Frailty Collaborative

Learning Session 2
12th October 2021
What was our idea?

- Develop mechanism on L6 to deliver against best practice CFS
- Frailty understanding / recognition / management of L6 staff
- CFS Training to all staff

What was our plan?

Clinical frailty score (CFS) Questionnaire sent to all staff month of Sept, staff given 2 weeks to reply.

Email / letter sent to all L6 staff informing them that L6 will be involved in Frailty collaborative. Aim of questionnaire was to get a picture of what is staff’s knowledge of CFS and why it is so important.

1. What do you understand by the term frailty?
2. Name 4 things that can cause patients to become frail?
3. Name the different ways frailty can affect patients?
4. Have you heard of clinical frailty score (CFS)- what is your understanding of this
5. Who carries out CFS and where may you have seen the score
2 ward consultants will carry out Take 5 brief discussions with all nursing staff to increase knowledge and awareness.

Resend questionnaire to retest staff knowledge following teaching.

Results discussed with staff.

Start to highlight each patient’s frailty score on patient’s headboards.

Use patients’ frailty scores of 5/6 to engage more mobility type exercises for patients to encourage patient mobility.

L6 collaboration with Palliative care – CFS/ACP.

Did it work?

Poor response from staff via both to questionnaire sent out via their work email / paper.

Not all staff wanted to engage due to – Lack of time due to increased staff work commitment/workload.

Staff shortages may have an impact of answering the questionnaire and education to staff.

Where do we go from here?

Based on our experience so far, if we were to describe ourselves as an animal it would be:

Because:
Pharmacy
What was our idea?

• What is the value of an acute care, frailty focused, medicines review by a Pharmacist.

• Can we get funding to explore a cross interface approach to delivering better medicines care for this cohort.

Team/Ward: Pharmacy

What was our plan?

• To test conducting a medicines review for people admitted to EAU with a CFS of 6.7 or 8.

• We applied for CCG funding to set up a program to explore a cross interface process.
• The review intervention was successful in the context of highlighting some medicines issues that needed to be resolved.
• Medicines review in acute care was achievable with caveats around time and content. It had value in informing potential medicines changes relating to acute issues including falls risk and cognition.
• Truly effective medicines care would require a joined up intervention and support process predominantly delivered by primary care. Unfortunately our funding bid was unsuccessful.

• The acute review intervention requires further discussion to refine content/documentation. Also a plan for upscaling and supporting the raising of awareness of colleagues about frailty to facilitate their engagement in review.
• Acutely we can conduct focused medicines review and implement some medicines changes but to achieve optimal benefit this needs significant ongoing review and support in the community.
• Need to look at how primary care, secondary care and community pharmacy teams can work together to deliver this.
• This needs a joined up cross interface process so that people with frailty are identified and then supported with their medicines care.
Intermediate Care
What is our idea?

- To audit and review risk assessments post falls undertaken by nurses, focusing on medication reviews and the monitoring of lying and standing BP with frail patients in IMC.
- Rehabilitation goes hand in hand with promoting independence and positive risk. It can increase the risk of falls and we wanted to look at how we can try and reduce this. Units involved (please note moving to The Bevan Unit – November 2021)
  - The Limes IMC unit
  - Heartly Green IMC unit
  - Louise Hilton ANP
  - Carol Smith Lead Nurse

What is our plan?

- To improve the reliability of completing the Falls risk assessment focusing on medications and postural hypotension to reduce harm.
- In order to do this, the ANP and the Lead Nurse would compile an audit tool looking at falls within the IMC units over a 4 week period.
- An anonymous RN staff questionnaire would be compiled to ascertain current practice and staff knowledge regarding completion of the Falls risk assessment and Falls Prevention care plan.
- Following a review of the data, refresher training in knowledge based and skills competencies would be agreed for all staff.
Jessica Smith

Emergency Department
Frailty

EMERGENCY DEPARTMENT

JESSICA SMITH - SENIOR SISTER
Aim: To improve the recognition of frailty in the Emergency Department

How?

Audit: 50 patients per week for 2 weeks who have attended ED via ambulance over the age of 65 looking at:

Is the CFS recorded in the triage document?
Is the CFS recorded by NWAS?
Is the CFS recorded formally during admission?
Is the CFS recorded on admission the same as the score recorded at triage?
If no was this higher or lower than the score on the admission document?

