

Clinical Audit Awareness Week #CAAW24



Part of Clinical Audit Awareness Week 2024, featuring the Clinical Audit Heroes awards



HQIP
Healthcare Quality
Improvement Partnership



Patient Safety - Effectively Utilising Clinical Audit To Prevent Avoidable Harm NQICAN Lunch and Learn Monday 24th June 2024 (12.30-1.30pm)

Your Lunch &
Learn Team today



Vicky Patel - Chair NQICAN
Marina Otley - Gen Sec NQICAN
Chris Gush - CEO HQIP
Rachel Pool - Head of Patient Safety
Implementation NHSE
Clinical Audit Hero – Patient Safety



Clinical Audit Awareness Week #CAAW24



**Monday 24th
June 2024
12.20-1.30pm**

**Tuesday 25th June 2024
12.20-1.30pm**

**Wednesday 26th June
2024
12.20-1.30pm**

**Thursday 27th June
2024
12.20-1.30pm**

**Friday 28th June 2024
12.20-1.30pm**

**Patient Safety -
Effectively
Utilising Clinical
Audit To Prevent
Avoidable Harm**

**Patient & Public
Involvement -
Effectively Utilising
Clinical Audit To
Improve Health & Care
by Involving, Engaging
& Informing Patients &
The Public**

**Health Inequalities -
Effectively Utilising
Clinical Audit To
Address Inequalities In
Health & Care**

**Influencing Change -
Effectively Utilising
Clinical Audit To
Influence Change At
Board Level**

**Sustainability -
Effectively Utilising
Clinical Audit For
Sustainability**

**Rachel Pool -
NHSE**

Kim Rezel - HQIP

**Danny Keenan - HQIP &
Charlotte Richardson -
NHSE**

Sam Riley - NHSE

**Zoe Lord - NHS
Horizons**



Who is YOUR Audit Hero?

#CAAW24



HQIP

Healthcare Quality
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*Part of Clinical Audit Awareness Week 2024, featuring the Clinical Audit
Heroes awards*

Clinical Audit Awareness Week 2024

Lunch & Learn events – welcome from...

Chris Gush, CEO, HQIP

24 June 2024

#CAAW24 NQICAN Patient Safety Lunch & Learn



HQIP
Healthcare Quality
Improvement Partnership



Agenda

- HQIP Chris Gush CEO #CAAW24
- Introduction NQICAN and #CAAW
- What does preventing avoidable harm mean to you from a clinical audit perspective?
- Key Speaker - Effectively utilising Clinical Audit to prevent avoidable harm
- Clinical Audit Hero Winner announced
- Winner of the Patient Safety Clinical Audit Hero Award presents
- Opportunity for questions framed on Patient Safety
- Interactive Evaluation
- Close and celebrate #CAAW24!



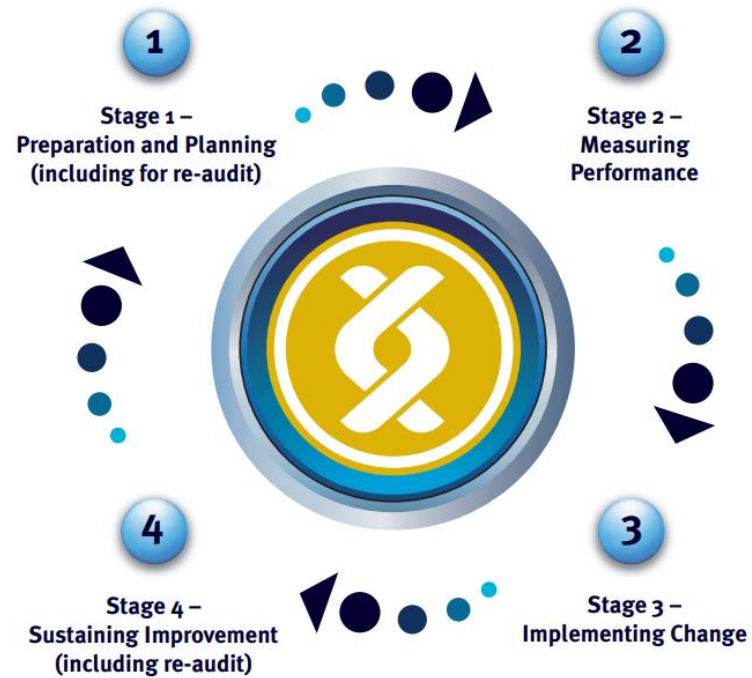
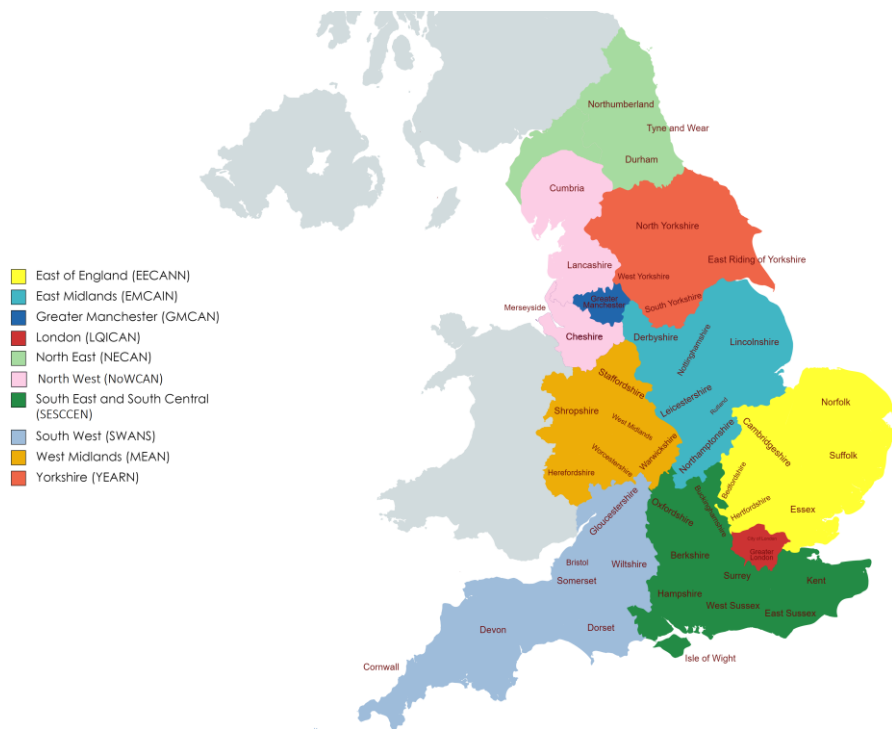
Please let us know– *what does utilising Clinical Audit to prevent avoidable harm look like to you* - by typing into the chat



Who is YOUR Audit Hero?

#CAAW24

Clinical Audit Awareness Week #CAAW24



Clinical Audit Awareness Week

#CAAW24



Clinical Audit – measures care against evidence based standards. #CAAW23 challenged attendees to consider Clinical Audit in their own organisation in terms of:

- Clinical Audit strategies having a clear objective aligning with the PSIRF – go and talk to your Patient Safety Team
- Clinical Audit programmes consisting of Clinical Audits that focus measurement on Patient Safety Concerns - evidencing learning from avoidable harm – speak with your Patient Safety Specialists
- Clinical Audit findings and action plans taken forward with the focus on preventing avoidable harm – complimenting SIPs not duplicating



Clinical Audit Awareness Week #CAAW24



- **Implementing Evidence based Care** - do we have effective processes to implement/adopt that are safe? How do we know they are safe & effective? Do we measure when we implement/adopt to ensure we are preventing avoidable harm?
- **Clinical audit programme** – does it include clinical audits driven by patient safety themes/concerns? What are the top 5 concerns in your organisation/ICB/Nationally?
- **Strategic** – does your organization's Clinical Audit & PSIRF policies align?
- **Engagement & Involvement** – do you attend your pt safety committee?
- **Triangulating information** – do you triangulate clinical audit outcomes with Patient feedback & Staff surveys
- **Themes & areas of concern** – any worry spots? Adapt methodology for areas of concern/risks of significance as opposed to low risk areas/no concern
- **Collaboratively working** – do you take forward recommendations and actions with the patient safety and patient experience teams?
- **Education & training** – What is available and what is attendance like?
- **Sharing & learning events** – does your organisation hold these?



Clinical Audit Awareness Week

#CAAW24



Key Speaker
Rachel Pool
Head of Patient Safety
Implementation
NHSE



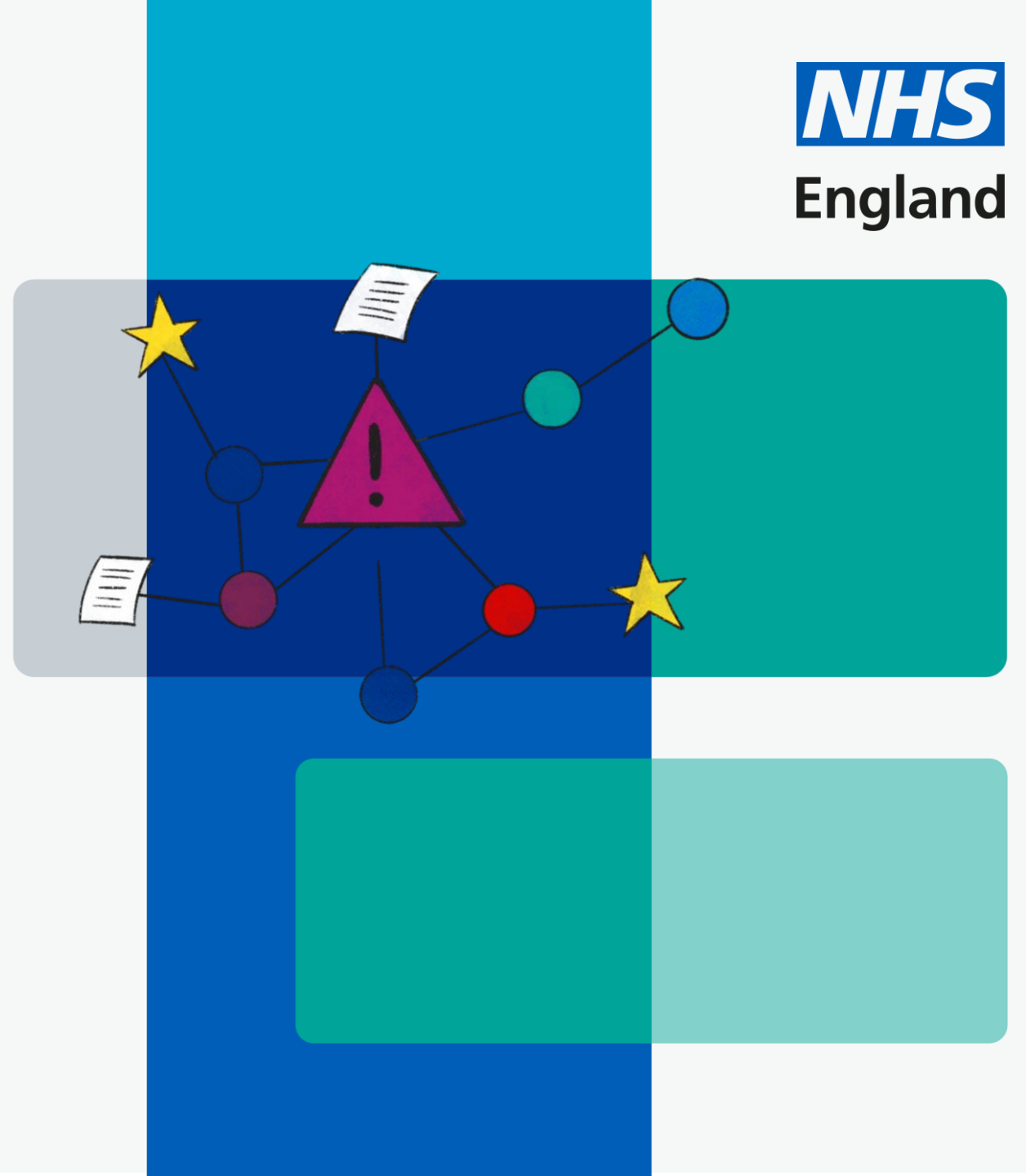
Who is YOUR Audit Hero?

#CAAW24

The Patient Safety Incident Response Framework

NQICAN

Rachel Pool 24 June 2024




Clinical Audit

Make your mark




Policy context



Serious Incident Framework

Supporting learning to prevent recurrence

“The Framework aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that ‘incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working’”




House of Commons
Public Administration Select Committee

Investigating clinical incidents in the NHS

Sixth Report of Session 2014–15


Report, together with the report of the Parliamentary and Health Service Ombudsman

Ordered by the House to be printed 24 March 2015



Parliamentary and Health Service Ombudsman

A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged



BRIEFING
Learning from serious incidents in NHS acute hospitals

A review of the quality of investigation reports June 2016

Introduction

“It is safe” is one of the five questions CQC asks on every inspection of health and social care services in England. We have found many good and outstanding services over the past three years, and yet, safety continues to be our biggest concern. One of the most common issues we find is the way that organisations investigate, communicate and learn when things go wrong.

We wanted to get a better understanding of these issues, so we decided to carry out a review of a sample of serious incident investigation reports. We also wanted to test a method that we could use in our inspections and identify ways that we could help to encourage improvement.

Our review included a sample of 14 investigation reports from 24 NHS acute hospital trusts, representing 15% of the 119 acute trusts in England at the time of this review. We used an assessment Framework based on NHS England’s Serious Incident Framework and associated guidance, templates and tools (further information about how we carried out this review is included in the appendix).

Many of our findings are not new, but they echo many of the issues raised by the [Public Administration Select Committee](#) in March last year, the [Lawson Commission](#) in July 2015, the [Department of Health](#) in December 2015. They also provide further evidence of the need for a step change in the way that serious incidents are investigated and managed in the NHS.


This briefing provides a summary of our findings, based on five opportunities for improvement:

1. Prioritising serious incidents that require full investigation and developing alternative methods for managing and learning from other types of incident.
2. Routinely involving patients and families in investigations.
3. Engaging and supporting the staff involved in the incident and investigation process.
4. Using skilled analysis to move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident.
5. Using human factors principles to develop solutions that reduce the risk of the same incidents happening again.

