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.

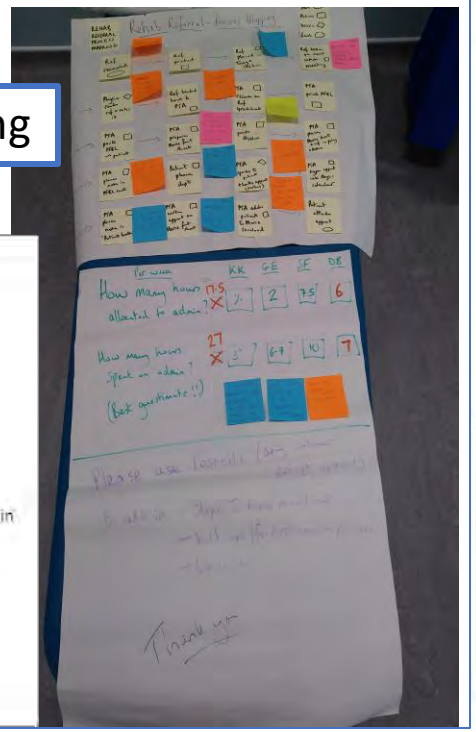
Stage of the QI Journey:

Testing Changes

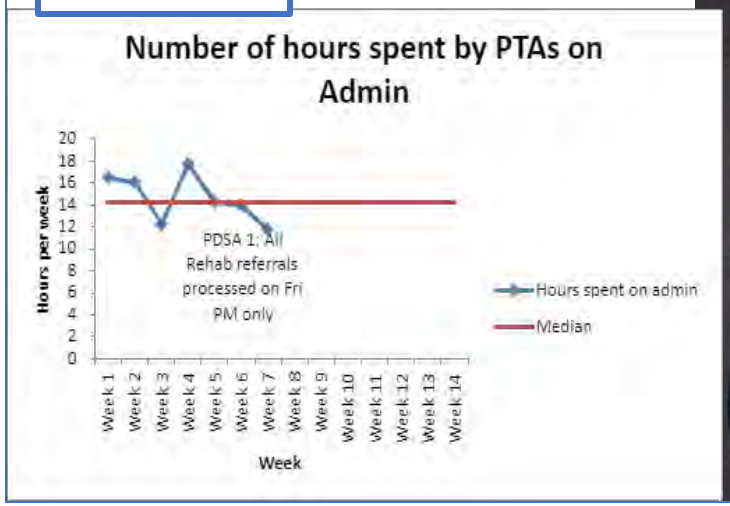
Current status:
Second PDSA cycle starts 26/6/23, and a third one planned (delegate PECOS ordering to the wider Admin team at B & S CH).
Note: Once Morse is fully functional, referrals will all be electronic and some current admin practices will be obsolete. However, the development of Morse is slow. 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 cycle s (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.

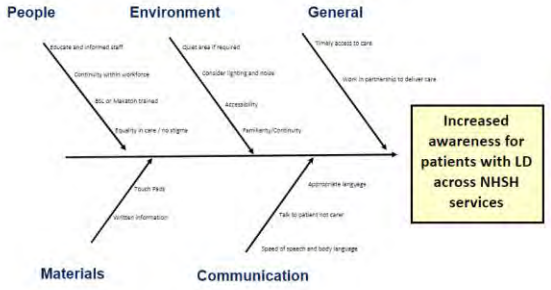
Stage of the QI Journey:

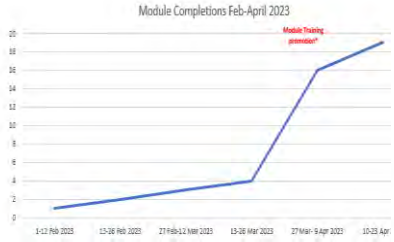
PDSA Cycle 2 (paused)

