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**Introduction**

*We are delighted to present a book of abstracts of projects undertaken in the Diploma in Leadership and Quality in Healthcare.*

We are keen to share with the wider health system these important improvement initiatives in order to share the learning from them, to highlight the quality improvement methodology adopted and to acknowledge the leadership shown by those who carry them out.

The Diploma in Leadership and Quality in Healthcare was developed and launched in 2011 by the Health Service Executive (HSE) and the Royal College of Physicians of Ireland (RCPI) to support and develop clinical leaders to drive quality improvement across the health system.

This book contains abstracts outlining the projects undertaken by graduates of the Diploma from 2016-2018. The projects address issues such as patient safety, leadership, quality, waste and financial matters. The author’s details are outlined for each abstract; please note the author’s job titles are based on when they completed their project and may not be current.

We hope that you enjoy reading about the body of work undertaken and find it useful. Finally we would like to thank all of the graduates from the Diploma for sharing their learning and allowing the publication of this book.

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“CHATTERING”: Clinical Handover Among Teams To Ensure Risks Identified and No child Gets missed

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Abstract

Background
There was no formal structured clinical handover among medical teams as part of the patient safety system. Handover occurred on an ad hoc basis with or without consultant supervision with no designated location, time or defined attendance. The aim of this project was to improve patient safety and experience so 100% of patients admitted in the previous 24 hours were handed over using ISBAR3 (Identify, Situation, Background, Assessment, Recommendations, Risks, Read-back) from the on call team to the admitting consultant and team at a designated time and location by 30th June 2018.

Methods
The current admission process was observed and mapped. Baseline data was established on location, timing, attendance at handover and Non-Consultant Hospital Doctor (NCHD) knowledge and use of ISBAR3. Implementation tasks included, identifying a project sponsor, presentations to medical and nursing staff and Grand Rounds, identifying a suitable handover location and start time, designing supporting documentation and consultant led coaching in the language of ISBAR3. The team predications were tested through the process of numerous PDSA (Plan, Do, Study, Act) cycles. Medical and Nursing staff, and parents were consulted by interview or questionnaire on different aspects of handover.

Results
Clinical handover using ISBAR3 now occurs 100% of the time Monday to Friday at a designated time and location. Handover is consultant or Specialist Registrar led 100% of the time. Attendance from Registrars increased from 70% to 90%, Senior House Officers (SHOs) from non-attendance to 100%, and bed management from non-attendance to 80%. Average time to handover a patient decreased from 4.2 to 1.5 minutes

Discussion
Clinical handover is valued by the Corporate Management Team as part of the patient safety system. This was a cost neutral project, with potential human resource cost savings. It has the capability to positively affect safety and experience for all patients and staff. A structured clinical handover occurs on weekdays however challenges persist in achieving 100% Consultant led handover due to workload and locum cover. Junior doctor attendance has improved significantly, and a joint handover with Bed management has proved valuable to improving patient safety and experience. The project requires ongoing leadership and future plans include extending this process to weekends and
evening handovers. This project’s work will form part of the foundation of clinical handover in General Paediatrics in the New Children’s Hospital.
Improving Joy in work by creating a mentorship programme for Junior Doctors in Temple Street – A Reflection

Authors
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Abstract
The aim of this project was to improve the sense of wellbeing support for NCHDs in one of Dublin’s Children’s Hospitals. This was in response to multiple confirmed reports of stress among this group of doctors. The aim was to set-up a mentorship programme which would improve the sense of support for this group. This is also a reflection on the broader concept of “joy in work” as it relates to the project aim and this is based on the IHI’s white paper on this topic (2).

Method
The initial plan was to provide a mentoring programme for Senior House Officers (SHO’s). A survey was manually distributed to get the opinions on the SHO’s on this idea, based on results of this, the survey was extended to include registrars and then an additional change was made to the type of programme which could be offered and a further electronic survey was carried out. The results of these combined with the reflective piece of work have informed the progression of this study.

Results
The initial survey which was distributed manually and available to SHOs was completed by 8 SHOs and showed that all believed that if wellbeing at work was supported, quality of patient care improves. 5/5 felt that their wellbeing was currently supported, and all replied that a mentorship programme would improve the sense of wellbeing support. Half felt this should be provided by a consultant. The second survey was extended to registrars and showed similar results except that 7/8 felt currently supported. 4/8 agreed that a mentorship programme would help the sense of wellbeing and once again 4/8 felt that this should be provided by a consultant.

The initial intention had been to set up a peer mentorship programme, but results of above surveys indicated more interest in consultant involvement (the “what matters to you”). Based on this the next survey was to get opinion on how a mentorship group would work. This idea was based on the successful mentorship programme which runs in Melbourne Children’s Hospital. This survey was an electronic survey and was completed by registrars, SHOs and 1 intern, 15 non-consultant hospital doctors (NCHDs) completed in total. 13/15 were interested in the idea of a mentorship programme. 8/15 though that a consultant should be involved.
Conclusions

The concept of joy in work is a participative process and a mentorship programme which could improve the sense of camaraderie in a group of junior doctors who report daily work stress, could contribute to improving joy in work for this group. By conducting surveys, the appetite for such a programme became evident and further development of the survey allowed the “what matters to you” conversation to begin by finding out what type of a mentorship programme the target group would find most helpful. The results are based on small numbers but there is overall support for a programme with increased need in more junior medical staff. 50% of those surveyed felt consultants needed to be involved which was not the initial intention but is a very important outcome. This will allow demonstration of engagement with the concept of “joy in work” at a more senior organisational level.

The effect of this change needs to be measured which can be a challenge as there is no direct measure meant for joy in work, but a daily visual measure would seem like a reasonable first step.
Good to Go: The Introduction of Nurse Led Discharge in Gastroenteritis

Authors
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Temple Street Children’s University Hospital

Abstract
The Emergency Department (ED) at Temple Street Children’s University Hospital (TSCUH) has the highest volume of attendances among paediatric EDs in Europe. Current hospital infrastructure, limited isolation capacity, age/weight restrictions, and specialty needs combine to form an intricate system of patient flow. Some patients experience significant delays in awaiting transfer to inpatient beds or discharge from the emergency department, this is evidenced in the hospital ‘trolley wait’ and patient experience data.

A theory of change proposed that non-complex patients may be eligible for discharge by trained nursing staff using a set of agreed criteria. This intervention could decrease delays in patient discharge through a reduction in the time spent waiting for a medical review prior to going home.

Methods
Baseline data was collected and analysed to confirm the existence of delays for patients with gastroenteritis awaiting discharge. Surveys of parents and the workforce were undertaken to establish attitudes to the process of nurse led discharge (NLD) and discharges outside of standard working day hours. A number of plan, do, study act (PDSA) cycles were conducted in developing a baseline data collection method and a criteria tool to aid discharge decision making. A training programme was developed in collaboration with clinical education staff. Data collection continued and results were analysed following the introduction of the new process.

Results
Baseline data demonstrated a median of 120 minutes delay for patients with gastroenteritis awaiting discharge. Following the initial introduction of NLD there was a reduction to a median of 35 minutes delay for patients with gastroenteritis awaiting discharge and this has been sustained. 13 patients were discharged by NLD. There was no increase in admissions or readmissions during the study period and no patients discharged by NLD were readmitted within 30 days.

Discussion/implementation
Challenges encountered during the project included difficulty gaining support from staff and identifying an effective method of data collection.
Financial implication
In reducing the length of time to discharge for a number of patients it can be reasoned that savings were achieved through the cumulative saving of ‘bed days’ with improved patient flow. No additional costs were incurred as a result of the change in practice.

Number of patients/clients/service users affected positively
13 patients were discharged using NLD during the pilot period and a mean reduction in time to discharge of 88mins per patient. The earlier time of discharge will have directly improved the experience of these patients. Additionally, the saving of available space and time to care for staff in the emergency department will potentially have indirectly improved the experience of many others.

Conclusions/plans for further development or wider dissemination of project
It is intended that NLD will be used throughout the hospital for a range of suitable conditions once it has been fully established and confirmed as effective in the ED and our short stay unit. Project outcomes will also be submitted for publication to contribute to the body of evidence.
Improving the Care of Stroke Patients at St Vincent’s University Hospital

Authors
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St Vincent’s University Hospital

Abstract

**Background**
Stroke is the third leading cause of death and the leading cause of severe disability. Organised stroke care has been shown to reduce mortality and disability.

**Aim**
To improve the care of acute stroke patients admitted to SVUH by implementing early admission to the ASU and implementing of a care bundle.

**Methods**
Team based approach with frequent stakeholder involvement with data collected from PDSAs to drive forward our quality agenda.

**Results**
Baseline data suggested low admission to the ASU within 12 hours and consequently delayed screening for dysphagia and referral to a stroke therapist being prolonged. By stakeholder engagement and implementing some simple interventions we were able to improve admission to the ASU from 20 to 80% within 12 hours. Our time to dysphagia assessment fell from a median time of 19 hours to 5 hours. Time to a therapy assessment fell from 37 to 16 hours.

**Conclusion**
By engaging with stakeholders in the ED and bed management we were able to improve admission to the ASU. However, due to the problems within the acute hospital sector / service we were unable to reach our specified aim of 100% admission to our service. We were able to implement simple interventions which led to earlier dysphagia and therapy assessments.
Expanding the SABR Lung Treatment Service in SLRON

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Abstract

Aim
To increase our utilisation capacity of Lung SABR treatment slots from 70% to 80% by the 31st of May 2018.

Methods
A retrospective analysis was carried out of patient care paths to identify where treatment delays were encountered. The team investigated these delays further to try and establish why they had occurred. Potential key areas of improvement were identified along the patient care path. As part of the QI project several ‘tests of change’ were introduced to help eliminate inefficiencies identified on patient care paths.

Results
An analysis of the data from January to April this year showed that the tests of change had resulted in a reduction in the time required for completion of ‘RO_1’ task along with a significant reduction in variation. The planning task review saw an initial improvement in January, however the median time increased in February followed by a decrease in March and another increase again in April.

Conclusion
The greatest success story of this project is the improvement in staff moral and respect for the various disciplines responsible to ensure the delivery of SABR process. The staff engagement and feedback sessions carried out throughout the project were pivotal to this success as staff began to develop a more positive attitude as they took ownership to the tests of change they were helping to develop, design and implement.
To Increase the Average Number of Patients Being Managed in the Maternity Day Unit

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Abstract

Background
Maternity Day Unit (MDU) is an outpatient clinic for pregnant women who are experiencing complications with their pregnancy, but they are not required to stay in the hospital. It provides care for pregnant women from 22 weeks onwards in a relaxed family friendly environment. Our recent audit has shown that half of our inpatient admissions in the Antenatal Ward do not required high intensity foetal or maternal monitoring and can be safely managed in outpatients MDU.

Methods
Before making an appropriate changes to increase MDU capacity we performed several “plan, do, study, act” (PDSA) cycles to test an idea by trialling a change on a small scale and assess its impact, building upon the learning from previous cycles in a structured way before wholesale implementation. We collected the data and measured the outcome to ensure if changes we made resulted in improvement, and we demonstrate this process by using run charts. We used driver diagram as a model to help identified the series of the steps needed to order to effect change. In order to demonstrate our findings we used run charts to plot data over time, as it is one of the most powerful tools in quality improvement.

Results
Our data collection results showed that utilization of MDU is incomplete and there is need for improvement of the service. After using several PDSA cycles and measuring outcome, we found that by making a specific appointment systems we doubled amount of patients we can review daily in outpatient service. This also allowed us to utilise our staff more effectively. One of the most important changes were made when we allocated dedicated Obstetric registrar for MDU. This also freed up labour ward registrar from extra duties. The change of administration of medication reduced the amount of visits to MDU and increased MDU capacity, which allowed us to examine more patients. By increasing outpatient appointments and reducing inpatient stay we reduced the costs of inpatient stay, and improved patient and their family satisfaction with our service.

Conclusions
In order to improve our MDU and to make our work safer and more efficient we need to review our practice on regular basis by conducting audits. When changes have to be made the PDSA cycles and run charts are important to
demonstrate what changes need to be done and what factors influence change. Our project demonstrated that small changes, as an efficient appointment system, dedicated registrar for MDU and changes in different administration of medications could double capacity of outpatient MDU and reduce inpatient admissions when high intensity foetal or maternal monitoring is not deemed to be necessary.
Quality Improvement: The Deteriorating Child – Initiative and Collaboration (Qidic)

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Abstract

Background
Paediatric patients rarely suddenly deteriorate but do so over time, thus there is an opportunity to identify and mitigate this risk. The aim of this project is to identify 100% of children at risk of deterioration on two inpatient paediatric wards by May 1st, 2018 at both daily huddle and handover activities. Data collected in November 2017 demonstrated a lack of consistency in the recognition of at-risk children, communication deficits at handover and huddle and variance in the use of Paediatric Early Warning Score (PEWS). Staff involved included doctors – Consultants and NCHDs, Departmental Business Manager and Nursing staff.

