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
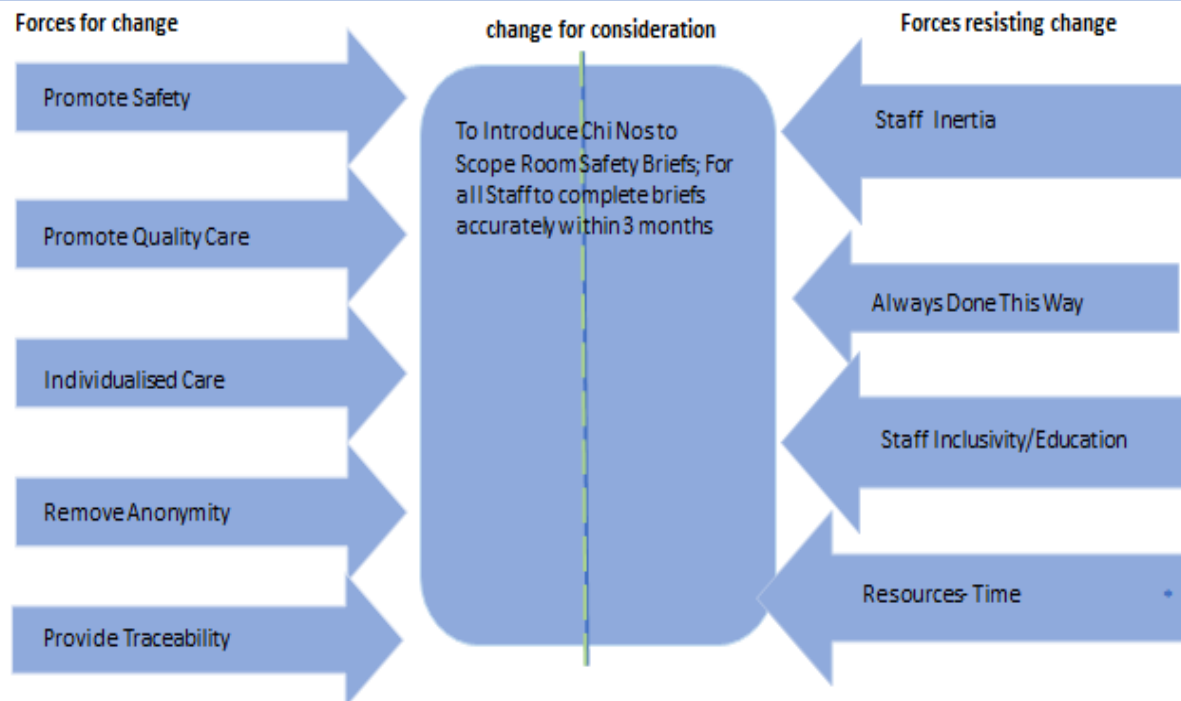
Stage of the QI Journey:
Implementing changes

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

Forces for change
- Promote Safety
- Promote Quality Care
- Individualised Care
- Remove Anonymity
- Provide Traceability

change for consideration
To Introduce Chi Nos to Scope Room Safety Briefs; For all Staff to complete briefs accurately within 3 months

Forces resisting change
- Staff Inertia
- Always Done This Way
- Staff Inclusivity/Education
- Resources- Time

Act
Add chi number to safety brief, audit compliance. Redesign Briefs if necessary, Post feedback review.

Plan
Tasks: Meeting with head medic/management & unit sister. Agree plan. Educate staff & review resources. Gather baseline data
Test: Idea of including Chi No.s.

Study
audit to measure compliance. Meetings with staff nurses to keep them informed and obtain feedback.

Do
Educate staff for the need to change Carry out the plan, Introduce Newly Designed Safety Briefs to Rooms; implement audit .

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.

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)
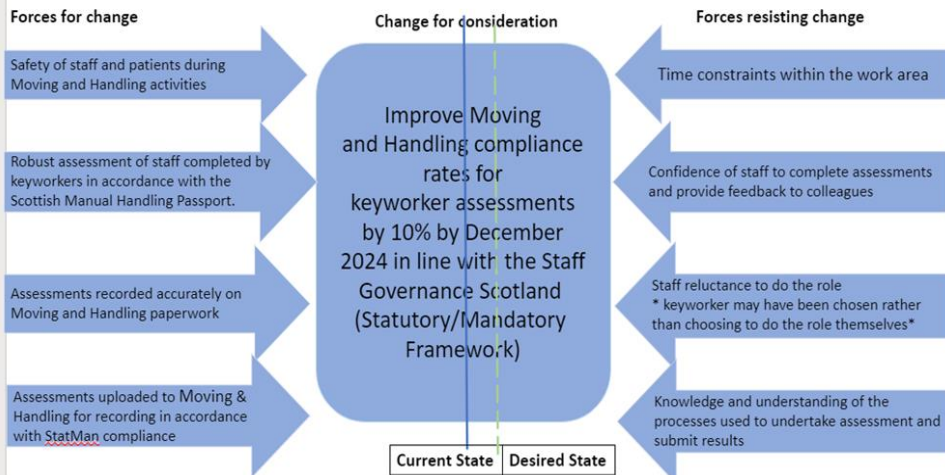
Stage of the QI Journey:
Testing Changes

The Quality Improvement journey:

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

Forcefield analysis

Forces for change
- Safety of staff and patients during Moving and Handling activities
- Robust assessment of staff completed by keyworkers in accordance with the Scottish Manual Handling Passport.
- Assessments recorded accurately on Moving and Handling paperwork
- Assessments uploaded to Moving & Handling for recording in accordance with StatMan compliance

Change for consideration
Improve Moving and Handling compliance rates for keyworker assessments by 10% by December 2024 in line with the Staff Governance Scotland (Statutory/Mandatory Framework)

Forces resisting change
- Time constraints within the work area
- Confidence of staff to complete assessments and provide feedback to colleagues
- Staff reluctance to do the role * keyworker may have been chosen rather than choosing to do the role themselves*
- Knowledge and understanding of the processes used to undertake assessment and submit results

Current State | Desired State

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.

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


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

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
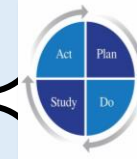
Area of Learning – Successes – Challenges

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

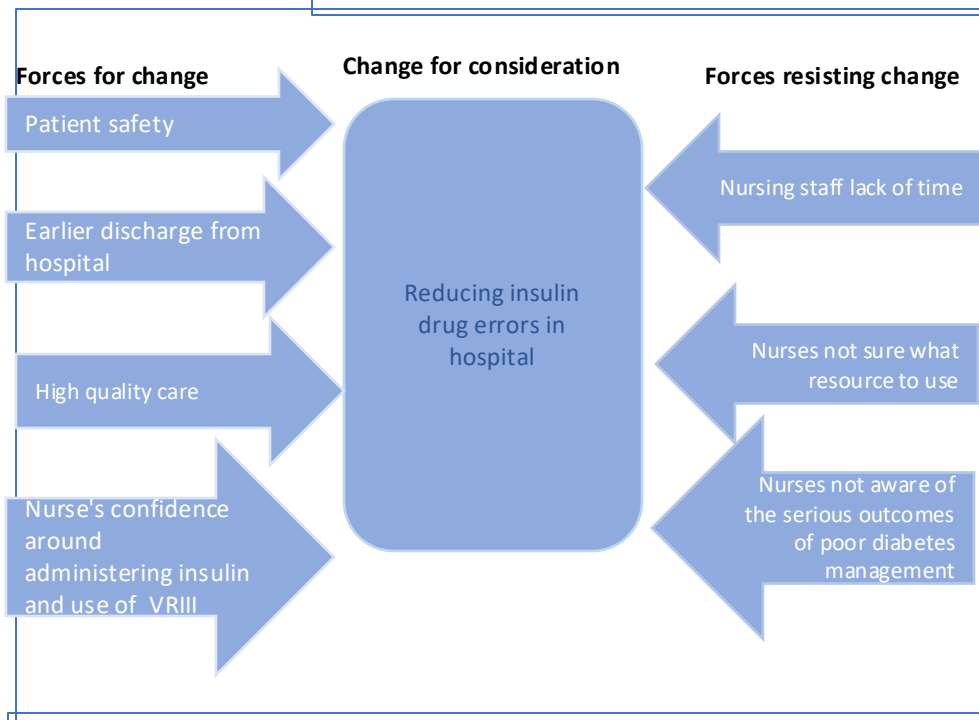**QI Project Team:** Angela Delaye DISN

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

The Quality Improvement journey:

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

Forces for change
- Patient safety
- Earlier discharge from hospital
- High quality care
- Nurse's confidence around administering insulin and use of VRIII

Change for consideration

Reducing insulin drug errors in hospital

Forces resisting change
- Nursing staff lack of time
- Nurses not sure what resource to use
- Nurses not aware of the serious outcomes of poor diabetes management

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.