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





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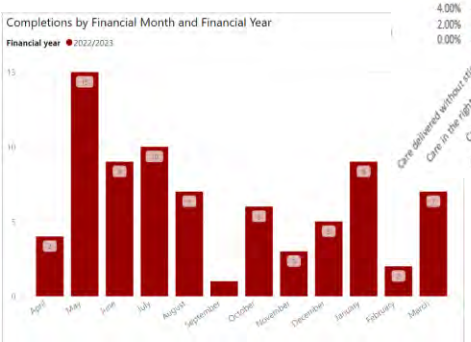
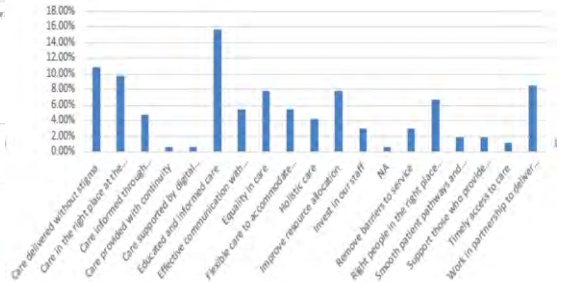
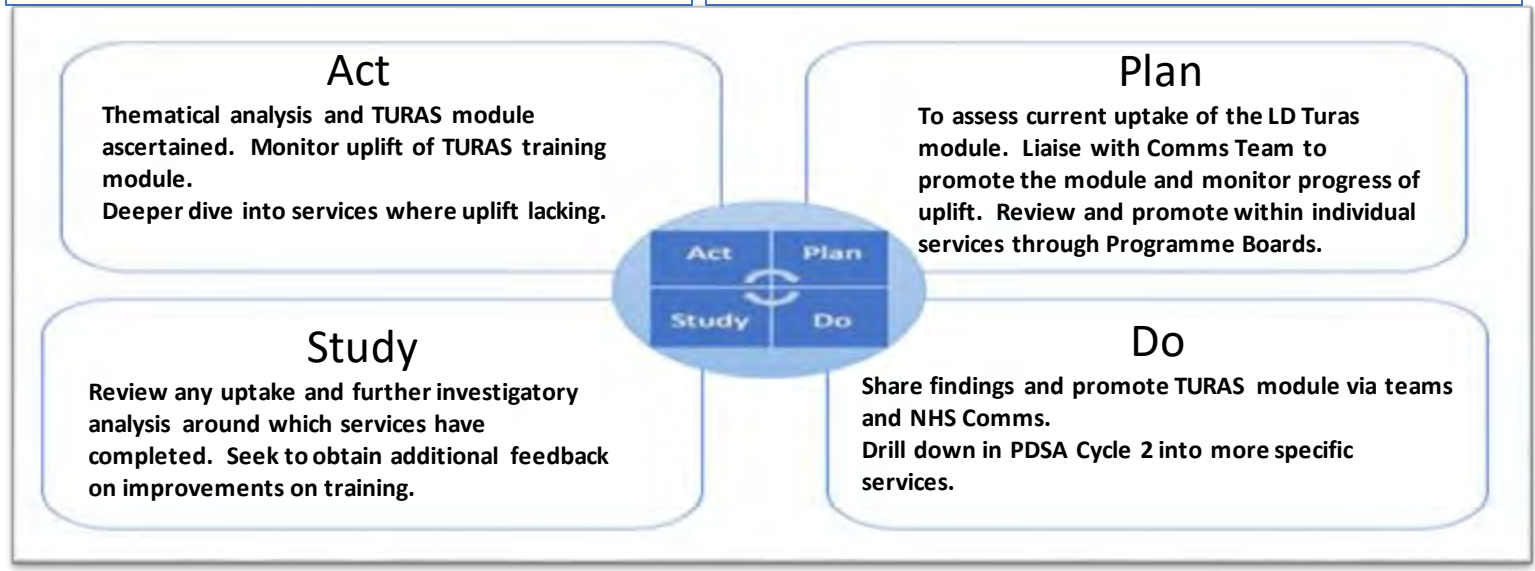




User Feedback



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

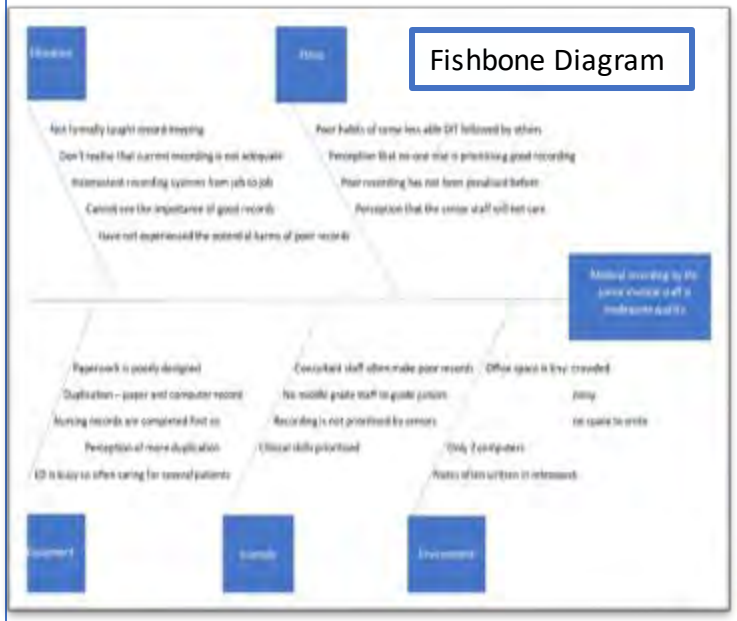
Current status:

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



Act

Education as to why the change is important along with a request to change seems to be effective for most, so this approach should continue but with a less gentle manner, and involving all educational supervisors for support as improvement is not optional.

Plan

Email all the junior doctors explaining why ID is required and asking them to use the rubber stamp provided to them with the name, grade and GMC number on it. Predict a small improvement from median 50% to @60%

Study

Median improved more than predicted (although variability is high) from 50% to 67.5%. There was some kick-back to the changes being requested, some viewing GMC Good Practice as optional and one declining to change.

Do

An email was sent to all the junior doctors, copied to the educational supervisors and clinical lead, explaining why identification was important and asking that the ID stamps be used. 2 follow-up emails sent to those who were slow to reply.