Method
The team reviewed available literature and adopted principles from Cincinnati Children’s Hospital and Situation Awareness for Everyone (SAFE-RCPCH), we focused on the following with multiple metrics defined:

- Adoption of “Watcher” principle – defined as a patient with expressed family concern, clinician ‘gut concern’, high risk therapies, elevated early warning score or communication concerns
- Improvement of handover and huddle activities

The team developed a multi-pronged approach that targeted effective clinical handover and huddle with identification of all children at risk of deterioration i.e. “watchers”, auditing handover and huddle between January and May 2018 and validated the children identified as “watchers” at these encounters compared to those identified at ward round review.

Results
A number of tests of change targeting handover have included venue and time alterations, prompting to use ISBAR and change in handover documentation. Handover took place every morning from January 8th – July 7th, 2018 with consultant attendance > 90%, NCHD attendance 100% and use of single venue more recently. Other metrics include prioritization of sick patients on rounds.
Key handover metrics improved over the duration of this project and the term “watcher” was introduced. Changes in practice have been sustained with ongoing coaching, regular education updates and handover is now a protected daily activity.

**Conclusion**

The identification of children at risk of deterioration improved over time. The task of improving situation awareness leveraging daily huddles and handovers was challenging and in particular we underestimated the challenge of introducing new tasks with the nursing and medical teams. The financial implication of a deteriorating child is approximately 1000 euros per additional night stay. Situational awareness is key to safe patient care this can be enhanced through standardised approach to interdisciplinary communication. The next steps are to ensure continuous quality improvement of this initiative and to share the learning with colleagues.
Patient Handover in General Paediatrics

Authors

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South/South West Hospital Group (S/SWHG)

Abstract

Background

Successful implementation of a full consultant-delivered service in General Paediatrics in University Hospital Waterford (UHW) will require changes to current working practices and rosters as well as compliance with the European Working Time Directive. Effective patient handover is a key performance priority to ensure continuity of care and patient safety and will be used in the service evaluation.

Aim

By July 2018, 100% of patients on the Paediatric Ward in UHW will have a correct am and pm handover, as defined by the handover bundle/checklist.

Methods

This is a Quality Improvement project requiring frequent stakeholder engagement to share data and employ agreed interventions using the PDSA method to improve outcome.

Results

Baseline documentation of patient handover available in terms of timeliness of weekday am handover and consultant and NCHD attendance at this handover were excellent at 100% and remained so throughout the project. At baseline, however, a standardised permanent record of handover was non-existent at 0% and attendance of nursing staff at handover was inconsistent at 36%. In addition, anecdotal evidence suggested that the pm handover was not formalised with consistent medical attendance as well as the fact that updates on jobs for both discharged and non-admitted patients were variable. These factors necessary for correct handover were improved to 100% at project end.

Discussion

Timely daily handover with 100% multidisciplinary attendance utilising a standardised, electronic patient handover system was achieved. This project will be sustained and further improved through ongoing multidisciplinary input/communication and the support of an electronic system which will ensure 100% compliance with, and ongoing review of, the standardised patient handover mnemonic. Further doctor-nurse engagement is required to develop the role of the nurse at both am and pm handover to ensure consistent attendance.
Financial implication

Although this project cannot show a firm reduction in length of stay, adverse events, re-admission rate and re-attendance to the PAU/ED, documented feedback from some front-line providers perceived efficiencies from changes incurred.

Patients/Staff outcomes

Implementing an electronic-based documentation system was generally perceived to have had an impact on patient safety as well as job satisfaction, with some front-line providers maintaining the view that it had also improved patient satisfaction.

Conclusions

This project developed and implemented a checklist for correct handover on the Paediatric Ward in UHW.
Identification of the Underlying Causes of Acute Ischaemic Stroke and TIA through the use of appropriate Investigations

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Abstract

Background
Stroke is a leading cause of death and disability worldwide, with 10,000 people having a stroke-related event in Ireland annually. Patients who have an initial ischaemic stroke or TIA have a 26% risk of recurrence within 5 years. This risk can be reduced by identifying and treating the underlying cause of the ischaemic event.

Aim
By May 2018, every patient who is admitted to St Luke’s Hospital with acute ischaemic stroke or confirmed TIA will have the appropriate investigations to identify the underlying cause, excluding patients who are at end of life or for other reasons are deemed medically unfit / unsuitable for such investigations.

Methods
The methodology was based on the API Model for Improvement, which involved a series of Plan, Do, Study, Act (PDSA) cycles to evaluate small tests of change in the work setting.

Results
Baseline data showed that 50% of patients presenting with ischaemic stroke or TIA had their underlying cause identified; throughout the project this improved to 66%. The percentage of patients receiving all of the standard investigations improved from a mean of 88% to 100%. The implementation of the new process did not have any impact on patient length of stay in hospital.

Conclusion
Implementation of a standardised bundle of care is an effective way to ensure consistency and reduce variation. The most effective intervention was increasing awareness of the investigations that needed to be completed, through communication with the key stakeholders. If the implementation of the standardised investigation bundle prevents even one stroke per year, the savings accrued will more than offset the cost of the additional investigations carried out. Ultimately, sustenance of the improvements gained through this project will require the commitment of the stroke team to take full ownership of the new process, with ongoing communication, monitoring and evaluation.
Breast MRI Waiting List Improvement Initiative

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Abstract

Background
National and international guidelines from the RCR (2017), NICE (2017) and HIQA (2017) recommend using MRI for diagnosis and surgical planning of symptomatic breast patients as well as screening of high-risk asymptomatic patients. In Beaumont hospital at the start of this project there was difficulty in accessing MRI for breast patients this mainly resulted in asymptomatic screening patients having limited access to MRI.

Aim
Our project aim was to decrease breast MRI outpatient waiting times from 15 months to less than 1 month for symptomatic breast patients and less than 3 months for breast screening patients by 1st April 2018

Methods
The project team used a team-based Quality Improvement methodology to engage the various stakeholders and communicate to them. Data was an important aspect of the methodology with the team collecting data to understand and communicate the problem to various stakeholders. The project team also used the PDSA cycle as an improvement tool.

Results
At the start of the project the waiting list was >18 months, currently all patients have a scheduled appointment within 2 months. This was achieved by adding an additional 8 slots for breast MRI which equated to an additional 300% capacity. At the outset <5 of patients had a scheduled appointment this has changed to 94%. Finally, the TAT reduced from 194 days to 72 days and will continue to reduce over time.

Conclusion
This project has hit it target aim and has overall improved the quality of the service offered to our patients. A team-based Quality Improvement methodology was a good fit for this project as it was complex and required an in-depth review focusing on the root causes.
Reduction in Unnecessary Admissions to a Paediatric Ward Using an Ambulatory Model Of Care

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Abstract

Background
Unnecessary hospitalization of children represents poor quality, inefficient care delivery for the acutely unwell child and family, as well as an unnecessary burden of work for staff and has significant financial impact for hospital budgets.

Aim
To improve quality of patient care through the reduction of unnecessary hospitalization of children with acute self-limiting illness using an ambulatory care model. Unnecessary admission is defined as length of stay less than 24 hours on a hospital ward, with resolution of illness on discharge.

Methods
Quality Improvement Project using an ambulatory care model through the development of a Paediatric Decision Unit (PDU), in a non-tertiary paediatric unit. Team based with interventions using Quality Improvement Tools to achieve reduction in unnecessary hospital admission.

Results
Reduction in unnecessary admissions to hospital from 22% to below 5% over 9-month period. 50% reduction in actual number of children with length of stay less than 1 night, with significant cost savings to hospital budget, €49,784 over 2 four-month periods compared. High patient satisfaction rating more than 93%. Treatment failure rate, 6%, defined as representation to hospital within 72 hours discharge home.

Conclusion
An ambulatory model of care, when introduced as a Quality Improvement initiative, is effective in the reduction of unnecessary hospital admission for the child presenting with mild to moderate acute self-limiting illness, and represents significant cost savings to hospital budgets.
**Why Are We Waiting??**

**Authors**
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**Abstract**

**Background**
Following a sustained increase in inpatient activity (37% increase 2015 – 2016) the Pulmonary Rehabilitation Service had ceased due to a lack of resources. Patients in our catchment area with chronic lung disease were not being afforded evidence-based treatments in line with the clinical care programmes.

**Aim**
To reduce the waiting time for access to pulmonary rehabilitation from 22.4 to 3 months by June 14th, 2018 in NGH.

**Methods**
Team-based QI project with frequent stakeholder engagement. We endeavoured to introduce a collaborative, multidisciplinary, rolling pulmonary rehabilitation service in NGH. Increasing capacity to better meet the demands on the service and reduce waiting times.

**Results**
Baseline measurement showed that the pre-existing cohort model of service delivery would yield maximum capacity of 30 patients annually and result in waiting times of mean 22.4 months, median 22 months. By redesigning the model of service delivery into a collaborative, rolling PRP we reduced waiting times to mean 15.9, median to 16 months. By increasing class capacity to all 15 rather than 10 patients per group we noted a further drop in wait times to mean 7 months and median 7 months. Our final intervention restructured our process end to end and aimed to reduce waste. This intervention reduced our waiting time to mean 4.3 months, median 4 months. We continually tracked demand, capacity and utilisation and found that despite these changes there is a gap between potential capacity (90) and actual utilisation (65) of approx. 25 patients annually.

**Conclusion**
The changes made to the service reduced waiting times considerably for the programme but did not meet the desired target as set out by a national clinical audit conducted by the RCPL in 2018. They recommend that 85% of patients should access PR within 90 days of referral. The gap in potential capacity and actual utilisation of the programme remains a challenge. This is likely due to the nature of our patient’s chronic disease requiring additional sick days and hospital appointment days.
Refusals to travel, patient empowerment and documentation improvement in the National Ambulance Service: A Quality Improvement Project

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Abstract

Background
A recognised component of modern ambulance work is that a patient has the right to refuse treatment and or transport (RTT). The National Ambulance Service (NAS) Medical Directorate has regularly re-issued a guidance document to NAS staff to ensure that these persons are dealt with in a consistent manner. The 2017 national rate of RTT increased from below 8% in 2012-2014, to 11.3% of calls (24,735). RTT related complaints also increased. A quality improvement project was initiated to facilitate a better patient decision making process. It was hoped by improving the quality of clinical information provided to a patient that the patient would be able to make a more informed decision regarding their refusal of treatment.

Aim
We hoped to empower patients to participate in a shared decision-making process by improving the quality of documentation from 63.5% to 90% of required clinical information* (As dictated by the medical directorate guidance document) in Mallow Ambulance Base for all patients that engaged with and subsequently refused to travel to hospital with the National Ambulance Service by 29th July 2018.

Methods
To establish a baseline, a retrospective analysis was conducted on a randomised selection of both paper and electronic Patient Care Reports (PCR) from across the country, on RTT calls closed between 1st Jan 2017 and 9th Nov 2017. Staff were engaged on how to achieve the stated aim.

Results
The quality of clinical information collected and recorded was improved from an average of 63.2% to 83.4% of required information.
Discussion
In addition to the planned quality improvement initiatives, several confounding factors occurred including the introduction of an electronic PCR and an organisation wide audit of RTT documentation.

Conclusion
Clinical information collected on RTT in Mallow NAS Ambulance Base was better than the baseline data measured. We were unable to ascertain if this information had helped improve patient experience. The NAS is in the process of developing alternative care pathways to support staff and provide a more patient centred service. Enhanced mechanisms of patient and staff engagement combined with an education program could bring about further and more widespread improvements.
Improving Medication Safety in a Children’s Hospice by Reducing the Risk of Harm from Internal Prescribing Errors

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Abstract

Background
Medication errors are recognised as a common source of adverse healthcare incidents. Following a cluster of low arm medication errors in a children’s hospice, an improvement in medication safety was identified as a key organisational priority. An aim to eliminate all internal prescribing and transcribing errors to zero in the hospice service by May 2018 was agreed.

Methods
Baseline data was collected and examined in detail. A cause and effect diagram with further root-cause analysis was completed to determine potential initial areas for improvement. The initial focus was on the establishment of a “sterile cockpit” to reduce distraction and interruption of prescribers during task. Interventions included provision of a separate printer in the office to remove the need to leave the office and the use of signage to remind all of the need to avoid interruptions.

