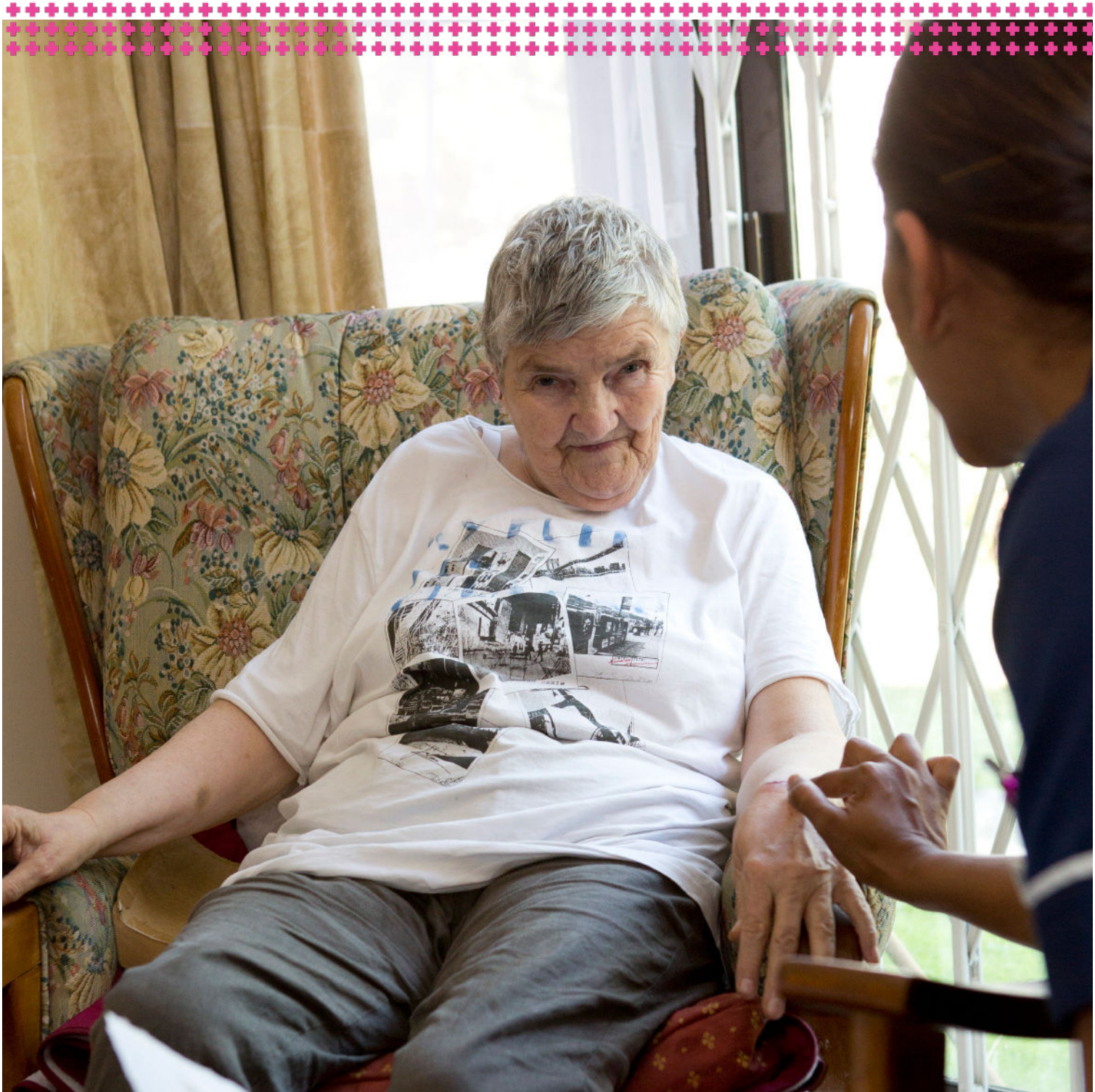
The Queen's Nursing Institute

Community Nursing Innovation Programme:

Complex Needs

Summary of Final Reports 2022



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'Nurse-led projects are one of the most direct ways in which the QNI helps nurses improve patient care. The QNI has funded over 300 innovative projects across the whole range of community nursing specialties.'

Nurse-led projects are one of the most direct ways in which the Queen's Nursing Institute (QNI) helps nurses improve patient care. Since 1990 the QNI has funded over 300 innovative projects across the whole range of community nursing specialties. Sharing the results of these projects helps us to drive improvements in knowledge and practice. Often, these funded projects become part of mainstream services.

In 2021, a cohort of 10 new Complex Needs innovation projects commenced their programme. The projects were supported as part of the QNI's Community Nursing Innovation Programme, thanks to a major grant from the Burdett Trust for Nursing. Each of the nurse-led projects benefited from funding of up to £5000 and a year-long programme of professional development from the QNI.

The projects were based across North and South Wales and England including Wolverhampton, London, Leicester, Bedfordshire, West Yorkshire, Kent and Nottingham.

