National Learning Event – 11th June 2013

A New Mindset for NHS Wales
Aneurin Bevan Health Board
The vision statement for Aneurin Bevan Health Board is:

- Working with you for a healthier community
- Caring for you when you need us
- Aiming for excellence in all we do

**ABHB Aims – Reducing Mortality and Harm**

- **Aim**: To have a RAMI in line with top performing UK organisations and eliminate seasonal and weekly variation in RAMI by June 2013

- **Aim**: To establish the Global Trigger Tool as a measure of patient harm and reduce adverse events per 1000 patient days to 10 by June 2013
Mortality & Harm Group overview of:
- RAMI, Mortality Rate, Raw Mortality
- 30 day condition specific mortality (MI, CHF #NOF, Stroke, Septicaemia, Pneumonia)
- Drill down to specific areas of work eg. Pneumonia, Sepsis
- Learning from Mortality Reviews

Developments
- More in depth view of community mortality data
- Publication of site specific RAMI
- Met with CHKS to explore other mortality indices for assurance eg. Crude mortality with limited adjustment for age, bed days, spell
Mortality Reviews

- Providing assurance, driving improvement – Learning from mortality and harm reviews in NHS Wales – Lead Author – Dr Grant Robinson MD ABHB

- Mortality Reviews at RGH and NHH
  - Weekly mortality reviews both sites
  - >1750 reviewed at NHH
  - Condition specific reviews at RGH (sepsis)

- Process being set up at YYF

- Senior consultant staff including Anaesthetics, Paediatrics, Surgery, Medicine, Primary Care GP

- Quality and Patient Safety Committee – overview/themes as part of QI report at every meeting, within section on reducing RAMI.

- Board – flagged as a process to reduce RAMI within Performance Report every 2 months.
Mortality Reviews - Learning

- Themed reviews at RGH reported within QPSC and at Deteriorating Patients Group
- NHH mortality review – specific issues raised with individuals for learning, and themes with illustrative examples were e-mailed to senior staff and all Consultants
- Sepsis has a major but often unrecognised contribution to deaths in hospitals, and it is not well understood
- Themes from reviews:
  - Inappropriate escalation of care to DGH at end of life
  - Failure to recognise or respond to the deteriorating patient
  - Failure in care process – PVC, HAT
  - Delays in Care
  - Unclear medical management plans for acute patients not admitted via ED or EAU
Adverse Events per 1000 Patient Days

GTT currently carried out in RGH and NHH. Harm study carried out at both sites.

Full participation with All Wales Harm Study at both sites.
ABHB HARM DRIVER DIAGRAM

Outcomes

- Improved Team Working
- Enhanced Recovery after Surgery
- Reduce Patient Falls in Hospital and Intermediate Care
- Reduce Pressure Damage
- Improve Medicines Management
- Reduce HCAI
- Identifying Depression in Long Term Conditions
- 1st Episode Psychosis
- Improve Care for People with Dementia

Primary Drivers

Secondary Drivers

Action

- Safety Briefings
- SBAR
- WHO Checklist
- Risk Assessment
- TCAB
- Reduce Inappropriate use of Antipsychotics
- Medicine Reconciliation
- Missed Doses
- Positive Patient ID
- Anticoagulants
- Insulin
- Peripheral Lines Bundle Insertion and Maintenance Bundle
- CAUTI Initiation and Maintenance Bundles
- Case Identification
- Appropriate Intervention
- Early Diagnosis and Identification
- Information to Carers and Patients
- Improved Care on General and EMI Wards

Reduce Harm (adverse events per 1000 patient days) to 10 by June 2013

- Falls Bundle
- Hourly Rounds
- Daily Goals
- Real Time Document
- Quiet Time
- Skin Bundle
- Hourly Rounds

3 - Monthly Review for Patients with Dementia
Taking the Driver Diagram Forward

• The 1000 Lives Steering Group
  – representation from all Divisions and Localities
  – aims to embed the priorities for reducing mortality and harm

• Receives presentations from each of the mini-collaborative areas
  – embeds the spread of interventions in the Divisions and Localities
  – measurement system for all the interventions, ABHB-wide.

• New priorities/drivers to reduce mortality/harm
  – identified through triangulating data from concerns, mortality review and CHKS data
  – interventions developed for further change

Priorities for Reducing Mortality and Harm

• MEWS to NEWS
• MEWS in the Community and Mental Health
• RRAILS and SEPSIS
• Fractured Neck of Femur
• Transforming care for Older People
• Falls in Hospital
Aneurin Bevan Continuous Improvement (ABCi)

- Commenced November 2012
- Five Arms
  - Leadership
  - Training Methodologies
  - Modelling Unit
  - Project Support
  - Knowledge Management
- Partnership collaborative with Department of Mathematics in Cardiff University
- Presented at Cumberland Collaborative May 2013
- Currently have 25 live ongoing projects across Aneurin Bevan Health Board and growing
- Developed a workshop in February 2013 – Safe Emergency Care
- Leading to programme of shadowing patients through health journey
ABCi – find out what we are doing...