These issues raise important questions about how we now work together across the system to align expectations and create the right environment for open reporting, learning and improvement. The development of the new Healthcare Safety Investigation Branch and the move of the NHS Improvement provides a timely opportunity for us to come together to develop a shared definition of good practice and agree how we will work together to support and encourage improvement.

CQC Briefing: Learning from serious incidents in NHS acute hospitals 1

“Despite pockets of best practice, good intentions and strong leadership, clinical incident investigation and complaints handling fall far short of what patients, their families, clinicians and NHS staff are entitled to expect”



The problem with root cause analysis

analysis

Muhammad Farhad Peerally,¹ Susan Carr,² Justin Waring,³ Mary Dixon-Woods¹

INTRODUCTION

Attempts to learn from high-risk incidents such as aviation and nuclear power have been a prominent feature of the patient safety movement since the late 1990s. One noteworthy practice adopted from such industries, endorsed by health care systems worldwide for the investigation of serious incidents, is a root cause analysis (RCA). Broadly understood as a method of assessing the identification and management in the aftermath of adverse events, RCA is not a single technique. Rather, it describes a range of approaches and tools drawn from fields including human factors and safety science that are used to establish how and why an incident occurred in an attempt to identify how to, and similar problems, might be prevented from happening again.¹ In this article, we propose that RCA does have potential value in healthcare, but it has been widely applied without sufficient attention paid to what makes it work in its contexts of origin, and without adequate consideration for the specifics of healthcare.² As a result, its potential has remained under-realised and the phenomenon of organisational forgetting³ remains widespread (see 1). Here, we identify eight challenges facing the usage of RCA in healthcare and offer some proposals on how to improve learning from incidents.

The unsuitability quest for ‘the root cause’

The first problem with RCA is its name. By implying—even inadvertently—that a single root cause for a small number of cases can be found, the term ‘root cause analysis’ promotes a flawed induction: ‘one’ incident investigation in the aftermath of an adverse event is possible to identify the cause and other factors contributing to the genesis of a particular adverse event,⁴ but one investigation in a single linear narrative that

displaces more complex, and potentially, complex of multiple acting contributors to how even unfold.⁵ This is a tendency shared by use of some RCA tool (such as timelines or the ‘five whys’) and to have a rigid template rather than a system view.

‘5 WHYS’ AS A TEACHING TOOL

The pedagogical requirement for ‘5 whys’ is that it creates an ‘aha moment’ by revealing the hidden influence of a latent

THE PROBLEM WITH ‘5 WHYS’

Alan J Card

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BACKGROUND

The ‘5 whys’ technique is one of the most widely taught approaches to root cause analysis (RCA) in healthcare. Its use is promoted by the WHO, the English National Health Service, the Institute for Healthcare Improvement, the Joint Commission¹ and many other organisations in the field of healthcare quality and safety. Like most such tools, though, its popularity is not the result of any evidence that it is effective.^{2–6} Instead, it probably owes its place in the curriculum and practice of RCA to a combination of pedigree, simplicity and pedagogy.

In terms of pedigree, ‘5 whys’ traces its roots back to the Toyota Production System (TPS).⁷ It also plays a key role in Lean⁸ (a generic version of TPS) as well as Six Sigma,⁹ another popular quality improvement (QI) methodology. Taiichi Ohno describes ‘5 whys’ as central to the TPS methodology:

“The basis of Toyota’s scientific approach is to ask why the issue whenever we find a problem... By repeating why five times, the nature of the problem as well as its solution become clear. The solution, or the how-to, is designated as ‘1H’. Thus, ‘The why equal one how’ (1W=1H). (ref. 5, p. 123).”

This quote also makes the case for the technique’s simplicity. Asking ‘why’ five times allows users to arrive at a single root cause that might not have been obvious at the outset. It may also inspire a single solution to address that root cause (though it is not clear that the ‘1H’ side of the equation has been adopted as widely).

For instance, the cause of the aircraft’s crash was not an issue at all, and while there were ‘ten upsets’ (ref. 14, p. 10) at the moment, they were not a major problem. Instead, most of the clearing was necessary because swarms of

which illustrates the importance of digging deeper into a causal pathway. This quick and easy learning experience can be a powerful lesson in systems safety and QI.

Possible the most famous ‘5 whys’ case study to be used in the way focuses on efforts to preserve the Washington Monument.¹⁰ Details vary slightly depending on the source, but it usually looks something like this:

Problem: The Washington Monument is deteriorating.

Why? Hard chemicals are being used to clean the monument.

Why? The monument is covered in pigeon droppings.

Why? Pigeons are attracted by the large number of spiders at the monument.

Why? Spiders are attracted by the large number of spiders at the monument.

Why? Moths are attracted by the fact that the monument is firm to be lit at night.

Solution: Turn on the lights one hour later.

This is a great teaching example because the ‘root cause’ is an inanimate. Who would think that, before exploring the issue in depth, that lighting choices could endanger a notable monument? But, as is so often the case, reality is messier than this simple illustration.

Just Gross¹¹ investigated the foundation of this example and discovered that many of the details are incorrect. And, crucially, the broader story is still incomplete.

In terms of the story’s details, the monument is question was actually the Lincoln Memorial, and it was not being damaged by the use of harsh chemicals. The real culprit was simply water. Pigeons were not an issue at all, and while there were ‘ten upsets’ (ref. 14, p. 10) at the moment, they were not a major problem. Instead, most of the clearing was necessary because swarms of

- [1] Peerally MF, Carr S, Waring J, et al The problem with root cause analysis *BMJ Quality & Safety* 2017;**26**:417–422.
- [2] Card AJ. The problem with ‘5 whys’ *BMJ Quality & Safety* 2017;**26**:671–677.

Patient safety incident response framework (PSIRF)

From prescription to principles



Compassionate

Engage meaningfully with those affected by patient safety incidents through answering questions, addressing concerns, and involving those affected in any learning response.



Proportionate

Not all incidents require a learning response. Focus responses on areas where there's the greatest potential for learning and improvement.



Systems-based

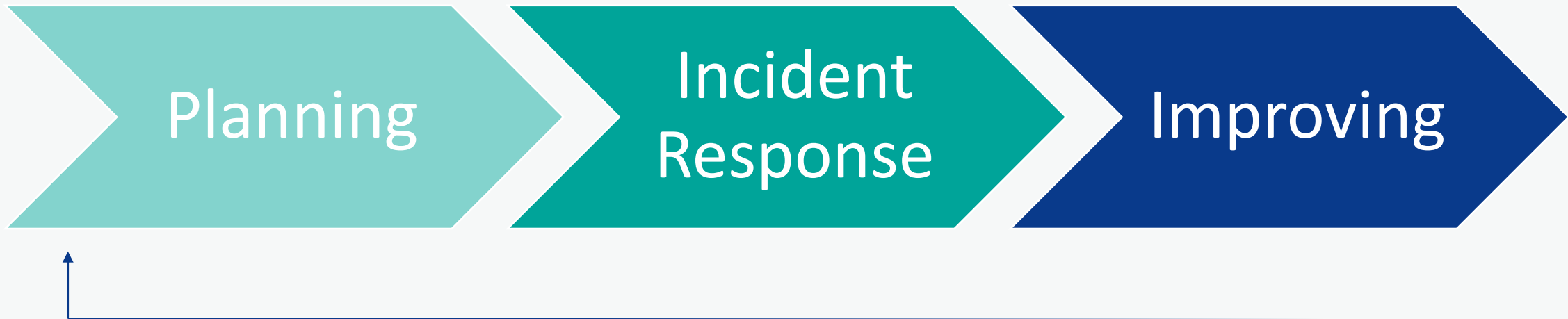
Looking beyond the decisions and actions of people/individuals delivering care to consider the influence of the wider system and the complex interactions that occur.



Supported

Oversight of learning from patient safety incidents should focus on enabling improvement and collaboration.

PSIRF



PSIRF

From a framework to a movement

- “Not implementing a framework, leading a culture change”
- Building connections, enabling conversations
- Change in narrative and openness
- Oversight functions less transactional
- Tangible and **measurable** change





PSIRF 2023 Successes

Learning &
Change

Collaboration &
Cross-system
working

Safe space

Investment &
Long-term
approach

"At both ICB and regional level PSIRF Groups developed as a safe space to share and learn, escalate concerns, “pinch with pride”, develop whole system working and reduce silos, act as a critical friend, foster self-reflection and provide insight, and act as a professional support network.

This is helping to encourage and model the learning healthcare system, patient safety culture, and quality improvement approach that PSIRF is aiming to achieve. "

PSIRF 2023 Successes

Learning &
Change

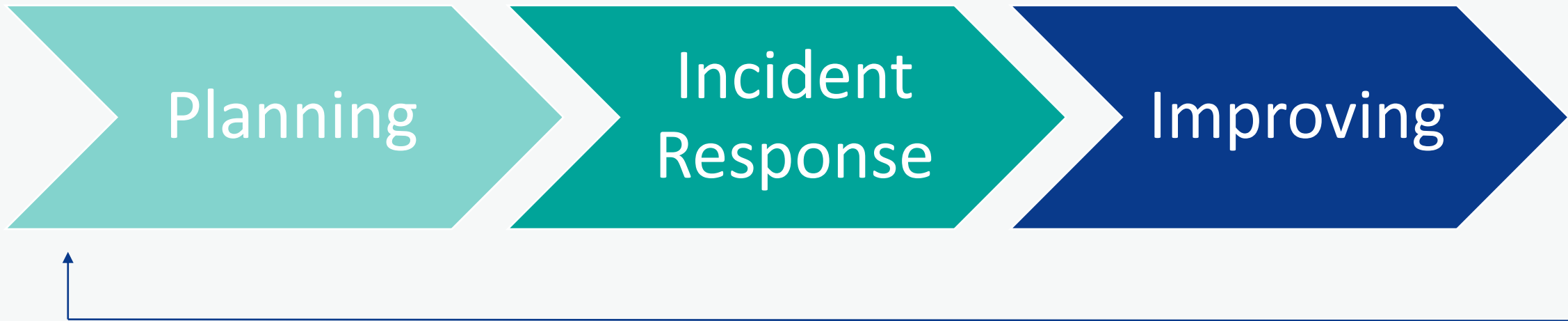
Collaboration &
Cross-system
working

Safe space

Investment &
Long-term
approach

- “Not implementing a framework, leading a culture change” ✓
- Building connections, enabling conversations ✓
- Change in narrative and openness ✓
- Oversight functions less transactional ✓
- Tangible and **measurable** change ✓

PSIRF



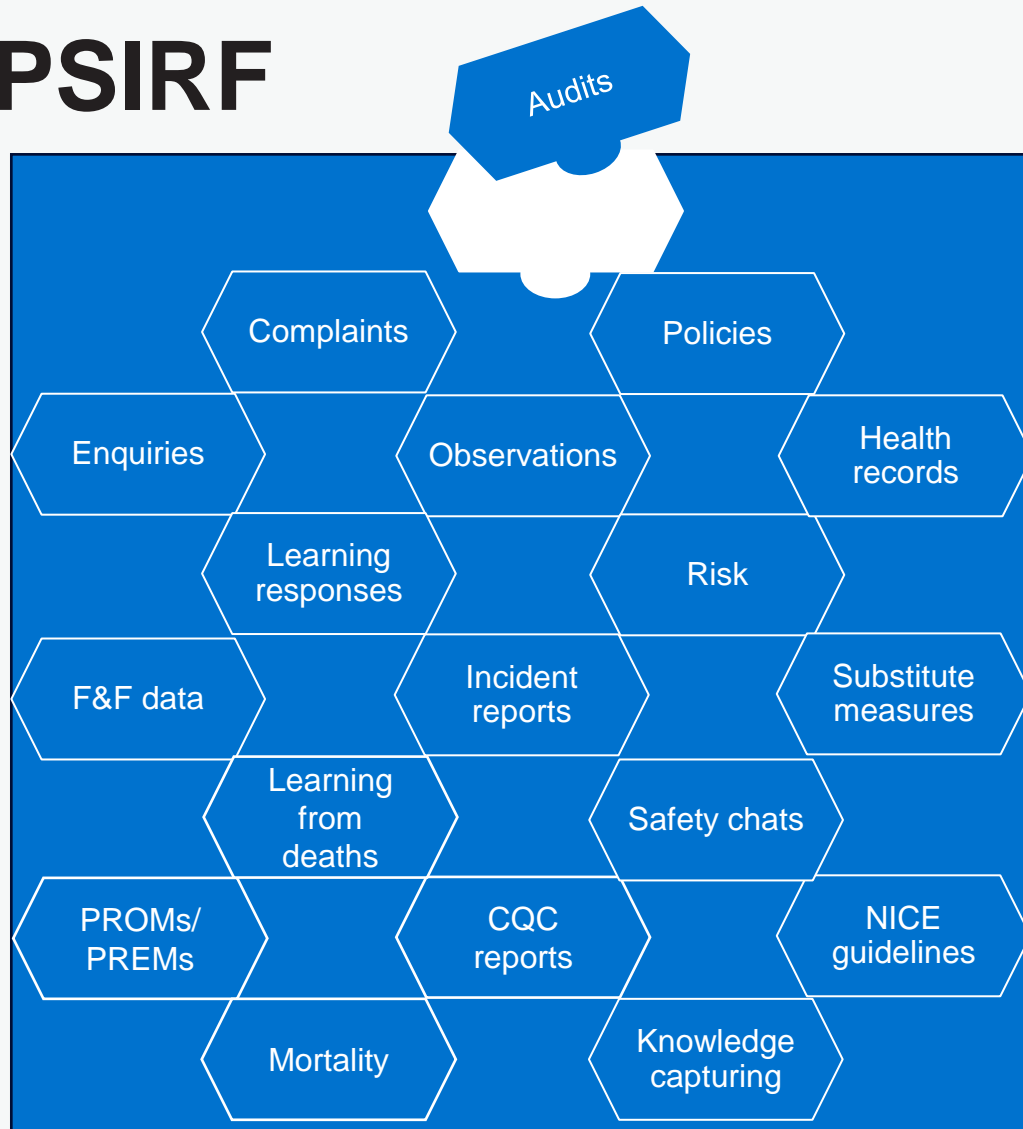
PSIRF

PSIRF, Standards, Oversight roles and responsibilities specification, Supporting guidance, Toolkit



Compassionate Proportionate Systems-based Supported

PSIRF



Clinical Audit

Make your mark



Clinical Audit

“Are we doing the right thing in the right way” ¹

National Diabetes Audit

1. Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
2. What percentage of people registered with diabetes received the nine [National Institute of Health and Care Excellence \(NICE\) key processes of diabetes care](#)?
3. What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and cardiovascular disease risk reduction?
4. What percentage of people registered with diabetes are offered and attend a structured education course?
5. For people with registered diabetes what are the rates of acute and long-term complications (disease outcomes)?

