NHS Ayrshire and Arran Deteriorating Patient Storyboard

Creating the Conditions

- Working on building relationships with key stakeholders early on in the concept and regular check ins/updates
- Share patient stories
- Focus on the people, ensure they are connected to the why/purpose and can see where it sits within the bigger picture

Understanding your system

- Use of prioritisation matrix
- Process mapping
- Staff surveys
- Focus groups
- Inter profession project teams
- Force field analysis

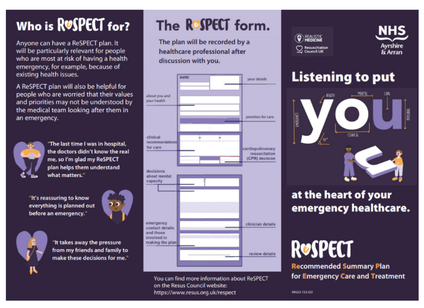
"If you do what you've always done, you'll get what you've always gotten" Tony Robbins

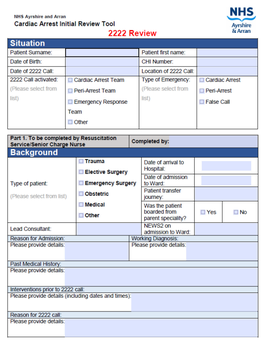
Aim

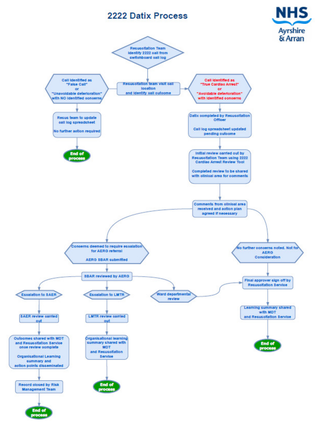
A reduced number of true cardiac arrests per 1000 discharges across both acute sites in NHS AAA by March 2024.

Testing Changes

- Implementation of NEWS2
- eReSPECT currently in testing phase
- DATIX as platform for reporting true cardiac arrests
- Review of true cardiac arrests and agreed process for escalation of concerns
- Data collection process change







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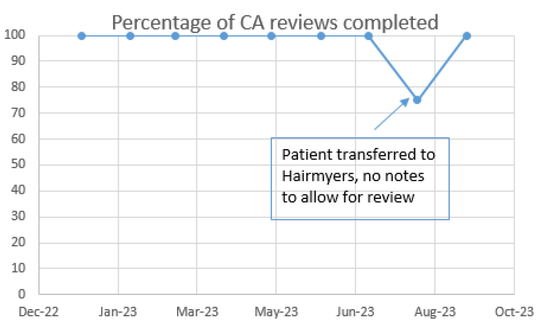

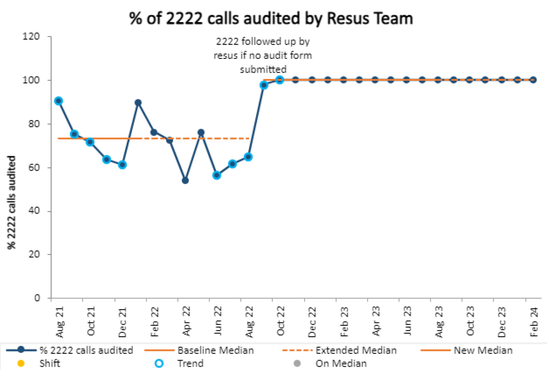

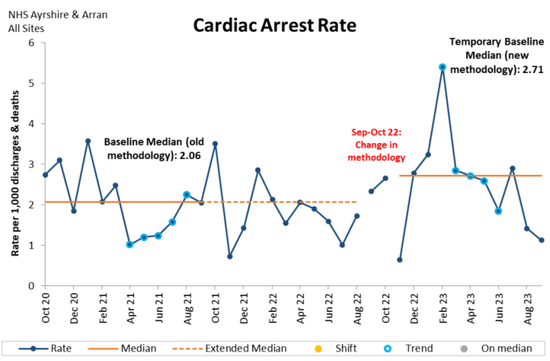

Implementation and spread

Implementation Checklist

NEWS2

We implement when we have tested a change and know that it works and now we want to make it business as usual.

