Improving patient care by transforming the reliability of processes and communication in theatres, wards and community settings

This pack includes tools for students and educators to improve care in NHS Wales.

Further resources can be found online at: www.1000livesplus.wales.nhs.uk/students-tpc
WHAT THEY’RE SAYING ABOUT TRANSFORMING PATIENT CARE....

“During my time as a theatre sister and more lately as an educationalist I have taught many students about transforming patient care. However, I have in turn learned a great deal more from them. If given a facilitative environment they will ask ‘innocent’ questions which result in us inquiring into the evidence base for our practice.”

Allyson Lipp, Nursing Lecturer, University of South Wales

“The whole process has pulled people out of a rut and has encouraged them...It seems to be infectious with staff trying to outdo each other on the ideas front!!!”

Julie Willoughby Ward Sister, East 2, Cardiff & Vale University Health Board

“We encourage our students from day one to become part of the team at the team briefing stage and that the environment is conducive to facilitating everyone’s feelings and thoughts. At the forefront of all our minds is ensuring the patient has the safest and highest standard of care within our environment.”

Cheryl Davies, Chair All Wales Theatre Manager Forum

“As a nursing student, the ‘Students Transforming Patient Care’ campaign has been an excellent learning opportunity to allow me to engage with the team members on my placement and has given me more confidence and the skills to share my ideas that will really help make a difference to the quality of care my patients receive.”

Helen Price, nursing student, University of South Wales

“With the broad experiences encountered through their academic studies and clinical placements, students are best placed to share the innovations and improvements they have seen working in practice. Students can, and should, provide a valuable contribution to the improvements being driven within teams, engendering a continuous cycle of learning and improvement to Transform Care.”

Barbara Davies, Senior Nurse and Transforming Care Programme Manager Cardiff and Vale University Health Board

STUDENT COMPETITION
To be in with the chance of attending the International Forum on Quality and Safety in Healthcare in Paris, all you need to do is explore one or more of the tools in Section 2 and complete the template in Section 3.

Send your entry to 1000livesplus@wales.nhs.uk by Friday 17 January 2014 and you could be on your way to the most talked about international quality improvement conference in the world!

www.1000livesplus.wales.nhs.uk.students-tpc
WHAT’S IN THIS PACK?

1. Transforming patient care

2. Small changes to transform patient care
   - Safety and Reliability
   - Better communication and teamwork
   - Well Organised Environments

3. How to get involved!

4. Leads in placement organisations

5. How to champion better care

6. Resources

Many of the key learning points and items of note within this pack are highlighted with an exclamation mark.

Opportunities for student and educator discussions are highlighted with a question mark.

*If you are reading a printed version of this pack all weblinks and resources are available at: www.1000livesplus.wales.nhs.uk/students-tpc

CASE STUDIES

The case studies included within this pack have been led and designed by colleagues across NHS Wales. These changes are benefitting our patients, improving staff morale, increasing safe and reliable care and reducing waste.

www.1000livesplus.wales.nhs.uk.students-tpc
1. TRANSFORMING PATIENT CARE

Transforming Patient Care aims to engage all health profession students and educators in improving the experience and outcomes of care for patients.

The campaign includes useful questions to allow everyone to better understand their environment and identify small improvements to the systems or processes around them.

It focuses on enabling students and educators to identify small, but significant changes for the benefit of their patients, resulting in faster recovery. These changes will benefit patients and staff leading to better communication and teamwork; well organised work environments; and, improved safety and reliability.

Transforming Patient Care has led to key changes to how ward, community and theatre settings are managed, resulting in:

- Better quality of care and improved patient and staff experience.
- Improved efficiency creating a more comfortable environment.
- Improved communication between staff and patients.
- Increased staff morale leading to patients feeling more confidence about the care they are receiving.

The campaign aims to help students and educators to sustain improvements through:

- Better communication and teamwork
  - Briefings and de-briefings
  - Patient Status at a Glance (PSAG)
- Well Organised Environments
  - 5S
  - Activity mapping
- Safety and Reliability
  - Safety checklists
  - Care bundles

If you’re a medical, nursing or ODP student on theatre placement, you can use the Students Transforming Theatres pack to improve the reliability of processes and communication in theatres.