- Governance and quality
- Structure of care¹
- Process of care¹
- Outcome of care¹
- Learning at different levels

1. Benjamin A. Audit: how to do it in practice BMJ 2008; 336 :1241 doi:10.1136/bmj.39527.628322.AD

Citing: Smith R. Audit and research. British Medical Journal 1992; 305 :905 doi:10.1136/bmj.305.6859.905

PSIR Priorities



Engagement
with public
and local
HealthWatch

Plan based
upon
learning and
improvement
potential

Plan clear to
patients and
families

How are inequalities considered?

PSIRF and inequalities

Some patients are less safe than others in a healthcare setting. The PSIRF provides a mechanism to directly address these unfair and avoidable differences in risk of harm from healthcare:

- The PSIRF's more flexible approach makes it easier to address concerns specific to health inequalities: it provides the opportunity to learn from patient safety incidents that did not meet the definition of a 'Serious Incident'.
- PSIRF prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans.
- Tools in [the patient safety incident response toolkit](#) prompt consideration of inequalities during the learning response process including when developing safety actions.
- [Engaging and involving patients, families and staff following a patient safety incident](#) gives guidance on engaging those with different needs.
- The framework endorses a system-based approach (instead of a 'person focused' approach) and is explicit about the training and skill development required to support an approach. This will support the development of a just culture and reduce the ethnicity gap in rates of disciplinary action across the NHS workforce.

'Through our implementation of [PSIRF], we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these. We are already actively considering language barriers and social deprivation in our incident reviews ~ Acute provider

PSIR Planning Retrospective

Just the beginning of the safety journey

- “Not implementing a framework, leading a culture change”
- Plan enables more informed decision making moving away from reactive/bureaucratic approach
- Rich source of data about safety concerns across trusts in England

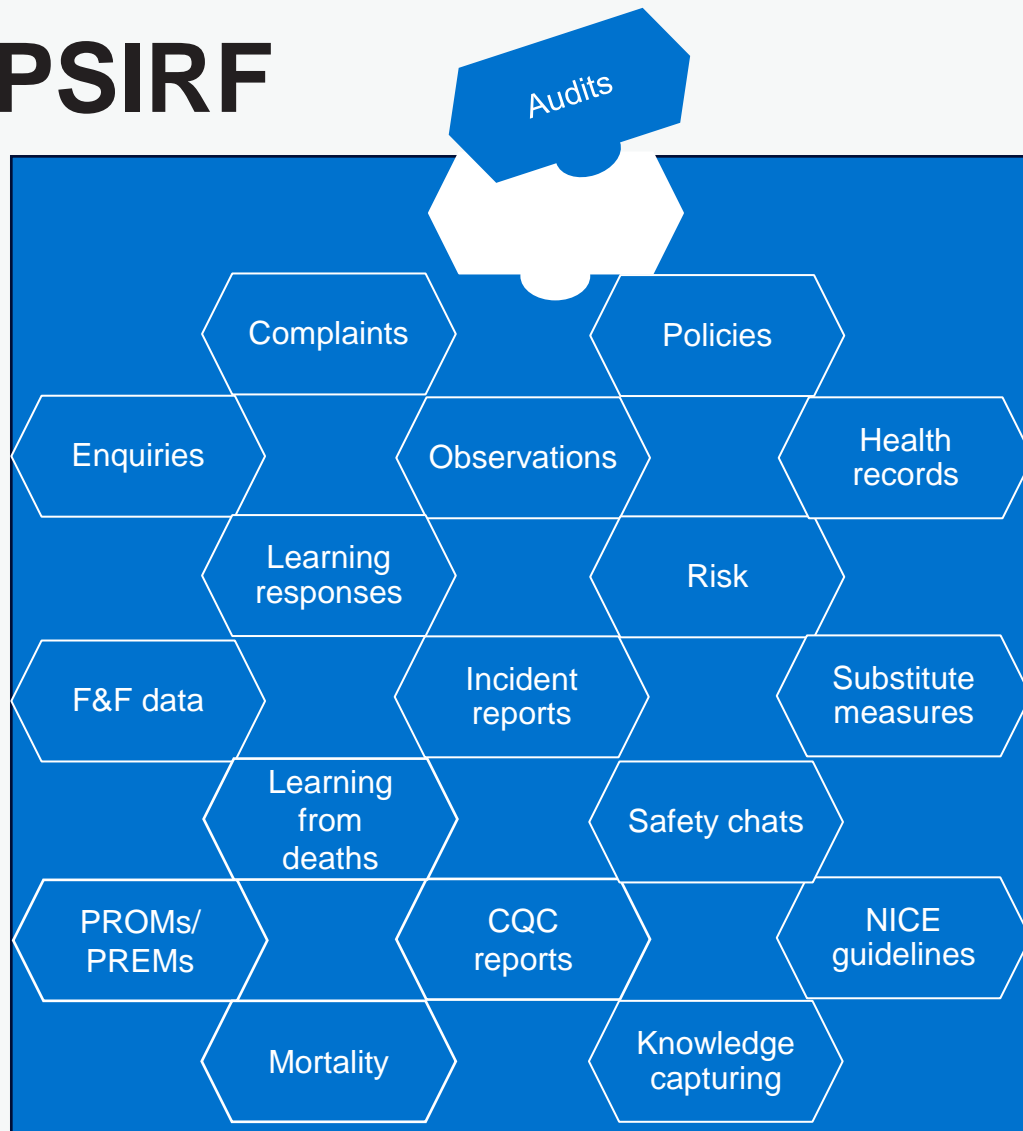


CONTINUING TO LEARN & EVOLVE OVER FUTURE YEARS

Opportunities to:

- Improve clarity for patients
- Focus more on inequalities
- Focus on ‘improvement’ priorities rather than ‘response’ priorities

PSIRF

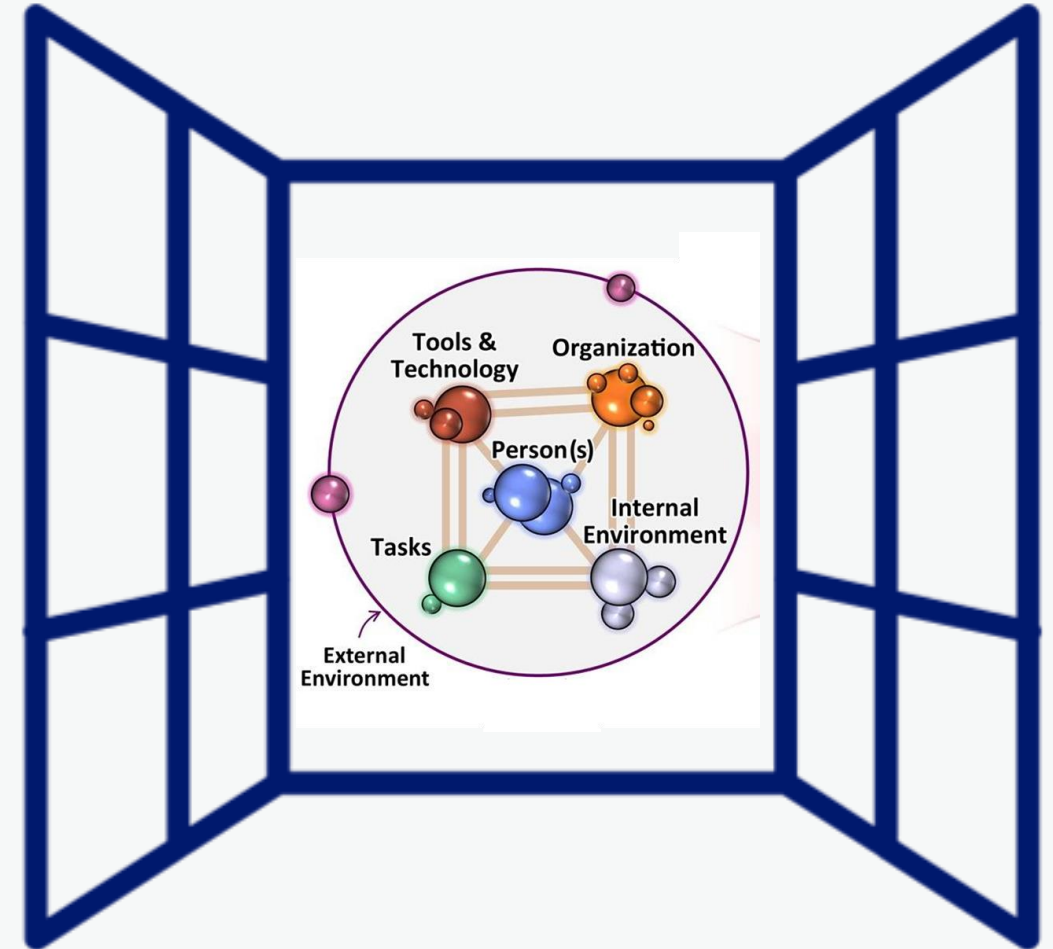


Systems based approaches



How is the approach different?

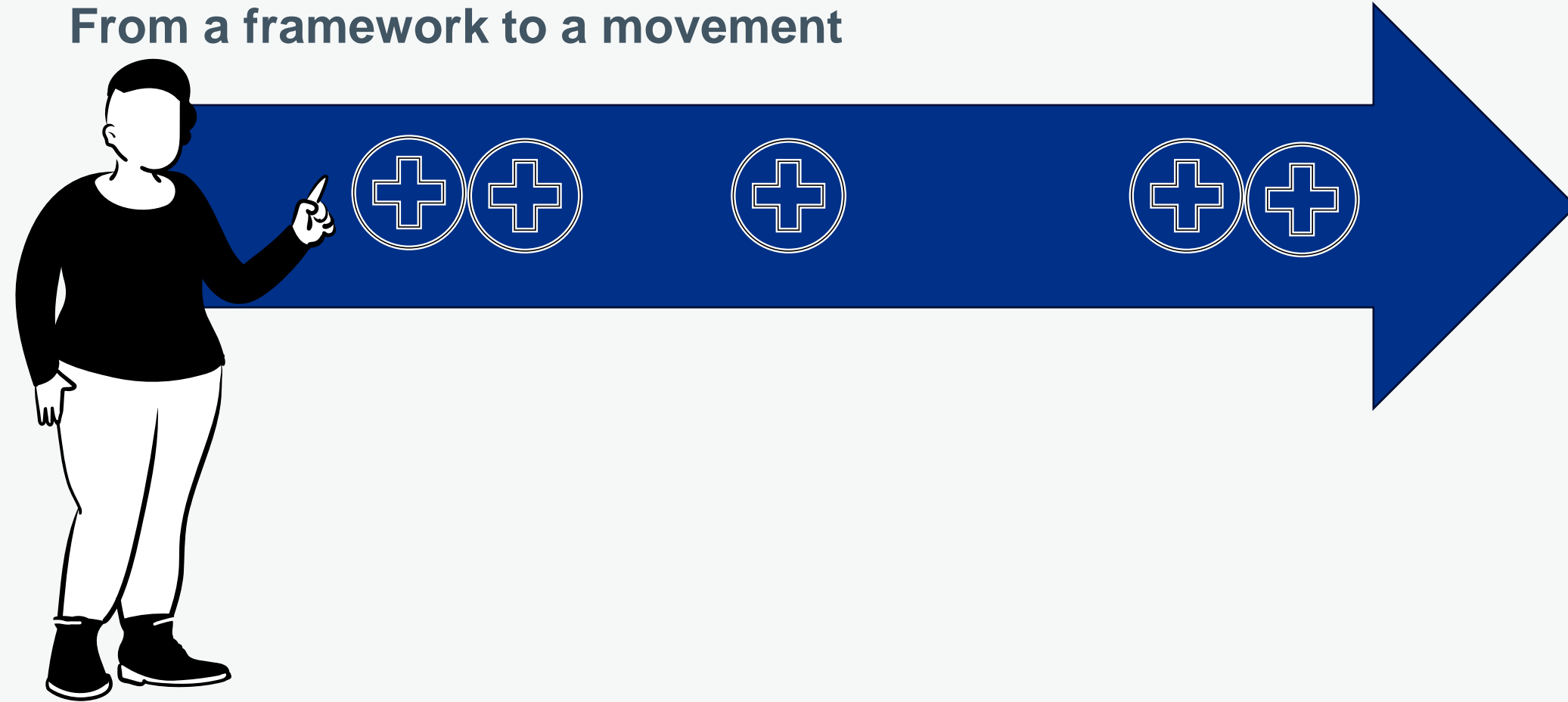
- Uses incidents as a 'window on the system'



[Analysis of clinical incidents: a window on the system not a search for root causes | BMJ Quality & Safety](#)