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

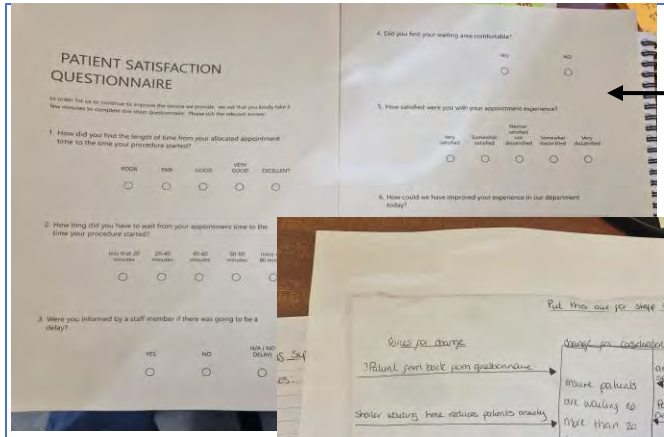
QI Project Team:
Highland Urology Clinic, Raigmore Hospital

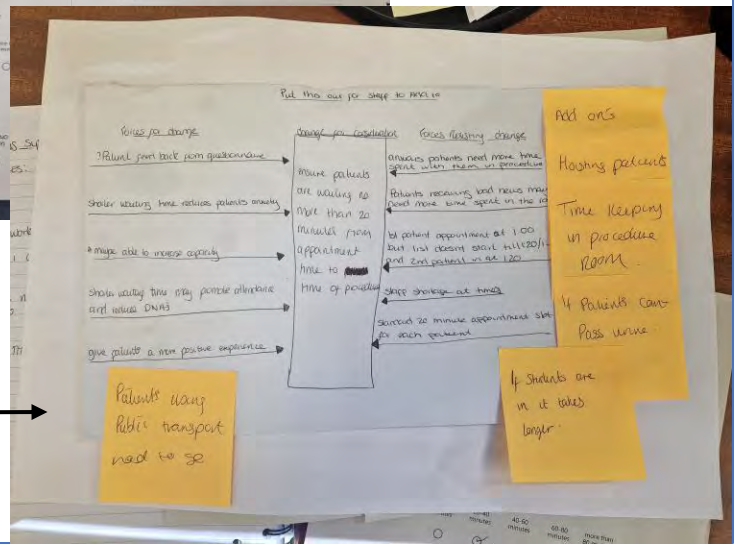
QI Project Aim:
By 1st July 2023, patients attending the Highland Urology Clinic for a cystoscopy, will wait no longer than 20 minutes from the time of their appointment, till the time the procedure starts.

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


Act- adapt
- Speak to admin staff again to have the actual appointment times changed depending on the procedure
- Repeat PDSA cycle and hope to see a decrease in waiting times.

Plan
- Amend appointment times using the 12 point per list system.
- Discuss with all stakeholders
- Record patients waiting time
- Record patients views by utilising the patient satisfaction questionnaire.

Study
- Some of the consultant's lists are training lists so have less patients - not true reflection of results
- Although the patients have been allocated different points/length of appointment the appointment times have remained the same so the bottle neck still happens.

Do
- Appointment times changed for just 1 consultants list, at the moment
- Patients waits being recorded
- Patients' satisfaction questionnaires being disseminated

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

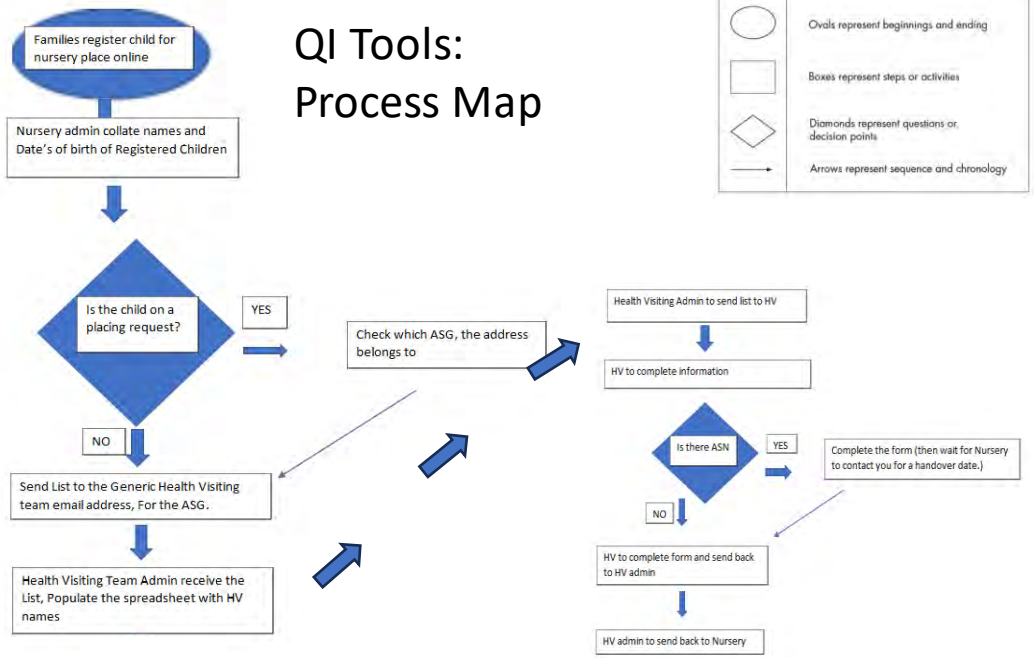
QI Project Team:
Inverness East and Nairnshire Team

