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.
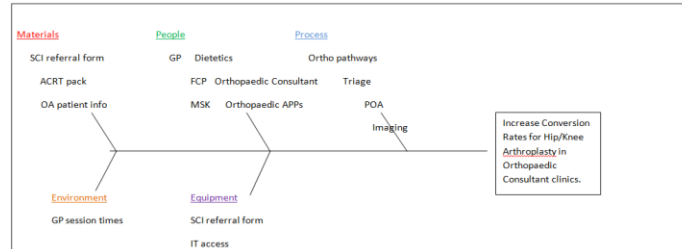
Stage of the QI Journey:
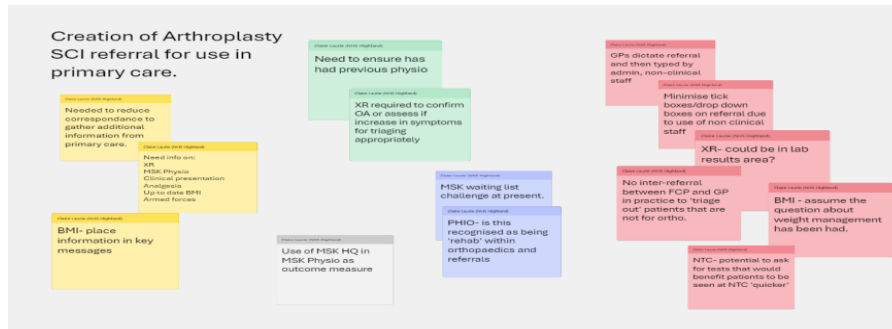
Current Status:
Testing Changes

The Quality Improvement Journey

Current Process Diagram:

Fishbone Diagram:

Materials
- SCI referral form
- ACRT pack
- OA patient info

People
- GP   Dietetics
- FCP   Orthopaedic Consultant
- MSK   Orthopaedic APPs

Process
- Ortho pathways
- Triage
- POA
- Imaging

Environment
- GP session times

Equipment
- SCI referral form
- IT access

Increase Conversion Rates for Hip/Knee Arthroplasty in Orthopaedic Consultant clinics.

White board

Creation of Arthroplasty SCI referral for use in primary care.

Act
Amend SCI form appropriately and test again.

Plan
Construct mock SCI Arthroplasty referral form for use within NHSH primary care

Study
Evaluate if clinician can triage primary care SCI referrals with information in new mock form.

Do
Test new mock SCI form within Orthopaedics completing fields from actual referrals

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.
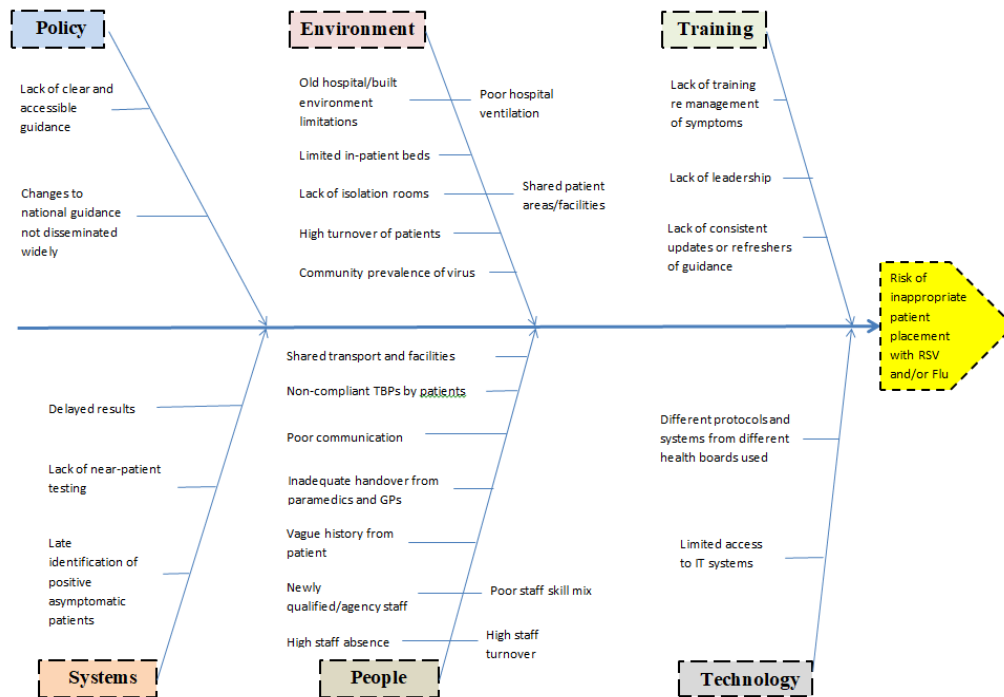
Flash report – SIFS Cohort Rachel Hobson