(PDSA cycle diagram: Act | Plan / Study | Do)

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 QI 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)

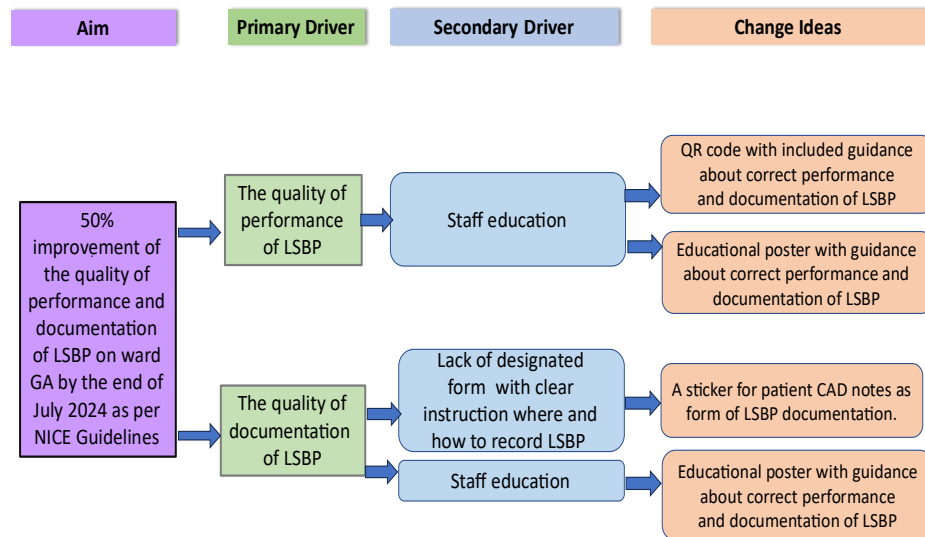**QI Project Team:** Ward GA Raigmore Hospital

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.

The Quality Improvement journey:

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

QI Tools Used: Drivers Diagram

Aim	Primary Driver	Secondary Driver	Change Ideas
50% improvement of the quality of performance and documentation of LSBP on ward GA by the end of July 2024 as per NICE Guidelines	The quality of performance of LSBP	Staff education	QR code with included guidance about correct performance and documentation of LSBP
			Educational poster with guidance about correct performance and documentation of LSBP
	The quality of documentation of LSBP	Lack of designated form with clear instruction where and how to record LSBP	A sticker for patient CAD notes as form of LSBP documentation.
		Staff education	Educational poster with guidance about correct performance and documentation of LSBP

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.
.

Act | Plan
Study | Do

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)
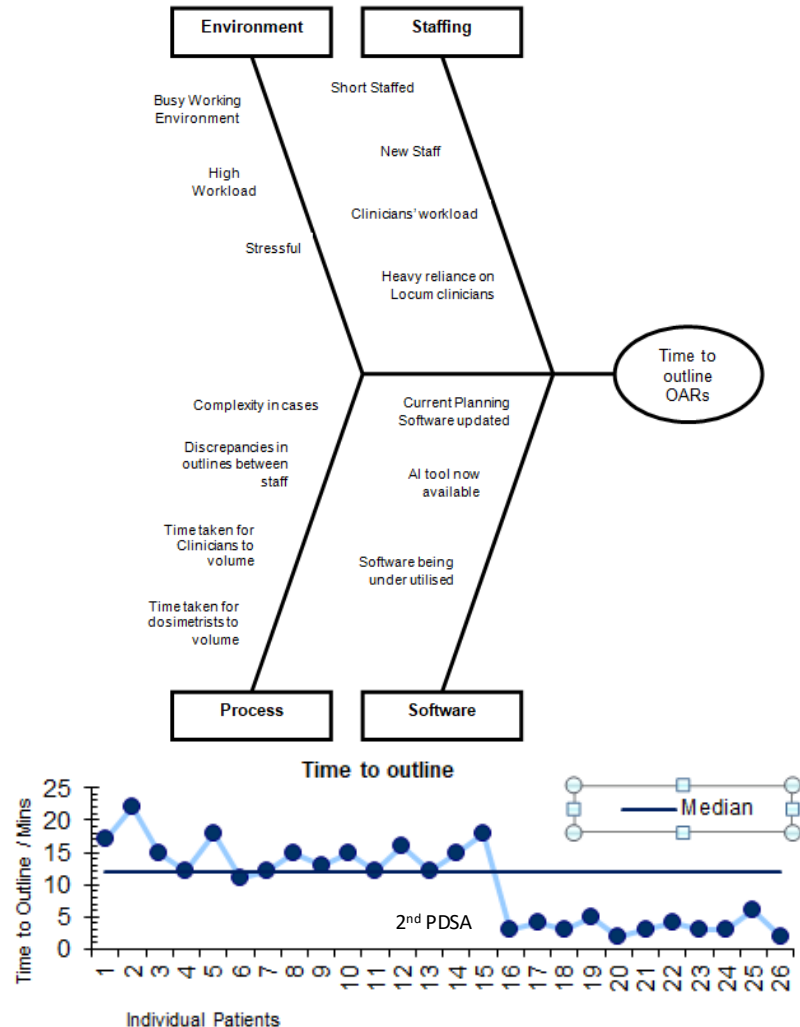
Stage of the QI Journey:

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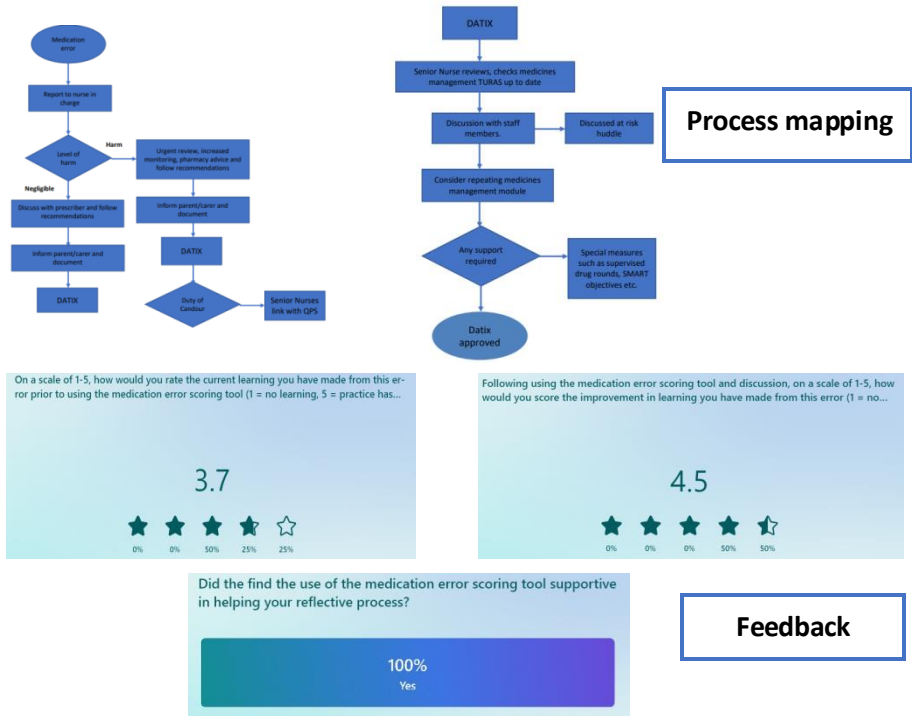
QI Project Team: Highland Children's Unit, Raigmore Hospital

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

On a scale of 1-5, how would you rate the current learning you have made from this error prior to using the medication error scoring tool (1 = no learning, 5 = practice has...

3.7
★★★⯨☆
0% 0% 50% 25% 25%

Following using the medication error scoring tool and discussion, on a scale of 1-5, how would you score the improvement in learning you have made from this error (1 = no...