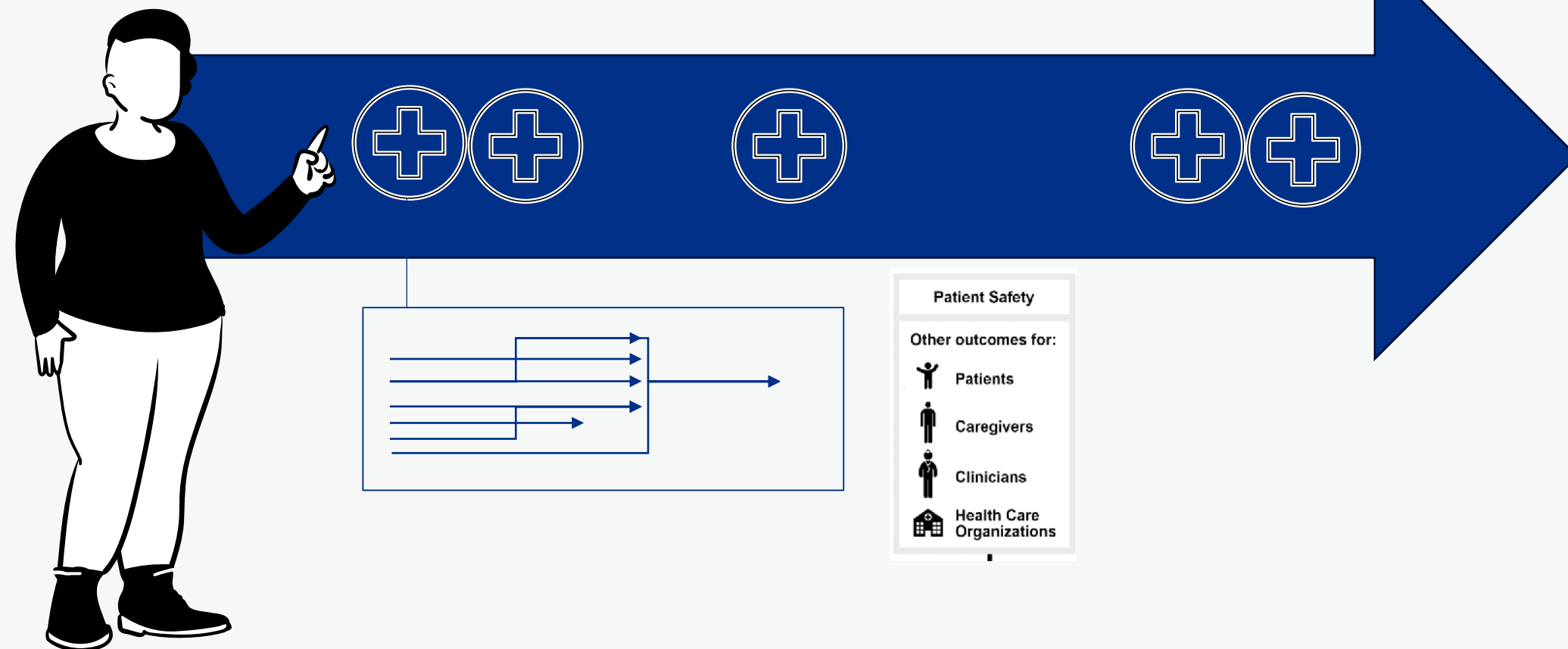
Audit's role

From a framework to a movement



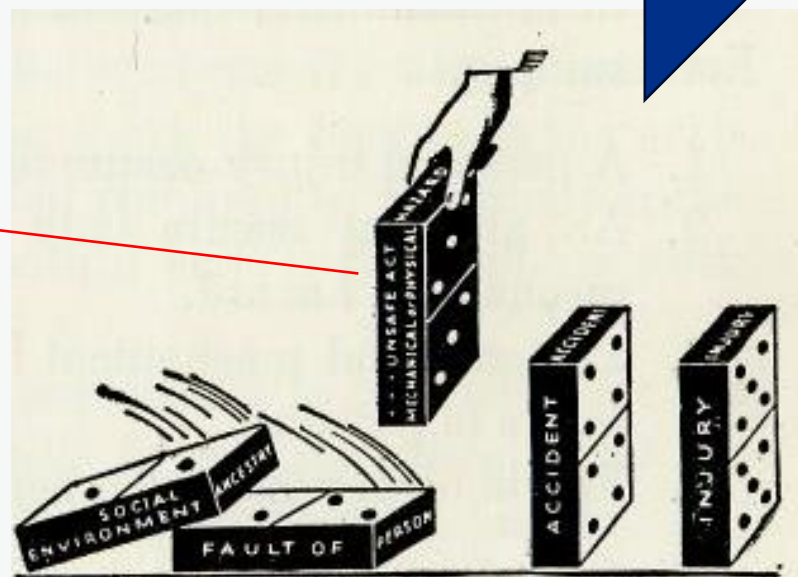
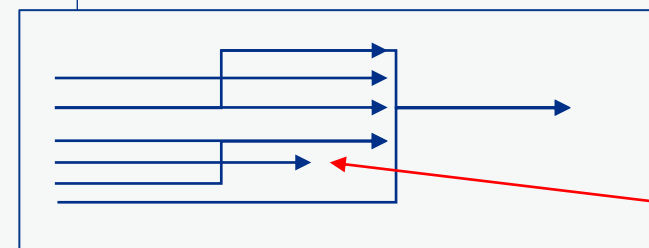
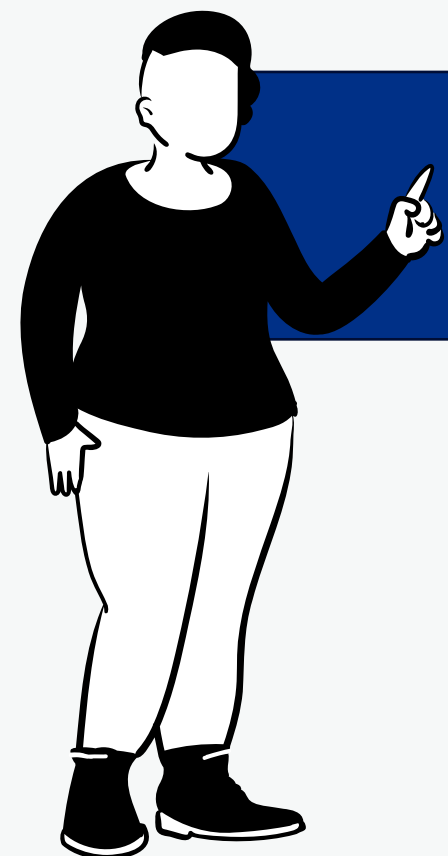
Audit's role

From a framework to a movement



Audit's role

From a framework to a movement



Heinrich, H. (1941) *Industrial Accident Prevention: A Scientific Approach*. Second Edition. New York, McGraw-Hill Book Company.

Systems based approaches

How is the approach different?