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

The Quality improvement journey:

Current status: plan to collect data after introducing change tool

Policy
- Lack of clear and accessible guidance
- Changes to national guidance not disseminated widely

Environment
- Old hospital/built environment limitations
- Poor hospital ventilation
- Limited in-patient beds
- Lack of isolation rooms
- Shared patient areas/facilities
- High turnover of patients
- Community prevalence of virus

Training
- Lack of training re management of symptoms
- Lack of leadership
- Lack of consistent updates or refreshers of guidance

Systems
- Delayed results
- Lack of near-patient testing
- Late identification of positive asymptomatic patients

- Shared transport and facilities
- Non-compliant TBPs by patients
- Poor communication
- Inadequate handover from paramedics and GPs
- Vague history from patient
- Newly qualified/agency staff
- Poor staff skill mix
- High staff absence
- High staff turnover

People

Technology
- Different protocols and systems from different health boards used
- Limited access to IT systems

Risk of inappropriate patient placement with RSV and/or Flu

Act – predicted: adapt tool and timeframe

Study – assess any improvements

Plan – create tool to collect data for 2 weeks after discussion with staff

Do – after 2 weeks implement educational tool to change behaviours. Gather data for another 2 weeks

Act | Plan
Study | Do

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

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.
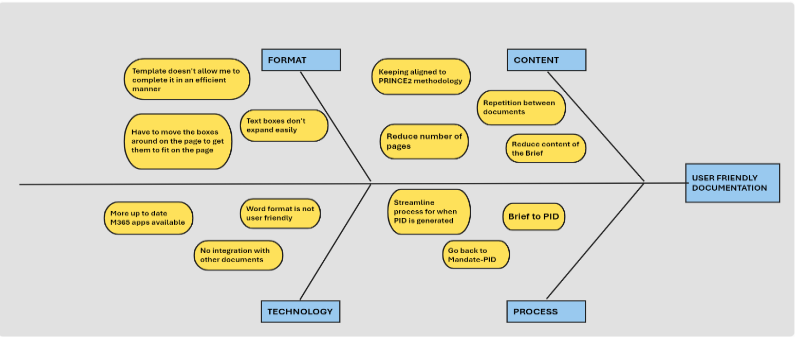
Stage of the QI Journey:
Testing Change

The Quality Improvement journey:

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

In general, how user friendly do you find the brief and PID PID documents?

- Promoters 1
- Passives 6
- Detractors 2

-11 NPS® (-100 to +100)

In general, how satisfied are you with the brief and PID documents?

- Promoters 1
- Passives 5
- Detractors 3

-22 NPS® (-100 to +100)

Please rate how much you agree with this statement: "The templates allow me to complete the brief and P..."

- Promoters 1
- Passives 4
- Detractors 4

-33 NPS® (-100 to +100)

Fishbone Diagram

Fishbone diagram categories: FORMAT, CONTENT, TECHNOLOGY, PROCESS → USER FRIENDLY DOCUMENTATION

Act
- Adopt successful change.
- Collect and review data.

Plan
- Look at the feedback from the data collected.
- Gather qualitative feedback and discussion with team and use fishbone diagram to structure.
- Look at common themes to see where we can make changes.
- Engage team with project.

Study
- Collect post change data to see if the documents are efficient (self-reported).
- Consider aim statement: decide if any more changes can be made.
- Revisit fishbone diagram to decide on possible new changes.

Do
Start the test of change by:
Making **one** change (different technology)

Microsoft 365 Copilot

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

The Quality Improvement journey:

