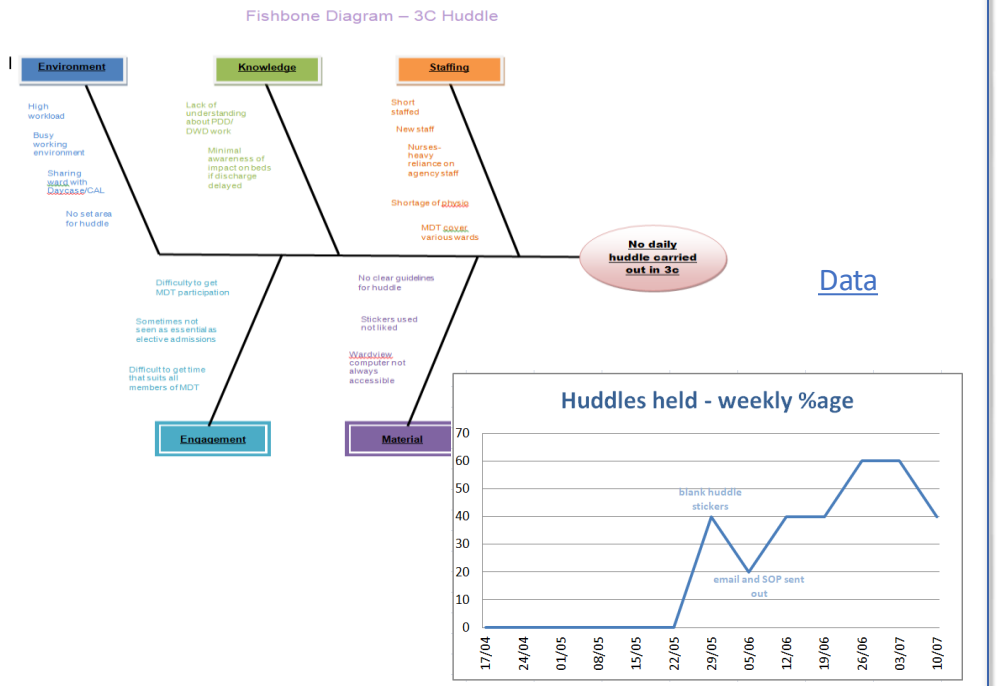
QI Project Aim: By Sept 2023 Ward 3C will complete 60% of daily huddles Monday-Friday in line with the NHS Scotland: Centre for Sustainable Delivery 'Discharge without Delay' paper

Stage of the QI Journey:

Testing Changes

Current status:
PDSA cycle 2
Looking at changing time of huddle to see if MDT attendance/participation improves.
Measure attendance of MDT members at each huddle

QI Tool



Data

Act
- Continue with changes already made
- Huddle stickers (Adopt at present – adapt at later date when huddle more established)
- SOP (Adopt) – helpful for new staff
- PDSA Cycle 2 focusing on changing timing of huddle to hopefully increase MDT attendance

Plan
- Initially implement small changes (as detailed in Do section) – measuring attendance Mon-Fri
- Engage with staff that are substantive in post
- Reinforce huddle is a mandatory requirement for all wards to improve a patient's journey and reduce delayed discharges
- Work together to find a solution that meets every discipline's availability
- Capture baseline data

Study
- As predicated still difficult to get MDT representation at huddles
- Huddles still mainly reliant on SCN/SSN
- Data reviewed - small improvement in % of huddle carried out noted but still room for improvement
- Feedback from MDT members suggests current 1015hrs not suitable due to staff breaks

Do
- Change from disliked stickers to blank huddle stickers
- Complete SOP to help staff awareness of expectations from huddle
- Email staff info about DWD/PDD work
- Reminder about huddle at safety brief each morning
- Buy in from SSN to help with data collection
- Collect data weekly

Area of Learning – Successes – Challenges

Area of Learning – Recognising the importance for starting a project on a small scale and setting a realistic timeframe to achieve aim; importance of getting staff on board to change idea and understanding reason for project. All sessions of course been extremely helpful/beneficial for current and future projects.

Successes – Although we have not yet achieved 60% compliance of daily huddle consistently, I definitely feel that a small improvement is better than no improvement and will hopefully result in good patient outcomes eg patients better informed of discharge date/ reduced LOS for each individual if discharge well planned and patients well informed. Positive feedback received in respect of change in huddle stickers.

Challenges – Minimal substantive staff in post in nursing and physio teams which may have hindered consistent compliance of huddles - heavy reliance on different agency staff.

Our next planned test is to change the time of the huddle to an agreed time to ascertain whether this improves huddle compliance/MDT representation. Will continue with PDSA cycle until 100% huddles achieved. Whilst daily huddles are a mandatory requirement and should in theory be easier to implement in an elective ward, in practice it actually proves more of a challenge.

Flash report – SIFS Cohort 2 – Amy Smyth, Workforce Systems Specialist (Jobtrain)

QI Project Team:

Workforce Systems Team/Recruitment Team within People & Culture

QI Project Aim:

Reduce Jobtrain data quality errors to under 10% by September 2023 to enable accurate reporting of number of vacancies per job family, in line with metrics set for ADP 2023/24 (linked to Together we Care Strategy)

Stage of the QI Journey:

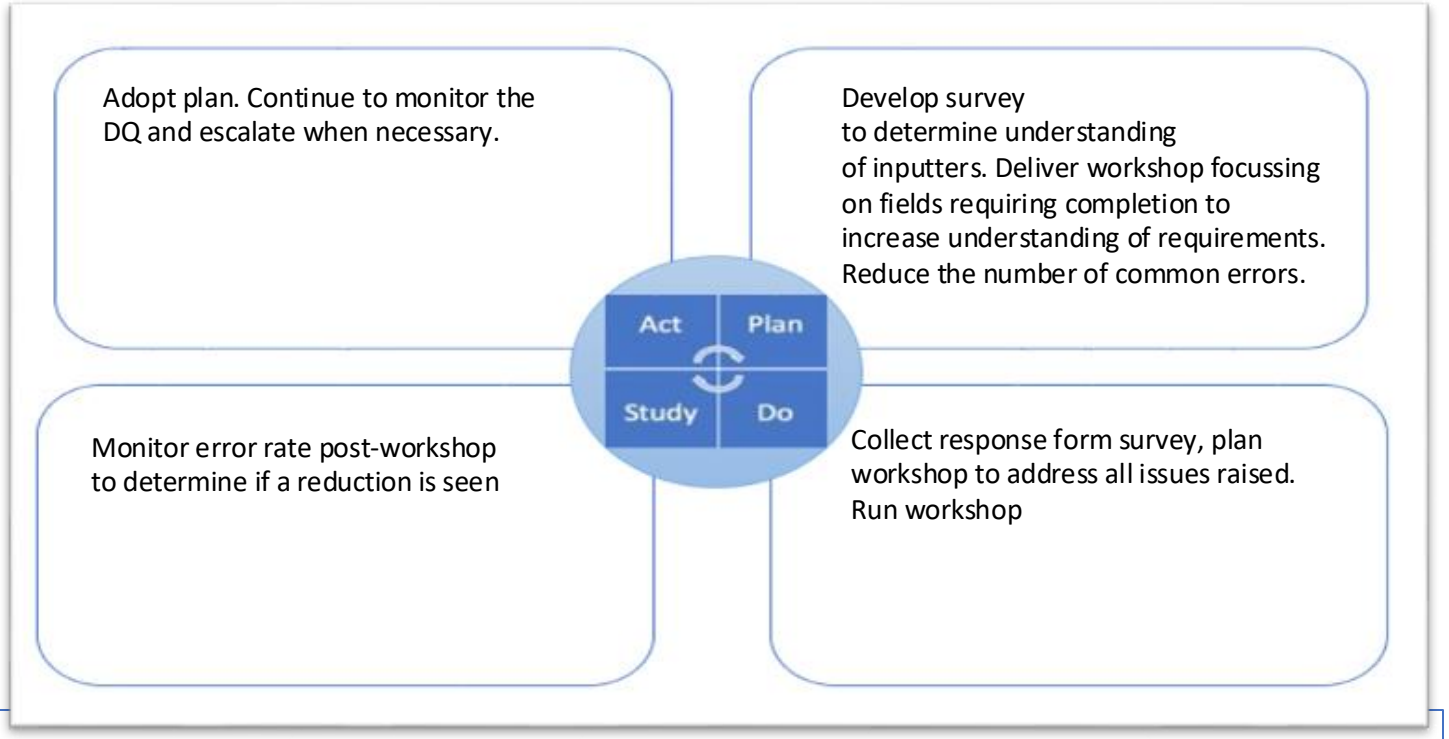
Testing Changes

Current status:

PDSAs – develop understanding of data quality and importance of fields. Deliver workshop focusing on data fields requiring completion within Jobtrain, their importance and escalation

QI Tools used

Data



Area of Learning – Successes – Challenges

1. It has been a challenge to set time aside for this project due to conflicting demands between the teams involved in the improvements
2. Engagement from the team who input to the system has been lacking which has hindered this test of change
3. We have agreed the workshop content covering the fields required
4. I have learned a lot of new things i.e QI tools
5. The timeline of my project aim did not take into account to allow time to see a reduction in inputting errors

Cohort 3

Flash report – SIFS Cohort 3 – Lorna Renwick

QI Project Team: Lorna Renwick & HV team Inverness West

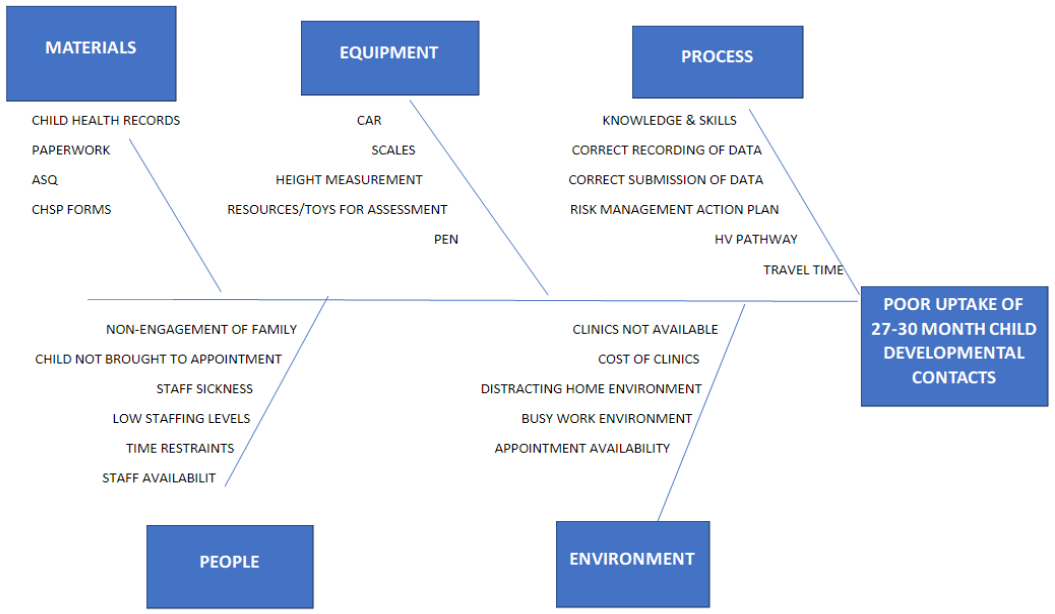
QI Project Aim: By March 24, the uptake of 27-30m contacts will increase to 95%, in line with the Integrated Childrens Services Performance Management Framework.

Stage of the QI Journey:

Return to Understanding my System

Current status: second PDSA cycle started 13/11/23- one team selected to implement project. Data reporting training arranged.

QI Tools – Fishbone



Act

- Project too big- next PDSA cycle to focus on one team
- Provide training for correct completion of CHSP forms

Plan:

- Communicate to teams what is required and why
- Update action plans to prioritise 27-30m contact
- Request access to data platform
- Provide clinics and bank staff for teams with lower staffing.

Study

- Minimal improvement in data reports
- Data forms incomplete/incorrect

Do:

- Not all teams able to prioritise contact due to staffing pressures
- Data collection forms not completed correctly and in a timely manner.

Area of Learning – Successes – Challenges

I have learnt that my initial project was too big therefore moving forward, I will concentrate on one team at a time rather than Highland as a whole. The first PDSA cycle demonstrated that child health surveillance forms were incomplete, thus impacting data collection. I have learnt that there is a requirement for training to ensure accurate reporting or data.

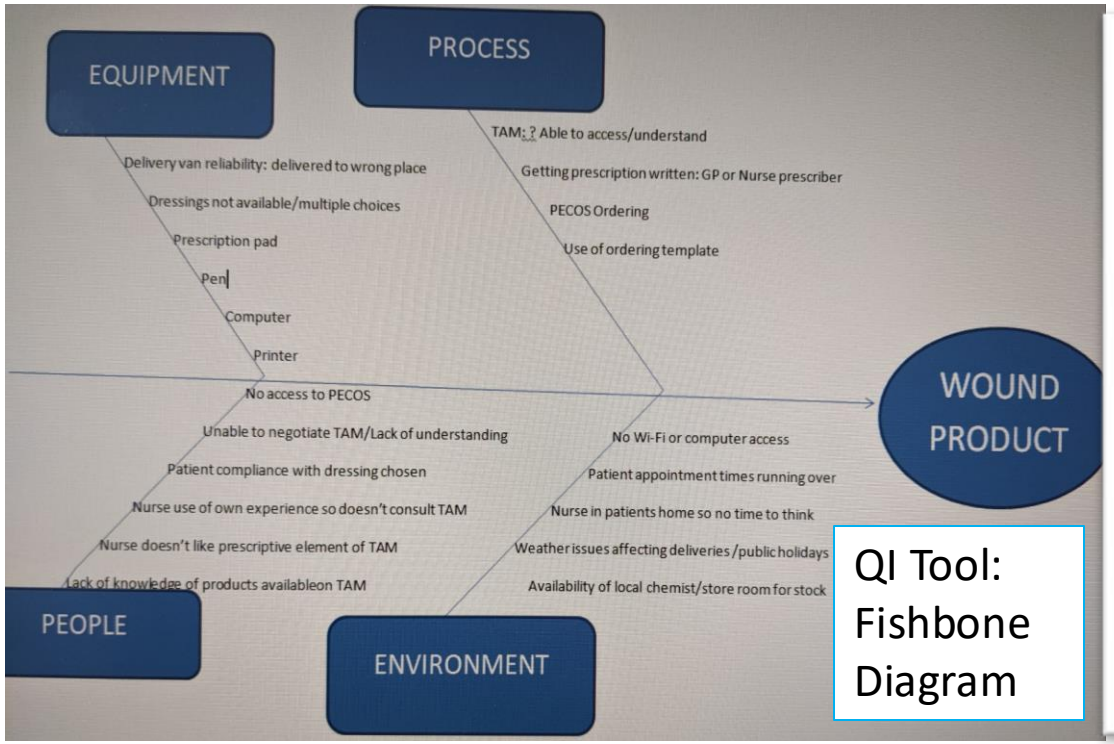
Flash report – SIFS Cohort 3 – Tracy Sutherland

QI Project Team: Tracy Sutherland, Pharmacy Technicians; Dingwall, Dornoch, Munlochy Medical Practices, TV & procurement

QI Project Aim: By December 2023 there will be a reduction of 20% of the off formulary wound care items prescribed in Dingwall Medical practice, Dornoch Medical Practice and Munlochy Medical Practice and as per TAM Wound Care Formulary aligning to HHCSP savings aims for 2023/2024

Stage of the QI Journey: Testing changes

Current status: The project is ongoing. I have sent the booklet to TVLG for ratification and hope once achieved this will be sent out across North Highland. Initial results look promising with a reduction in off formulary spending expecting to be reduced by more than 20% by December 2023



QI Tool: Fishbone Diagram

Act

Cycle 1: 25/10/23: Add pathway(TIMERS) to booklet and PECOS codes to make the booklet more user friendly

Cycle 2: 31/10/23 Booklet sent to TVLG for ratification so whole North NHS Highland roll out can begin. Explanation sent out by TV and myself that all emails from myself for training events would be only for formulary products even though sessions being run by product reps

Plan

Cycle 1: 10/10/23: Following data analysis from questionnaire and Fishbone develop a wound care booklet

Cycle 2: 26/10/23: Contact reps and get samples of the different products and their sizes and redevelop booklet and run more product specific education sessions

Study

Cycle 1: 25/10/23: The booklet lacked information that nurses needed although was good for the pharmacists, so nurses still wanted products that weren't always appropriate as lack of understanding how to use the products appropriately

Cycle 2: 31/10/23: Initial reports look good (PRISMS data not yet available). Feedback is positive in booklet being useful/helpful but not all emails being passed to practice nurses for them to be able to attend as lack of understanding that the sessions did only promote formulary products

Do

Cycle 1: 10/10/23: Give out booklet and explain how to use it. Practices liked the booklet and felt it made their prescribing role easier which was what I had predicted

Cycle 2; 26/10/23: Not all practices passing on education events to the nurses. Needed to explain to practice managers about the teaching sessions I was organising as they weren't passing the sessions emails to the practice nurses which was unexpected

Area of Learning – Successes – Challenges

- **SUCCESSES:** The nurses and pharmacy technicians liked the booklet and found it useful. Initial reports have shown that other practices are looking at their repeat prescribing and changing to formulary items, so savings are already being made
- **CHALLENGES:** Originally it was getting buy-in for my project with other departments who all felt they were too busy to help, this became a success after I produced the original booklet, and they could see the benefit. Getting nurses to realise the benefit of keeping to formulary. Putting the cost benefit in how many nurses the overspend would have created made the amounts involved more "real" to them and got better buy-in for the project. The length of time it is going to take to get the booklet ratified so it can go beyond just the select few teams who are piloting. Getting practices to pass all training events to practice nurses and then getting them to attend. Tissue Viability to make wound training mandatory for nurses so this challenge is being addressed

Flash report – SIFS Cohort 3 – Debbie Fraser, ANP Deputy Lead

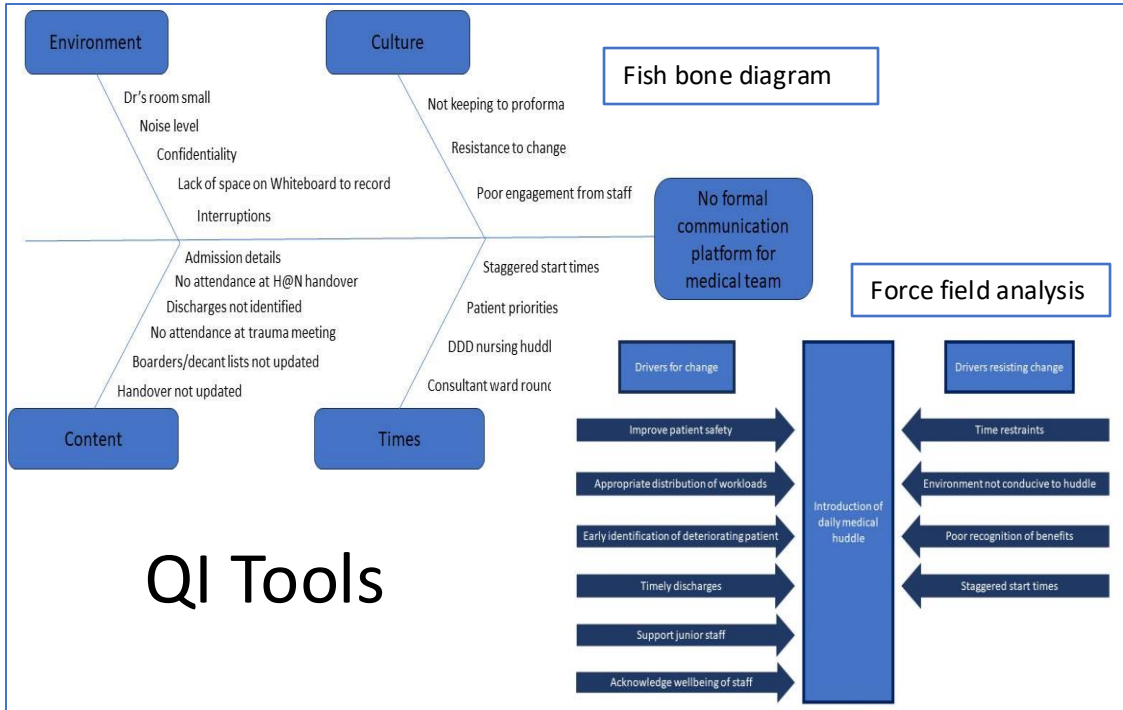
QI Project Team: Ward 3A, Raigmore Hospital

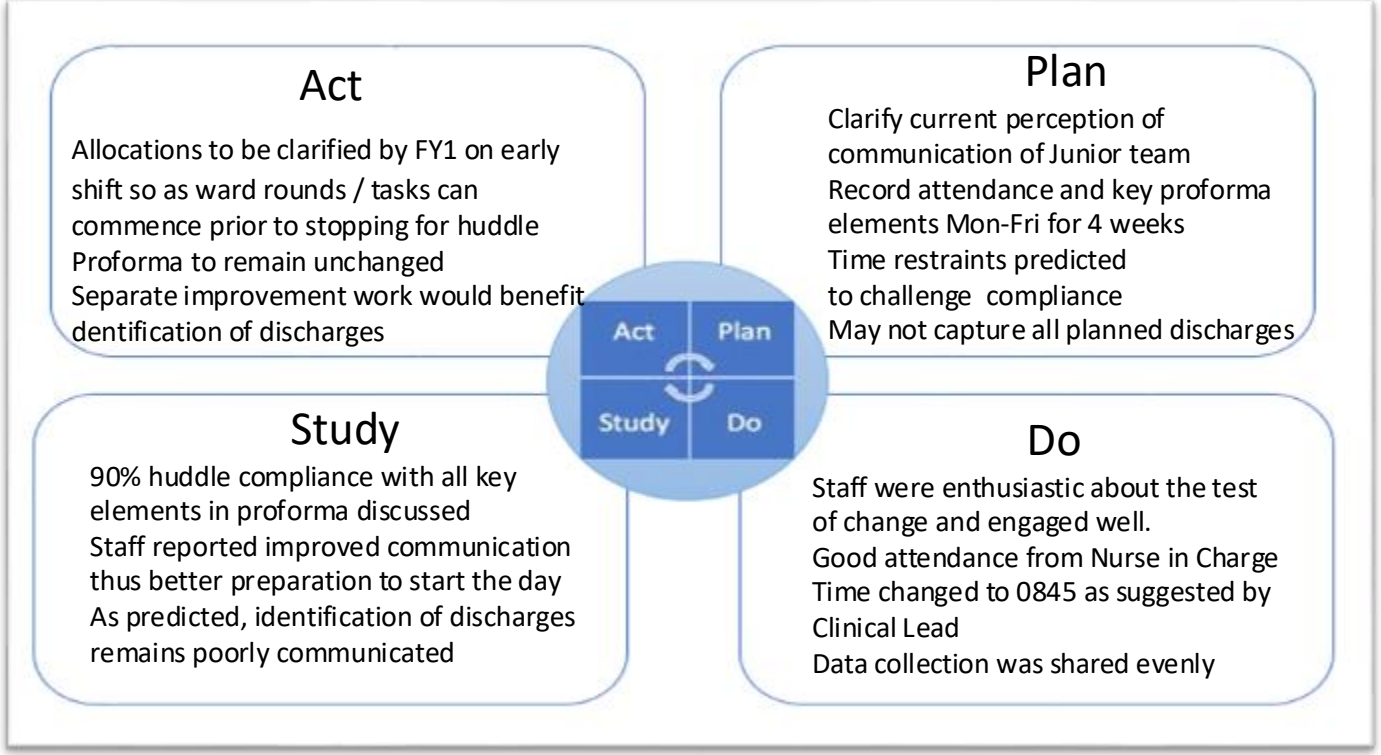
QI Project Aim: Introduction of daily medical huddles on ward 3A to improve communication with compliance rate of 60% by December 2023 in line with recommendations from Healthcare Improvement Scotland 2021

Stage of the QI Journey: Testing changes

Current status:
PDSA 1 completed > adapt.
PDSA 2 to commence 6/12/23 in line with new Junior Medical team rotation

QI Tools





Area of Learning – Successes – Challenges

Staff reported improved communication and felt better supported.
Deteriorating patients were reviewed more promptly (although this was not formally measured)
Identification of patient discharges remains poorly communicated and would likely benefit from separate improvement work

Flash report – SIFS Cohort 3 - S/N S Frame & SSN Doreen MacDonald

QI Project Team:
Ward 7C
Raigmore Hospital

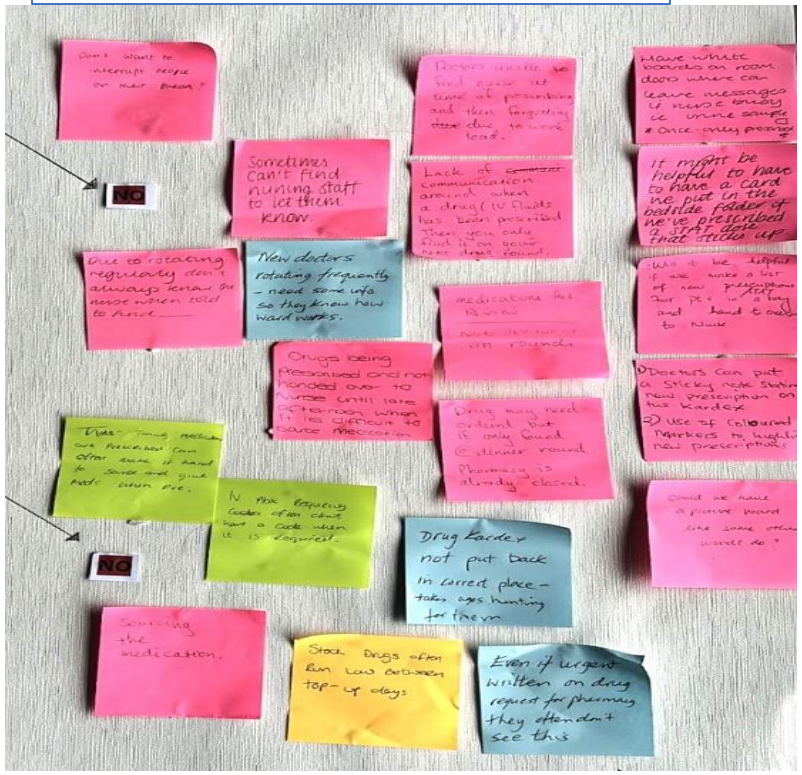
QI Project Aim:
By the end of Jan 2024 all new medicines prescribed whilst in ward 7c will be administered on the day of prescribing

Stage of the QI Journey:
Testing Changes

Current status:
Testing first change

QI Tools Used

Process Mapping



- Pen attached to beside laminates
- Laminates out on Dr's ward round trolley
- Jars and counters outside patient's rooms to help make it easy for staff to collect data
- Notice in Dr's room changed weekly to remind them of laminates

- All trained staff informed of upcoming project
- Enlisted help of 2 medics to assist with collecting data /disseminating information
- Baseline data collected Mon to Fri 0900-1630hrs for 2 weeks

Act | Plan | Study | Do

- Dr's/NPs not completing laminate on each occasion. Difficulty finding pens, rushed and laminates not near them on ward rounds
- Difficult getting data collection done when project staff not on shift

- Microsoft online survey issued for staff on the ward to complete
- Wipeclean template made for staff to write on re new medications prescribed- bright orange in colour
- One patient, one room tested using new template for new medication prescribed

Area of Learning – Successes – Challenges

Area of learning/ successes - Making the Microsoft online survey and distributing throughout the team to help staff engagement and convenient access for staff to contribute their ideas/ opinions as ward often so busy. This was also helped involve the team in project decision making as using the new process helped staff feel more a part of the change. Laminates started being used already and staff saying they are helping as they are a good visual prompt. Jars and counters are better for collecting data.