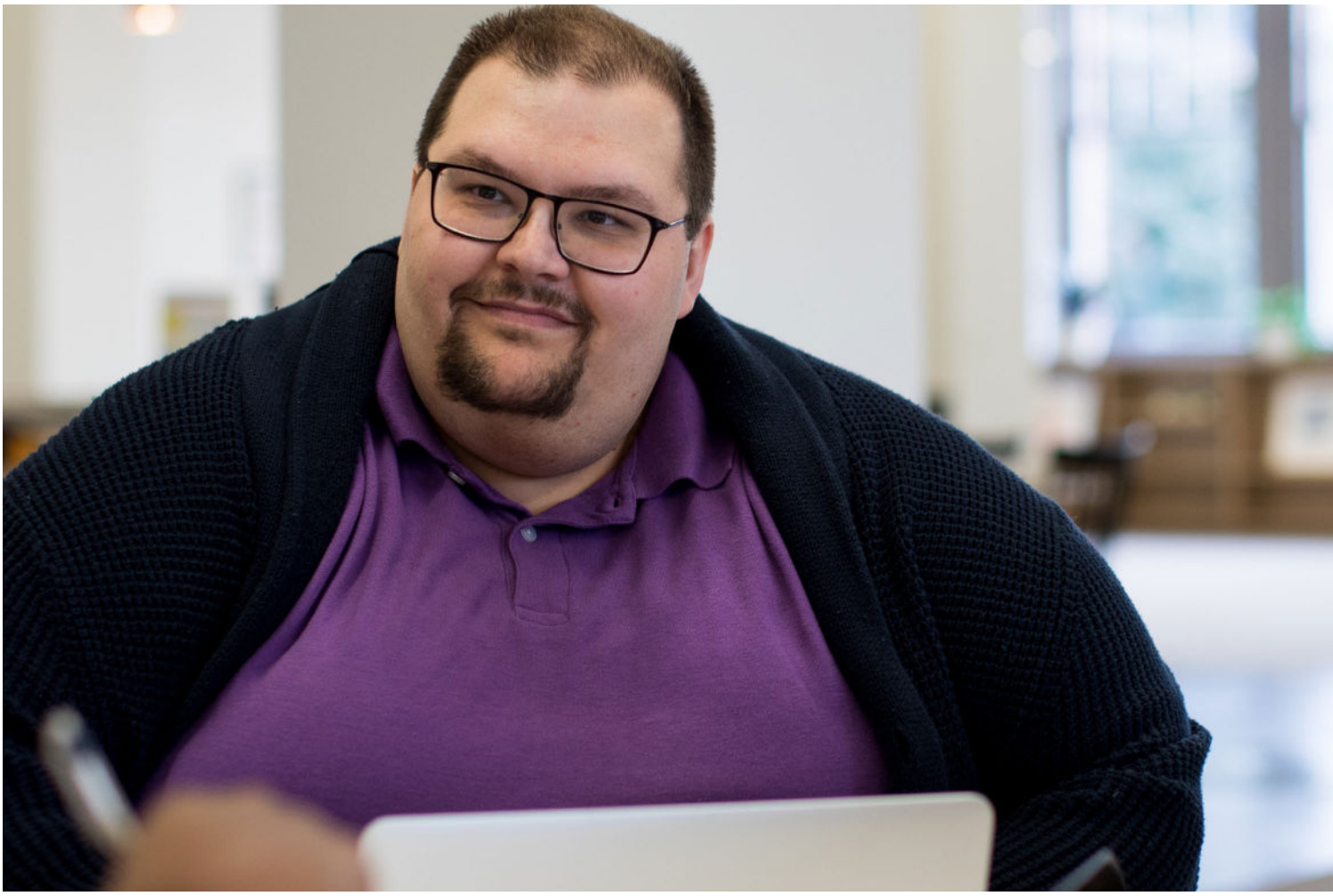
Sue Boran, Director of Nursing Programmes (Innovation) said, 'It has been an absolute pleasure to support these projects over the past year. They started in the middle of a pandemic and all workshops and support meetings were held online. It is to the credit of all the project leads and co-leads that they have succeeded with such extraordinary improvements to the health and well-being of people with complex needs in diverse community settings such as Care Homes, General Practice, prison and at home.'

All names of individuals who participated in the projects have been changed to protect anonymity

With thanks to

Burdett Trust for Nursing

BEAT Diabetes



Name of project team
Sheree-Leigh Woodall, Staff Nurse; Chelsey Went, Staff Nurse, West Midlands

What was the overall aim of your project?
To empower participants to change their thoughts and behaviours to lead a healthier lifestyle and manage their Diabetes more effectively.
As not all participants finished the course we had to adapt sessions in order to meet the needs of the remaining participants.

Please provide a brief summary of the project
12 participants were invited to undertake a 12 week course to help empower them to change their lifestyles, thoughts and diets to help improve their diabetes management, and to enable better self-management.

Each participant had access to specially designed Diabetes meal choices from a new menu and allocated time slots for gym sessions.

Observations were taken weekly by healthcare staff consisting of: blood pressure, weight, waist measurements, and blood glucose test.

A HbA1c test was recorded at the start and end of the course as a measure of the course's impact on the management of their Diabetes. Weekly health promotion talks were also provided to help educate and empower participants.

Photo courtesy of Unsplash

'Jack says that his mental health has improved and he is more positive about his future health realising he can do things, and be in control. He feels that the programme has really changed his mindset.'

What were the key outcomes?

- Increased health education
- Increased health promotion
- Closer monitoring of HbA1c levels at the start and end of the course
- Changes to participants thoughts & behaviour towards their Diabetes
- Increased healthier lifestyle for participants

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

Intended outcomes were to promote Diabetes education and improve quality of life by empowering participants to change their lifestyle habits.

The case study written regarding the journey of one of the participants has proved the positive impacts the project has had on the individual. He has changed his eating habits, his mind set, he is exercising more, he has more energy and is sleeping better. The results of his HbA1c and other observations showed a marked weight loss and the impact that the course has had on him.

What have been the challenges in delivering your project?

- Covid-19 and restricted access to the gym
- Challenges with nurses having protected time to spend with the participants. This resulted in not all data being collected and some weekly sessions and health promotion talks were not held.
- Staff sickness and people leaving their job roles; challenges with nurses to have protected time to spend with participants, this resulted in not all data being collected, some weekly sessions and health promotion talks were not held
- Challenging behaviour from some participants meant they were unable to continue with the course
- Some participants did not receive their special meal choices which caused frustration and absenting themselves from the course.
- Some of the older participants did not enjoy the gym sessions as much as the younger ones.

What have been the positive benefits either personally or professionally in the undertaking of this project?

- Building a good rapport with the patients
- Catering to the patients' needs
- Practicing good health promotion
- Helping to empower patients to change their lifestyle habits
- Developing role as a Practice Nurse
- Improving patient quality of life

What do you feel have been the outstanding achievements of the project to date?

The case study written shows the positive impact the project has had on the individual's life. The individual has even continued to eat and drink healthier. He feels much better, sleeps better, has more energy and has less joint pain, he even feels this project has benefitted his mental health.

The Participant in the case study thanked the healthcare staff for all the support, help, knowledge and understanding gained from the course.

What will happen to your project now?

Due to the current staffing shortages and ongoing covid situation is has not been possible to follow on with another programme yet.

If a new programme was to take place then the utilization of Health Champions would be an alternative in order to help keep on top of participant monitoring and health promotion.

In future the interview process would be more in depth to establish commitment to the course, ensuring the special Diabetes menu is up to date and available and that the gym is available for the participants.

What did the QNI do well to support you?

- Regular Zoom calls helped us all to keep up to date with the progression of the projects
- QNI are very approachable
- The Nursing Programmes Manager visited the prison to gain an insight into the healthcare environment and the challenges faced by nurses in delivering care.

What can the QNI do to improve its support to nurse project leaders in the future?

Visits to the establishment during the Project in action.