Current status: PDSA cycle 1 - Test

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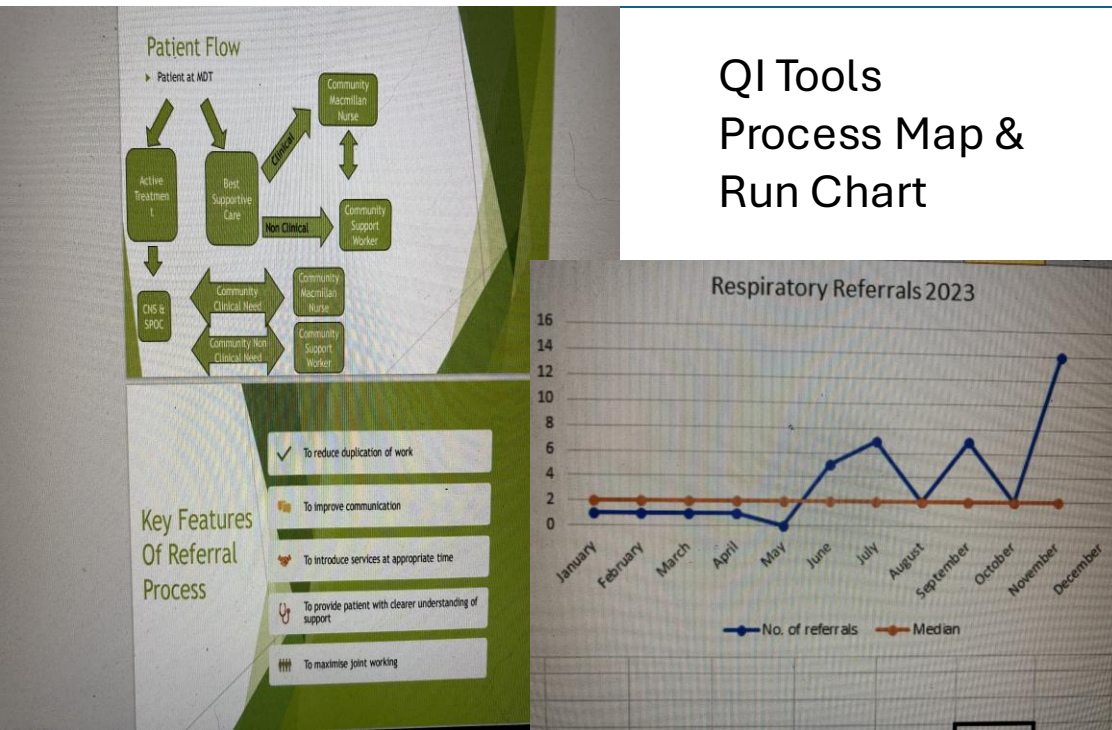
Act
Discuss with all 8 SPOC's and site specific CN's and feedback findings.
What do we need to change before rolling out referral process in all areas?
Can current community staffing levels cope with new increase in referrals?

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

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.
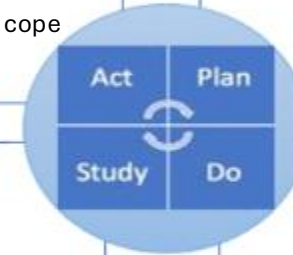
Area of Learning – Successes – Challenges

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

**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

The Quality improvement journey:

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

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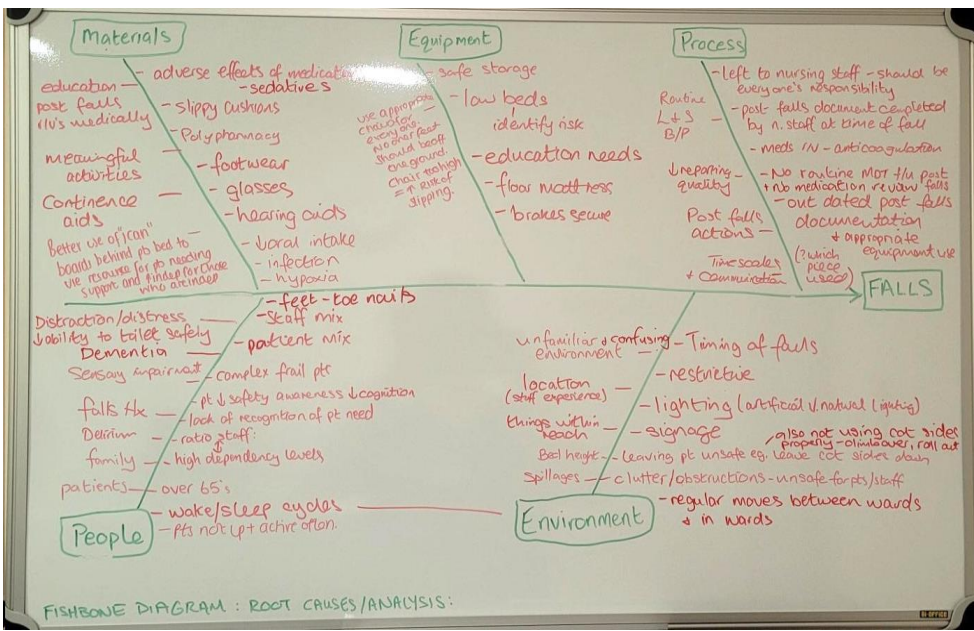
Act: provide teaching to staff to ensure medication reviews are completed for each patient after every fall, ensuring reduction in medications associated with increased risk of delirium and falls