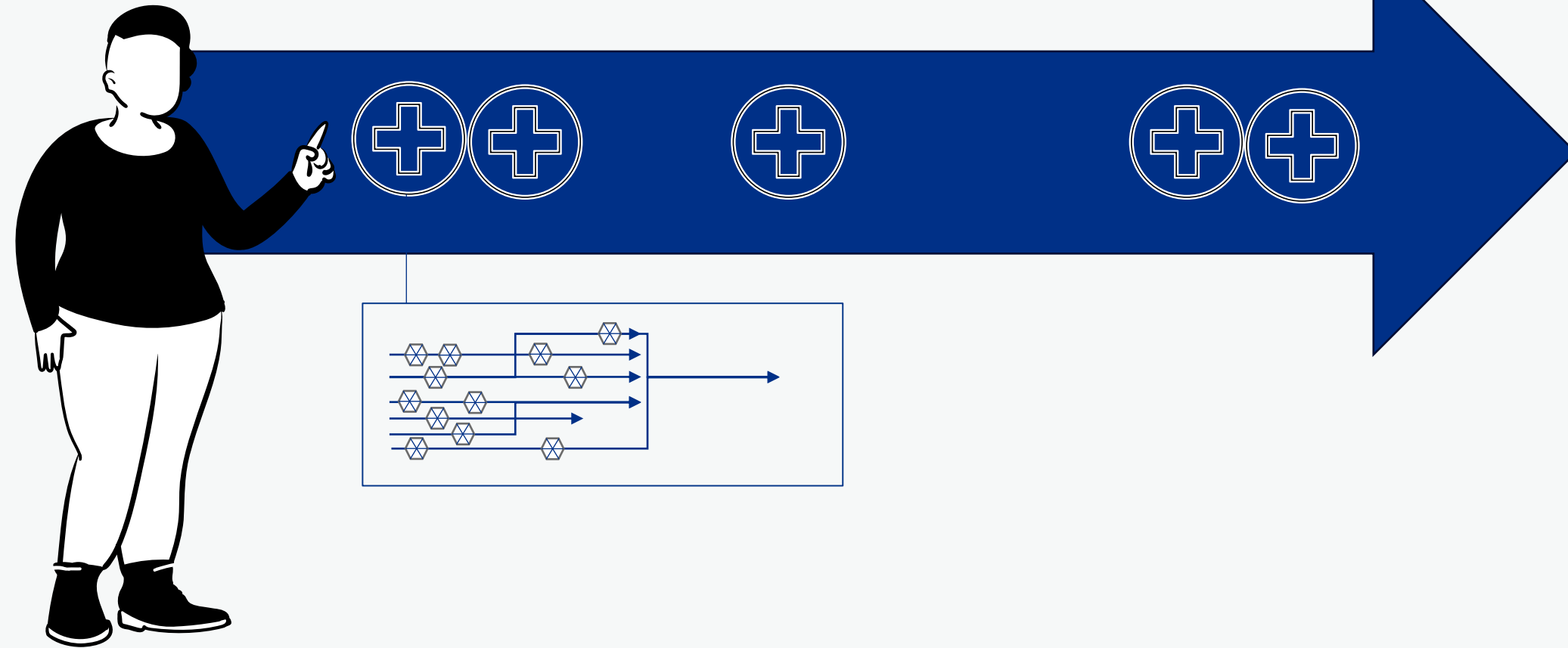


**Fixed range of
human
capabilities and
functioning**



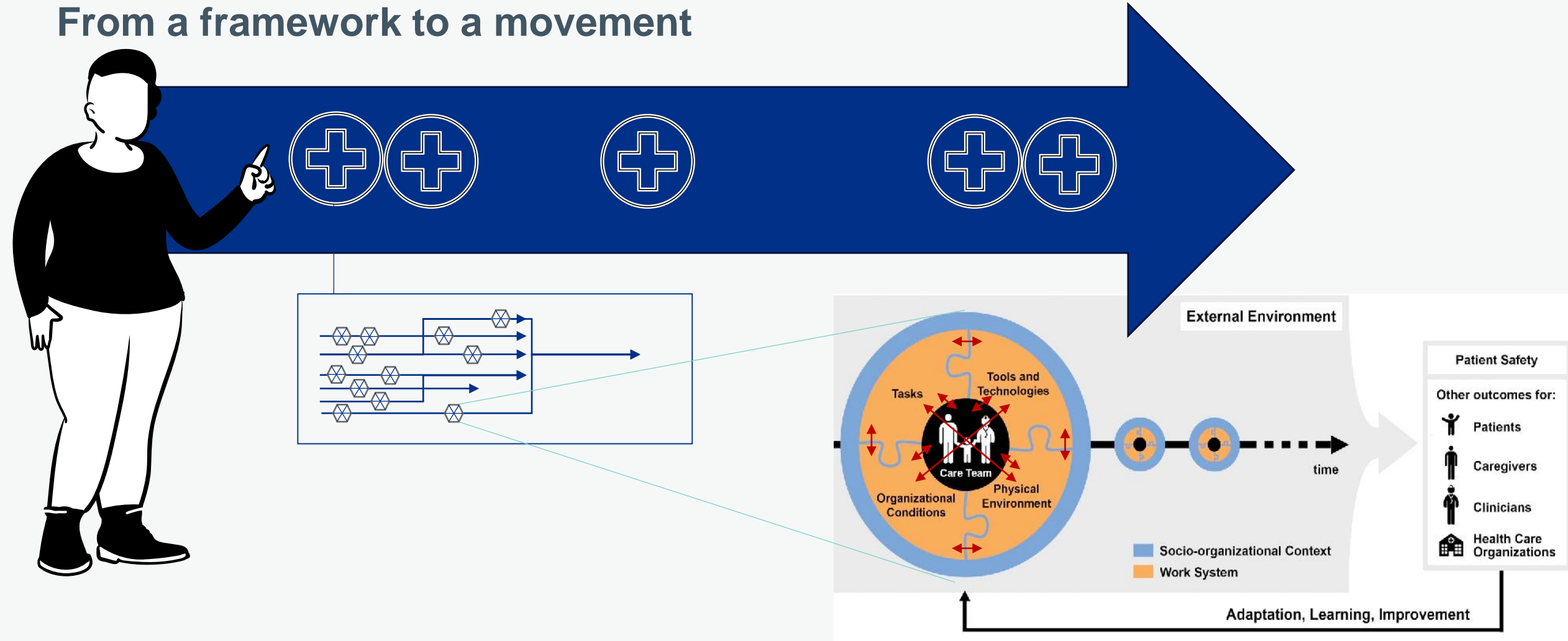
Audit's role

From a framework to a movement



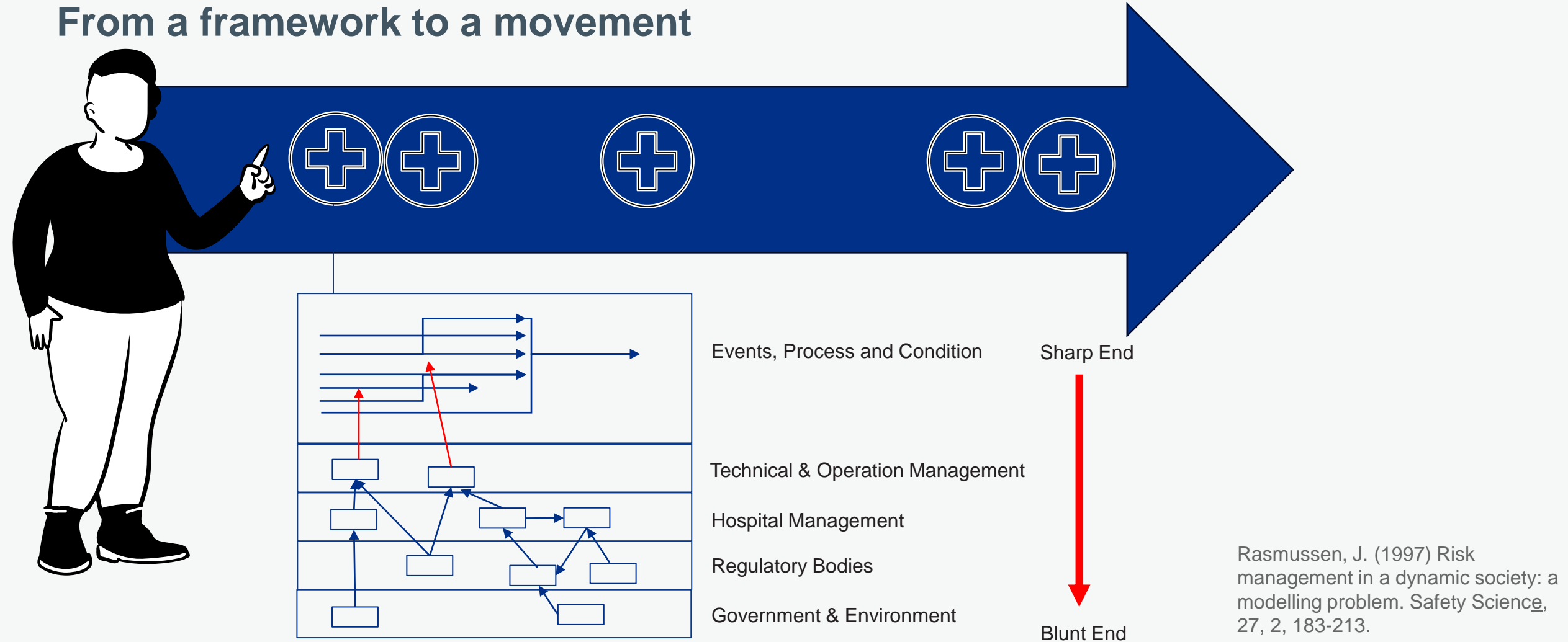
Audit's role

From a framework to a movement



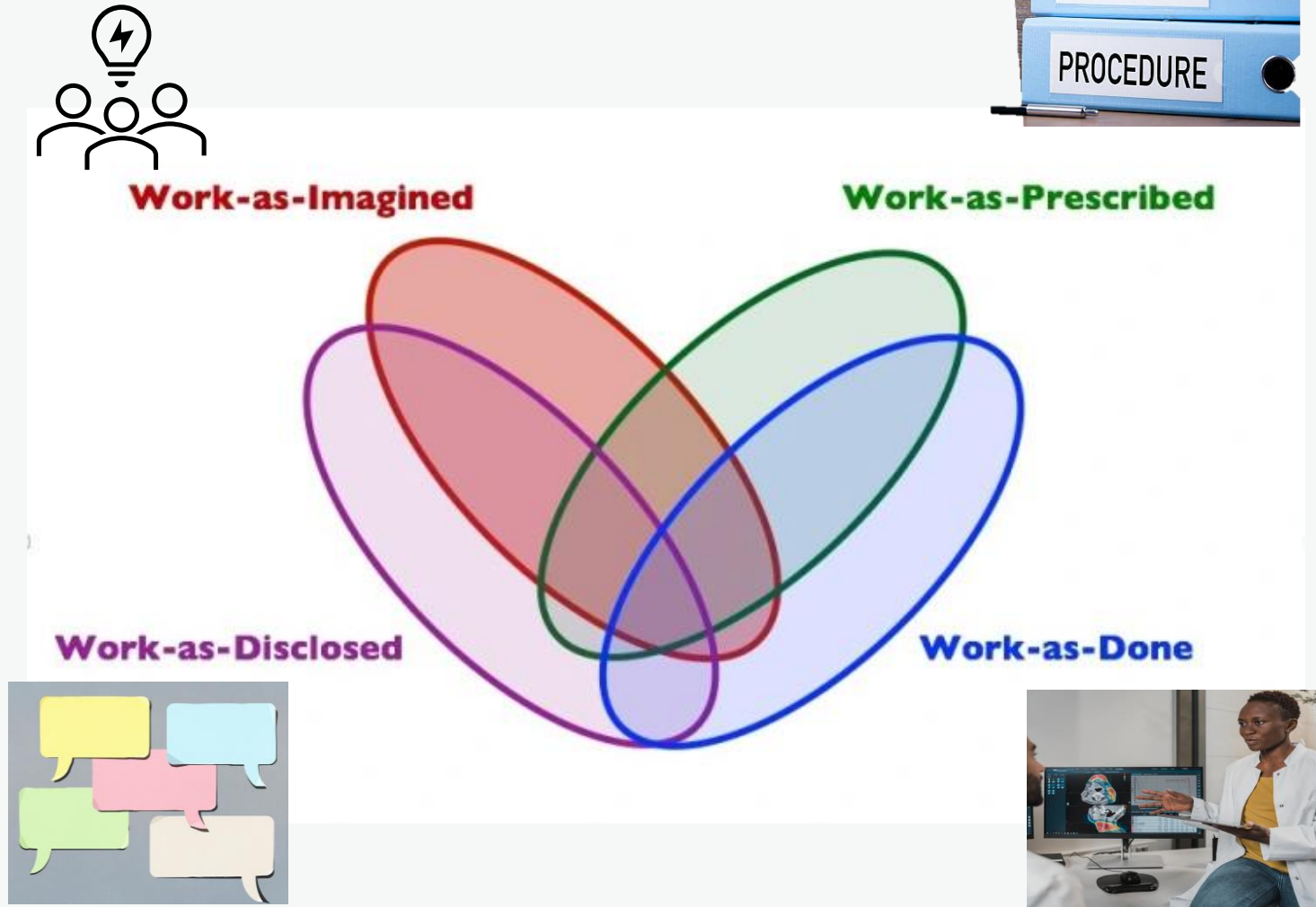
Audit's role

From a framework to a movement



Work-as-Done

- Gap between types of work
- Adaptions can be the resilience to make healthcare function
- Disclosure of drivers and barriers
- Operational know-how



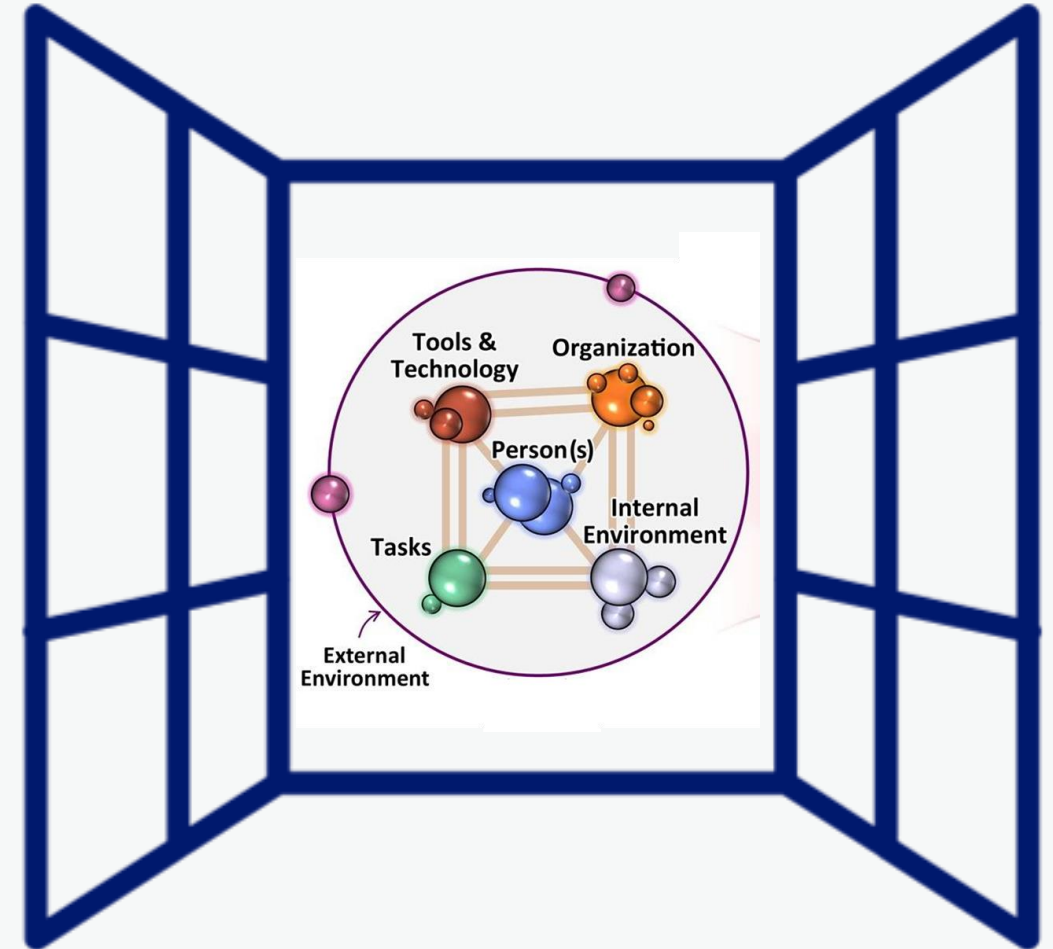
Shorrock, S. (2016) The Varieties of Human Work – Humanistic Systems. Available from: <https://humanisticsystems.com/2016/12/05/the-varieties-of-human-work/> (Accessed: 2 February 2022).

Systems based approaches



How is the approach different?

- Uses incidents as a ‘window on the system’
- Recognises safety arises from interactions and not from a single component as such learning does not focus on uncovering a (root) cause, but instead explores multiple contributory factors
- Emphasis on exploring everyday work shifts the focus from developing quick fixes to understanding wider system influences



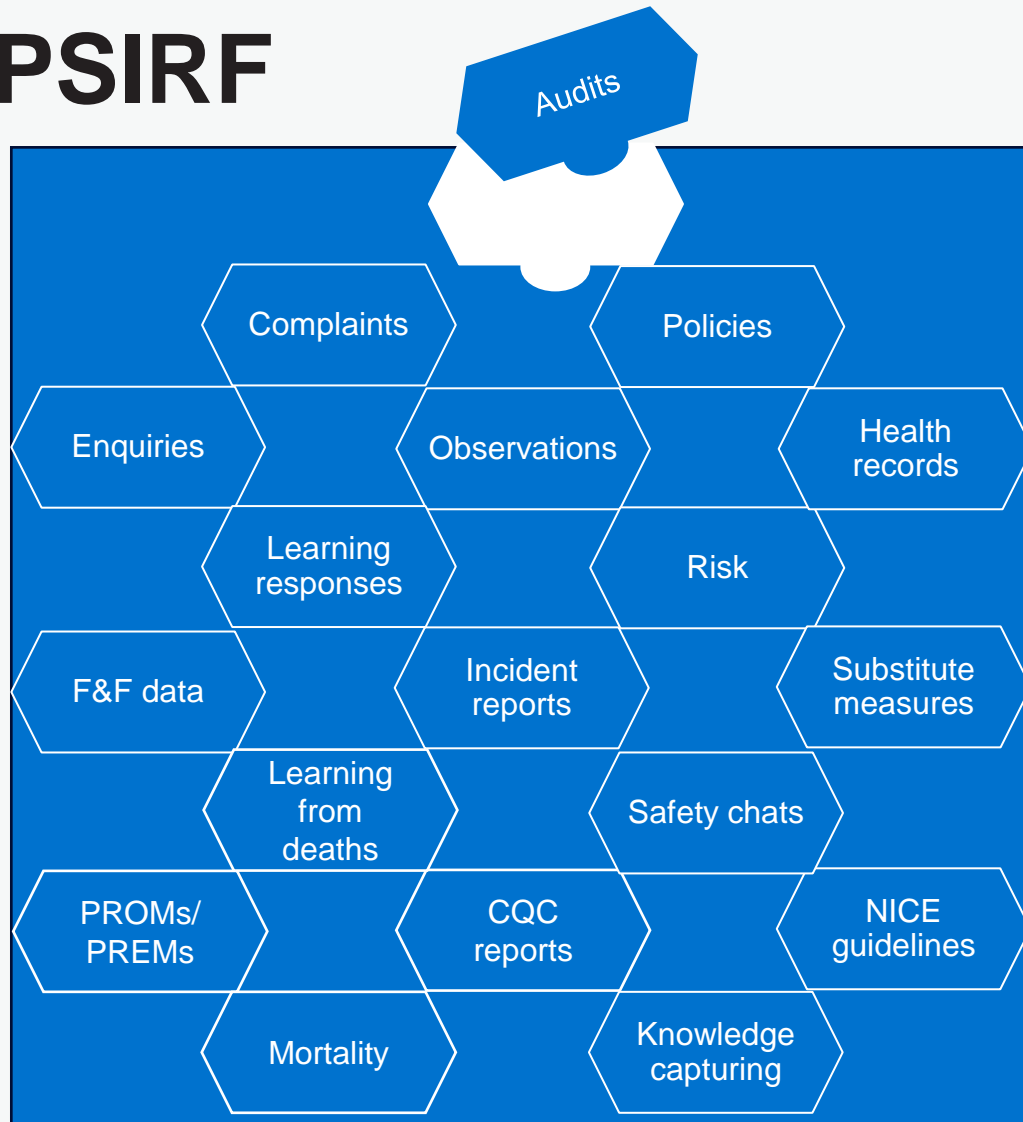
[Analysis of clinical incidents: a window on the system not a search for root causes | BMJ Quality & Safety](#)