There are 5 key steps to successful implementation

Step 1: Standardisation:

List all the processes/ jobs/ tasks necessary to maintain the change idea. Make sure you align roles and responsibilities to each and how often they need done so everyone knows what is expected of them

Tasks	Who	Frequency Daily weekly/ monthly / when required	Tools required
Raise awareness of NEWS2 organisation wide	Resus/QI/Practice Development	August until 'go live' date	Communications, F2F drop in sessions, distribution of awareness via chief nurses/CNMs, Deteriorating patient Facebook group, virtual drop in session for community sites, removal of old NEWS charts, ANP/medical awareness
Confirm final version of NEWS2 via SLWG	Resus/governance/ documentation group	Tabled at August governance meeting	Final version of NEWS2 (medical photography working on this 10/08/22) Version control will sit with Resus?

PDSA – Test of change for NEWS2 Document

Aim		
By October 2022, 95% of patients within NHS Ayrshire & Arran Acute areas will have NEWS2 document in place for recording of vital signs. This will be done in line with national Guidance		
Change idea		
To test draft NEWS2 document within CAU UHA, St 3, 3D on 3 patients/appropriate number		
PDSA objective: Describe the objective for this PDSA cycle	**Cycle No: 1**	**What questions do you want answered for this test of change?**
To check if the document can be used appropriately and all information is recorded. Do staff have any feedback on how they were able to use the document.		Is the chart simple to complete? Are there any training needs required for the Department to enable staff to complete the chart. Is the layout appropriate and is there anything missing?
Predict what will happen when the test is carried out.		**Measures to determine if prediction succeeds**
Staff unaware how to complete chart Confusion around new chart Charts not fully completed Staff too busy to take time to familiarise self with document		Staff feedback on the document. (more measures to follow after first test)
Plan		

Testing of Version 1 of the MDT Review Tool in alignment with SPSP Collaborative - Deteriorating Patient

You said		We did
Review could have been shorter if preparatory work had been completed.	1	Guidance on pre-work for the review will be created.
37.5% disagreed that the MDT were well represented – stating no medical representation within review 2.	2	The pre-work guidance will include advice on appropriate representation for the circumstances.
It was recognised that the debrief document would have been useful to help with timeline of events for review 2.	3	The pre-work guidance will include requirements to chronologically list events prior to the review
The case summary and SBA sections of the review will be completed prior to the review – would this be circulated to staff prior to the review and then discussed for accuracy?	4	The pre-work guidance will include requirements for the SBA and case summary to be shared with the participants prior to the review.
It was apparent that the 'Why did the event occur' section was a repeat of points already discussed – could this framework be used to guide prior sections – is there value in completing this section as a stand-alone section?	5	Resolved by the above.
Staff questioned how the learning will be shared both locally and organisationally – could there be a list of potential options for the review team to select which is most appropriate for the case ie. Simulation of case, learning summary, circulation of review tool to all staff directly involved?	6	The 2222 Datix process map shall be updated to close the learning loop by disseminating feedback to AND, CNM's and the EIC Newsletter.
Within 'Background' section the 3rd question appears to be worded incorrectly and requires clarification and both review teams found the wording ambiguous.	7	Resuscitation Team to investigate and advise on options.
Within 'Background' section the 5th question could be reworded to include terminated or terminated due to ROSC?	8	The final 2 questions in this section shall be re-positioned prior to "Was a natural death anticipated?"

Enablers for success

- Proactive and motivated team
- Collaborative working with QI team
- Securing Senior support to make positive change

Challenges we encountered

- Initial barriers to MDT approach to cardiac arrest reviews due to anticipated increase to workload
- IT challenges with implementation of eReSPECT
- Managing opposing expectations from key stakeholders and reaching compromise for final version of NEWS2 chart

Next Steps

- Our wish going forward is to build on existing work and increase the number of cardiac arrests that have an MDT review. The aim is to extrapolate quality learning to share within the Organisation
- Explore ways to better close the loop on the learning and improve feedback to the floor
- Seek best approach to securing protected time for clinical lead for deteriorating patient work
- Agree next areas of focus for future improvement work

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