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

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:
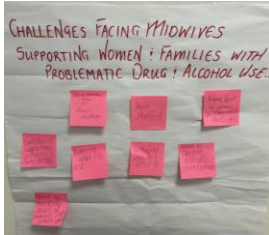Testing changes

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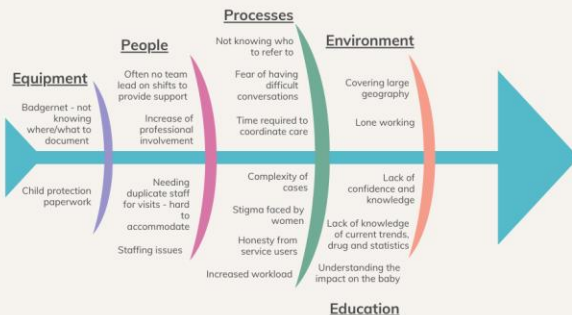
Current status:
PDSA 2 completed > adapt
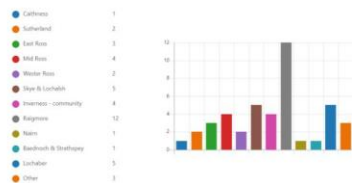PDSA 3- will commence 15/01/24, when we launch the 'Advice and Support' Sessions.

QI Tools Used

CHALLENGES FACING MIDWIVES SUPPORTING WOMEN AND FAMILIES WITH PROBLEMATIC ALCOHOL AND DRUG USE

Equipment
- Badgernet - not knowing where/what to document
- Child protection paperwork
- Staffing issues

People
- Often no team lead on shifts to provide support
- Increase of professional involvement
- Needing duplicate staff for visits - hard to accommodate

Processes
- Not knowing who to refer to
- Fear of having difficult conversations
- Time required to coordinate care
- Complexity of cases
- Stigma faced by women
- Honesty from service users
- Increased workload

Environment
- Covering large geography
- Lone working
- Lack of confidence and knowledge
- Lack of knowledge of current trends, drug and statistics
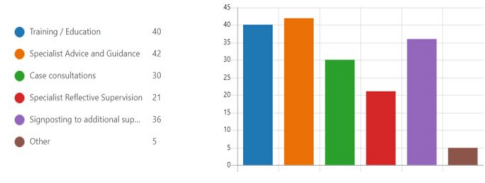- Understanding the impact on the baby

Education

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

- Training / Education — 40
- Specialist Advice and Guidance — 42
- Case consultations — 30
- Specialist Reflective Supervision — 21
- Signposting to additional sup... — 36
- Other — 5