Clinical Audit

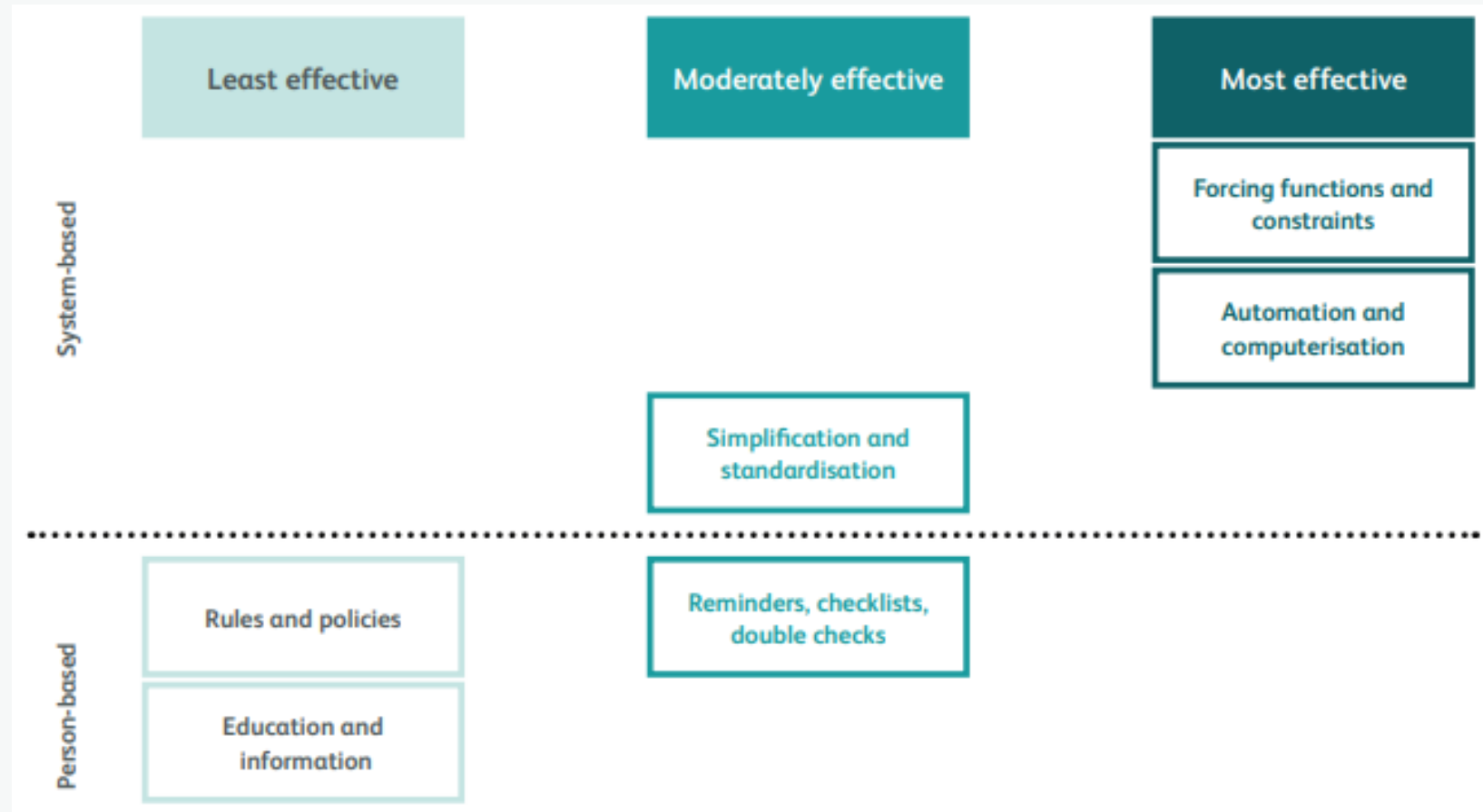
Make your mark



PSIRF



Hierarchy of Effectiveness



Improvement

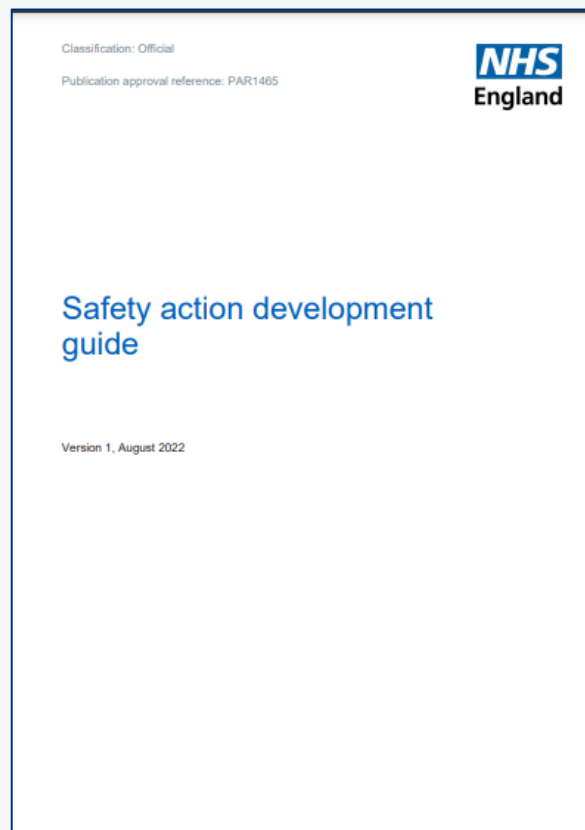


Table 1: Overview of safety action development according to context

	Local context	Organisation context
Definition	Specific area for improvement highlighted by a single (or multiple) learning responses	Broader area for improvement identified across several learning responses – likely not in response to any single patient safety incident but incidents with common contributory factors across events. Likely require radical system redesign
Examples of areas that may require improvement	Environment layout and characteristics (eg light, noise) Tool design Task design Training	Deep routed organisational issues, likely with long histories and dynamics, eg: <ul style="list-style-type: none"> Staffing, rotas, etc IT infrastructure Workload Fatigue Culture Handovers Procurement Policies
Development team	Learning response team Involvement of local team to design and implement Quality improvement team Those affected by the incident	Learning response team Involvement of local and broader team to design and implement (eg leadership, management) Quality improvement team Those affected by the incident
Tools	SEIPS/HFIX (see Appendix A) iFACES (see Table 3)	
Methods for developing safety action	Interviews Observations Focus groups Desktop reviews Simulation/testing Standards quality improvement methods such as PDSA cycles	Qualitative review of patient safety learning response findings Surveys Literature reviews – what has worked well elsewhere? Focus groups Consensus panel – reaches a wider group of members with experience of work
Expectation for recording	Included in learning response report (eg patient safety incident investigation (PSII) report) after an individual incident response or in wider safety improvement plan as appropriate.	Included in a safety improvement plan bringing together findings from various responses

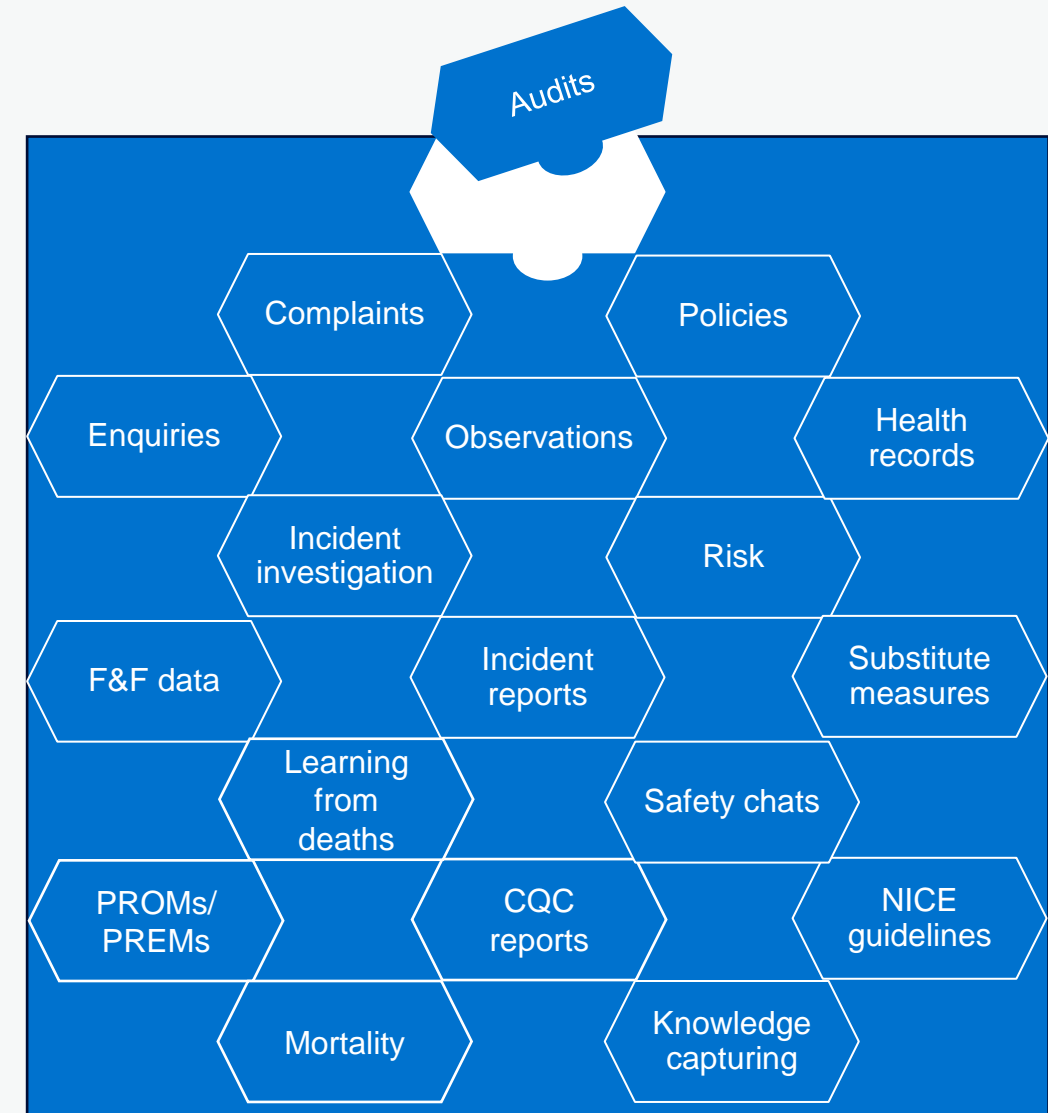
Area for improvement	Set out where improvement is needed	
Work system	Person(s)	How can individual or team characteristics be modified or changed to reduce risk or improve performance?
	Tasks	How can the task or activity be modified or redesigned to reduce risk or improve performance?
	Tools and technology	How can tools, equipment or technology be modified or redesigned to reduce risk or improve performance?
	Internal environment	How can the physical environment be modified or redesigned to reduce risk or improve performance?
	Organisation	How can organisational factors be modified or redesigned to reduce risk or improve performance?
	External environment	How can regulatory or societal factors be modified or redesigned to reduce risk or improve performance?

Table 3: iFACES criteria and scoring rubric

Criterion	Low	Medium			High
	①	②	③	④	⑤
<u>Inequality</u> Does the intervention ensure fair treatment and opportunity for all?	The intervention is not accessible to the diverse population that will use it.	The intervention accommodates some inequalities but further investigation is needed.			Inequalities are reduced by this intervention.
<u>Feasibility</u> Can the change be implemented relatively easily or quickly?	The intervention does not exist today nor is it likely to become available in the near future; it is highly impractical and not suitable for your organisation.	The intervention exists but is not readily available or will require modifications to better fit the context in which it is intended to be used.			The intervention is readily available and could be implemented in a relatively short period of time without much effort.
<u>Acceptability</u> Will those being impacted by the intervention readily accept the change?	The intervention will not be tolerated by those it impacts. People are likely to consistently resist the change and attempt to work around the change.	The intervention will be tolerated by those it impacts. There may be moderate resistance but attempts to undermine the change will not be wide spread.			The intervention will be readily accepted by those it impacts. People are likely to welcome the change and make every attempt to ensure it works.
<u>Cost/Benefit</u> Does the benefit of the intervention outweigh the costs?	The cost of the intervention is exorbitant relative to its minimal expected impact on safety and performance.	The intervention is moderately expensive but cost could be justified by its expected benefit. Return on investment (benefits) is relatively equal to cost.			The cost of the intervention is nominal relative to the expected impact on safety and performance.
<u>Effectiveness</u> How effective will the intervention be at eliminating the problem or reducing its consequences	The intervention will not directly eliminate the problem or hazard and it relied heavily on wilful compliance with the change and/or requires humans to remember to perform the task correctly.	The intervention reduces the likelihood of the problem or hazard occurring but relies in part on human memory and/or wilful compliance with the change.			The intervention will very likely eliminate the problem or hazard and it does not rely on wilful compliance with the change or require humans to remember to perform the task correctly.
<u>Sustainability</u> How well will the intervention last over time	The impact of the intervention will diminish rapidly after it is deployed and/or will require extraordinary effort to keep it working.	The benefits of the intervention may have a tendency to slowly dissipate over time and will require moderate efforts to maintain its benefits.			The impact of the intervention will persist over time with minimal efforts being required to maintain its benefits.

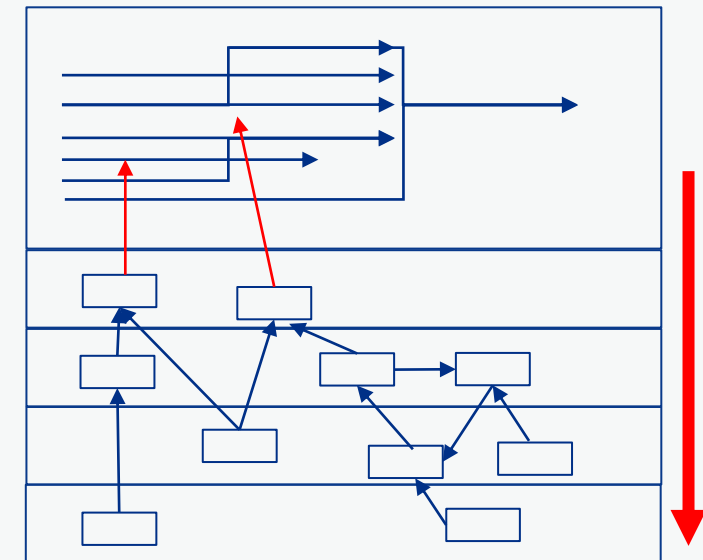
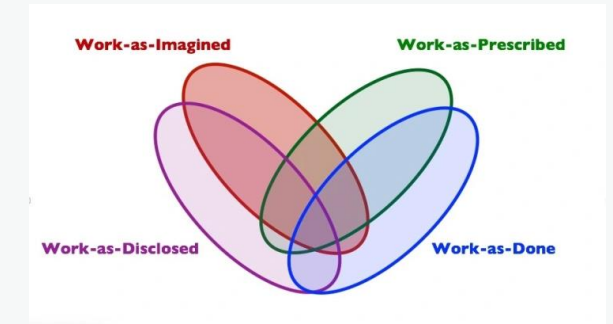
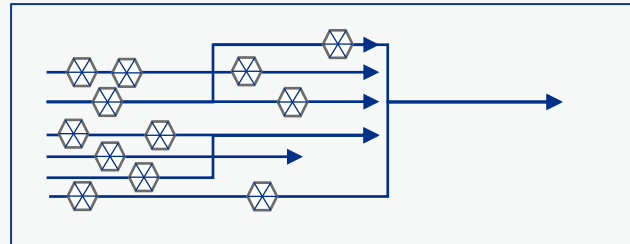
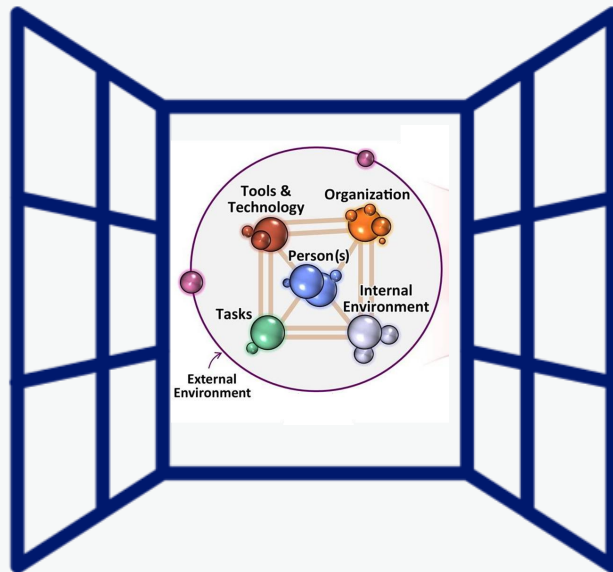
Clinical Audit