Education: Developing nurse education using national education forums

Questionnaire: Developing a questionnaire to give out to patients at front door triage who are over 75 to aid the clinicians in doing the CFS on assessment in ED
District Nursing

Janet Brady & Michelle France
Irlam and Swinton District Nursing Teams

FRAILTY

To align the Clinical Frailty Scale with the DN comprehensive assessment
To assess all patient’s frailty scale using the DN comprehensive assessment.

**Education and training**
- Provide training for team members / team awareness
- Provide an A5 copy of clinical frailty scale
- Push use of e-learning.
- Promote leaflet “Promoting independent living at home and frailty prevention”.
- Ensure staff are competent re completion of comprehensive assessment.

**Empower patients and carers**
- Provide leaflets and information of support groups including Health Improvement Team.
- Refer to MDTs e.g. Falls team, Bladder and Bowel, Dietetics, pharmacy, GP.
- Observe and action ADLs e.g. clothing / shoes, mobility, emotional wellbeing.
- Action safety issues in the home such as risk of trips and falls

**Empower Staff and Sharing information**
- Identify health deficits and implement care plans for both long and short term DN caseload management.
- Ensure CFS is documented on EPR.
- Implement Advanced care planning and preferred place of death.
- Liaise with patient, relatives MDT
DID IT WORK
The teams are in the early stages of the test of change.
Clinical Frailty Scale cards have been discussed and given to staff in the Swinton team.
Comprehensive assessments / CFS have been completed on all new patients’ admitted onto the Irlam DN caseload

WHERE DO WE GO FROM HERE
We aim to promote independent living at home and frailty prevention.
Encourage advanced care planning for patients scoring 7 or above and avoid hospital admission.
Seek advice from QI how to measure our outcomes.
Physiotherapy & Occupational Therapy (Emergency Village)
Nutrition and Hydration Collaborative

#NCAreduceharm
Day Surgery Ward
What was our idea?

Day Surgical Ward

- To improve / increase awareness in the importance of Nutrition and Hydration for day surgical patients

What was our plan?

- Pre test questionnaire/information gathering to establish current awareness of the importance of nutrition and hydration in day surgical patients
- Survey size = 9 RN and 1 TNA of differing nursing backgrounds and length of service and experience in caring for day surgical patients
- The results/feedback identified areas where further training and learning opportunities were required.

Areas for further development included
- To ensure that all staff including new starter have completed the MUST training
- To develop an information board and resource folder for all staff and student nurses to access which contains evidenced based information relating to the importance of nutrition and hydration in a day surgical patient
- To design a poster for staff and patients giving advise, guidance and contact information
Did it work?

• Post test questionnaire devised and given to staff
• Reassess the findings and identify any further training and learning opportunities
• Information board, resource folder, in house teaching sessions/group discussions are in place
• Information posters and healthy eating leaflets are available for patients to access
• All staff have now completed the MUST training and Nutrition and Hydration has been included as part of the new starter induction process within the day surgical unit.
• Specific dietary information is available for patients as required
• Staff have the knowledge and skills to engage in health promotion opportunities with patients (making every contact count)
• Staff have a clearer understanding of who to contact for further nutritional support and advice.

Where do we go from here?

• To continue to follow up to date fasting requirements in line with trust policies and procedures
• Continue to provide evidence care and promote a healthy lifestyle for our patients
• To continue to liaise with the nutrition support team for support and guidance
• Time allocated for training/discussion
• Always making every contact count with regards to nutrition and hydration and promoting a healthy diet
• Share positive feedback from patients

Based on our experience so far, if we were to describe ourselves as an animal it would be a caterpillar because we are slowly transforming into a butterfly.
Community Stroke Team
What was our idea?

HMR Community Stroke Team

- To create a patient self-administered fluid intake chart for patients who are not drinking ideal amounts of daily fluid (6-8 glasses)

What was our plan?

- To identify appropriate patients through direct conversations with patients
- To discuss fluid intake during initial MDT assessment
- To carry out short questionnaire pre and post weekly chart completion
- To provide a further week of daily charts if still fluid intake still needs support
- Patient and/or carers to complete independently
Did it work?

