Nursing and AHP led improvement

support  collaborate  challenge  improve  inspire
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@jkfillingham

#improvefalls
Building multidisciplinary energy
What is the best way to spread new knowledge?

Social connection/discussion is 14 times more effective than written word/best practice databases/toolkits etc.

Source of data: Nick Milton
http://www.nickmilton.com/2014/10/why-knowledge-transfer-through.html

Source of image: www.happiness-one-quote-time.blogspot.com
Building social energy

FIND RELEVANT PEOPLE & CONTENT

SHARE YOUR WORK WHERE OTHERS CAN SEE
INTERNAL PLATFORMS OR EXTERNAL SOCIAL NETWORKS

WORK OUT LOUD

GIVE BACK BY SHARING, COMMENTING & CONNECTING PEOPLE

MAKE IT A PART OF YOUR ROUTINE

Tanmay Vora @tnvora QAspire.com
Nursing & AHP Improvement example in practice.....
National Reporting & Learning Systems show that there were 246,000 inpatient falls (2015)

Falls Collaborative aims

• Improve falls reporting in trusts
• Increase Quality Improvement skills
• Reduction in falls on wards participating in the programme
• Encourage falls away from mainly nursing or patient safety issue towards a multi professional focus
• Re-energise the falls prevention improvement movement.
• Ensure that Trusts have the information & tools to reduce injurious in patient falls and improve reporting & care.
Let’s hear from those involved.....

https://youtu.be/Dk1gp-zP2Ns
Nursing & AHP improvement the journey

- Learning about improvement methodology
- Becoming a change agent
- Building the change team – identifying roles and responsibilities
- Establishing systems and processes for change
Nurses & AHPs mapping the process

- Completing a process map
- Identify gaps in process map to inform tests of change (PDSAs)
- Engaging colleagues & updating Trust Board
- Start testing changes selected clinical areas
Falls Improvement Collaborative

KCHFT has set a clear target for the reduction of all falls with harm acquired within our care for 2016/17 2017/18

Our team
Ali Strowman - Chief Nurse & Executive sponsor
Nick Plummer – Head of Performance
Wendy Bennett – Team Sister
Ruth Herron – Deputy Chief Nurse
Sam Freelove – Physiotherapist
Sally Hall – Lead Allied Health Professional (AHP)

The Whitstable & Tankerton Community Hospital Team!

90 day rapid improvement cycle

The aim of this programme is to:
- Improve falls reporting
- Increase Quality Improvement skills
- Reduce the number of falls on the wards participating in the programme

The IHI Breakthrough Series Collaborative model provides a framework to enable rapid testing of changes to learn, adapt and plan for scale up and spread of the work.

Tests of change:
1. Accurately take and record lying and standing blood pressure on admission
2. Ensure that the mobility aid is suitable and within reach thus allowing the person to mobilise safely
3. The call bell (or alternative) is within reach and the person understands how and when to use it
4. Review of medication on admission by the pharmacist or Doctor - Patients on FOUR or more medicines are at greater risk of having a fall Regular medication reviews play an important part in falls prevention.
5. Complete a bedside vision check on admission using the RCP bedside vision check
6. A falls prevention personalised care plan is in place and is shared by the team with the patient and their family - this will ensure all who need to know are aware of the risk factors and strategies to enable safe care

Edenbridge Hospital - Lying & standing blood pressure taken on admission

- Lying & standing blood pressure accurately taken and recorded on admission
Falls Improvement Collaborative – EAU West Cumberland Hospital

Why Focus on falls
The clinical area we are testing our improvement work is the Emergency Admissions Unit. We have chosen this area as it has a high falls rate and in previous years a number of these falls have led to harm to the patient. Engaged in the project team are, nurses, health care assistants, physiotherapist and Doctors using a multidisciplinary approach to ensure a multifactorial approach to falls is achieved.

Tests of Change so far:
So far during this falls collaborative we have engaged the staff on the unit in order for them to help us make the changes successful. We have worked alongside the physiotherapists who are currently developing a teaching plan that will allow them to teach the nursing staff on the unit, to safely assess patients to use mobility aids out of hours. We have developed a new pack regarding the falls multifactorial tool to aid staff to ensure the correct actions are taken for the individual patient.