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

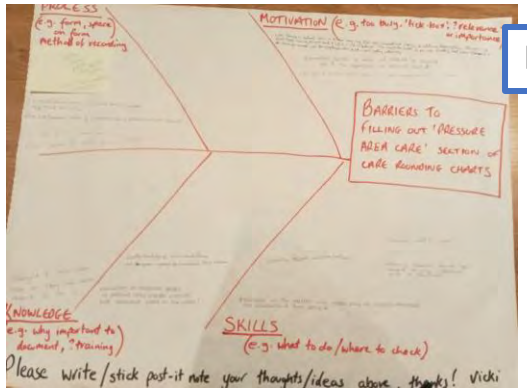
QI Team:
Badenoch & Strathspey Community Hospital
March-June 2023

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).

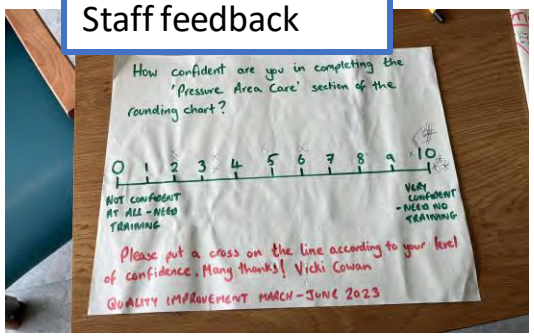
Stage of the QI Journey:

Testing Changes

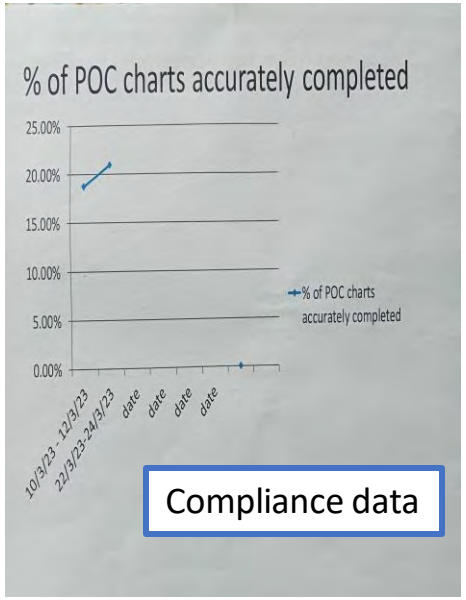
Current status: PDSAs – As lack of staff confidence was main issue identified from QI tools, PDSA 1 will test the introduction of mini training sessions on the ward around pressure area care. These will be done on an ad-hoc basis by myself and 2 other Band 5s to try and capture as many shift patterns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

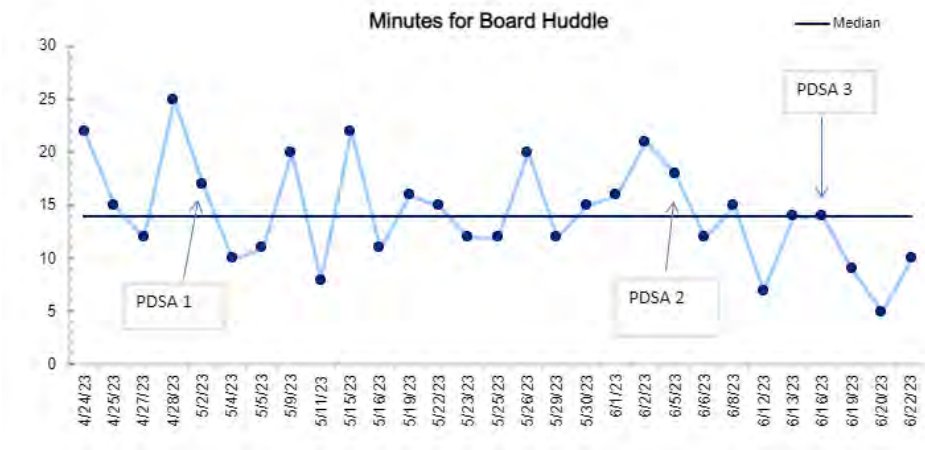
QI Project Team:
B&S Community Hospital Inpatient Ward

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 reduction. 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.

