Simplicity at Heart

Annette Bartley

Session Objectives

• To focus on the importance of trying to create focus and keep improvement work simple within a chaotic context
• To share a personal journey of improvement
• How to generate the will and connect the head, the heart and the hands of clinical teams
Understanding the context of frontline care

- What’s good about it?
- What’s not so good?
- What could be improved?

Life can be complicated

Which Direction? Get the picture
How do we make sense of all the expectations placed upon clinical microsystems? How do we bring the work into a coherent whole?

**Health Foundation Safer Communities**

**National Patient Safety Agency (NPSA)**
Safety Alerts Matching Michigan

**NHS III LIPs Productive Series**

**WHO World Alliance for Patient Safety**

**Department of Health (DoH)**
High Quality Care for All IP&C

**CNO High Impact Changes**

**QUIPP & Safety Express**

**Safer Patients Network (SPN)**
The Health Foundation (with IHI)

**CQUIN targets**

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**The Reality in Practice**
The Politics of Hope

“We got used to the politics of disappointment -- figuring out how soon we were going to be let down. ... There’s a different dynamic in the ... politics of hope. It’s much more challenging. It means you’ve got to get up and do something. There’s opportunity. If you don’t take advantage of that opportunity, you really have to bear responsibility for not doing so. That’s how I see the time we’re in.” Marshall Ganz

http://mitworld.mit.edu/speaker/view/1047
http://www.youtube.com/watch?v=NglXpj94Zzo
http://www.youtube.com/watch?v=LhCoz5hMhTI

Co-coordinating Care
Getting it right
Getting to Goal

• Will
• Ideas
• Execution

Change vs. Improvement

Of all changes I’ve observed, about 5% were improvements, the rest, at best, were illusions of progress.

W. Edwards Deming

– We must become masters of improvement
– We must learn how to improve rapidly
– We must learn to discern the difference between improvement and illusions of progress
A Personal Improvement Journey

The Journey Begins

• Health Foundation/IHI Fellowship
• 5,000,000 lives campaign
• TCAB
• Ascension Hospital System’s
  – Getting to Zero campaign
  – The SKIN Bundle
    • Surface/SKIN Inspection
    • Keep moving
    • Increased moisture/incontinence
    • Nutrition
TCAB Core Themes
IHI/Robert Wood Johnson Foundation 2003

• Transformational Leadership
• Teamwork and Vitality
• Safety and Reliability
• Value Added care
• Person Centredness

Deming’s Thoughts on Transformation

Metanoia:
• Reorientation of one’s way of life
  *(The New Economics. Deming, p. 95, 1993)*
• Begins with individual
• More than a change
• Develop new habits of mind
Transformational Leadership

- Empowerment
- Leadership at every level
- Clarity of vision
- Shared purpose

Michelangelo’s Thoughts on Transformation

“In every block of marble I see a statue as plain as though it stood before me, shaped and perfect in attitude and action. I have only to hew away the rough walls that imprison the lovely apparition to reveal it to the other eyes as mine see it.” …. Michelangelo
“I saw the angel in the marble and carved until I set him (her) free.” .... Michelangelo

Transformational Leadership

- A leader is not an administrator who loves to run others, but one who carries water for his people so that they can get on with their jobs“

- Creating Lollipops moments

http://www.ted.com/talks/drew_dudley_everyday_leadership.html
Teamwork and Vitality

- Clarity of purpose
- Clear and shared aims
- Local ownership for improvement
- Focus on safety
- Recognition and reward
Teamwork and Vitality

What exactly is Vitality?
1. exuberant physical strength or mental vigor: a person of great vitality.
2. capacity for survival or for the continuation of a meaningful or purposeful existence: the vitality of an institution.
3. power to live or grow: the vitality of a language.
4. vital force or principle.