90 day rapid improvement cycle
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What have we learnt?
- From process mapping a patient’s Journey we have learnt that although we complete the multifactorial tool on every patient we admit into the hospital, we don’t always implement the correct safety measures from this tool.
- Also after talking to staff on the Unit we learnt that obtaining equipment proved an issue for staff and they would often spend long periods of time obtaining this. We have since ordered a large amount of sensor alarms to ensure that this delay is avoid.
- Nursing staff complete a large amount of paperwork and therefore to make these changes obtainable we have made the new documentation a tick list and therefore reducing the amount of time staff will spend on completing this, but also this is clearly visible to ensure all aspects are complete.

The tests we are planning next:
- Work with the physiotherapist to implement the teaching plan with regards to falls and mobility aids.
- Implement the new paperwork which will come into affect when patients trigger on the falls assessment, this includes information on the bedside boards to alert staff.
- Liaise with North West Ambulance Service to ensure patients bring mobility aids into hospital.

Falls Incidents

<table>
<thead>
<tr>
<th>Contributory Factors</th>
<th>7</th>
<th>6</th>
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<th>5</th>
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<tr>
<td>Confusion</td>
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<td>Patient Factors/Condition</td>
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<td>Physical &amp; Mental Stressors</td>
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<td>Mobility</td>
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<td>Continence</td>
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<td>Unintentional</td>
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<td>Medication (Prescribed)</td>
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<td>Factors</td>
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<td>Alcohol</td>
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Types of Falls Incidents

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<th>Falls Incidents</th>
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The clinical area we are testing our improvement work is the Emergency Admissions Unit. We have chosen this area as it has a high falls rate and in previous years a number of these falls have led to harm to the patient.
Why focus on Falls

- The acute stroke and neuro-rehabilitation ward was chosen due to the high number of patient falls reported on the Trust’s incident reporting programme. There were 75 reported between 1st September 2016 and 10th February 2017.
- The project team comprised of nurses, occupational therapists and physiotherapists. A multi-disciplinary approach was essential due to the rehabilitative nature of the ward, and to ensure the whole team took collective ownership of the improvement work.

90 day rapid improvement cycle

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- Improve falls reporting
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The IHI Breakthrough Series Collaborative model provides a framework to enable rapid testing of changes to learn, adapt and plan for scale up and spread of the work.

Tests of Change so far:
- The ward team met and completed a process-mapping exercise and identified potential areas for improvement.
- PDSA cycle planned.
- Daily “safety huddles” were implemented for a two week pilot period, focusing on the patients at risk of falls and discussing team strategies for reducing the risks.
- The ward environment, specifically the toilet areas, were reviewed and improvements were identified.

What have we learnt?

- Environmental improvements can be made in the toilet areas, for example, location of pull-cords for requesting assistance, finding alternative storage areas for commodes, replacing the energy saving lighting with standard lighting.
- The ward team are unable to hear alarm calls in certain areas of the ward.
- The ward do not have an adequate supply of sensors for use with the at risk patients.
- “Safety huddles” need to be held late morning to target the maximum number of staff.
- Visual cues placed on the wall above the beds of “at risk” patients are useful and help the team to be more aware during their daily work.

The tests we are planning next:

- Formal review of “safety huddle” pilot and implement changes as required.
- Action identified environmental changes.
- Contact estates to address the problems regarding the team being unable to hear the alarm calls.
- Highlight the lack of sensors to senior management.
- Commence use of a “safety board” on the ward to celebrate successes and lessons learned.
Measuring the impact of change

- Collecting data to understand the impact of changes.
- Preparing a Comms plan to share improvement journey with colleagues.
Pinching with pride

- Share learning & testing scale-up
- Capture the learning about how programme has improved quality of patient care
- Calculate the cost avoidance from scaling up the project
- https://youtu.be/GXR_2tXOKvQ
# Building the social & MDT energy

## #improvefalls

### The #improvefalls Influencers

#### Top 10 by Mentions
- @nhsimprovement 328
- @zoopackman117 120
- @mrsjmckenna 112
- @sttrust 51
- @kathrynperera 44
- @jkhollingham 41
- @subathiru 38
- @juliejwindsor 34
- @hallrshally 29
- @northcumbrianhs 29