Challenges - Trying to get staff engagement. We also have a high turnover of medical staff so it is hard trying to keep new staff updated and getting them engaged in the process too. Collection of data can be sporadic especially when project staff are not on shift. Ongoing prompting of staff when they forget to use laminates.

Flash report – SIFS Cohort 3 by Abby Chambers, Senior Staff Nurse, GA

QI Project Team:

Abby Chambers – lead
Ward GA nursing team

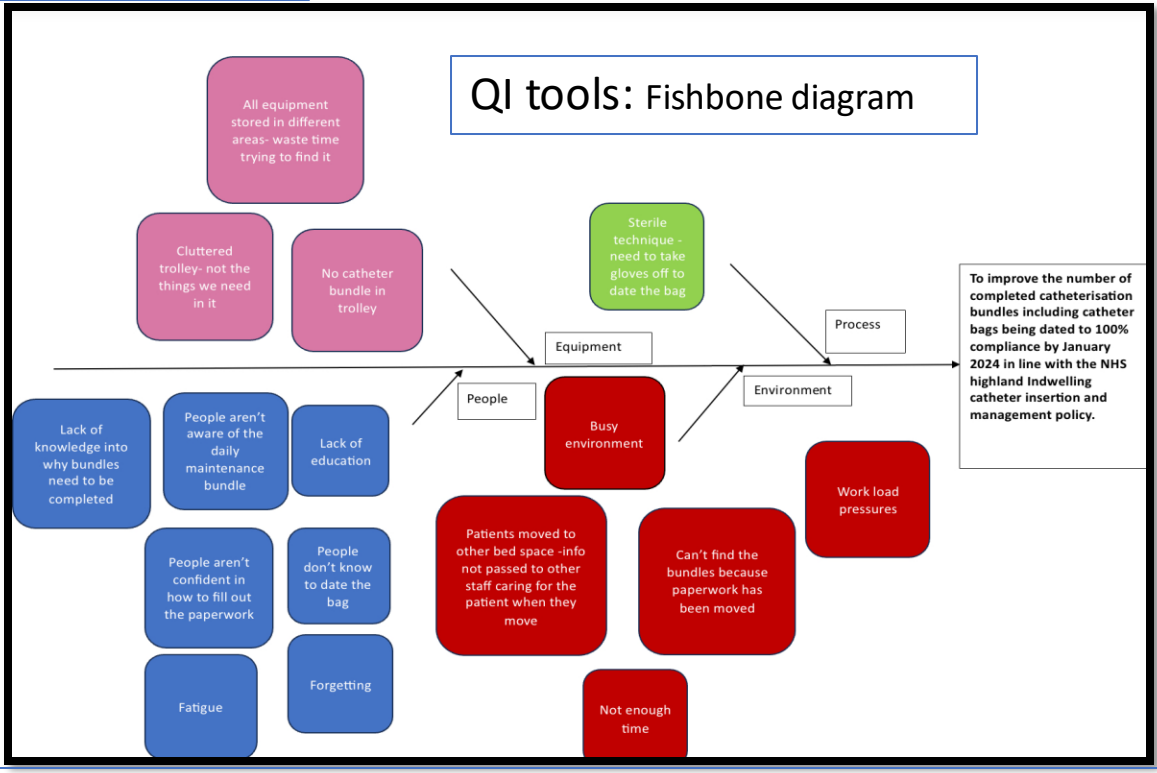
QI Project Aim: To improve catheter care in ward GA specifically the completion of catheter bundles and the dating of catheter bags to 100% by January 2024, in line with NHS Highland Indwelling catheter insertion and management policy.

Stage of the QI Journey:
Testing changes

Current status:

1st PDSA cycle completed, "revamp catheter trolley," adopted and adapted – 2nd PDSA cycle in process currently. Continue measuring by audits catheter care documentation, catheter bags dates and catheter trolley stock.

QI tools: Fishbone diagram



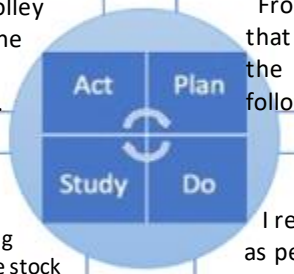
Act

We are going to adopt the trolley in GA and continue to use it but move to our next a PDSA cycle.
This will aim to support staff knowledge on how to re-stock the trolley testing a laminated pictograph attached to the trolley to direct staff. We will also trial adding the catheter trolley check to the daily triage checklist so that it is routinely restocked.

Plan

PDSA 1 – Catheter trolly revamp
Test that if the trolley is well organised then staff will follow the correct procedure as per NHS Highland guidelines.

From our fishbone we discovered that messiness of the trolley was one of the reasons staff felt unable to follow procedure fully.



Study

No improvement in the percentage of documentation being completed or bags being dated as per guidelines. Through auditing the stock in the trolley on a fortnightly basis I have found that the trolley is not being restocked correctly.
Band 5 staff have fed back that they like the new trolley but often have found it is not stocked when they need to use it. This has drawn me to the conclusion that a second PDSA is warranted to test some further change ideas.

Do

I reorganised ward GA's catheterisation trolley as per the order of procedure/process as per NHS highland catheterisation policy. Including the catheter care bundles in the final drawer of the trolley to prompt staff to complete. I created I laminated sign above the trolley to highlight its location and also include a reminder about dating the bags and completing the paperwork.

Area of Learning – Successes – Challenges

Successes

Staff Feedback: positive feedback from staff about the creation of the trolley **QI Tools**: Engaging & supporting staff to get involved with ideas for change
Improving staff knowledge & understanding: I found that knowledge around catheter care was lacking when I spent time brainstorming with staff so this allowed me to focus energy on education

Challenges

New processes: I have found that the trolley is being used but is not being restocked which is inconvenient for the next time it is needed, I understand new changes take time to embed.
Data: I have found it very difficult to obtain harm data regarding catheter associated UTIs – this is an ongoing challenge. The Infection Control team do not gather data on CAUTI so I will look at alternative sources.
Communication: Due to the vast size of the GA nursing team I have found communicating change to the team to be a challenge. In my second PDSA cycle I have utilised the GA WhatsApp group to communicate change.
Staff buy in: Maintaining focus on improvement is difficult in a busy receiving area and the comment of ,"not more paperwork," has been mentioned at times. Currently in GA there are a number of QI projects ongoing and this can be overwhelming for the staff when they are already working at peak capacity. Going forward I remain mindful of this but I am confident we will get there.

Flash report – SIFS Cohort 3 – Kirsty Mclaughlin

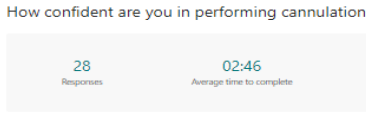
QI Project Team:
Kirsty McLaughlin & Ward 6C Raigmore

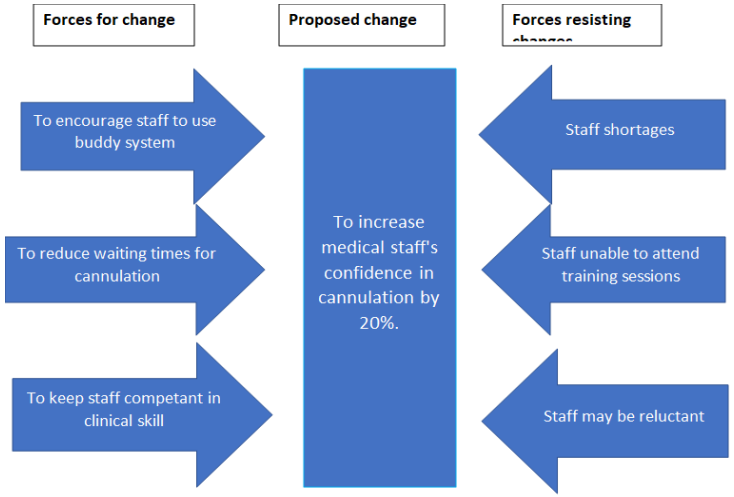
QI Project Aim:
To increase nursing staff confidence by 20% in performing cannulation through a buddy system provided by assistant practitioners by March 2024.

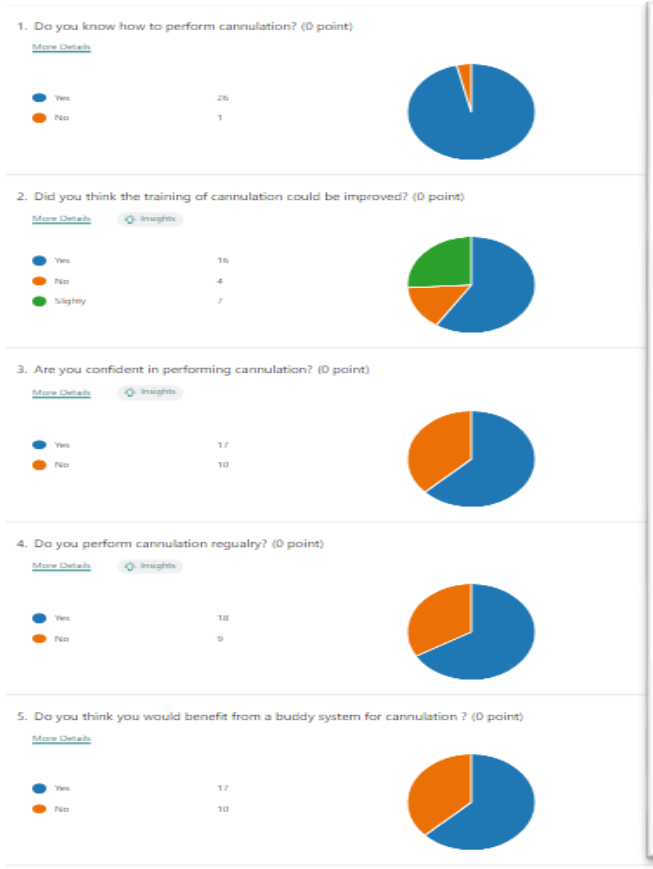
Stage of the QI Journey:
Testing changes

Current status:
Testing if a buddy system with staff improves their confidence in cannulation.

QI Tools – Staff Survey & Forcefield Analysis

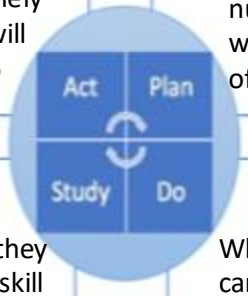






Act
I will adapt this test .My next test will be to further widen the staff I teach but also explain my job role. I realised staff are not aware of what my purpose is in discussion with nursing staff who believe it is solely to cannulate & take bloods. I will also create new materials to advertise & help learning.

Plan
Test a buddy system for nursing staff to increase their confidence in cannulation and reduce my day-to-day workload of routine cannulation. Invite 1 nursing staff member to buddy with me from Ward 6C (an area of regular high requests)



Study
The 3 staff I spent time with felt they had more confidence to use this skill and would now attempt cannulation themselves before calling me. I felt this was time well spent and will collect data around no. of requests to assess the impact this has.

Do
When I put out the offer 3 staff came back to me asking to buddy up – I decided to support all 3 nurses and took them through training then supervised practice in cannulation

Successes – Challenges - Learning

Successes - The feedback I received from participant's was positive they felt like they benefited from the buddy system and felt like it was more of a supportive way to learn.
Challenges - It's difficult to get staff members who are willing to participate in the buddy system. Some staff see the issue however are not willing to help make a change.
Learning - In the Next PDSA cycle I will approach this differently by advertising the buddy system better (i.e making posters and putting it in staff rooms). I will also be creating a step-by-step guide on cannulation as I think visually this will help. Also perhaps approaching the newly qualified nurses may be a starting point as they might be more keen to participate.

Flash report – SIFS Cohort 3 – David Hockley, Assistant Practitioner

QI Project Team:

Microbiology dept.
7C Gastro / Renal Team.

QI Project Aim:

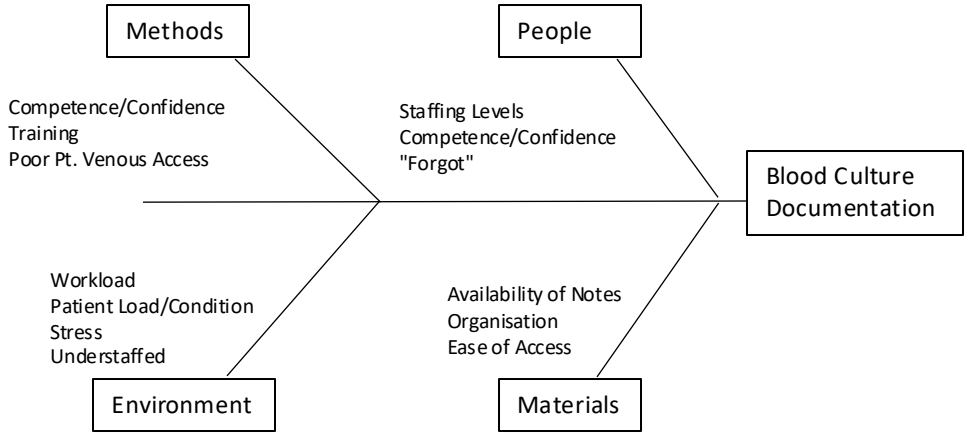
"By March 2024, 100% of patients requiring multiple Blood Culture sampling will have appropriate documentation as per NHS Highland Peripheral Blood Culture Collection Standard Operating Procedure."

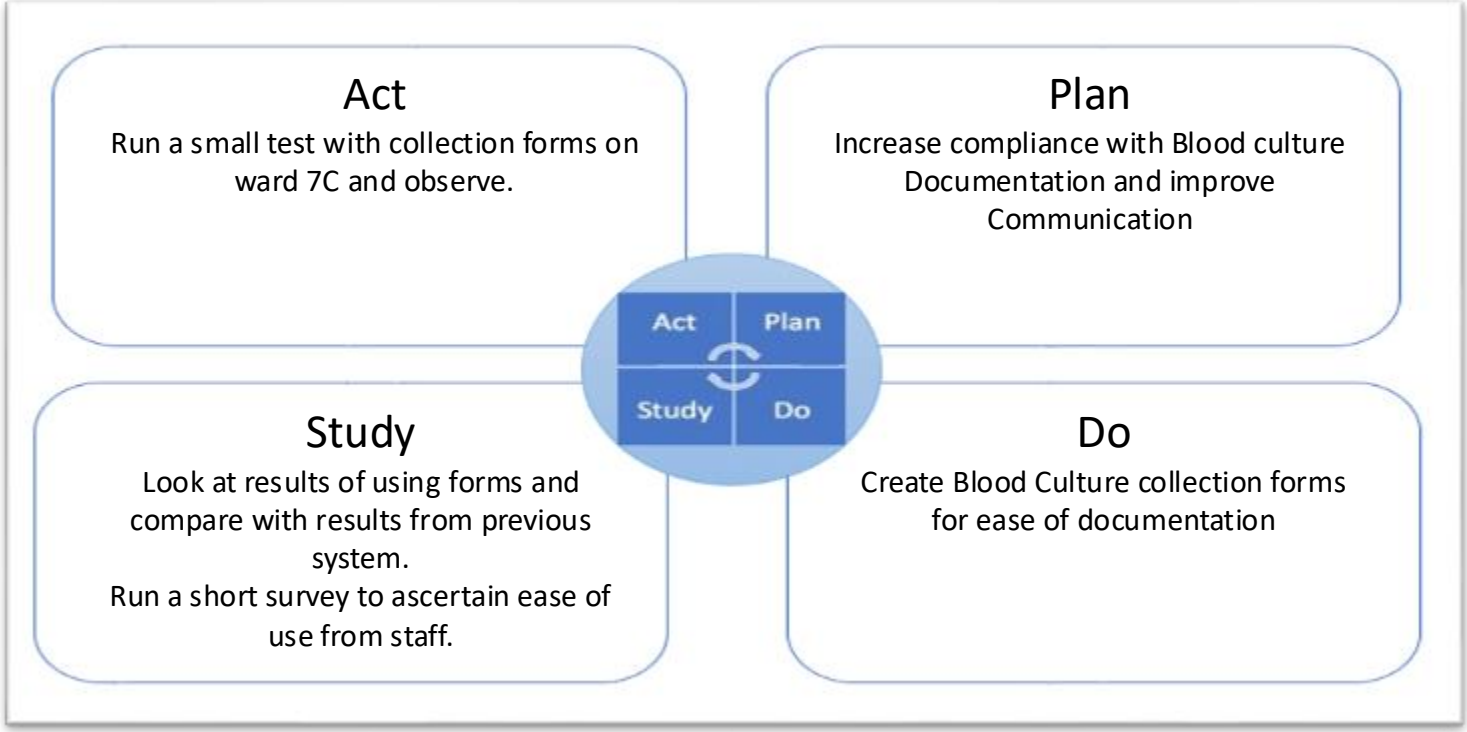
Stage of the QI Journey: 4

"Testing Changes"

Current Status:

Small trial underway on 7C, and will reassess and evaluate at the end of the trial period (10/12/23)





Area of Learning – Successes – Challenges

Communicating with the teams has proved challenging due to staffing levels and a constantly busy environment.
Ensuring anonymity of the patients and working around it has also been difficult. I have compiled raw data from results reporting and notes held at ward level.
While this will give a reasonable indication of correct documentation, there is scope for errors; This is mitigated in part by ensuring both datasets are from the same date range.
Culture collection forms created and a short testing period of two weeks to begin soon (27/11/23).

Cohort 4

Flash report – SIFS Cohort 4 – Claire Laurie

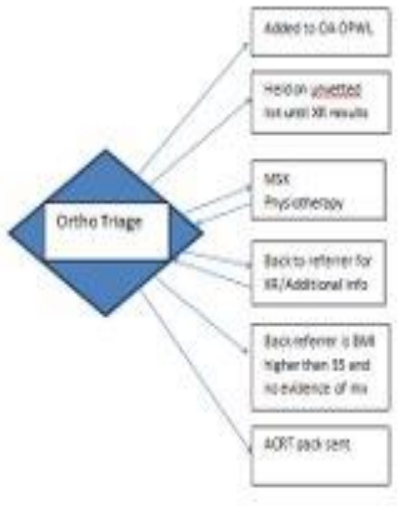
QI Project Team:
Advanced Physiotherapy Practitioner in Orthopaedics.

QI Project Aim: Develop an arthroplasty SCI gateway referral proforma for Orthopaedics to ensure that 90% of GP referrals have appropriate information, in order to make an ACRT decision, aligning with Modernising Patient pathways and Realistic Medicine by March 2024.

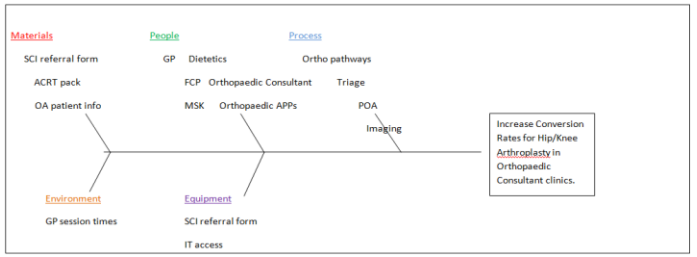
Stage of the QI Journey:

Current status: TESTING CHANGES

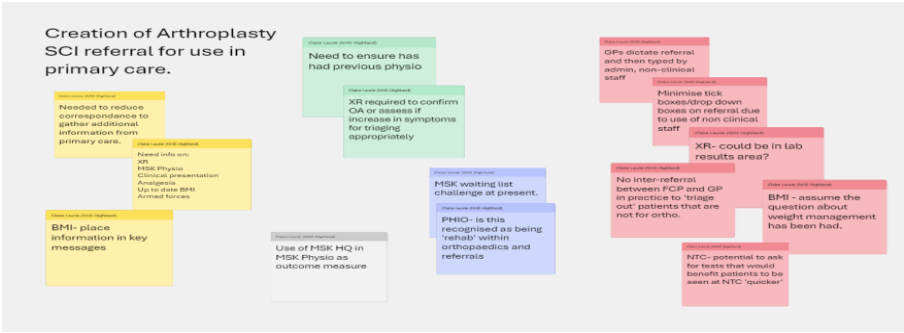
Current Process Diagram:

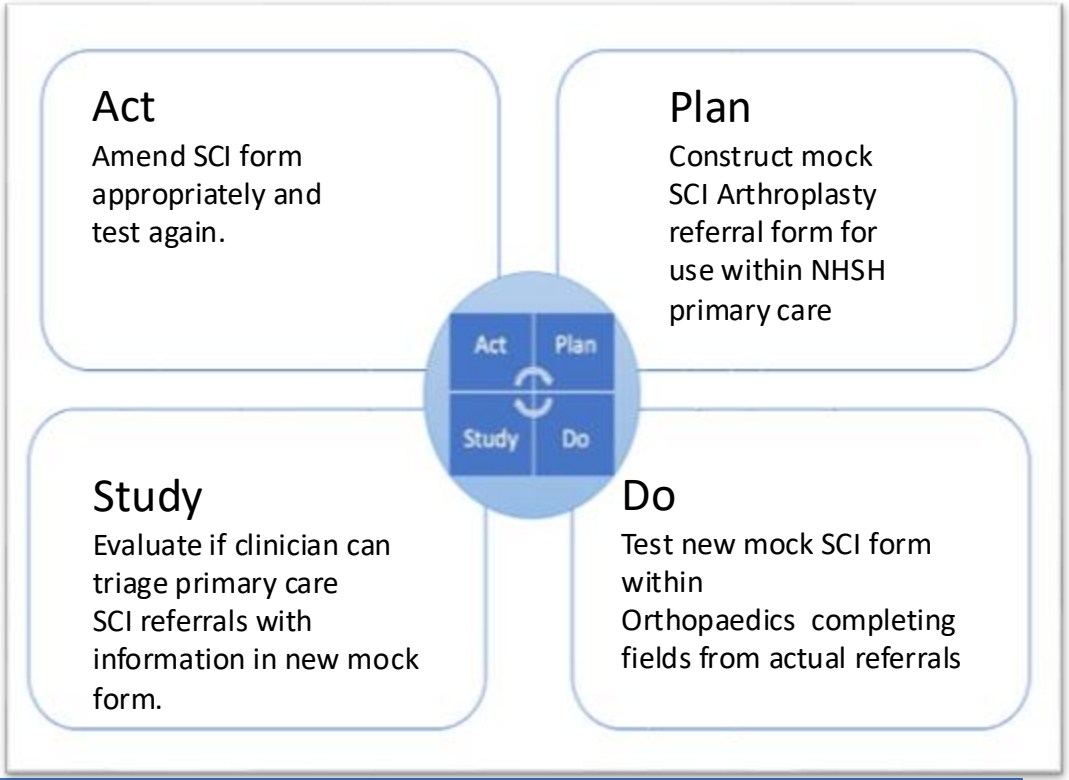


Fishbone Diagram:



White board





Area of Learning – Creating a specific aim at the start of projects is something I haven't done before but is very helpful in focusing what you are trying to achieve.
Successes – Getting all stake holders within a meeting to discuss and agree on changes to form.
Challenges- Keeping the PDSA small!!!!. I wanted to go straight to the main event immediately. Must learn to be patient.