Visit www.1000livesplus.wales.nhs.uk/students-tpc for regular updates and new resources!
You can find out more about the improvements taking place here. You can read examples of students already transforming patient care below:

- Milford Haven Breastfeeding Group
- Nursing students improving the quality of fluid balance recording practice
- Improving the quality of stroke patient care - a multi-disciplinary approach
- Use of colour and improved signage to help dementia patients locate toilets
- Let’s Get Mentally Active!
- Quality in patient-centred care planning: nursing interventions to alleviate constipation

**Abertawe Bro Morgannwg University Health Board**

Staff on East Ward, a 26 bedded elderly care ward in Gorseinon Hospital, have focused on ensuring clinical areas and storage facilities are organised efficiently.

Heddfan Ward at Cefn Coed Hospital, which cares for dementia patients, has saved eight hours a week by creating a wheelchair storage bay so staff don’t waste time searching for wheelchairs to transport patients.

They have also improved their ward environment by colour coding doors to bedrooms and bathrooms. The different colour doors provide a visual prompt, benefitting patients by helping to maintain their personal dignity and independence for as long as possible.

Ward D at Neath Port Talbot Hospital is an acute medical and cardiology ward. Some of the patients are at high risk of falls, and need support getting in and out of bed. Staff now put a picture of a maple leaf above the patient’s bed to easily identify those patients who need assistance when moving.

**Aneurin Bevan Health Board**

Transforming Theatres has led to the universal adoption of pre-list safety briefings. Staff say that team working has greatly improved and they feel able to contribute to improvements and feel more valued as a result.

The improvements in the theatre environments in all sites are a visible achievement. Corridors are clear, emergency kit is in dedicated positions, anaesthetic rooms have been standardised, clutter has been removed and store rooms have been rationalised.

You can read more in the report here.

[www.1000livesplus.wales.nhs.uk.students-tpc](http://www.1000livesplus.wales.nhs.uk.students-tpc)
2. SMALL CHANGES TO TRANSFORM PATIENT CARE

Students are ideally placed as fresh eyes on the healthcare system and their knowledge and enthusiasm is a vital resource to the NHS. Educators can use the materials as part of the campaign to supplement existing educational content.

1000 Lives Plus has created this pack to equip students with skills to identify improvements, and to help those who are responsible for teaching them to find practical ways to support them in this. It explores three key areas:

- Safety and Reliability
- Better communication and teamwork
- Well Organised Environments

By taking part in this campaign, you can:

- Develop skills to identify small changes to improve the systems around you.
- Work with students from different health professions.
- Apply your knowledge and enthusiasm to make a difference to your patients.
- Gain transferable skills that your patients and future employers will look for.
- Share your experience with a national and international audience.

Read the Quality Improvement Guide for Educators and Students to help you with the activities in the three areas.

To make the next step in your improvement journey, complete the Improving Quality Together Bronze e-learning module. Improving Quality Together is the national framework for improvement skills in NHS Wales, and the modules introduce the Model for Improvement and a person-centred approach to care. The framework is recognised by educators and future employers – and you will receive a certificate of completion. Visit www.igt.wales.nhs.uk for more information.

You can also access the IHI Open School courses focusing on: quality improvement, patient safety, patient- and family-centered care, managing health care operations, leadership, and population health.

To be in with the chance of attending the International Forum on Quality and Safety in Healthcare in Paris, complete the template in Section 3. Send your entry to 1000livesplus@wales.nhs.uk by Friday 17 January 2014.

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SAFETY AND RELIABILITY

Transforming Patient Care focuses on human factors to address how staff can make their daily work environment and activities safer. Maintaining reliability in care and treatment delivery in an often chaotic environment under stressful conditions make it inevitable that error will occur.

Patient safety needs to be seen as the number one priority within healthcare organisations - the “first, do no harm” principle. A central tenet of healthcare improvement work is that harm and waste are not caused by bad people but instead by bad systems.

