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.

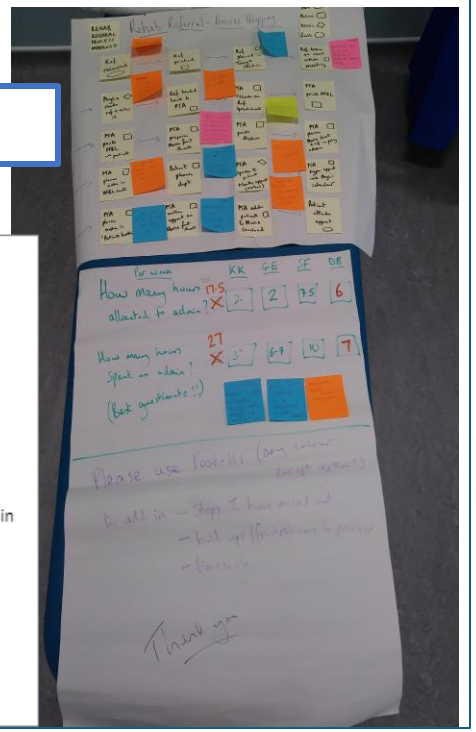
Stage of the QI Journey:

Testing Changes

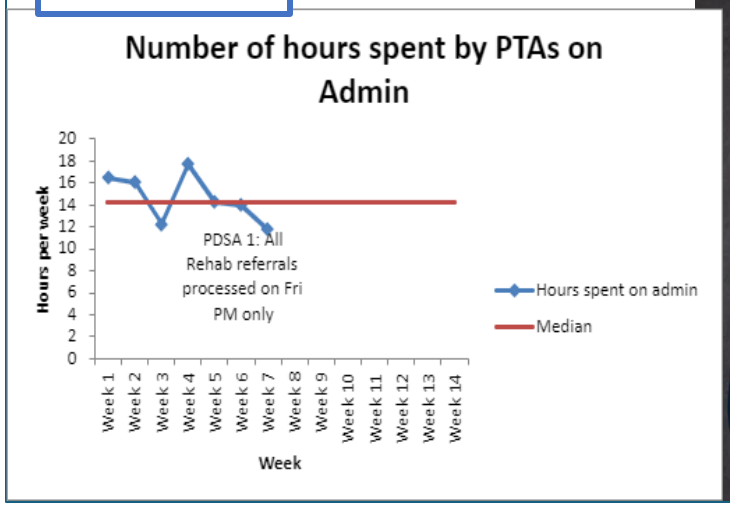
Current status:
Second PDSA cycle starts 26/6/23, and a third one planned (delegate PECOS ordering to the wider Admin team at B & S CH).
Note: Once Morse is fully functional, referrals will all be electronic and some current admin practices will be obsolete. However, the development of Morse is slow. 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 allmy team together at same time, asking staff to record admin time on a tick sheet – additional work
Successes – improved skills on Teams and on Excel. Trainers Laura and Jade accessible for help – Teams meetings with them made all the difference
Involved my team and got their ideas for the Process Mapping. Course run on Teams – would have been harder to attend if held at Inverness
Lightbulb Moments – you don't just measure before and after a change, measurement needs to be ongoing so that you can carry out repeat PDSA cycles (PDSA Ramp) or even Parallel PDSA ramps
- Use of Process and Balancing Measures in addition to Outcome Measures – gives a more rounded picture and provides checks/balances
- QI projects can be motivating and refreshing – great to introduce changes and refresh how we do things for benefit of patients and staff

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

QI Project Team:
Mental Health & Learning Development Services

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

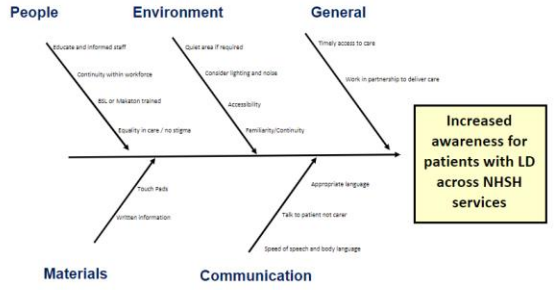
Stage of the QI Journey:

PDSA Cycle 2 (paused)

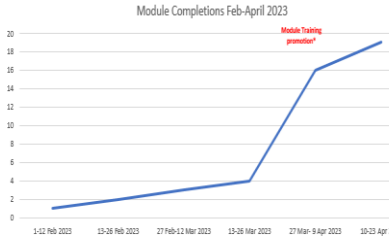
Current status:
First PDSA cycle complete. Uplift has been increased from 0-2 per month, to 16 and 18 respectively fortnight.
PDSA Cycle 2: Analysing data from TURAS to drill down and focus/drive within individual services across the organisation. Completions as expected have dropped down again.