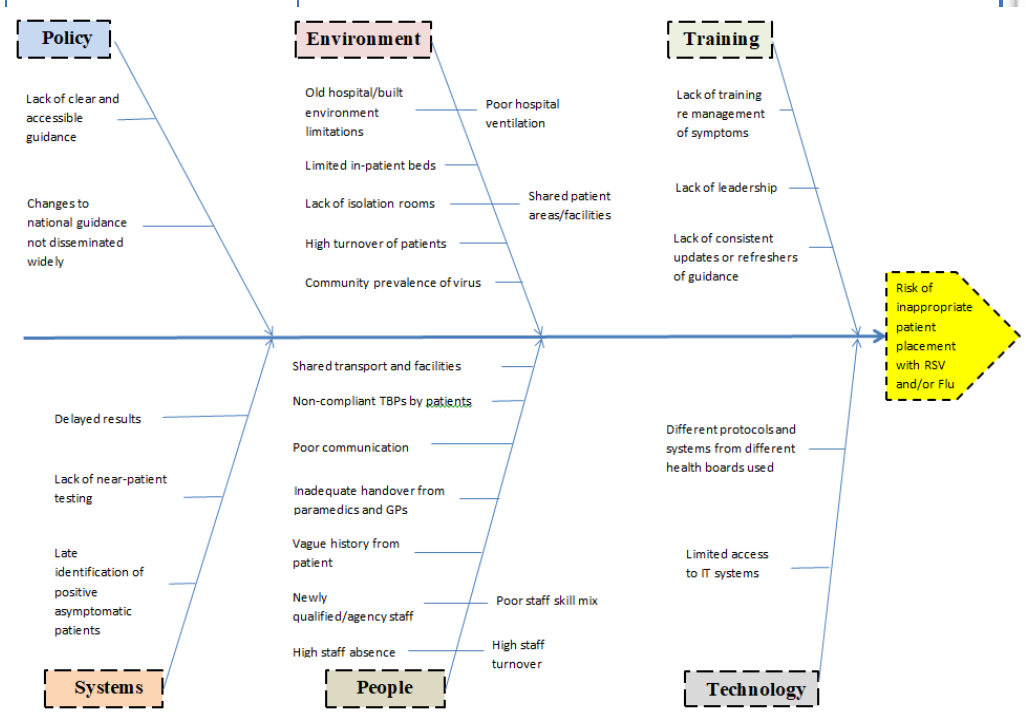
Flash report – SIFS Cohort Rachel Hobson

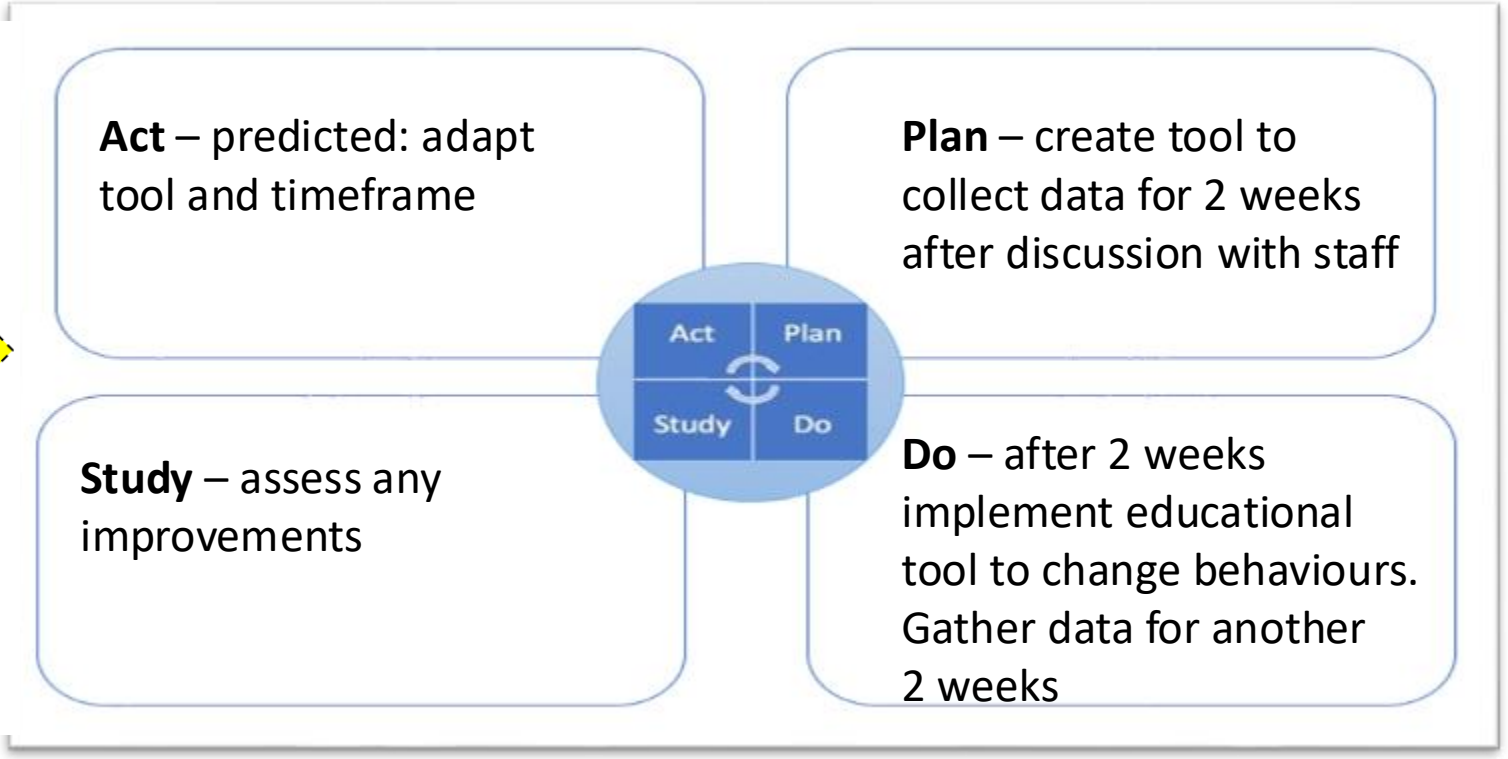
QI Project Team: Rachel Hobson IPCN

QI Project Aim: To create a 'never event' of inappropriate patient placement with Covid, RSV and/or Flu within the waiting area of an A+E, to reflect the National Infection Prevention and Control Manual. I aim for an improvement of 100% by January 2024.

Stage of the QI Journey: test change

Current status: plan to collect data after introducing change tool





Area of Learning:
successes – staff engagement with collecting data
challenges – distance from site

Flash Report – SIFS Cohort 4 – Sarah Slavin, eHealth Projects Manager & Alice Johnston, eHealth Projects Officer

QI Project Team:
eHealth Project Delivery Team

QI Project Aim:
To improve efficiency of completing the brief and PID (Project Initiation Document) documentation by the eHealth Project Delivery Team by 25% in line with PRINCE2 Agile methodology. Measured by user reported feedback, we aim is to achieve this by January 2024.

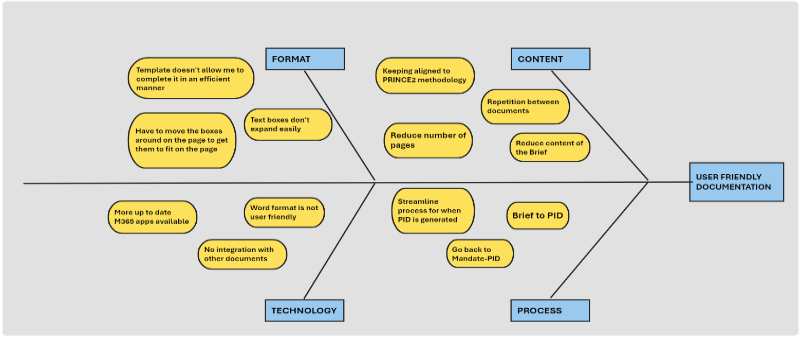
Stage of the QI Journey:
Testing Change

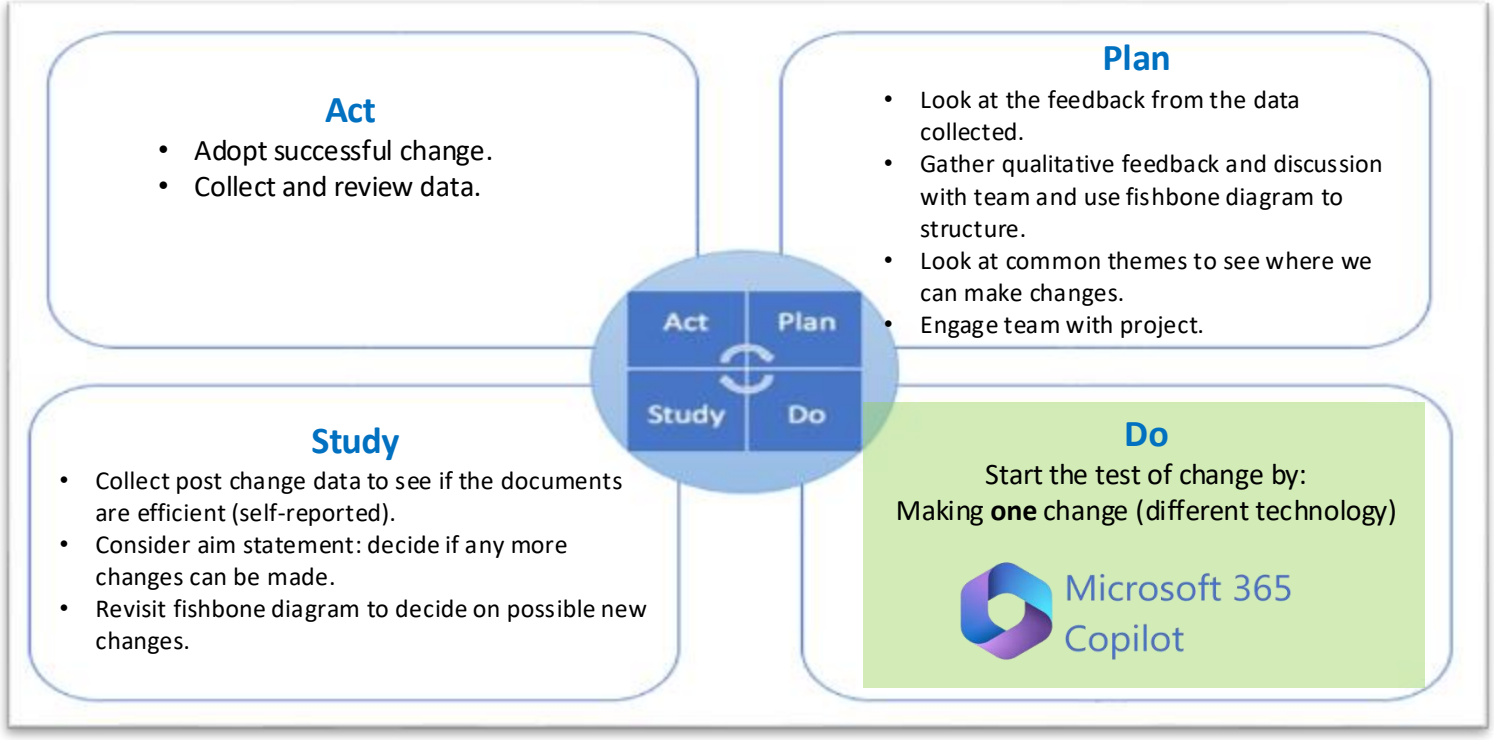
Current status:
PDSA Cycle 1: Our project has been delayed while we wait for Microsoft CoPilot, which will change the way we work. Our project needs to align with this new change to remain current.

QI Tools Used

User Feedback

Fishbone Diagram





Area of Learning – Successes – Challenges

Area of Learning:
- That you can make changes and they don't all have to work.
- Expect to need to be flexible with your plans.
- It is helpful to structure discussion to avoid going off topic.

Successes:
- Team engagement once the project started.
- Team wanting to work towards a change/ different digital solution.
- Coming together with a shared aim.

Challenges:
- Setting time aside for this project due to working part-time.
- Meeting with the team due to conflicting project demands.
- External variables that you can't control for this project. We were delayed as waiting for Microsoft Copilot licenses.

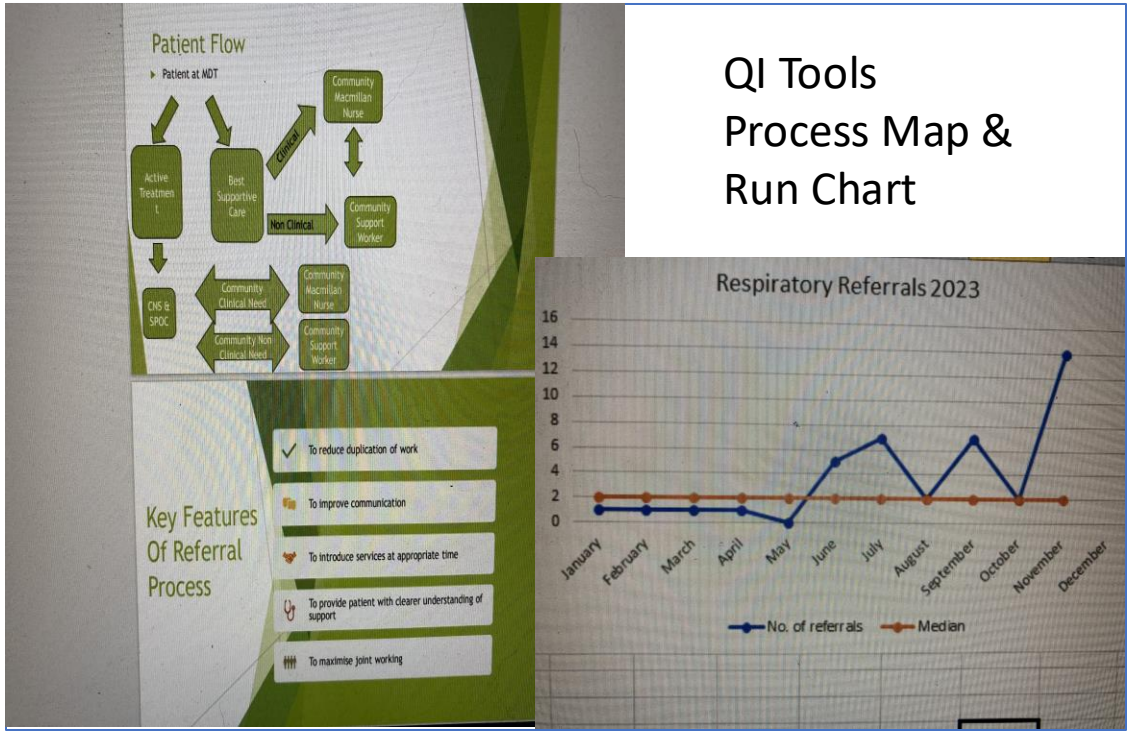
Flash report – SIFS Cohort 4 – Shirley-anne Smith

QI Project Team:
Macmillan Community Support Worker

QI Project Aim: I aim to increase referrals from the 8 site specific Acute Service Cancer Support workers by 25% by December 2023. This will be in line with the Scottish Governments Cancer Strategy and Action Plan.

Stage of the QI Journey:
PDSA cycle 1

Current status:
PDSA cycle 1 - Test



QI Tools
Process Map &
Run Chart

Act

Discuss with all 8 SPOC's and site specific CN's and feedback findings.
What do we need to change before rolling out referral process in all areas?
Can current community staffing levels cope with new increase in referrals?

Plan

Decision made to initially start with Lung/respiratory patients. Newly devised referral process to be implemented. SPOC and CN's to meet weekly after MDT to refer all patients discharged from Oncology. Currently patients are handpicked for referral and there is no joint decision made for either clinical/non-clinical support

Act | Plan
Study | Do

Study

What impact did referral process have on number of referrals?
How was admin time affected?
How do SPOC and CN's feel about new process?

Do

All referrals to be processed within 1 week of receiving with confirmation email sent to referrer with contact details for assigned Community Support Worker.
Initial contact to be HNA sent manually/electronically
Follow up call within 1 week.

Area of Learning – Successes – Challenges

The run chart has proved that the referral process has worked. There is now a better understanding of our role in the community and a willingness to refer.
Communication has also improved significantly between acute and community services. Less time is being utilised by clinical staff on non-clinical referrals.
It was quite difficult to get all of the teams together at the same time and also difficult to encourage some to adapt to the change in referring.
Light bulb moment was realising that there was no standard referral process in place to follow.
Changes to make for PDSA cycle 2 – cut down admin time for bulk referrals from MDT – send Pt name and CHI only

Flash report – SIFS Cohort 4 – Helen McCloughlin (ANP)

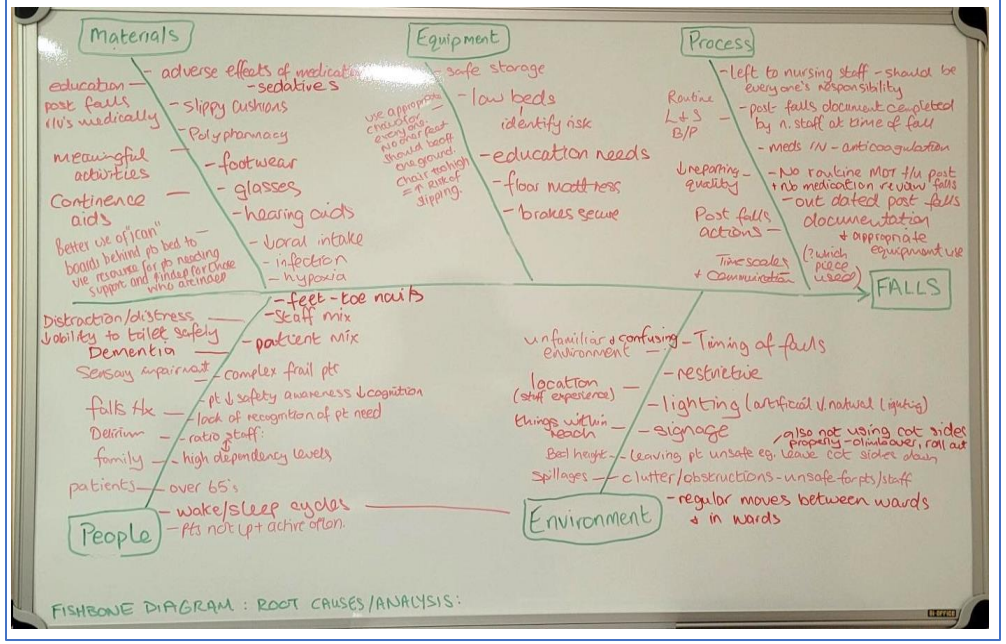
QI Project Team:
Medicine for the elderly team, Raigmore Hospital

QI Project Aim: To reduce the number of older adult inpatient falls by 20% in ward 2C, by March 2024, in line with the SPSP Acute Adult Programme Falls Reduction Change Package (2023), under the National Falls Improvement Aim from Healthcare Improvement Scotland.

Stage of the QI Journey:
Testing Changes

Current status: 1st PDSA completed- with prompt at morning huddle, post falls review took place concluding impaired cognition as root cause-did not initiate a medication review. 2nd PDSA planned after the following actions are completed: doctor's induction 06/12/2023, list of drugs that may cause harm in this cohort of patients

QI Tool: Fish bone diagram



Act: provide teaching to staff to ensure medication reviews are completed for each patient after every fall, ensuring reduction in medications associated with increased risk of delirium and falls

Plan: improved falls prevention strategies including 4AT, medication reviews, lying and standing blood pressures

Study: no falls prevention strategies were implemented, lack of knowledge identified in relation to medications that may cause harm in the frail older adult

Do: one fall was highlighted at the morning MDT huddle, no intervention completed as deemed to be secondary to cognitive impairment

Areas of learning →

Successes:

Raised more awareness of the need for more comprehensive reviews
Identified gaps in knowledge and understanding of MDT post falls reviews
Increase number of staff being motivated in this improvement process
Developed and improved MDT working relationships with everyone focusing on common goals

Challenges:

Other teams did not use or refer to the current post falls bundle-perceived as being a nursing document
Poor prescribing knowledge in the frail older adult
Initially lack of cohesiveness among the team- team effort not always recognised
Lack of post falls document for junior medical teams to use a prompt in their post falls reviews

Flash report – SIFS Cohort 4 – Hazel Inglis and Cat Clark

QI Project Team:
Hazel Inglis and Cat Clark (Specialist Midwives for Drugs and Alcohol)

QI Project Aim:
By April 2024, "Pregnancy Alcohol and Drugs Advice and Support Sessions" will be attended by 50% of midwives supporting women and families who are affected by continued drugs or alcohol use during pregnancy, to enhance outcomes in line with the Scottish Government (2018) "Rights, Respect and Recovery" strategy.

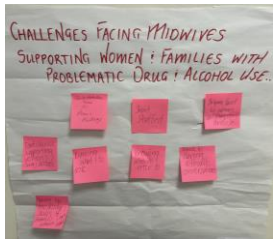
*Baseline 0

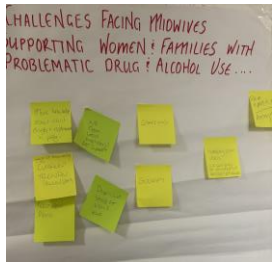
Stage of the QI Journey:

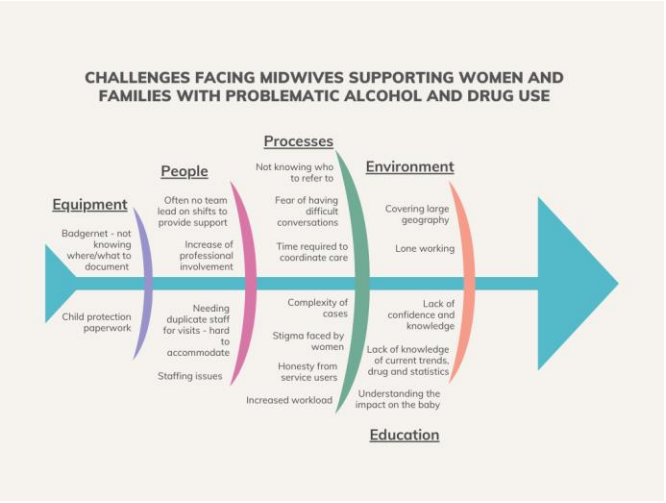
Testing changes

Current status:
PDSA 2 completed > adapt
PDSA 3- will commence 15/01/24, when we launch the 'Advice and Support' Sessions.

QI Tools Used

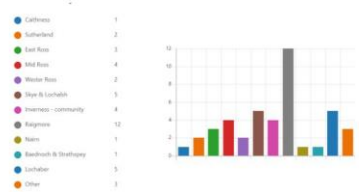






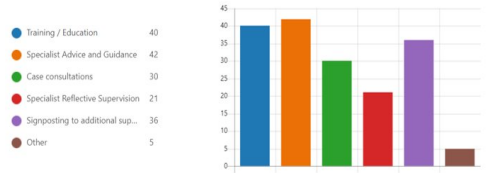
Staff Scoping Survey

- September 2021, a scoping survey went out to 110 midwives
- 43 responses (39%)



Results

- Midwives were asked what they would like to see from the Specialist Midwife role



Act- adapt

- Synchronizing our personal work diaries to the booking system
- Change booking sessions from 30-minute consultations to 1 hour

Plan

- Majority of midwives will find the process easy to use
- Majority of midwives will report that the instructions on the booking page were clear
- Day and timing of sessions will suit most midwives

Study

- 10 midwives found the system easy to use
- 9 midwives found the instructions clear.
- We noticed that our personal work diaries did not sync with the booking page, so a booking was made when we had other commitments.
- If two bookings were made back-to-back, this would not give any flexibility for any over-run/technical issues/complexity of case discussion

Do

- 10 midwives tested the booking system
- 10 appointments were made, and automatic emails sent out to the Specialist Midwives email address and to midwife making booking with link to the virtual session

Area of Learning – Successes – Challenges
Using QI methodology has ensured that our project has stayed focused on our intended aim whilst making manageable changes in a structured way.
During this project we have seen great enthusiasm from our colleagues who have kindly supported us through our PDSA cycles.
Challenges have included tackling technology (MS Bookings system) and staffing pressures.

Flash report – SIFS Cohort 4– Susie Bennett

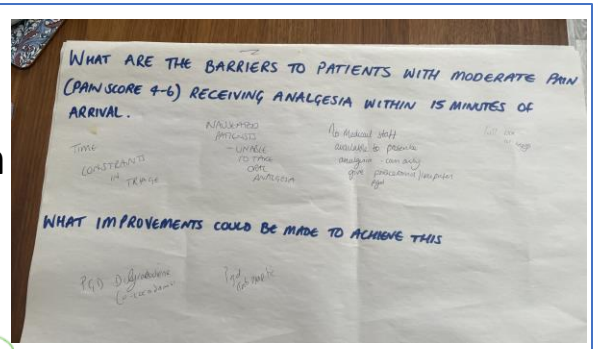
QI Project Team:
Susie Bennett –
ED, Raigmore

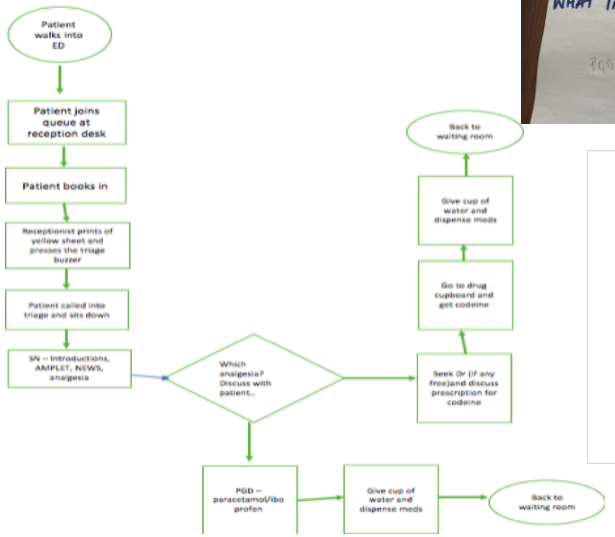
QI Project Aim:
50% of self-presenting adults to ED with a moderate pain score (4-6) will be offered appropriate analgesia within 15 mins of triage by March 2024 as per Royal College of Emergency Medicine best practice guidelines

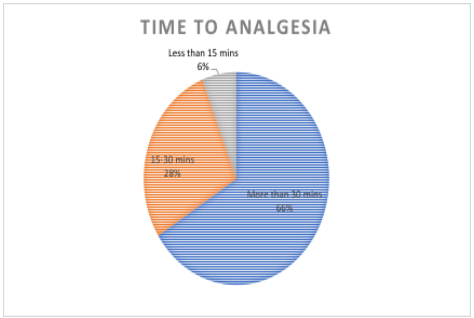
Stage of the QI Journey:
Testing change

Current status:
Now pgd is ratified – test with staff if this results in reduced time to analgesia

QI Tools
Process Map & Staff Feedback, Data Collection







Act
Adopt....

Plan
Change idea to test – create a new Pgd which will ensure that nurses can offer and then dispense analgesia within 15mins. We are not meeting this target because we are not able to dispense independently.

Study
When I test this pgd with 1 nurse on 1 patient I will learn what worked well and what needs improved i.e. education/Look into how best to launch pgd so that staff are informed and use it

Do
Now requires testing in ED – does pgd improve time to analgesia? Prediction is Yes.

Area of Learning – Successes – Challenges

Data collection is time consuming and requires time also from admin staff who are a little reluctant.

Introducing a PGD was a much more complicated process than I had anticipated but everyone I approached about it was very supportive. Have meeting with Claire – clinical governance/pgd sub group re what is involved with ratifying new pgd (see process below!). The planning stage of my project to test this change idea has been lengthy but I hope ultimately worth it to make the change happen.

Complete application form → Write PGD in template document → Get template signed off by consultant → Get template signed off by pharmacist Jane Wylie → Get it all submitted by 17/11/2023 Attend PGD sub-group committee to present case → Launch ratified PGD in ED

Flash report – SIFS Cohort 4 – Katie Thomson.

QI Project Team:

Katie Thomson (NTC-H)

QI Project Aim:

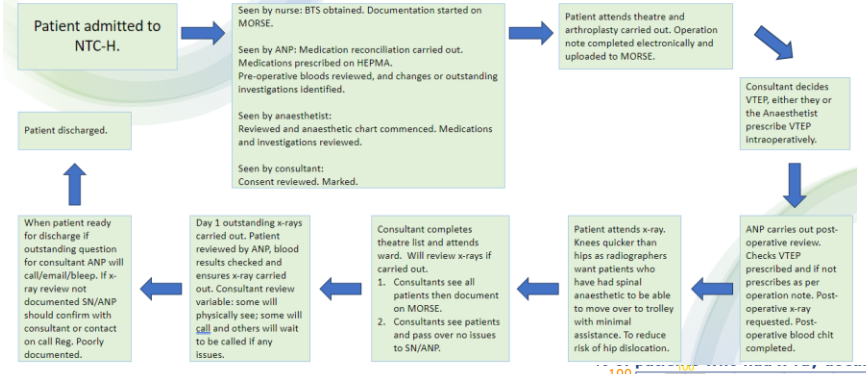
By December 2023, 100% of NTC-H Arthroplasty patients will have a post operative review by a consultant documented on morse. This review will include a comment on the patient post operative x-ray.

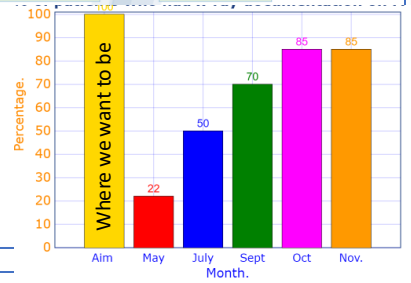
Stage of the QI Journey: PDSA cycle 2.