- Small number of patient participation and small number of patient need
- Challenges with staff participation; needed prompts to keep reminding team to
- Easy and simple to administer when required

Where do we go from here?

- Continue to use with patients that require fluid intake monitoring.
- Continue to check daily intake during initial assessment
- Incorporate #Butfirstasip into daily sessions as this seems to be a more useful and practical activity that can benefit all our patients
- Regular reminders in weekly MDT Team meeting

Based on our experience so far, if we were to describe ourselves as an animal it would be a squirrel because small but determined in achieving goal.
Clinical Assessment Unit
What was our idea?

- To improve completion of fluid balances
- Educate staff on the importance of fluid balance charts
- Introduce Fluid Balance badges for bed boards
- Introduce different coloured lids for water jugs

Clinical Assessment Unit

What was our plan?

- Carry out an audit to establish compliance
- Devise a display to educate staff
- Add on to safety huddle patients on fluid balance
- Encourage use of white lids for patients on fluid balance
- Patient handover to highlight patients on fluid balance charts
Did it work?

- Audit to be carried out to establish any improvements
- The Fluid balance symbol fell off board
- The white lids are not being used as there is already a colour coded system in place.
- The handovers are not always completed with the information required

Where do we go from here?

- Pre assessment audit completed – improvement required in fluid balance accuracy and calculation
- Encourage staff to input staff to fill handovers correctly
- Team discussion identified that handover was the area we would focus on.
- Post education and guidance audit still required

Based on our experience so far, if we were to describe ourselves as an animal it would be a bee because bees keep the eco system thriving and without them life would begin to fail. Patients require Nutrition & Hydration to improve their health & wellbeing.
Rapid Response Team

#NCAreduceharm
What was our idea?

Rapid Response Team

- To ensure that at least 90% of RRT patients identified at risk of malnutrition on initial MUST screen are receiving nutritional education and written information.

What was our plan?

- Source appropriate and trust approved educational resources in regards to BAPANs Food First initiative.
- Deliver training sessions for RRT on the food first initiative.
- Staff to complete MUST on initial visit as per usual process, patients that are identified as at risk to be given appropriate education and resources during initial visit or be visited by RRT staff and provided with education and resources.
Did it work?

- The patients asked found the food first information useful.
- MUST screening was carried out for 80% of patients audited, which was an improvement, dietary advice provided 100% of the time for identified at risk patients.
- It was difficult to embed in to the team due to this practice being outside of the usual role of some of the MDT.
- Staff felt happier referring straight to dietician without giving dietary advise first.
- Some staff needed multiple training sessions until they felt confident discussing nutritional advice with patients.

Where do we go from here?

- RRT to test reviewing MUST score and appropriate action taken during each daily safety huddle to try to embed the processes within the team.
- Send out the results of the test of change to the team and remind staff of the importance of completing MUST score and providing education.
- Complete follow up audit.

Based on our experience so far, if we were to describe ourselves as an animal it would be a tortoise because we have been slow to make progress and want to hide away from change.
Outpatients Team
What was our idea?

- To make nutritional advice more accessible within the out-patient setting
- To work with specialist teams in OPD
- Develop a test of change around nutrition and hydration

Outpatients Team

What was our plan?

- Devise a questionnaire for OPD patients to complete to describe their nutrition status and collect data
- Devise a questionnaire to establish if there was a need in OPD for nutritional literature
- Discuss with dietetics to see if its feasible to devise a basic information leaflet for patients who attend OPD
Did it work?

- The test of change questionnaire which was devised showed a need for information around this subject

Where do we go from here?

- Discuss with dietetics to see if it's feasible to devise a basic information leaflet for patients who attend OPD

Based on our experience so far, if we were to describe ourselves as an animal it would be:
Because:
Wolstenholme IMCU
What was our idea?