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

Act | Plan | Study | Do

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

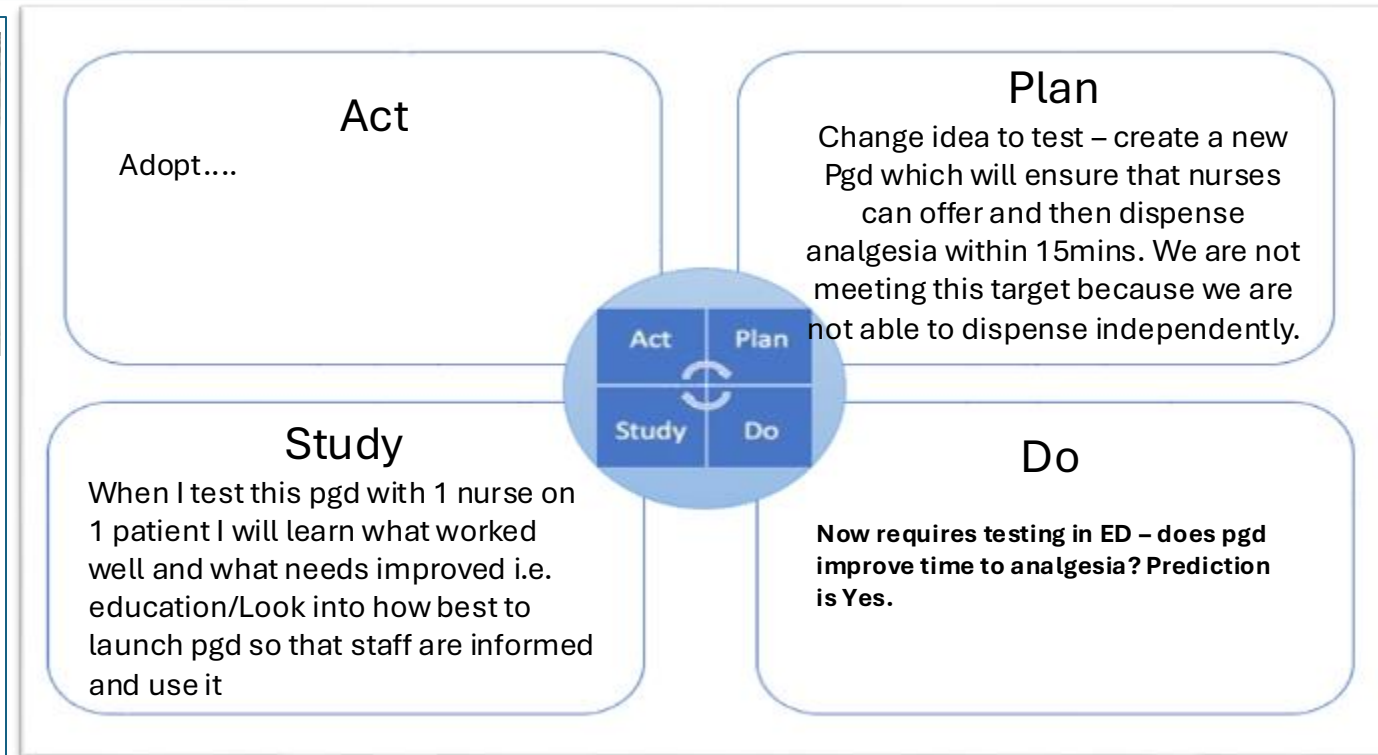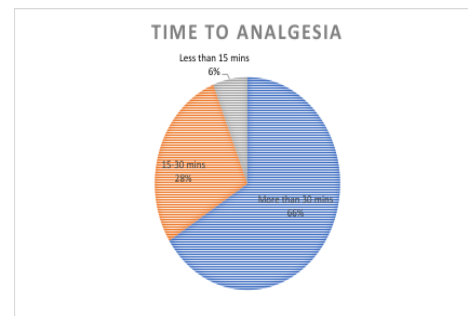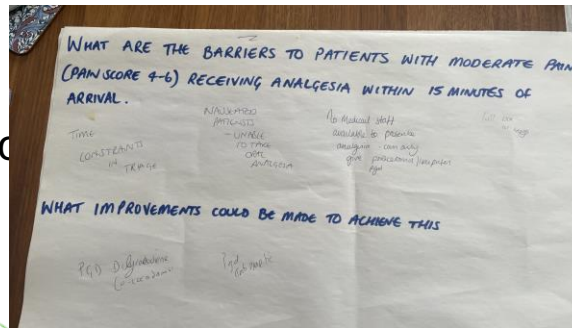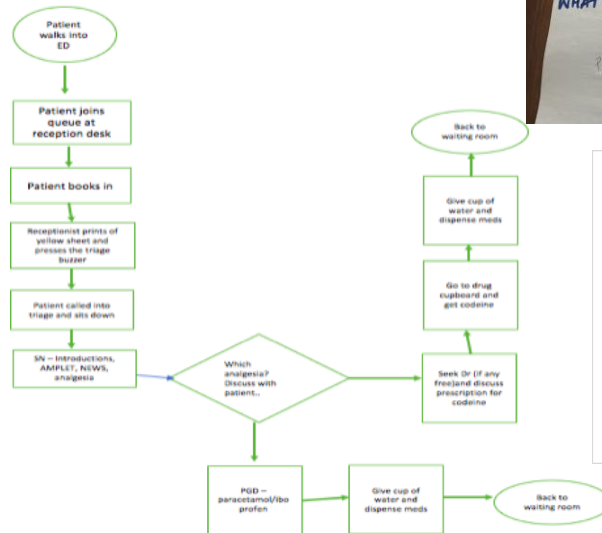**QI Project Team:**
Susie Bennett – ED, Raigmore

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

Handwritten note: WHAT ARE THE BARRIERS TO PATIENTS WITH MODERATE PAIN (PAIN SCORE 4-6) RECEIVING ANALGESIA WITHIN 15 MINUTES OF ARRIVAL.
WHAT IMPROVEMENTS COULD BE MADE TO ACHIEVE THIS

TIME TO ANALGESIA
- Less than 15 mins 6%
- 15-30 mins 28%
- More than 30 mins 66%

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.