4.5
★★★★⯨
0% 0% 0% 50% 50%

Did the find the use of the medication error scoring tool supportive in helping your reflective process?

100%
Yes

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.
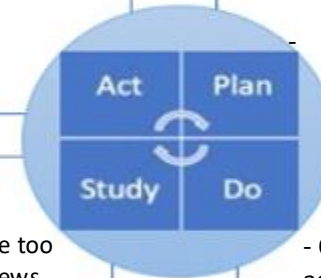
Area of Learning – Developed a much clearer understanding of QI process which has improved confidence for future use. Found using a standardised tool help guide discussion when reviewing the error and wasn't onerous to complete. Overall aim is to include medication error scoring tool in a toolkit for 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
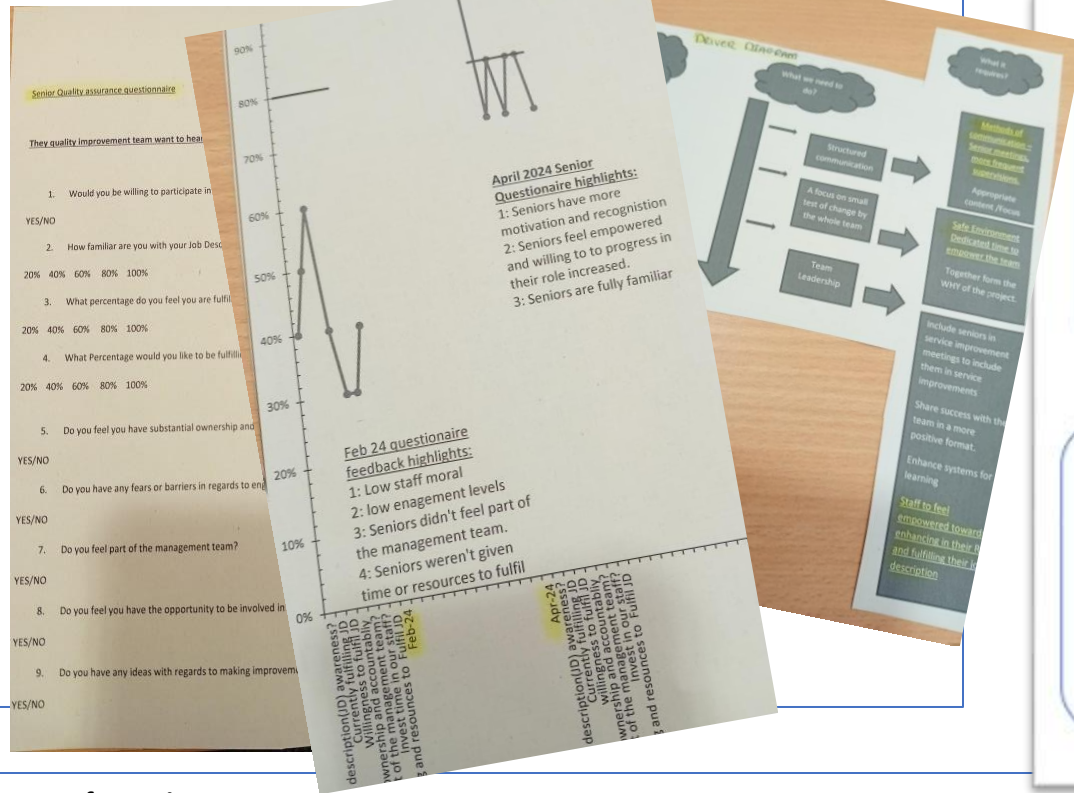
Act
- Implement fortnightly senior meetings with an agreed focus on Job descriptions **(ADOPT)**.
- Reference job description quotes and key areas throughout supervisions 6 weekly **(ADOPT)**
- SOP created for time management to focus on prioritisation to enhance overall willingness to fulfil their full 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

FISHBONE DIAGRAM

Staff/People
- Over ordering & over stocking
- Order patient specific not checking other wards
- No ownership
- Stock not returned if wrong
- Same weekly order each week
- No formal stock management process
- No regular date checks

Method

Environment
- Same product lots of wards
- Not enough space to store items
- Lack of central store location
- Each ward storing own stock
- Out of date ward supplies
- Stock take

Measurement

Process
- Each ward ordering own stock
- Stock not being rotated/no system for this
- Minimum quantity of packs
- MH hospital not regular users of many ward supplies
- No ownership
- Expiry dates vary on items from months/years
- Shelving not labelled

Materials

Ward stock of medical supplies – going out of date

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.

Act	Plan
Study	Do

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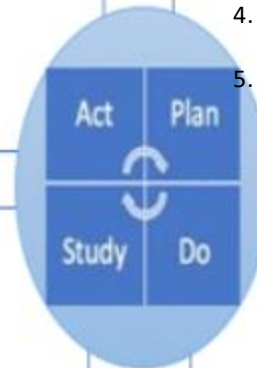
Successes
All wards aware of what is available and what the additional "specific" ward items are in case needed for a specific patient for a short period of time
Created the Kanban and Centralised cupboard

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

To offer 90% of patients attending community diabetes service in South and Mid NHS Highland, access to patient centred structured education by August 2024

- Focus consultation on self-management skills
  - Encourage patients to develop problem solving skills → Strict adherence to referral criteria
  - Change expectation- discharge plan on referral → Letter explaining the service philosophy
- Increase type of resources available- make it more inclusive
  - Written/Visual/Audio → Algorithm and video available on Padlet
  - F2F information session → Role out ENGAGE in local community