1. Audit can inform the safety profile of an organisation and PSIR planning



Clinical Audit

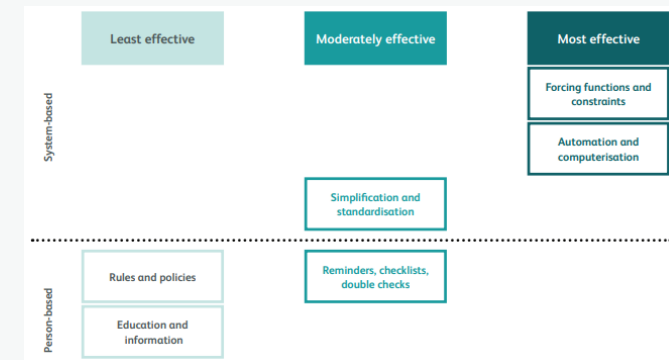
1. Audit can inform the safety profile of an organisation and PSIR planning
2. PSIR and PSIRF can be used to understand better what audit is highlighting (PSIRF toolkit)



Clinical Audit

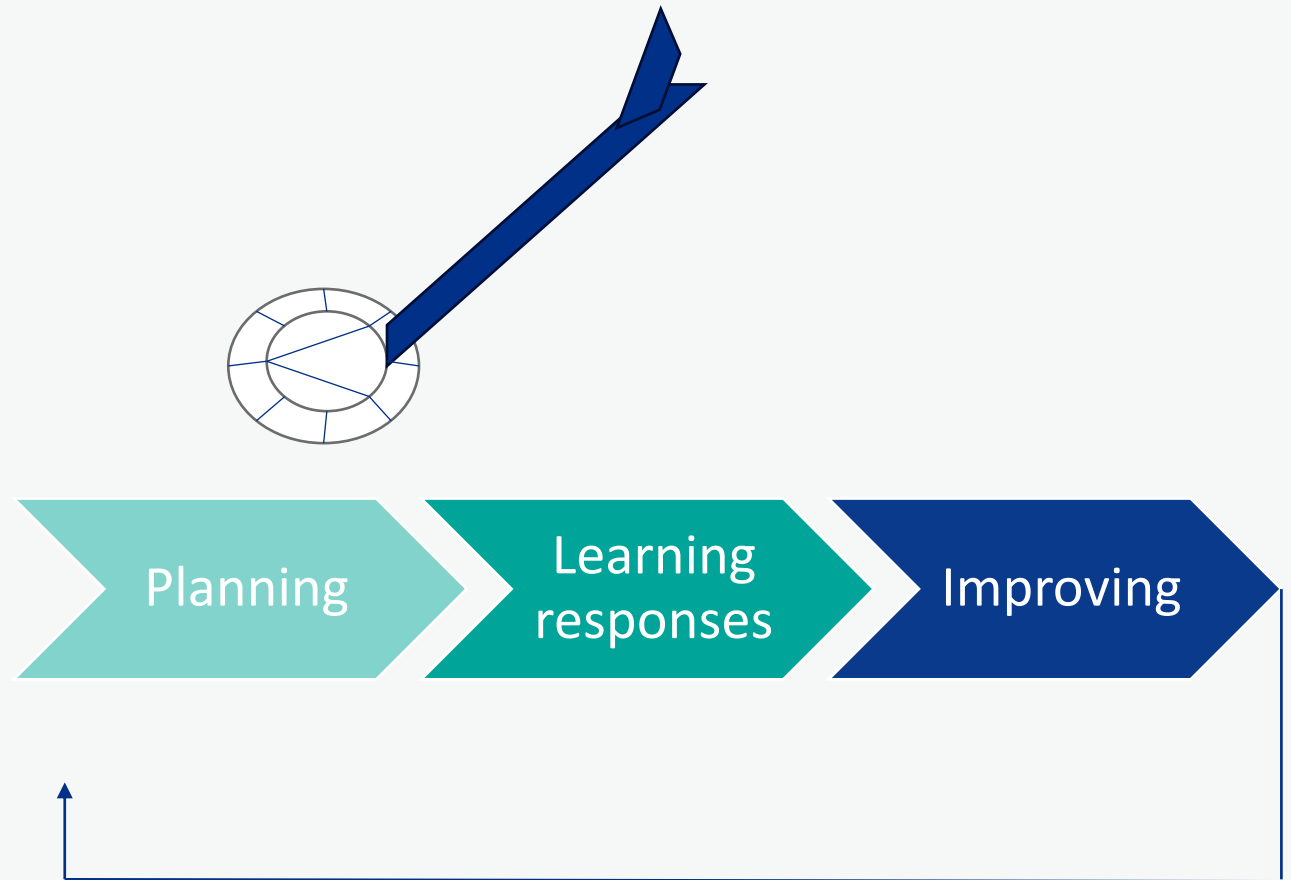
1. Audit can inform the safety profile of an organisation and PSIR planning
2. PSIR and PSIRF can be used to understand better what audit is highlighting (PSIRF toolkit)
3. PSIR focus on effective improvement rather than response (PSIRF toolkit)
4. Audit can be used throughout PSIR

HFIX & iFACES



PSIRF

1. Audit can inform the safety profile of an organisation and PSIR planning
2. PSIR and PSIRF can be used to understand better what audit is highlighting (PSIRF toolkit)
3. PSIR focus on effective improvement rather than response (PSIRF toolkit)
4. Audit can be used throughout PSIR



Rachel.pool2@nhs.net

Head of Patient Safety
Implementation

Thank You



@ptsafetyNHS



<https://www.england.nhs.uk/patient-safety/incident-response-framework/>

CLINICAL AUDIT AWARENESS WEEK 2024

Featuring the Clinical Audit Heroes Awards



PATIENT SAFETY And the winners are...



#CAAW24

INFLUENCING CHANGE

Highly Commended

Gastroenterology
Department
Sandwell and West
Birmingham NHS Trust



Sandwell and West Birmingham
NHS Trust

INFLUENCING CHANGE

And the winners are...

Northumbria
Parkinsons Disease QIP
Team
Northumbria Healthcare
NHS Foundation Trust



Northumbria Healthcare
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NHS Foundation Trust



Northumbria Healthcare
NHS Foundation Trust

A graphic featuring a large blue arrow pointing to the right. The word 'THE' is in a green box above the arrow, and 'NORTHUMBRIA WAY' is written in white on the arrow itself.

**THE
NORTHUMBRIA WAY**

PEOPLE CARING FOR PEOPLE

Healthcare Quality Improvement Partnership Clinical Audit Heroes Award 2024

Dr James Fisher (on behalf of the Northumbria Parkinson's Disease QIP team)

building a caring future

HOSPITAL | COMMUNITY | HOME

www.northumbria.nhs.uk

The Northumbria Parkinson's QIP Team

Dr. James Fisher, Consultant Geriatrician

Amanda Gordon, Practice Development Lead

Rachel Carter, Director of Patient Safety

Amber Cruddos, Practice Development Nurse

Suzanne Herkes, Patient Safety Improvement Facilitator

Charlotte Scott, Senior Clinical Pharmacist

Rachel Magee, Speech & Language Therapist

Elaine Bolam, Speech & Language Therapist

Michael Hardy, Pharmacy Technician Team Leader (Informatics)

Dr. Giovanni Di Paolo, Internal Medicine Trainee

Callum Brown, Improvement Facilitator, Patient Safety and Improvement Team



Northumbria Healthcare
NHS Foundation Trust

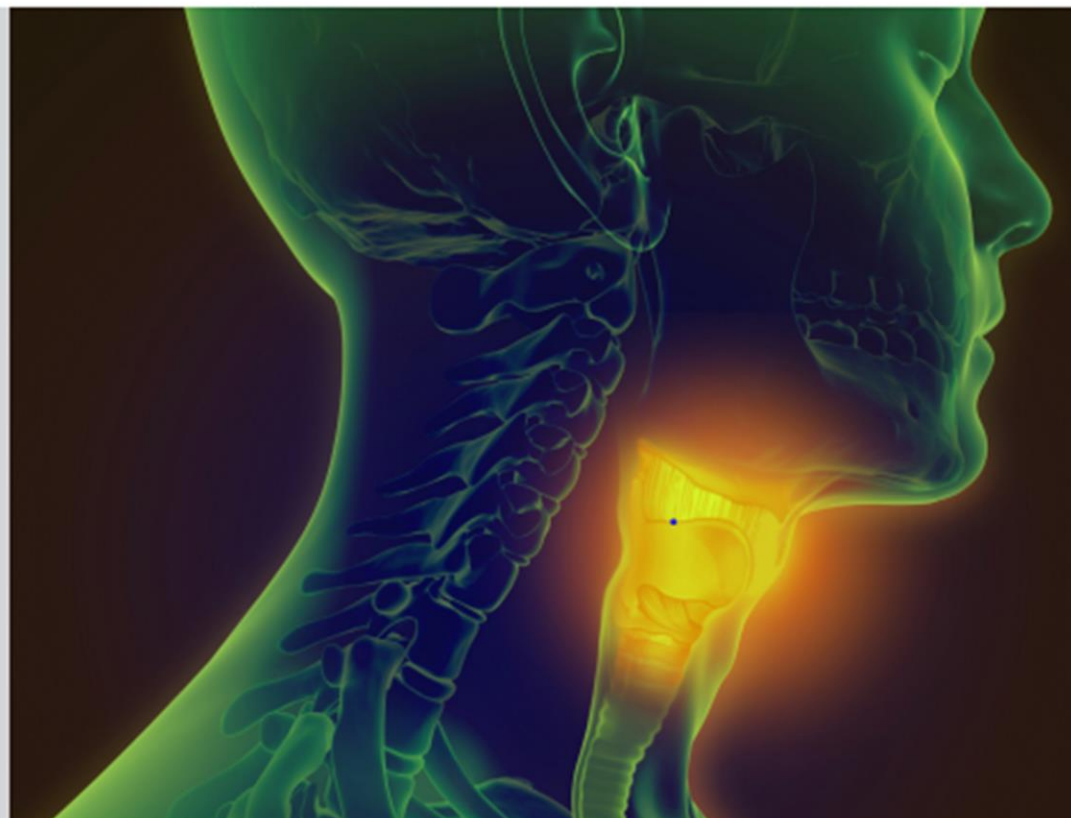


Why Parkinson's?



Hard to Swallow?

A review of the quality of dysphagia care provided to patients with Parkinson's disease aged 16 years and over who were admitted to hospital when acutely unwell



Northumbria Healthcare
NHS Foundation Trust







Aims & Objectives

- To reduce delays in time critical medications
 - Eradicate delays in administration of Parkinson's (PD) medicines of over 60 minutes
 - Ensure that 95% of PD medicines are administered within 30 minutes



Northumbria Healthcare
NHS Foundation Trust

PARKINSON'S^{UK}
CHANGE ATTITUDES.
FIND A CURE.
JOIN US.

PART 1: THE FIRST 24-48 HOURS AS IN-PATIENT

Confirm their medicine regime	Ask the patient and their relatives what they take and when
	Refer to most recent information - clinic letter, repeat prescription or discharge summary
Get the medicines in on time	When was the last dose given? When is the next dose due? Ensure handover to colleagues
	Zero tolerance for missed meds - they are always available - consult Omniview / on-call pharmacist
Think swallow for all patients	Can they swallow food, fluids and their medicines?
	Ask for an early ward-based swallow assessment for all patients and then, if indicated, a speech and language therapy (SaLT) review.
What to do if nil by mouth?	Don't let patients miss their medications: suddenly stopping them can be life-threatening
	Use our non-oral medication calculator to determine dose / route required: pdmedcalc.co.uk
Being proactive	Aim to sit the patient out of bed or, at the very least, up in bed (to reduce risk of pneumonia)
	Early referral to physiotherapy
	Ensure bowels are working - constipation very commonly causes worsening PD symptoms
Avoid culprit drugs	These include: haloperidol, metoclopramide, prochlorperazine
Let us know they are an in-patient	Contact the PD team on 0191 2934167 or parkinsons@northumbria-healthcare.nhs.uk
	Leave a message if there is no one available and we will get back to you

Staff Nurses

Junior Doctors

Pharmacists
and Pharmacy
Tech

Advanced
Care
Practitioners

Nutritional
Assistants

Speech &
Language
Therapists

Physicians'
Associates

Ward
Managers

Ward Sisters

Healthcare
Assistants

Trainee
Nursing
Assistants

Consultants &
Registrars

172 staff
trained
across
3 wards

Parkinsons think medication!

Get it on time

Zero tolerance for missed meds

Think swallow

Contact the PD team

Search 'Parkinsons' on the staff portal to find out more

Adult Nursing Assessment

[Previous assessment](#)

Does the Patient have any of the following?

