Students Transforming Theatres

Improving patient care by transforming the reliability of processes and communication in theatres

This pack has been created for students and educators giving them the tools to improve care in NHS Wales. Medical, nursing and ODP students will find this pack invaluable on theatre placements.

Further resources can be found online at: www.1000livesplus.wales.nhs.uk/students-tpc

Student and Educator Pack
“Transforming Theatres is a programme that aims to change the culture within departments. It gives all staff the tools to, firstly, better understand then take control of their own environment and make the improvements that are important to them and more importantly their patients.”

Mike Fealey, Transforming Theatres Programme Manager

“We discuss the Transforming Theatres programme with our perioperative overseas students and have presented details of the programme at conferences in Saudi Arabia. Based on the feedback we have received the programme is viewed as an excellent mechanism to empower staff to make improvements for their patients and also for the entire perioperative team. The international agenda for improving patient safety during surgery can be enhanced by the international implementation of the Transforming Theatres programme.”

Julie Young, Programme Manager for Perioperative Practice Programmes, Cardiff University

“We recognise that clinical settings within critical care can be very intimidating for any student body therefore as perioperative practitioners and mentors we strive to promote a positive learning environment. 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. Working closely with mentors will enable the students to actively engage with the perioperative environment learning practical/clinical/ and accessing the academic knowledge they require to enjoy their placement.”

Cheryl Davies, Chair All Wales Theatre Manager Forum

“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

“What Healthcare Students gaining experience in the Operating Theatres can make a difference by driving CHANGE forward:
C – Culture (The culture maybe different but the Patient experience is paramount)
H – Hierarchy (Hierarchy exists but is not identifiable by uniform)
A – Achieve (You can achieve goals)
N – Nurture (You will be nurtured)
G – Gain (What you gain is up to you)
E – Excellence (Hopefully is what you will achieve)”

Lynne Vickery, Theatre Team Leader, SSSU, Cardiff & Vale University Health Board

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WHAT’S IN THIS PACK?

1. How Transforming Theatres can improve patient care 4

2. Transforming Theatres in Wales – the journey so far! 6

3. Small changes to transform your theatres 8
   - Safety and Reliability
   - Better communication and teamwork
   - Well Organised Theatres

4. How you can get involved! 16

5. Transforming Theatres leads in placement organizations 21

6. Your Transforming Theatres checklist 23

7. Resources 24

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.
1. HOW TRANSFORMING THEATRES CAN IMPROVE PATIENT CARE

Operating theatres play a central role in the delivery of care in NHS Wales today. In them the most basic and complex surgical procedures take place, bringing together the clinical expertise and resources to provide the best outcome for patients. And with around three million surgical operations performed in the UK every year, it’s essential that theatres are running as efficiently as possible – benefitting patients, maintaining staff morale and reducing waste.

The work is integral to the 1000 Lives Plus national programme and the Welsh Government’s quality priorities in supporting organisations and professionals to deliver the highest quality and safest care for the people of Wales.

The focus on ‘Transforming Theatres’ is maximising the use of operating theatres and surgery sessions, while ensuring that the way they are run does not compromise safety. The initiative is led and designed by theatre staff themselves. Those involved in this area of care are analysing ways to improve team interaction and defining the factors that are important to create a ‘perfect operating day’.

Those factors include emphasising issues such as improved communication and planning, greater efficiency, and a better theatre environment.

The work encourages regular analysis of relevant data to inform improvement decisions. This has involved a range of measures including more surgical briefings for team members, improvements in pain control, and better management of theatre stocks and stores which has in turn led to cleaner, less cluttered theatres and theatre corridors.

Transforming Theatres is also building on work to make surgery safer and includes the use of the World Health Organization’s Safer Surgery Checklist.

The procedure checks the patient’s identity, the correct site for operation, ensuring all necessary equipment is available and providing an opportunity for discussing any complications that may arise. Potential risks such as haemorrhage, reaction to antibiotics and allergies are also highlighted.

Patients will see the benefit as surgery becomes even safer, with staff applying proven tools, techniques and methods to improve the process – ensuring that patient safety and the quality of care are at the forefront of all that they do.

The vision for ‘transformed theatres’ will provide a template that eventually every operating theatre can implement.

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The approach is helping staff have a clearer focus on a number of areas, which will include implementing the safer surgery checklist and identifying potential issues.

This improved efficiency will ensure patients have their operation on time and reduce inconvenience from cancellations.