- Opportunity arose following the Nutrition and hydration Collaborative group
- Wolstenholme staff identified that the aim was to improve patient hydration in the yellow zone of the Wolstenholme unit
- A strapline of #butfirstadrink was adopted - this had been used on previous National campaigns when we did an ideas Internet search
- Yellow area was furthest away from the Unit kitchen and would therefore save time for staff to prepare drinks for patients and increase the opportunities that drinks were offered to patients (other than water jug fresh water changes three times a day)
- The QI Team have supported the project throughout - this helped unit staff to remain focussed and motivated and also enabled us to link with other staff in the Trust to share resources

What was our plan?

Prepare for Launch day
Get all staff on the Unit involved - this was key to the project success
Gather the resources
Engage all staff on the unit by sharing the project vision and aim

We considered some resources which would enhance the patient experience with the #butfirstadrink project:
- Purchased yellow travel mugs for patients
- Bottled water requested and received from the catering department
- Different flavour cordials purchased from supermarket as the NHS supply range is very limited
- Weekly Mocktail events #healthytuesday which has grown with more frequent events and has led on to the offer and provision of fruit kebabs and fruit shakes more regularly during the week
- Fridge purchase for drinks to be cooled

We did a search for patient friendly fluid charts to ensure the patient was at the centre of the project change and was actively involved in their own hydration intake
A number of charts were identified and shared with the patients for their feedback of which they preferred
- Internet search for patient friendly fluid charts to ensure the patient was at the centre of the project change and actively participated in their own hydration intake
- 3 fluid charts were identified and shared with the patients for their feedback of which they preferred

Further into the project QI shared a contact who was completing a similar which has a Pre and Post assessment questionnaire – this also had a fluid chart attached

A urine colour chart was also trialled with the different concentration of urine colours for patients to consider - visible representation with sample containers were produced
- Unfortunately over time these sample pots had to be disposed due to poor shelf life of the apple juice!
Did it work?

• Internet search for patient friendly fluid charts to ensure the patient was at the centre of the project change and actively participated in their own hydration intake
• 3 fluid charts were identified and shared with the patients for their feedback of which they preferred
• Further into the project QI shared a contact who was completing a similar which has a Pre and Post assessment questionnaire – this also had a fluid chart attached
• A urine colour chart was also trialled with the different concentration of urine colours for patients to consider - visible representation with sample containers were produced
  ➢ Unfortunately over time these sample pots had to be disposed due to poor shelf life of the apple juice!

Where do we go from here?

What's going well:
• The whole team have been very engaged with the #butfirstadrink approach – it’s important to keep up the momentum and keep staff motivated to be involved
• Patient feedback has been excellent – really enjoy the events and the drinking awareness and healthy focus
• HCA staff have really enjoyed supporting patients with completing the questionnaires
• Ongoing review of the different resources and approaches have enabled staff to revise and implement new methods to get the best outcomes and achieve the aim of the project

The Big ask was to be able to purchase cordials such as Vimto which we now have done and is being given out at meal times as well as on the #butfirstadrink hydration station

Based on our experience so far, if we were to describe ourselves as an animal it would be: because:
Paediatric Specialist Feeding Team
**Paediatric Specialist Feeding Team**

- To increase the number of referrals from UCC to the Health Visiting Specialist Feeding Pathway

**Aim:**
- To reduce re-presentation at urgent care for reflux/colic/CMPA related issues
- To ensure an appropriate evidence based pathway is followed
- To increase staffs education pertaining to feeding issues
- To improve patient experience
- To support children's `4/5/6/- service model-reducing A&E attendances

**What was our idea?**

**What was our plan?**

- To provide urgent care staff with a presentation of the specialist feeding teams treatment pathways
- To collate numbers of referrals following distribution of the presentation
- To liaise with urgent care staff to assess understanding of the process and processes to increase referrals
Did it work?

• To date there have not been an increase in referrals

Where do we go from here?

• Awaiting a meeting with UCC staff to determine if there may be a different way of engaging UCC staff to make referrals to the service

Based on our experience so far, if we were to describe ourselves as an animal it would be: 
Because:
Emergency Assessment Unit – Salford Care Organisation
What was our idea?

Improve nutritional screening at the ‘front door’

SRFT Emergency assessment Unit (EAU)

Dietetics on EAU

- Baseline data to get an idea of current practice
- Educate new and existing staff on current nutritional screening and discharge info (MUST tool, policy, risk assessment, weights and BMI)
- Collaborations & teamwork

What was our plan?