- Follow us on Twitter! - Account @ABCiab
- Internet pages to go live June 2013
- Facebook page to go live June 2013
- Annual celebration event
- Intranet pages already live – check out the ABCi bulletin board
Every Day Counts
For Megan

Who is Megan?
The face of our campaign in Aneurin Bevan Health Board

A fictitious patient who uses our services
The person who challenges what we do

Quote!
I have been a nurse for nearly 50 years and teaching nurses and carers for nearly 40 years. In 2004 I was diagnosed with breast cancer and was treated for it with surgery, chemotherapy and radiotherapy. Unfortunately in 2011 my husband died from lung cancer so I also spent some time caring for him. I therefore went from a nurse to a patient to a carer and learnt a lot on this journey. Because of all this I now chair the very active Patient Liaison group at Velindre Cancer Centre and use some of my knowledge hopefully to help others.
Every Day Counts
For Megan
Why the campaign is a priority for us.

- Patient centred care, “get in and get out safely”
- People who don’t need to be admitted to hospital receive their care in community settings
- People who need to go into hospital receive safe, effective care as quickly as possible
- People who are ready to leave hospital are supported to return home safely, and without delay
- Whole systems approach to patient care
Every Day Counts
For Megan
Programme Overview

- Monthly Challenge & Support review CEO, Executive Lead, Programme Mgr, Corporate.
- Oversight Board - 6 week review with Chief Exec, Divisional Mgrs, General Mgt, Clinical leads, Senior nurse’s.
- Ward level operational meetings every 2 weeks.
- Ward corporate support & PDSA reviews weekly/fortnightly.
Every Day Counts For Megan
Transforming Care for Older People

• Started the (TCOP) programme in September 2012
• 6 Pilot wards on three hospital sites in ABHB
• 2 Year roll-out of designed learning sets (3 x 30)
• 272,000 days to go at on 30 wards
• 15 Community & 15 Acute wards to be targeted
• 300+ staff will be involved with this programme
• Supported from

IHI & 1000 Lives + Improvement methodology
• Development of driver diagram at ward level (½ day)
• Supported by PDSA cycles developed by the teams
• Using collaborative reviews “whole systems approach”, Mapping the patient journey end to end
• Corporate resource on the ward every week x 2
• Patient surveys and shadowing key to success
• “KO AWATEA Good practice” learn from New Zealand

ABCi
Patient and Family Centred Care - Overview

- Programme working with the Kings Fund funded by Health Foundation
- Improvements are based on the patient’s experience of care rather than our view of their experience
- Patient shadowing is the core method for understanding the patient’s experience of care
- Used IHI Model for Improvement to implement changes

- Working on fractured neck of femur and diabetic foot care experiences
- A Guiding Council, chaired by the Director of Nursing, oversees the work
- A Working Group for each care experience is taking forward the improvements in each care experience
Outcomes

Primary Drivers

Excellent Care Experience for Patients with a Diabetic Foot problem

Secondary Drivers

Changes / Interventions

Timeliness of Treatment and Care

Diabetic Foot Team Review within 24hrs of admission

Right Information at the Right Time

Admission to Diabetic Ward

Patient Involvement in Care

Information checklist to A&E team

Co-ordination of Care and Discharge

Diabetic Nurse Assessment of Ability to Administer insulin and monitor Glucose levels

Happy Staff

Good communication within/between teams

Staff engagement and feedback

Driver Diagram for Diabetic Foot Care
Patient and Family Centred Care – Next Steps

- Working Groups have:
  - undertaken patient shadowing to understand current patient care experience through the patient’s eyes and collected patient stories
  - Developed the ideal patient care experience
  - ensured that membership covers the whole patient care experience
  - Developed driver diagram to identify from differences between current and ideal care experience, the primary drivers they will work on, and the actual changes they will make
  - Determined the measures that will demonstrate the improvements being made
  - Beginning to collect the data

- Launch Event held in early November in ABHB
- Faculty Days held within ABHB on Staff resilience and snorkelling, with one more day on Experience Based Co-design in June
- Participated in Learning Events at the Kings Fund on Staff Experience and Speaking up for our Patients
- Using shadowing in other areas to understand patient experience through the patient’s eyes

#NOF PFCCTeam
Creating exceptional patient experience in hip fracture care

We will provide the best care and an exceptional patient and family experience for patients admitted with a hip fracture.

Tell me what’s wrong and understand my fears

Sort out my pain and tell me what’s going to happen

I want to feel safe and look after my needs

Get me to the right place quickly

This is me

1. Engagement with WAST
2. Prehospital patient information
3. Prehospital alert
4. Evidence based prehospital care

1. Rapid triage and A+E pathway integrated into Clinical Bundle and admission protocol
2. Rapid access ilio-fascial block and pain monitoring
3. Preadmission patient information

1. Engagement of staff in A+E : Better communication, customer service and staff conduct
2. Communication with family members
3. Early access to food & drink
4. Personal wish plan

1. Rapid admission protocol with ring fenced bed on dedicated ward
2. Orientation consultation on admission
3. Encourage early involvement of family and personalisation of environment

1. Personal care plan
2. Patient information consultation
3. Appointment of patient advocate
National Clinical Audit and Outcome Review Plan – ABHB progress