Results
The project showed both a reduction in prescribing errors but also a concurrent improvement in medication safety across the whole service. The number of prescribing errors has been low with a maximum of 4 in a month, the longest gap between errors has now been 5 months. There has been a consistent reduction in medication errors across the service with a trend below the median of 9 per month for the past 6 months.

Discussion
This project has demonstrated a sustained improvement in medication safety in our service. Work is ongoing with service users to support their engagement with the medication guideline and it is hoped that this will lead to further improvements. The project has had very low-cost implications and although there is limited cost benefit demonstrated, it has reduced the risk of a costly serious medication error. Children attending a children’s hospice are medically fragile and any project to improve the safety of a service will be of benefit to the children and their families.
To Increase Social Inclusion for Individuals in Community Staffed Residences (CSRs)

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Abstract

Aim
Rehabilitation and Recovery Mental Health services are moving away from focusing on symptom control and congregated living towards social inclusion and helping individuals to live the lives they want to live according to the recovery model. Social inclusion can be thought of as incorporating 9 domains including employment, participation in family and neighbourhood, involvement in arts and culture, volunteering and sports and exercise. We wanted to focus on improving the sports and exercise domain, in particular walking, as our quality improvement project. Our hope was that if residents walked more, not only would health and fitness improve, but there would be opportunities to meet other people when walking. In addition, there could be opportunities to join walking groups of people without mental illness in the community. Our goal was to increase social inclusion in a group of residents with mental health difficulties living in a Community Staffed Residence (CSR) by increasing physical activity through walking. The number of steps per day would be measured using a pedometer. The aim was for residents to walk 10,000 steps per day. We also hypothesised that if residents smoked less they would have more money to get involved in their community.

Method
Over a 9-week period, residents living in a 12 bedded CSR in Mullingar were asked to wear a pedometer every day. We also recorded the number of cigarettes smoked per day. We developed a driver diagram, a communication plan and intervention strategy around Plan-Do-Study-Act (PDSA). Our outcome measures were number of steps per day. A secondary measure was the number of cigarettes smoked daily. Our process measures were the number of pedometers worn per day and the number of checklists completed by the nursing staff in the CSR.

Results
Of 7 residents who initially agreed, 3 ultimately completed the study. Some residents had difficulties managing the pedometers and some were lost in the early stages. However, for those that completed the study, the median number of steps increased to 10,000 per day. Checklist recording was not optimal at times. A walking group was the most effective intervention. One resident stopped smoking (previous heavy smoker). However, the median number of cigarettes increased.
Conclusion

The number of steps was increased for several residents. However, we felt that had not won the “hearts” of most residents or of the staff. We hope to repeat this in another residence as we have learned important lessons.
Implementing a Discharge Summary for Deceased Patients

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Abstract

Background
It is hospital policy for a Discharge Summary to be sent to the GP for all patients who leave hospital after an admission, however this does not happen when a patient dies. This may cause a problem for the GP who has had a relationship with the deceased as they have no information about the patient’s final illness and the family may often approach them for answers in relation to the deceased’s death. This project aimed to implement a Discharge Summary for all in-patients who die in hospital.

Methods
We initially explored the value of a Discharge Summary for deceased patients, to hospital doctors, GPs and the patient’s family. We studied the clinical and administrative process of how what happens after a patient’s death. Subsequently we explored the barriers to the Discharge Summary’s completion. Following on, we implemented a series of tests of change to determine how the process could be improved.

Results
A total of 579 in-patients died during the period of our project. For those patients, 120 Discharge Summaries were completed (November 2017 - June 2018). We found that doctors (Interns) were willing to complete the Discharge Summary as part of the patient’s final care pathway and did not consider it an extra or onerous task. Nevertheless, even though the Interns agreed to this task, they could not achieve it until they received a prompt and a physical space was created for them to do so and the patient’s chart was available.

Discussion
We saw a significant improvement in Discharge Summaries after working with the hospital’s Death Notification Office. They now prompt the Interns to complete the Discharge Summary and provided a space for them to work from. While no direct financial implication can be reported, we hypothesise that project outcomes have effects on hospital reputation, HIPE data and reduction in complaints.

Conclusions
We are continuing our project with this year’s Intern group and the process will further improve when an electronic record in implemented in the hospital in October. Processes are already in place to implement a Discharge Summary for patients who die in the Emergency Department.
South Doc Antibiotic Prescribing Improvement Project

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Abstract

Background and Aim
It is estimated, that by 2050, Antimicrobial Resistance will be responsible for 10 million deaths annually and cost USD$100 trillion in lost global production. Ireland’s level of broad-spectrum antibiotic use is mid to high in comparison to European counterparts. In an Irish out of hour’s doctor’s service in Winter 2016/2017, 45% of antibiotics prescribed were non-preferred broad-spectrum antibiotics and Co Amoxiclav accounted for 34% of all antibiotics prescribed.

This project aimed to:
   a) Reduce prescribing of broad-spectrum antibiotics (red panel) from 45% to 22.5% by end June 2018
   b) Reduce the % of Co Amoxiclav prescribed from 34% to 17% by end June 2018.

Methods
We carried out a number of interventions in an Irish out of hour’s service to:

1. Influence a change in GP antibiotic prescribing patterns
2. Influence patient’s perceptions of antibiotics.

GP interventions included:
- Introduce an antibiotic prescribing trigger tool on the GP software system to nudge towards appropriate prescribing and to enable collection of real time prescribing data
- Provision of mouse mats, posters and audit tools on Green/Red antibiotics
- Text messages with educational nudges.

Patient interventions included:
- Leaflets on arrival and audio-visual display priming them to not expect an antibiotic

All GPs and some patients where involved through engagement sessions, qualitative interviews, tests of change and education programmes. There was governance and support at leadership level from the Health Service and GP boards.
Results

a) June 2018: Red Panel antibiotics now 16.8% of antibiotic prescriptions
b) June 2018: Co Amoxiclav prescriptions now 11.6% of all antibiotic prescriptions

Conclusions and plan for further development

The quality of antibiotic prescribing can be improved by combining multiple interventions to address different aspects of the process. Patients and GPs understanding of appropriate antibiotic prescribing improved as a result of the project. These results will lead to less harm to patients from inappropriate prescribing and help limit antimicrobial resistance.

The key factors critical to the success of our project were:

- Clear roles & responsibilities
- Celebrate improvements
- Involve patients GP and staff at all stages of improvement journey
- Have real time data to influence improvement
Reduce the Incidence of Medication Errors at St Francis Hospice Dublin

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Abstract

Background
Medication incidents are a risk to patient safety. Incidents may be classified based on harm to patients or based on the point in the process where the incident occurs.

Aim
The aim was to reduce medication incidents by 80% at a specialist palliative care unit.

Methods
A quality improvement project was developed to analyse the types of incidents. Pareto charts were used to demonstrate the commonest types of incidents. The commonest and the most serious incidents were chosen as targets for improvement. The types of incidents were discussed with clinical staff and the MMC and strategies were explored to address these. Small tests of change were devised and tested. There were a total of six tests of change, to address three different problems identified, namely drug omissions, wrong rates of infusion and errors related to multiple infusions.

Results
On review of medication errors, there was a 60% reduction in medication incidents. There were none of the most serious incidents, and a considerable reduction in omissions.

Discussion
The members of the quality improvement team learnt about data and incident analysis and were able to use this knowledge to identify the commonest and most serious errors. The QIP team provided informal and formal education to staff about the incidence. The use of Pareto charts made it possible to demonstrate to staff the commonest errors. Using small tests of change ensured that there was opportunity for staff to engage in improvement. There was good engagement with staff in the process. There was a strong emphasis on engagement with staff most affected by the changes, the nursing staff, but also engagement with all clinical and non-clinical staff who encountered patients on the ward. The numbers of patients involved are small and there is no evidence of any financial gain as a result of this project, but there is a commitment to continue to improve quality. The ethos and culture of the organization was recognized and respected by having a person-centred approach to the QIP.
Conclusions

As this project was successful in reducing errors, and was inclusive and maintained staff engagement, there is reason to be optimistic that the next most common cause of medication incidents can be addressed successfully.
Improving the Lung Cancer Patient Care Pathway

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Abstract

Background
Lung Cancer is the leading cause of cancer mortality in Ireland representing approximately 20% of all Cancer deaths. Lung Cancer kills more Irish people every year than Breast and Colon Cancer combined. Its incidence is projected to increase by 141% in women and 61% in men between 2010 and 2030. Timely access to surgery directly correlated to patient outcomes (DoHC 2017).

Aim
To ensure that all patients with a diagnosis of Isolated Lung Cancer have their first surgery performed within 30 working days from discussion at Lung MDT. Four re-sections p.w. are required to meet demand capacity, and was agreed as baseline requirement at the outset.

Methods
Team based QI Methodology Project involving active participation at weekly Lung MDT Meeting including tracking patient outcomes consistent with Aim Statement, thereby embedding Project processes.

Results
Baseline activity data June-September 2017 reviewed demonstrated significant waiting times for patients outside the clinical KPI of 30 working days to surgery following recommendation by Lung MDT. This KPI had not been measured heretofore and challenges experienced regarding the introduction of KPI are not to be underestimated. Positive patient outcomes directly attributed to this Project includes 157 patients having first Lung Surgery chronologically which was not always the case historically. Lung Surgery scheduling is now within 30 working day KPI. At the time of writing, just 15 patients are awaiting Lung surgery dates. A patient discussed on 24th July 2018 with a target surgery date of 5th September 2018 was operated upon 30th August 2018 – ahead of KPI.

Conclusion
We are currently implementing the Lung Cancer Project Model at the combined Cardiology/Cardiothoracic Surgery MDT Meeting - ensuring equity of access for both Lung and Cardiac patients respectively. Similar Tracker Documentation is in use. Importantly, the Administrator attending the Lung MDT now attends Cardiac MDT resulting in increased accountability and equitable patient focus in both clinical streams. Moreover, this Project has resulted in a concerted focus regarding the ‘modus operandi’ of MDT Meetings.
Decision-making Process for Long-term Care Patients in the Mater Hospital

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Abstract

Aim
Our aim was to improve the quality of shared decision-making around long-term care for patients in the Mater Hospital by June 2018
- Increase knowledge and confidence for staff
- Decrease variation in time to completion of CSAR’s
- Increase number of decisions made at Case Planning Meetings
- Improve formal recording of decision in Patient’s chart

Background
The enactment of the Assisted Decision-Making (Capacity) Act 2015 requires all care providers to seek and record patient’s preference in relation to their care. At present there is no standardised tool/format for recording the outcome of CPMs. The current hospital process for shared decision-making is variable leading to confusion, work duplication, inefficiencies and mixed messages for family and/or patient.

Methods
We focused on stakeholder engagement, communication and inclusion, project champions (Medicine for the Older Person and Neurology), gathering qualitative baseline data (chart audit – 35 patients) and trialling various interventions/tests of change. We completed a staff and patient questionnaire, assessed a chart sticker and poster as visual cues, and developed one-page form for LTC record keeping.

Results
Patients and families were largely satisfied with the LTC process. 42% of staff were unsatisfied with their knowledge about LTC. The introduction of the guideline poster, centralised storage of CSAR forms and electronic recording of the LTC process improved efficiencies and provided data for operational and analytic purposes. Initially 9.8 days was required for completion of the CSAR form following the LTC decision. This decreased by 2.6 days during the study and, as the average length of stay is 5 days, potentially frees over 700 bed days for another 150 patients.

Discussion/Implementation
Providing solutions and increasing awareness of LTC process among staff and the public will improve patient care. Slowness and uncertainty with the LTC process cause staff frustration and sometimes confusion and stress for patients and family. These issues often delay patient discharge to an appropriate care facility. With the implementation of the
guideline poster, centralised storage of CSAR’s and the Electronic Patient Record of the CPM, we now have more visibility and oversight of patients listed for long-term care.

**Conclusion**

As a result of this project, patients and family will have better and quicker LTC placement and the Mater Hospital will be in a stronger position to implement the required procedures included in the Assisted Decision-Making (Capacity) Act 2015.
Improving Governance in Galway & Roscommon Mental Health Services

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Abstract

Background
Two participants on the 2017-2018 RCPI/HSE Diploma in Leadership and Quality in Healthcare were paired to work together for the purpose of undertaking a quality improvement (QI) project. This Project Team had knowledge of staff dissatisfaction with the organisational structure and function of the Galway Roscommon Mental Health Services’ (GRMHS) Clinical Governance Committee (CGC). The Project Team proposed a QI project to support the service in improving governance of the CGC, thereby improving committee members’ satisfaction with the revised structure and function of the committee and its subgroups. The project was supported by senior managers and the Area Management Team.