Forcefield analysis

Forces for change
- Improve efficiency of service
- Facilitate patient self-management of their diabetes
- Reduce waiting list for follow-up appointments/reduce random phone calls
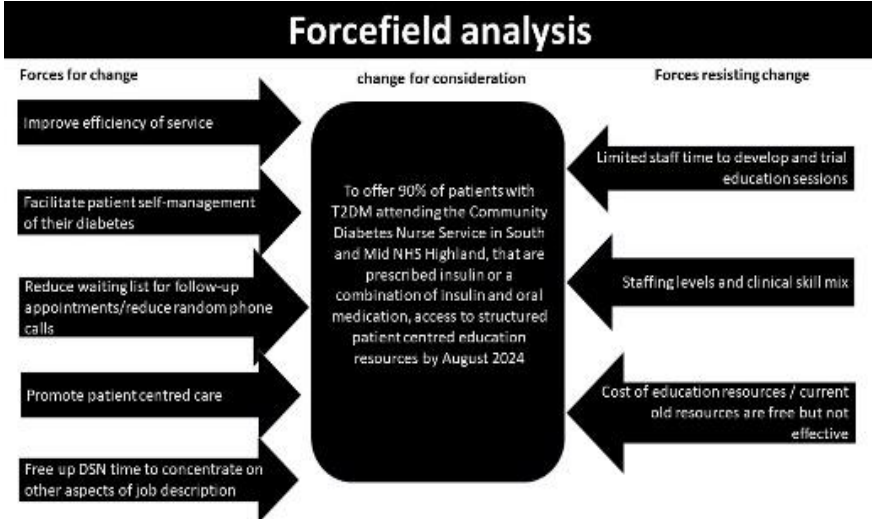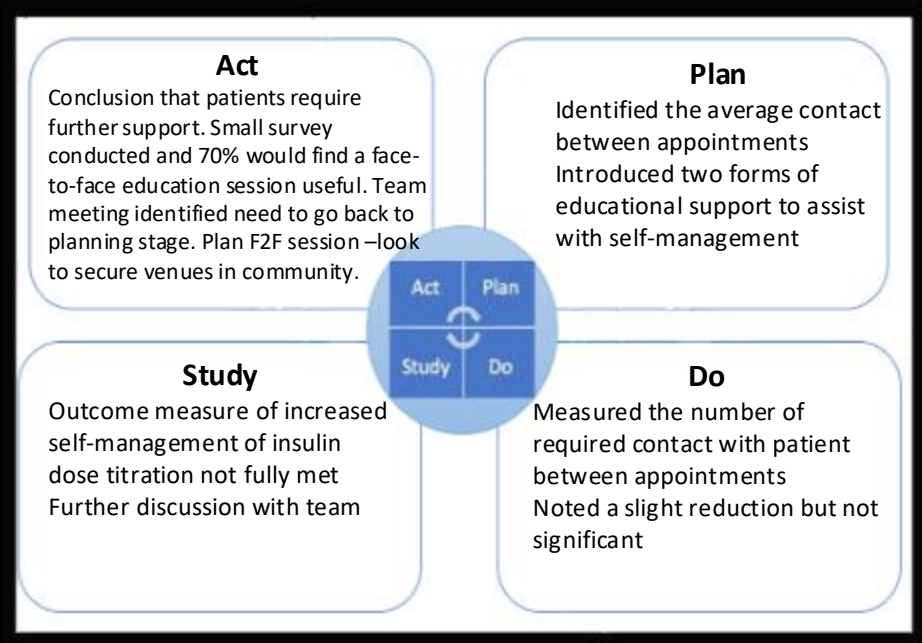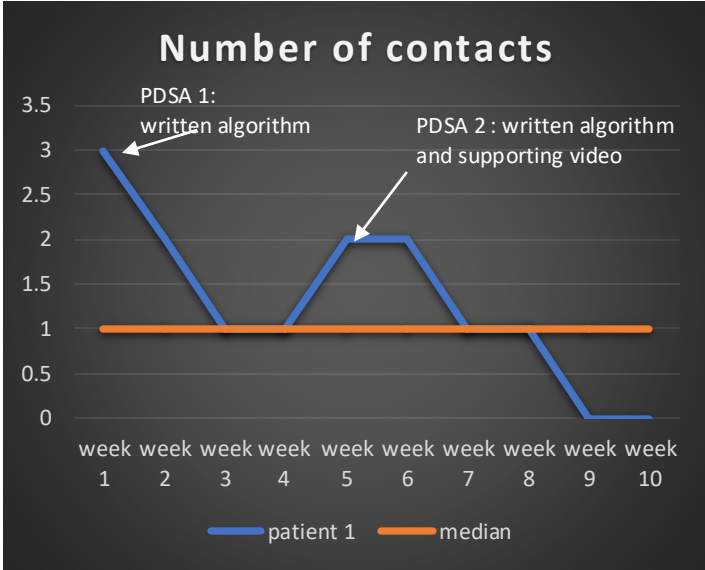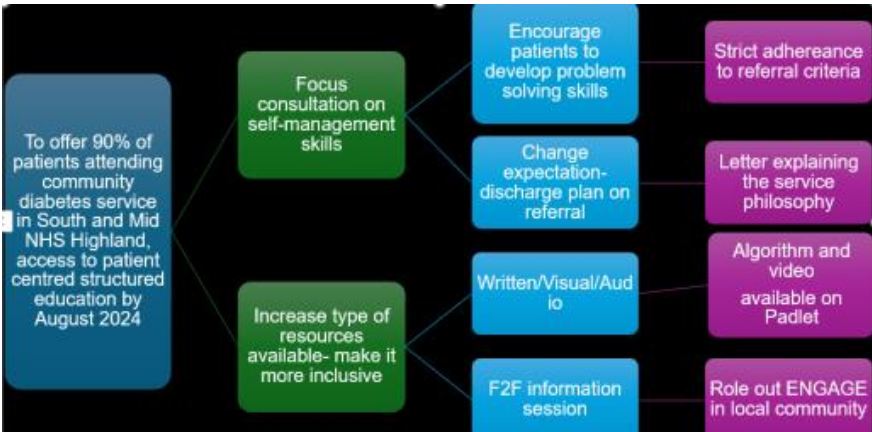- Promote patient centred care
- Free up DSN time to concentrate on other aspects of job description

change for consideration
To offer 90% of patients with T2DM attending the Community Diabetes Nurse Service in South and Mid NHS Highland, that are prescribed insulin or a combination of insulin and oral medication, access to structured patient centred education resources by August 2024

Forces resisting change
- Limited staff time to develop and trial education sessions
- Staffing levels and clinical skill mix
- Cost of education resources / current old resources are free but not effective

Data – Run Chart

Number of contacts

PDSA 1: written algorithm

PDSA 2 : written algorithm and supporting video

(y-axis: 0, 0.5, 1, 1.5, 2, 2.5, 3, 3.5)
(x-axis: week 1, week 2, week 3, week 4, week 5, week 6, week 7, week 8, week 9, week 10)

— patient 1   — median

Act
Conclusion that patients require further support. Small survey conducted and 70% would find a face-to-face education session useful. Team meeting identified need to go back to planning stage. Plan F2F session –look to secure venues in community.

Plan
Identified the average contact between appointments. Introduced two forms of educational support to assist with self-management

Study
Outcome measure of increased self-management of insulin dose titration not fully met. Further discussion with team

Do
Measured the number of required contact with patient between appointments. Noted a slight reduction but not significant

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)
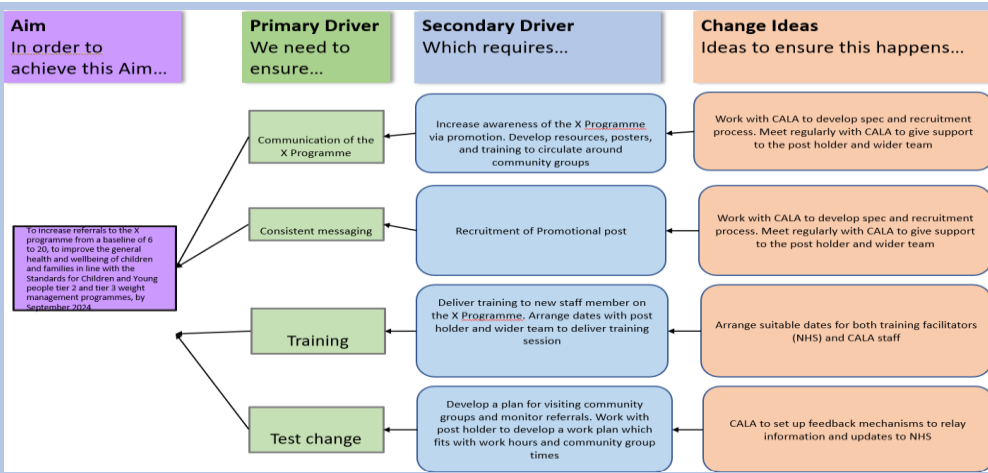
Stage of the QI Journey:
Developing Aims – PDSA cycle 2

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

QI Tools Used

Aim — In order to achieve this Aim...

Primary Driver — We need to ensure...

Secondary Driver — Which requires...

Change Ideas — Ideas to ensure this happens...

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

- Communication of the X Programme → Increase awareness of the X Programme via promotion. Develop resources, posters, and training to circulate around community groups → Work with CALA to develop spec and recruitment process. Meet regularly with CALA to give support to the post holder and wider team
- Consistent messaging → Recruitment of Promotional post → Work with CALA to develop spec and recruitment process. Meet regularly with CALA to give support to the post holder and wider team
- Training → Deliver training to new staff member on the X Programme. Arrange dates with post holder and wider team to deliver training session → Arrange suitable dates for both training facilitators (NHS) and CALA staff
- Test change → Develop a plan for visiting community groups and monitor referrals. Work with post holder to develop a work plan which fits with work hours and community group times → CALA to set up feedback mechanisms to relay information and updates to NHS

Fishbone diagram — Low referral rate to the X Programme
- Material: Literature
- Equipment: Tech
- People: Resource, Training, Stigma, Don't see the problem, Recruitment
- Environment: Online training, Time, Travel
- Process: Triage, Referral route, Clarity, Awareness
- Knowledge: Training
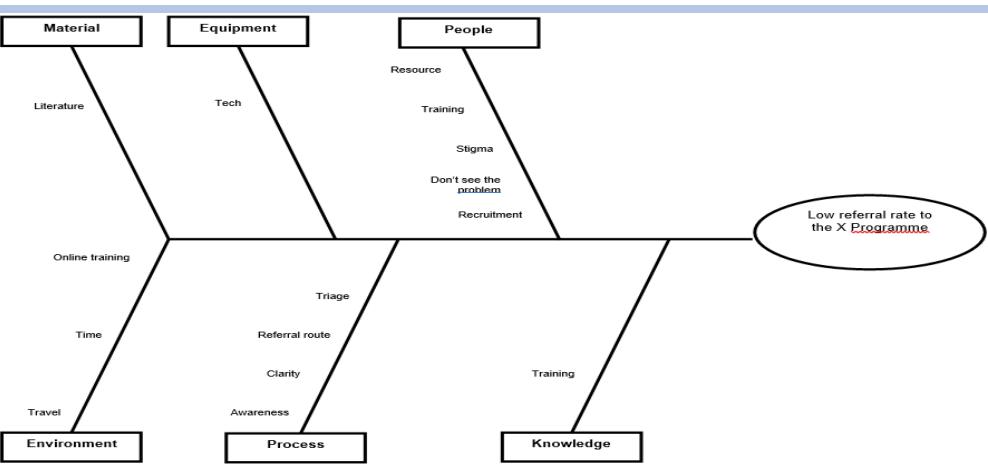
PDSA cycles (Plan / Do / Study / Act)

Plan

PDSA1: Develop a person specification for the recruitment of promotional post within CALA. Discuss the role with CALA colleagues. Check NHS financial plan to allocate funding.