Current status:

At the start of the project (May 2023) only 22% of patients having a documented x-ray review. The data from Oct/Nov shows that 85% of Arthroplasty patients have a documented review that comments on post operative x-ray.

Process Mapping.





Act

Had 1 week of terrible compliance while on AL – related to IT issues.

CURRENTLY: New consultants rotating so checked all their IT access – requested what they needed and went through how to document on MORSE.

Plan

Best practice should be that patients check x-rays are reviewed on the of surgery. To avoid patients mobilising on intraoperative fractures/ unstable implants. This should be documented on Morse. At the start of the project (May 2023) only 22% of patients having a documented x-ray review.

My prediction would be that all consultants would be doing this, (especially after it was noted a patient mobilised on a peri-prosthetic fracture). However, I knew this wasn't the case, so gathered the data to

demonstrate this.

Study

Looked for trends in the data – was there a certain day of the week it was worse? A particular consultant that wasn't documenting?
Spoke with consultants who weren't documenting as much – had no training on MORSE, no help with IT access ETC.

Do

Knew that a problem when starting any change would be getting people on-board. Particularly in ortho.

Gathered data.
Spoke with Clinical director who was unaware that other colleagues were not utilising MORSE.

Area of Learning – Astronomical points and getting stressed: when IT was down.
Successes – Ward staff noticing more documentation. Less time having to track down consultants.
Challenges – Rotation of consultants, feel like it was on track and then would have new consultants who would be rotated over so it was like starting at square 1 again. IT challenges, for every new consultant that started they had to have access to MORSE requested then would need to have the continuation sheets added, then taught how to use MORSE. Network issues, MORSE going down for hours at a time and having to revert to paper notes which altered the data.

Flash report – SIFS Cohort 4: Eilidh Moir

QI Project Team:
NHSH Health Improvement/ CMH/ Primary Care/ Elemental

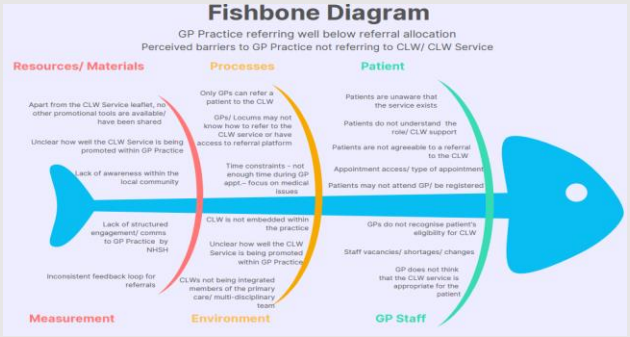
QI Project Aim: By July 2024, we will increase patient referrals from [redacted] Medical Practice to the Community Link Worker Service by 50%, moving towards the GP Practice's identified level of allocation.

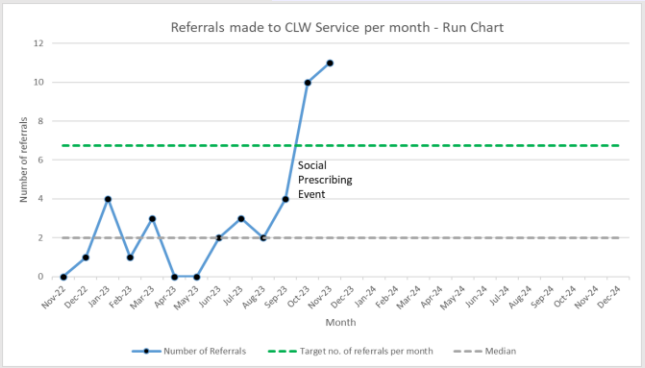
Stage of the QI Journey: Testing Changes

Current status: PDSA 1 – incomplete

QI Tools Used

Fishbone





Run Chart

Act

Feedback requested from other GPs at different Highland practices.
Feedback will be considered and referral guide will be adopted. Discussions to be progressed with e-health re. having guide available on Vision if possible, allowing all those referring to the CLW service to have easy access to the referral guide.

Plan

1st Change Idea: Create a "How to Guide" for referrers to the CLW service.
PDSA objective: To ensure all GPs have access to the referral platform Elemental, know how to access the system, and know how to refer patients to the CLW service.

Study

Not yet received any feedback re. referral guide, e.g. if it has been useful or whether it has been distributed to all GPs at the practice. Unclear whether all GP's have access to the elemental platform.
Referrals to the CLW service have increased but this does not correlate with this change idea.

Do

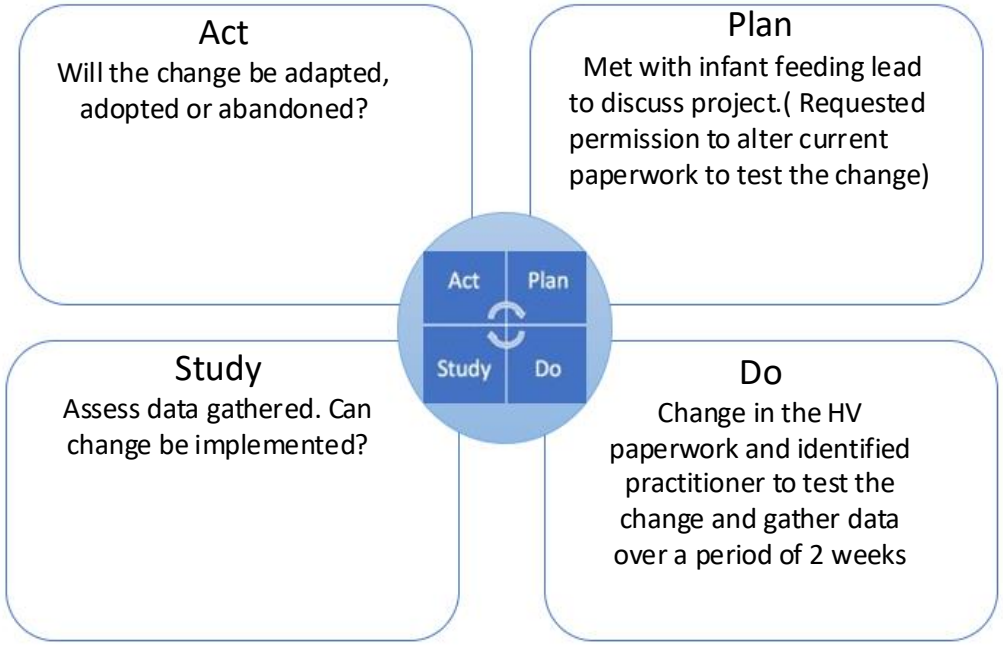
Referral guide (how to generate a referral through vision' sent to 1 GP at practice. Request made for GP to review to ensure it was an accurate representation of the process of making a referral from a GP's perspective. GP to distribute guide to practice colleagues. Request made to feedback if all GP's have access to the elemental platform.

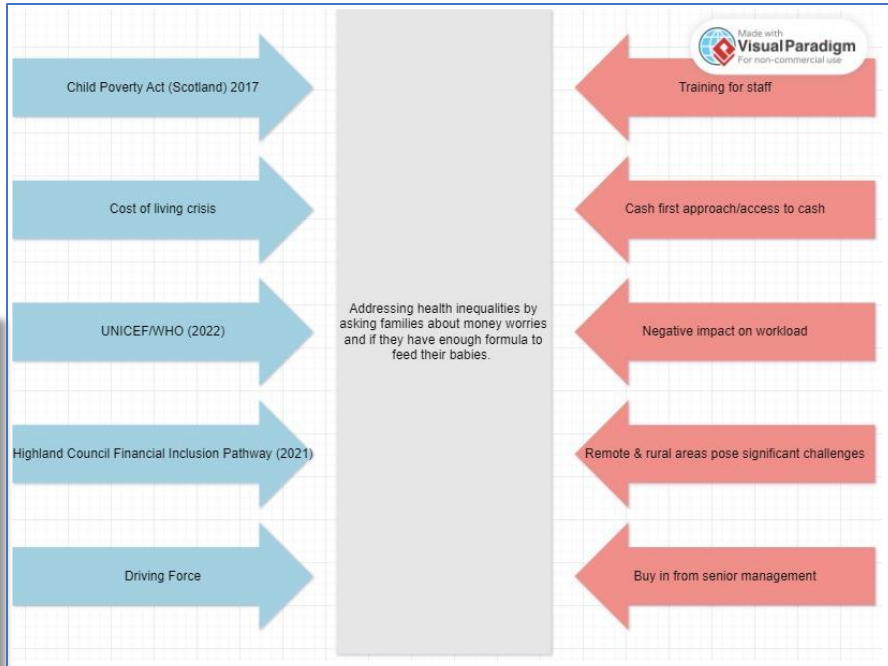
Area of Learning – QI tools and how to use them properly; importance of understanding systems; I will take learning into future projects/ work with regards to possible future expansion of the CLW service and practices that are referring below/ above allocation.
Challenges – understanding (and to what degree) the complex systems; overlapping changes; meaningful engagement and collaboration with all teams/external organisations.
Successes - referrals have increased dramatically to the service however these have been a consequence of other interventions.

Flash report – SIFS Cohort 4 – Zoe Cruickshank, Wendy Tait & Nikki Rearie

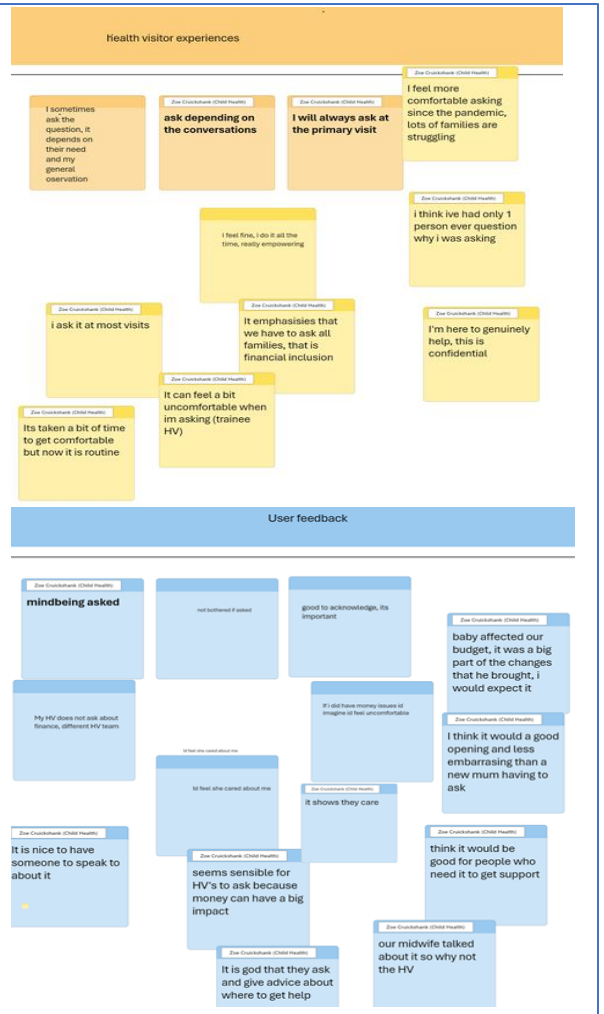
QI Project Aim: By May 2024, 90% of staff from the Inverness West HV team and FNP at all core contacts on the Universal HV pathway (2015) will routinely enquire about money worries. If an infant under 12 months is formula fed and the family has disclosed money worries, they will be asked if they have sufficient funds to purchase formula milk. This is in alignment with UNICEF 2022.

Stage of the QI Journey: Testing Changes





QI Tool – User feedback & Forcefield Analysis



Area of Learning

Successes- Good buy in from immediate team members. Working in an area of high depravation so team have a good understanding of inequalities that exist therefore are keen to promote initiatives that address this.

Challenges- We have learnt that this project is not as simple as we first thought. That engaging senior management to understand our system more is challenging. We are very much still at the understanding our system is ongoing.

Cohort 5

Flash report – SIFS Cohort 5 – Andrew Rankine

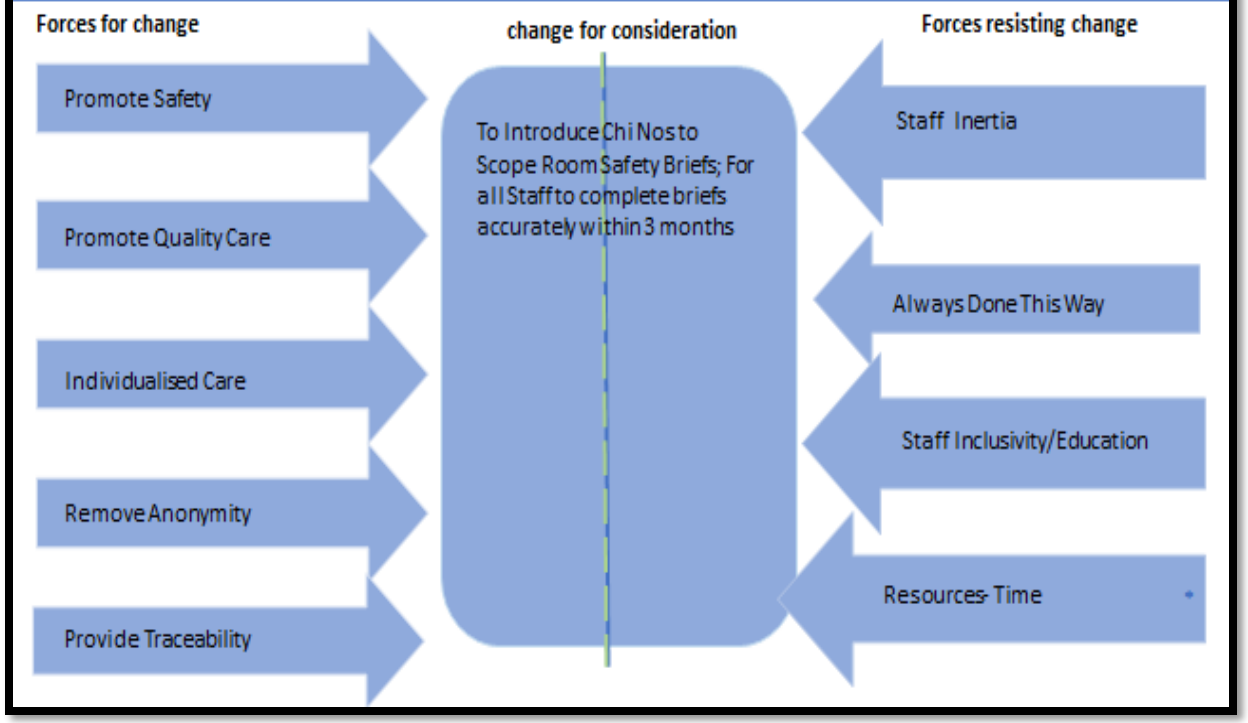
QI Project Team:
Endoscopy Team, Raigmore Hospital

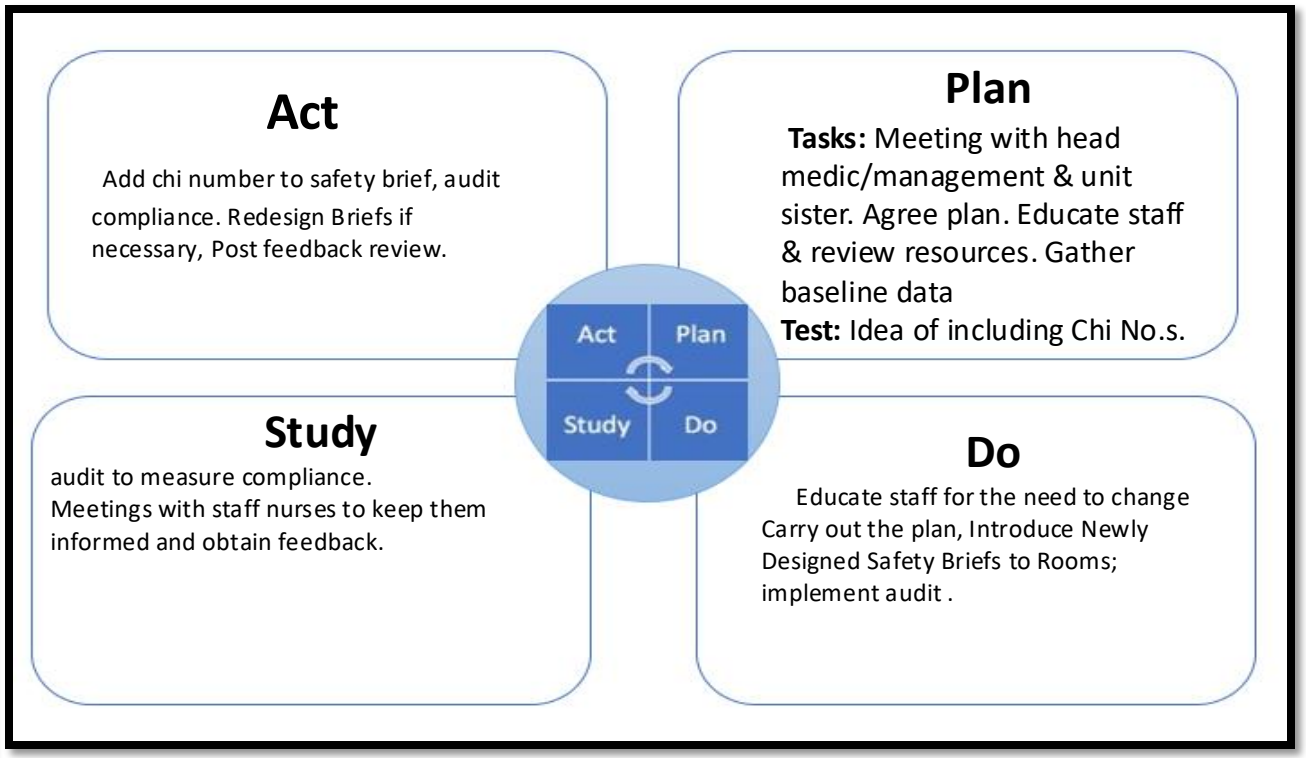
QI Project Aim: 100% of room safety briefs in Raigmore Endoscopy suite will display Chi Numbers in line with Jag Accreditation(National Endoscopy QI Tool) by April 2024

Stage of the QI Journey:
Implementing changes

Current status:
Project Has Been Completed With 100% Compliance (Post Audit Data) And Within 3 month time Period. I had to test the change and review the quality cycle journey twice before the above results were achieved

Forcefield analysis





Area of Learning – Successes – Challenges

The Final Safety Brief Required Redesigning Two Times Post Staff Feed Back On Ease Of Use.
The Staff Could See The Benefits Of The Proposed Change Once Its Purpose Had Been Explained To Them.
Keeping The Team Enthused During The Data Collection Phase.
Feedback On The Change By The Joint Advisory Group On Gastrointestinal Endoscopy (JAG) Accreditation Quality Assurance (QA) Standards.

Flash report – SIFS Cohort 5 – Christine MacLeod

QI Project Team: Moving and Handling Team

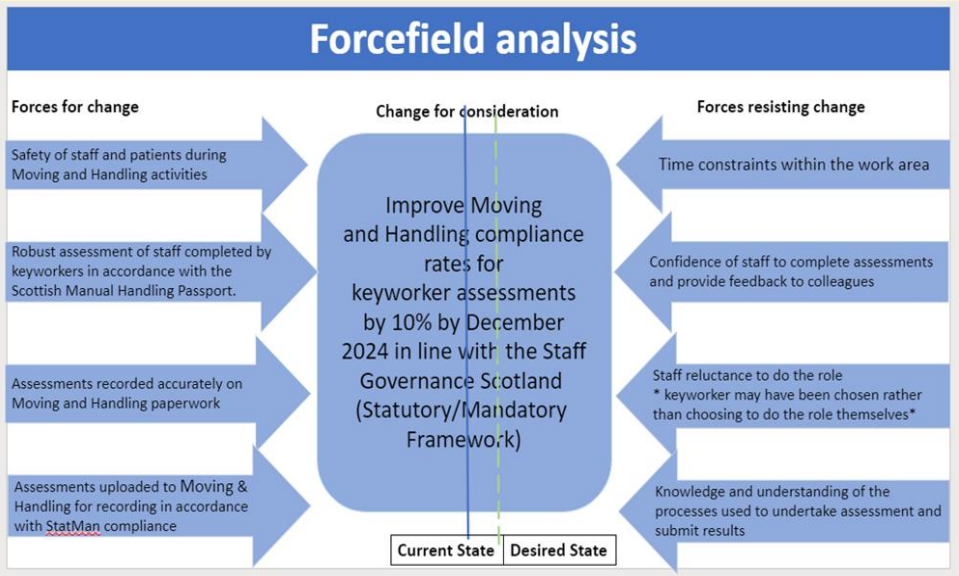
QI Project Aim: To improve Moving and Handling compliance rates for keyworker assessments by 10% by December 2024 in line with the Staff Governance Scotland (Statutory Mandatory Framework)

Stage of the QI Journey:
Testing Changes

Current Status:
PDSA Cycle 1 - **Complete** – 7 delegates attending February 2024 course identified in the Keyworker Core Sheet. Analysis so far states 3 of the initial 7 have completed between 2 and 5 assessments as requested.

PDSA Cycle 2 – May 2024 cohort, reduce the number of changes – focus on assessment and feedback skills.

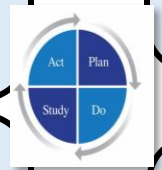
QI Tool Used



Act
Adopt – completion of up to 5 assessments within the 8–12-week period between the end of the 2-day training and the follow up date.

Amend – Focus on assessment and feedback skills providing additional time during the initial 2 days to focus on these skills and build confidence.

Study
- 42% of the cohort of 7 has undertaken and submitted 2 or more assessments within the workplace at present. This cohort of staff are due to return for their follow up day shortly.
- Only 1 evaluation form reply received. Stating they felt somewhat confident to undertake assessments and provide feedback within the workplace



Plan
To test whether requesting staff to complete and submit up to 5 competency assessments within the workplace over an 8 – 12 weeks period will improve compliance rates and confidence in the M&H Keyworkers

Do
- 7 Keyworkers to attempt up to 5 assessments within the workplace and feedback at their follow up day.
- Monitor submissions from 7 keyworkers through Keyworker Core Sheet and Keyworker Returns

Area of Learning – Successes – Challenges

There are lots of benefit of using the QI processes when undertaking a project whether big or small. It gives you structure to formulate your project to implement change. Starting with the project charter, this helps outline your intentions, which in my project changed as I moved through the process, but it gives you the tools you need to bring your project to a point where change can potentially happen.

Successes: An increase in the return of competency assessments from the February cohort. Engagement of staff who have been receptive of the change. Using the forcefield analysis gave me the key points to focus on to try to implement change within the keyworker programme.

Challenges:: It has been challenging to complete the project due to staff absence, annual leave and having access to the keyworkers within their work area. This impacted my original project and directed me to look at the current cohort of keyworkers instead.

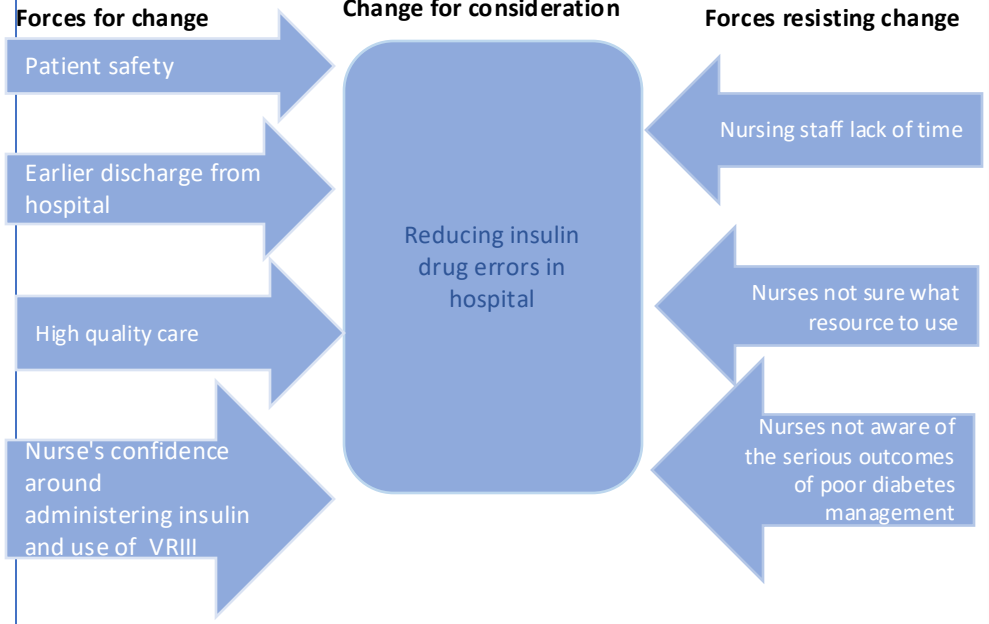
Flash report – SIFS Cohort 5 – Angela Delaye

QI Project Team: Angela Delaye DISN

AIM: To reduce insulin related drug errors by 20% in Raigmore hospital by getting staff to complete bite sized education modules on my Turas education page by April 2025.(as per pillars of practice, NHS Scotland career framework)

Stage of the QI Journey: Testing /implementing

Current status:
PDSA cycle 1 led to changes being made to the project prior to official rollout on wards. Implementing PDSA cycle 2



Act
Production of ward diabetes folder containing valuable inpatient information. Link to my Turas education page / QR code, and tick box beside staff member's name to tick when completed 4 bite sized modules and watched VRIII video. Feedback sheets. Liaise with charge nurse on importance of staff completing education.

Plan
Trial project initially on wards 4c,5c and 6c for 12 weeks. Then rest of hospital if it is successful. Results will be used for future PDSA for roll out of project to whole hospital.

Study
Feedback already obtained from management and clinical educators. Which has made me adjust a few things prior to official trial.

Do
Discuss the planned project with charge nurse/ward clinical educators/management and the rationale behind it, they will filter information down to ward staff and let them know its compulsory.

Area of Learning – Successes – Challenges

LEARNING: The QI course made me rethink my language after seeking advice, tone was more friendly and encouraging now its more factual (making staff aware of recent increase in ward development of DKA due to missed insulin), reminding staff to be responsible for their own learning and practice and have a duty of care towards their patients. I'm taking the approach of presenting the facts as they are, sick patients with diabetes are vulnerable and nursing staff are putting them at risk due to lack of knowledge of diabetes. Nurses are expected to be accountable professionals who use their knowledge to make evidence-based decisions about care. (NMC, 2023)

I have provided information to charge nurse after feedback from clinical educators (PDSA 1) on specifics of the education; length of time it will take to complete the modules, watch the video and date of expected completion.

SUCCESSES: QI course made me think about who my team is. Even though I have done all the work for the education alone I need to consider hospital charge nurses and clinical educators as the wider hospital team who will support me in the project. I learned I have to consider future planning, how will I keep the education relevant and make sure staff continue to engage.