Aim
By the end of June 2018, the satisfaction of members of the GRMHS CGC will have improved by 10% in relation to the Committee’s structure and function.

Methodology
A number of measures were chosen for studying outcomes, processes, and balancing measures in relation to this project. The measures were determined based on a Driver Diagram. The Project Team also conducted a mapping exercise to identify relevant stakeholders and their roles.

The Project Team devised two principal methods to gather relevant information relating to the process and outcome measures identified. These included an online survey of all members of the GRMHS CGC and its subgroups, and a Request for Information (RFI).

The Project Team planned to create a report for the CGC and each of its subgroups based on the information above, framed under each of the six Drivers for Improvement as per the HSE Framework for Improving Quality (2016). It was anticipated that the Project Team would meet the CGC to review the results and discuss areas for improvement suggested; identify one area where an improvement could be made; commence a QI project to implement and measure the change; and then re-circulate the survey to CGC members to assess if the change resulted in a perceived increase in satisfaction.
**Results**

Of the six committees reviewed, the Clinical Governance Committee itself had the lowest level of staff satisfaction, with more than half of the respondents moderately or very dissatisfied with the structure and function of the committee. As a result of the survey and RFI, areas for improvement were identified for example: strengthening the role of the chairperson; limiting staff membership on multiple committees; involving service users and families; improving communication with frontline staff; developing an ‘actions agreed’ templates for committees; and the use of QI methods to effect improvements.

The Project ceased progression at this point, however, due to circumstances outside of the Project Team’s control. The Project Team was unable to support the service in implementing a QI project within the timeframe allocated for this project to be completed by the end of June 2018.

**Discussion and conclusion**

Although the Project Team did not achieve its aim, by virtue of undertaking this project the Project Team provided important baseline information to the service which may influence future positive developments in its clinical governance structure and function. The Project Team also achieved several unplanned benefits, including the spread of local QI knowledge and awareness of the HSE Framework for Improving Quality (2016).

The Project Team made a number of reflections based on their experience and learning from this project that may help inform future similar projects of this kind.
Embedding Quality Improvement in Outcomes for Residents

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Abstract

Background
A designated centre was selected in CHO1 based on concerns raised by the registered provider. The findings from a self-assessment of the quality of care and support provided to residents residing in this designated centre undertaken in December 2017 revealed that the centre was non-compliant across all regulations and nationally mandated standards for residential services for children and adults with disabilities. (Health Information Quality Authority, (HIQA) 2013).
This project relates to a designated centre located on the outskirts of a large town providing residential services to 5 adults with a mild to moderate intellectual disability ranging in age from 30 to 65 years. This centre provides 12-hour nursing and 24-hour social care support to residents.

There was an urgent need to ensure this designated met full compliance with regulations and standards in order to provide assurance that residents were receiving high quality care and support which was individualised, safe, effective and meeting residents assessed needs and preferences. The ultimate aim of this study was to improve compliance in 32 regulations from 0% to 100% by 31st May 2018.

Methods
A team-based quality improvement (QI) project with regular collaborative multidisciplinary working with all relevant stakeholders to agree interventions to improve the provision and delivery of quality services for residents and share feedback on progress.

Results
The self-assessment findings conducted on the 12/07/2018 demonstrated compliance rate of 100% across all 32 regulations. These findings were validated by the Person in Charge and senior management. A review of documentation, observations of practice and a review of 5 service users questionnaires demonstrated improvement and satisfaction under the following outcomes;

- service users experience of care
- personal outcomes
- safety and risk management
- leadership and governance
- staff team development
Conclusions

The identification and implementation of a new self-assessment judgement framework workbook including a guidance document to respond to HIQA’s enhanced monitoring approach increased staff capacity to improve their readiness and capability to self-assess the performance of the designated centre against regulations and national standards. Although improvement was noted across all regulations resulting in the designated centre achieving full compliance, ongoing implementation of standardised work practices including surveillance of monitoring systems by senior management is required. This can be achieved by active open communication, engagement and consultation with all staff and residents to ensure the sustainability of robust governance and oversight arrangement to foster and enable a culture of continuous quality improvement.
Improving care in an adult intellectual disabilities (ID) service through effective documentation of healthcare needs in the care plans of 28 residents

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Abstract

Background
St. Raphael’s, Youghal, County Cork is a HSE community service providing full time residential support to 97 adults with varying degrees of intellectual disability. This service consists of three centres: St. Raphael’s Residential Centre, Oakvale and Youghal Community Hostels.

Local problem
In 2015 and 2016, HIQA carried out several inspections of a various number of the 18 outcomes relating to the National Standards for Residential Services for Adults with Disabilities in this service. Outcome number 11 - Healthcare Needs, was found to be of Major Non-Compliance during inspections in August 2015, May / June 2016 and November 2016. These major non-compliances were a result of healthcare needs of the residents not being fully addressed, resulting in poor quality and safety, which required action and improvement.

Methods
Consequently, a quality improvement project took place using the Model for Improvement to address this and improve the quality and safety of care for the residents. A bespoke Excel tool for gathering information from care plans was developed by the QI team. Information on the processes of assessment, planning, implementation and evaluation of the healthcare needs of each of the residents was gathered and documented, using this tool. The Quality Improvement (QI) team, which consisted of two members of the Social Care / Quality Improvement (SC/QI) team, reviewed each resident’s care plan along with each resident’s named nurse and/or key worker. Notes were taken as to what improvements were required. The Clinical Nurse Manager (CNM) from the residential centre provided oversight of this process. The QI team then reviewed each care plan again once the work was deemed ‘completed.’ This continued for the 28 residents care plans until the aim of 100% was reached.

Interventions
One of the first interventions of the improvement project (during PDSA Cycle 1) was to commence a Care Plan Development Group who provided oversight of the care plan process with all staff. During the Study Phase of PDSA Cycle 1, the group made the decision to pilot assessment tools to be used during the health assessment process. Two assessment tools were piloted, and a decision was made by staff to amalgamate both tools into one. This was done, and the tool was implemented in the service. Following this, during the PDSA Cycle 2, Study Phase, a Care Plan template was
developed and implemented in the service. The next intervention during PDSA Cycle 3, was to develop a Care Plan Policy for the service. During each PDSA cycle STUDY phase, there was discussion about any further interventions required. A second round of three PDSA cycles commenced in November 2017. The Care Plan Policy was implemented in the first cycle, concerted efforts were made during the 2nd and 3rd cycles to complete the care plans and by the end of the third PDSA cycle the aim was reached. After the aim was reached in April 2018, a questionnaire was issued to obtain staff feedback on whether they thought the QI process on Care Plans helped with the quality and safety of care for the residents.

**Results**

The aim was reached before the specified timeframe of end of May 2018. The second round of three PDSA cycles was reviewed and discussions took place to help with spread and sustainability when the QI team are no longer providing support to the service. The following will help with sustainability:

- Standardisation (assessment form, care plan template, care plan policy)
- Documentation (assessment, planning, implementation and evaluation of healthcare needs)
- Training (staff training on the assessment form, the care plan template & the care plan policy, as well as person centred documentation). Training in workshop format with peer to peer support.
- QI Methods (Run charts, measuring outcomes of care and using PDSA cycles)
- Resourcing (resources were obtained for archiving documents)
- Quarterly Audit Programme (CNMs will oversee a quarterly audit of the care plans)

**Conclusions**

The outcome of this project was positive. Reaching the aim has proven to be invaluable for St Raphael’s in moving to a more person-centred focused delivery of care for its residents. The way of working between staff and the QI team on a one to one basis proved to be very beneficial. Staff members commented on the learning and the relevance of the work for both themselves and the residents.

100% of the care plan healthcare needs section were complete by the end of the third PDSA cycle, which was before the specified timeframe. The new health assessment form was used to assess each service user’s healthcare needs and a corresponding support plan was implemented and evaluated accordingly. The Care Plan template and Care Plan Policy were also implemented.

Follow up questionnaires to staff returned positive feedback on how the quality and care of all residents included in the project has improved. Staff knowledge and skills around using improvement methods and PDSA cycles has also improved. (47.6% return rate with 100% positive responses.)
Improving the effectiveness of Quality and Safety Committees in an Irish Community Healthcare Organisation

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Abstract
The HSE is in the process of ongoing organisational change, a significant part of which has been the establishment of the Community Healthcare Organisations (CHO). In 2016 the Irish HSE published a national guidance paper on Quality and Safety Committee “Quality and Safety Committee Guidance and Resource” to increase and strengthen committee governance. Quality and Safety governance committees play a vital role in multi-disciplinary oversight within Irish healthcare settings. The 2016 HSE committee publication placed a renewed focus on Quality and Safety Committee structures within South East Community Healthcare as a means of assuring a quality service at a time of significant change. Furthermore, the move from an Integrated Service Area (ISA) structure to CHO Divisional structure brought about a blurring of communication and reporting lines, which was compounded by the geographical spread of the CHO in South East region.

The purpose of the project was to review and improve the effectiveness of quality and safety committees in South East Community Healthcare. This involved a baseline assessment of the volume and effectiveness of committees structures within the CHO. A detailed assessment of the processes and practices of the CHO level Quality and Safety committee and a satisfaction survey was conducted. This survey allowed the committee members to rate their level of satisfaction with the various committee processes and practices using a 10-point Likert scale. The results of the survey and various assessments were used to target opportunities for improvement. The project cultivated in a number of interventions and recommendations which concentrated on the areas for improvement and has resulted in an enhanced level oversight and accountability at divisional and CHO level within South East Community Healthcare. The tools, templates and manual developed as part of this project will be shared with all other CHO quality and safety personnel for their own adaptation and implementation. The financial investment associated with the project was limited to the time given by the project group members. *For the purposes of clarity, the document will use the word CHO, when generally referring to Community Healthcare Organisations nationally, but will use South East Community Healthcare (SECH) when specifically referring to matters local to South East Community Healthcare.
To provide early access to information (to support future independent living) for young people (20-35) with an enduring mental illness in the Clondalkin catchment area by August 2018

Authors
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Abstract

Aim
The aim of this project was to provide early access to information (to support future independent living) for young people (20-30 years of age) with an enduring mental illness in a mental health service by August 2018.

Background
As a result of the shortage of housing, many young people in the service are continuing to live in their family home later in life which can impact on their personal skills and their ability to live independently. This project is part of a larger plan to establish a programme to give information to service users in relation to housing support and it is envisioned that this plan will take a period of 4 years to develop. For the purposes of this project, it was decided to look at the service users' ability to access information on services. In 2017, 55% of the service users referred to the service is under the age of 35. Currently there are over 11 groups in the service, a number of which are all aimed to improve a service user's socialisation and independent living skills. However, information on these groups is distributed on a “need to know” basis via recommendation by a staff member.

Methods
In order to determine what would be the best method to use for this project we carried out a survey of service users, met with staff in the service and also met with the Consumer Panel. We also selected one group, the Socialisation Group, to determine if our project was making an impact on the strategies we were implementing.

Results
We conducted seven tests of change by creating an information pack (posters, leaflets, videos) and by testing improvements in one group, the Socialisation Group. While it is difficult to estimate the number of people who have seen the promotional documents for the groups, there has been an increase the membership of the Socialisation Group from 5 to 18 members.

Conclusion
Overall, service users have positively responded to this initiative and though not every service user may need a particular group, they are satisfied to have the information about the groups should they require it.
‘My Clothes Matter To Me’

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Abstract

Background
Lost or misplaced items of clothing have been a longstanding problem in residential care settings. This causes upset and distress to residents, families and staff with cost implications to families having to replace missing items. Residents clothing going missing may also affect a resident’s, dignity and therefore raise safeguarding concerns. Due to a consistent number of complaints regarding missing items of clothing in Cherry Orchard Hospital, we decided to address this problem for our Quality Improvement Project.

Aim
The Aim Statement of our project was; from 31 May 2018, all residents in Willow East Unit will have their personal clothing items returned to them from the Cherry Orchard Laundry Service.

Method
A team-based quality improvement project engaging with residents, relatives and staff. Through quality improvement methods and tools we aimed to increase satisfaction by eliminating missing clothes, enhancing dignity and respect and increasing staff awareness of the link between resident’s dignity and their personal clothing items.

Results
As of 31 May 2018, there were no complaints relating to missing items of clothing.