PDSA2: Staff member will feel confident to visit community groups to promote the X Programme. A plan will be generated for them to visit community groups.

Do

PDSA1: Spec written and shared with CALA. Finances allocated to the post agreed. CALA completed a financial plan of how the money will be spent. CALA advertised the post internally.

PDSA2: Post recruited to internally at CALA. Training dates circulated. Training delivered. Plan developed for post holder to visit groups to promote X programme.

Study

PDSA1: Post appointed to in-house at CALA. Decision made to amalgamate this post with current Active Play post with a similar remit

PDSA2: Post holder now ready to visit groups and promote X Programme

Act

PDSA1: Adopt – continue with next step
Begin to think about training for the new post holder. Develop a plan of actions for them beginning their role.

PDSA2: Adopt – continue with next step.
Begin to record the data of number of groups visited. Continue to record X Programme referrals.

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

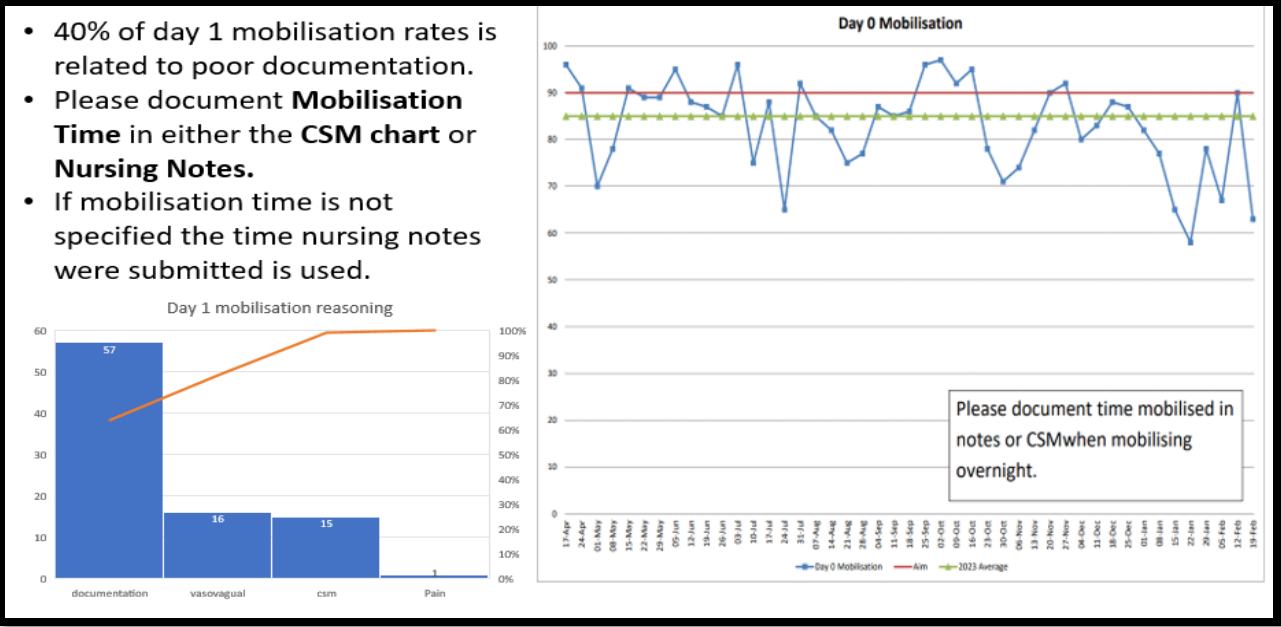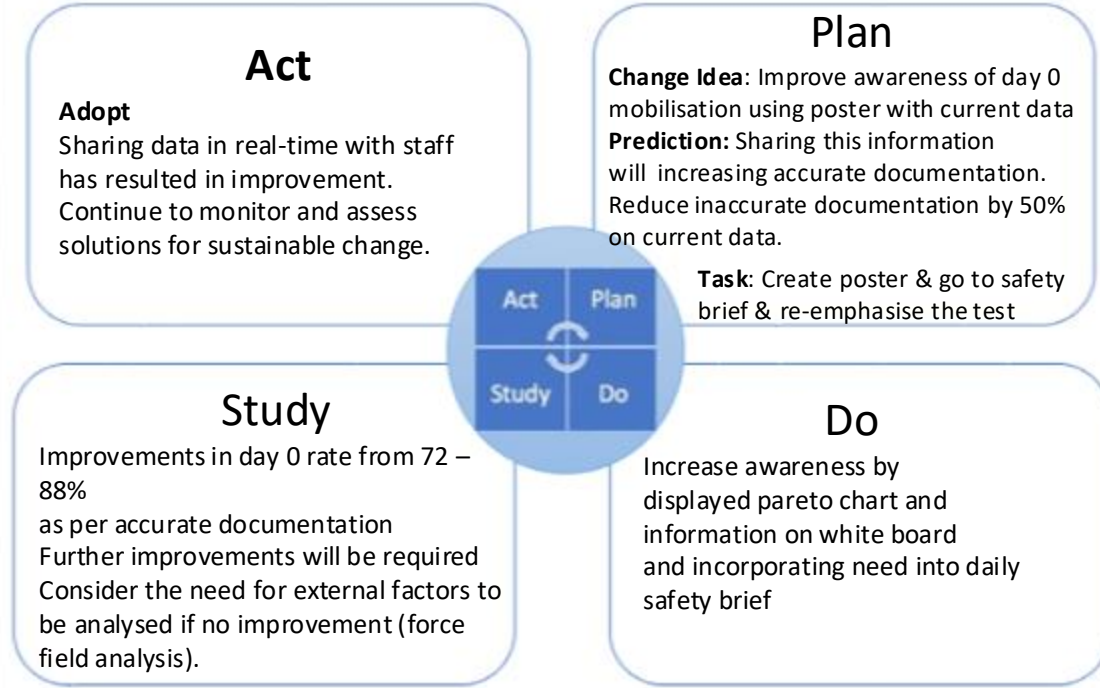| QI Project Team: Elective Orthopaedics, NHS Highland	QI Project Aim: Reduce inaccurate documentation of day 0 mobilisation of arthroplasty patients from 40% to 10% by December 2024 as per the recommendations of good practice by ARISE (arthroplasty rehabilitation in Scotland Endeavour)	Stage of the 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.

Day 1 mobilisation reasoning (Pareto chart: documentation 57, vasovagual 16, csm 15, Pain 1)

Day 0 Mobilisation (Run chart) — Day 0 Mobilisation, Aim, 2023 Average

Please document time mobilised in notes or CSM when mobilising overnight.