• Clinical Effectiveness Group chaired by Medical Director responsible for ensuring:
  – Overview of NCA&OR Plan at ABHB
  – Clinical Lead for each audit
  – Register of National Audits
  – Feedback re: each audit to CEG
    • Priority audits full presentation
    • Other audits via feedback template
    • Timetable of feedback devised
  – Learning and Action as a result of audit
• Annual Report drafted to go to Q&PS Committee in October
• Positive visit from NCA&OR Advisory Group
Patient Stories – Progress

- Task and finish Group established with multidisciplinary membership from across ABHB
- Consent forms developed and agreed including a consent form to collect staff stories
- How to guide developed
- Database established
- 35 stories currently loaded to database

- Staff and equipment resources mapped across ABHB
- Divisional leads for patient stories established
Patient Stories

• Development of a database which includes clear classifications to allow effective search for and use of the stories

• Framework for feedback to story teller agreed.

• Workshop to support story takers being arranged in the next two months to maintain enthusiasm and focus
RRAILS

Team Members

- Linda Alexander – Clinical Lead
- Jan Barrett – 1000 lives coordinator
- Outreach team RGH
- Outreach team NHH
- Lilibeth Delarama – ANP YAB
- Coral Cole – ANP YYF
RRAILS Progress

- NEWS has been implemented across all acute sites ABHB
- Deteriorating Patients Group overview
- Organisational review of NEWS (Documentation, communication, response and escalation, relationship with T,C, priority within organisation, night cover in response sick patient)
- One observation chart across all acute sites.
- NEWS part patient planning boards
- Pilot work being done looking at more detailed outcome data relating to patients admitted to ITU with SEPSIS: timeliness of referrals to outreach, sepsis six bundle compliance on wards and patient outcome.
- Sepsis audit being part mortality review by medical director
- Continual assessment cardiac arrest data
- A RRAILS education programme has been put together and is currently being utilised by all nursing staff in YYF supported by senior nurse and hospital manager, and USC NHH supported by senior nurse and divisional nurse, and certain areas within RGH. Feedback has been very encouraging.
- The next stage is to get this programme implemented across the rest of the organisation
SBAR

- SBAR is the tool of choice to standardise and improve communication across ABHB. It is commonly used when referring a sick patient to the relevant teams, some areas are using it when receiving patients to their areas, hospital at night are using it, and we are encouraging wards to develop it as a ward handover aid. It is a big part of the RRAILS work and is incorporated into the RRAILS education package for staff.

Safety briefing.

- Bundle compliance to demonstrate quality improvement
- Ward Acuity
- Bed occupancy
- Admissions
- A non ICU measure of severe sepsis
- AOF monitoring tool returns
COMMUNITY HOSPITALS
• YAB community hospital pilot for NEWS
• Staff training took place in July 2012, and the pilot commenced August 2012.
• All wards in YAB have implemented NEWS

MENTAL HEALTH (NEWS)
• NEWS training for Older Adult Mental Health In-Patient services was rolled out in August 2012 in YYF. It remains a part of a much broader module that deals with the monitoring of physical illness in the older adult with mental health problems

Community Resource Team Newport
• Piloting NEWS within a community setting to assess its effectiveness in supporting the admission, assessment and decision making process for patients who are accepted and treated through the Newport Community Resource Team.
**RRAILS Barriers**

- To look at concerns raised by the outreach teams re pressures which have affected the commitment they can make to auditing and teaching.
- To look at concerns raised by ward staff re amount training they need for all collaborative but the pressures do not allow them the time to attend.
- Understand impact of change in ANP hours at RGH on response to patients triggering.
- Engagement of medical staff needs to improve to ensure we implement this work effectively.
- Look at how data is collected via nursing metrics.
- A&E – Review data collection methods eg. safety briefing or Symphony.

**RRAILS Next Steps**

- Support wards in implementation phase to increase spread sepsis bundle.
- Look at implementing sepsis bags in each area. (Initial meeting taken place with pharmacists and microbiologist.)
- Continue to audit progress and sustainability and feed back to relevant committees (Q&PT Safety, 1000 lives steering group, deteriorating patient group, PNF scheduled and unscheduled care)
- Establish an RRAILS collaborative within ABHB
- Work to work with A&E departments
- The scale of the challenge remains in ensuring the improvements of acute illness continues.
- The support from senior management has to continue.
Transforming Care

Team Members
• ABHB Project Lead
  • Rhiannon Jones (ADN)

• Transforming Care Facilitators
  • Ann Price
  • Carol Hadfield
  • Karen Smith
  • Elaine Ward
  • David Timmins
  • Sue Pearce
  • Mary Hopkins
  • Rachel Lee

Driver Diagram
• Continue spread of Transforming Care across ABHB using primary drivers:
  – Staff Well Being – To use a range of tools that demonstrate staff engagement, experience and team spirit
  – Efficiency – Evidence an increase in the time RN spend with patient in direct care to improve quality of service
  – Safety – Use of Safety Crosses to demonstrate improvements in safe and reliable care
  – Patient Centeredness (Experience of Care) – to evidence patient experience and achieve target of 95%
Transforming Care: Maintaining Transformation

Status
- All wards are Transforming
- Focus now on maintenance, sustainability & reliability
- Continuing support from Public Health Wales
- Facilitator roles maintained
- Senior Nurses engaged
- Currently undertaking review of all wards