It also looks at such issues as timing of operations, improving pre-operative assessments and best practice in recovery wards, so that people can return home sooner after surgery. The focus on human factors addresses how staff can use knowledge of human factors to make their own daily work environment and activities safer. The principles of human factors work to counter the natural human propensity to error. In other safety critical industries, human factors training focuses on teamwork, communication, flattening hierarchy, managing error and situational awareness and decision making. This focus, combined with an open culture, is key to delivering improved patient care in theatres, and across organisations as a whole.

These initiatives have the potential to revolutionise the way operating theatres deliver care whilst ensuring the best outcome for our patients.

Cardiff and Vale University Health Board SSSU developed their own resource to support and this has been adapted and adopted across Wales!

You can download the handbook here.

Transforming Theatres is supported by the Welsh Audit Office and the Delivery and Support Unit.

To find ways to make a difference, students and educators should discuss Transforming Theatres and link with the theatre manager in the placement organisation.
Background

Transforming Theatres promotes an approach where efficiency and productivity are integrated but with the main emphasis firmly on patient safety. The increasing financial constraints on the NHS have resulted in an increasing focus on improving patient safety and enhancing the efficiency and productivity of operating theatre departments.

Wales has been collecting information from all the operating theatre departments since 2003, so we have an idea of how we have been performing. This information is derived from measures, or Key Performance Indicators (KPIs), developed by the Theatre Managers. An analysis of these KPIs show that although there has been improvement in most areas, there is still room for further improvement in all Health Boards.

Getting Started

Transforming Theatres is a culture and behaviour change programme focusing on:

The Transforming Theatre programme has adopted this model from NHS England’s Institute for Improvement and Innovation’s Productive Operating Theatre (TPOT) programme (on which Transforming Theatre is based).

Team performance and well being is at the top because if the team perform well safety and reliability will improve which leads to an increase in value and efficiency. And when all of these areas are optimised the patient will have a better experience with improved outcomes.

Transforming Theatres drew several improvement initiatives together under one aim, to ‘transform the quality and safety of patient care in NHS Wales operating theatres.’
Transforming Theatres promotes the use of the ‘Model for Improvement’. This simple structure helps individuals and teams plan and make changes that will result in real improvements. There is an emphasis on planning and collecting data before devising, and then testing, possible solutions.

Find out more about using the Model for Improvement here: [www.iqt.wales.nhs.uk](http://www.iqt.wales.nhs.uk).

Examples of students using the model to make small changes to patient care can be found in The Quality Improvement Guide for Educators and Students.

**Transforming Theatres Modules**

Theatre teams have been supported through modules that provide them with the time to identify areas for improvement, collect relevant information, make the necessary changes and understand the lessons learned from other safety critical industries regarding functioning teams.

The modules are:

- **Visioning** – using audit sessions, visioning brings together large groups of multidisciplinary teams to consider what they want to achieve. The team identify factors that result in a ‘good day’ and then list what is currently stopping them from achieving this.
- **Knowing How We’re Doing** – focuses on the importance of data and information in any improvement process e.g. run charts, driver diagrams, photographic evidence, surveys. This information acts as a baseline to reflect on progress made.
- **Well Organised Theatre (WOT) / Operational Status At a Glance (OSAG)** – tools & techniques to improve the working environment e.g. Activity follow, 5S, stock rationalisation.
- **Human Factors sessions** – relates to the interaction of humans & technical systems.

These sessions were complementary and supportive to the introduction of briefings, debriefings and the WHO Checklist as tools to support improvements as well as OSAG.

See section 3 for ways that you can get involved in these activities on your theatre placements.
3. SMALL CHANGES TO TRANSFORM YOUR THEATRES

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 theatres

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.iqt.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 4. Send your entry to 1000livesplus@wales.nhs.uk by Friday 17 January 2014.

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 SAFETY AND RELIABILITY

Transforming Theatres 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

The World Health Organisation “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.

Components of the Checklist are designed to address safety issues at 3 distinct points in time for a surgical patient:
1) When the patient ‘signs-in’ to the operating room, prior to induction of anesthesia;
2) During the “Time Out” period immediately prior to incision;
3) During the post-operative “sign-out” stage, before the patient leaves the operating room.
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 a placement – this is a collaborative effort and should not be done on your own.

A really simple change: ID badge sized aide memoirs were produced and distributed to help staff remember the key points for the Surgical Safety Checklist!

Consider how to improve the safety and reliability in your placement area. Refer to the 5 simple steps in Section 4: How to get involved!
Better Communication and Teamwork – Briefings and De-Briefings

Surgical work generally occurs in teams, especially in the operating room itself. Teamwork is essential in healthcare today and communication within the team is indicative of the organisational culture. Hierarchy, “handoffs” and transitions, and different communication styles between professions all contribute to communication failures.