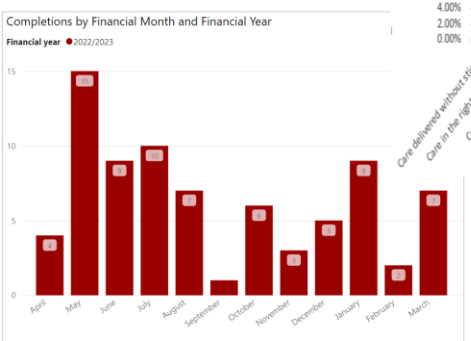
QI Tools

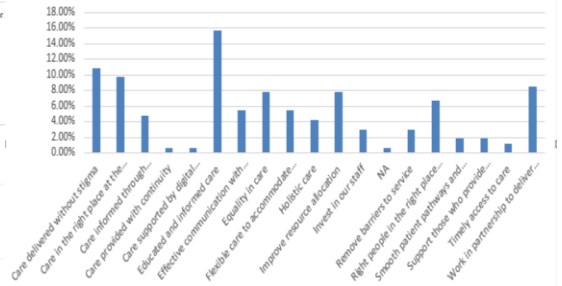
Fishbone Diagram



Data







User Feedback

Act

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

Plan

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

Study

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

Do

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

PDSA Cycle 2:

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

Area of Learning – Successes – Challenges

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

Flash report – SIFS Cohort 1 – Adrienne Swan, REP

QI Project Team:

Belford ED Medical Team

QI Project Aim:

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

Stage of the QI Journey:

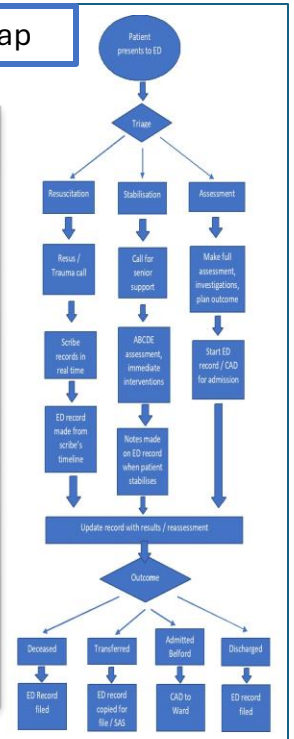
Testing changes

Current status:

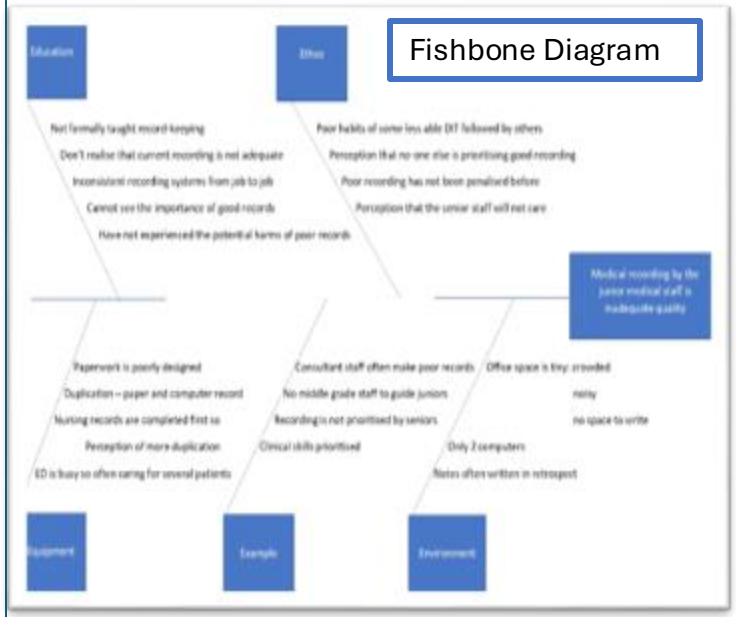
Testing different methods of changing how well written medical records are made in the ED and reinforcing the importance of this task