Barriers
- Leadership development
- Developing teams
- Senior Nurse
- Engagement education

Progress & achievements
- A ‘Model of Leadership’ development implemented
- Team engagement through leadership model
- Current review of all wards engaging
- Senior Nurses in review education and
- Maintenance of Transforming Care
Transforming Care - Data

- **Staff experience:**
  - Staff experience sourced through Snorkelling, Deep Diving and HSE Questionnaire. Teams engaged through feedback and engagement of changes made.
  - Increased compliance with PADR
  - Leadership & Management Model used to create leadership structures and engage in safety culture
  - Team leaders created and leading on Transforming Care work streams

- **Patient experience:**
  - Monthly patient experience feedback collated, (qualitative & Quantitative). Dementia training, Kings fund project

- **Efficiency**
  - Improvements through, Well organised ward works teams & Progress with process modules
  - Standardised system for ‘Patient status at a Glance’
  - Clear links to other improvement work streams such as ‘Megan,’ – 1000 Bed days

- **Safety & reliability:**
  - Skin bundle implemented, Safety Boards in place, Developing safety cultures across all wards & departments
  - All bundles being rolled out using improvement methodology

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**Next Steps**

- Continue to Transform and develop efficient & effective systems
- Spread of Transforming Care across departments
- Create depth of evidence to demonstrate improvements
- Ensure alignment with all quality Improvement work streams
## Improving the Reliability of TIA Services

### Progress

- Compliance monitoring continues.
- Telephone referral system commenced August 2012 and improvements in complying to high risk patient review noted.
- At RGH, hot slot appointments created to increase clinic availability.
- At NHH – developing system to expedite appointments for high risk patients.

### Content and Interventions

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<thead>
<tr>
<th>Content</th>
<th>Drivers</th>
<th>Interventions</th>
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<tbody>
<tr>
<td>First Point of Contact-symptom recognition and referral</td>
<td>Use ABCD2 to stratify risk</td>
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<td></td>
<td>Give aspirin immediately, if appropriate</td>
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<td></td>
<td>Refer immediately onto appropriate pathway, electronically or by telephone and fax</td>
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<td></td>
<td>Give patient information in appropriate format</td>
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<tr>
<td><strong>Prevent stroke through timely management of TIA</strong></td>
<td>Specialist assessment and commence investigations within one day of first contact</td>
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<td></td>
<td>Carotid investigation within two days of first contact</td>
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<td>Carotid Intervention, if appropriate within 7 days of first contact</td>
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<td></td>
<td>Individualised secondary prevention strategy agreed with patient at specialist assessment by someone with appropriate training and supported with written information</td>
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<td></td>
<td>Communicate treatment plan back to GP within one day of specialist assessment</td>
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<tr>
<td><strong>Timely management of high risk TIA (ABCD2 Score =/&gt; 4)</strong></td>
<td>Specialist assessment and commence investigations within 7 days of first contact</td>
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<td></td>
<td>Carotid investigation within 7 days of first contact</td>
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<td></td>
<td>Carotid Intervention, if appropriate within 7 days of positive carotid investigation</td>
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<td>Individualised secondary prevention strategy agreed with patient at specialist assessment by someone with appropriate training and supported with written information</td>
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<td></td>
<td>Communicate treatment plan back to GP within one day of specialist assessment</td>
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<tr>
<td><strong>Timely management of Low Risk TIA (ABCD2 Score =/&lt; 3)</strong></td>
<td>Ongoing secondary prevention and risk management following TIA within one month</td>
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<tr>
<td></td>
<td>Review medical management of risk factors</td>
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<tr>
<td></td>
<td>Advice on lifestyle risk factors from someone with appropriate training</td>
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<td></td>
<td>Written personalised secondary prevention plan and information provided</td>
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Acute Stroke Bundles implemented at Royal Gwent and Nevill Hall

First 3 hours
First 24 hours
First 3 days
First 7 days

Royal Gwent

First 3 hours
First 24 hours
First 3 days
First 7 days

Nevill Hall

First 3 hours
First 24 hours
First 3 days
First 7 days
Stroke Rehabilitation Bundles
YAB, YYF, St Woolos, Chepstow, County hospitals

Compliance rate for bundle 1 from Nov 2011 to Apr 2013

% patients

YAB

Compliance rate for bundle 2 from Mar 2011 to Nov 2012

% patients

YYF

Compliance rate for bundle 4 from Jul 2011 to Feb 2013

% patients

St Woolos

Compliance rate for bundle 1 from May 2011 to Mar 2013

% patients

Months

County

Compliance rate for bundle 1 from Jul 2012 to Jan 2013

% patients

Chepstow
Acute Stroke, Rehab and TIA

**Barriers**

- Lack of clarity of some rehab bundle measures has highlighted risk of inconsistent reporting between units. Overcome by setting up working group which agreed guidelines
- Acute: Site capacity issues impacting on transfer of patients to ASU.
- TIA: Delayed referrals from GP into TIA service. Inconsistent accuracy of dataset analysis not reflecting service provided.