Gathering data on insulin errors was very quick and easy to get from datix. **CHALLENGES**. I foresee pushback from busy staff nurses regarding finding time to do education.

Flash report – SIFS Cohort 5 – Barbara Konicka-Niemiec (AP)

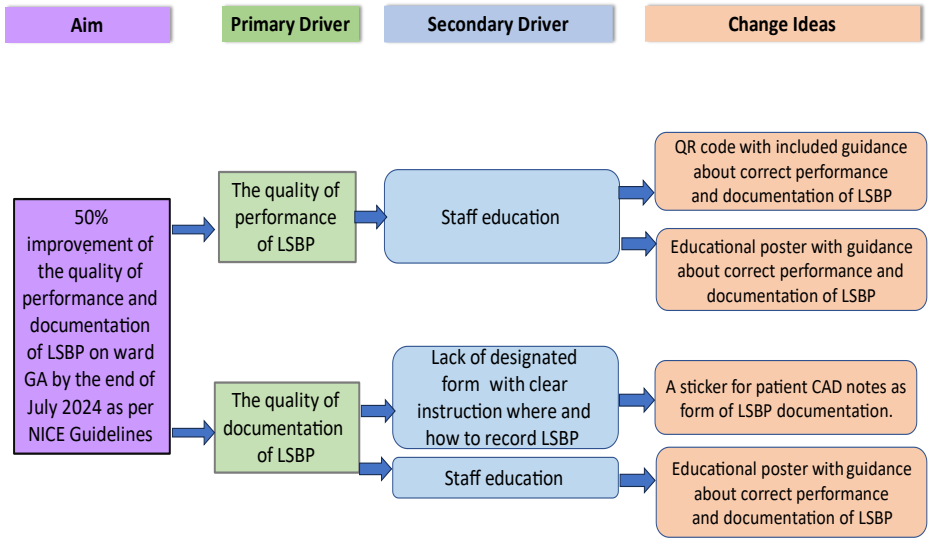
QI Project Team:
Ward GA
Raigmore Hospital

QI Project Aim: 50% improvement of the quality of performance and recording of LSBP on ward GA by the end of July 2024 as per NICE guidance

Stage of the QI Journey:
Test of change.

Current status: First PDSA cycle completed.
Second PDSA cycle to be started on the 1st of May 2024.

QI Tools Used: Drivers Diagram



Act: Abandon QR code.
Adapt QR code content in to educational poster, which will be available in the fall prevention section,
on main corridor in ward GA.

Plan: Design QR code with guidance of LSBP performance and documentation.

Study: During 10 days of QR code availability it was scanned only 15 times which is less than daily staffing (day+night shift) for ward GA! Staff members reported difficulties with scanning QR codes as not allowed to access mobile phones while working. Audit carried out from 29/03/24-19/04/24 showed that 40% (4/10) of LSBP were done and documented properly. Although it is significant rise, it has been noted that all performed measurements were carried out by one member of staff. Therefore, further education is needed.

Do: Print out and place QR codes on the big room windows. Communicate test of change and reason to all staff involved during morning and evening safety brief. Dynamic QR code will be available on the ward 29/03/24-07/04/24.
.

Area of Learning – Successes – Challenges

Challenge: communication with staff members, changes were not appropriately mentioned on the daily morning handovers as agreed. Resistance/ poor engagement of the staff. Difficulties to audit LSBP due to shift pattern and not all LSBP were done immediately upon requests.

Learning: I have learnt a lot about QI tools and PDSA cycle as well as to keep changes small/ one at time.

Successes: Increase in numbers of correctly performed and documented LSBP, positive feedback from staff who scanned QR code.

Flash report – SIFS Cohort 5 – Elaine Cowie

QI Project Team:

Radiotherapy Physics: Treatment Planning

QI Project Aim:

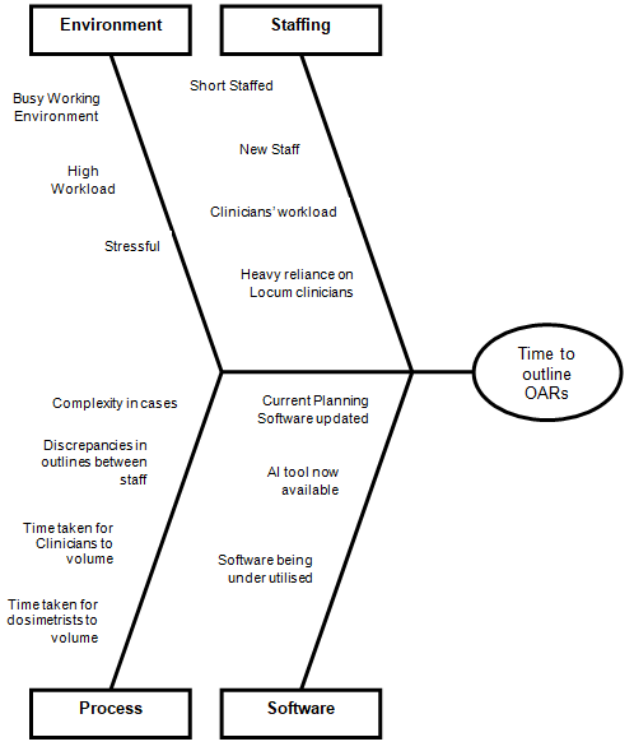
To commission the "Deep Learning Segmentation" module within the Radiotherapy treatment planning software by June 2024 to reduce the time taken to delineate Pelvis OARs. In line with guidance by National Institute for Health and Care Excellence (NICE)

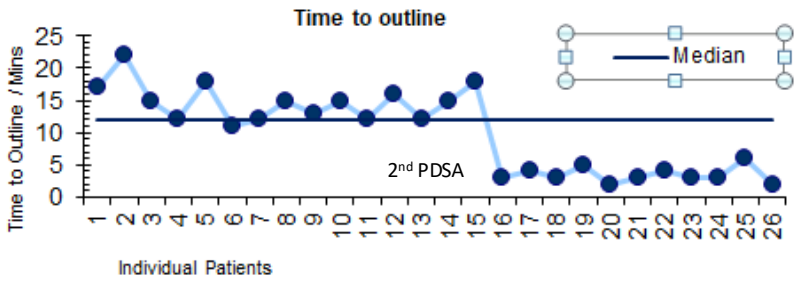
Stage of the QI Journey:

Testing Changes

Current status:

1st PDSA Cycle complete – 10 patients within database and DLS software ran. Problems arose with the cohort of patients selected.
2nd PDSA cycle – Alternative patients identified and input into the database.
3rd PDSA cycle to start 29/04/24 – implementing changes





Act

- Adopt – software runs better than expected
- Currently still being tested
- Gearing up to Implement into clinical planning workflow – Training, Update protocols, templates, scripts.

Plan

- To see if the DLS software reduces the time taken to outline patients internal anatomy for pelvis patients.

Study

- Review accuracy of volumes and Score results
- Pin down Clinician to score results
- Time taken to volume measured Versus volumes produced by the DLS software

Do

- 10 Patients in Database and Run DLS software.
- Generate the output data into an excel spreadsheet.

Area of Learning – Successes – Challenges

Initially I felt the QI tools weren't a good match for my auto-contouring project. It felt like I was working in reverse, forcing a problem to fit a solution I already had. I had to step back and look at the entire system to make sense of it. I now have a much deeper understanding of the QI tools and I feel confident that I can adapt them to be more effective for scientific projects in the future.

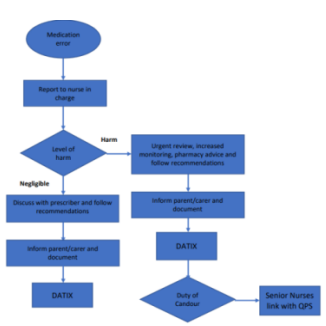
Flash report – SIFS Cohort 5 – Emily Gate (Medicines Management Development Nurse)

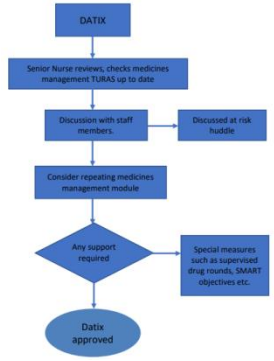
QI Project Team: **Highland Children's Unit, Raigmore Hospital**

By May 2024, there will be a 25% improvement in applying a structured approach to encourage learning from medication errors on the Highland Children's Unit. This is in line with Patient Safety Incident Response Framework (2022).

Stage of the QI Journey: Testing

Current status: **PDSA Cycle 3** – Using tool with reported errors and adapting each time.





Process mapping

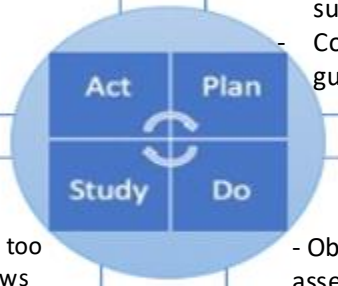
Feedback

Act

- Adapt - Minor tweaks made;
- Plan in place to trial in other areas acute adult ward and mental health.

Plan

- Poster in place so staff are aware QI project underway;
- Attend weekly risk huddle to discuss medication error;
- Meet with staff member involved in error to support and discuss;
- Complete medication error scoring tool to guide analysis and encourage reflection



Study

- Factual statement – initially though might be too onerous however ensured staff members views were recorded which were missed from Datix;
- Added medications which were not included;
- Review format to include page numbers/breaks
- - Positive response from staff.

Do

- Obtain pre completion of the tool feedback to assess what learning from error has already taken place;
- Complete medication error scoring tool and reflective discussion;
- Obtain post completion of tool feedback to identify if there has been an improvement in learning.

Area of Learning – Developed a much clearer understanding of QI process which has improved confidence for future use. Found using a standardised tool help guide discussion when reviewing the error and wasn't onerous to complete. Overall aim is to include medication error scoring tool in a toolkit for medication error reviewers;

Successes – Positive feedback from staff involved (100% in usefulness in supporting reflective process). Supporting beginning of another QI project;

Challenges – Shift patterns of staff can cause challenges in timely review. Ensuring Datix reviewers understand this will not be too time consuming to use and might even ensure reviews are more efficient and comprehensive.

Flash report – SIFS Cohort Care at home Manager Emma MacArthur

QI Project Team: Care at Home team

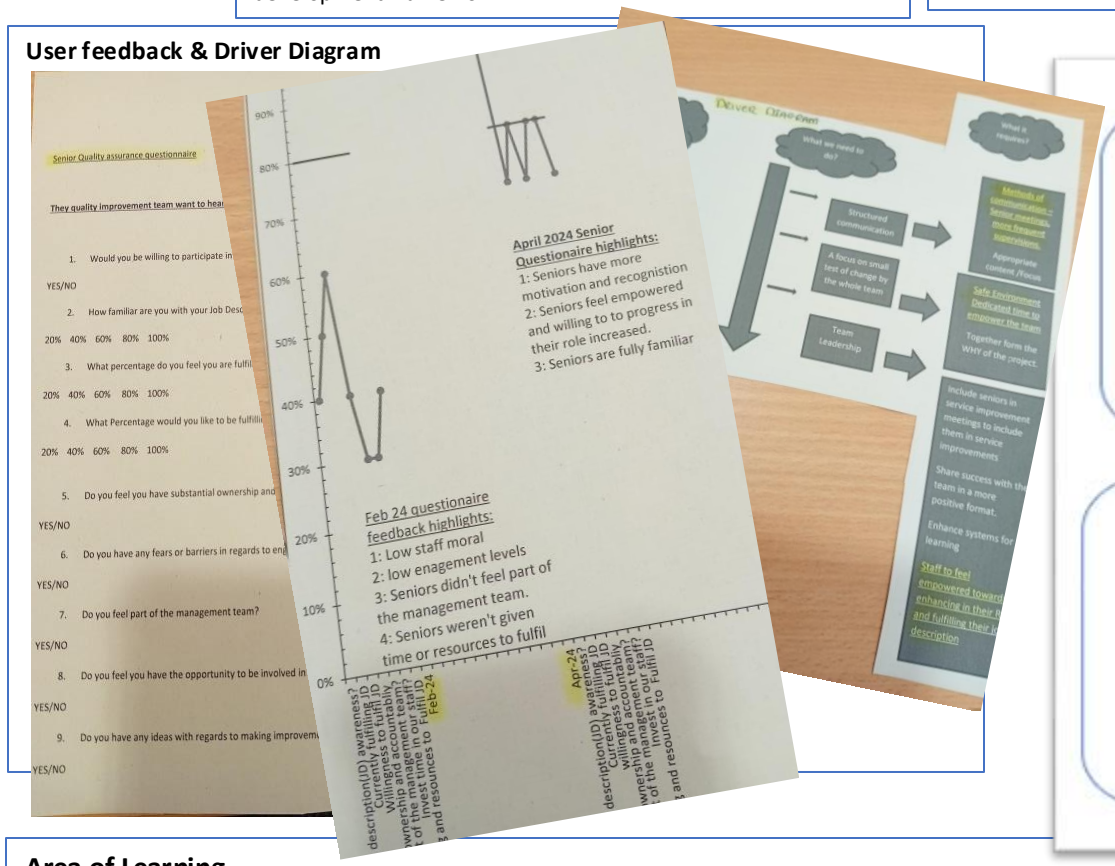
QI Project Aim:
To Improve senior staff knowledge and awareness of the senior job description by 100% within the Care at home team by May 2024 in line with the care at home NHS learning and development framework.

Stage of the QI Journey:

Testing change

Current status:
1st PDSA cycle completed – The data produced following the first PDSA shows 100% of senior staff are aware of their Job Description, Following first cycle data it also highlights the uptake of development opportunities to be 70% demonstrating an increase from baseline. The uptake of Role specific opportunities with more engaged staff have increased the overall percentage.
2nd PDSA cycle – planning stage – We hope to achieve further increase by dedicating time to training and development opportunities such as career progression and specific champion roles.

User feedback & Driver Diagram



Act
- Implement fortnightly senior meetings with an agreed focus on Job descriptions **(ADOPT)**.
- Reference job description quotes and key areas throughout supervisions 6 weekly **(ADOPT)**
- SOP created for time management to focus on prioritisation to enhance overall willingness to fulfil their full Job description.
- Email circulation as collection methods **(ABANDON)**. Face to face is a more efficient source of gathering accurate evidence/feedback.

Plan
- We are **delivering more frequent team meetings** and workshops focussing on Job description changed from **fortnightly to weekly**. More opportunity to highlight gaps.
- We have **increased the amount of supervision** - format focuses on areas of the job description in monthly group supervisions and 6 weekly 1:1's instead of 6 weekly Senior meetings increasing the overall opportunity to formalise a more robust framework for team and individual development opportunities and how we together categorise these. The seniors and manager will utilise QI tools to highlight areas of improvement.

Study : Testing has succeeded part predictions
- Feedback received from the senior team was positive and highlighted a positive improvement to senior awareness and engagement in their JD and willingness to adapt to change and progression BY 60%
- Feedback highlighted commitment from the senior team to work towards development and improvement change BY 40%
- Feedback highlighted that more focus and work is required to enhance more development and learning opportunities within the team. This will be another PDSA specific Focus.

Do
- Key elements of JD were highlighted at morning Huddles on 12 occasions where tasks highlighted key role specific discussion points.
- A SOP was completed to support seniors to time manage more productively. This was the main barrier which was highlighted in the Driver Diagram.
- More frequent senior meetings were implemented with a FOCUS on areas of the senior JD which they found difficult or problematic.
- **feedback questionnaires were resent at the end of the 1st PDSA cycle to collate data to evidence change.**

Area of Learning
- Recognising the importance of starting a project small with one main focus and ensuring timeframes are realistic and measurable. I have recognised the importance of ensuring there is a plan for on-going review and continuous measurement of data.

Successes:
Good engagement from the senior staff team.
- Exceptional willingness to adapt to a more integrated team working approach
- Communication and being listen to was highlighted as our main rule throughout the project.

Challenges:
- Staff engagement through e-mail was time consuming– it was highlighted that arranging face to face sessions to collate information and feedback was more beneficial with an increased level of understanding and accuracy shared.
- The senior shift pattern, work on a rotation and this posed restrictions of meeting days and times to ensure all Seniors were able to be part of all discussions, Team recordings of meetings were taken and shared with seniors who were unable to attend .

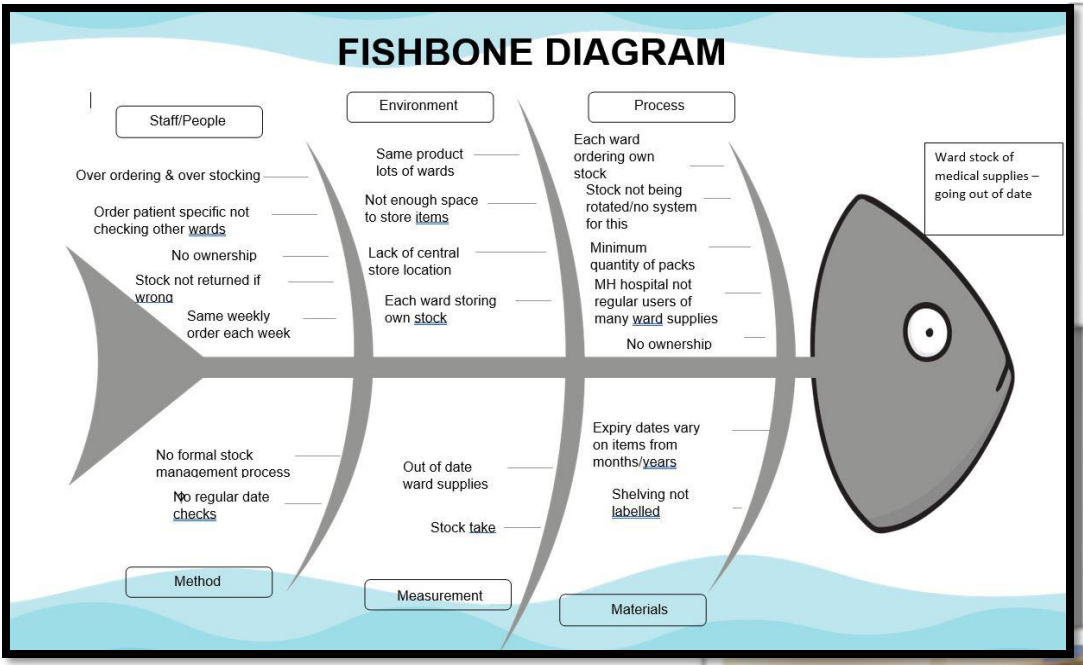
Flash report – SIFS Cohort 5 – Gayle MacBean

QI Project Team:
SCN/ Business Support

QI Project Aim:
To reduce ward supplies waste by 40% within 6 months in line with NHS Strategy to reduce harm and waste by creating sustainable ways to reduce, return and recycle.

Stage of the QI Journey: First PDSA cycle complete, Kanban implemented

Current status:
First PDSA cycle complete. Kanban is up and running we are monitoring and adjusting the process after feedback. Training for staff planned



Act
1. Training for staff on how to implement Kanban
2. Continue to monitor waste levels
3. Continue to monitor ward stock levels

Plan
1. To reduce the ward waste by 20% by creating centralised store.
2. Ask each ward what is required and how many weekly.
3. Collate items that the whole hospital use and how many are needed weekly numbers from wards to predict the stock needed
4. Find out how much is being spent review budget
5. Predict that this will help reduce waste.

Study
1. Amount of waste reduced across wards and was greater than predicted. PDSA cycle identified that the hospital stock previously held exceeded what was required weekly by about 20%

Do
1.Kanban cupboard created for whole hospital.
2 Staff responded well although some stock ran out
3. Realised staff needed trained in use of Kanban
3. Waste was reduced 80% from implementation

Successes
All wards aware of what is available and what the additional "specific" ward items are in case needed for a specific patient for a short period of time
Created the Kanban and Centralised cupboard

Challenges
Wards want to still order directly and overstock – needed SCN support to prevent this

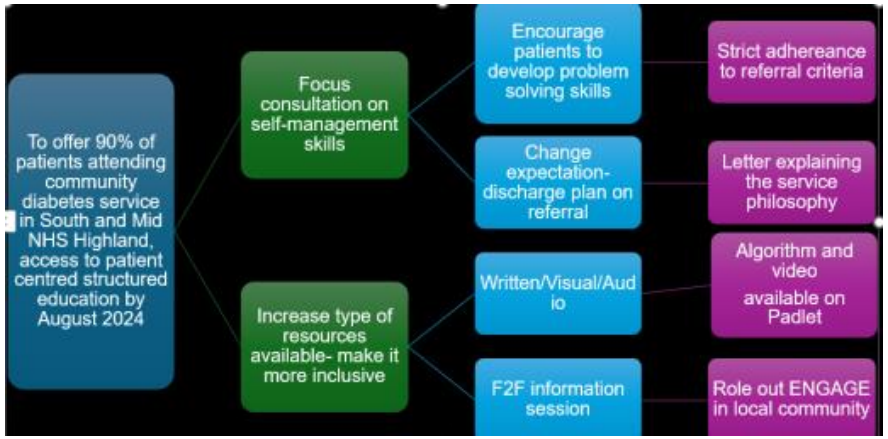
Flash report – SIFS Cohort 5 – Tracey Roe

QI Project Team: Community Diabetes Nurse service, South and Mid NHS Highland

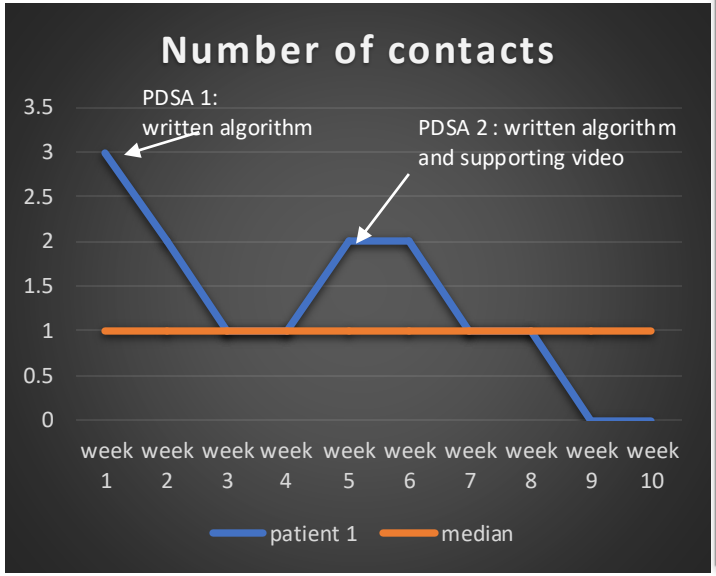
Stage of the QI Journey: Testing changes

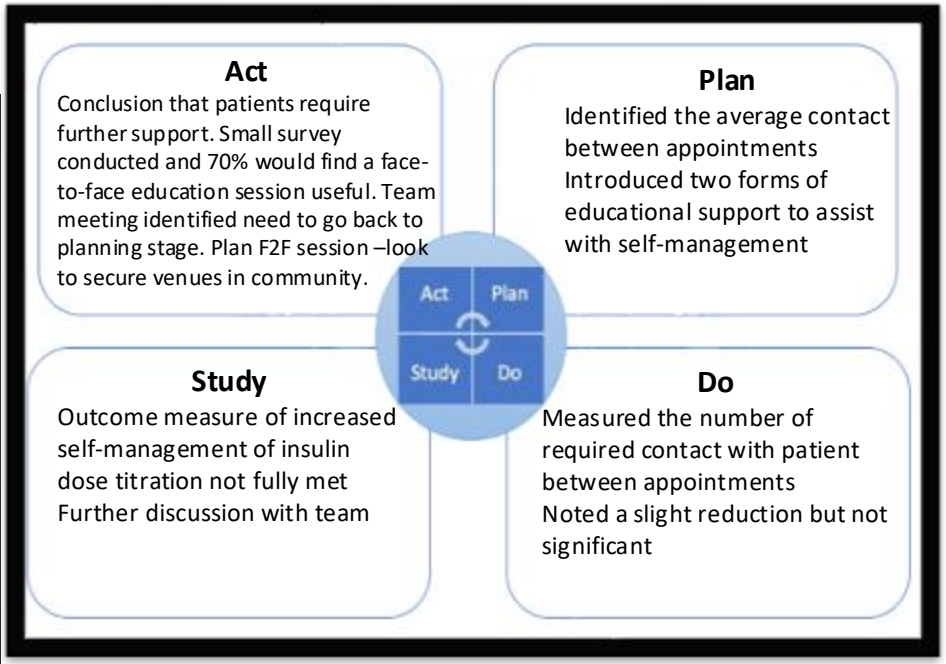
QI Project Aim:
To offer 90% of patients with T2DM referred to the Community Diabetes Nurse Service in South and Mid NHS Highland access to structured patient centred education resources by August 2024, to support self-management of their diabetes (as per NICE/SIGN guidance).

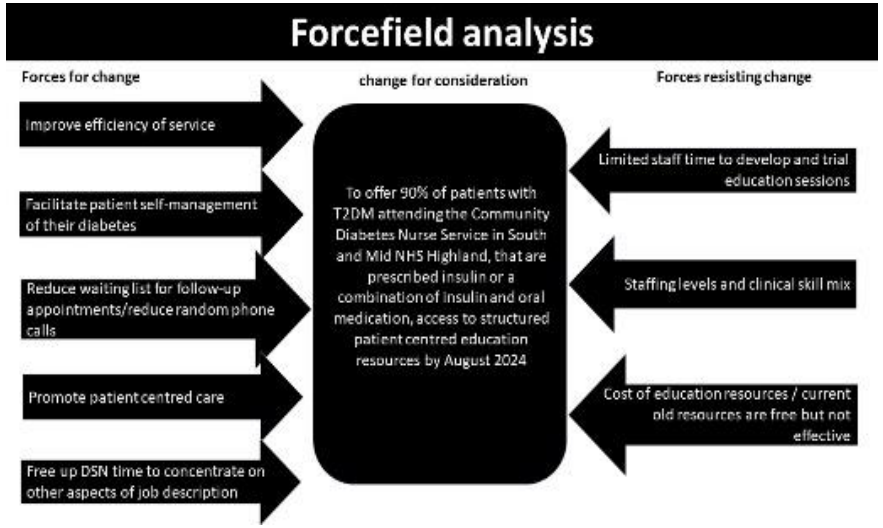
QI Tools



Data – Run Chart







Area of Learning: – This learning experience has increased my knowledge of the QI process. I had already started the project prior to being accepted on the SIFS course, however I would not have been able to get this far without understanding the QI structured approach. In hindsight if I had not had already started the project, I would now approach it slightly different. I do wonder if running more PDSA cycles on an increased number of patients it would yield better results.

Successes – My initial PDSA cycles so far have not been successful, but the process has highlighted where further improvement can be made, and I am excited to take the project to the next step.

Challenges - There have been several challenges.