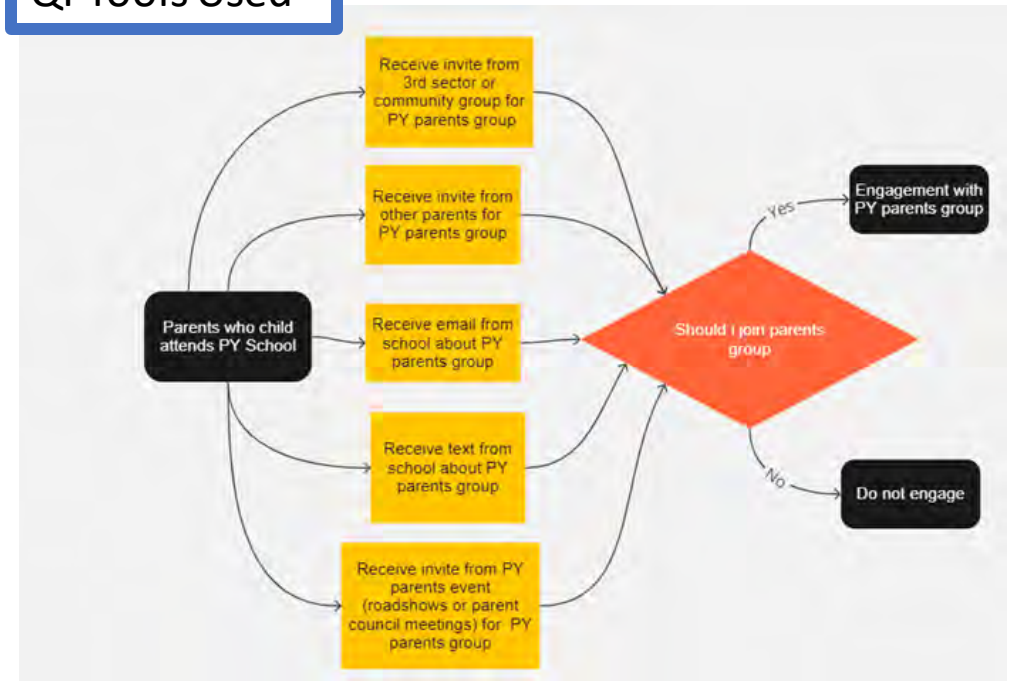
Stage of the QI Journey:

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.

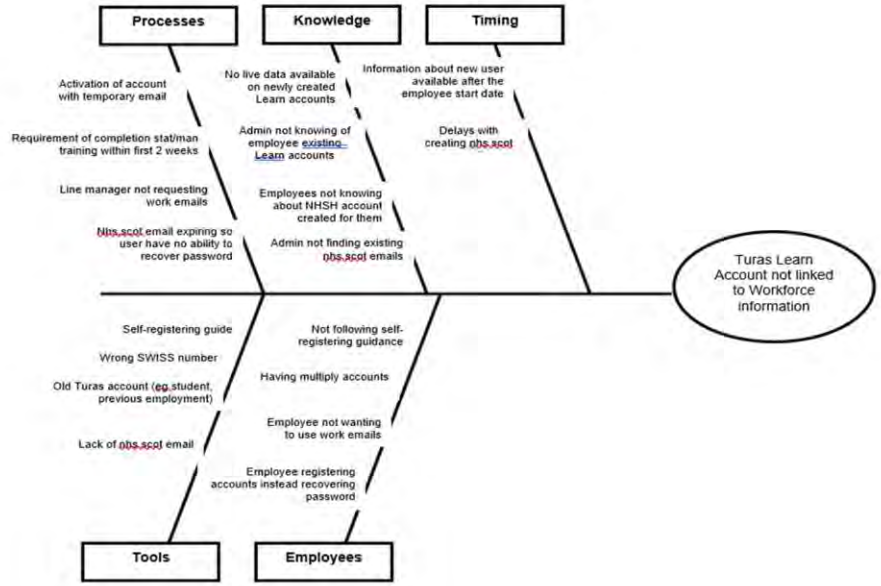
Stage of the QI Journey:

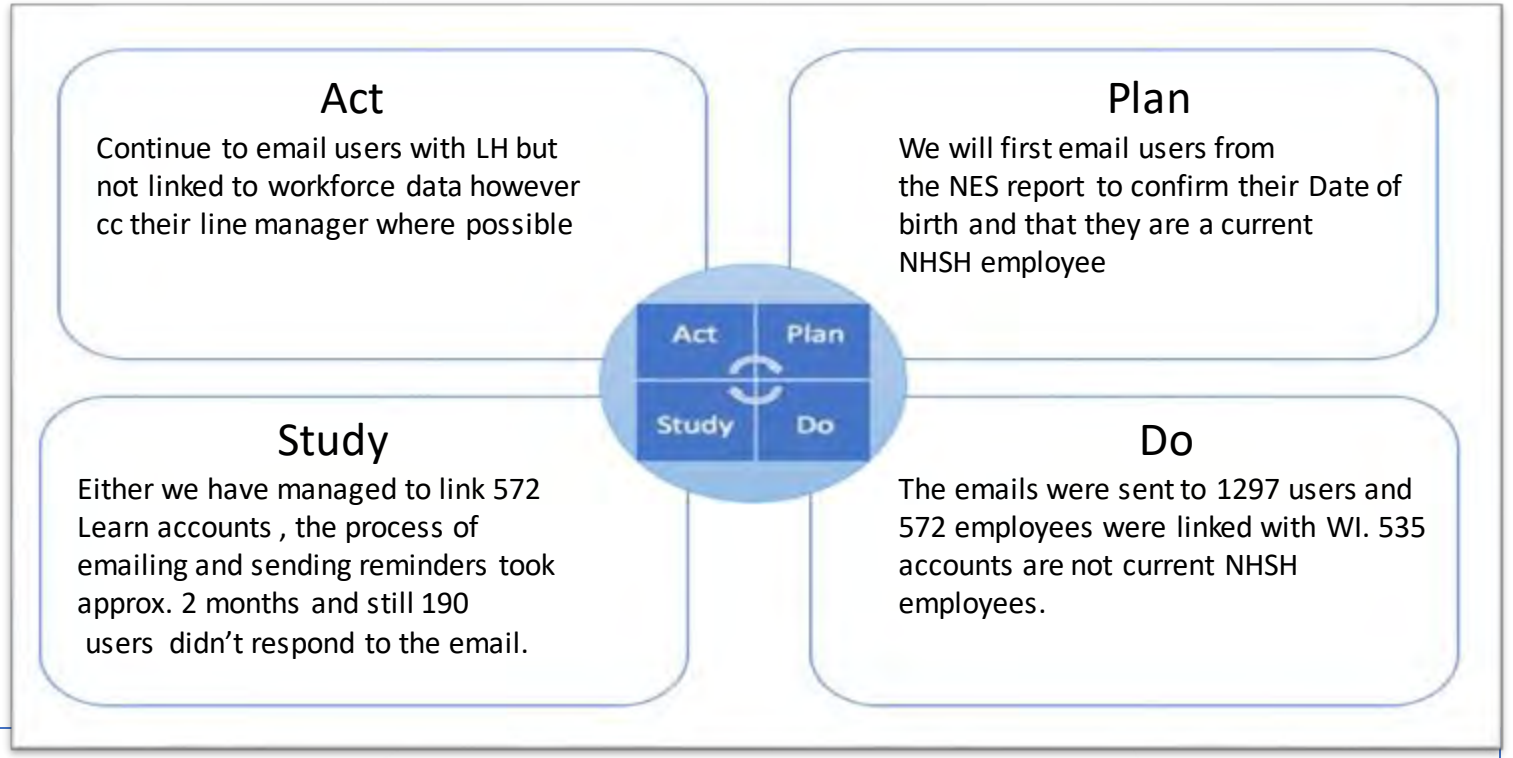
Implementing Changes

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

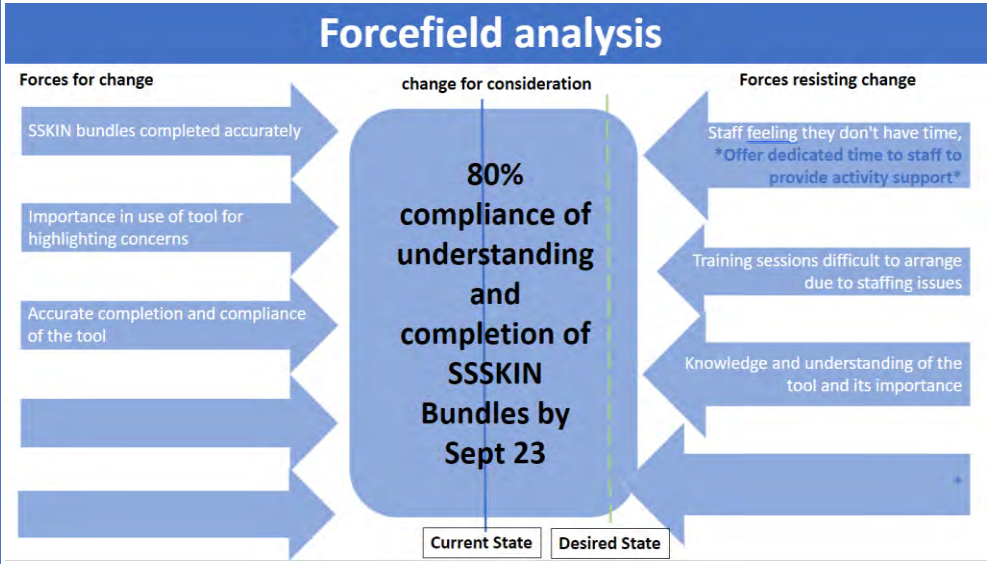
QI Project Team:
Mains House

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:

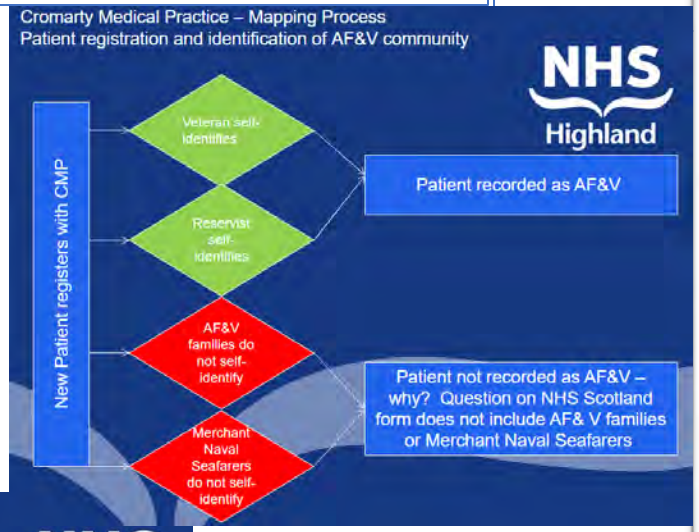
Adopting Changes

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

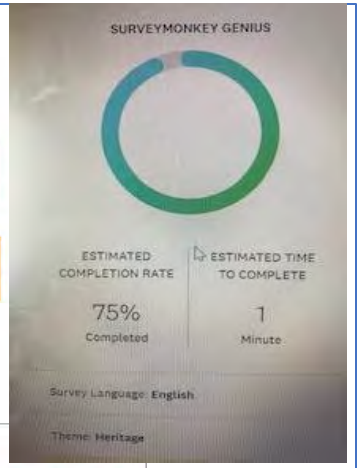
Stage of the QI Journey:

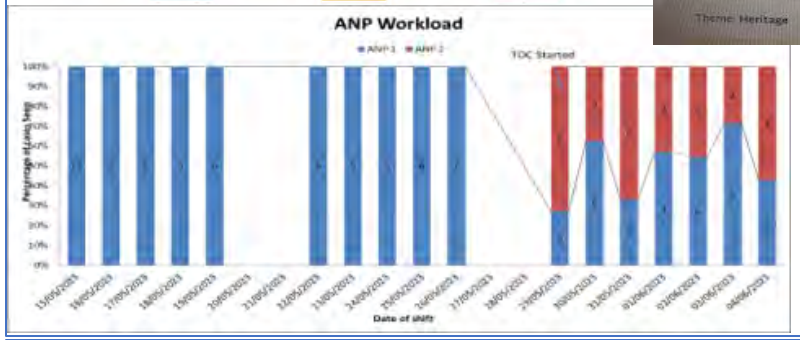
Testing Changes

Current status:

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

QI Tools Used





Act

Adopt new changes and continue to collect Feedback from staff via Jamboard and Survey Monkey. Continue to collect and review data.

Plan

Look at the feedback and data and see the themes on a force field analysis. Discuss with team how and where we can best make the changes. Look at resource and rota.

Study

Start to collect the data to see the changes and compare to the baseline data. Predictions better than expected. Keep engaged with the team and their feedback

Do

Start test of change to change the shift patterns to have 2 staff on during M-F 6pm- midnight. This has now been running 3 weeks

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.

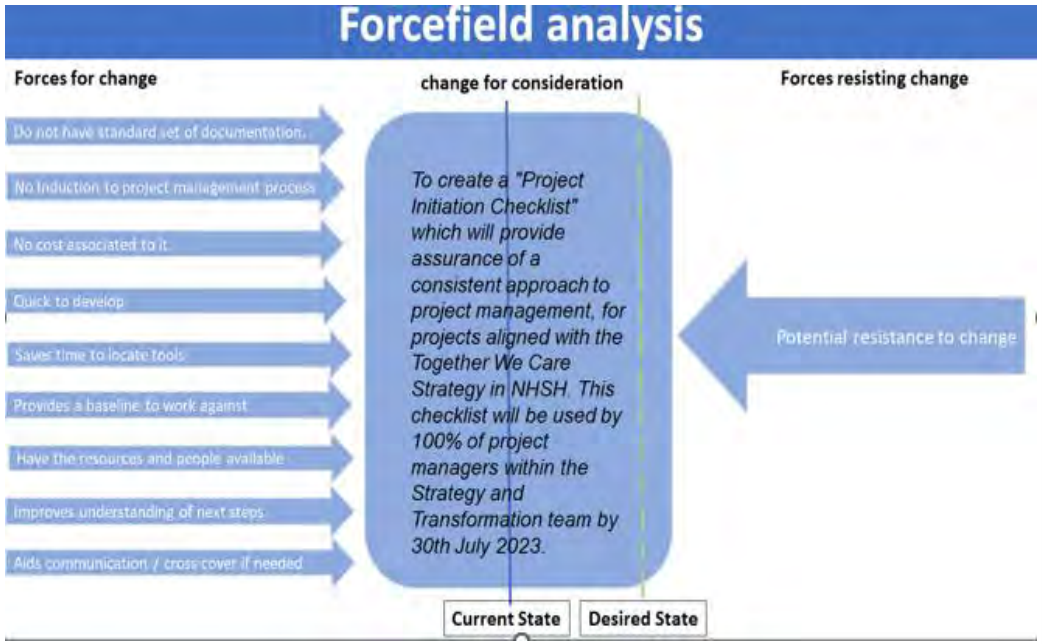
Stage of the QI Journey:

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

Act | Plan | Study | Do

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

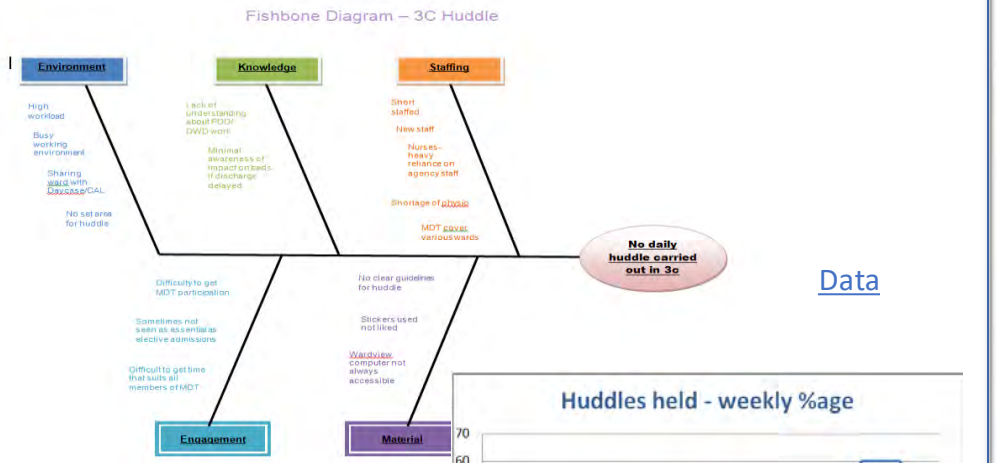
QI Project Aim: By Sept 2023 Ward 3C will complete 60% of daily huddles Monday-Friday in line with the NHS Scotland: Centre for Sustainable Delivery 'Discharge without Delay' paper