**Next Steps**

- TIA: Consistent Seven day service
- Acute: Direct admission to ASU.
- Life After stroke – new programme area launched
- ABHB Stroke Delivery Plan being finalised, with revised membership of Stroke Board and associated Work Stream groups
Driver 1: Tier 2 to improve specialist advice & support to primary care, including pre-referral advice & shared care arrangements

Bundle: consultancy, liaison, supervision, training, signposting, information.

Improvements:
- Variety of information on ABHB Intranet
- Designated contacts established and advice available
- Training work group set up and training strategy developed – 4 levels of training, Msc Mod
- DVD “Introduction to Eating Disorders” in development
- Patient and carer information group established – development of a wide range of material for professionals, patient’s and carers.
- Designated contacts established within new Primary Mental Health Care teams
- Training being provided to new PMHCT.
- Data collection tool developed to record advice provided.
Driver 2: improved assessment care co-ordination & interventions for Tier 2

**Improvements:**
- Wide range of material available for service users, carers and professionals on Intranet
- Guidelines and prompt sheets for assessment and care planning developed
- Audit tool to measure compliance of standards set within driver measured 100% compliance with assessment bundle and 70% compliance with treatment bundle at Tier 2 for all referrals in 2012
- EPEX system input codes developed to capture monthly data (to be converted into run charts)
- Fortnightly SCEDS meetings and monthly supervision available from Tier 2 lead
- Designated contacts per tier 2 team
- Transition arrangements for CAMHS established
- Patient held record developed and currently being piloted
- ED Training strategy formulated jointly with CAMHS and out for consultation
- Patient and carer information group established
- DBT, psycho-education and SEED groups established
- Tier 2 care pathway
- Fortnightly SCEDS meetings
- Patient and carer representatives on all sub groups e.g. training, information.
- Working with Nicola Gray to develop WARRN risk assessment and management training module
Driver 3: improved provision of tier 3 specialist eating disorders service

- **Improvements**
- Tier 3 team fully established; Clinical lead, Specialist Clinician, OT, Dietitian, Tier 2 lead, administrator
- Tier 3 clinicians received additional training; DBT, CBT-e, IPT, MET
- Number of groups developed; DBT, SEED, Nutrition, psycho-education
- Transition arrangements with CAMHS
- Interface with Tier 4 service
- Regular SCEDS meetings with Tier 2
- Patient and carer involvement

Driver 4: improved acute medical in-patient care for patients with anorexia

- **Challenges**
- Medical refeeding bed identified in NHH.
- Training provided to ward staff
- Tier 3 team to visit any inpatients daily.
- Links established with dietitians
- Small number of admissions unable to compile run charts.
- Implementation and monitoring team in place and will continue to work on improving the provision against the re-feeding bundle.
- High cost Low volume specialist provision
- Option appraisal for Tier 4 SEDS in Wales is currently out to consultation.
Depression

Depression target goal

“To improve detection, assessment and treatment of depression in hospital population”

High levels of co-morbidity in long term conditions, targeted conditions are:

• diabetes
• coronary conditions
• neurological conditions
• respiratory conditions
• Cancer

Pilots completed in Weight Management and Cancer Services

Patients screened for signs of depression
Depression – Pilot services

Head and neck cancer pilot

- Patients screened using cancer specific ‘Distress Thermometer’. The multidisciplinary team decided to screen all patients at the pre-treatment clinic.
- In May 2011 no mood screening routinely took place in the Head and Neck cancer clinic.
- In May 2012 56 patients were screened.

Hearty Lives Torfaen Weight Management Service

- All patients attending the weight management group screened pre and post group. The numbers screened are 10 patients per month.
- 210 patients have been screened in 2011-2012. Of these patients 30% screened positive for possible depression and 70% were already being prescribed antidepressant medication. (These groups overlap.)

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[Graphs showing patient screening numbers for 2011 and 2012]
Depression

Difficulties

• Staff confidence - fear of uncovering need they can’t meet
• Environmental – no privacy
• Identifying appropriate place in care pathway - e.g. In acute setting mood screening complicated by understandable distress/acute exacerbation/fatigue
• Insufficient specialist resources (liaison/clinical psychology time) to deliver screening as separate activity

Success

• Where mood/psychosocial needs screening occurs as part of holistic assessment approach
• Target embedded in teams’ core activity and owned by service rather than seen as something someone else does
• Clear onward referral routes
• Where right person asking at right time (someone who knows patient)

Learning from ABHB pilots has contributed to 1000lives+ review of depression target.
Driver: part one of the mental health measure
Enhanced Recovery After Surgery

- Well established in Colorectal
- Orthopaedic hip and knee replacements
- Some principles integrated into #NOF pathway
- Urology introduced ERAS for cystectomy/radical prostatectomy
- One consultant testing ERAS in gynaecology

Structure
- Project Board in place
- Clinical Hubs in each area
- Measurement Support from ABCi Project Support Team

Next Steps
- ABCi to support ERAS one day event
- Establish efficient data collection
- Clinical nurse specialists to support ERAS process and ongoing education
ERAS - orthopaedics

- Reduction in LOS for TKR/THR
- Data from CHKS for ALOS
ERAS - Urology

- Two consultants have implemented ERAS in Urology for Cystectomy and Radical Prostatectomy
- ALOS below for all cystectomies (sources CHKS)

![ALOS Urology Consultants 1 & 2 combined - Cystectomy (includes Cystoprostatectomy, Cystourethrectomy, Cystectomy)](image-url)
Improving Mouth Care for Adult Patients in Hospital (MAH) – “OPEN WIDE!”