> 65 Years Old

Diabetes

☒ Parkinsons

Neuropathy

Stroke

None of the Above

pdmedcalc.co.uk



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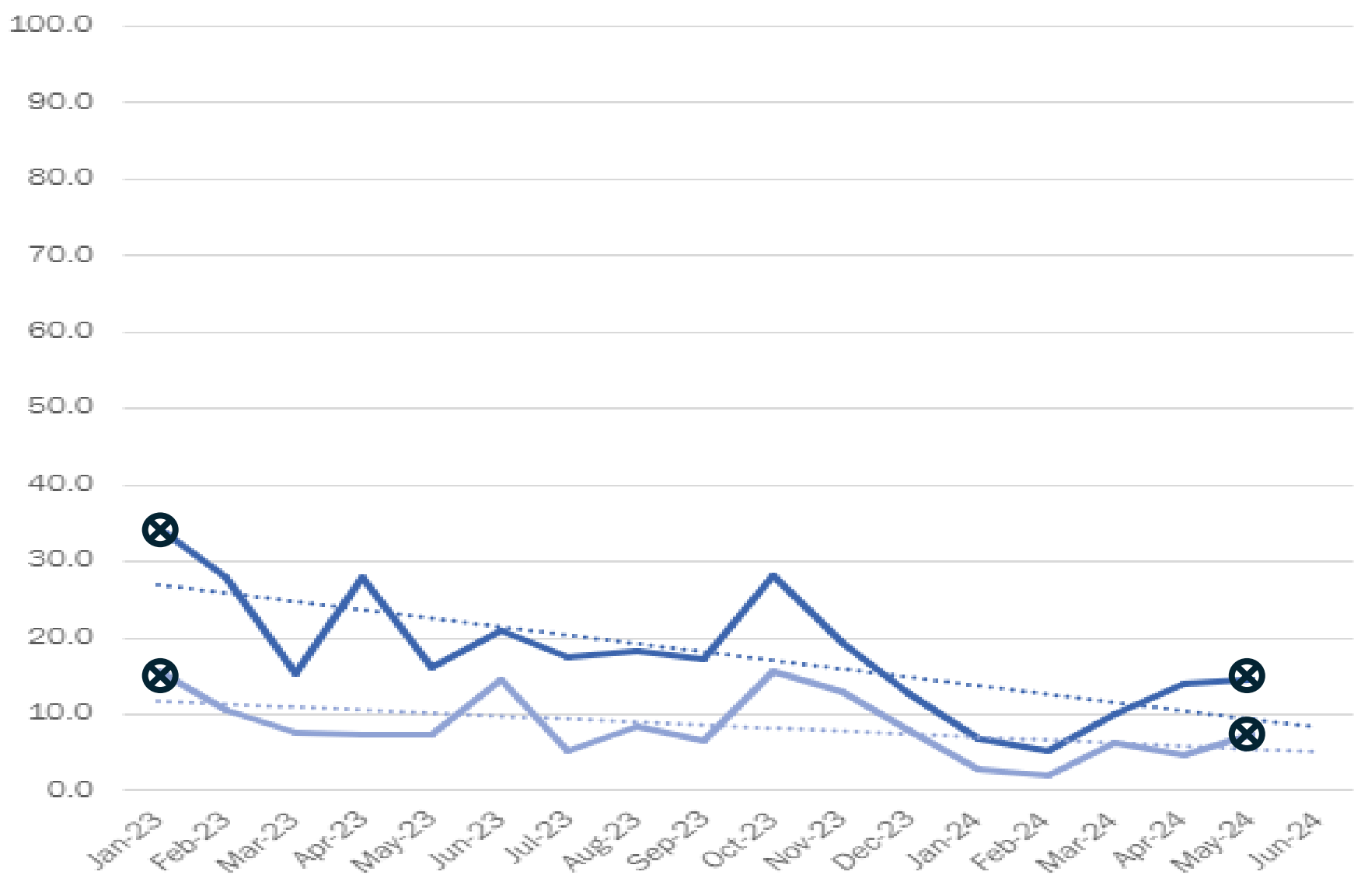
Northumbria Healthcare
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PDMedCalc

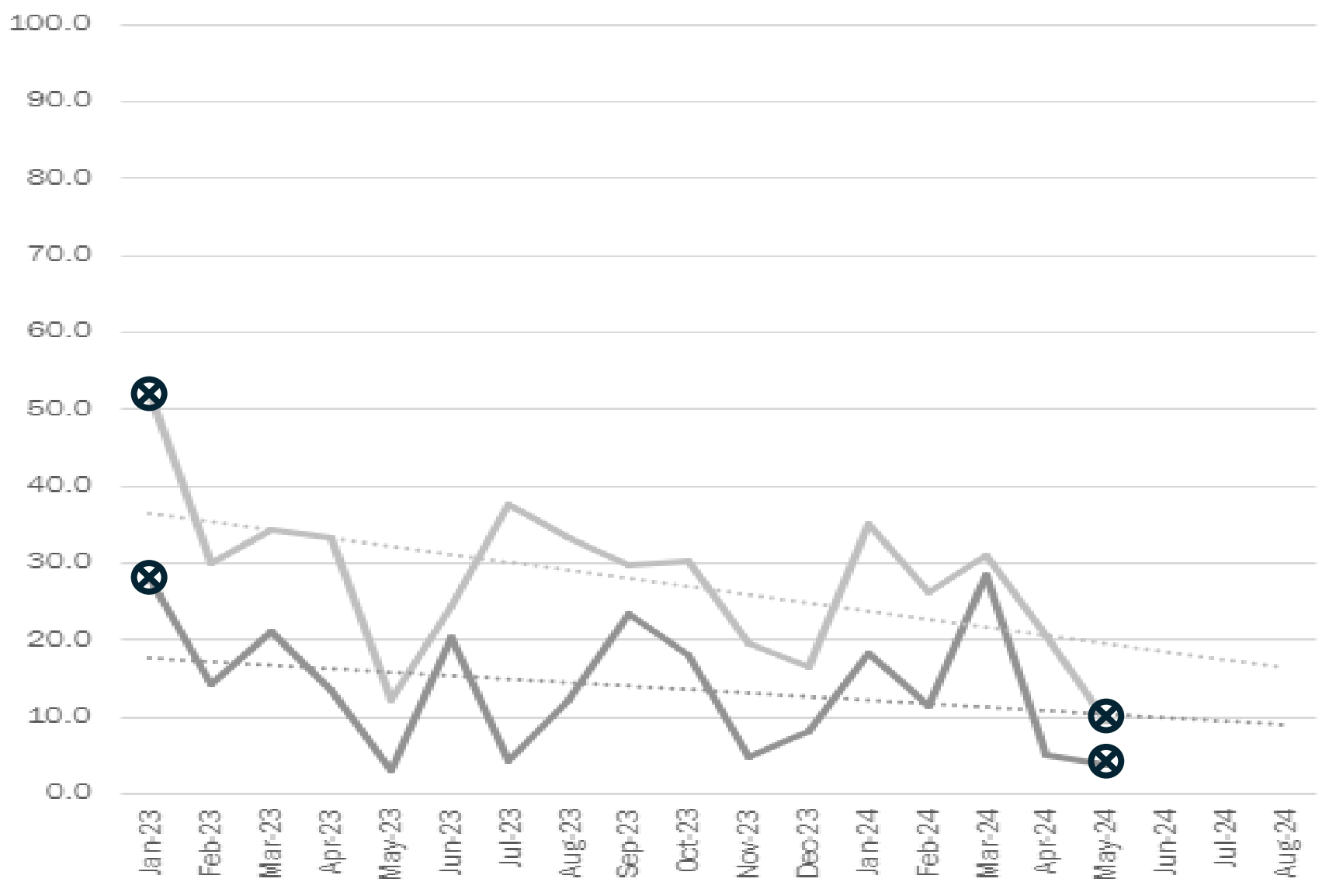
Who is this tool for?

Doctors, nurses and pharmacists who are looking after patients with Parkinson's Disease (PD) who have been admitted to hospital and are unable to take their medications orally.

% Delayed Ward 9 NSECH



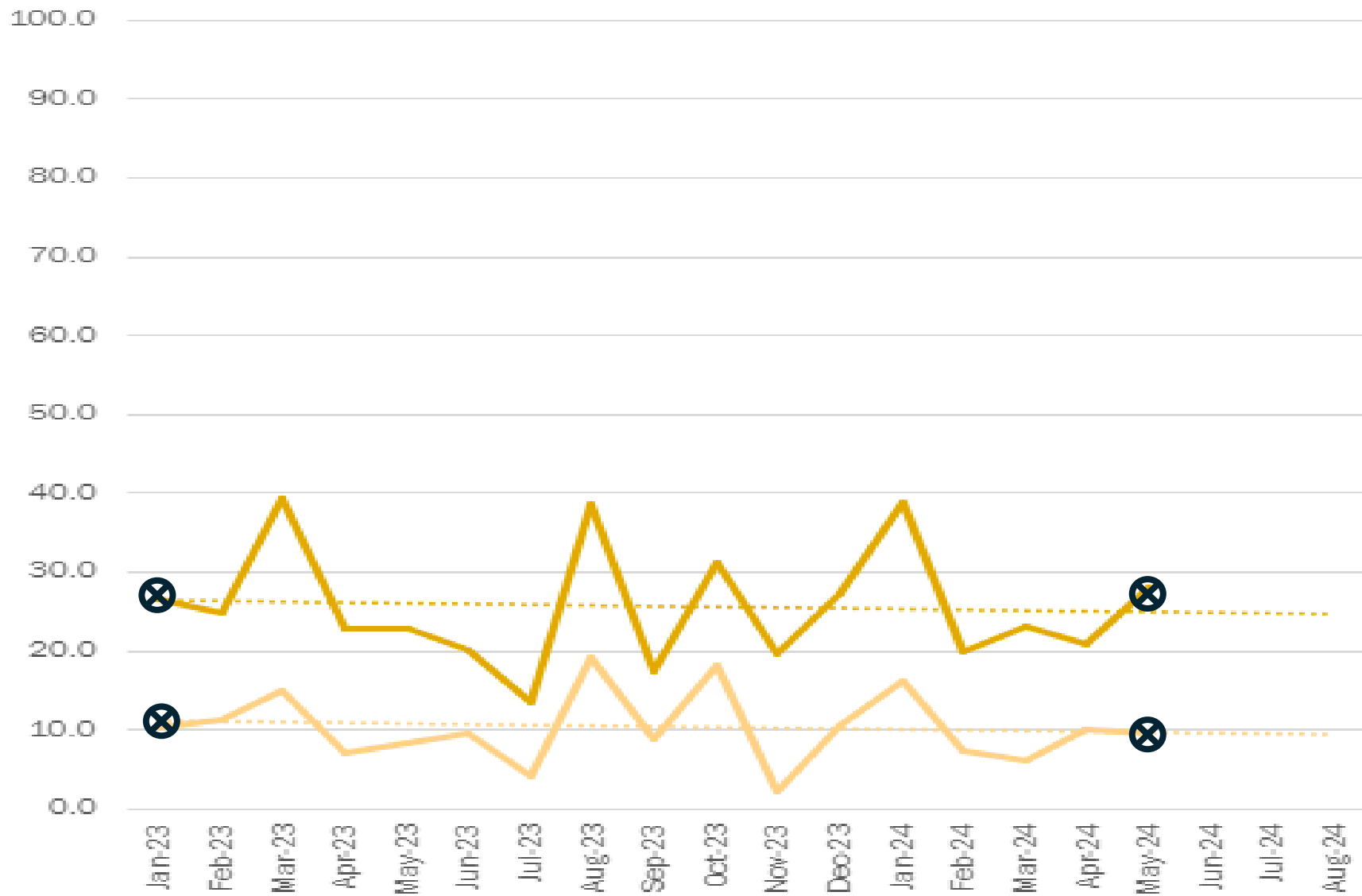
% Delayed Ward 3 NSECH



% Delayed Ward 6 NSECH

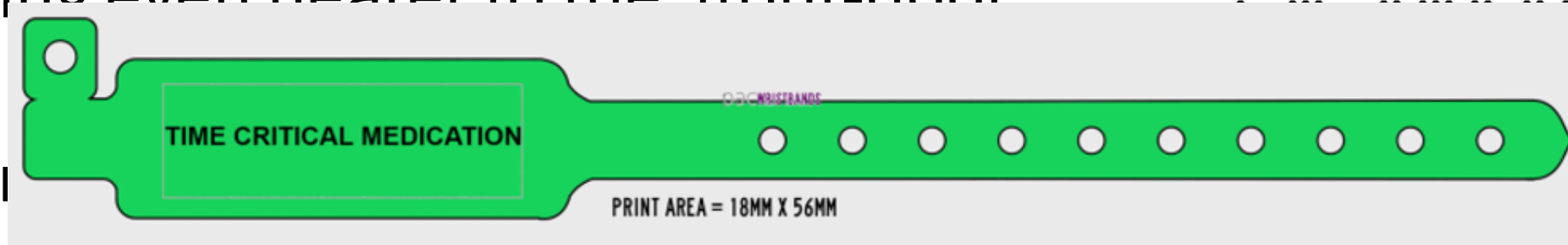


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What next?

- Time critical medicine wrist-band
- Pushing even nearer to the 'front-door'
- Parking
- Microteaching part 2



Lessons to share

- Harness the power of patient experience to win hearts and minds
- Micro-teaching, macro-impact!
- Embedding learning in the workplace
- Tech solutions offer potential, but pain... get expert help early!

Two stylized blue birds flying in the upper left corner of the slide.

Thank you

James.Fisher@nhct.nhs.uk

pdmedcalc.co.uk



Clinical Audit Awareness Week

#CAAW24



Opportunity for questions



Who is YOUR Audit Hero?

#CAAW24

Clinical Audit Awareness Week

#CAAW24



EVALUATION – MENTI

Your feedback is important to us

Please take a couple of minutes to complete our evaluation form



Part of Clinical Audit Awareness Week 2024, featuring the Clinical Audit Heroes awards

Evaluation



Who is YOUR Audit Hero?

#CAAW24

Clinical Audit Awareness Week #CAAW24



Monday 24 th June 2024 12.20-1.30pm	Tuesday 25 th June 2024 12.20-1.30pm	Wednesday 26 th June 2024 12.20-1.30pm	Thursday 27 th June 2024 12.20-1.30pm	Friday 28 th June 2024 12.20-1.30pm
Patient Safety - Effectively Utilising Clinical Audit To Prevent Avoidable Harm	Patient & Public Involvement - Effectively Utilising Clinical Audit To Improve Health & Care by Involving, Engaging & Informing Patients & The Public	Health Inequalities - Effectively Utilising Clinical Audit To Address Inequalities In Health & Care	Influencing Change - Effectively Utilising Clinical Audit To Influence Change At Board Level	Sustainability - Effectively Utilising Clinical Audit For Sustainability
Rachel Poole	Kim Rezel	Dr Charlotte Richardson & Danny Keenan	Sam Riley	Zoe Lord



Thank you for joining us today

Please join us again tomorrow for a focus on Patient & Public Involvement