It is important to recognise however that safety is a key component in the much broader quality improvement agenda.

Safety checklists provide the opportunity for the whole team to share information about potential safety problems and concerns about specific patients. They enable the whole team to report on safety issues as part of their everyday work.

The World Health Organisation (WHO) Patient Safety Curriculum Guide for Medical Schools (2009) includes the following principles on human factors:

- Avoid reliance on memory
- Make things visible
- Review and simplify processes
- Standardise common processes and procedures
- Routinely use checklists
- Decrease the reliance of vigilance

A really simple change: National Early Warning Scores across Wales.

A pocket-sized card carried around by doctors, nurses and other ward staff in Wales, acts as a small yet simple reminder of the NEWS scoring system. The cards enable staff to ‘score’ their patients against known risk factors and call for a response depending on the total score.
It provides frontline clinical teams with a standardized approach to deteriorating patients, meaning life-threatening conditions like sepsis are spotted earlier and stopped more quickly.

You can download the NEWS app for iPhones.

A really simple change: Device Safety Briefing
Using the device safety briefing, clinical teams are able to review catheter necessity daily. These briefings focus the minds of every clinical caregiver on whether there is any need for catheter and ensures that adequate maintenance occurs reliably for every patient, every day, every shift.

This intervention forms part of the STOP Campaign which aims to reduce the unnecessary use of peripheral venous cannulas (PVCs) and urinary catheters in NHS Wales. You can get involved here.

The WHO states that checklists allow complex pathways of care to function with high reliability by giving users the opportunity to pause and take stock of their actions before proceeding to the next step.

The WHO “Safe Surgery Saves Lives” is an effort to improve global surgical safety, to reduce surgical mortality, and complication rates. To achieve this goal, WHO created an evidence-based Surgical Safety Checklist and this has been adapted and adopted across all Health Boards in Wales.

Each component builds on effective teamwork, keeping all surgical team members attuned to the needs of
the patient, and prepared for any expected complications. Work with your peers and your practice mentor to discuss how the checklist is used on your placement – this is a collaborative effort and should not be done on your own.

Consider how to improve the safety and reliability in your placement area. Refer to the 5 simple steps in Section 3: How to get involved!

**Better Communication and Teamwork**

Teamwork is essential in health care and communication within the team is indicative of the organisational culture.

Communication between members of the team is not always effective, sometimes because the message is delivered in an uncoordinated, unorganized manner, resulting in the message being received differently than intended – a bit like ‘Chinese Whispers’.

Hierarchy, “handoffs” and transitions, and different communication styles between professions all contribute to communication failures.

Observational studies have identified that using a structured team brief reduces the number of communication failures and promoted proactive and collaborative team communication and even though there is scepticism from some health professionals those who did participate felt that it had a positive impact.

**Briefing**

A briefing is a short team discussion that only takes around five minutes. A briefing improves communication, allows team members to share knowledge and manages the work environment.

Briefing the team prior to the commencement of a shift is vital to ensure that all the team are aware of any special requirements or potential issues that are anticipated. It also provides a way of ensuring all members of the team feel free to voice concerns and can raise issues. They also allow the whole team to anticipate potential problems or challenges.

A typical briefing includes:

- Introductions for who is present on the team.
- Define the objective.
- Identify major steps.

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• Check critical treatment and equipment.
• Ask ‘What if?’
• Check understanding by reading back.

Some of the ways in which team briefings can be developed are:

• Allocating five minutes before the start of the shift where the core members of the team can meet to discuss the requirements of patients and any safety concerns.
• Identify in advance a list of safety issues for discussion e.g. patient allergies, anticipated complications etc., potentially using a structured checklist.
• Using a de-briefing session at the end of the operating list to review any issues raised, answer concerns or discuss incidents.

Try to encourage the use of debriefs. These can be quick and very simple. Just get the team to tell each other:

✓ One thing that went well.
✓ One thing they could have done more of.
✓ One thing they could have done less of.