Conclusion
With the introduction of four simple interventions we were able to raise awareness amongst all staff involved in the laundry process of the importance of personal clothing items to residents, enhance the culture of person centeredness and eliminate lost clothing items in a short period of time at a very low cost.
Optimising Available Capacity of Physiotherapy Service

Authors
Ms Anne Naughton, Primary Care Services Manager (Lead), Clonbrusk Primary Care Centre Athlone
Ms Caroline Lennon-Nally, Quality Improvement Advisor, HSE
Ms Deirdre Carey, Risk and Incident Officer, HSE

Abstract

Background
There was evidence over a period of time that the Physiotherapy Service in Clonbrusk Primary Care Centre in Athlone, Co. Westmeath had not been working to its full capacity. This was due to a combination of factors such as lack of agreed administrative and operational policies and procedures, ineffective administrative processes, untimely communication between the physiotherapy and administration teams, and also with patients. This led to an inability to effectively manage the allocation and rescheduling of appointments, which resulted in the underutilisation of potential appointments and poor attendance at scheduled appointments.

Aim
To optimise the use of the available capacity of the Physiotherapy Service to increase attendance by 10% in Clonbrusk Primary Care Centre (CPCC) by the 31st May 2018.

Methods
A team-based quality improvement project was established. There was weekly engagement with key stakeholders in order to share data and agree interventions to improve outcomes. A project team from the RCPI Diploma in Quality and Leadership worked with the CPCC service team, which consisted of staff from the administration and physiotherapy departments to implement this initiative.

Results
One of the targets for improvement was to improve the efficiency of work processes. Changes in these processes led to more streamlined and effective management of the booking system and also facilitated an improvement in communication with patients. These changes increased the number of available appointment slots and improved utilisation of same. One of the most substantial measured outcomes was the improvement in the ‘Did Not Attend’ (DNA) rate with the trend reducing by 3% from January 2018 to May 2018. This was due to the changes in process but primarily resulted from the introduction of a ‘Short Messaging Service’ (SMS) to remind patients of their appointments. Another positive outcome from this project was the increased efficiency of the physiotherapists’ time and the increase in available appointments.

Conclusion
This quality improvement initiative involved the use of the knowledge and skills gained as a result of participating on the Diploma in Leadership and Quality in Healthcare. The knowledge and skills enabled the staff involved to review
baseline data, negotiate, test, agree and implement multiple interventions. There have been significant process changes within the administration of the physiotherapy service in order to achieve these improvements. The supervision and monitoring of these processes will be necessary if the progress made to-date is to be sustained. There are opportunities for similar improvements within other primary care services in the CPCC, which can be achieved and spread by using the learning and experience gained from this project.
Using Data to Support Improvement

Authors
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Ms Gemma Moore, Qualitative Evaluation and Research for Quality Improvement, Quality Improvement Division
Ms Emma Hogan, Stratification, Quality Improvement Division
Ms Victoria Taylor, Quality Improvement Manager, RCPI

Abstract

Aim
This project set out to contribute improvements to the process of implementing actions arising from incidents in St Mary’s Hospital, Phoenix Park, Dublin and therefore to improve patient safety management within the hospital.

The aim of this project was:
*“To improve the management of actions & presentation of incident data by 30% through the introduction of a data tracking & presentation tool by 31th December 2018”*

This project takes place within the context of developing Quality & Safety Structures and processes within Community Health Organisation Dublin North City & County (CHO DNCC).

Methods
Initially a process map of the incident management process within the organisation was developed and an interview was conducted with the Quality and Safety Manager in the organisation. It was apparent from the interview and the process map that the incident management process was quite extensive and there was a need for improvement.

- The following two areas were prioritised for improvement:
  - The development of an incident and action “Log”
  - Improving the processes for the collection, access to and display of data resulting in the development of the “Incident and Action Tracking Tool (IACTT)” with interactive dashboard

A number of tailored interventions were put in place:
- The introduction of an Excel based incident and action tracking tool which improved the existing St. Mary’s log
- The provision of graphical display of data aimed at increasing awareness and engagement
- The development of an interactive dashboard which included timeline visualisation and guidance text to support learning
- The provision of training to the Q&S manager to enable the use of the new tools
- Demonstration of the dashboard to the Quality and Safety Subcommittee for feedback and refinement
- Simplification of the dashboard following feedback to allow the Sub Committee use the tool at Meetings
Results
An Excel based "Incident and Action Tracking Tool (IACCT)" with accompanying visualisation dashboard was successfully introduced in St. Mary’s. The tracking tool comprises of two sheets, one for incidents and the other for actions. IACCT provides a consistent linked reporting structure for actions that have arisen as a result of incidents. It can be live edited and reviewed during the fortnightly Quality and Safety Sub Committee. The visualisation dashboard builds on the data provided in the tracking tool, providing a way to simply navigate through, explore and display the data. This dashboard provided the Quality and Safety Manager with a clear and visual way of presenting the data to this committee, including Pareto charts, run charts, c charts, stacked bar charts and timeline visualisations for both incident and action data.

The proportion of incidents presented at fortnightly Quality and Safety subcommittee increased from a baseline of 13% to 100%. The number of actions recorded with an assigned responsible person increased from 67% to 100% and reported satisfaction with the visualisation of data increased from 61% to 96%. The composite weighted measure of the management of actions & presentation of incident data increased from 49% to 99% exceeding the aim of the project.

Conclusion
This project aimed to improve the management of actions & presentation of incident data through the development of a data tracking and presentation tool which was successfully developed and introduced in St. Marys Hospital. The findings of the project indicate that a significant improvement has been achieved in the effective management of actions and presentation of incident data along with the Q&S committee’s awareness, understanding and governance of this data. The tool received excellent feedback from the staff at St. Mary’s Hospital. Due to the success of this QI project, the project team will continue to work with St. Mary’s Hospital to provide training and support fortnightly to enable the regular use and further refinement of the tool. The team will also aim to work with a wider group of staff to ensure multiple users can assist at meetings and spread its usage to other sit.
The Management of Non-Clinical Complaints Mid West Community Healthcare 2017

Authors
David Wrenne Complaints Manager
Mid-West Community Healthcare

Abstract

Background
Service users and their families are entitled to make complaints in relation to the services they receive from Mid-West Community Healthcare (MWCH).
MWCH covers the geographical areas of Counties Limerick, Clare and North Tipperary and provides non-acute hospital related services.
All non-clinical complaints should be managed in accordance with the Health Service Executive policy on complaints management Your Service Your Say (YSYS)

Aim
To ensure compliance with the recently revised national policy on complaints management Your Service Your Say 2017 (YSYS 2017) in the areas of Clare, Limerick and North Tipperary.
The project aims to ensure that all investigations are conducted in a standardised manner and format, using trained investigators. To ensure that all recommendations arising from such investigations are implemented and any learning is shared within the organisation.

Methods
A quality improvement project with stakeholder engagement to share data and agree interventions to improve outcomes.

Results
A total of 73 complaints required the appointment of a complaints officer to investigate the complaint i.e. 73 investigations were commenced.
A total of 54 (74%) of the complaints were completed inside the designated timeframe of 30 working days. A total of 19 (26%) required an extension of a further 20 working days.
All investigations were completed inside the extended timeframe.
A total of 44 (60%) of the complaints were upheld or partially upheld.
A total of 39 recommendations were made following investigations where complaints were upheld or partially upheld.
In a total of 27 (37%) of the complaints made, the complaint was either resolved informally or resolved locally or withdrawn.
During the calendar year 2017 a total of 103 members of staff were trained by the complaints manager in complaints management.

**Conclusion**

This review has indicated that complaints are being handled and resolved. The availability of the complaints manager to assist with the procedure around the investigation of complaints has led to a significant improvement in relation to timeframes in the closing out of investigated complaints. This is in particular due to complaints being resolved informally, without the need where possible to undertake a formal investigation.

Work in relation to the implementation of recommendations is ongoing and will continue to be so.
Improving access to rehabilitation for Hip Fracture Patients - Improving patient flow by improving the discharge process

Authors
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Abstract

Background
CSO figures show that there is an increase in the number of people in Ireland over the age of 65yrs. The rate of hip fractures increase substantially with age due to decreased bone density and muscle mass, problems with vision and balance and co-morbidities which can increase risk of falling. The highest proportion of hip fractures is recorded in the 80-89 age groups. The Blue Book Standards for hip fracture patient care recommends that patients should have hip surgery within 48hrs of triage and should have access to rehabilitation when medically fit post-operatively. The aim of this project was that by March 2017, 75% of home dwelling patients would access a rehabilitation facility once stable post-operatively.

Methods
The following methods were used to facilitate this project
• Project team established
• Stakeholders identified
• Communication plan was developed
• Baseline data was collected and analysed
• New processes implemented
• Process mapping of patients flow from orthopaedic ward to rehabilitation ward
• PDSA cycles to test change
• Weekly staff meetings to review data and discuss variances
• Safety crosses

Results
Baseline data showed delays to theatre, patients going to non-orthopaedic wards and not accessing rehabilitation. Early interventions put in place did not improve the outcomes. Process mapping identified the discharge process in the rehabilitation facility as a constraint to the flow. Average discharge time was 14.30 and admission time was 16.58. Intervention put in place was “Home by 11am”. This required input from the multidisciplinary team to succeed. A predicted discharge date was given to each patient on admission and reviewed daily. Communication processes were improved. There was an 87.4% improvement in patient discharge before 11am.
Discussion and Conclusions

It was not possible to improve hip fracture patients access to rehabilitation as it would have impacted negatively on other fracture groups’ outcomes. The flow process between the two hospitals improved, by addressing the discharge process and implementing the “Home by 11am” initiative. Approximately 40 patients per month were positively affected by this project. It reduced their time in hospital and gave certainty to their discharge plan therefore improving their overall hospital experience. It is planned to further develop this project to other non-orthopaedic areas of the hospital.
A Quality Initiative to Improve Endorsement of Histopathology Reports - A Key Indicator of Effective Communication that Can Enhance the Diagnostic Process and Minimise Patient Harm

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Abstract
The highest risk for patients during a hospital stay is contracting a healthcare associated infection (HCAI). Prevention and control of HCAs is an important element of providing safe healthcare for patients and is achieved through compliance with the National Standards for the Prevention & Control of HCAs (Health Information and Quality Authority (HIQA), 2009). Notwithstanding the fact that Wexford General Hospital (WGH) achieved significant improvements in infection prevention following HIQA inspections in 2014 these improvements were not sustained into 2015 particularly in the area of hand hygiene (HH) - this was the rationale for choosing this topic for the QI project. The projected outcomes for the QI project were to improve compliance with HH best practice in ICU (WHO 5 moments of hand hygiene) and to improve attendance at HH training, and to monitor / reduce the incidence of ICU acquired infections.

The overall aim statement for the WGH QI Project was ‘to increase the compliance with the five moments of hand hygiene from *50% to the HSE target of 90% for all clinical staff in ICU WGH by end of June 2016’. (*50% was based on the baseline HH observational audits carried out the WGH Dip team amongst nursing, medical, orderly, household and HSCP staff groups in ICU in February 2016).

The Intensive Care Unit (ICU) was chosen as the area of focus for the QI project because ICU is a high risk area for Healthcare Associated Infections (HCAs). There were two phases of data collection – baseline and post improvement. Methods were drawn from improvement science methodology and included use of PDSAs, process mapping, run chart and other interventions.

Results demonstrated a measurable improvement in hand hygiene practice following post improvement phase audit from a baseline of 50% to 92% (HSE target is 90%). In addition 100% of core ICU staff had attended and were up to date with hand hygiene training by June 2016. The overall project target was reached and slightly exceeded. There were a significant number of incidental improvements as well.
Reducing Absenteeism and Improving Staff Wellbeing

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Abstract
The HSE recognises the contribution, ability and dedication of its staff as a key component in delivering quality service (HSE Managing Attendance Policy and Procedure, 2009). Poor attendance or absenteeism can lead to disruption of service, reduced productivity, creation of backlogs, reduced quality of service and challenge management in managing work schedules and roster. The Quality Improvement Team at Clonskeagh Community Nursing Unit aimed to decrease absenteeism by focusing on frequent illness absence among nurses and healthcare assistants of Clonskeagh Community Nursing Unit from an average 7% to 4.5% by July 2017.

For the purposes of this project, after identifying the contributing factors to absenteeism, the team focused on the implementation of policies and staff engagement. Various quality improvement tools were used such as, PDSA testing, process mapping and annotated run charts. Tailored interventions were put in place including:

- Staff satisfaction survey
- Health awareness campaign
- Team building exercises
- Data cleansing and reconciliation of historic data held on HR systems
- Revision of time returns for salaries
- Revision and standardisation of return to work interview process

Result
Poor attendance at work directly affects outcomes (HSE Managing Attendance Policy and Procedure, 2009). The QI team initially focused on impact of absenteeism on three areas: Cost of Care, Continuity of Care and Culture within CCNU. The terms absenteeism and sick leave have negative connotations but we found that by focusing on management and staff wellbeing in a positive way we were able to make progress. Overall absenteeism has reduced due to a number of factors, one of which we believe was the focus of, and the work undertaken within, our project.