ABHB Team:
• Executive Nurse Director
• Assistant Director of Nursing PSQ & Patient Experience
• Clinical Director Dental Services
• Divisional Nurse & PSQ representation
• Senior Nurses
• Ward Managers & Mouth Care Champions
• Dental Hygienists
• Our Patients!
Improving Mouth Care for Adult Patients in Hospital (MAH) – “OPEN WIDE!”

Progress & Achievements:
• Currently being piloted across 3 Divisions and in 5 inpatient areas of ABHB
• Mouth care assessment being performed within 24hrs of admission
• Implementation of appropriate mouth care plan and mouth care monitoring form.
• Use of safety briefing to handover specific information and the total number of patients on A,B&C plans.
• ABCi support identified to assist with data collation aspects of implementation
• Improved standard of documentation and recording of care regarding this element of patient care provision
• Dental support now available for inpatients
• Staff training
Barriers

- Independent v Dependant patients
- Level of documentation and auditing requirements
- Limited support to facilitate measurement
- Spread

Next Steps

- Consolidation of measurement & auditing practice
- Spread to early adopter sites
- Increase teaching sessions
- Formal auditing of the prescribing of oral care products and associated medicines
- Rollout of e learning tool for MAH
Transforming Maternity Services

Mini Collaborative Team Members
Anju Kumar
Deb Jackson
Anurag Pinto
Caroline Davis
Claire Roche
Debbie Pimbley
Gwyneth Ratcliffe
Helen Erasmus
Louise Taylor
Matt Turner
Mike Byrne
Sajitha Parveen
Rachel Fletcher
Suzanne Hardacre
Tim Watkins
Liz Smith
Jayne Beasley

What are we trying to achieve?

OVERALL AIM:
To improve experience and outcomes for mothers, babies and their families within Maternity Services

Progress Made
Implementation & Spread of Sepsis Six Plus Two across the Service – Proforma updated and ratified. Sepsis boxes in all areas
Spread Care Bundles (Admission, Recognition and response) to all areas throughout the Division - RGH - Triage, DAU, Ward B4 & Main Delivery Unit - NHH - DAU, Ward 1/2 & Main Delivery Suite
Data collection Identified leads in all areas, data collection audit sheets in use. Data Gathering Processes to Improve Process & Outcome Measures in all Areas. Data input into spreadsheet and reports generated for display on wards
Data Collection different in some areas Triage, RGH - All Admissions Data - Ward B4 Snapshot Data
Whiteboards - In all areas, sharing evidence & information

Achievements To Date
MEOW’s Charts in use across maternity services.
Admissions, Recognition & Response Bundles - Working well on B4 and AAU at RGH - Working well in NHH DAU Senior Midwifery Manager to meet with B5 Manager and Birth Centre Manager plan roll out - Senior Midwifery Managers to meet to discuss roll out of all care bundles to 2/1 in NHH.
Sepsis Six Plus Two Bundle - Sepsis Six tool adapted for maternity - In use on B4 and AAU plan roll out to Labour ward in RGH.
Quality & Patient Safety Improvement & Measurement department involvement - Local meeting set up to validate data - A3 Structured Progress Report followed by CG day presentation.

Reduce mortality and harm by improving the recognition and response to the acutely deteriorating woman.
Reduce mortality and harm from venous thromboembolism in pregnancy and the postnatal period.
**Implementation Plan/Next Steps**
- Spread Bundles utilising experiences from pilot areas
- More work needed to capture VTE Outcome Data
- Severe Sepsis Mortality Rate - Needs to be established
- Stillbirth Audit planned to establish Management and Rate

**Strengths**
- The group are enthusiastic and committed to the collaborative
- Both Midwifery and Obstetric staff have embraced the care bundles
- The venous thromboembolism risk assessment document has been successfully implemented, audit performed in Feb 2013
- The sepsis care bundle has been successfully implemented in all high risk areas
- The admissions, recognition and response care bundles have been successfully implemented and well received by staff working within the pilot areas
- Maternity services have attended all webex sessions relating to the mini collaborative

**Evidence of Progress**

<table>
<thead>
<tr>
<th>% compliance with admission Bundle by month</th>
<th>Numbers of multidisciplinary reviews by month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage</td>
<td>Triage</td>
</tr>
<tr>
<td>% Compliance</td>
<td>Number</td>
</tr>
<tr>
<td>Jul 12</td>
<td>% compliance with admission bundle</td>
</tr>
<tr>
<td>Aug 12</td>
<td>% compliance with admission bundle</td>
</tr>
<tr>
<td>Sep 12</td>
<td>% compliance with admission bundle</td>
</tr>
<tr>
<td>Oct 12</td>
<td>% compliance with admission bundle</td>
</tr>
<tr>
<td>Nov 12</td>
<td>% compliance with admission bundle</td>
</tr>
<tr>
<td>Dec 12</td>
<td>% compliance with admission bundle</td>
</tr>
<tr>
<td>Jan 13</td>
<td>% compliance with admission bundle</td>
</tr>
<tr>
<td>Feb 13</td>
<td>% compliance with admission bundle</td>
</tr>
</tbody>
</table>