What advice would you give to other nurses starting an innovation project?

- Ensure protected time is allocated to spend on the project.
- Ensure adequate staffing.

Do you have any final comments?

Joining the project towards the end and taking over from members of staff who have left was a challenge. I thoroughly enjoyed the experience and built a great rapport with the participants but felt my time was not protected due to staffing shortages and sickness which did not give the participants the full experience of the programme.

Covid has caused a lot of restrictions with social distancing, access to gym equipment, isolation and staff sickness, but seeing the positive results has been very rewarding.

Promoting Oral Health in Care Homes

Name of project lead

Pauline Rawle, Community Services Matron, Leicestershire

What was the overall aim of your project?

- The overall aim was to improve oral health for residents living in care homes in Leicester, Leicestershire & Rutland (LLR):
- For care home managers and staff to know how to access dental services
- To raise awareness of the current dentistry offer in LLR
- To ensure care home staff are aware of the importance of daily oral care for residents
- For care home managers and staff to know how to access free dental services for residents in receipt of pension credit
- For staff to know how to use the Edmonton Frailty Score and Oral Health Pathway

Please provide a brief summary of the project

The oral health project was designed to improve health outcomes and lived experience for a small sample of care home residents in LLR.

Following the completion of the survey, training sessions were delivered to care home staff to increase their knowledge, skills and confidence in completing oral health care.

It was identified that a robust and consistent training offer is needed - funding and a training provider is currently being sought.

'It is heartening to know this is being taken seriously at a strategic level and I have the support and encouragement to continue this work, long term.'

What were the key outcomes?

As a result of the survey the project lead developed the oral health promotion teaching session with colleagues.

Three teaching sessions were delivered via MS Teams on the following dates:

- 19th July 2021 - 16 attendees
- 22nd July 2021 - 17 attendees
- 3rd August 2021 - 16 attendees.

Participants attended and fed- back that the sessions were useful and well received. Some of the care home staff had received no oral health care training and did not routinely perform oral health care with their residents. This cohort felt more confident to perform oral health care because of attending the oral health education sessions.

Key Outcomes:

- Findings from the initial survey indicate that access to oral health care remains problematic for residents living in LLR
- It has been established that there is a clinical need for a consistent approach to teaching care home staff about the importance of regular oral health care.
- A proactive care home training offer needs to be in place and strategic discussions are underway to secure a training offer with funding, for LLR Care Homes.
- The care home training offer will take a blended approach with face to face and online delivery offered
- Written information in the form of a flow chart has been drafted and circulated electronically to inform care home staff how to access the current dentistry offer. The flowchart will be printed and laminated.

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

This project has highlighted the need for more resources to be prioritized to promote oral health for vulnerable adults residing in care homes.
It was disappointing to learn that so many residents do not get taken to the dentist for regular dental health check-ups. Many care homes access dental services only when there is a problem.
There is a need for more proactive health promotion and prevention awareness, training and education.
It is heartening to know this is being taken seriously at a strategic level and that there is support and encouragement to continue this work, long term.

What have been the challenges in delivering your project?

- The covid pandemic has restricted face to face training for care home staff
- Training via MS Teams was challenging due to resource limitations and staff knowledge, skills and confidence
- It is hoped that future training delivery will be face to face when covid restrictions are lifted and funding is secured.

What have been the positive benefits either personally or professionally in the undertaking of this project?

I have developed tenacity to follow through, long term, the promotion of oral health in LLR care homes. I anticipate that securing a long-term training offer for care home staff will be an achievement that will greatly benefit residents.

What do you feel have been the outstanding achievements of the project to date?

A strategic agreement to scope and fund a LLR wide training offer to care homes which was not a part of the original plan.

What will happen to your project now?

This work is now prioritized as a part of the Enhanced Health in Care Homes Framework and will be ongoing.

What did the QNI do well to support you?

- Networking
- Information / teaching sessions
- Encouragement
- Offer of support to write up and publish work.

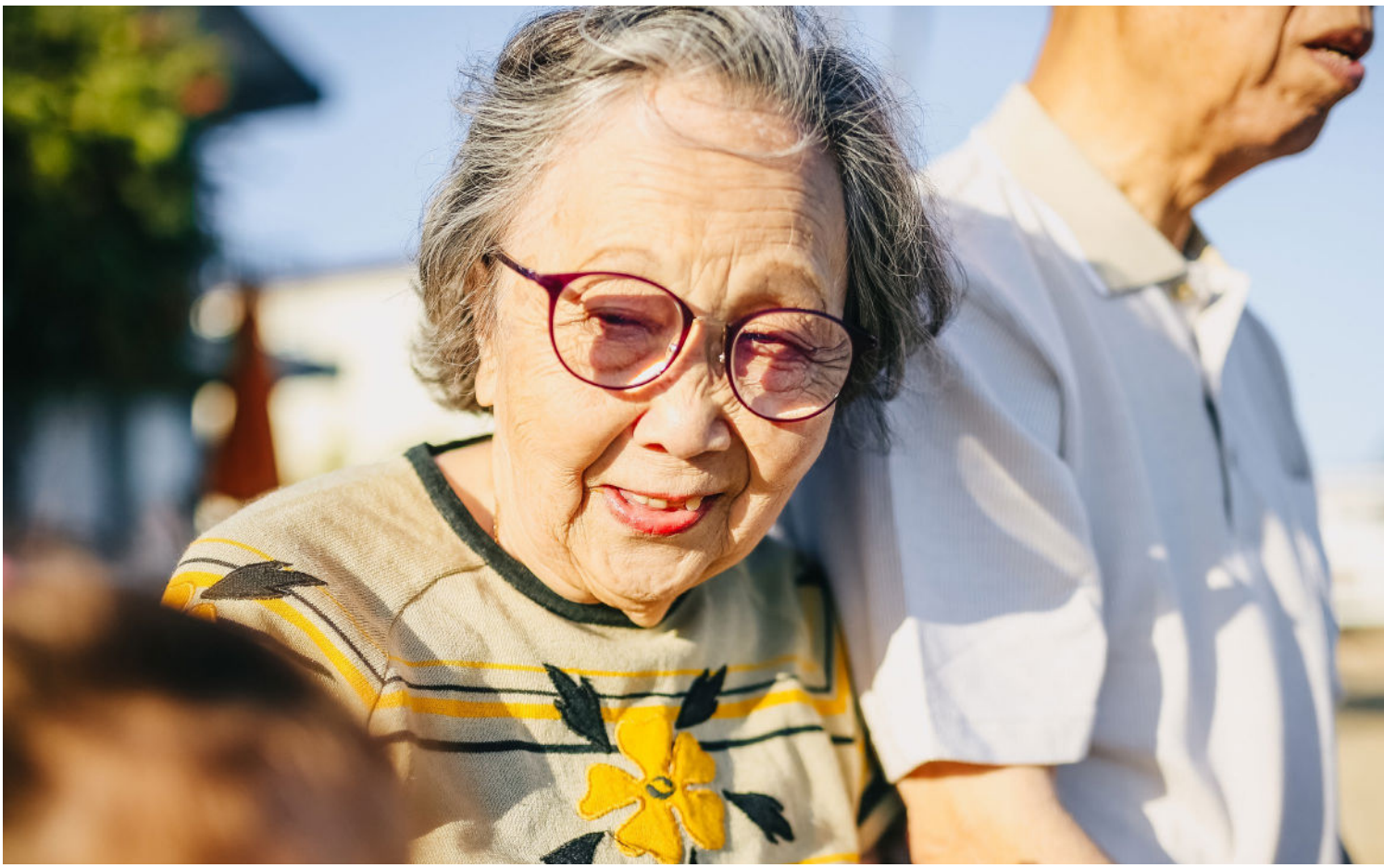
What can the QNI do to improve its support to nurse project leaders in the future?