Firstly, I think I have focused on the incorrect data collection

Secondly, there are too many variables that can impact on an individual ability to self-manage their own disease process.

Flash report – SIFS Cohort 5 – Sarah Mackenzie

QI Project Team:

Sarah Mackenzie – NHS Highland
Corrina Shearer – Care & Learning Alliance

QI Project Aim:

To increase referrals to the X programme from a baseline of 6 to 20 (N), to improve the general health and wellbeing of children and families (S) in line with the Standards for Children and Young people tier 2 and tier 3 weight management programmes (A), by September 2024 (T)

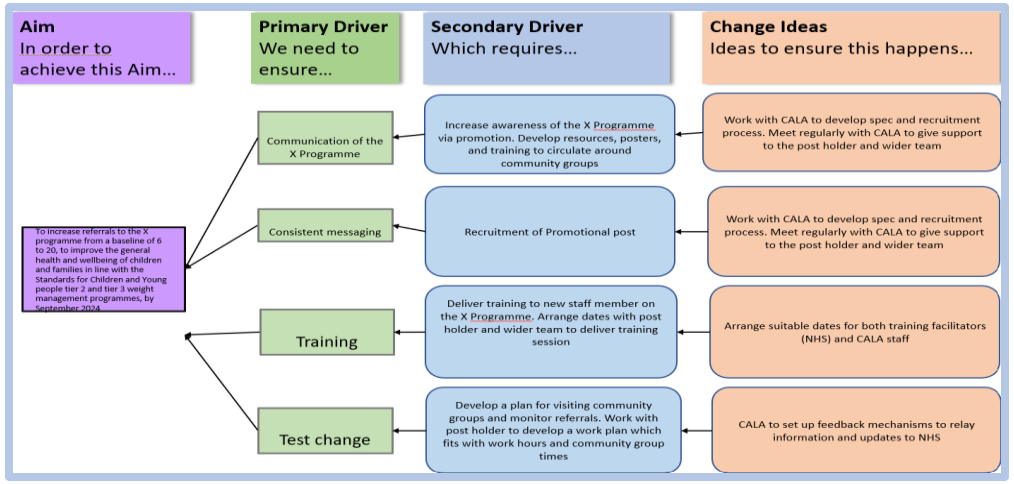
Stage of the QI Journey:

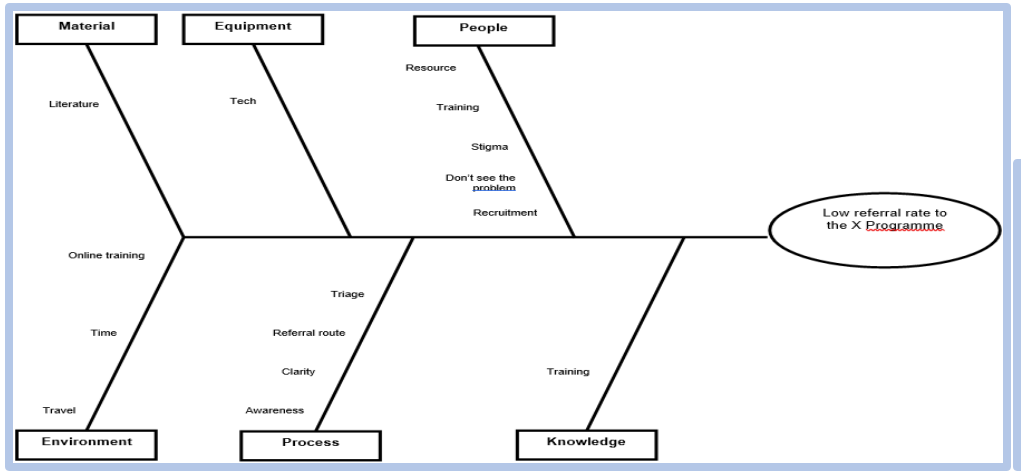
Developing Aims – PDSA cycle 2

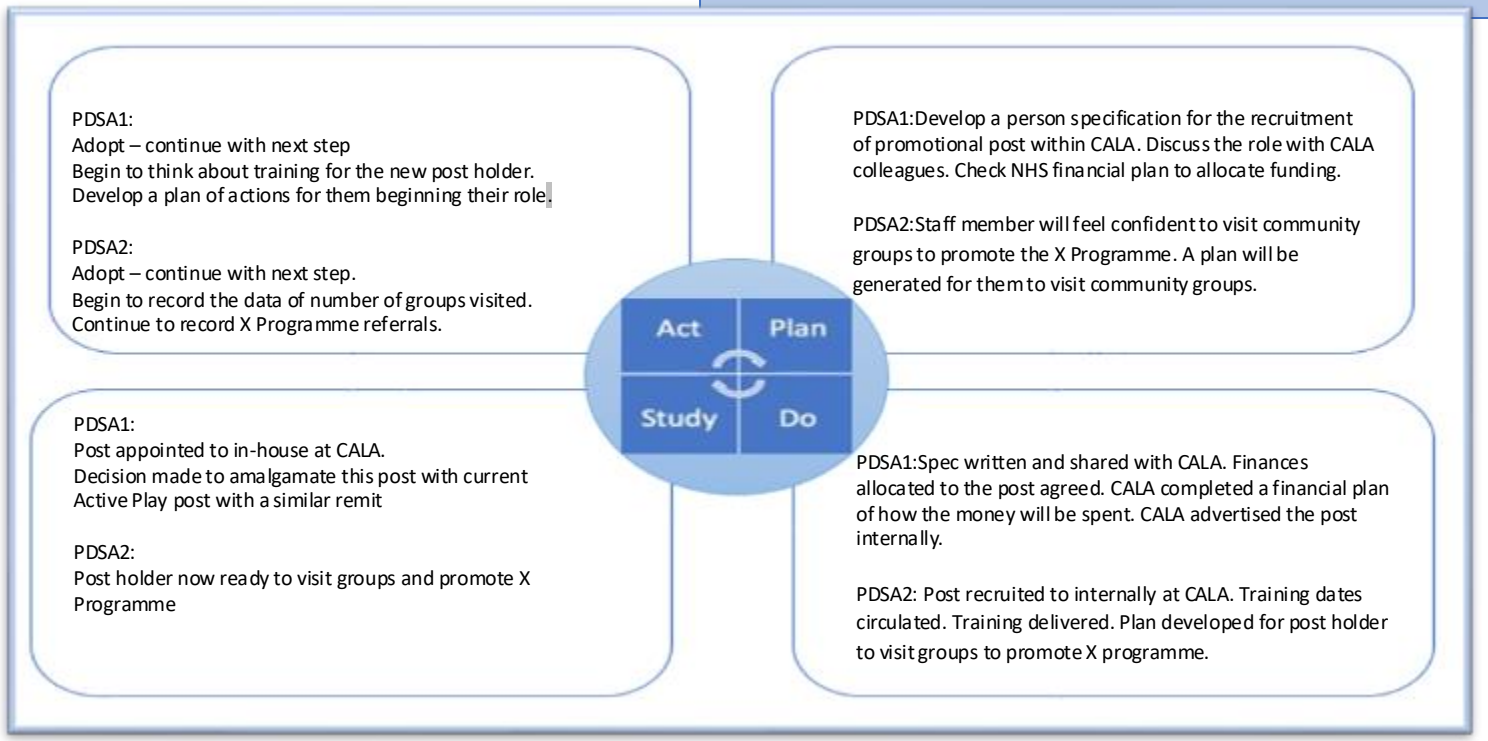
Current status:

Second PDSA cycle is complete – training the new recruit, developing a plan for promotion of the X programme.

QI Tools Used







Area of Learning – Successes – Challenges

Learning - I have learnt that each PDSA cycle needs to be kept small in order to measure it's impact. Using different QI tools has helped me to identify changes which might work and the order in which I need to try these changes. This first cycle has focussed on recruiting to the promotional post. This was completed successfully, and the next cycle will focus on training the post holder and developing an action plan for them.
Successes – post was recruited to easily as CALA managed to do this internally. Great cross-organisation work with CALA.
Challenges – conflicting priorities, and staff availability meant that meetings between CALA and NHS may not have happened as quickly. This was not a major challenge as both were keen to get the project off the ground so made time when they could.

Flash report – SIFS Cohort 5 – Rebecca Clark

QI Project Team: Elective Orthopaedics, NHS Highland

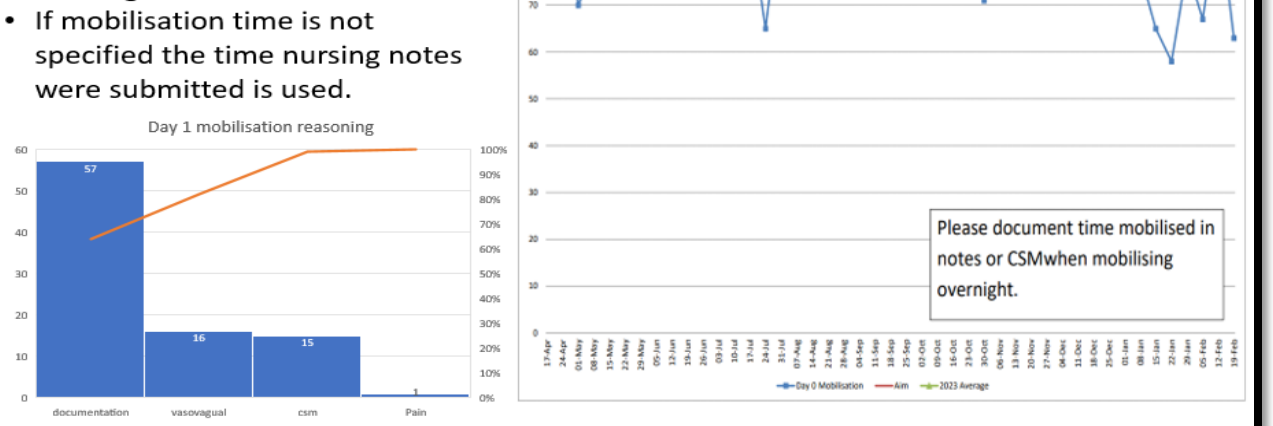
QI Project Aim: Reduce inaccurate documentation of day 0 mobilisation of arthroplasty patients from 40% to 10% by December 2024 as per the recommendations of good practice by ARISE (arthroplasty rehabilitation in Scotland Endeavour)

Stage of the QI Journey: Testing changes

Current status: Continue to monitor and share the data to ensure the compliance remains high.

QI Tools – Pareto Chart & Run Chart

- 40% of day 1 mobilisation rates is related to poor documentation.
- Please document **Mobilisation Time** in either the **CSM chart** or **Nursing Notes.**
- If mobilisation time is not specified the time nursing notes were submitted is used.



A pareto chart was used as the initial QI tool to identify that poor documentation was the leading cause of day 1 mobilisation. This chart was then placed with a run chart and displayed on the whiteboard to increase awareness of the statistic as well as, after discussion and education with ward management, emphasis on accurate documentation of mobilisation time being brought up at every shift change

Act

Adopt
Sharing data in real-time with staff has resulted in improvement.
Continue to monitor and assess solutions for sustainable change.

Plan

Change Idea: Improve awareness of day 0 mobilisation using poster with current data
Prediction: Sharing this information will increasing accurate documentation. Reduce inaccurate documentation by 50% on current data.

Task: Create poster & go to safety brief & re-emphasise the test

Act | Plan | Study | Do

Study

Improvements in day 0 rate from 72 – 88%
as per accurate documentation
Further improvements will be required
Consider the need for external factors to be analysed if no improvement (force field analysis).

Do

Increase awareness by displayed pareto chart and information on white board and incorporating need into daily safety brief

Area of Learning – Successes – Challenges

Success & Future Plans

On reflection, the pareto chart was appropriate to display the initial problem with inaccurate documentation however does not accurately document the success of the first PDSA cycle. Inaccurate documentation was reduced to 31% as the reasoning for day 1 mobilisation. However, during this PDSA cycle day 0 mobilisation increased from an average of 72% (on identifying the decrease in day 0 mobilisation that began early December 2023) to 88%. Inaccurate documentation is no longer the leading cause of reported day 1 mobilisation.

Continued work is required to reduce inaccurate documentation of initial mobilisation times. In the next PDSA cycle a force field analysis will be used to consider the factors that influence inaccurate documentation such as demand at the start of a nightshift.

FLASH REPORT (SIFS Cohort 5) *Dr Nikki Thomson, Clinical Psychologist*

QI Project Team:
Drug & Alcohol Recovery Service (DARS) Psychological Therapies Team

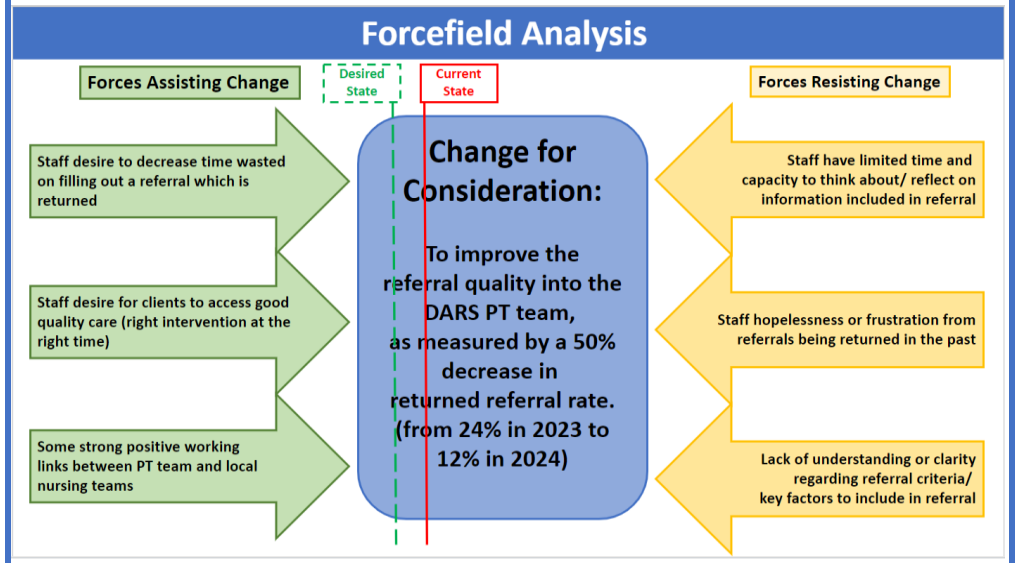
QI Project Aim: By December 2024, to improve the referral quality into the DARS PT team, as measured by a 50% decrease in returned referral rate. This is part of broader improvement work to meet MAT Standards 6, 9 & 10 (Scottish Government, 2021).

Stage of QI Journey:

Testing

Current Status:
Further PDSA cycle(s) required with broader scope and including "late adopter" and management voices.

Area to insert pictures of QI Tools Used:



Change idea: create decision-making flow chart to support staff's understanding and clarity about when to refer to DARS PT team.

ACT

Further adaptation of chart required to clarify language further (e.g. the difference between severe and complex)

Further PDSA cycle(s) required with broader scope and including "late adopter" voices

PLAN

Question to be answered: will a decision-making flow chart support staff understanding/clarity about the appropriateness of referrals?

Introduce flow chart to small number (n=2) of staff to gauge utility and other feedback

STUDY

Brief feedback questionnaire (pros/cons) was overall positive and staff felt it was likely to save time.

Useful discussions had in addition to questionnaire which highlighted differences in understanding of certain language (e.g. what does "complex" mean?)

DO

Create very brief feedback questionnaire
Identify staff to involve in PDSA cycle
Distribute flow chart and questionnaire

Area of Learning: The benefit of using the QI processes in even small projects. Some of the thinking was already happening subconsciously but the added structure fleshed this out and increased my confidence in the change I was trying to implement.
Successes: Positive feedback from staff regarding the flow chart, especially the added bonus of it being time saving (can use that as a "selling" point)
Challenges: Balancing making the flow chart comprehensive vs it being unwieldy/too long.

Flash report – SIFS Cohort 6 – Heather Mackay

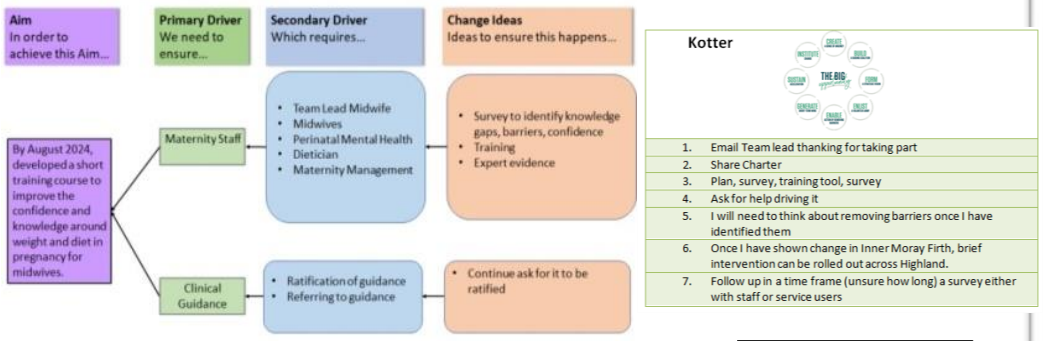
QI Project:
Public Health Improvement

QI Project Aim:
By October 2024, I will improve midwives knowledge & awareness to reduce weight stigma by 50%. This aligns with Scottish Government's, A healthier future: Scotland's diet and healthy weight delivery plan 2018

Stage of the QI Journey:
Testing changes

Current status:
Data is still coming in. Plan to continue to add some details and implement as part of a larger training package.

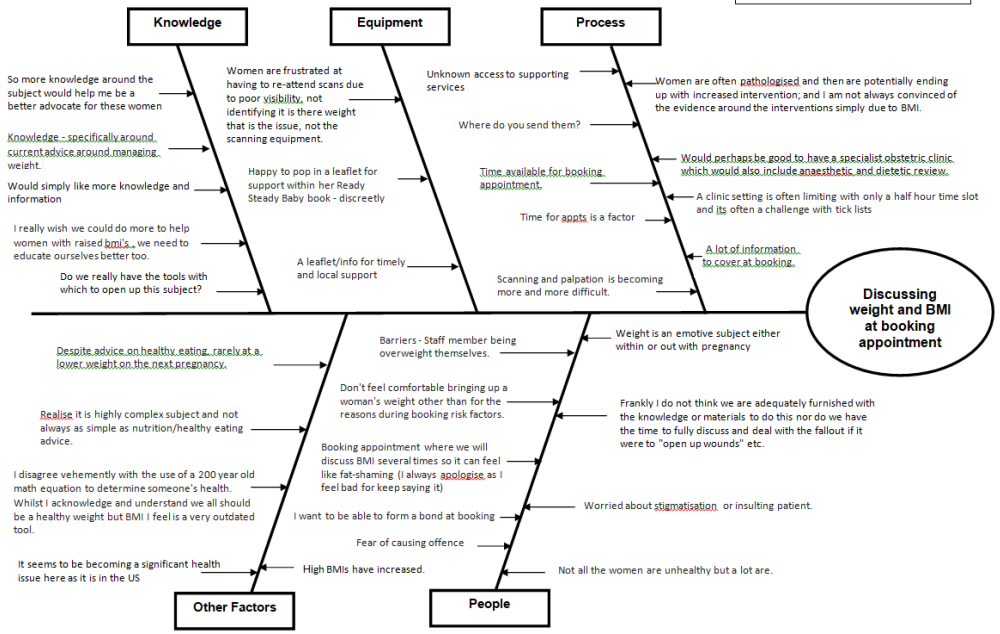
QI Tools



Kotter

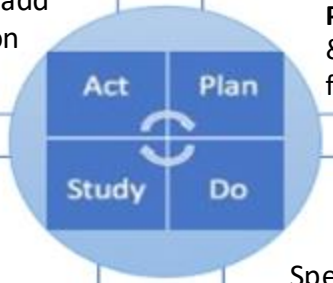
1.	Email Team lead thanking for taking part
2.	Share Charter
3.	Plan, survey, training tool, survey
4.	Ask for help driving it
5.	I will need to think about removing barriers once I have identified them
6.	Once I have shown change in Inner Moray Firth, brief intervention can be rolled out across Highland.
7.	Follow up in a time frame (unsure how long) a survey either with staff or service users

Staff Midwife Survey April 2024



Act
Adapt
This test was a success based on my measures. Feedback highlighted some additional resources are required and information around training. I plan to add these links and then test the animation with another round of staff

Plan
Change Idea: Make animation clip highlighting importance of weight stigma for staff
Tasks: Send via email & create survey to gather feedback via Microsoft survey. Create the animation
Prediction: 100% survey return & >50% reduction in weight stigma via feedback survey would signal success



Study
Measures:
Weight stigma had reduced by 75% on feedback
100% return on survey was achieved.
This took 10 days to receive all returns and review data

Do
Spent time making an animation on Yvond highlighting what weight stigma is
Animation sent to 13 midwives with guidance and time limit to reply

Area of Learning – Successes – Challenges
- Identifying the small change I could make was challenging. I wanted to discuss diet but the fishbone diagram let me know that I had to address weight stigma first.
- Time frame was challenging. I need to allow longer time for responses to surveys.
- Excellent level of engagement from midwives. Important views of staff collected.
- QI tools in Turas was a good resource. Helped me to remain focused and identify what were my next steps.

Flash report – SIFS Cohort 5 – John Carson

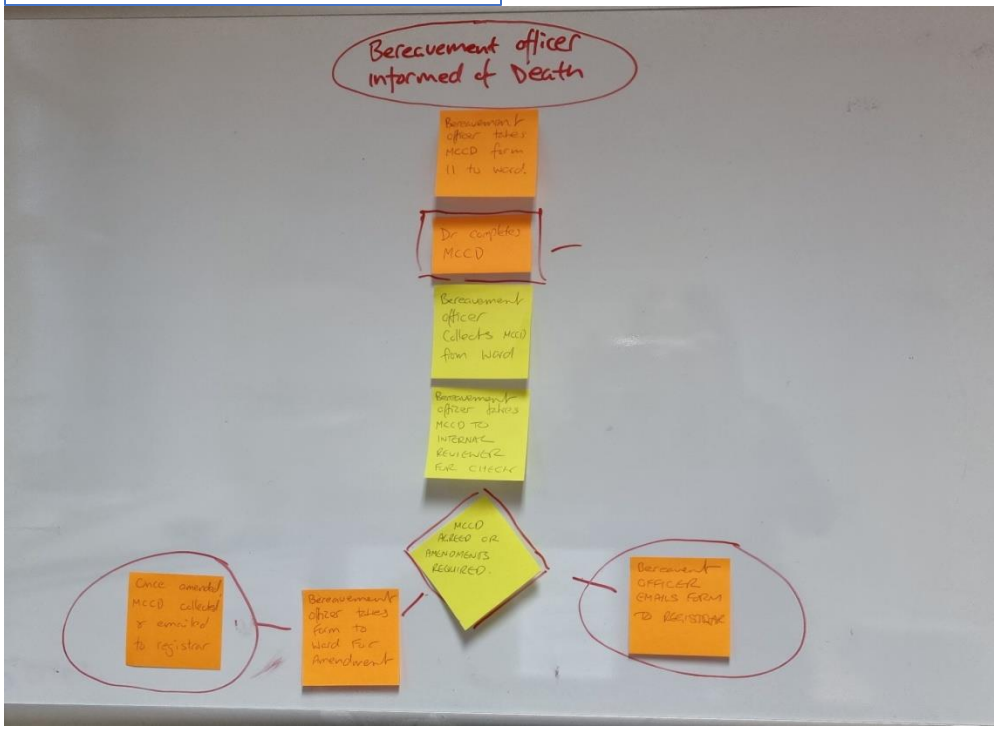
QI Project Team: John Carson & Claire McColl

QI Project Aim: To reduce the number of MCCD forms requiring amendment at point of internal review by 50% By August 2024 in line with -Medical certificates of cause of death:guidance on completion-gov.scot(www.gov.scot)

Stage of the QI Journey: Testing changes

Current status: PDSA / test of change 1
Commencing second PDSA 22/04/24

QI Tool: Process map



Act

Discussed feedback, added note that " failure " needs additional info. Guidance sheet to be tried with all MCCDs for one day.
Will **adapt** this change.

Plan

Test giving an updated guidance sheet with key points for completion of MCCD to Drs when delivering to wards.

Study

Sheet felt to be helpful. 1 x MCCD accepted as first completed.
Feedback to add info re " failure " wording – needs to be qualified.

Do

Guidance sheet given with one MCCD on 19th April. Discussed with Dr on the ward & asked for feedback.

Area of Learning-
Successes –All team supportive of trying change & fully involved
Challenges-Keeping to one change at a time , lots of ideas !
- Some IT issues (run charts especially !)
-Time – especially to get started – easier once commenced 1st .