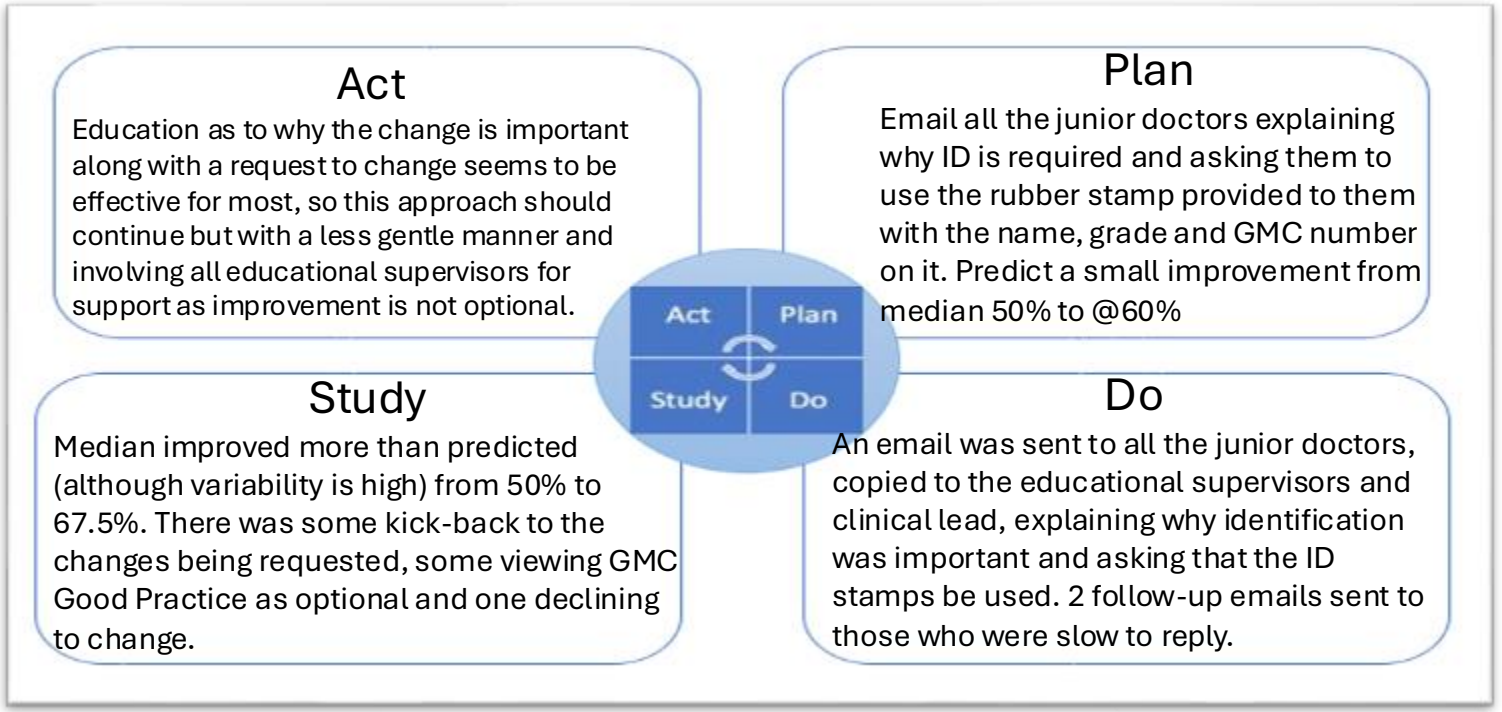
QI Tools

Process Map



Fishbone Diagram





Area of Learning – Successes – Challenges

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

Flash report – SIFS cohort 1 – Emma Zineldin

QI Project Team:
Highland Urology Clinic, Raigmore Hospital

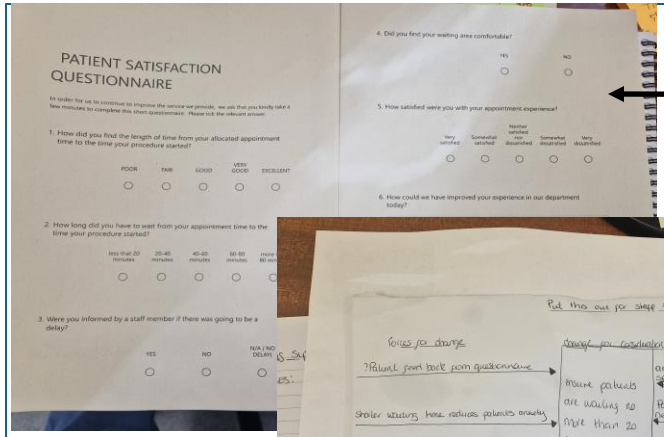
QI Project Aim:
By 1st July 2023, patients attending the Highland Urology Clinic for a cystoscopy, will wait no longer than 20 minutes from the time of their appointment, till the time the procedure starts.