The online sessions enabled access to information without having to travel. This was very helpful, and I enjoyed the evening support sessions.

What advice would you give to other nurses starting an innovation project?

- Follow your vision and your passion.
- Collaborate – don't do it alone.
- Promote clinical evidence-based practice.
- Ensure you have support from your employer and seek to protect time to progress the project in a timely manner.

Digitalising Clinical Care



Name of project lead

Anita Astle MBE, Managing Director/Registered Manager; and Damian Mann, Nursing Associate, Nottinghamshire.

What was the overall aim of your project?

Our overall aim was to identify if it was possible to use digital technology to predict when deterioration would occur in frail older people with complex needs, living in a care home.

We broke down our overall aim into several questions:

- Is it possible to predict deterioration in frail older people with complex needs?
- Can digital technology be used to identify deterioration in frail older people with complex needs?
- What digital technology is required to support the recognition of deterioration?
- Can early detection of deterioration in frail older people with complex needs prevent hospitalisation?

Our overall aim has not changed throughout this project, however, we found ourselves having to research and source additional resources that we had not fully recognised as necessary when planning our project. These resources were devices that could read and record clinical observations such as pulse rate, blood pressure, temperature, respiratory rate, and oxygen saturation without the need to physically disturb the individual being monitored. In addition, we sourced cups which monitored and recorded the volumes drank by individuals.

Please provide a brief summary of the project

Wren Hall Nursing Home used digital care planning software, Person Centred Software (PCS). All care and catering staff record all their interactions and interventions with/for our family members (residents). The software analyses the data and generates a report.

Photo by RODNAE Productions from Pexels

'I have found it rewarding to watch Damian grow both personally and professionally - this has also benefited me too.'

During the first 3 months of the project, we reviewed and collated data for five family members, who had experienced the most frequent incidence of deterioration, during their time in our care.

This data was used to create a baseline for each individual. The collated information was entered into an excel spreadsheet and used to compare against the captured data of family members who were showing signs of deterioration.

Baseline observations were recorded manually using apparatus such as sphygmomanometers, stethoscopes, thermometers, oximeters. Our aim was to move swiftly to using sensors which would capture this data periodically without staff having to physically disturb family members.

We had envisioned using an algorithm which would analyze the data collected and alert us when signs of deterioration were evident.

We were able to review historic data relating to previous confirmed infections for the five individuals. We noted the relevance of data relating to falls, behavioural incidents, change in fluid/diet intake and changes in sleeping pattern. In addition, we noted that changes for each family member were unique to them; offering staff additional indicators to observe in addition to the standard signs of infection staff would normally look out for.

These unique indicators were added to personalised deterioration plans for each family member and were shared with staff. These deterioration plans were updated through project team and clinical lead meetings.

The most common reason for deterioration in family members was caused by urinary tract infections. PCS captured the volumes of drinks offered and actually consumed. As investigators we became concerned that staff were not recording these volumes accurately. We therefore retrained staff regarding the importance of adequate hydration and accurate recording of fluid intake. We also began looking of other ways to address this situation. We found an innovative device called Aquatime – a cup which has a sensor fitted enabling the volumes of fluid drank to be recorded and sent remotely to a computer or tablet. Aquatime is based in Denmark and we became their first UK customer. We introduced Aquatime's founder to PCS and this enabled Aquatime data to be recorded directly into PCS.

At the start of this project, Wren Hall Nursing Home had a digital ecosystem in place. Our digitalized care planning software interfaced with our nurse call system and our electronic medicines administration system. Throughout our project we have grown our digital ecosystem by adding Feebris and Aquatime data.

What were the key outcomes?

- We identified that each family member will show signs when deterioration is taking place. These signs are increased incidents of falling, increased incidents of distressed reactions or increased withdrawal and inactivity
- We identified that signs evident when deterioration is taking place are unique to the family member and the same sign is evident each time the family member deteriorates i.e. the family member will either experience a number of falls when deteriorating or increased incidents of distressed reactions or will become more withdrawn and not eat or drink
- We identified it is possible to act on these unique signs of deterioration to minimize the ill-effects of deterioration
- We identified that unless a suitable algorithm is in place, digital technology alone will not alert staff that deterioration is taking place
- We identified that where staff know family members and the family member's unique signs of deterioration, prompt treatment can be accessed and the experience of ill-being minimized
- We identified that it was possible to prevent hospitalization of frail older people who experience deterioration.

Since undertaking the project, we have been able to identify specific trends through interrogating data recorded within our care planning software in-depth. By analyzing data weekly, we have been able to influence family members' health

through more timely referrals to dietician, falls team and by working more proactively with other MDT professionals such as CPN and GP's.

Our contact with other MDT professionals has been more frequent and earlier than our previous norm. As a result we have been able to act on behalf of the family members at Wren Hall in a timelier manner to initiate changes in medication and earlier detection of medication related issues (falls, lethargy, hallucinations). This has resulted in fewer behavioural incidents, fewer accidents such as falls and fewer incidence of infections; our family members are showing increased signs of well-being on a day to day basis. The 5 family members identified at the start of the project have lower rates of infection and antibiotic use has been minimal. This has been enabled due to the data collected everyday by the staff at Wren Hall. We can reflect and implement changes in ways of working to benefit the family members daily.