A really simple change: ID badge sized aide memoirs were produced and distributed to help staff remember the key points to address during a briefing and debriefing:

PATIENT STATUS AT A GLANCE (PSAG)
Clinical teams have used human factors’ principles to improve communication. The PSAG board promotes situational awareness for the entire clinical team. It uses visual management tools to enable staff to actively manage issues as they arise, making it easy for staff to access all the information they need. It allows everyone in the team to know what is going on.
A whiteboard can be used in a central area to capture ‘real time’ information which supports the day-to-day running of the work environment e.g. which staff are working that shift, list order changes, awaiting equipment. When an PSAG is used effectively, the outcome is a safe, well-controlled, effectively planned theatre environment.

**A really simple change:** On some wards, ‘Board Rounds’ are used to lead the discussion, before the ward round, to review the patient’s pathway towards discharge. This means that the multi-disciplinary team focus on exactly what remains to be done to get the patient home as soon as possible once they are well.

An agenda for the ‘Board Round’ is pinned next to the Patient Status Board (see right) and this forms the basis for the discussion.

Consider how communication and teamwork skills can be improved in your placement. Refer to Section 3: How to get involved!
WELL ORGANISED ENVIRONMENT

The Well Organised Environment enables a team to look at their area and decide collectively what they want to change and what they can do to improve their processes. Staff from all disciplines can take the time to really look at their environment and are empowered to make sustainable changes with lasting benefit to the whole team and patients in their care.

Staff can visually see the improvements and improve their working environment. Doing this work themselves means they have ownership and a vested interest in sustaining the improvement and understand why it has been done. If someone else does it for you, you’ll never find anything – it’s a bit like trying to find the teaspoons in somebody else’s kitchen! It means faster and more accurate access to equipment, which is easier for staff whether they are familiar or unfamiliar with the area. If someone sends you to find something you can be confident it’s not there, not that you just can’t find it. And most importantly, it releases more time to spend with patients.

A really simple change: A department was disposing of glass paracetamol bottles in the sharps bin. It costs more to dispose of contaminated waste than it does to dispose of ‘ordinary waste’. They agreed a new disposal process within their organisation and the bottles are recycled with all ordinary glass. This is more environmentally friendly and saved the organisation more than £4,000 per year in reduced disposal costs.

A Well Organised Environment creates a highly visual and organised working area and uses Lean Tools and techniques to create sustainable organisation. 5S is one of these tools, and is a method of standardising the work environment, so that you always have the right equipment and it’s ready to be used!

It helps removes unwanted materials, maintains correct stock levels, ensures equipment is serviced and charged ready for use, manages numerous documentation and keeps the working areas organised in a way everybody understands and is useful to the whole team.

Wards, theatres and community settings can also make savings in stock rationalisation and reduction without impacting on the efficiency of the department.
5S:

- **Sort/Sift** – sometimes items are kept in work areas or stores unnecessarily. Review all items: are they needed? What are they used for? How often and when are they used? Are they still valid? Clutter creates wasted time searching for items, ineffective use of space, and potential health and safety risks.
- **Set** – this is about setting the area so you can instil control, such as positioning items where they are needed, visual management and communicating when and why things have been repositioned. Clearly identify key items and their location.
- **Shine** – clean the work area and ensure the area is maintained to a high standard. In a NHS environment, 5 minutes spent tidying and sorting the immediate work area at the end of the day can save hours in a week searching for materials or equipment.
- **Standardise** – a standard must be agreed, communicated and displayed visually to ensure the area continues to be well organised and standardised.
- **Sustain** – the hardest part is to maintain and improve the area so that it always looks in control and in a good condition. 5S should be used as part of daily operations, standards should be continuously improved and the area audited to sustain the improved theatre environment.

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**A really simple change: Using 5S to improve the environment on a critical care ward**

A team wanted to increase the time they were spending at the bedside by reducing time spent in motion, collecting supplies and equipment or searching for things in the store room.

Using the 5S method they updated the bedside lockers, removing the supplies that were rarely or no longer used and replaced them with items that the nurses frequently went to collect. They reviewed the store room with any obsolete or expired stock being removed. Supplies were regrouped into a more logical order with less frequently used items placed on the higher shelves.