<table>
<thead>
<tr>
<th>July/August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
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</thead>
<tbody>
<tr>
<td>Retrospective base data collection and Project planning</td>
<td>Analysis of baseline data</td>
<td>Implementation of pathway / training and active data collection</td>
<td>Active data collection without training or input from dietetics</td>
<td>Write up</td>
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PDSA 1

Adjusting training sessions/resources to meet the knowledge gaps

PDSA 2

Educate on existing material in a pathway format

COPE huddle attendance

Attending Nursing huddle

PDSA 3

Monitoring change of practice - Implement long-term action plan
1) Education
✓ trained new nurses F2F (10) 100% positive feedback
▪ Add hoc training on EAU – rather difficult as everyone is busy
✓ We encouraged ownership of nursing staff to provide patients with the correct discharge info
▪ After week one changed this to Band 2 DA to take this on

2) Dietetic COPE huddle attendance
✓ Working well, MDT communication will never replace a screening tool!

3) Social media awareness
✓ Good way to get staff’s attention and share info

Outcomes:
▪ Too early to check change of screening trends

Cat
Calming, intelligent, playful, independent, friendly but also feisty and determined when we have to be 😊
Oldham Care Organisation

Pressure Ulcers: Learning Session 2
Team presentation

ICU
**What was our idea?**

**Team/Ward:** Intensive Care Unit

- To Produce a Resource Booklet that new Nurses can access and support their Learning in pressure Ulcer Prevention.
- Access that is readily available whether in Covid or non Covid areas.
- An educational tool that will support their Critical Care training programme
- Support mandatory training and aid specific PU Training within our unit
- The booklet will support within it appropriate use of pressure relieving aids within critical care, to reduce the risk of developing pressure ulcers.

**What was our plan?**

- To devise a tissue viability resource booklet that covers PU prevention specific for an intensive care patient
- Information to be gathered by Trust intranet, NICE guidelines, EUPAP, experience and our TVN team
- Booklet to be approved by TVN specialist Nurse, ADNS and Lead nurse.
- Booklet to be available in print in PBE office along side CCP workbooks, on the desktop at the nurses station
- Future plans to upload to educational whatsapp group being set up with PBE’s
Did it work?

• Rolled out on the desk top week commencing 20th September.
• Feedback from PBE’s all positive and advising the new staff to obtain a copy to achieve their competences
• Too early to tell if working as only been available one week.

Where do we go from here?

Future to upload the resource booklet on to the educational WhatsApp group, currently being devised by the ward manager and PBE Team.
At 3 months to obtain feedback sheets from staff
Team presentation
• The Ward manager to arrange a focus group with the Lead Nurse and the ward based tissue viability link nurses in August 2021
• The focus group to develop a visual que to be displayed at the patient’s Bedside of what pressure prevention equipment should be used for individual patients
• The ward manager to develop an audit and the Lead nurse to audit the use of pressure prevention aids in use prior to test of change.
• Commence the test of Change October 2021 for a period of one month
• Ward Manager/Lead Nurse/Practice based educator to conduct weekly audits.
• Ward manager to arrange further focus group and questionnaire in November 2021 to gain feedback.

Team/Ward: Ward F9, ROH

• What was our idea?
  • To introduce a visual que at patient bedside to identify what pressure prevention equipment should be utilised to reduce the risk of the patient developing Damage.

• What was our plan?
  •......hourly turns
Did it work?

- Staffing levels became a huge barrier to implementation of test of change.
- Focus group was arranged for 26th August, however staffing levels and staff sickness lead to only ward manager attending.
- Practice based educator and ward Manager discussed vision of test of change and practice based educator designed the visual aid and the audit tool.
- Delay in audit due to reduce staffing levels and reduced leadership
- Test of change implemented 11/10/21

Where do we go from here?

- Continue test of change until 07/11/21
- Ward manager to arrange focus group W/c 08/11/2021

Based on our experience so far, if we were to describe ourselves as an animal it would be: 
Because: Ward F9 have been a slow starter!
Team presentation
What was our idea?