Our original thinking and aspiration was that by capturing family members clinical observations continuously, we would be able to recognise signs of deterioration sooner and instigate timely intervention, thus minimising the distress and associated ill-being for family members.

Physical changes when a person if suffering with infection e.g. raised temp and high pulse are known consequences and should be noticeable in everyone. However, our family members do not always inform us that they are feeling unwell and we will only know this if their temperature is raised and if we have measured it, which is usually triggered by the individual looking flushed.

We observed that before the nursing team identified deterioration and/or infection, our family members behaved differently, with an increase in the number of distressed reactions displayed, or experienced an increased number of falls. Although we recognised this trend, the unintended learning was the that we gained evidence that showed individual family members repeatedly responded in the same way to deterioration, with an increase in falls or distressed behaviour.

We recognised that in order to enhance the well-being of our family members we must focus on each individual and what is changing for them in their presentation and in how they are acting and the environment around them.

By identifying each person's individual response to deterioration, we can have a major impact in supporting their well-being day to day. Our aim is to identify this for each individual, add it to their care plan and train our staff to notice what is happening beyond clinical observations. An increase in the number of falls experienced is relatively easy to notice but withdrawal to ones own room or from activities is often a more subtle change and often harder to notice in a timely manner.

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

- Meeting colleagues from Feebris and using their technology as part of our project
- Meeting colleagues from Aquatime and using their technology as part of our project
- Identifying that we had an issue with the accuracy of staff data recording fluid intake.

What have been the challenges in delivering your project?

The main challenge has been communicating effectively with the whole team at Wren Hall to ensure in-depth reporting takes place and getting staff to change their reporting and note specific changes.

We have spent time promoting and encouraging staff to increase the depth of their written reports. This involved them being actively involved with the new way of working and being at the forefront of collecting and recording the data.

There were initial issues about being actively present to lead the change and support staff to recognise the signs and symptoms of deterioration and in motivating staff to have faith in the long-term project goals. We originally struggled to get the digital monitoring system up and running in the way we wanted. This meant that more work has been required with analysing the data, which created a back log of work to begin with. However, having identified this as an early problem, enabled adaptation to give it the time required.

What have been the positive benefits either personally or professionally in the undertaking of this project?

This project has enabled me to delegate the day-to-day management of the project to Damian who has no previous experience of project management. This has helped Damian with the development of confidence and competence in delivering presentations and training sessions to colleagues and in becoming proficient in using the Person Centred Software to analyse the data collected.

I have found it rewarding to watch Damian grow both personally and professionally, which has been of benefit to me too. I have a need to be in control and although I seek others' views, it is easy for me to plough ahead without considering their views and/or different perspectives.

This project has given me the opportunity to trust and act upon Damian's judgement. I have found this extremely fulfilling because of the sense of pride in watching Damian thrive.

Through this project new links have been made with companies that we would not have otherwise engaged with. As a result we have broadened our digital ecosystem and introduced new technology into the UK. This has in turn raised the profile of Wren Hall Nursing Home and the perception of care home nurses with these companies. Feebris' CEO gifted Wren Hall Nursing Home their technology as she was so impressed by this project and she wanted to support its success.

What do you feel have been the outstanding achievements of the project to date?

- Damian has successfully managed this project despite predominately working night shifts and having the challenge of conducting the project during a pandemic.
- We have grown our digital ecosystem increasing the efficiency and effectiveness of our nursing care team.
- There have been no hospital admissions through deterioration as a result of the learning from this project.
- We have connected with new companies that are now adding value to our organisation and project.
- We have been able to predict deterioration and proactively manage this deterioration sooner than was our norm prior to undertaking this project.

What will happen to your project now?

Wren Hall Nursing Home will continue to resource this project moving forward with the intention of rolling it out to all 54 family members.

Having collated the data that we have up to now, we aim to evidence our findings on a larger scale.

Our Project Lead sits on the East Midlands Managing Deterioration Advisory group and is seeking this group's support to create the required algorithm required to increase the ability of digitally preempting deterioration using a digital ecosystem.

What did the QNI do well to support you?

The QNI has supported us well through the workshops which have been of great help in guiding us through this project. These workshops have helped us have a clear vision of what we want to achieve and the steps we needed to put in place to achieve it.
The support sessions were also beneficial by helping us stay focused and on track. It was useful hearing others progress as this offered reassurance and balance at times when we may have been floundering or overwhelmed.

What can the QNI do to improve its support to nurse project leaders in the future?

We feel that the QNI could possibly demystify Quality Improvement (QI) for nurse project leaders.

Often Nurses are put off by the terms Project Management and Quality Improvement. However, these can be simplified and successfully completed through following simple processes/models. Informing nurse project leaders of such processes/models may be of benefit.