Safety and Reliability

- Prevention
- Detection
- Mitigation
Value Added Care

• Nurses spend between 35-45% of their time in value-added care.
  – Activity follow
  – Getting the house in order!
  – A place for everything in its place.
  – Reducing documentation
  – Relocating supplies near the beside
  – Improving communication

Person Centred Care

• “If quality is to be at the heart of everything we do, it must be understood from the perspective of patients and their families.”
Welsh Healthcare

- Population 2.98 million
- Devolved responsibility for the National Health Service
- 71,467 WTE staff
- 7 Local Health Boards integrating primary, secondary care, community and mental health

The 1000 Lives campaign

Aim:
To save 1000 lives and to avoid up to 50,000 episodes of harm in Welsh healthcare between 21 April 2008 and 21 April 2010
- Improving Leadership for Quality
- Reducing Healthcare Infections
- Improving Critical Care
- Reducing surgical complications
- Improving Medical & Surgical Care
- Transforming care at the bedside (TCAB)
Improvement requires a clear aim

Measurement & Action

A model for improvement...

**Aims**
- Measurement
  - Ideas, evidence, hunches, other people etc.

**What are we trying to accomplish?**
- How will we know that a change is an improvement?
- What changes can we make that will result in the improvements we seek?

The fourth question: how to make changes

**Process:**
- **Act**
- **Plan**
- **Study**
- **Do**

The three fundamental questions for improvement

Langley, Nolan et al 1996
Repeated Use of the PDSA Cycle

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?

Changes That Result in Improvement
- Very Small Scale Test
- Follow-up Tests
- Wide-Scale Tests of Change
- Implementation of Change

Hunches Theories

Very Small Scale Test

Hunches
Theories

AP SD

AP SD

AP SD

AP SD

AP SD

AP SD

Changes That Result in Improvement

Health Care Processes

Current - Variable, lots of autonomy not owned, poor if any feedback for improvement, constantly altered by individual changes, performance stable at low levels

Desired - variation based on clinical criteria, no individual autonomy to change the process, process owned from start to finish, can learn from defects before harm occurs, constantly improved by collective wisdom - variation

Terry Borman, MD Mayo Health System
Framework for Reliable Design

Reliability occurs by design not by accident

The Truth is we all make mistakes!
Making the connections

• Engaging the whole team
• Transforming Care

National learning community
Increasing time in value-added/direct care

BCULHB
Ward 11 time has increased from 50% to 70%!
Ward 1 time at the bedside has increased from 52% to 67%!

Spread across Wales
Some units now at 80%!

Preventing in-hospital patient falls

36% Reduction in in-hospital falls

One year without a fall Ward 9
Hywel Dda LHB
Patient team members and stories

ABM LHB
Winners of “Improving Quality through better use of resources” NHS awards

Improving Patient experience

Patient Satisfaction improved from 80% to 100% in pilot ward in Hywel Dda LHB

Slide courtesy of Dave Williams Improvement Advisor IHI
What makes it personal?

Danny’s Story

Why focus on pressure ulcers?

• An estimated 4–10% of patients admitted to an acute hospital develop a pressure ulcer
  1. Clark M, Bours G, Defloor T, 2004
• estimated that up to 30% of patients may suffer and 20% of patients in care homes, skilled nursing facilities
• Substantial financial costs—from £1,064 for a grade 1 ulcer to £24,214 for a grade 4
• The total cost in the UK is estimated to be £1.4-£2.1 billion annually, comprising 4% of total NHS expenditure.
• In the USA the average cost of each of those pressure ulcers is estimated to be $43,180 per hospital stay.
• Estimated annual cost $11 billion
• Because it matters!.!
Tissue Viability Care-The reality...

- Inevitable consequence
- Focus largely on mitigation
- Root cause analysis
- Education and Training
- Equipment
- Grading /Staging of Pressure Ulcers
- Treatment
- Measuring Prevalence
- Lots of activity but ...

A new direction?