Stage of the QI Journey:

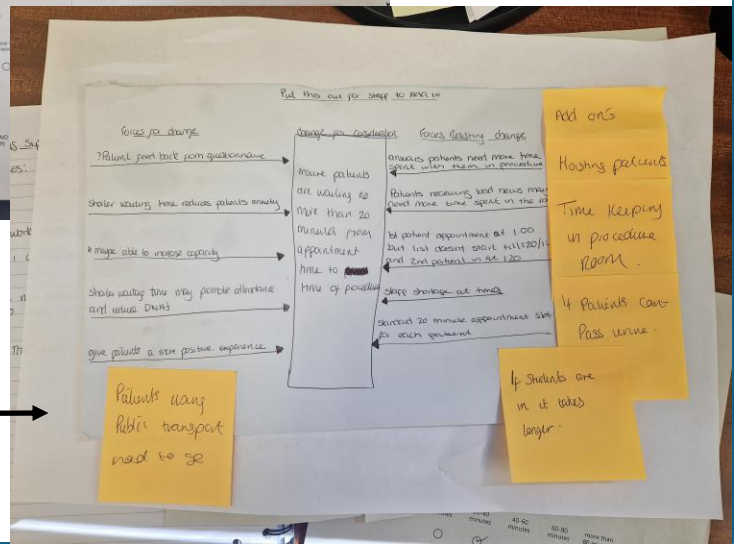

Testing Change

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

QI Tools - User feedback



QI Tools - Forcefield Analysis



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

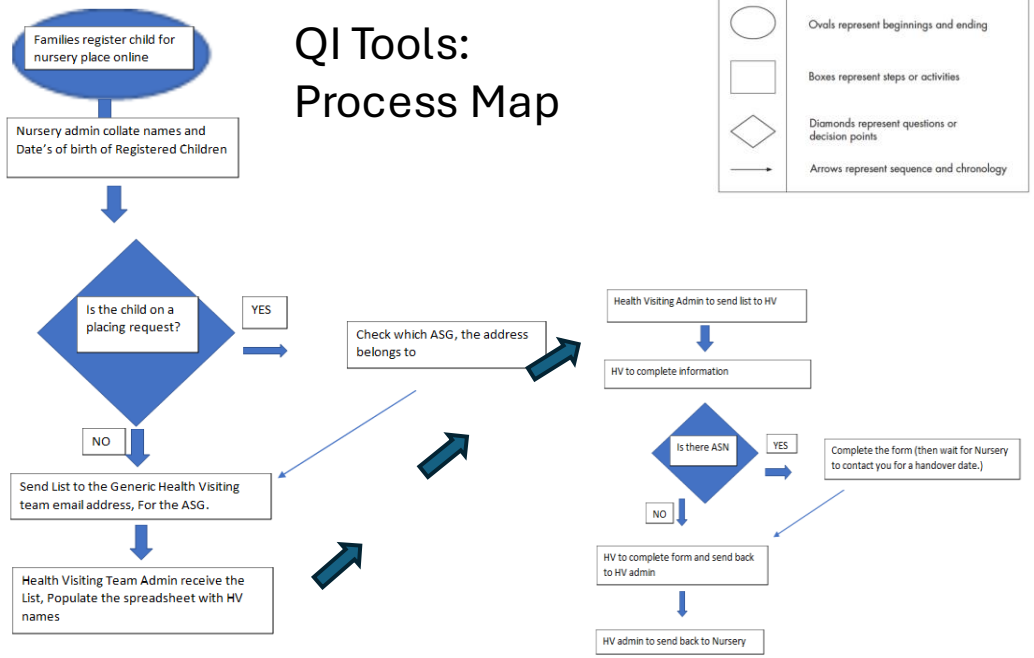
QI Project Team:
Inverness East and Nairnshire Team

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

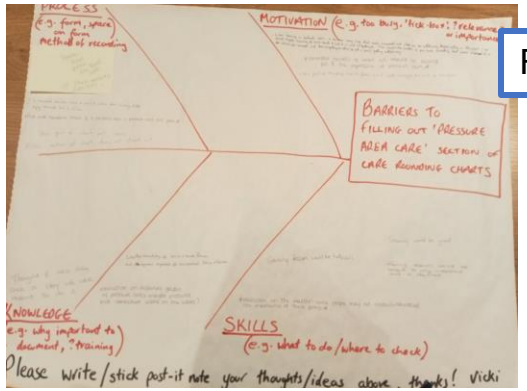
QI Team:
Badenoch & Strathspey Community Hospital
March-June 2023

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).