**Results:** a colour-coded visual management system was developed to make sure that anything can be found within 3 seconds.

The nursing team are delighted with the new look store room and now spend much less time getting what they need.

Look at the difference 5S has made to this work environment on the next page – *where would you rather work?*
**ACTIVITY MAPPING**

A spaghetti diagram can help understand how care is delivered on your placement by providing an overview of the process. It notes distances travelled in addition to pinpointing poor layout, bottlenecks and any other inefficiencies.

To build a spaghetti diagram, you can follow these steps:

- Draw the layout of your placement area.
- Observe the delivery of care, draw a line from point 1 to point 2, to point 3 etc.
- Keep a note of time it takes staff, distance travelled and any interruptions along the way e.g. finding equipment or supplies.
- Once the spaghetti diagram is drawn, look for waste in the process. This could be unnecessary time wasted in retrieving supplies, waiting around etc.
• Discuss with your educator or practice mentor ways in which this care could be delivered in a more efficient way e.g. hand hygiene – is the alcohol gel located in the best place? Does the layout mean staff have to travel unnecessary steps to use it?

A really simple change

A ward at Withybush Hospital used spaghetti diagrams to map the commode cleaning process.

Using this technique they made the process more efficient and reduced the likely-hood of steps being missed out.

Consider how your working environment can be improved. Refer to the 5 simple steps in Section 3: How to get involved!

To be in with the chance of attending the International Forum on Quality and Safety in Healthcare in Paris, complete the template in Section 3. Send your entry to 1000livesplus@wales.nhs.uk by Friday 17 January 2014.
3. HOW TO GET INVOLVED!

The small changes in this pack are examples of ways students can make a difference. They also provide information for educators to supplement the curriculum content.

Follow the simple steps outlined below and complete the template.

Read the Quality Improvement Guide for Educators and Students or complete the Improving Quality Together Bronze e-learning module to help you complete the template.

Share your experience with 1000livesPlus@wales.nhs.uk by Friday 17 January 2014 and you could win the chance to meet experts in healthcare and quality improvement and meet other like-minded students at the International Forum on Quality and Safety in Healthcare in Paris on 8-11 April 2014.

GETTING STARTED:

1. Take 5 minutes to look around you and observe your placement area.

2. Think about the tools in Section 2 of this pack and consider is there a small change that could transform patient care? Examples of this could be:
   - Do you spend ages looking for the right equipment?
   - Is it difficult to remember all information given in handover?
   - Are all the key points addressed during briefings and debriefings?
   - Are there too many things to remember in busy times?
   - Do you always know everything you need to know to do your job properly?
   - Are you equipped to do what you’ve come into work to do?

3. Discuss these with your Transforming Care lead and practice mentor - what is the problem you have identified? Think about the questions in the Model for Improvement:
   - What are we trying to accomplish?
   - How will we know that a change is an improvement?
   - What change can we make that will result in improvement?

4. Use the template starting on page 18 to share with your lecturer and 1000 Lives Plus how you intend to make a change to transform patient care. Email your completed
template to 1000livesplus@wales.nhs.uk. A word version of this template is available at www.1000livesplus.wales.nhs.uk.students-tpc

5. Receive your certificate of completion and be in with a chance to win our competition to attend the International Forum on Quality & Safety in Healthcare.

**STUDENT COMPETITION**

Share your experience with 1000livesPlus@wales.nhs.uk by Friday 17 January 2014 and you could win the chance to meet experts in healthcare and quality improvement and meet other like-minded students at the International Forum on Quality and Safety in Healthcare in Paris on 8-11 April 2014.

You can adapt the content of your completed template for submission to the following events:

- **1000 Lives Plus Master-class**, 18 November 2013
- **NHS Wales Awards 2014**: Student Category by 24th January 2014.

**Template Guidelines:**

- The abstract word limit is 600 words.
- Please use Harvard referencing.
- Please complete all parts however, please note that some of part 2 is optional and need only be completed if you have implemented a change.