#### Top 10 by Tweets
- @zoe packman117 120
- @celecko 41
- @alisonsmith2306 18
- @jk hollingham 12
- @subathiru 11
- @nhsimprovement 9
- @kathrynperera 8
- @fjw2810 7

#### Top 10 by Impressions
- @nhsimprovement 109.2K
- @celecko 71.5K
- @exercise works 47.5K
- @nhsengland 43.5K
- @drumesh prabhu 34.8K
- @jk hollingham 31.5K
- @kathrynperera 27.4K
- @zoopackman117 26.2K
- @ger isoc 21.4K
- @leeds chatter 21.1K

### The Numbers

- 810,946K Impressions
- 680 Tweets
- 312 Participants
- 0 Avg Tweets/Hour
- 2 Avg Tweets/Participant

Our recent tweet about patient falls received a record number of views (34,400), clicks (1359), and retweets (159). It was our most shared tweet as NHS Improvement to date.

Twitter data from the #improvefalls hashtag from Fri, March 3rd 2017, 2:05PM to Tue, July 4th 2017, 2:05PM (Europe/London).
<table>
<thead>
<tr>
<th>Safety huddle - E &amp; N Herts</th>
<th>Monthly ward based RAG rating displayed on huddle board, falls rate - S Tyneside</th>
<th>Lying &amp; Standing blood pressure proforma to complete in ED - E &amp; N Herts</th>
<th>Graphics - Wolverhampton</th>
<th>Video for Nurses day - George Elliot</th>
<th>Falls grab bags in bathrooms - Wolverhampton</th>
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</thead>
<tbody>
<tr>
<td>Repeat falls identifier</td>
<td>Lying &amp; standing BP guidance for BP machine</td>
<td>Baywatch - Croydon</td>
<td>Lying &amp; standing BP sticker in notes</td>
<td>CSW engagement - Croydon</td>
<td>Identification of risk on transfer</td>
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<tr>
<td>Carers &amp; patient impact slides &amp; videos</td>
<td>Magnet for frequent fallers - Sheffield</td>
<td>Lying &amp; standing BP training - United Lincs</td>
<td>Post falls review - Portsmouth</td>
<td>No caffinated drinks after teatime - South Tyneside</td>
<td>High risk medication cards on drug trolleys</td>
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<tr>
<td>How to trigger medications review - North Cumbria</td>
<td>Safety huddles - E &amp; N Herts</td>
<td>Falls lead job description - Dudley &amp; Northampton</td>
<td>Falls week - Dudley</td>
<td>Use of volunteers</td>
<td>MDT safety huddles - Sheffield</td>
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<tr>
<td>Decaffinated drinks - Northampton</td>
<td>Colour coded walking aids - Dudley</td>
<td>What side of the bed do you get out of? - Croydon</td>
<td>Wrist bands; supervision, dependendet A0/02</td>
<td>Tag system to include all MDT</td>
<td>Using CSW workforce to implement a modified visual assessment of patients - South Shields</td>
</tr>
<tr>
<td>Improve system for capturing postural BPs - Dudley</td>
<td>Review &amp; develop audit process</td>
<td>MDT care planning</td>
<td>Slipper exchange</td>
<td>Staff &amp; patient awareness information leaflets - Kent Community</td>
<td>Walking aid tagging; 'pimp my frame' - Dudley</td>
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<td>Safety bundle - Dudley</td>
<td>Swarm process - Portsmouth</td>
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Nursing & AHP service improvement
benefits of working together

- Site visits
- Process mapping as a tool to drive change
- Multidisciplinary approach
- The ‘social movement’ philosophy of creating & sustaining change
- Sharing and networking – pinch with pride
- Lessons learned applied to other collaboratives
- Professional Leadership team working in matrix way
- Cross boundary working with; Horizons team, Royal College of Physicians, Public Health England, NHS England
The end of the journey – well not quite……

- Falls collaborative website https://improvement.nhs.uk/resources/patient-falls-improvement-collaborative/
- Case studies
- Improvement tools
- Clinical updates
- National Practitioner network to be established
- Economic evaluation of programme
- International collaboration with New Zealand
- #improvefalls
Lunch

Activities:
• The red bead game – London Wall
• PDSA Ping Pong – London Wall
• Improvement cinema
• Q networking lounge