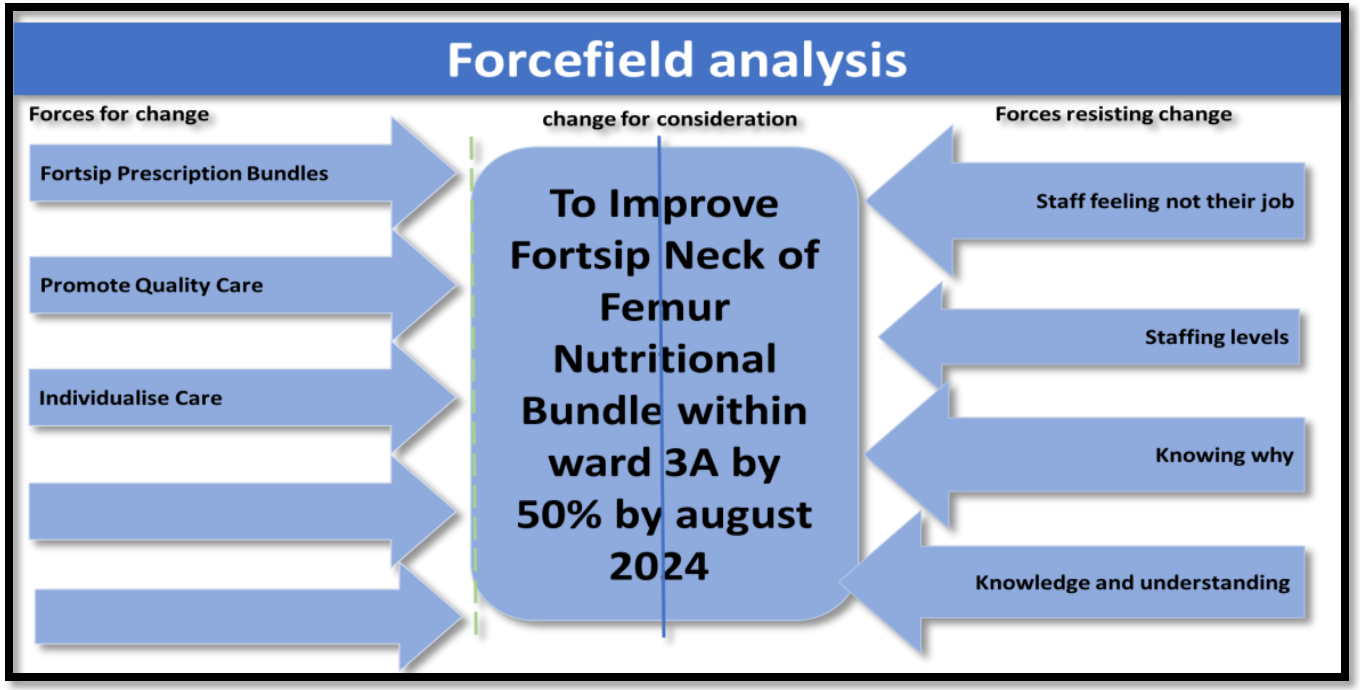
Flash report – SIFS Cohort Kathleen Chambers

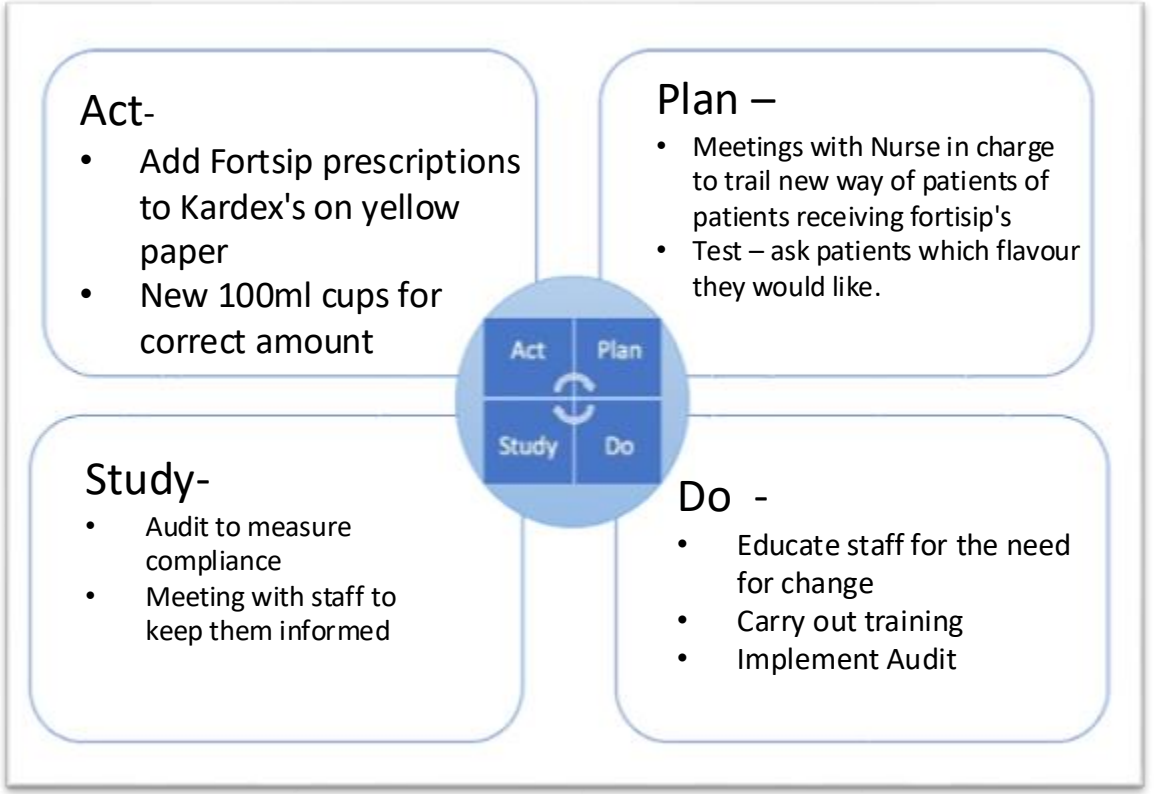
QI Project Team:
Ward 3A

QI Project Aim:
To improve Fortisip Neck of Femur Nutritional Bundle within ward 3A by 50% by August 2024 as per Scottish Government guidelines

Stage of the QI Journey: Testing

QI Tool:





Area of Learning

- The staff could see the benefits of the proposed change and it proposed change and its purpose explained to staff
- Keeping staff moral up while change happens
- Feedback from staff
- Learning that PSDA cycle needs to be small to measure its impact using QI tools help me to identify change
- Continue work is required to improve documentation with Neck of Femur Bundle

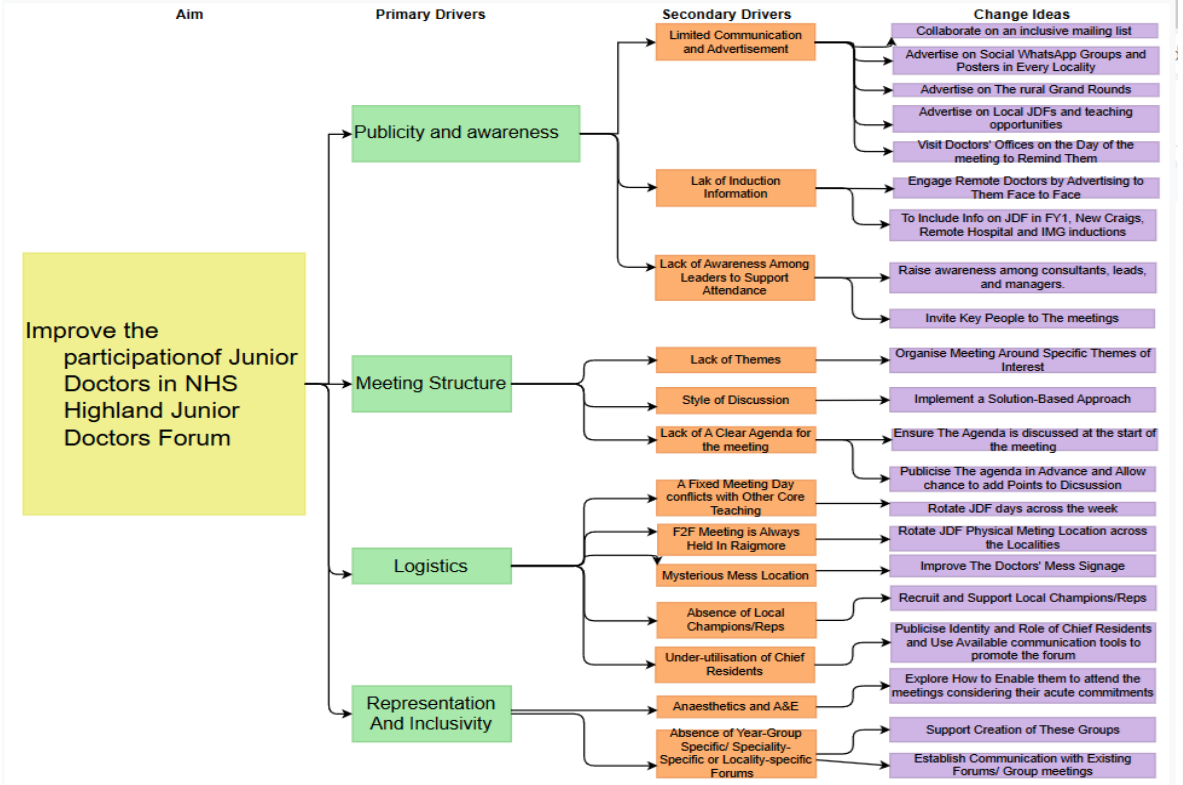
Flash report – SIFS Cohort 6 – Hamed Emara

Project Team: Hamed Emara, CT1 Psychiatry, New Craigs Hospital

QI Project Aim: To increase number of Junior Doctors attending JDF by a 100% from 6 to 12 people by September 2024. In line with NHS Highland Together We Care strategy.

Stage of the QI Journey: Testing Changes

Current status: Finished PDSA 1 and Planning PDSA 2



-Communications: Adapt to apply these changes to a wider audience.

-Advertise to Rural Grand Rounds – Abandon

-Rotate the day of the Junior Doctor Forum - Adopt

- Get contacts of admin staff for rural/remote hospitals
- Seek invitation to present at Rural Grand Rounds
- Plan to go to Caithness
- Get access to Raigmore Whatsapp social group
- Email DME admin to change the date of the next forum

The JDF was attended by 9junior doctors (2 cons, 2 admin staff, 1 Geriatric higher trainee, 1 med reg, 1 junior psych trainee, 1 junior Dr in ICU via teams, 5 F1s in med and surgery). **This is a 50% increase from the baseline number (6 attendees). This fits my prediction.**

Improve publicity/Communication :

- Send invitation emails to junior doctors in rural/remote localities via admin staff
- Advertise JDF on NCH JDF and teaching sessions.
- Advertise to Rural Grand Rounds
- Engage Caithness Drs by meeting Face to face
- Advertise on Raigmore social whatsapp group
- Visit Doctors' offices in Raigmore on the day of the forum.

Rotate the day of the Junior Doctor Forum
Gather attendance data

Learning - Learned that engagement with Jr Dr Forum is extremely low and that there is room to make big improvements. Learned about brainstorming as a QI tool and about the simultaneous implementation of bundles of change ideas. Learned to simplify and make the aim focused. Learned how valuable ChatGPT can be in the QI process.

Successes – I managed to quickly realise that a QI approach to this would be best. I took the initiative and got some shareholders on board. The driver diagram is a good fit here. Engaged shareholders eg DME and Education governance. Identifying key contacts for remote and rural locations

Challenges- The Project covers a massive area of the Highland and Argyle and Bute. Hard to get in touch with the people in remote areas. Poor communication channels in the system needs to improve.

Flash report – SIFS Cohort 5 – Donna Cowan and Susan Ross

QI Project Team: Donna Cowan, Specialist Midwife and Susan Ross Advanced Perinatal Mental Health Nurse, Perinatal and Infant Mental Health Team, NHS Highland (North)

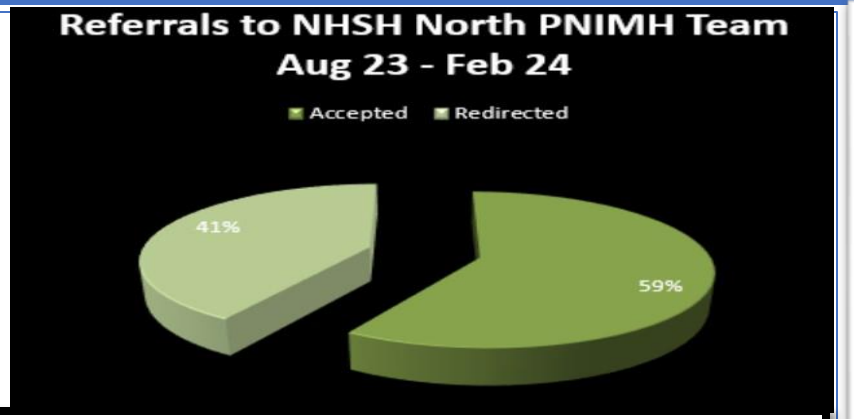
QI Project Aim: To reduce the number of redirected referrals by 10% into the Perinatal and Infant Mental Health Team within 6 months as per NHS Highland Together We Care Strategy 2022-2027.

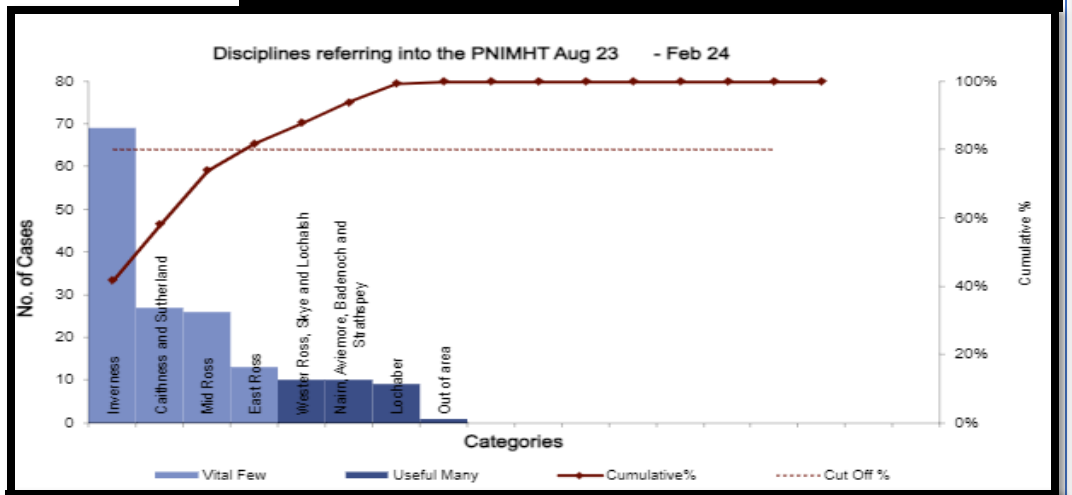
Stage of the QI Journey:
Testing changes

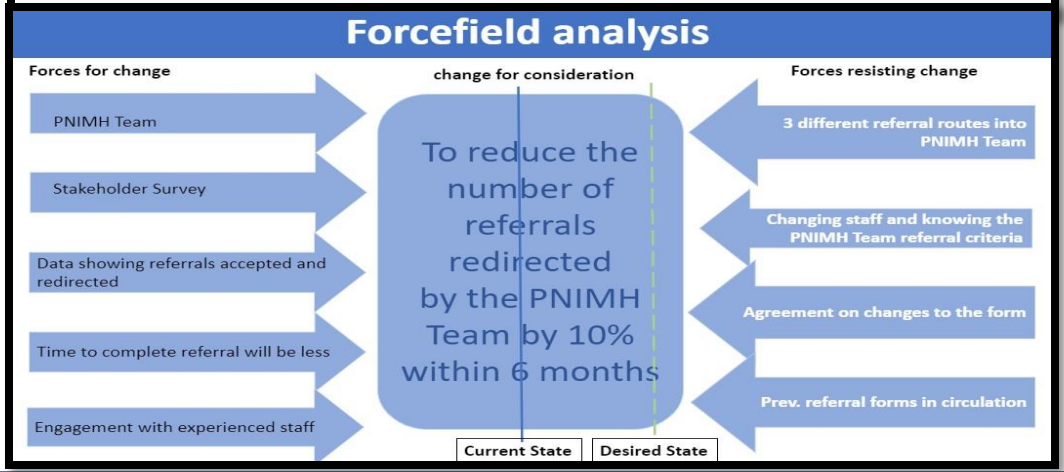
Current status of project:
Process map referral form for PNIMHT to review referral form, then arrange a meeting with top 3 colleagues in top 3 areas.

QI Tools Used

- Pareto Chart
- Forcefield Analysis
- Referrer Feedback
- Data collection







Act:

- From the data and feedback from the testing group, the project team will now adopt this change idea.

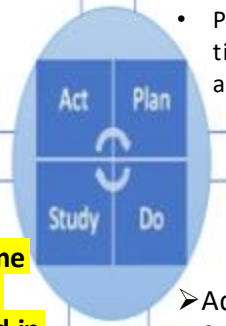
Plan:

Change idea:

- Make alterations to the digital referral form

Predictions:

- The PNIMH team will receive on average 2 less redirected referrals in testing week
- Professionals will report less time taken to make referral and feedback positively overall



Study:

- **Midwife reports less time taken to fill out referral form, criteria embedded in referral form useful,**
- **PNIMHT - appropriate referral and accepted for assessment. More information given in relevant section**

Do:

- Adapted version of referral form sent to Easter Ross Midwife to use for next referral

.

Area of Learning - Using QI Methodology we are focused on one change idea to achieve our project aim. This test of change will help us refine our PDSA and advise if we need to return to understanding our systems or implement.
Successes – Good team support, increased QI knowledge
Challenges – Workload pressures, creating a user-friendly referral form

Cohort 6

Flash report – SIFS Cohort 6 – CECYP Health Team (Argyll & Bute)

QI Project Team:
Alice Johnston &
Sarah Simpson
CECYP Health Team (A&B)

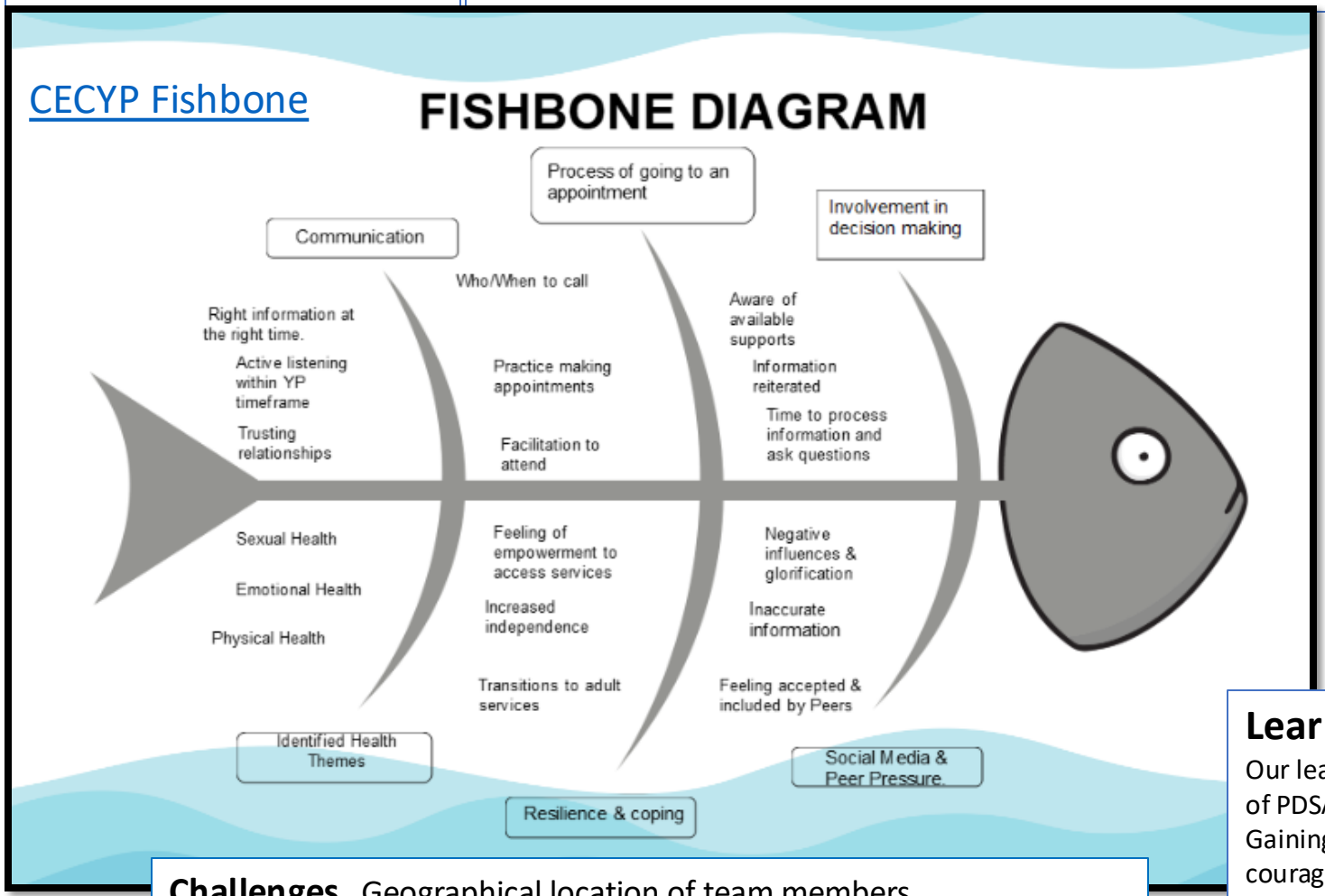
QI Project Aim: **50%** of young people in Dunclutha will report feeling actively listened to, in terms of emotional health by December 2024 line with The Promise Scotland. (Five Foundations – Voice)

Stage of QI Journey: Testing Changes

Current status:

PDSA Cycle 1 - Ongoing

CECYP Fishbone



ADAPT - Ensure monthly key time is carried out along with weekly check in with a staff member of young person's c hoice. Monthly drop-in sessions with CECYP health team to promote joint working and ensure early intervention for specific health needs of young people. Above changes to be incorporated into PDSA Cycle 2 commencing July 2024.

YP to feel actively listened to and empowered to address their emotional needs by accessing support at a time of need. Possible resistance from staff due to busy shifts/schedules. Increased opportunities for positive connections

Act | Plan | Study | Do

Carers were unable to provide all sessions requested due to other tasks/duties/time constraints. They felt this was unachievable to provide immediate response. Carers found that YP were overly demanding of attention due to unstructured check ins. YP felt confident requesting support but unable to have individual time with staff on every request#.

For 1 week allow YP to choose own check in time with staff rather than carer led allocated time. Alice and Sarah to discuss ch ange idea with staff and YP - request feedback on this afterwards.

Challenges - Geographical location of team members.
Small team covering large geographical area and vast inclusion criteria
Resistance to change from staff & time constraints of house staff

Learning & Successes

Our learning - Knowledge and implementation of different QI Tools and use of PDSA Cycles.
Gaining confidence in addressing issues within residential homes and having courageous conversations with staff.
Increased confidence when advocating on a young person's behalf.
Encouraged opportunities for Alice and Sarah to review impact of CE health team to date.

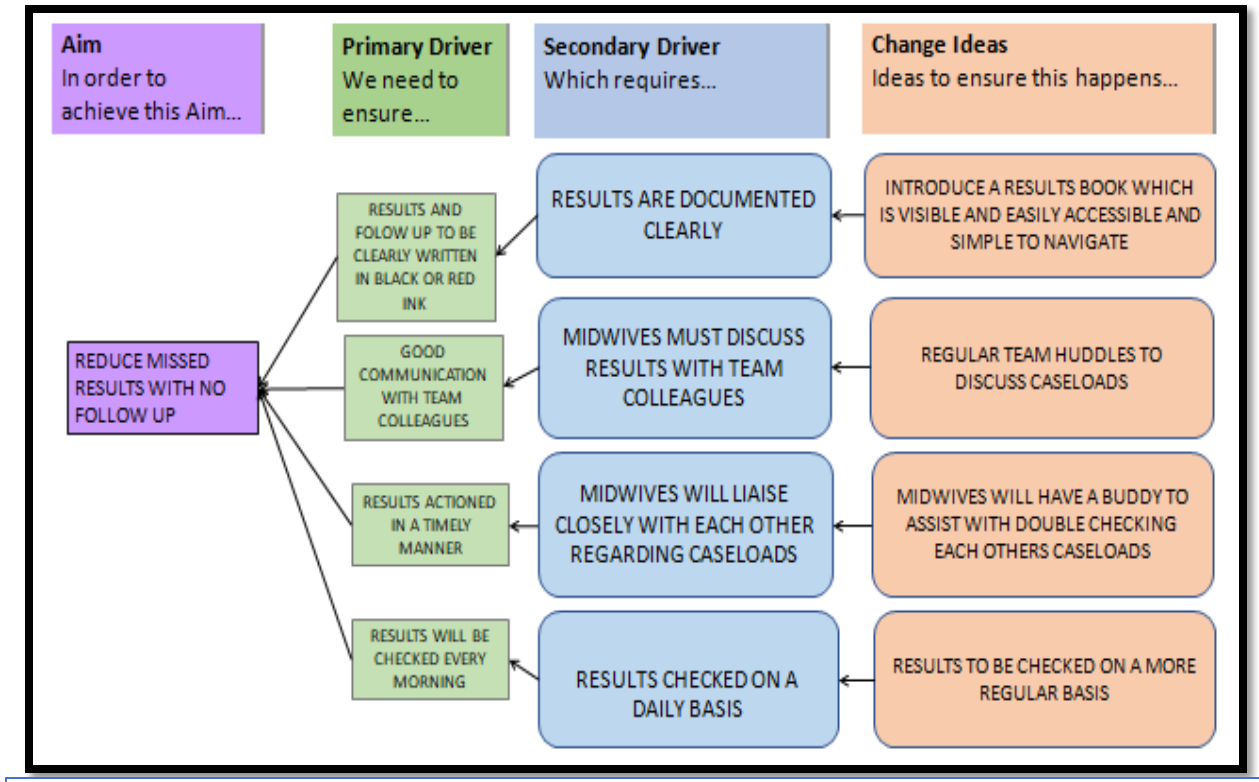
Flash report – SIFS Cohort 6– Christine Campbell

QI Project Team:
Campbeltown MLU

QI Project Aim:
Reduce number of missed results with no follow up for antenatal patients by 75% in order to provide the best and safest patient centred care for maternity services within our MLU by Dec 24 in accordance with Antenatal Care NICE Guidelines (NG201), 19th Aug 2021.

Stage of the QI Journey:
Testing Changes

Current status:
PDSA 1st cycle



Act:
Staff meeting to discuss change ideas. Adapt new changes. Introduce a simple results book that is easy to navigate and complete daily.

Plan:
Educate staff to complete regular documentation of all results that require to be actioned.
Clear plan to be put in place.
Implement small changes

Study:
All team midwives happy with new way of documenting all results. Pleased to have a buddy midwife to share responsibility of following up results needing actioned.

Do:
Ask for feedback from team midwives to discuss compliance.
Continue to monitor implemented changes.

Challenges
1: All team members having to adapt to new way of recording results.
2: Time taken to get used to the new way of working.
3: Some results not recorded in book so team colleagues not aware of samples obtained.
4: Following up missed results time consuming.
5: Due to missed results another book was introduced to monitor Haemoglobin & Ferritin levels and to dispense TTO medication.

Successes
1: All team members on board with new results book.
2: Missed result numbers have greatly reduced.
3: Positive feedback and team members prefer this way of recording results.
4: Results book now part of daily tasks.