**Barriers**
- Resources/Staffing Issues
- Education
- Engagement
- Change Environment

**Staff Comments**
Outcome indicators

- Monitoring of admissions to Obstetric HDU

Next steps

- Sepsis bundle in use at YYF birth centre
  - Work ongoing to investigate initiation of sepsis 6 plus 2 in birth centre setting – currently agreement for initiation of oxygen, catheterisation and venous canulation to be established whilst awaiting ambulance transfer
  - Establishing a set of birth centre indicators to display progress and monitoring for staff and women – currently agreement to collect numbers of transfers to obstetric unit and ambulance delays
- Refine data collection from maternity wards
- Refine outcome indicators and collection methods

Welsh Initiative for Stillbirth Reduction (WISR).

- Task and finish group established
- Post mortem and consent training in place for all medical staff
- Planned update sessions for midwives regarding the customised growth chart
- Review of department reduced fetal movement’s guideline underway.
- Consultant obstetrician to undertake the guideline for previous stillbirth. An audit of the standards set by the RCOG for the management and follow up following still birth is about to commence
- Still birth pathway in use

Monitoring of post natal readmissions for sepsis

Monitoring of incidence of thrombosis

Incidence of maternal death
Reducing Healthcare Associated Infections; C.A.U.T.I Drivers

**Aim**
To reduce catheter associated infections by achieving 95% compliance with Insertion and maintenance bundles based

**Primary Drivers**
- Inappropriate catheterisation and catheter selection
- Delay in removal of urethral catheters.
- Infection Risk from prolonged use of catheter.
- Risk factors associated with clinical practice of catheter care.
- Integration of primary and secondary care urethral catheter management

**Secondary Drivers**
- Insertion Bundle
- Maintenance Bundle
- CSU Bundle

**Interventions**
- Reason for insertion
- Catheter choice
- Insertion technique
- Follow up requirements
- Catheter supports
- Use of PPE
- Clean receptacle
- Continued Need
- Circuit continuously connected
- Catheter hygiene
- Drainage balance
- CSU collected
- Technique
- Result
- Treatment.
- Reference documents on all aspects of catheter management

Maintenance Bundle (phase 1)
- Clarified variations in baseline practice
- Allowed review of practice & associated documentation.
- Established ideas & ownership of ward based staff
- Created realistic & workable core processes that remained adaptable to service needs
- Incorporates catheter assessment within patients daily review.

Insertion Bundle (phase 2)
- Recently introduced process
- A blue sticker aids quick & easy uniformity of practice.
- Insertion details & standards achieved placed in medical notes
- Acts as procedure guide
- Visible reminder for nursing & medical staff
- Aids removal assessment & planning.

- Process measures
- Compliance for each bundle
- Individual ward basis

% Total Compliance with full bundle by month
nhward 4/1

% Total Compliance with full bundle by month
nhward 4-2

% Total Compliance with full bundle by week
Critical Care

% compliance

0% 20% 40% 60% 80% 100% 120% 140%

% Total Compliance with full bundle

- **Outcome measure**: Reduction of short term Catheter days
- **Benefits**: live data tool aids progress sharing.
- **Barriers**: Combining outcomes for divisional feedback.
  - Inability to annotate graphs to demonstrate
  - When new wards engage & alter trends.
Peripheral Venous Cannulation (PVC)

To achieve 95% compliance with the PVC maintenance bundle

<table>
<thead>
<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the PVC bundle elements</td>
</tr>
<tr>
<td>Integrate patient into care</td>
</tr>
<tr>
<td>Develop an infrastructure that promotes a team safety culture &amp; quality care</td>
</tr>
<tr>
<td>Check the PVC in situ is still required. Remove or replace after 72-96 hrs</td>
</tr>
<tr>
<td>Check dressing if remaining in situ</td>
</tr>
<tr>
<td>Clean hubs prior to access</td>
</tr>
<tr>
<td>Remove PVC if signs of inflammation, phlebitis or infiltration</td>
</tr>
<tr>
<td>Ensure patient/carer fully understands the PVC maintenance care bundle</td>
</tr>
<tr>
<td>Involve patient/carer in goal planning</td>
</tr>
<tr>
<td>Robust induction programme for staff. Build staff knowledge &amp; competency in quality improvement work</td>
</tr>
<tr>
<td>Implement daily safety briefings</td>
</tr>
<tr>
<td>Replace administration set after 72 hrs</td>
</tr>
<tr>
<td>Perform hand hygiene before and after PVC procedure</td>
</tr>
<tr>
<td>Ensure patient/carer fully involved</td>
</tr>
<tr>
<td>Report VIP score over 2 &amp; take blood culture</td>
</tr>
<tr>
<td>Feedback compliance to ward</td>
</tr>
</tbody>
</table>
Peripheral Venous Cannulation (PVC)
Reducing Peripheral Venous Catheter Associated Infections linked to Healthcare Settings