Act
Adopt….

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 ultemately 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

QI Project Team:
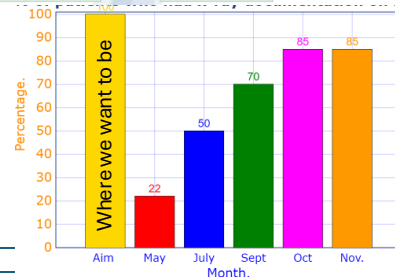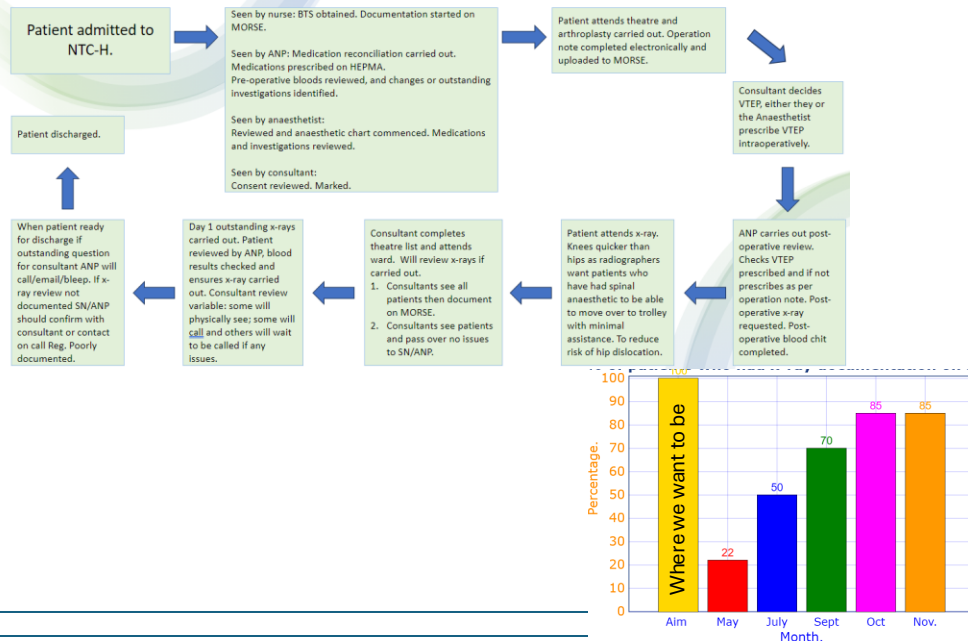Katie Thomson (NTC-H)

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.

Testing Changes
Identify specific change ideas, test and refine using PDSA

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.

Patient admitted to NTC-H.

Seen by nurse: BTS obtained. Documentation started on MORSE.

Seen by ANP: Medication reconciliation carried out. Medications prescribed on HEPMA. Pre-operative bloods reviewed, and changes or outstanding investigations identified.

Seen by anaesthetist: Reviewed and anaesthetic chart commenced. Medications and investigations reviewed.

Seen by consultant: Consent reviewed. Marked.

Patient attends theatre and arthroplasty carried out. Operation note completed electronically and uploaded to MORSE.

Consultant decides VTEP, either they or the Anaesthetist prescribe VTEP intraoperatively.

Patient discharged.

When patient ready for discharge if outstanding question for consultant ANP will call/email/bleep. If x-ray review not documented SN/ANP should confirm with consultant or contact on call Reg. Poorly documented.

Day 1 outstanding x-rays carried out. Patient reviewed by ANP, blood results checked and ensures x-ray carried out. Consultant review variable: some will physically see; some will call and others will wait to be called if any issues.

Consultant completes theatre list and attends ward. Will review x-rays if carried out.
1. Consultants see all patients then document on MORSE.
2. Consultants see patients and pass over no issues to SN/ANP.

Patient attends x-ray. Knees quicker than hips as radiographers want patients who have had spinal anaesthetic to be able to move over to trolley with minimal assistance. To reduce risk of hip dislocation.

ANP carries out post-operative review. Checks VTEP prescribed and if not prescribes as per operation note. Post-operative x-ray requested. Post-operative blood chit completed.

Bar chart – Percentage of patients that had x-ray documentation:

Month	Percentage
Aim (Where we want to be)	70
May	22
July	50
Sept	70
Oct	85
Nov.	85

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.