Staff well-being is now an intrinsic element of staff engagement within the unit while undertaking data analysis and process mapping, key work practices in the area of time administration were identified as being non-compliant due to lack of awareness and training. These are now compliant. This project will have its impact in the long term as measures to ensure sustainability have been put in place.
Improving the Quality of Prescribing on an Acute Medical Admissions Unit

Authors
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Abstract

Background
Medication error is a common source of patient harm, accounting for 19% of the total. Reported errors represent a fraction of actual errors and feedback to front-line prescribers can prove challenging.

Methods
Team-based QI project with frequent stakeholder engagement to share data and agree interventions to improve outcome.

Results
Baseline documentation of allergy status was good and remained so throughout, at 85-97%. Baseline compliance with identification of prescribers by name and MCRN was poor at 41%, improving to 62% at project end. At baseline, 49% of kardexes had no avoidable medication errors, improving to 80-90%. Acknowledgement of pharmacist concerns in the kardex was non-existent at 0%, improving to 60-70% at project end. Legibility was 85-100% throughout.

Conclusions
Baseline compliance with standards for good prescribing were much worse than we had anticipated, but improved significantly during the project, through frequent multifaceted stakeholder engagement and data-sharing. Sustainability and further improvement will be facilitated by the implementation of an electronic prescribing system which will ensure 100% compliance with allergy status documentation, identification of prescribers and legibility. This project cannot show a firm reduction in the occurrence of serious medication errors, but it is hoped that the Medication Safety Minute initiative will contribute significantly in this regard, through frequent feedback to front-line prescribers of common medication errors and other vital information on safe prescribing. Ultimately, improvement in medication safety will require continuous improvement in the institutional culture around safety and prescribing in particular.
Eliminating Coagulase Negative Sepsis in the Neonatal Intensive Care Unit

Authors
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Abstract
Nosocomial infections are known to be associated with neonatal morbidity leading to increased length of stay in the hospital and increased cost for the hospital. The rate of Coagulase Negative Staphylococcus Sepsis (CONS) in our institution has been increasing since 2015, and is above the Vermont Oxford Neonatal Network (VONN) national average. The aim of this project was to reduce the CONS rate from 3.5% to zero% using a quality improvement initiative.

Methods
A multidisciplinary team was configured to develop an audit tool looking specifically at the blood culture taking technique used by neonatal nurses and doctors. The results of this audit led to a number of Plan Do Study Act (PDSA) cycles which addressed various noncompliance audit issues. Guideline updates played a central role in education regarding neonatal infection prevention.

Results
The audit of Blood Culture technique demonstrated noncompliance in almost all areas of the process including failure to wear gloves, failure to clean the key site and failure to take the appropriate volume of blood for analysis. Despite education and re-auditing and ensuring 100% compliance with the Blood Culture guideline there were CONS positive Blood Cultures. This prompted us to scrutinise the reason for CONS colonisation and demonstrated that the more the skin of a neonate was breached the higher the chance of developing CONS infections.

Discussion / Implementation
The reason for CONS infection rate was more basic and fundamental than hand hygiene / poor Blood Culture technique alone. Once we put the infant at the centre of care, we discovered that being more patient focused than task oriented, helped reduce the potential colonisation of infant with CONS.

Financial Implication
The total cost in 2016 for 9 patient episodes of CONS was estimated to be €10,539.18. There was also a personal cost in that parents, particularly mothers, were separated from their infants leading to separation anxiety, delayed bonding and delay in establishing breast feeding.

Conclusions & Plans for future development
The aim of the study has not been achieved as this is a work in progress. In order to reduce the CONS sepsis rate we will continue with education and audits of hand hygiene and Blood Culture technique. The daily ward round will have the neonate at the centre ensuring patient centred care. There are processes in place to prevent unnecessary blood
sampling and thus reduce infection rates. The team is also looking at purchasing a ‘Countdown Clock’ telling all people who work / visit the neonatal unit, how many days it was since the last CONS infection.
Recalibration of a Large Acute Hospital GI Endoscopy Waiting List

Authors
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Deirdre O’Keeffe, Quality Improvement Division, Health Service Executive

Abstract

Background
There has been significant growth in the demand for colonoscopy over the past decade as a diagnostic tool. This increase has been further compounded by the introduction of colonoscopy as an effective method for colorectal cancer screening which has resulted in an exponential increase in colonoscopy demands, forcing endoscopy units to bear an excessive burden of work. With the establishment of the Hospital Groups within the Irish healthcare system it became apparent that one approach to solving the problem of growing waiting lists is to consider each hospitals capacity within the group and match the demand.

Methods
The goal of this Quality Improvement (QI) project was to recalibrate a large acute hospital GI endoscopy waiting list and minimise patient waiting times using the Model for Improvement and the Plan-Do-Study-Act (PDSA) improvement process. Data was collected from June 2016 to April 2017. Information collected included; referral letter, procedure type, age, gender, time on the waiting list, history of previous procedures, reason for procedure and family history of bowel cancer.

The following QI interventions were implemented sequentially: pooling of all endoscopy referrals waiting above 6 months on the waiting list; validate all patients on the waiting list waiting from 24 to 3 months; patients were offered a choice of waiting longer or to travel within the group hospitals with a shorter waiting time; assess the appropriateness of the clinical indication for colonoscopy against agreed guidelines at time of procedure; feedback to all primary consultant of pooling and internal sourcing; 0 to 3 months referrals administrative and clinical validation prior to placing a new patient on the waiting list. Baseline and on-going measures were collected and charted.

The initial stages of this project were key to its success; get agreement from all the consultants to allow pooling of referrals under their names; designate the level 3 hospitals to create 20% extra capacity within their current resources and establish whether patients were willing to travel within the group hospital for a shorter wait.

Results
Pooling waiting lists along with the application of guidelines to determine the appropriateness of the procedure are key steps in addressing the issue. A telephone survey revealed that 92% of patients were happy to travel to another hospital. Following 6 interventional PDSA’s to reduce the waiting list times there was a drop in the number of patients waiting from 2764 to 690 within the first 6 months of starting this project. Following our quality improvement project there was a drop of 48% in patients waiting in June 2017 compared with figures from the previous year.
Applying QI methods and tools improved endoscopy waiting list times. Given the increased endoscopy demand, strategies should be implemented to reduce the wait time for endoscopy.

Financial Implications
Based on 2014 HSE submitted costs for Colonoscopy (Minor complications), the average cost for a day case was calculated at €554. This project identified that 40% of 2764 patients did not require a colonoscopy resulting in a saving of approximately €612,502.40. If these patients were referred to a private service for treatment the cost of each colonoscopy would be calculated as €950.00 resulting in a total spent of €1,050,320. Approximately 80% of patients during a hospital patient satisfaction survey indicated they were very satisfied with the new service they received.

Conclusions
Pooling endoscopy waiting lists and internal sourcing offers the potential to reduce endoscopy waiting times for patients. The majority of patients are willing to travel to another hospital. However, 8% of respondents were not willing to travel. The preferences of this group are important in policy decisions. Given the increased endoscopy demand, strategies should be implemented to reduce wait times for endoscopy.
Improving the quality of prescriptions for intravenous fluids in the department of medicine in Cavan & Monaghan Hospital

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Abstract

Background
Medication error and adverse drug reactions occur frequently, leading to a high burden of patient harm in the hospital setting. Cavan & Monaghan Hospital have identified medication prescribing standards as an area for improvement within the hospital. We aim to increase compliance of intravenous (IV) fluid prescribing from 70% to 100% in adult medical inpatients in Cavan & Monaghan Hospital by May 2017.

Methods
The model for improvement was used, supported by other quality improvement tools to assess the key areas to target for improvement. Baseline data was collected on eleven key standards for medication prescribing and a pareto chart was developed to identify the three standards most frequently missed. These included generic name of medication, strength of fluids and duration/rate of fluid infusion. The improvement group focused on improving these key standards.

PDSA cycles were used to test and implement changes to improve the standard of prescribing.

- PDSA 1: Education of medical prescribers on the standard required
- PDSA 2: Communication of prescribing standards by email and hand-outs to all medical prescribers
- PDSA 3: Engagement of junior medical staff through speed networking event
- PDSA 4: Rewarding of good prescribing practices
- PDSA 5: Awareness session and provision of prescribing guidance to all prescribers
- PDSA 6: Revision of the IV fluids section of the medication chart
- PDSA 7: Engagement with nursing teams to support zero tolerance campaign for poor prescribing practices.
- PDSA 8: Second revision of the IV fluids section of the medication chart

Results
Improvement was achieved by increasing the median compliance of three key standards by 60% (10% to 70%). This resulted in an overall improvement of 30% in median compliance with eleven standards. The median compliance for these standards improved from 70% to 100%. This was sustained for 5 weeks.

Discussion
Reducing prescribing error required the improvement group to co-design and implement a more error-resistant system.
Financial implications

Potential cost savings: €46,349 for this cohort of patients

Number of patients positively affected: 220 individual intravenous fluid prescriptions were reviewed.

Conclusions

Staff engagement is critical to changing clinical practice. The next steps will be to spread this change to other departments within the hospital.
To safely increase the rates of spontaneous labour, and decrease the rates of induction of labour, in patients having their first baby through the introduction of a Post-Dates Assessment Clinic

Authors
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Abstract

Background
The Maternity Unit is based in a Level 3 Regional Hospital in a large rural town and is a Consultant led unit with three full-time Consultant Obstetrician/Gynaecologists. In 2016, 2,081 mothers were booked for delivery here, 707 of whom were having their first baby (Irish Maternity Indicator System IMIS 2016). The National Institute for Health and Care Excellence (NICE) recommend that women with uncomplicated pregnancies should be given every opportunity to have a spontaneous labour (NICE Guideline CG70 2008).

The National Maternity Strategy 2016 states that all pathways of care will strive to support the normalisation of the birth process as much as possible. Induction of labour (IOL) is the process whereby a labour is initiated artificially with drugs such as oxytocin and prostaglandins. The rate of IOL at the commencement of our project was 34.4% among first time mothers (IMIS). We chose to focus on first time mothers whose pregnancies continued beyond their due date, with no other complicating factors, a cohort of approximately two to three patients each week.

Method
The Model for Improvement (Langley et al 2009) was used as the framework for improvement. The aim of the project was to safely increase the rates of spontaneous labour, and decrease the rates of induction, in patients having their first baby through the introduction of a postdates assessment clinic. We examined the existing referral pathway and baseline data and found variation in the definition of prolonged or post-dates pregnancy (from term + 6 to term + 10). We developed a pathway that would include an assessment at 41 weeks of maternal and foetal wellbeing and a date for induction at term + 12. We sought agreement from key stakeholders and designed a protocol for the postdates assessment to take place in the existing Foetal Assessment Unit. Education of medical and midwifery staff was required prior to our first test of change using the Plan, Do, Study, Act cycle (PDSA) and continued throughout the project period.
Results

There was broad acceptance of the changed pathway and co-operation from stakeholders involved. Once the change is embedded in the primigravid group we hope to use the data to show that the change represents an improvement, that is a reduction in IOL (and other interventions including emergency caesarean section) and thereafter spread the change to all appropriate maternity patients. There is potential for significant improvements in patient experience and cost savings.
Sleep Clinic Outpatient Improvement Project

Authors

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Abstract

The “Sleep Clinic” in Sligo University Hospital (SUH) was identified as having challenges because waiting times for patients were in excess of 24 months. There is an increasing number of referrals and limited capacity within the existing system. The aim of the project was to reduce the time that patients wait from referral for possible obstructive sleep apnoea syndrome (OSAS), to clinical assessment, diagnostic test and treatment from 24 months to 3 months. In common with many projects and services in the HSE, resources are limited and while we could spend our time wishing for more - more time, more equipment, more personnel - our aim was to try and do this project within the existing budget while perhaps identifying potential transferrable ideas.

This project used the tools demonstrated in the Quality Improvement course to identify improvements which were implemented with varying degrees of success. We reviewed the process – from initial referral by the General Practitioner through the pathway of triage and appointment, to the first appointment and clinical assessment, diagnostic investigation and follow up appointment with the results. We assessed the demand and capacity of the service. Through targeted PDSAs, we initiated improvements to the service.