- Quality Improvement Methodology
- Shifting the focus to Prevention
- Real time measurement
- Partner with Patients and families
- Making the connections
- Keep it simple
- Life is complicated enough!
Reduce the Percentage of Hospital acquired Pressure Ulcers (per 1000 patient days) by 50% by 2010

- **Risk Identification**
  - Understand the risk factors for acquiring pressure ulcers
  - Understand the local context & analyse local data to assess patients on ward/unit most at risk
  - Utilise patient ‘At risk’ cards to quickly identify those at increased risk

- **Risk Assessment**
  - Assess pressure ulcer risk on admission for ALL patients
  - Re-assess skin every 8 hours where necessary
  - Initiate and maintain correct and suitable preventative measures

- **Reliable Implementation of the SKIN ‘bundle’ ‘Ascension health’s initiative 2004’**
  - Address these areas:
    - Surface
    - Keep Moving
    - Incontinence
    - Nutrition

- **Identification, grading of pressure ulcers existing on admission/transfer & appropriate intervention**
  - Initiate and maintain correct and suitable treatment measures
  - Utilise the local Tissue Viability nursing expertise

- **Education**
  - Educate staff regarding the assessment process, identification and classification of, and treatment of pressure ulcers
  - Educate Patients & family
  - Develop patient information pack

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**Developing a systems-based approach to the prevention of pressure ulcers**

- **Risk Identification**
- **Risk Assessment**
- **Communication of Risk status**
- **Appropriate preventative strategy implemented**
- **Evaluation of outcome**
Communication

- Verbal
- **Safety Briefings/Safety Huddles**
- Written
- **Documentation/charts**
- Visual
- **Visual cues**

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### PUP Pressure Ulcer Prevention

**Patient Name**

<table>
<thead>
<tr>
<th>Date</th>
<th>Surface</th>
<th>Keep Moving</th>
<th>Incontinence</th>
<th>Nutrition</th>
<th>Waterlow</th>
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K - keep moving

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### Weekly Compliance Chart

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K - keep moving

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**SKIN Bundle Communication tool for Pressure Ulcer Prevention**

- **Date**
- **Surface**
- **Keep Moving**
- **Incontinence**
- **Nutrition**
- **Waterlow**

**TM Ascension Hospitals System**
Abertawe Bro Morgannwg University NHS Trust
TODD Number of pressure ulcers - Anglesey Ward Morriston

ABM U LHB
Angelsey ward
758 days without a pressure Ulcer
4 years with only one grade 2

System wide results
14% incidence rate
reduced to <0.6%
93 units 4 hospital system
Now in primary care
National roll out!
UK Spread/Denmark

Winners of "Improving Quality through better use of resources" NHS awards 2009
The SKIN care bundle, which won an NHS Wales award in 2009, won the Patient Safety in Clinical Practice section of the Health Service Journal/Nursing Times Patient Safety Awards 2010.

Results
• >50% reduction in pressure ulcers in all pilot wards
• 1 site has just gone 3 years with only 1 grade 2 pressure ulcer /93 ward spread
• Many units have reached over 600 days
• System wide results 14% to < 1% incidence
• Spread across Wales, Scotland, Northern Ireland, USA, Denmark

Celebrating Success
Making the connections

- Risk assessment
- Communicate
- Preventative action
- Measure impact

- Partner with patient

Change 1: Real Time Education
Change 2: PURA & SSKIN in Admission Forms
• Recorded on Safety Cross – no evidence in notes
• Recorded on safety Cross – no evidence in notes
• Patient on Care Pathway for the Dying (PC) G2
• Patient refusing to turn – (PC) G1
• Patient not receiving optimal nutritional support (S) G2
  • Reviewed Operational Definition
Ascension

UCLH

UCLH PRESSURE ULCER PREVENTION CAMPAIGN 2011

KEEP THE PRESSURE OFF!

ONE PRESSURE ULCER IS ONE TOO MANY.
BE A HERO - AIM FOR ZERO

University College London Hospitals NHS Foundation Trust
Keeping it simple

• Form a team- you might think you have one?
• Make it personal!
• Connect hearts, heads and hands
• Coach and empower others
• Focus on TCAB core themes as a framework
• Aim, measure, act!!
• Don’t ever lose heart!
• Celebrate what you want more of!
In summary

‘If you can imagine it you can create it. If you can dream it, you can become it, and if you do it you can make a difference’

Arthur William Ward

People may not remember what you did or what you said, but they will always remember how you made them feel.” -Maya Angelou