- Band 6 daily pressure ulcer checklist
- Once daily senior nurse co-ordinating to check for patients with pre-existing damage/vulnerabilities.
- Nursing staff to highlight concerns with skin integrity to senior nursing staff on a daily basis.
- All patients at risk/with vulnerabilities or with existing damage to have skin inspection daily by nurse in charge.

Team/Ward: T7

What was our plan?

- Checks to be integrated as part of band 6 daily checks for nurse in charge.
- Aim to increase awareness of vulnerabilities, preventative measures and actions required when skin damage is present.
- Aimed to provide staff with the opportunity to highlight concerns and receive support with completion of required actions for pressure damage.
Did it work?

• Non compliance from staff of all bands resulted in inconsistency of completion and escalation.
• Ongoing work relating to staff attitudes, behaviours and standards- completion and escalation entirely dependant on staff on shift.
• Daily prompts at huddles used to encourage staff and remind of purpose.
• Pressure ulcer free month in July used as motivational technique, good effect for short periods.
• Inability to complete not escalated to band 7 and above team for support.

Where do we go from here?

• Use of daily checklists to continue on T7, additional work surrounding bedside handovers implemented.
• Opportunity to question skin integrity/vulnerabilities with colleagues at bedside handovers.
• Additional support checklist has been implemented for band 6 to complete. 2 hourly zone checks/staff checks to take place. Opportunity for band 6’s at periodical times throughout the day to re-visit the pressure ulcer checks with staff in each area of the ward.

Based on our experience so far, if we were to describe ourselves as an animal it would be: Because:
Team presentation

AMU

#NCAreduceharm
What was our idea?

- To improve Skin assessment on admission by using a medical illustration application to photograph skin damage and wounds on admission.
- This in turn could improve the documentation of wound care by improving access to photography capabilities via use of a mobile application instead of out of hours camera.

Team/Ward: AMU & tissue viability team

What was our plan?

- Tissue Viability team selected the acute medical unit to trail the Healthy IO application.
- Staff will document wound care using the ‘SPOT’ application for wound care. This will be accessible during a 7 month free trial from the application company. The staff will complete an assessment using the app prior to referral of patients to the TVN.
- Acute medical unit – this ward has been supplied with 5 iPads with access to the SPOT application.
- Training Organised for staff by the Healthy IO team
• Still in the 1st 3 weeks of using the application, training for staff is still ongoing with the healthy IO team. Staff starting to use it in daily practice however still requiring more training and staff engagement.

We predict:

• Use of the application will improve the quality of referrals, particularly with regard to photographic documentation.
• The improved documentation and access to photography.
• Use of the app will ensure all pressure ulcers (irrespective of category) are recorded on admission to the Trust and can be shared with community teams. This will enable the TVN to validate the pressure ulcers appropriately and escalate harms accordingly.
• Use of the app will greatly improve wound documentation/tissue type and measurements.
• Use of the app will ensure a ‘starting point’ of the patients skin is recorded on admission to the Trust.
• Use of the app will enable the TVN to document wound healing rates. It will show improvements or deterioration.

• Data will be collected for a period of 3 months prior to implementation of the application and during the 7 month trial period. This is currently ongoing.
Team presentation

East Cluster

#NCAreduceharm
What was our idea?

- Apples to Ulcers
- Unify Categorisation of PU
- Using a Visual tool “Apples to Ulcers”
- For easier relation of physiology of PU categorisation

Team/Ward: East cluster DN/TV team

What was our plan?

- To send out related supporting material to the team
- To set up x2 ToC workshops with theory/practical elements
- To evaluate sessions with individual staff members
Did it work?

- Reading materials sent out were not reviewed prior to sessions.
- Sessions were successful with more of a focus around feedback in particular to theory aspect. Staff report positive feedback.
- Highlighted areas of opportunity for further educational sessions to expand on original session with certain focuses.

Where do we go from here?

- To adapt the session further to cover areas highlighted by participants.
- To incorporate the Apples to Ulcers tool in other aspects of training to reinforce the sessions and so it becomes familiar to the teams.
- To create an evaluation sheet for completion at the end of each session.
- To continue to respond and adapt the sessions based on highlighted areas/outcomes expressed by participants.