The results showed that we increased Sleep Clinic Outpatient capacity for new patients by 100% and Sleep Study/Test capacity by 125%. While we have dealt with a significant increase in numbers of referrals, we have created longer waits for tests and results. The increased numbers of patients in the system highlighted the need for a database to track patients from referral through the process to the review.

It has been challenging to identify the financial impact of this project. However, given that the existing Consultant has increased the capacity of her clinics, this equates to the costing of one additional clinic per month and avoidance of referring patients to the Private Sector. A cost avoidance measure equivalent to one clinic per month results in a €30,000 savings per annum, along with a savings in terms of avoidance of outsourcing costs of €28,200 (based on additional 188 patients seen in 2016/7).
Overall the project has demonstrated that it was not possible to achieve our aim of a 3 month time from referral to treatment without significantly addressing the lack of capacity and resources in the system. However, we did successfully see and treat an additional 184 patients as a result of this project.
Fracture Clinic Redesign OLOLH Drogheda

Authors
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Ms Áine Davern – Assistant Director of Nursing
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Abstract

Background
Our lady of Lourdes Hospital Drogheda is the trauma centre for the north east region of Ireland with 7 fracture clinics per week seeing 19,586 patients in 2016. Clinics can have as many as 100 attendances with some patients waiting 3 hours to be seen. A re-designed fracture clinic process creates the opportunity for simple fractures to be managed by the multi-disciplinary team via a protocol driven Virtual Fracture Clinic (VFC).

Methods
The HSE Framework for quality improvement was used to guide the initiation, planning and implementation of the project. Data was collated to determine condition trends, which demonstrated that many patients can be safely managed by self-care or physiotherapy rather than the need to see a consultant. The voice of the patient was captured to ensure any re-design meets the needs of the service user. Protocols were agreed with all health-care providers for conditions suitable to be managed in a re-designed patient pathway. Stakeholders were engaged with the planning and formation of project. Each suitable patient is treated in the emergency department (ED) and thereafter x-rays and ED notes reviewed virtually by the consultant. The patient does not need to attend the clinic, but is contacted by phone and a plan of care initiated.

Results & Conclusion
The new process is evaluated by auditing the numbers attending the virtual fracture clinic and analysing patient satisfaction and experience. Results to date indicate a positive trend towards reduced number of consultant led appointments with 441 patients successfully managed in the new pathway. These patients are all spared at least one unnecessary attendance to hospital. An estimated cost saving of €23,985 has been achieved. Data indicates an enhanced patient experience, with a difference of 4 points in median scores on a 10 point likert scale, between a virtual clinic group and a traditional fracture clinic group. Developing the initiative across all regional sites is the next step in mainstreaming the new process.
Reliability of Reporting and Investigation of Adverse Events and Near Misses in an Acute Psychiatric Unit

Authors
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Martina Queally, Chief Officer Community Health Organisation 6

Abstract

Background
The aim of this project is to increase the reliability of the reporting and investigation of all adverse events and near misses within an acute psychiatric unit (Unit A).

Methods
Methods including process mapping, focus group discussions with frontline staff, and an anonymised, random, retrospective review of 57 patient charts were used. Plan-Do-Study-Act (PDSA) cycles were selected and implemented in order to link system knowledge to effective redesign, and to test improvements.

Results
The findings of the project related to specific staff issues, structures and systems that support service improvement. A level of under-reporting was identified. Whilst all serious incidents were investigated, it was not evident that all incidents, particularly those categorised as minor, were reviewed and investigated as appropriate. There was ambiguity amongst staff in relation to the definitions of particular risk categories, and a lack of clarity regarding the requirement to review all incidents.

Discussion and Implementation
In order to provide assurance and monitor adherence of the reporting aspect of national policy, audit of the identification and reporting of adverse incidents/ near misses is required. The development and use of a trigger tool will assist with identification of under-reporting. The enhancement of structures and systems within the unit will be achieved through the establishment of a local Quality & Patient Safety (QPS) committee and a Local Incident Management Team (LIMT).

Financial Implementation
Increased costs are associated with the release of staff for training. The cost is mainly incurred by provision of replacement staff. There is a small cost associated with ‘lunch and learn’. It is anticipated that the above costs would be offset by savings achieved through early identification, prevention and improved management of risks due to reduction in medical costs relating to harm, legal costs and claims.
The expectation is that the outcomes of this project will improve quality and patient safety, not just in the unit where the project was conducted, but will impact positively on the risk management system across the Mental Health Division within the CHO. It also has the potential to be a source of learning for other divisions.
Analysis of Acute Services Performance

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Abstract

Background
The purpose of this QI project is to improve the understanding of the performance of acute services and enable better decision making by presenting performance data in different formats. Acute Services is the largest area of public health activity and spending. In light of this it is vital to ensure that there is a strong quality and improvement focus including measurement for improvement on acute services.

Methods
Our smart aim is to improve the effectiveness of the presentation of information on a selection of indicators related to acute services performance from its current baseline of 5.2 to 10 (on a 10 point scale) by January 2018. We applied a variety of QI tools throughout the project cycle and undertook six PDSAs as tests of change related to a vector of measures.

Results
Through our learning from PDSA cycles we facilitated managers understanding of performance information by improving the average effectiveness rating from 5.2 as our baseline to 8.4 out of 10.

The openness of stakeholders to new ways of reporting and analysing performance information is encouraging. However, we identified that there will be cost associated with implementation of the initiative in terms of training in SPC methodologies and analysis and the development of leaders/managers in measurement for improvement.

Discussion/Implementation
Developing the project gave us an opportunity to make the time and space too really ‘think’ about the fact that that there is another way of presenting and interpreting data.

Financial Implications
There are two types of potential savings associated with this initiative

- saving in multiple executives’ time in interpreting and understanding performance results
- more effective decision making leading to more efficient use of service resources

Conclusions and Future Plans
On-going initiatives to introduce a QI mind-set are taking hold with a strong appetite among leaders in the health service. As our initiative is sponsored at senior management level in the HSE the opportunity for implementation, sustainability
and spread is optimum. We will continue to champion the use of QI methodologies to improve understanding and decision making with the ultimate aim of improving the provision of services to patients.
The Introduction of a Standardised Clinical Handover Tool to a Multidisciplinary Team in an Irish Healthcare Organisation

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Abstract
In recent years many clinical incidents in hospitals have been linked to an identified lack of quality in communication particularly relating to the handover of clinical information. In Ireland, following the HIQA Patient Safety Investigation Report into Services at University Hospital Galway (2013), the National Clinical Effectiveness Committee were requested to develop National Clinical Guidelines to address the issues raised relating to clinical handover. The National Clinical Guideline Number 11 for Communication (Clinical Handover) in Acute and Children’s Hospital Services (DOH, 2015), is one of these guidelines. The Chief Executive, Executive Clinical Director and Director of Nursing in all acute hospitals are responsible for the dissemination and implementation of this guideline. This quality improvement project was undertaken to achieve this objective. It was decided to commence the project in a single clinical area with the following aim in mind which was considered achievable: The Aim: 100% of Medical Patients on St Martha’s Ward MMUH will have their clinical Information handed over by Nursing and Medical staff using the ISBAR tool by April 2017. Using a series Plan Do Study Act (PDSA) the tool was designed, reviewed and implemented.

Initially in paper version, resistance to its implementation across the whole MDT was experienced. The project team tried different methods to overcome the resistance but did not succeed within the timeframe of the project. The project was expanded at the request of the medical staff to explore the option of an electronic version of the tool. At this point further studies are required to weigh up the costs of communication errors in the organisation versus the cost of the IT system, however, the project team can confirm that the nursing staff of St Martha’s Ward have fully embraced the ISBARRD tool and use it at every patient clinical handover. It has also been adopted for use across the MDT in Post-Acute Services. Future plans include the roll out of the tool across the Department of Nursing and the introduction of the tool to the General Internal Medicine daily meeting.
Quality Improvement Project in the dedicated Hepatitis B clinic, Galway University Hospital

Authors
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Background
A dedicated hepatitis B clinic was established in Galway University Hospital in 2016. Its aim was to provide streamlined and patient-centred care to this cohort of patients; previously they were attending either general Infectious Diseases or Hepatology clinics. After a few months it was noted that the rates of non-attendances seemed high; consequently these patients were not accessing care, which could lead to unmonitored progression of their disease. With this in mind, a quality improvement project began to help address this issue. The aim of the project was to reduce the number of patients missing their surveillance liver function tests by reducing non-attendance rates from a median of 6 to 0 per clinic in the 6-month period from January to June 2017.

Methods
A run chart was used to measure non-attendance rates in the clinic overtime. The first change project involved the clerical officer team making an additional patient reminder phone call. Data collated through a Pareto chart also showed that there was a heavy reliance on mobile phones and this was affecting the ability to contact patients. As a result the team began to consistently remind patients to update their details and cancel appointments if they couldn’t make it. Lastly an attempt was made to establish an alternative appointment system for surveillance bloods if a patient didn’t attend their scheduled slot.

Results
The median rate of non-attendance dropped from 6 to 4 over the 6-month project. This reduction was driven largely by the additional patient phone call, which had an immediate effect as evidenced by the run chart. Due to resource constraints blood testing appointments outside of normal clinic slots have not been made available as of yet.

Discussion
The additional reminder patient phone call is now ingrained in the process map of the clinic and additional clerical officer time has consistently been made available from this step. For an additional 24 hours of clerical officer time, a minimum of 24 patients were affected by this improvement project; these patients are now engaged in care and the potential progression of their liver disease has been arrested.
Conclusions
This project led to a definite improvement in patient care, but did fall short of our initial aim. Whether this project is applicable to the wider general outpatients also remains to be seen. This project has also highlighted that language is a major barrier to effective communication with patients in trying to encourage them to access care. The team are exploring the use of language specific and tailored reminder text messaging for the next change project.
Accessing a specialist service for substance misusers using e-consultation

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Abstract

Background Patient story
“Getting on methadone saved my life, I was on heroin for 12 years; strung out all the time, injecting in the groin, sleeping rough and in squats, never seeing my kids. I heard about the clinic from my friends and I made a call and got an appointment. I gave my 3 samples and was told I was put on the waiting list...that was for 10 months and things got worse. Then I started and 2 years later I’m not using any drugs, I’m on a training course and have my own place. I’m working to get to see my kids again”

Patients wishing to access Opiate Substitution Treatment (OST) from Substance Misuse Services (SMS) can experience unacceptably long waiting times. This results in increased waiting lists and patients disengaging from services. These patients remain at high risk of physical, psychological and social harm, and legal problems. The aim of the QIP was that all SMS patients would be assessed by a Specialist GP (SpGP) within 4 weeks of satisfying criteria for OST between 1st January and 30th June 2017 using e-consultation. We used tripartite e-consultation between 1 off-site SpGP, and the Substance Misuse Team (SMT) GP who was with the patient in the SMS clinic setting.

Methods
All patients who had satisfied OST criteria and who were on the SMS waiting list for SpGP assessment were recruited. There were no exclusion criteria so this cohort was representative of the total population of SMS patients. There was 100% uptake for the project (21 patients); the male: female ratio was 2.33:1, and the age range was 21 years to 63 years old. None had taken part in e-consultation previously.

Results
The results indicated that 100% of patients were assessed by a SpGP within 4 weeks of satisfying criteria for OST between 1st January and 30th June 2017 using e-consultation. 100% of these patients were very satisfied with e-consultation, mentioning improved access to services and improved quality of local services in feedback. 100% of patients who had e-consultation stated that they were positively affected by this QIP. The success of this project is encouraging for the use of e-consultation as a tool to enhance OST services nationally.
Quality and Safety Walkrounds (A Walk with a Purpose)

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Abstract
According to the HSE Quality Improvement Division: “Everyone in healthcare has two jobs when they come to work every day: to do their work and to improve it” (2016).

In an ever increasing regulatory environment, the overall aim of this project is to develop a reflective focused rather than inspection/compliance focused culture through listening and acknowledging staff experience at the frontline to improve the life experience of our service users. This project came about at an opportunistic time for us as the organisation was in the process of reconfiguring its governance and management structures to support the Organisation’s Strategic Plan 2017-2021.

The purpose of the project is to increase authentic person-centred engagement and partnership with our staff and service users by introducing quality and safety Walkrounds into two day and two residential settings across the organisation. Centred on the Model for Improvement by Langley, Moen et al (2009) we carried out over twelve tests of change over a six-month period to support the adoption of this innovation. Supported by the CEO, Executive Management Team and Strategic Safety Committee, a Steering Group comprising of twelve staff and one service user, was set up to oversee the project. In addition this pilot project seeks to impact the lives of seventy seven service users and thirty-two staff across the four pilot sites.