Achieve consistent 95% compliance with the insertion & ongoing care bundle for peripheral venous catheters

14.05.13

Implementation of bundle and full data collection

NHH: Insertion
CCU, 1/2, ITU, 4/1, 2/3, main theatre, x-ray

Rapid response Blaenau Gwent

Delivery/Maternity awaiting start date
A&E, 4/2, 4/4

Intended spread

RGH: Insertion
OSU theatre, HDU/ITU, CAU, CCU/D3W, MDCU, MAX

C5W, D1W/MAU, Main Theatre
C7W, outreach theatres, C6E, C6W, D4E, D2E
YFF - Theatres

Maternity Services awaiting start date
Re launch Paediatric wards May
D4W starting June
X-ray started May

NHH: Ongoing
CCU, ITU, 1/2, 4/1, 2/3

Rapid response Blaenau Gwent

Delivery/Maternity awaiting start date
Ward 4/2, 4/4

RGH: Ongoing
Ward D7E, OSU, B6N, D3W, CCU, ITU, HDU
C7E, MAX FAX,

C5W, D1W/MAU, C7E
C7W, C6E, C6W, D4E, D2E
YFF - ward 2/3

Maternity Services awaiting start date
D4W starting June
Re launch Paediatric wards May
Peripheral Venous Cannulation (PVC)

Example of Process data

- Barriers
  - Time
  - Sustainability

- Next Steps
  - Continue to spread
  - Re launch STOP campaign
  - Review device infections via All Wales prevalence
  - Continue to show case the good work done by all
Peripheral Venous Cannulation (PVC)
Reducing Harm from Falls in the Community

Gwent Falls Strategy

Based on extrapolation from epidemiological studies and data from Public Health Sources, Gwent can expect to have 33,400 residents (35% of the total 95,440 residents over the age of 65) at risk of falls, who would benefit from local fall services.

Population statistics by local authority areas (LAA) – 4060 (Blaina Gwent), 5240 (Monmouth), 5380 (Torfaen), 8400 (Newport), 10300 (Caerphilly)

The Falls Strategy includes people living in the Community, care homes, hospital and other settings.

AMBULANCE DATA FOR ABHB FALLERS 2012
Reducing Harm from Falls in the Community

Gwent Falls (Frailty) – Care Model

 Builds on the existing falls services in Gwent with some redesign to try and standardise approach and realign with frailty.

 Services to be integrated into a co-ordinated, cohesive and comprehensive falls service - encompassing population level health promotion and, for selected groups of individuals, screening, assessment and treatment.

 The service to be delivered through a four tier integrated rehabilitative care pathway model moving individuals along the care tiers wherever possible.

SINGLE POINT OF ACCESS (SPA) – CRT PATHWAY

Referrals from health and Social care professionals (A&E, Hospital, Ambulance, GP etc) to Single Point of access (SPA)

Community Resource Team

Urgent response

Elective response

Primary Medical need

Rapid response

CRT Falls / Reablement (Tier 2/3)

Tier 3 Medical assessment

Comprehensive Falls assessment and intervention

Review / Evaluation / Discharge / Follow up / Monitor
Reducing Harm from Falls in the Community

**GENERAL FALLS ASSESSMENT MODEL**

**TIER 1**
- Community (CRT) / Clinic based Specialist Falls Service including medical assessment / Specialist Falls Balance and Gait programme
- If - Complex needs identified
  - Significant gait & balance problem
  - Unexplained falls or falls related to dizziness / blackouts
  - Second opinion requested by patient / carer / GP

**TIER 2**
- CRT contact, consent, assess with FROP CoM Tool (Assessment tool). Develop action plan. CRT Falls MDT to agree interventions / referrals. Inform GP of outcomes.
- Faller referred to CRT via SPA

**TIER 3**
- Consultant led Specialist Balance Clinic
- Complex balance / dizziness problem
- Discharge patient or step to Tier 3 MONITOR

**TIER 4**
- Frailty
- Discharge patient or step to Tier 3 MONITOR

**TRIGGER**
- Community
- WAST
- A&E

**CONSULTANT LED SPECIALIST BALANCE CLINIC**
- Complex balance / dizziness problem

**CRT – Community Resource Team**
**SPA – Single Point of Access**
**FROP CoM – Falls Risk for Older People (Community)**
**MFFRAT – Multifactorial Falls Risk Assessment Tool**
Reducing Harm from Falls in the Community

Current position and the future

Agreed elements to the falls model -
- The Model itself
- Falls prevention and information
- Community non current faller pathway
- Community current faller pathway
- Care home non current faller pathway
- Care home current faller pathway
- Care home post falls pathway
- Accident and Emergency pathway
- WAST pathway

- Tier 1 Falls risk stratification screen – FROPCoM Screen
- Tier 2 Falls risk stratification tool – FROPCoM Tool
- Action plan

Achievements

- Model agreed
- Pathways completed
- Guidance for care homes being circulated – CSSIW engaged and waiting for sign off
- Care home resource pack done
- Pathways being shared with LMC
- Work awaiting to be signed off by Frailty OCG
- WAST – MOU being finalised for non urgent fallers – pilot to commence in March 13
- Frailty CRT’s at different level of implementation
- In patient steering group being restructured