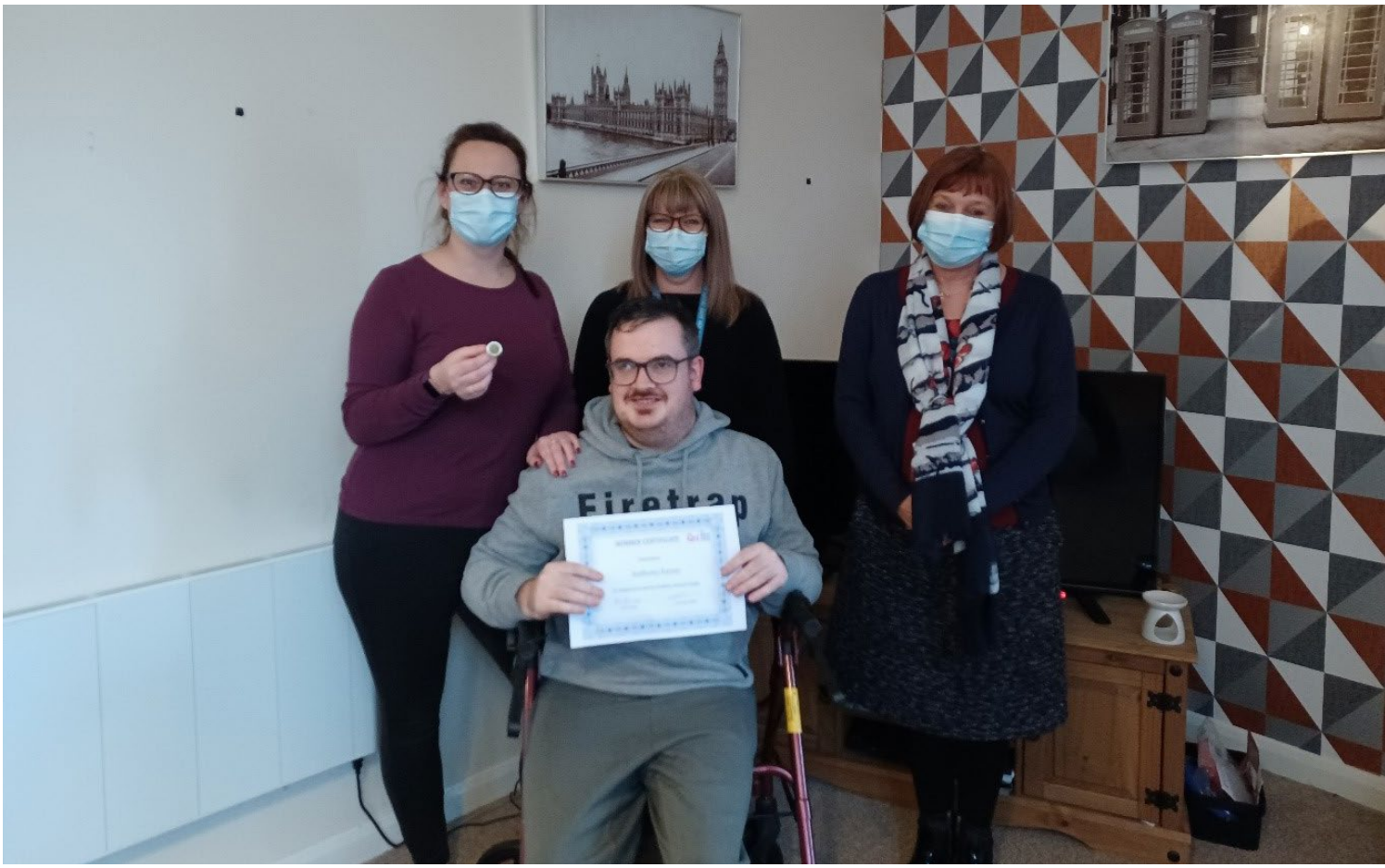
What advice would you give to other nurses starting an innovation project?

- Go for it
- Have a clear vision
- Communicate that vision clearly and widely
- Recruit colleagues to support your project
- Keep everyone affected by your project informed of progress and value their opinions/views
- Do not over complicate the project
- Keep focused and enjoy the process

Do you have any final comments?

Thank you QNI for supporting us to do this project and to make a difference to others.

Recognition of Good Respiratory Health



Name of project team

Fiona Sharp, Strategic Health Facilitator; Paula Spooner, Nurse Consultant, West Yorkshire

What was the overall aim of your project?

Improve the knowledge and understanding of respiratory health for people with a learning disability within the community and primary care nursing workforce.

Please provide a brief summary of the project

The project has delivered 10 hours of blended learning online about the importance of respiratory health for people with a learning disability. Specialists in learning disability and respiratory health have presented directly to the general practice nursing workforce. The learning has included presentations, quizzes, case studies, videos of specialist respiratory treatment such as rebound therapy, chest clearance and vibro vests involving patients with complex health needs by specialist physiotherapists.

Involvement of people with a learning disability has led to the production of an accessible booklet to be used in general practice, called 'How to look after my lungs' due to the pandemic. This now includes information on vaccination for flu, Covid 19 and pneumonia. The idea of designing the badge came from the project team thinking creatively how we could add further collaboration with patients. The winning badge is to be worn by those who have participated in the education sessions. Paid carers and families contributed to the development of 'My respiratory care plan', which is now being trialled throughout our specialist Trust in Calderdale, Kirklees, Wakefield and Barnsley.

Photo courtesy of Fiona Sharp: photo of the design-a-badge competition winner receiving his winners' certificate and the LD champion badge, he is pictured with our deputy director and two of his carers

'I feel the outstanding achievement of the project is the passion it ignited for reducing inequalities in health for people with a learning disability.'

What were the key outcomes?

- Develop relationships between the general practice nurse workforce, specialist learning disability practitioners and people with a learning disability
- Increase knowledge in the primary care nursing workforce, people with a learning disability and carers about the importance of respiratory health
- Develop local accessible information to be used during consultation about respiratory health.

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

There were several unexpected outcomes as a result of the project. One care provider found 20 people in their care who were not on the GP LD register, these patients have now received an annual health check for the first time and now have their reasonable adjustments and communication needs added to their clinical records.

During consultation on the My Respiratory Care Plan, paid carers' made changes to one woman's care plan regarding chest clearance.

An increase in calls to myself and the duty worker regarding signposting to dental services for people not registered or able to access mainstream dentists was as a direct result of one session regarding the importance of oral hygiene and how poor oral hygiene can increase risk of bacterial pneumonia.

Towards the end of the project, the motivation from people with a learning disability and the nursing workforce in general practice led to the LD Champion network.

Nurses asked for a wider range of health subjects and we revisited the local LeDeR findings and actions, to be the basis for our future educational programme.

What have been the challenges in delivering your project?

There have been a few challenges to our project, as a direct result of the pandemic, the coming together of people with a learning disability and data collection. Restrictions meant we could not meet publicly in groups, community venues were not booking or holding events, and whilst we had people in place for early data collection for inclusion in the project, these requests were not made due to conflicting priorities.

Also, in terms of the CCG, local performance management of general practice was paused so data could not be collected. We do plan to hold respiratory focused events in the future with the resources we have and the data will be published in due course, locally and nationally. The continuation of the educational project will provide a forum for reflection on the data and planning of future events. These elements of the project will be reported to the Strategic Health subgroup and the learning disability partnership board once completed.

What have been the positive benefits either personally or professionally in the undertaking of this project?

The positive benefits of undertaking this project have been my personal increased confidence in pitching an idea, working creatively, and approaching professionals to be involved. In the past I have led on CQUINS, KPI's, workstreams and care pathways which have involved lots of timed actions, which resulted in me taking on actions as my own. The project has professionally benefited me as I have hosted and facilitated but not taken all the actions for myself, which I believe has enhanced presentations and involvement.

What do you feel have been the outstanding achievements of the project to date?

I feel the outstanding achievement of the project is the passion it ignited in general practice for reducing inequalities in health for people with a learning disability; the involvement of people with a learning disability sparked the enthusiasm for a learning disability champion network within general practice, with the badge being a visual sign to patients of the extra specialist training undertaken and dedication of general practice staff.