The project has increased staff engagement and helped develop a culture of open communication. It has been an opportunity to identify, acknowledge and share good practice through the development and monitoring of action plans and subsequent database. The project also supports a proactive approach to minimising risk, through timely reporting and feedback. By adopting a partnership approaching dialogue and discussion with frontline teams, solutions to many of the issues raised were solved by the staff themselves. This has strengthened commitment and accountability for quality and safety and proves the theory ‘The answer is always in the room’.
From Broken Bone to Walking Home: The HIP ATTACK Pathway

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Abstract

Aim
To increase the number of hip fracture patients admitted through the ED in a Dublin tertiary referral teaching Hospital to the orthopaedic ward within 4 hours of arrival to exceed the national average of 14% by 30th June 2017.

Background
Hip fractures are one of the most devastating injuries resulting from a fall (HSE, NCAOP, DOH, 2008). Hip fractures specifically carry a high incidence of morbidity, disability and with mortality of 10% at one month and 30% at one year (Lisk et al, 2014).

Methods
Data from the Irish Hip Fracture Database showed that patients with hip fractures presenting to a Dublin tertiary referral teaching hospital were not meeting a key hip fracture care standard, Blue Book Standard 1. Using the IHFD data and additional data collected locally, there were obvious gaps in the care process. Delays in triaging and alerting relevant teams were identified. Process mapping, meetings and education with all key stakeholders and PDSA cycles were used to evaluate and drive change. The key step forward was the introduction of the ‘HIP ATTACK Pathway’.

Results
The median time for patients from time of arrival in ED to time to orthopaedic ward reduced from 11 hours in 2016 to 7 hours between the 1/1/2017 and 30/6/2017. Overall, the 4 hour target was achieved in 13% of patients(n=16), an improvement of over 6 percentage points from 2016 data. This is just shy of the 2016 national average of 14%. A significant improvement was noted in the second three months of the project with 19% (15/79) being admitted to the ward within 4 hours compared to 2% (1/45) in the first three months.

Conclusion
The introduction of the ‘HIP ATTACK pathway’ signified an appreciation of the priority for this group of patients. Appointing ownership that was visible to all stakeholders ensured that their role in the pathway was clear. This was key to driving sustainable change. Having clinical audit data for measuring the process of care was key to the success of achieving a sustained improvement.
Quality Street: Improving Patient Experience in the Emergency Departments of St. Vincent’s University Hospital and St. Michael’s Hospital

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Abstract

Background
Ireland lacks a comprehensive way to understand patient’s perception of their health service, as well as a structure for improvement in this area. This can impact negatively on patient experience and staff morale. Patients do provide unsolicited feedback to hospitals in the form of complaints, compliments and claims and some hospitals solicit patient comments regularly. However, these 4 forms of feedback are dealt with separately and are not in general shared with either staff or patients. The aim of this project was to improve patient experience by establishing and achieving a minimum standard of twice as much positive patient feedback as negative patient feedback in all pillars of the Irish National Healthcare Charter from October 2016 to May 2017 in the Emergency Departments of two Dublin hospitals.

Methods
Our team sought a method to: (1) Comprehensively view and analyse patient feedback in all of its varied forms (2) To understand patient feedback in the context of an agreed quality standard for the provision of care, (3) Provide a mechanism for patient feedback to serve as both a path and vehicle for quality improvement where an agreed standard was not being met.

Results
In our baseline 3-months one hospital was not meeting the 2:1 standard. Areas of worst performance were access and communication, where the proportion of negative feedback was 70% and 42% respectively (nearly the reverse of our desired ratio). At the end of the 3-month intervention period, the standard was met in both hospitals.

Discussion / Implementation
While many efforts contributed to the standard being met, key to this accomplishment was making all staff aware of patient feedback in a way that generated profound knowledge of patient’s perceptions of their care.

Financial implication
Our system has required no dedicated funding and operates quarterly. By comparison, the National Patient Experience Survey is a heavily funded project that annually solicits anonymous patient feedback data from a single month (May).

Number of patients/clients/service users affected positively
Between the two hospitals, 2047 more patients had a predominantly positive experience in the intervention period than in the baseline period.
Conclusions
There are plans for further development or wider dissemination of project by using the available information more efficiently, we have developed a sustainable, operating system that is cost-neutral or cost saving, and can facilitate genuine person-centred QI on a quarterly basis.
To Err is Human: Improving the Reliability, Efficiency and Cost Effectiveness of the Decontamination Process

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Abstract
To Err is Human: Improving the reliability, efficiency and cost effectiveness of the decontamination process by utilising data collated from the National Track and Trace System to identify and minimise “bottlenecks” in the decontamination process caused by human error.

Background
Effective and reliable decontamination of reusable invasive medical devices is key to minimising the risk of infection transmission (Kenters et al., 2015) therefore, maximising the reliability and efficiency of the decontamination process is a critical factor in delivering safe, effective care. In 2008 a National Electronic Track and Trace system was implemented by Health Service Executive across all Decontamination facilities in Ireland, providing a wealth of data relating to all aspects of the decontamination process. The primary aim of this project was to explore the efficacy of using data, generated by the National Tracking system, to identify “bottlenecks” (Goldratt, 1990) caused by avoidable human error, in the Central Decontamination Unit (CDU) in Temple Street Children’s Hospital (TSCUH) and to reduce these errors by 100%. The scope of the project included 2 sub aims: 1. Enhance staff understanding of their role in quality improvement, empower them to lead on, or engage in quality improvement to ensure sustainability of the change process. 2. Explore the potential of using data from the National Tracking System, to improve the reliability and efficiency of the decontamination process nationally, based on learning from the TSCUH pilot site.

Methods
The Team adopted the National Framework for Quality Improvement to guide the process; applied the theories of reliability and constraints to identify, understand and control error and variation in practice; used a combination of run charts, pareto charts and process mapping to illustrate and measure areas of avoidable error and improvement; surveyed frontline staff to measure engagement and their perceived understanding of their role in continuous improvement.

Results
The National Tracking System in TSCUH provided validated data identifying Types of “human error”. Pareto charts highlighted times of the day when errors were most likely to occur and process mapping illustrated areas for improvement. Similar findings were noted when TSCUH data was compared to randomly selected Acute Hospital CDU’s empowering staff to co-design a quality improvement checklist achieved a 100% reduction in cancelled wash cycles due to human error, over a period of 5 months. Using a 5 point Likert scale to survey shift in staff perceptions proved...
inconclusive, but all staff agreed / strongly agreed regarding importance of their role in continuous improvement and confidence to raise issues. The biggest shift was in staff perception that their role was supported by regular meetings.

**Conclusion**

Using data from the National Tracking System to implement local continuous improvement, unlocked the potential to improve the reliability and efficiency of the decontamination process nationally. Empowering frontline staff to co-design the checklist, led to sustained improvement over time. The learning from the TSCUH pilot site recognised the benefits of developing a QI and Measurement Foundation Programme for Decontamination practitioners nationally which will commence in September 2017.
Care of the Deceased Patient

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Abstract
Caring for the deceased patient is paramount. At all times dignity and respect of the deceased person should be maintained. The aim of the project was to ensure 100% compliance with the process for managing the body of the deceased patient immediately after their death and provide appropriate support to staff by July 2017. Ultimately the project was to identify best practice; how that could be achieved within our setting, to ensure dignity for deceased patients, reduce unnecessary distress for families and provide appropriate support for staff. To achieve this a number of different approaches were required; involving interaction with many stakeholders and review of international, national and local procedures and practice. Gaps in the process were identified particularly relating to the location of necessary documentation. In addition, staff support was highlighted as another area for improvement. This project has highlighted to the authors how change is continuous, persistence and collaboration with stakeholders is required to achieve improvements. Awareness of resistance both individual and organisational is also fundamental and learning how to cope with this is essential. To date some improvements have already been implemented and it is anticipated that more are likely following in the future.

Introduction
The purpose of this Quality Improvement was to identify an area within the authors’ organisation and to address key aspects utilising the tools provided during the course offered by the Royal College of Physicians of Ireland. The title of the project selected was ‘Care of the Deceased Patient- to ensure 100% compliance with the process for managing the body of the deceased patient immediately after their death and provide appropriate support for staff by July 2017’. The project was undertaken in a large teaching hospital in Dublin. Staff and families were engaged by way of Focus Group sessions and family meetings. The aim of these meetings was to establish knowledge, compliance, feedback from families and to determine the workings of the current process and if there was a requirement for review and thus improvement.

A literature search was conducted by use of databases including CINAHL, MEDLINE databases and Google search engine. Additionally tools such run charts, driver diagrams, PDSA cycles, stakeholder analysis were all utilised to inform this project.

Background
There are a wealth of concepts which come to mind when we think of Quality in relation to patient care and treatment; patient safety, respect, dignity, informed expert knowledge and standards in line with national and international best practice. The definition “meeting and exceeding the needs and expectations of patients and/or other customers, with
a minimum of effort, rework and waste” as outlined by Berwick & Plsek (2006) was at the forefront of our minds for our first meeting about this project.

In the first instance an informal discussion with the Director of Quality, Safety and Risk management took place where the requisite for this project was set forth. In the year prior to commencement of this project the Risk Management Team were tasked with a system review and analysis following an adverse incident relating to the management of a deceased patient. It was established that despite the fact a process was in place to address issues pertaining to the care of the deceased person, failings occurred and there was inapt adherence to the process. As a result of the review an internal investigation was initiated. The findings from the investigation were multi factorial including lack of knowledge of the existing process, lack of clarity, staff unaware of the existence of the process and procedures. Additionally staff were oblivious to the level of support available for families of the deceased. As a result this Quality Improvement Project was initiated with the belief and aim to improve outcomes for the patients and in this particular instance for the families unfortunately involved in the Bereavement Process. Furthermore it was anticipated that it would produce positive benefits for not only the staff but for the Organisation.

**Rationale**

A prerequisite of everyone’s business in healthcare is to deliver sustainable safe, effective person-centred care and support. Effective leadership and governance are fundamental to achieving this. In a well-governed service, clarity is required around what the service does how it does it and who is accountable. According to the Health Information and Quality Authority (HIQA) 2012), good governance arrangements acknowledge the inter-dependencies between organisational arrangements and clinical practice to deliver safe and reliable care. This was identified as a key component for the delivery, progression and success of this Quality Improvement Project.

Hence the rationale for this project is to ensure that the patient is central to everything we do. According to the Irish Hospice Foundation (date not available) “caring for the deceased patient is one part of the overall continuum of care given to patients at the end of life and those close to them. At all times dignity and respect of the deceased person should be maintained”. It is anticipated that the success of this project will be achieved by identifying best practice, reviewing current practice, and ensuring staff are supported and well informed. The project will ensure the organisations process meets with national and international best standards of care delivery where staff feel supported through the process and are equipped with the appropriate knowledge and education in order to guarantee full compliance with the process. Fundamentally the project aims to make certain that timely, safe and effective delivery of care is proffered to the patient and their family striving for the best possible standards, outcomes and experiences for all involved in the process.
Improving Patient Experience Times (PET) for Non-admitted Patients in the Emergency Department

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Abstract
Cork University Hospital’s Emergency Department (CUH ED) is now the busiest in the country seeing over 65,000 patients per year. It acts as a regional centre for secondary and tertiary care for the catchment population of 550,000. At the time of commencing this project the non-admitted patient experience time (PET) stood at approximately 70% falling short of the national expected target of 95% for discharge within 6 hours. Improving PET’s for patients will bring about a focussed approach to service delivery by complying with National Targets, comparable with other institutions of a similar size. In order to bring about an improvement in PET, the patient and their presenting condition will be critically examined to seek out improvements in their treatment pathway.

With the use of a driver diagram we identified clear drivers for change and a stakeholder map clarified who were the main players and who would enable us to carry out the project.

Early on it was evident that the key for the aim statement to succeed was not just held within the emergency department but would take an organisational approach with a focus not solely on the patient flow within ED, but on the flow of the patient throughout the hospital.

Engagement within the Emergency Department staff and Executive Management Board were key to winning support in delivering this project. Communication, both a “top-down and bottom-up” approach proved to be most successful, and communicating a shared vision and outlining everyone’s role in delivering this was essential in winning “the hearts and minds”.

The use of visual robust data to communicate daily flow was essential, and provides the stimulus to improve team performance.

At the time of completing Phase 1 of this, a 2 phase project, the 6 hour non-admitted PET had improved to 85%. The hospital recognises that sustaining this improvement and maintaining a culture of improvement and change is vital to delivering safe, clinically effective and person-centred care.