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

Briefing

Briefing the operating team prior to the commencement of the operating list is vital to ensure that all the team are aware of the surgery planned, the equipment needs, 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, without fear of reprisal and integrate the reporting of safety issues into everyday work. They also allow the whole theatre team to anticipate potential problems or challenges.

A briefing improves communication, allows team members to share knowledge and manages the theatre environment. A briefing is a short team discussion that only takes around five minutes. It’s an important aid in preparing the team for the expected and unexpected, allowing a conducive environment where members can talk openly, ask questions and support each other.

A typical briefing includes:
- Introductions for who is present on the team.
- Theatre list order.
- Types of patient on the list.
- Equipment issues or any specialist requirements.

Some of the ways in which team briefings can be developed are:
- Allocating five minutes before the start of the operating list where the core members of the team e.g. surgeon, scrub nurse, circulating nurse, ODP and anaesthetist can meet to discuss the requirements of that operating list 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.

If people say they have no time for a debrief or don’t value it catch them when they have a quiet moment. Tell them that you value their opinion and ask them to give you feedback using the 3 questions above. If that goes well ask them if they would like you to give them some feedback. Then tell them that if they did this as a team they would have done a debrief – it is that easy.

A really simple change:
Aneurin Bevan Health Board has led 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.

OPERATIONAL STATUS AT A GLANCE (OSAG)

Clinical teams have used human factors’ principles to improve communication. The OSAG 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 as an OSAG (or PSAG (Patient Safety at a Glance)) in a central area to captures ‘real time’ information which supports the day to day running of the theatre e.g. which staff are working that shift, list order changes, awaiting equipment.

Using an OSAG supports individual theatres and the effective management of the entire theatre suite. It provides the opportunity to improve patient flow by removing blockages and reallocating resources based on actual activity. It enables immediate and responsive corrective actions. By recording data, it creates measurable improvement, increases
reliability and facilitates real time responses. When an OSAG is used effectively, the outcome is a safe, well-controlled, effectively planned theatre environment.

Consider how communication and teamwork skills can be improved in your placement. Refer to Section 4: How to get involved!
WELL ORGANISED THEATRES

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. Theatre 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.

Well Organised Theatres creates a highly visible and organised working area and uses Lean Tools. Lean Tools can be just as effective in a NHS environment as in manufacturing. 5S is a method of standardising the work environment, so that issues are easily spotted. This means they can be controlled and corrected, before they become a major concern. It helps remove piles of unwanted materials, stock and equipment, manages the numerous documents, or records found in hospitals and keeps the working areas neat, tidy and organised. Theatres 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? Cluttered create 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 theatre 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.

Look at the difference 5S has made to this work environment below – *where would you rather work?*

**Before:**

![Before Image]

**After:**

![After Image]

**Consider how your working environment can be improved.**
**Refer to the 5 simple steps in Section 4: How to get involved!**

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4. **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](http://www.1000livesplus.wales.nhs.uk) or complete the Improving Quality Together Bronze e-learning module to help you complete the template.

Share your experience with [1000livesPlus@wales.nhs.uk](mailto: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](http://www.1000livesplus.wales.nhs.uk) in Paris on 8-11 April 2014.

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**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 Theatres 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.

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### 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.*

---

### Part 3: Share your learning

#### Lessons learnt

*what lessons have you learnt from this work? What would you do differently next time*

---

#### Message for others

*describe the main message from this experience that you would like to convey to others?*
5. TRANSFORMING THEATRE LEADS IN PLACEMENT ORGANISATIONS

Every health board and trust in Wales is involved in Transforming Patient Care. Each organisation has a nominated lead for this work and these are the people who can help you make a difference!

By contacting your lead, you’ll be able to contribute to the teams taking forward the improvements to transform the care they provide to their patients in theatre. Students can volunteer to be part of these teams, and learn about the improvement approach used across Wales.

**Abertawe Bro Morgannwg University Health Board**

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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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<tr>
<td>Karen Pask</td>
<td><a href="mailto:Karen.pask@wales.nhs.uk">Karen.pask@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Lead Role</td>
<td>Theatre Manager (North)</td>
</tr>
<tr>
<td></td>
<td>Theatre Manager (South)</td>
</tr>
</tbody>
</table>