What will happen to your project now?

Our partner Conexus organise all training and support to general practice in Wakefield. They agreed to support the learning disability education programme as part of their offer with no additional costs. There has been a recognition of the lack of educational courses addressing inequalities in health for vulnerable groups of people. The pandemic has highlighted these inequalities even further, and our programme fits within the inequality agenda. It also addresses local LeDeR findings and the sessions have all been planned in line with local actions. The programme will have national speakers, which we anticipate will attract a cost, but mainly keep the local perspective, with a view to continue the networking between clinicians. We did meet with NHSE on two occasions to discuss a wider ICS level general practice educational programme, however, we believe the key is to keep it local, to promote timely referral, ensuring reasonable adjustments are in place at point of referral and developing positive relationships between patients, families, and primary care.

Our new project is called the LD ACE programme (Achieving Change through Engagement) - General Practice. This programme is a direct result of the project which has been recognised across primary care, by clinical directors, leaders and the general practice workforce. The programme will be open to all working in general practice; administration, care coordinators, nurses, and GP's. Whilst the programme is keeping a local focus, we have developed a model which can be replicated in other localities across the ICS and we have already had talks with Huddersfield and Calderdale NHS Trust to share our model.

What did the QNI do well to support you?

Aga has been an amazing support, answering all my queries about funding and ordering. The QNI supported me very well in terms of clarifying my initial aims and outcomes, ensuring the project identified indicators and the resources from the outcome framework and planning triangle are definitely tools I have taken forward. The open and honest support sessions with Sue were fantastic, being able to bring updates and gain such an experienced nursing view to seeing the value in everything we all brought was invaluable in developing my confidence.

What can the QNI do to improve its support to nurse project leaders in the future?

A programme for qualified nurses at the beginning of their career who are running small scale projects as part of their role would be useful. Nurses are excellent at identifying unmet needs in patients and the services they receive, however the skills of running a project do not appear as part of pre-registration nurse training. I currently provide clinical supervision to nurses who have made improvements in care and services, but they do not recognise the skills they have developed in the process, and find it difficult to articulate their work, they often see the work as a nice thing to do.

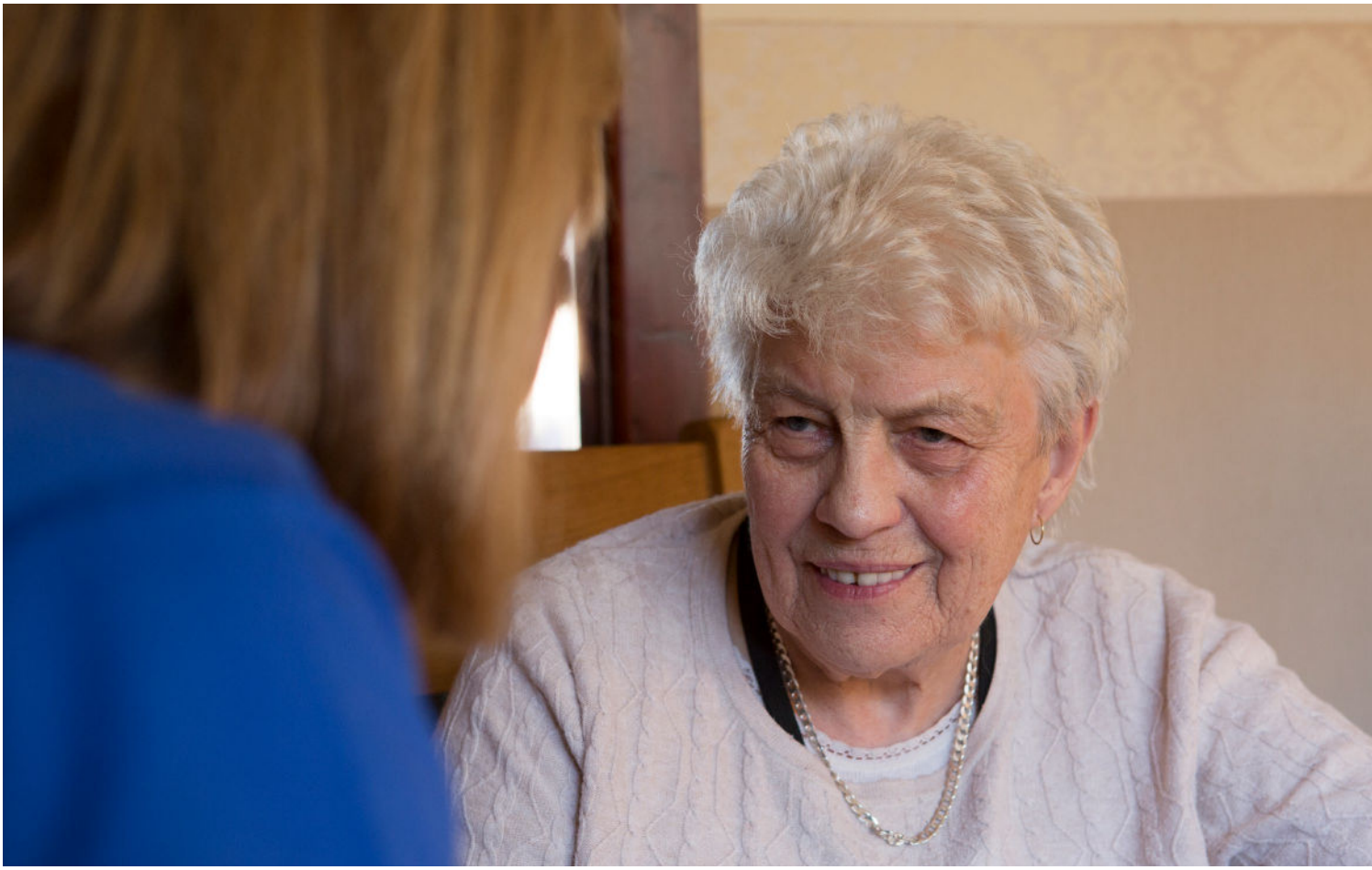
What advice would you give to other nurses starting an innovation project?

To fully engage in the process; if things need changing, change them and move on - you are in safe hands with the QNI project team. Attend all the planned and support sessions; at times it feels like your project isn't moving, however during these sessions other project leads help you to see how far you've come.

Do you have any final comments?