Flash report – SIFS Cohort 6 – Eilidh MacDonald SCN

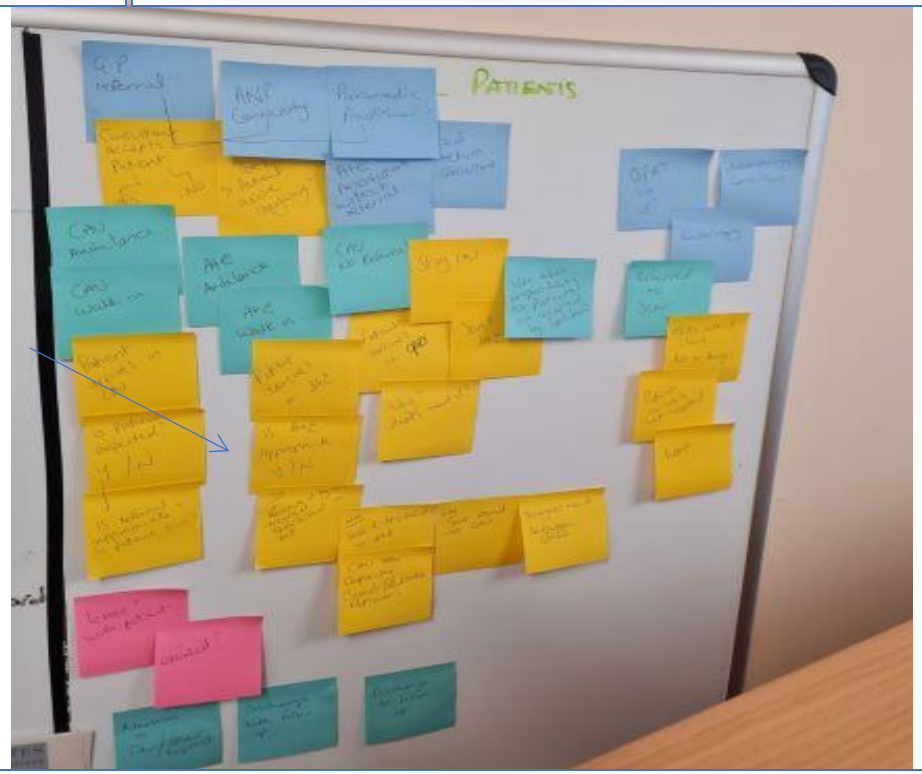
QI Project Team:
Combined Assessment Unit
Belford Hospital

QI Project Aim:
All appropriate GP referrals will be reviewed in CAU GP referral unit as per locally agreed protocol by October 2024.

Stage of the QI Journey:
Testing changes

Current status:
1st PDSA cycle testing changes by collecting data to compare to baseline audit to assess if change has led to an improvement.

QI Tools Used
Process Map



Act – Adapt
- Pathway to be circulated more widely to include GPs, CAU and A&E staff
- 'opening hours' to be extended beyond current 16.30 cut off; junior Dr and staff nurse rota to be amended accordingly

Plan
- Gather baseline data on the number of GP referrals inappropriately sent to A&E including LOS/breach times
- Agree and circulate CAU exclusion criteria/pathway with stakeholders
- Seek senior management approval to prevent 'bedding down' in GP referral area

Act | Plan
Study | Do

Study
- More activity seen in GP referral area.
- Patients fulfilling referral criteria are still attending A&E

Do
- Exclusion criteria written and agreed upon by clinical director and hospital manager
- Circulated to consultants
- GP referral area staffed Mon-Fri 0930-1700
- Senior management approval to 'protect' GP referral area from inpatient stays.

Area of Learning – Successes – Challenges

Challenges: Communicating the need for change by highlighting that the status quo was leading to crowding within the A&E department, increased breach times and poor flow throughout the hospital. Support from senior management to recognise the value in ring fencing an area for GP referrals vs inpatient beds. Consultants agreeing to follow newly agreed pathway.
Successes: Agreement and support from senior management. GP referral unit successfully ring fenced from inpatient use.
Going Forward: This project forms part of a wider restructure of services within the hospital. The plan for a new hospital has been shelved, therefore, we are being asked to adapt our working practices within our current infrastructure to improve capacity, flow and patient experience. Having senior management support for this project will continue to be beneficial in driving these changes forward.

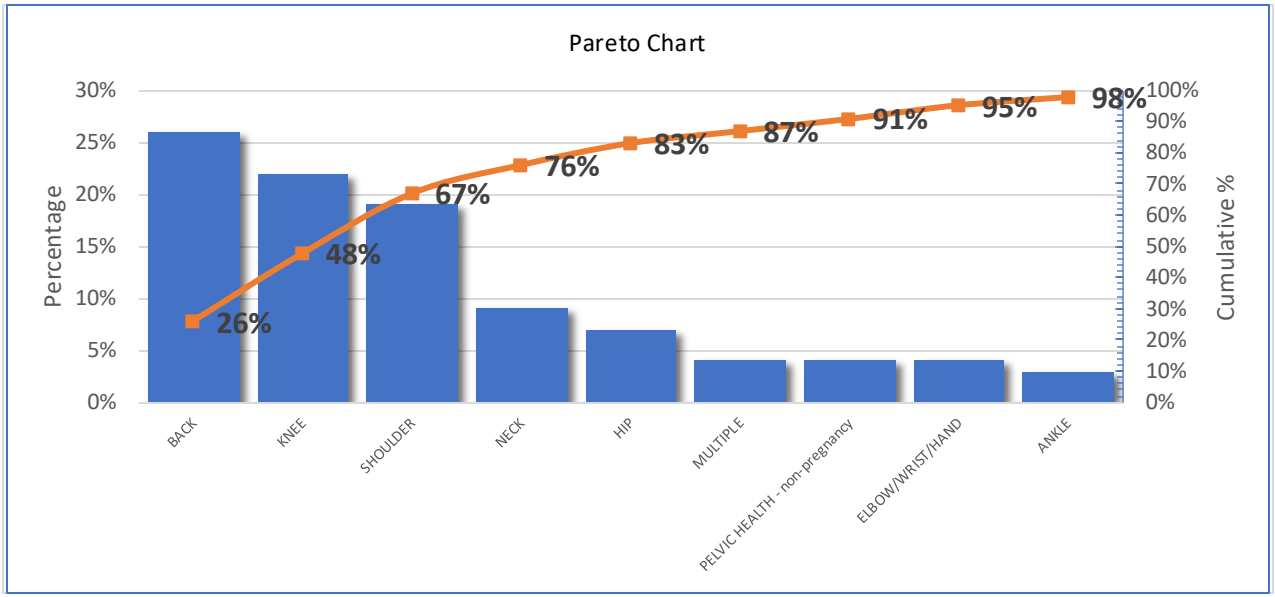
Flash report – SIFS Cohort 6 – Gemma Bruce

QI Project Team: Gemma Bruce Advanced Practice Physiotherapist LIH Oban

QI Project Aim: To improve the triaging of new referrals into the physiotherapy MSK service by 50% in order to support compliance with Scottish Government MSK waiting times Guidelines 2014 by June 2024

Stage of the QI Journey: Testing Changes

Current status: Reinforcing concept and providing feedback

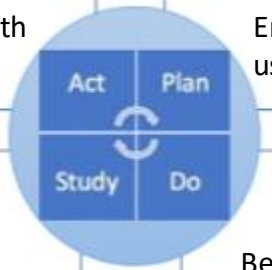


Act

Discuss with MSK staff involved in that triage process. Identify issues related to incomplete triaging. Establish new triaging guidelines and communicate with all triaging staff and admin.

Plan

Design new Triage Standard Operational Procedure
Discuss with Team Lead and all MSK triage staff and amend
Email all triaging staff requesting use of SOP. Arrange start date.

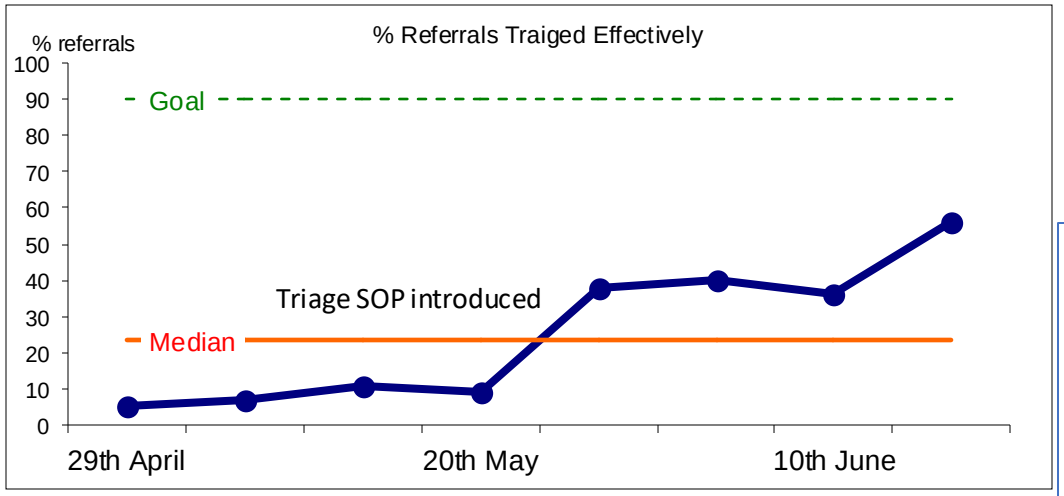


Study

Improved triage of new referrals allowing appropriate onward allocation.
Improved use of admin and physio staff time and resources
Identify modifications required and implement

Do

Begin new triage process.
Monitor weekly and collect data.
Provide immediate feedback to triage staff to reinforce SOP



Challenges

Initial Project was too big to fit within QI course timescale but is ongoing.
Underestimated the time required for the project and no dedicated non-clinical time allocated.

Successes

MSK team keen to get involved – happy to take on ownership of aspects of the wider project.
Improvement in triaging identified by MSK team and Admin staff

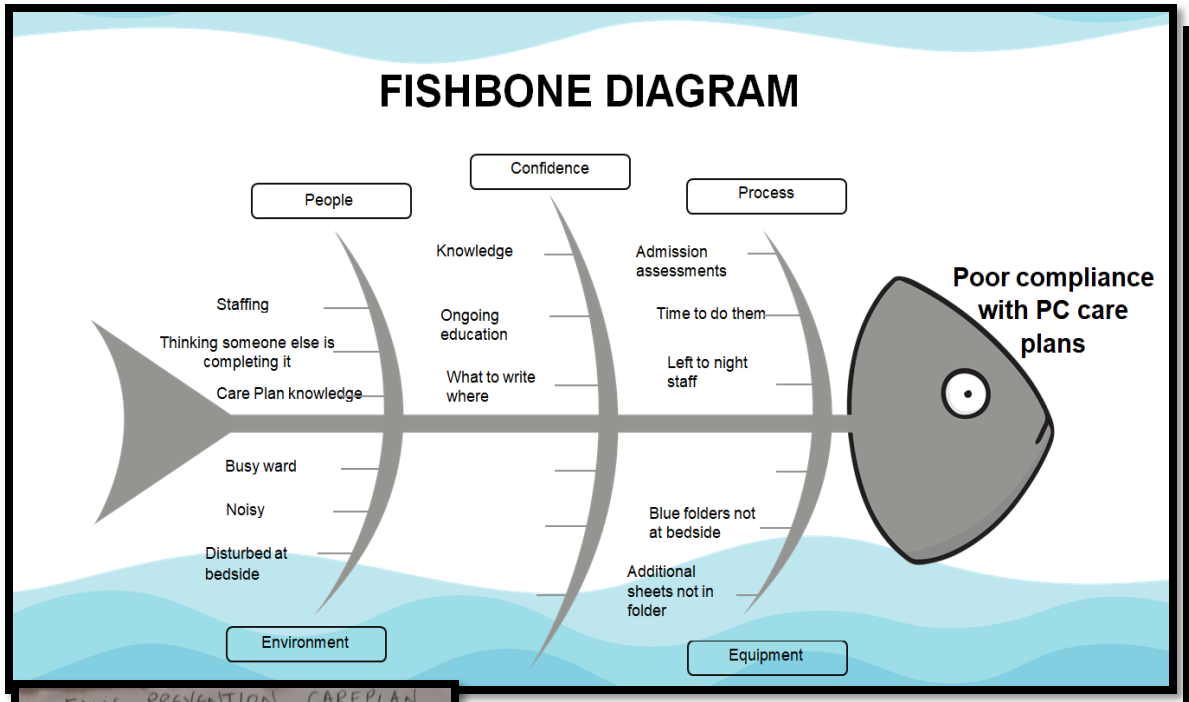
Flash report – SIFS Cohort 6 Joanne Hill Cowal Community Hospital

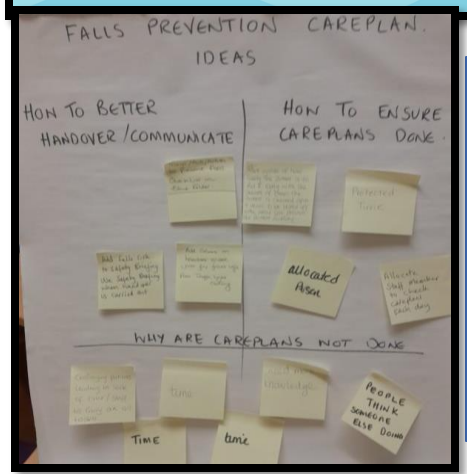
QI Project Team: Joanne Hill Inpatient ward Cowal Community Hospital

Aim: By 31/08/2024 all patients assessed at risk of falls in our ward will have an effective, person - centred falls care plan completed as per HIS SPSP falls driver diagram & change package.

Stage of the QI Journey: Testing Changes

Current status: Adapting PDSA 1 and testing again





Area of Learning

Reviewing this process helped me to see where there were gaps in our documentation from admission in care planning. My light bulb moments came at this time.

Challenges

TIME alloting protected time for the project. Keeping the change ideas small

Act

I will adapt this test and try again sharing the feedback with staff.
Staff on dayshift/nightshift may have different requirements and for staff I cannot see in person I
will create example care plans and share

Plan

Lack of knowledge identified as change idea - so plan to test refresher sessions for staff to improve their knowledge
Predicition: 4 staff will attend the session
Measures: All staff will report this has been helpful

Study

Staff feedback stated that they found the refresher session helpful but still had some questions around what to put in the SCP and KM sections
When I audited after the session I found that compliance with PC care plans was improved but quality could be better

Do

During first refresher session nursing staff were interrupted & I changed my approach to delivering 1-2-1 during the whole shift. I captured all staff on shift this way who were on day shift. All staff were then asked to review their paperwork and I would audit accordingly.

Successes

The project is having a positive impact on team moral as everyone involved and allows time for discussion and reflection on our practice

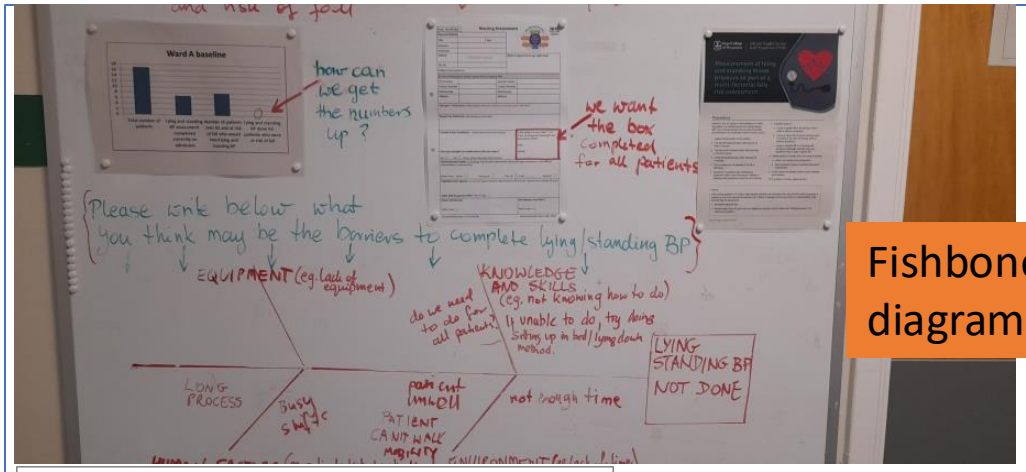
Flash report – SIFS Cohort 6 – Kinga Cholewa

QI Project Team:
Ward A, Lorn and Island Hospital, Oban

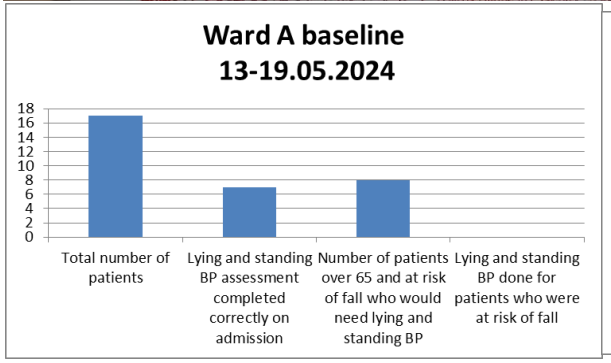
Aim: *Ward A Nursing staff will screen all patients and document lying/standing BP on admission for all patients over 65 and at risk of falls by June 2024 in line with the national fall's driver diagram.*

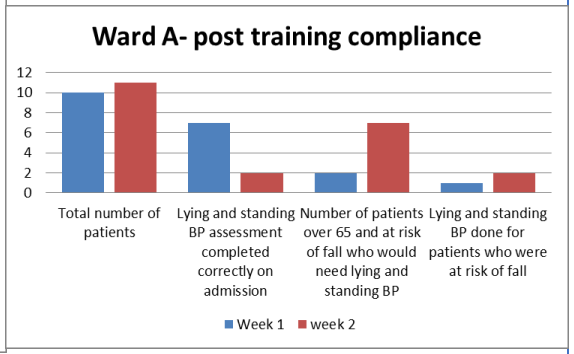
Stage of the QI Journey: Testing Change

Current status:
PDSA cycle 1- training completed, small improvement. Ward meeting will be arranged to understand lack of compliance.



Fishbone diagram





Ward meeting to be organised to find out why there is reluctance in completing lying/standing BP and what can be done to encourage staff to be compliant.

1.Prepare to carry out the training by gathering as much updated information as possible on the topic.
2.Anticipate possible questions from staff and prepare answers.
3.Review the off duty and organise the sessions on days which would capture most staff.
4.Prepare admission paperwork and blood pressure machine to demonstrate how to complete lying and standing BP on admission.
5.Display information on the board in front of nursing station so everyone can refer to it.

Staff was receptive when doing the training. But they were challenging it and saying that they won't drag patient out of bed, or is too busy or patient refused or patient is too unwell. After training completed, there was huge improvement in completing the assessment box. But lying and standing BP was still not done in all cases even if person completed the assessment and documented it was required

Information displayed on the board near nursing station. Dedicated bitesize session organised between 3-4pm each day on the days when staff members were available.

<u>Area of Learning:</u> I realised that making a change is about taking one step at the time. I had tendency to go with big projects but real change is happening if you are consistent and break down the process to small steps. I learned a lot about Quality Improvement process. Initially, I found it difficult to comprehend what is expected and by the 4th session it all fell into place.

<u>Successes:</u> High improvement in the completing the box, smaller improvement in doing lying/standing BP initially.

<u>Challenges:</u> Staff were a bit reluctant to get engaged in the process once engaged after initial improvement, the compliance dropped again

Flash report – SIFS Cohort 6 – RHONA HAMILTON AND LIZ TAYLOR

QI Project Team:
RHONA HAMILTON AND
LIZ TAYLOR
Helensburgh Advanced
Practice Physiotherapists

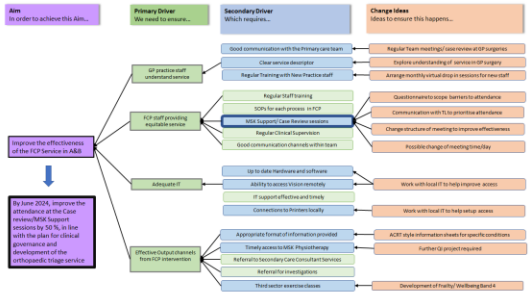
QI Project Aim:
By June 2024, improve the attendance at the weekly Case review/MSK Support sessions by 50 %, in line with the plan for clinical governance of the Primary Care Improvement Plan and development of the A&B Orthopaedic Triage Service.

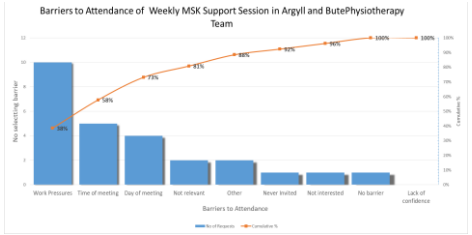
Stage of the QI Journey:
Testing Changes

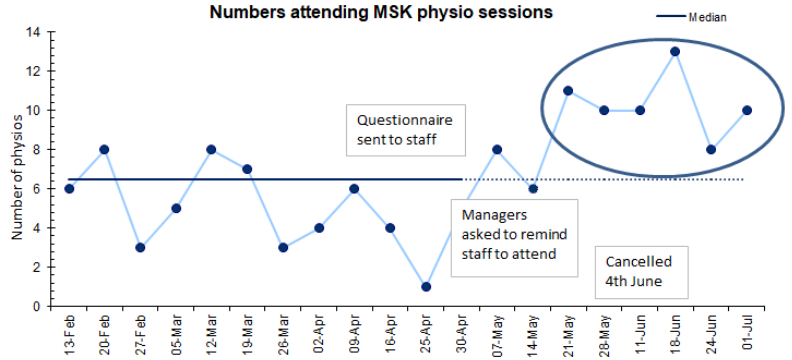
Current status:
Identify further change ideas to support attendance.
Run PDSA Cycles to assess effectiveness.

The Quality Improvement journey:

QI Tools Used







Act

Emailed APP leads to request feedback from all APP physio staff.
Ensure new staff are invited to sessions.
Continue to measure attendance.
Encourage staff at meeting to ask colleagues to come along.
Plan next change idea/test

Plan

Questionnaire to scope issues.
Discussion at APP staff meeting to scope change ideas.
Email to Locality Physio Team Leads to encourage attendance with all staff managing an MSK Caseload.

Study

Significant increase in attendance – 100%
6 data points above the baseline median - significant shift.
Positive feedback from staff re the new structure to the meeting.
Identified new staff not on invite list.

Do

Email sent to Team leads to support and encourage attendance.
Ensure all appropriate staff are on the Teams invite for the meeting.

Area of Learning – Challenges

1. Time Management - to plan/go over training/ meet with mentor/ rest of APP team.
2. Project too big to start with – changed aim after third module.
3. Understanding the QI jargon – which tools to use
4. Timescales of module dictating project choices.
5. Difficult getting engagement of staff – better to involve team at early stage.

Area of Learning – Successes

1. Understanding develops with each module undertaken
2. Awareness of future QI projects identified during the process.
3. Mix of Teams/ Face to Face training/ meetings and drop in's worked well
4. 100% increase in attendance at meeting - need to ensure maintain this level going forward.

Flash report – SIFS Cohort 6 – Lynn Dalrymple and Susannah Conran

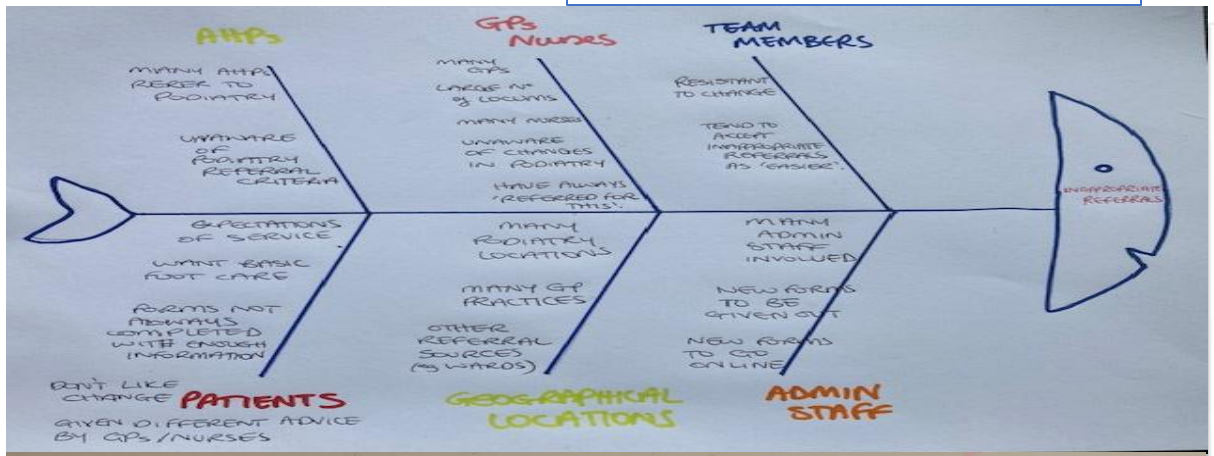
QI Project Team
Lynn Dalrymple and Susannah Conran.
Podiatry Leads in Helensburgh and Rothesay

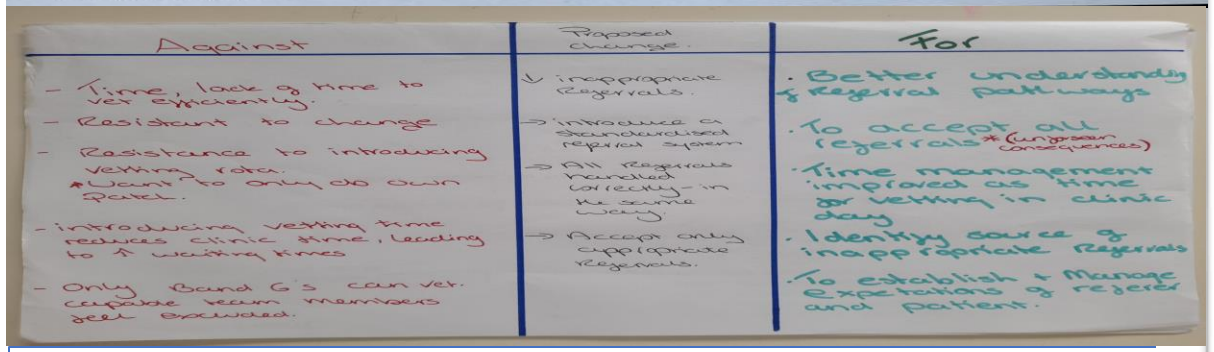
Aim: By 31.12.2024 90% of podiatry referrals will be in-line with the NHS Highland priority codes

Stage of the QI Journey:

Testing Changes

Current status: The first PDSA cycle has been started but we have not had significant returns from this to collect data. Once we have some data from this cycle we will do a further PDSA cycle using the self-referral form





Review the number of referrals after the change to see if the number of inappropriate referrals has decreased.
Next step is to start using the new self-referrals

Lack of information about the NHS Podiatry service has resulted in inappropriate referrals .
Plans to improve communication and information with GPs, nurses, FCPs and patients

Act Plan Study Do

The updated information for the GP practices has been sent out. So far there has been no contact from the GPs or health care staff.

Letter sent to the GP practices advising and updating them about current NHS podiatry practice. A copy of the Priority Codes table was included. We asked them to get in touch if any questions.
The self referral form has been redesigned to include information about the podiatry service and what is included and what is not. This has not been sent yet.

Successes The project highlighted to us the many areas that need to be thought about and addressed when making a significant change.
We learnt that to do a project well, it has to be broken down into the smallest parts of the process and these need to be addressed individually. What we thought would be a simple project turned out to be far more complicated and that by focussing on one area at a time, the project will ultimately be more successful as all variables have been considered.

Challenges Our project started too big and although we reduced the size (number of geographical areas included) it was still too big to get accurate data. However, it has been a good start to an important project and has made us familiar with the process and a taught us a new way of thinking when considering changes. This will be beneficial to the ongoing improvement plan and other further plans. Time was also a challenge when carrying out this project. This was partly because the PDSA cycle was too big but also because when giving thought to, and working on a project, time is needed. This highlighted to us how little time within our work time we allocate to working on changes that ultimately improve the service and save time.