### Hywel Dda Health Board

<table>
<thead>
<tr>
<th>Lead</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angie Oliver</td>
<td><a href="mailto:Angie.oliver@wales.nhs.uk">Angie.oliver@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Helen George</td>
<td><a href="mailto:Helen.george@wales.nhs.uk">Helen.george@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Ray Hughes</td>
<td><a href="mailto:Ray.david.hughes@wales.nhs.uk">Ray.david.hughes@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Sandra Brinson</td>
<td><a href="mailto:Sandra.brinson@wales.nhs.uk">Sandra.brinson@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Lead Role</td>
<td>Theatre Manager (Pembs)</td>
</tr>
<tr>
<td></td>
<td>Theatre Manager (Ceredigion)</td>
</tr>
<tr>
<td></td>
<td>Theatre Manager (Carms)</td>
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### Powys Teaching Health Board

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Lead Role</td>
<td>IQT Lead Contact</td>
</tr>
<tr>
<td></td>
<td>Theatre Manager</td>
</tr>
</tbody>
</table>

### Velindre NHS Trust

<table>
<thead>
<tr>
<th>Lead</th>
<th>Role</th>
</tr>
</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>
<tr>
<td>Lead Role</td>
<td>IQT Lead Contact</td>
</tr>
<tr>
<td></td>
<td>IQT Lead Contact</td>
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</tbody>
</table>
### 6. YOUR TRANSPORTING PATIENT CARE CHECKLIST!

<table>
<thead>
<tr>
<th>Action</th>
<th>Complete</th>
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</thead>
<tbody>
<tr>
<td>1. Follow your patient on their surgical journey: to give the patient the safest, most efficient and best possible experience of the perioperative environment which incorporates pre-assessment, anaesthetic room, theatre, recovery, ward.</td>
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</tr>
<tr>
<td>2. Understand how your theatre team interacts with patient safety as the main focus, learning the different roles and responsibilities of your team members. Find out what are the safety checks for swabs, needles, instruments and equipment and observe them being carried out.</td>
<td></td>
</tr>
<tr>
<td>3. Gain an understanding of how instruments and the environment are prepared and controlled to understand the purpose of infection policies and the maintenance of a sterile environment.</td>
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</tr>
<tr>
<td>4. Understand how health and safety plays a part on your theatre placement by learning the considerations with particular specialized equipment e.g. anaesthetic machines, lasers, diathermy etc.</td>
<td></td>
</tr>
<tr>
<td>5. Gain an understanding of the correct methods of transferring and positioning conscious and unconscious patients. Also the equipment and techniques used to safely maintain their position throughout the procedures.</td>
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</tr>
<tr>
<td>6. Gain a better perspective of normal and abnormal anatomy and how this is affecting the patients health.</td>
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</tr>
<tr>
<td>7. Gain an understanding of how certain drugs interact with the patients physiology. Learn the common side effects of the most common drugs in use.</td>
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</tr>
<tr>
<td>8. Take part in the 5 simple steps in Section 4: How you can get involved!</td>
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</tr>
<tr>
<td>9. Consider what small changes you can identify that could transform patient care. Submit your experience using the template on page 18 to <a href="mailto:1000livesplus@wales.nhs.uk">1000livesplus@wales.nhs.uk</a>.</td>
<td></td>
</tr>
<tr>
<td>10. Share your findings with your placement team and IQT leads in your organisation to discuss if there is an opportunity for them to build on the identified changes.</td>
<td></td>
</tr>
</tbody>
</table>
7. RESOURCES

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


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


Patient Safety First (2009) *The 'How to Guide’ for Implementing Human Factors in Healthcare*


**ARTICLES:**


*Success for Gwent operating theatres shake-up* (report in South Wales Argus, July 2011).

*Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care (John J. Nance)*

*Behaviours and rituals in the Operating Theatre.*

*Effect of a comprehensive surgical safety system on patient outcomes.* (de Vries et al; NEJM; 2010).

*“Who’s on the team today?” The status of briefing amongst operating theatre practitioners in one UK hospital* (2007; Journal of Interprofessional Care).

VIDEOS:

Elaine’s Story – Martin Bromiley is a pilot and also Chair of the Clinical Human Factors Group, which seeks to improve attitudes towards error among healthcare professionals. 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 to use the Surgical Safety Checklist – video by Harvard School of Public Health demonstrates how a simple series of steps can cut complications and lives.

How Not to Perform the WHO Safe Surgery Checklist – demonstration of a failed attempt to use the Checklist. This clip shows implementation of the Checklist without obtaining buy-in from clinical staff and providing appropriate education in the checklist use.

USEFUL WEBSITES:

NHS Institute Productive Operating Theatre website

Preoperative Assessment

Welsh Government Cancelled Operations Reports

The Association of Anaesthetists

The Royal College of Surgeons

The Association for Perioperative Practice

The Clinical Human Factors Group
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](http://www.1000livesplus.wales.nhs.uk)

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