PDSA cycle diagram: Act | Plan | Study | Do

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.

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

QI Project Aim: By July 2024, we will increase patient referrals from ███████ Medical Practice to the Community Link Worker Service by 50%, moving towards the GP Practice's identified level of allocation.
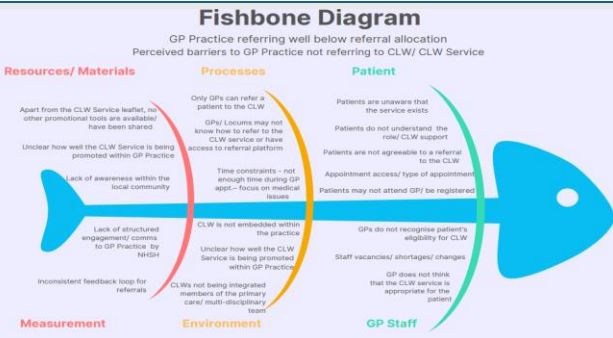
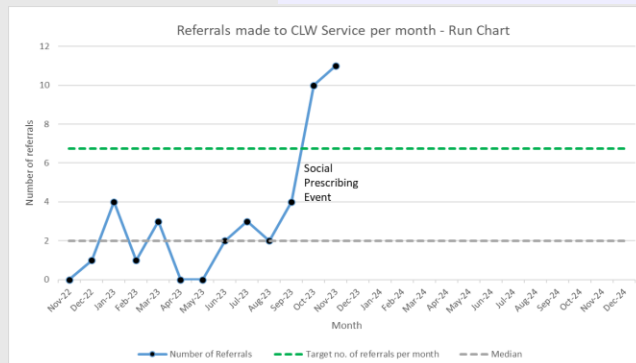**Stage of the QI Journey:** Testing Changes

The Quality improvement journey:

Current status: PDSA 1 – incomplete

QI Tools Used

Fishbone

Fishbone Diagram
GP Practice referring well below referral allocation
Perceived barriers to GP Practice not referring to CLW/ CLW Service

Resources/ Materials | Processes | Patient
Measurement | Environment | GP Staff

Run Chart

Referrals made to CLW Service per month - 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.