Based on our experience so far, if we were to describe ourselves as an animal it would be: Because:
Team presentation

Central Cluster

#NCAreduceharm
What was our idea?

- Establishing harm free care meetings-pilot site
- Weekly photographs of pressure ulcers
- Weekly harm free care meeting to ensure coordinated patient focus approach
- To enable ease of verification

What was our plan?

- To monitor photographs of pressure ulcers weekly at harm free care meetings
- To track SDTI and unstageable wounds for 6 weeks using the weekly photographs
- To monitor the photos to enable timely senior reviews if deterioration noted
- To ensure Holistic assessments are carried out and appropriate equipment in place to prevent deterioration
Did it work?

• Yes!!
• Enabled senior reviews and care plans to be changed much quicker
• Data....
• Case holders feel better knowing the pressure ulcers are improving
• It helps with Datix investigations

Where do we go from here?

• HRFT approached to start attending and a dedicated HRFT colleague assigned to each cluster team to closely manage patient under shared care
• Continue to review and evaluate the harm free care
• Continue taking the weekly photographs
• Band 5 staff nurses to attend

Based on our experience so far, if we were to describe ourselves as an animal it would be:
Because:
Team presentation

Butler Green

#NCAreduceharm
What was our idea?

➢ To reduce the incidence of pressure damage to our patients
➢ To use a device (SEM Scanner) to try and detect a problem beneath the skin's surface days earlier than the naked eye can detect.
➢ Clinicians to review and implement any intervention required

Team/Ward: Butler Green EIMC

What was our plan?

➢ To obtain SEM scanner and arrange training for staff within the unit
➢ Identify Patients who are within the criteria to scan (Waterlow between 11-20)
➢ Scan Mon-Fri for 8 weeks
➢ Evaluate clinical intervention as a result of the scanner readings
➢ Obtain new pressure damage data from last 2 years as a baseline for comparison
➢ Actual scanning of patients
Did it work?

➢ Ongoing with scanning and data collection
➢ Ongoing evaluation identified that
  • Need to increase scanning criteria to Waterlow above 10
  • Noted inconsistency in scanning partly down to staffing problems which made it difficult to embed process
  • No baseline information for new patients identified to scan.
To now establish with new patients what clinical intervention they already have including nutrition and continence

Where do we go from here?

➢ Continue with scanning and data collection
➢ Make changes identified
➢ Develop standardised pathways
➢ Embed process in line with existing roundings

Based on our experience so far, if we were to describe ourselves as an animal it would be: Bottlenose Dolphins
Because: They are adaptable optimists who tend to see the glass being half full.
Team presentation

5 DN Cluster Teams

#NCAreduceharm
Team/Ward: 5 DN Cluster Teams

- To build on existing HFC meetings that were introduced on the 1/4/21 following a previous test of change which saw a 40% reduction in PU incidents in one DN cluster team
- To standardise and minimise variation as 'spread' of original change was not achieving same results seen in original pilot area

- Devise SOP for process including TOR and agree responsibilities of meeting attendees
- Introduce a Mini RCA Tool to be completed for all new caseload acquired pressure ulcers
- Outcome of mini incident review to be presented at Divisional HFC PU panel
- Identify Trends and themes for learning re LIC identified for audit and training purposes
Did it work?

- On reflection this it should be considered a large scale change rather than a test of change.
- Therefore its likely that benefits such as:
  - Reduction in the incidence of PU
  - Reduction in number of CI &Si investigations will take some months to realise
- Time allocated to undertake HFC meetings is not enough
- Time to complete mini PU RCA is to long-currently 1.5-2hrs, using August PU data this equates to 40 hours additional time
- Audit of % PU validated from baseline of 20%

Where do we go from here?

- Need designated admin support of HFC meetings to update spreadsheet and record new actions.
- Review how we document on the new EPR need to utilise SSKIN and Pressure Ulcer Management sections so that information easily located
- Need Admin support for HFC PU panels – tracking of who needs mini PU RCA completing, which teams need to attend to present and logging themes on Datix
- Need to spend more time on completing actions for improvement, current focus is on the process of investigation

Based on our experience so far, if we were to describe ourselves as an animal it would be: Tortoise
Because: feel that steady determined progress will enable us to get to the finish line and win the race eventually