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

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:
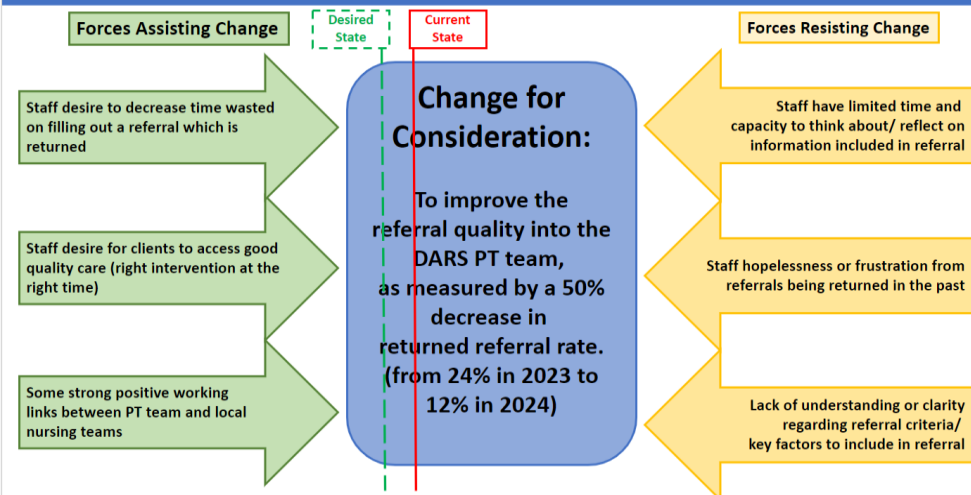
Testing

The Quality Improvement journey:

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:

Forcefield Analysis

Forces Assisting Change	Desired State / Current State	Forces Resisting Change
Staff desire to decrease time wasted on filling out a referral which is returned	**Change for Consideration:** To improve the referral quality into the DARS PT team, as measured by a 50% decrease in returned referral rate. (from 24% in 2023 to 12% in 2024)	Staff have limited time and capacity to think about/ reflect on information included in referral
Staff desire for clients to access good quality care (right intervention at the right time)		Staff hopelessness or frustration from referrals being returned in the past
Some strong positive working links between PT team and local nursing teams		Lack of understanding or clarity regarding referral criteria/ key factors to include in referral

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

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?)

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

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

Act | Plan
Study | Do
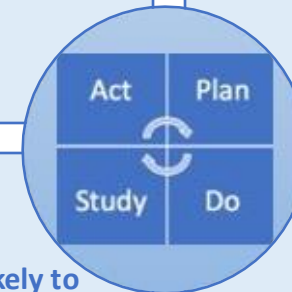
Area of Learning: The benefit of using the QI processes in even small projects. Some of the thinking was already happening subconsciously but the added structure fleshed this out and increased my confidence in the change I was trying to implement.
Successes: Positive feedback from staff regarding the 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.

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
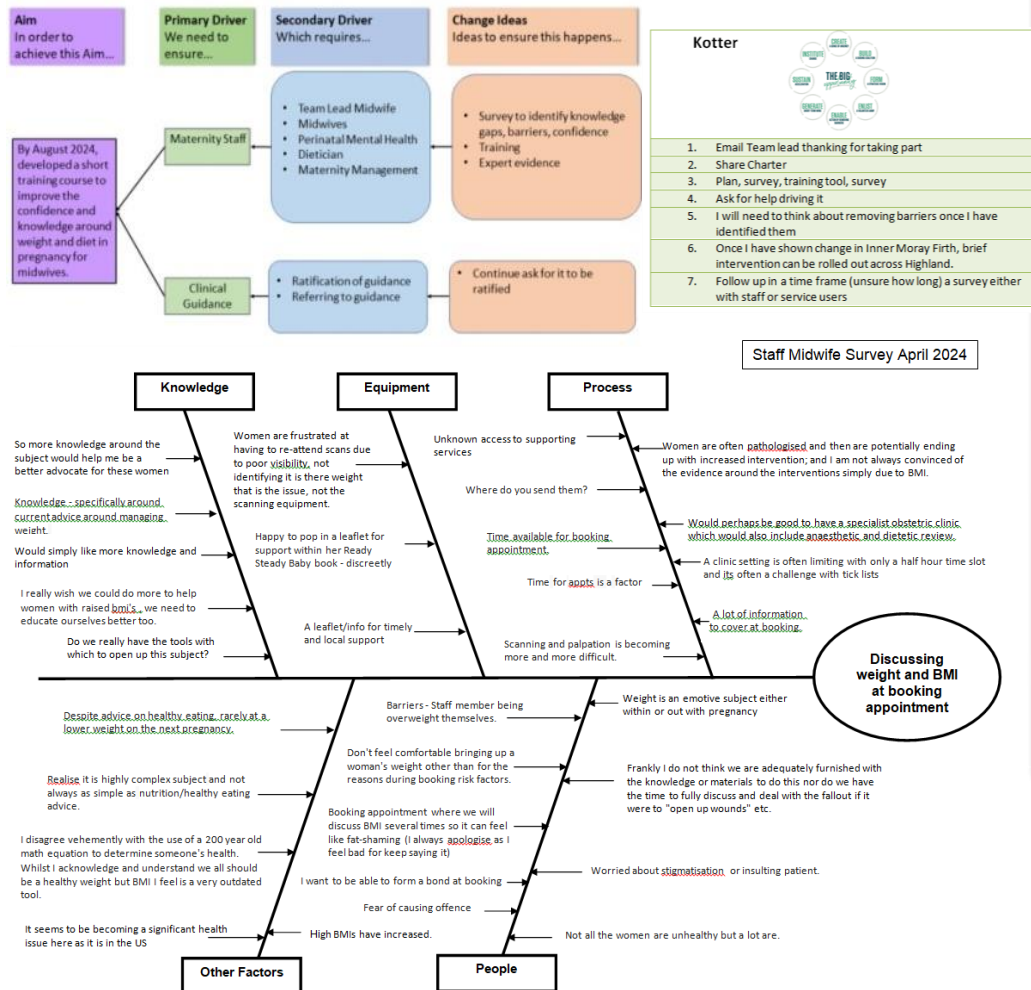
Stage of the QI Journey:
Testing changes

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

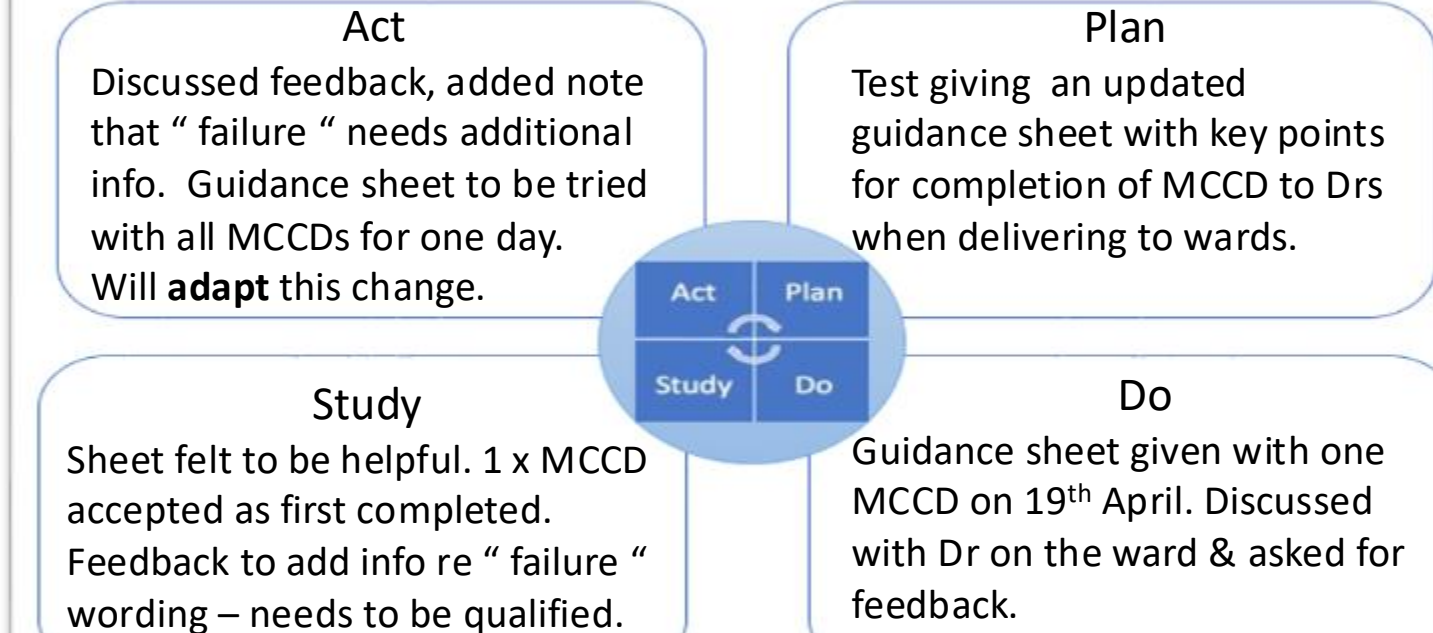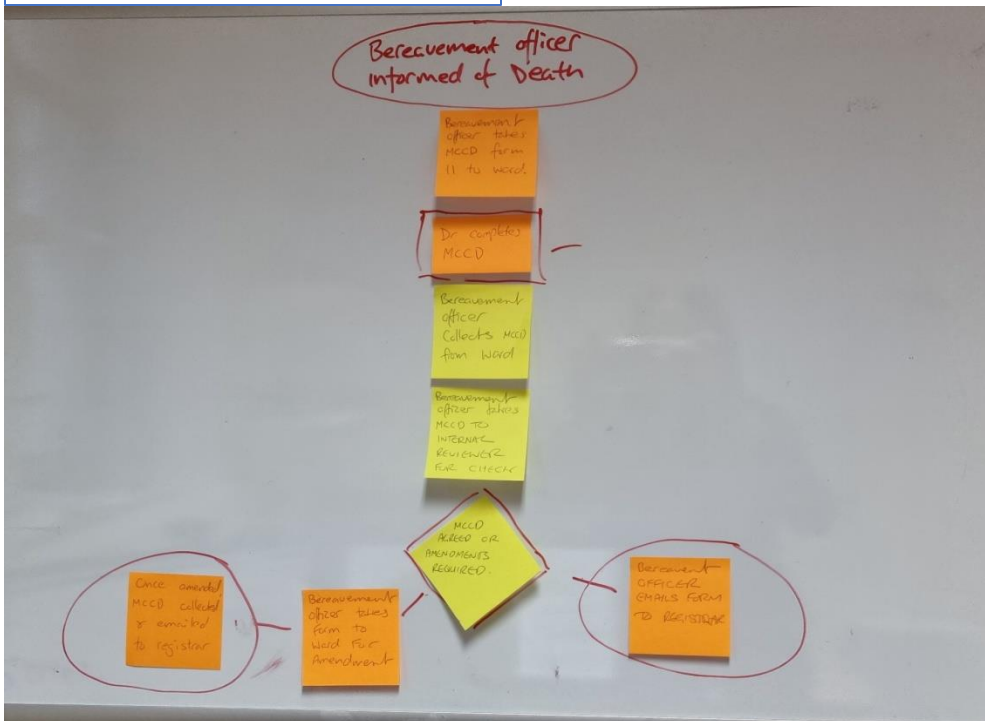**QI Project Team: John Carson & Claire McColl**