**Participation Checklist:**

- Discuss and agree your participation with your university lecturer and mentor.
- Only submit information that identifies a patient if you have the patient’s written permission and any other necessary permissions.
- Share your feedback in undertaking the activity with your university lecturer and mentor and the 1000 Lives Plus Student and Educator Community.
- Only undertake an activity where you feel you are competent and helping to improve care.
Part 1: Setting the scene

Context: Describe the setting or context where this improvement work was identified? E.g. nurse in a critical care setting.

Problem: What drew your attention to the issue? How was it affecting your staff involved? How did you assess the causes of the problem? How did you know it was a problem e.g. was it because of an audit, patient complaint or something that staff mentioned they found difficult?

Engaging staff: explain how you went about sharing your plans for change to staff and other groups and getting them involved?

The patient perspective: explain how the problem was affecting your patients and their families using a person-centred approach. How did you find out?

Part 2: Applying the Model for Improvement

What do you aim to achieve? This is your vision, the goals that your team set themselves!
**Creating a list of measures:** Explain what measures you identified to enable you to achieve your aim.

**Intervention:** outline the changes you plan to implement to achieve improvement so others can reproduce it. Explain the hoped for outcome if you have not yet implemented your proposal.

**Optional: only to be completed if you’ve implemented a change:**

**Strategy for change:** how would you go about making the proposed changes if you could make them? Discuss how you might ask the team on your placement to help you implement a PDSA cycle.

**Measurement for improvement:** how did you measure the effects of your changes?
### Effects of your changes

*describe the impact of your changes on your patients and the staff involved? How far did these changes resolve the problem that triggered your work? Outline the problems you may have encountered with the process of changes or with the change itself.*

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### Part 3: Share your learning

#### Lessons learnt: what lessons have you learnt from this work? What would you do differently next time

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#### Message for others: describe the main message from this experience that you would like to convey to others?
4. LEADS IN PLACEMENT ORGANISATIONS

Every health board and trust in Wales is involved in Transforming Patient Care. All organisations are also actively participating in Improving Quality Together.

Each organisation has a nominated lead for each piece of work and these are the people who can help you make a difference!

By contacting your lead, you could be part of a team transforming care in Wales.

### Abertawe Bro Morgannwg University Health Board

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<tr>
<th>Lead</th>
<th>Role</th>
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<tbody>
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### Aneurin Bevan University Health Board

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### Betsi Cadwaladr University Health Board

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## Cardiff and Vale University Health Board

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## Hywel Dda Health Board

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<th>Lead</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynn Turner</td>
<td><a href="mailto:Lynn.turner@wales.nhs.uk">Lynn.turner@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Howard Cooper</td>
<td><a href="mailto:Howard.cooper@wales.nhs.uk">Howard.cooper@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Rosanne Lyles</td>
<td><a href="mailto:Rosanne.lyles@wales.nhs.uk">Rosanne.lyles@wales.nhs.uk</a></td>
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</table>

## Velindre NHS Trust

<table>
<thead>
<tr>
<th>Lead</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>David Williams</td>
<td><a href="mailto:David.williams20@wales.nhs.uk">David.williams20@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Sarah Patmore</td>
<td><a href="mailto:Sarah.patmore@wales.nhs.uk">Sarah.patmore@wales.nhs.uk</a></td>
</tr>
</tbody>
</table>
## 5. HOW TO CHAMPION BETTER PATIENT CARE