Act | Plan
Study | Do

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.
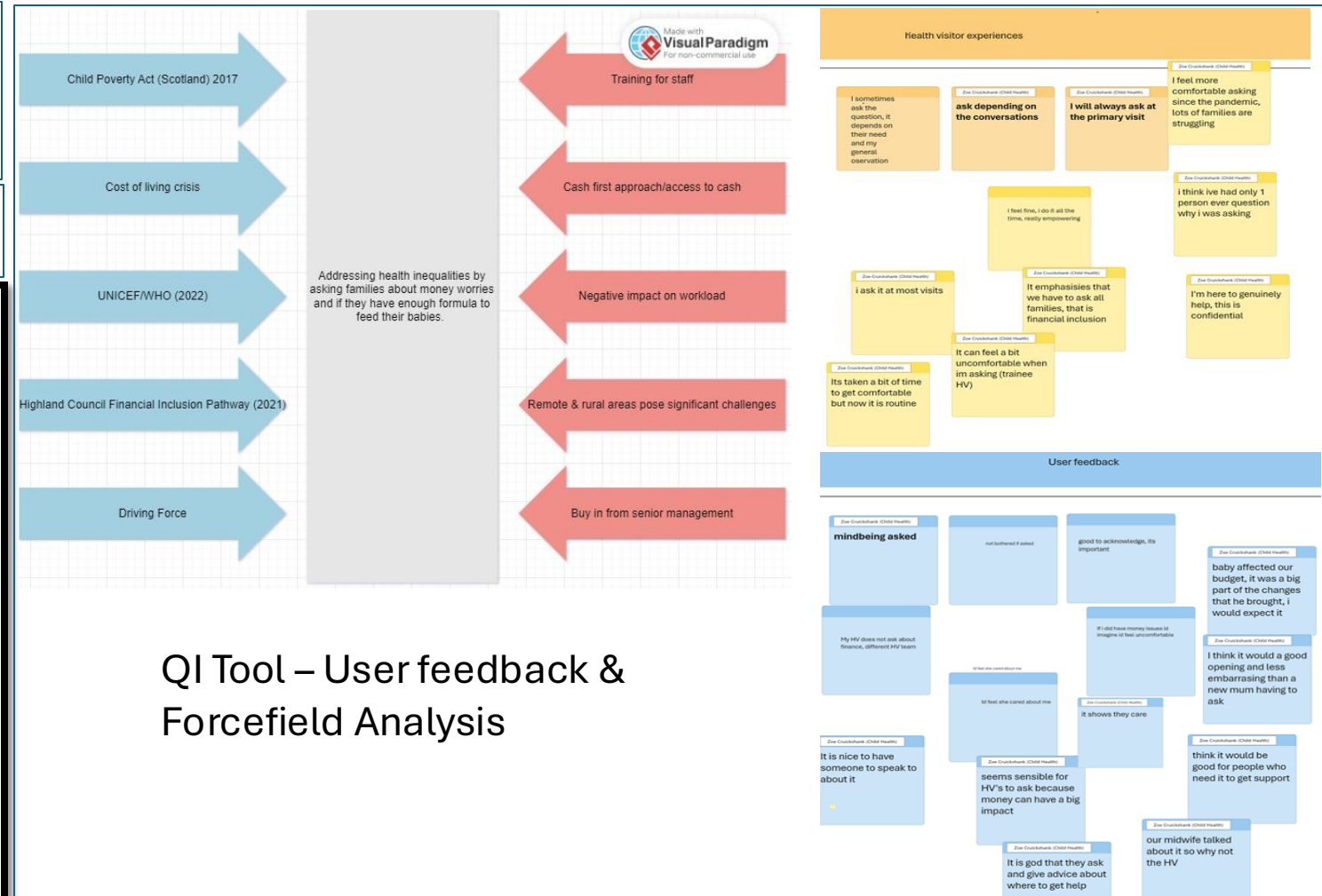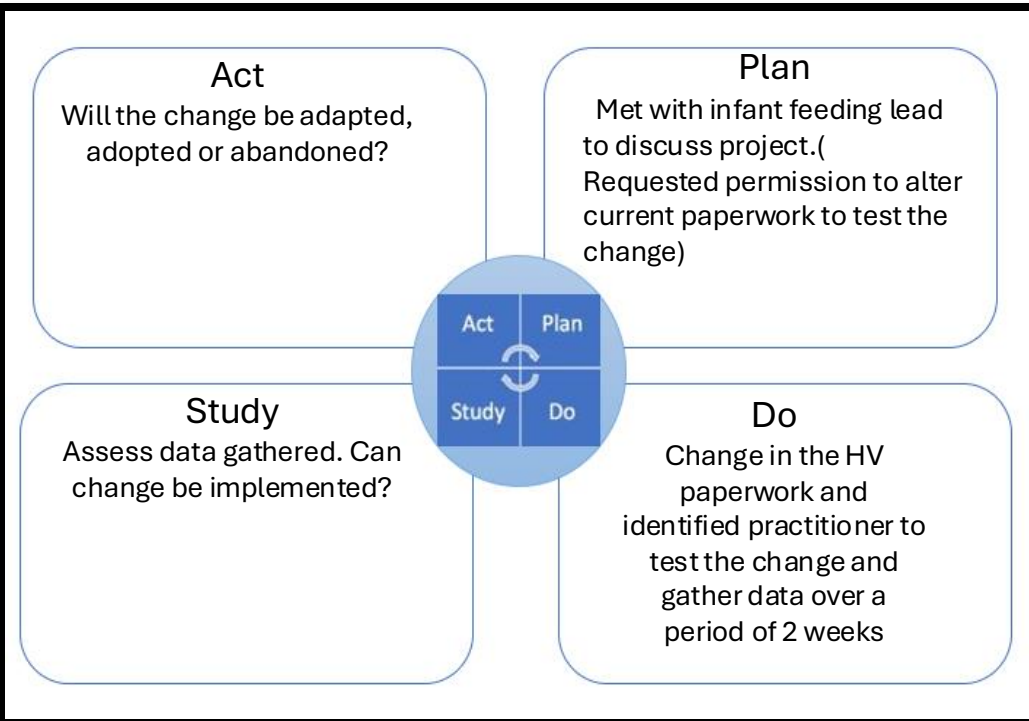**Successes** - referrals have increased dramatically to the service however these have been a consequence of other interventions.

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

Act
Will the change be adapted, adopted or abandoned?

Plan
Met with infant feeding lead to discuss project.(Requested permission to alter current paperwork to test the change)

Study
Assess data gathered. Can change be implemented?

Do
Change in the HV paperwork and identified practitioner to test the change and gather data over a period of 2 weeks

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.