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

The Quality Improvement journey:

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

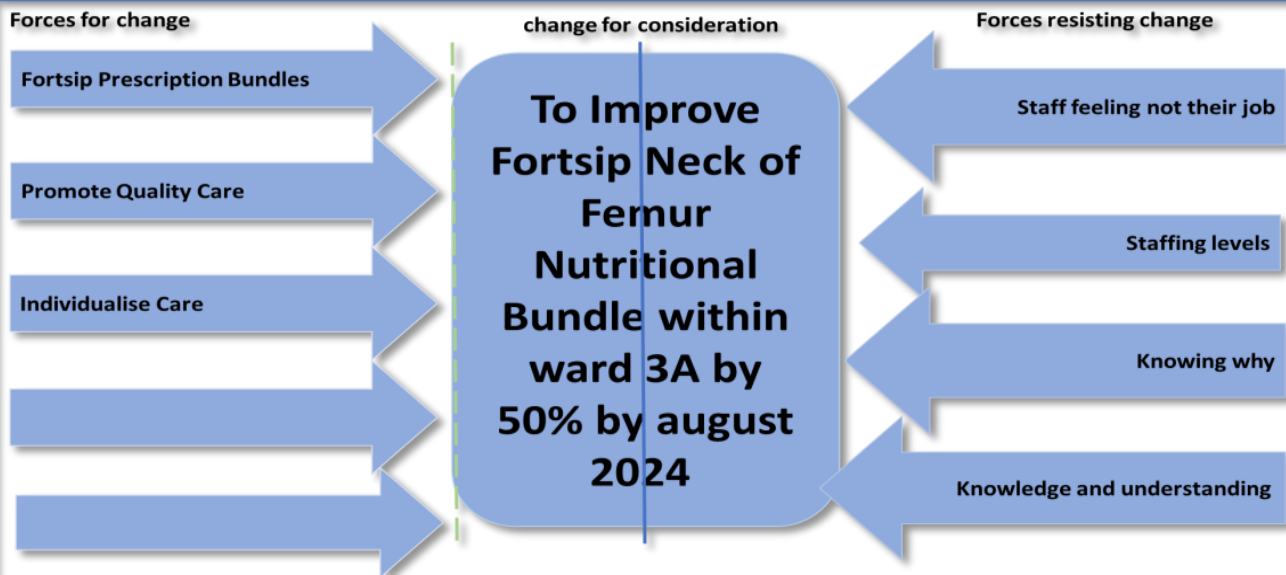**QI Project Aim:**
To improve Fortisip Neck of Femur Nutritional Bundle within ward 3A by 50% by August 2024 as per Scottish Government guidelines

Stage of the QI Journey: Testing

QI Tool:

Forcefield analysis

Forces for change	change for consideration	Forces resisting change
Fortsip Prescription Bundles	To Improve Fortsip Neck of Femur Nutritional Bundle within ward 3A by 50% by august 2024	Staff feeling not their job
Promote Quality Care		Staffing levels
Individualise Care		Knowing why
		Knowledge and understanding

Act-
- Add Fortsip prescriptions to Kardex's on yellow paper
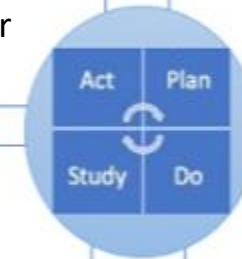- New 100ml cups for correct amount

Plan –
- Meetings with Nurse in charge to trail new way of patients of patients receiving fortisip's
- Test – ask patients which flavour they would like.

Study-
- Audit to measure compliance
- Meeting with staff to keep them informed

Do -
- Educate staff for the need for change
- Carry out training
- Implement Audit

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
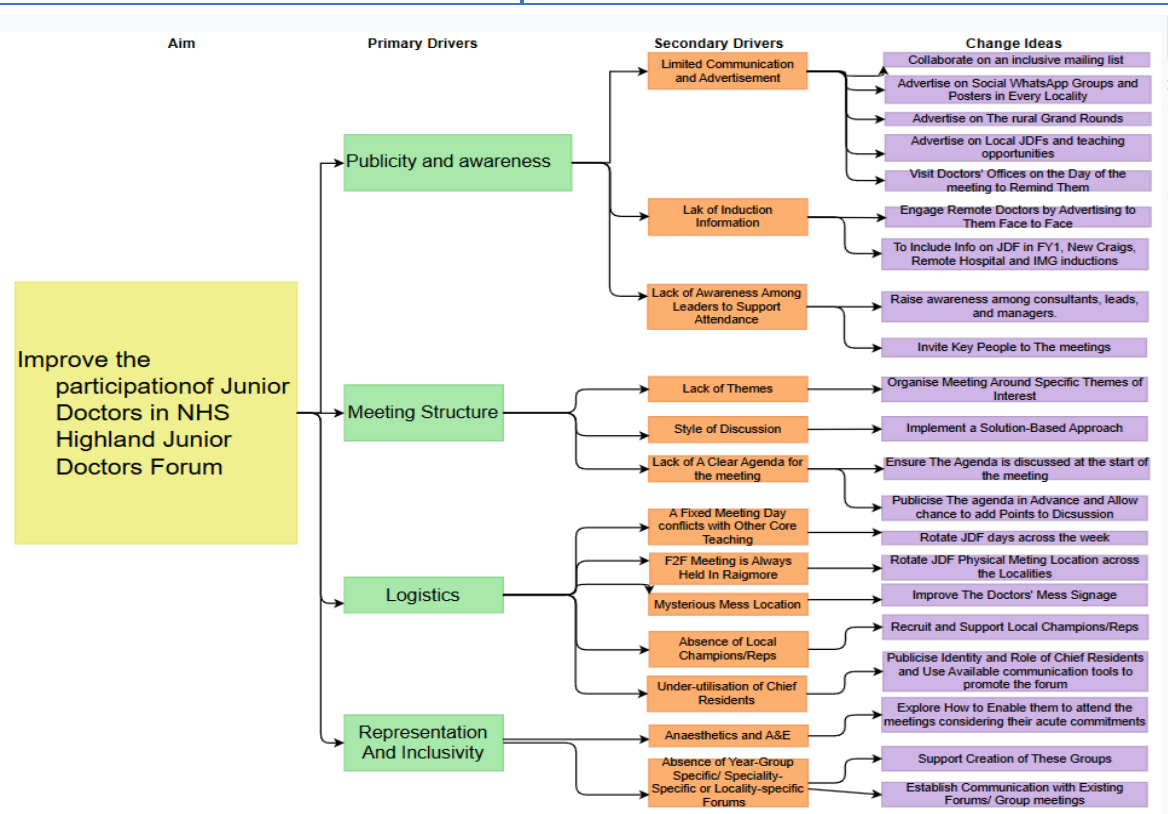
Flash report – SIFS Cohort 5 – Hamed Emara