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



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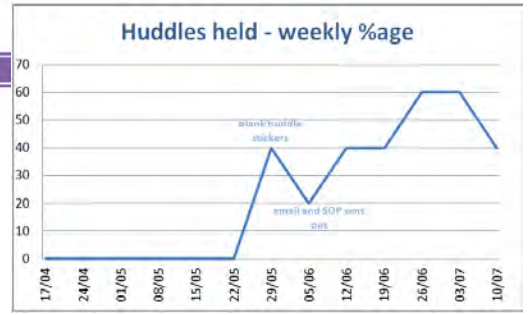


Act
- Continue with changes already made
- Huddle stickers (Adopt at present – adapt at later date when huddle more established)
- SOP (Adopt) – helpful for new staff
- PDSA Cycle 2 focusing on changing timing of huddle to hopefully increase MDT attendance

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

Act Plan Study Do

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:

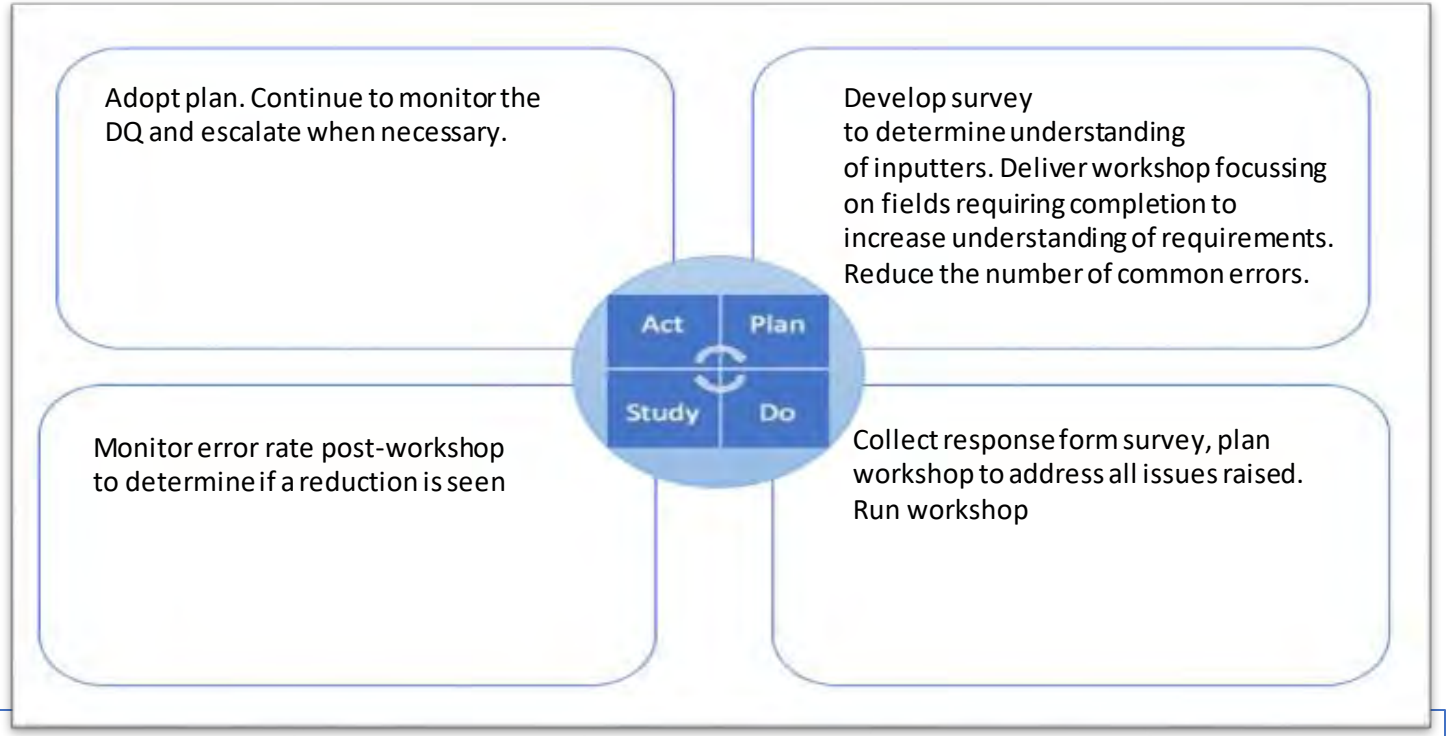
Testing Changes

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