PQIP API Collaborative

API Collaborative Session 2: Becoming change makers and Implementing DrEaMing

PQIP Perioperative Quality Improvement Programme

Thank you to those of you who were able to join us for our second API Collaborative session on 22nd November. We had 2 really inspiring talks and some time for discussion. We hope you found the session useful, but o get in touch if there is anything you would like us to include in future

A practical Introduction to making changes: Dr Carolyn Johnston

- Choosing a QI structure is important, there are many to choose from and the model is not important, but the usability for the team
- Data is important and can take time to gather so in the context of PQIP, use the data that is there
- Learn about your setting and how to adapt
- Test your ideas to help evaluate your actions in a complex environment and this can provide valuable evidence that te change will result in improvement
- Skills for improvement fall into technical skills, learning skills and "soft skills"
- However, the soft skills can be the most important as they enable you to identify stake holders and influence them
- Make patients influential in your projects
- The best improvement interventions are multifaceted interventions which include real time feedback, interaction, education and iterative change
- Consider how people adopt change and how they fit into the "adopting change curve"
- Remember the "transition curve" and how change can initially be perceived as a loss.

Systematic review of the application of the plan–do–study–act method to improve quality in healthcare | BMJ Quality & Safety
Skilled for improvement? - The Health Foundation
The habits of an improver - The Health Foundation
Diffusion of innovations – Wikipedia
the_change_curve.pdf (exeter.ac.uk)
https://www.youtube.com/watch?time_continue=2&v=9uUXgMNS23k&embeds_referring_euri=https%3A%2F%2Ftwitter.com%2F&source_ve_path=Mjg2NjY&feature=emb_logo

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Following on from Dr Johnston, Ruth Macdonald shared her invaluable insights into how to get patients DrEaMing and to embed and scale this despite a Covid pandemic and a move to electronic records.

Living the Surgical DrEaM: Ruth Macdonald

- It can take 17 years for evidence from research to be implemented into clinical practice, let alone embedded
- Enhanced recover pathways first emerged in 1997 and compliance to these pathways does improve outcomes for patients
- But implementation is patchy, and pathways have become complex and varied between specialities
- DrEaMing is a perfect care bundle to focus on to reinvigorate ERPs and standardise care

- Implementing change on the ground can be hard, finding a mentor or a coach can be really helpful
- Share ideas and use ideas from other sites or specialities that have worked
- Data is key so think about how to measure and get this data for feedback in a timely way
- Involve patients in every step
- Allow all staff to contribute and feel heard
- Find your champions
- Small and iterative PDSA cycles in real time
- Multi-media feedback e.g. videos, QR codes, post it notes, whiteboards, emails, presentations
- **DrEaMing huddles**
- **Exercise Alley**
- **DrEaMing as a post operative observation**
- **Clear, multiconsensus definitions on nutrition and ensure surgical teams specify for their patients**

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Key Discussion points

- Data collection can be all consuming, so need to find time and enthusiasm for QI

Find champions and like-minded people, find permanent members of staff and collaborate with the whole perioperative MDT. The PQIP team may be the place to start but if they don't have capacity, ask them to point you to changemakers in the ward staff/ enhanced recovery nurses

- Electronic record systems can make extracting data difficult and although some wards are practising DrEaMing this is not reflected in documentation and audit

Try to embrace EPR but if this is slow or difficult, brainstorm ways to circumnavigate this that work locally whilst still pushing for better systems in the electronic record.

- Some surgical specialities don't want patients to DrEaM or undertake the constituent parts

Look at what other sites are doing regarding the same specialities, is your site an outlier or is this standard practice? If they are an outlier look at evidence for changing practice (The Oliver et al 2022 DrEaMing paper clearly states exclusions so is a good place to start). Once you have the evidence then talk to the stakeholders with senior support. If this is standard practice, think about adapting DrEaMing pathways for these patients so they can still partake in the parts that are relevant as this still reduces complications

- What interventions could fuel the most change and therefore the most patients DrEaMing

There is definitely the opportunity to start DrEaMing initiatives with low hanging fruit… identify what this might be and start here. Some examples are patient education, staff education, using the surgical "time ut" or op note to clearly document patients can DrEaM