<table>
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<tr>
<th>Action</th>
<th>Complete</th>
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<tbody>
<tr>
<td>1. Take part in the 5 simple steps in Section 3: How to get involved!</td>
<td></td>
</tr>
<tr>
<td>2. Consider what small changes you can identify that could transform patient care. Submit your experience using the template starting on page 18 to <a href="mailto:1000livesplus@wales.nhs.uk">1000livesplus@wales.nhs.uk</a>.</td>
<td></td>
</tr>
<tr>
<td>3. Share your findings with your placement team and Improving Quality Together leads in your organisation to discuss if there is an opportunity for them to build on the identified changes.</td>
<td></td>
</tr>
<tr>
<td>4. Use social media such as <a href="#">Twitter</a> or <a href="#">Facebook</a>, and promote the Transforming Patient Care campaign. Remember to @1000livesplus or tag 1000 Lives Plus Student Network so we can see you raising awareness.</td>
<td></td>
</tr>
<tr>
<td>5. Discuss with your Chapter how you can use the resources to run a Transforming Patient Care campaign. Find out more about <a href="#">setting up your own Chapter</a>.</td>
<td></td>
</tr>
<tr>
<td>6. Use the Transforming Patient Care literature and resources in your university projects and essays.</td>
<td></td>
</tr>
<tr>
<td>7. Raise awareness of the Transforming Patient Care campaign at university – share your learning with your colleagues and educators.</td>
<td></td>
</tr>
<tr>
<td>8. Send your reflection to <a href="mailto:1000livesplus@wales.nhs.uk">1000livesplus@wales.nhs.uk</a> and we’ll publish your experience on our <a href="#">Community blog</a> and newsletter.</td>
<td></td>
</tr>
<tr>
<td>9. Showcase your work on a global platform by submitting the template starting on page 18 to the <a href="#">NHS Wales Awards</a> and the <a href="#">International Forum on Quality &amp; Safety in Healthcare</a>.</td>
<td></td>
</tr>
<tr>
<td>10. Take the next step on your improvement journey and complete the Improving Quality Together Bronze e-learning module – and gain your certificate of completion! Visit <a href="#">www.iqt.wales.nhs.uk</a> for more information. You can also access the <a href="#">IHI Open School courses</a>.</td>
<td></td>
</tr>
</tbody>
</table>
6. RESOURCES

Before you get started, why not access some of these useful resources below to give you a bigger picture of what transforming patient care really means. These can also be used in your academic assignments!


Check a Box. Save a Life: Student Improver’s Handbook


Elaine’s Story: Martin Bromiley is a pilot and also Chair of the Clinical Human Factors Group. Martin’s personal story informs much of his work, as his wife died after a ‘routine’ operation in 2005. In this video, Martin talks about the clinical procedures his wife experienced, and how failings in non-technical skills contributed to her death.


How to do the WHO Surgical Safety Checklist: Video by NPSA adapted for England and Wales.

How Not to Perform the WHO Safe Surgery Checklist: Video demonstration of a failed attempt to use the Checklist.


STUDENTS TRANSFORMING PATIENT CARE

Students Transforming Patient Care aims to engage all health profession students and educators in improving the experience and outcomes of care for patients. The campaign includes useful questions to allow everyone to better understand their environment and identify small improvements to the systems or processes around them. These will benefit patients and staff and lead to better communication and teamwork, well organised work environments, and improved safety and reliability.

Visit [www.1000livesplus.wales.nhs.uk/students-tpc](http://www.1000livesplus.wales.nhs.uk/students-tpc) for regular updates and new resources!

ABOUT 1000 LIVES PLUS

1000 Lives Plus is the national improvement programme, supporting organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales. You can follow 1000 Lives Plus on Twitter [@1000livesplus](https://twitter.com/1000livesplus)

Visit [www.1000livesplus.wales.nhs.uk](http://www.1000livesplus.wales.nhs.uk) to find out more.

ABOUT THE 1000 LIVES PLUS STUDENT & EDUCATOR COMMUNITY

The 1000 Lives Plus Student and Educator Community is an active network of students and academics enthused by quality improvement and patient safety. It aims to create a shared understanding and language to set about improvement, equipping the workforce of the future with quality improvement knowledge, skills and experiences. The Community provides access to national and local resources, news and events, national activities and support for students to lead improvement work locally.


IMPROVING QUALITY TOGETHER

Improving Quality Together offers students and educators the opportunity to develop a standard set of core improvement skills universal across all universities and professions.

It is for all staff - clinical and non clinical - and will enable everyone to introduce small changes that can make a big difference.

The Bronze level includes e-modules to introduce the Model for Improvement and a person-centred care approach to care.

Visit [www.igt.wales.nhs.uk](http://www.igt.wales.nhs.uk) to find out how you can take part and gain your certificate!