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

Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Ideas
Improve the participation of Junior Doctors in NHS Highland Junior Doctors Forum	Publicity and awareness	Limited Communication and Advertisement	Collaborate on an inclusive mailing list
			Advertise on Social WhatsApp Groups and Posters in Every Locality
			Advertise on The rural Grand Rounds
			Advertise on Local JDFs and teaching opportunities
			Visit Doctors' Offices on the Day of the meeting to Remind Them
		Lak of Induction Information	Engage Remote Doctors by Advertising to Them Face to Face
			To Include Info on JDF in FY1, New Craigs, Remote Hospital and IMG inductions
		Lack of Awareness Among Leaders to Support Attendance	Raise awareness among consultants, leads, and managers.
			Invite Key People to The meetings
	Meeting Structure	Lack of Themes	Organise Meeting Around Specific Themes of Interest
		Style of Discussion	Implement a Solution-Based Approach
		Lack of A Clear Agenda for the meeting	Ensure The Agenda is discussed at the start of the meeting
			Publicise The agenda in Advance and Allow chance to add Points to Discussion
	Logistics	A Fixed Meeting Day conflicts with Other Core Teaching	Rotate JDF days across the week
		F2F Meeting is Always Held In Raigmore	Rotate JDF Physical Meting Location across the Localities
		Mysterious Mess Location	Improve The Doctors' Mess Signage
		Absence of Local Champions/Reps	Recruit and Support Local Champions/Reps
		Under-utilisation of Chief Residents	Publicise Identity and Role of Chief Residents and Use Available communication tools to promote the forum
	Representation And Inclusivity	Anaesthetics and A&E	Explore How to Enable them to attend the meetings considering their acute commitments
		Absence of Year-Group Specific/ Speciality-Specific or Locality-specific Forums	Support Creation of These Groups
			Establish Communication with Existing Forums/ Group meetings

## PDSA Cycle (Act / Plan / Study / Do)

Act:
- 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**

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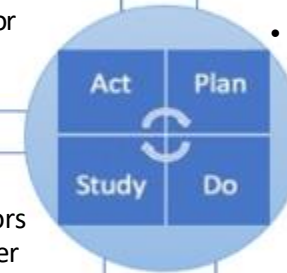
Study:
The JDF was attended by 9 junior doctors (2 cons, 2 admin staff, 1 Geriatric higher trainee, 1 med reg, 1 junior psych trainee, 1 junior Dr in ICU via teams, 5 F1s in med and surgery). **This is a 50% increase from the baseline number (6 attendees). This fits my prediction.**

Do:
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

Summary

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.

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.

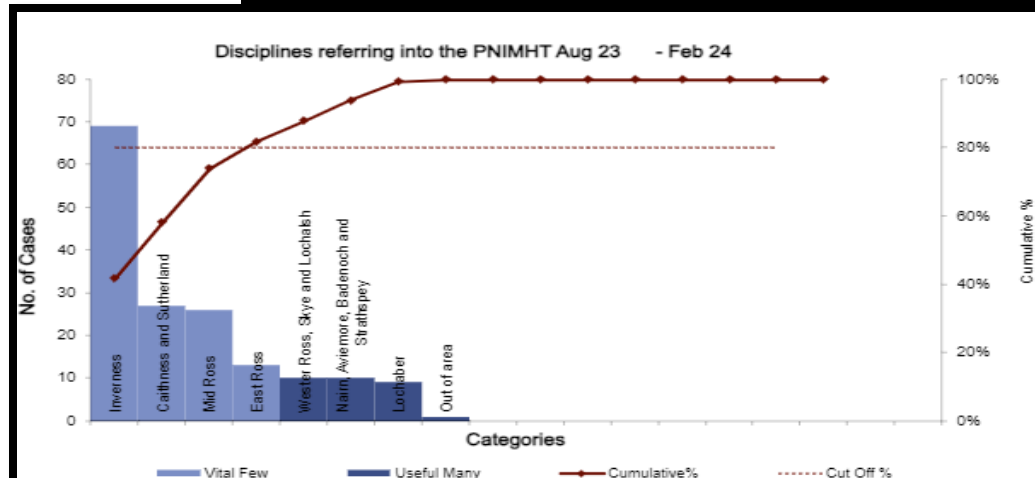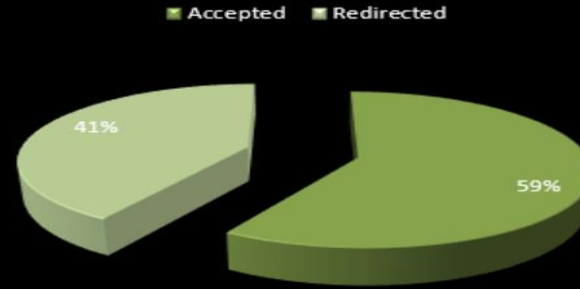**Stage of the QI Journey:** Testing changes

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.
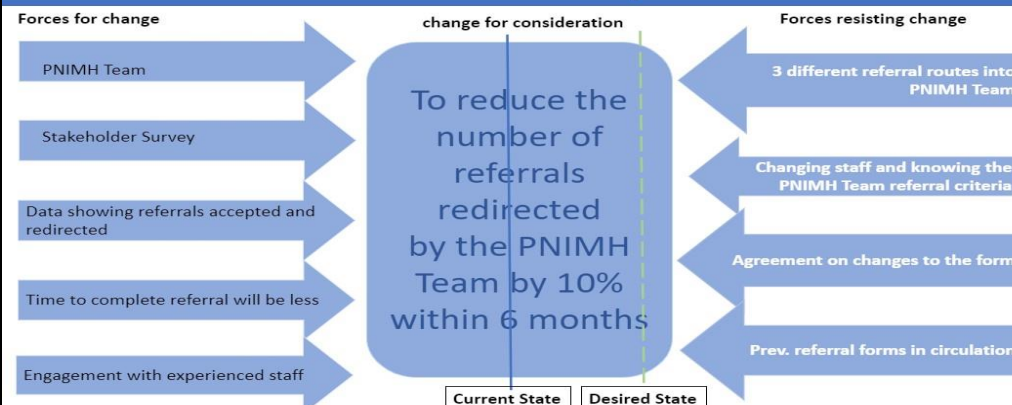
QI Tools Used

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

Referrals to NHSH North PNIMH Team Aug 23 - Feb 24

Accepted ■ Redirected

Pie chart: 41%, 59%

Disciplines referring into the PNIMHT Aug 23 - Feb 24

Legend: Vital Few — Useful Many — Cumulative% ...... Cut Off %

X-axis categories: Inverness, Caithness and Sutherland, Mid Ross, East Ross, Wester Ross, Skye and Lochalsh, Nairn, Aviemore, Badenoch and Strathspey, Lochaber, Out of area

Forcefield analysis

Forces for change: PNIMH Team; Stakeholder Survey; Data showing referrals accepted and redirected; Time to complete referral will be less; Engagement with experienced staff

change for consideration: To reduce the number of referrals redirected by the PNIMH Team by 10% within 6 months

Forces resisting change: 3 different referral routes into PNIMH Team; Changing staff and knowing the PNIMH Team referral criteria; Agreement on changes to the form; Prev. referral forms in circulation

Current State | Desired State

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