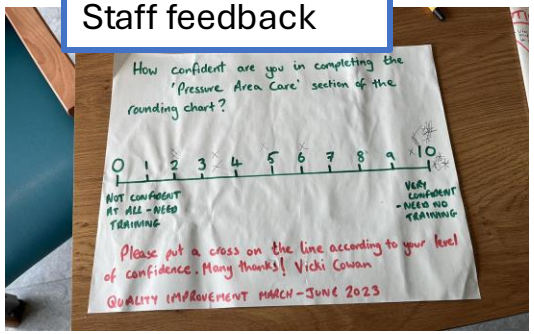
Stage of the QI Journey:

Testing Changes

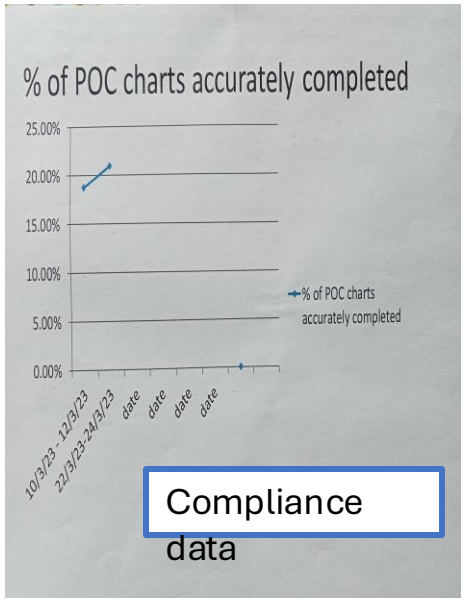
Current status: PDSAs – As lack of staff confidence was main issue identified from QI tools, PDSA 1 will test the introduction of mini training sessions on the ward around pressure area care. These will be done on an ad-hoc basis by myself and 2 other Band 5s to try and capture as many shift patterns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

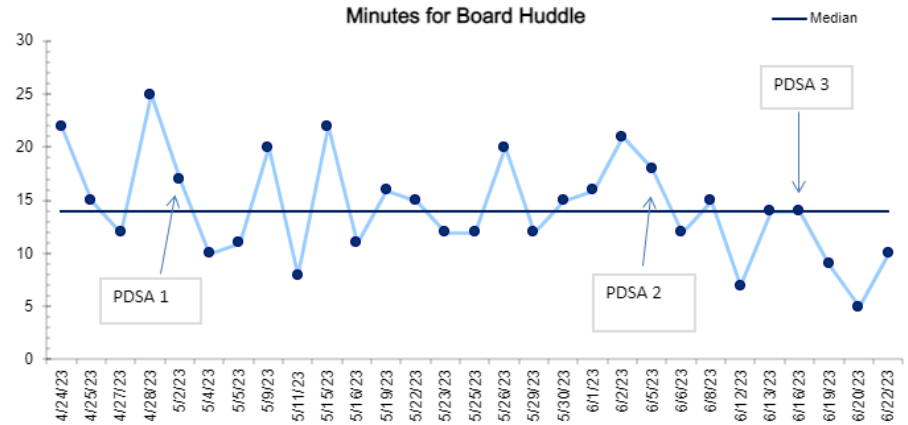
QI Project Team:
B&S Community Hospital Inpatient Ward

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 red uction. On a Friday as we head into the weekend there is more lengthy discussion of patients knowing that the only medical support over that period would be from OOH.

Success

- The compiling development of the process mapping and the run charts are two of the areas I have found most useful. Developing the process map including all the team involved in the board round was useful as a collective approach and benefited all future discussions around what changes could be of benefit.
- The run chart has in some ways changed the focus of the projects aim of the board round lasting no more than 10 minutes. Given that the median point is 15 minutes and that times where the Board Round has exceeded this it would be reasonable to consider a target time of 15 minutes which would still represent an efficient time wh ile 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.