Despite feeling very nervous and apprehensive, I have thoroughly enjoyed the process, from application to interview, including the invaluable learning and support sessions, right through to evaluation. The support from QNI and Burdett Trust have ensured that I have evaluated our project in a meaningful way with the aim of its continuation. I am so thrilled our project has been adopted by our CCG and will be running in 2022, I am confident we now have learning disability on the primary care agenda to improve access and the health of people with a learning disability.

Reducing Inconsistencies in Respiratory Care



Name of project team

Siân Jones, Karen Vennard, Lead Nurses, Primary Care Respiratory Team, Wales

What was the overall aim of your project?

The aim was that all patients with a respiratory condition were provided with a unified service and home visit if unable to attend a clinical appointment due to the complex nature of their condition. The service would provide all patients with a unified patient assessment review across Gwent.

The project did alter during the process mainly due to the problems associated with the Covid-19 pandemic. This meant that a proportion of the patient cohort were not seen because of staffing issues and a member of the team needed to step in and provide a significant level of support visits due to pandemic pressures.

Please provide a brief summary of the project

Other primary care and community teams do not do an annual review of this specific patient group on a regular basis. It was noted by team members when working in GP surgeries that the common issue highlighted was due to the very nature of being a housebound patient, that they were not included in QOF with regards to their annual respiratory reviews.

As they may only be seen by a health care professional when they have medical issues, these patients may have had other worsening chronic conditions or the development of new medical issues which may only come to a head when the symptoms become severe. This patient group were treated for crisis management as opposed to preventative management. This meant that they were disadvantaged regarding their care for a number of years and the risk of hospital admission was high.

The patients now have a contact they can go to if they have any concerns about their lung condition. They now feel they are not forgotten and are more comfortable they have an action plan to follow when they become unwell.'

What were the key outcomes?

- Respiratory patients would remain well and unnecessary hospital admissions would be avoided
- They would receive the same level of care despite being cared for by different GP surgeries
- Any new conditions would be identified and referred onto the appropriate healthcare professional.

Briefly describe your experience of implementation: what changes if any had to be made?

- We provided a training programme for staff participants and invited all community health care professional teams to attend. However, not all were available to attend on the day, so we had to ensure the training was available to access on demand. This was done by recording the training and giving access to any team members who required this
- Implementation of GP practice involvement. The Health Board has 78 GP practices and all were contacted and invited to be part of the project by way of providing a patient list. Only 20 practices became involved in the project but this still provided a cohort of 300 patients
- Community healthcare professional teams across the Health Board were invited to participate. A proportion of the teams embraced the role whereas other teams appeared quite averse to supporting the project. The project co-lead had to support with the home visits for one locality due to staffing issues
- Health Board locality involvement. As the Health Board has 5 localities, each area was encouraged to participate. However, one locality did not have any GP practices who wished to be part of the project. The NCN lead for the locality in question discussed with the practices about participating following a discussion with the Medical Lead for Primary care. Following this, one practice joined the project.

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

What was unexpected was the number of housebound patients who had not received an annual review of their lung condition. By having multiple co-morbidities in this patient group there is a question of whether their other long term conditions are not reviewed on a frequent basis either and is each condition treated as reactive as opposed to preventative. A percentage of this patient group were not receiving the services they required, in fact these patients were not having any services, including district nurses, so they were 'slipping through the net'. So, whether the patient required someone to talk to via the befriending service or care due to inability to look after themselves, such as requiring social services, this was identified and arranged following a referral to the relevant services.

We plan to continue this service annually for this patient cohort. This will allow us to measure the impact going forward on quality of life and wellbeing.

New standardized paperwork has been developed for use going forward which can be used by all respiratory services and with the Welsh Community Care Information System (WCCIS). The WCCIS Programme has been procured to support the transformation of community, social care, mental health and therapy services across Wales. WCCIS is a unique system that will allow local authorities and health services to share care records and optimise services for citizens across Wales, as required by the Integrated Health & Social Care, Social Services and Well-being (Wales) Act.

WCCIS will provide a mobile solution to deliver workflow functionality for Mental Health, CAMHS, Learning Disability, Young Persons and Community Nursing staff, delivering scheduling and information and thereby allowing transformational service change to better deliver person-focused, coordinated care that meets the needs of individuals and their families. Wider local impact will be audited in the next 12 months.

What have been the challenges in delivering your project?

There have been some challenges during the project time. The main challenge has been staffing issues due to the pandemic. Staff have been deployed to support work streams associated with the pandemic, staff sickness due to catching Covid-19 and ongoing current staff shortages due to staff leaving/retiring.

There have been a small number of community teams who have not been enthusiastic about participating in the project despite management stating they had capacity to support.

There was also one locality where the staff declined visiting and reviewing patients with asthma. They stated it was because they do not treat patients with asthma. Despite explaining the aims of the project and offering training, they still did not engage and other staff were asked to support patients with asthma in this locality.

What have been the positive benefits either personally or professionally in the undertaking of this project?

The main benefit of being able to undertake this project has been to highlight the inequality of support and care to patients who are unable to attend the GP practice for a review of their chronic disease. This project will be a baseline for identifying the need to continue this work on an annual basis.

We feel this has enhanced the leadership skills we possessed before the project started. We have been given the tools to set up a project, to delegate appropriately and to effectively work alongside a multidisciplinary team and share our vision in order to reach the same goal.

Please provide details of how you have you promoted your project?

We have not promoted our project yet but plan to do so going forward within the Health Board and externally.

What do you feel have been the outstanding achievements of the project to date?

We feel the 2 outstanding achievements of this project are:

1. We have provided an education programme to a large number of community staff who would otherwise not have had the opportunity to access this education easily. This is usually due to poor staffing numbers and the inability to be allocated relevant time for learning. That education programme is accessible whenever the staff require a refresher; they can inform their colleagues that the training is available if they wish to learn about lung conditions and how to care for a patient with any of these diseases.
2. The patient group has been happy to receive the visits and to ensure they are being cared for appropriately. These patients now have a contact they can go to if they have any concerns or worries about their lung condition. They feel they are now not forgotten and are more comfortable they have an action plan to follow when they become unwell.

What will happen to your project now?

We plan to continue this working model across the Health Board. It is unlikely there will be any further funding from our organization, but we as an expanding respiratory team will organize our workloads to accommodate this type of work stream. We have also built up very good working networks with other primary care and community teams, some of which are happy to continue to support this work.

What did the QNI do well to support you?

- They provided us with monthly training sessions/support meetings
- They provided the tools for us to use to plan out our project
- They provided specialist training sessions with professionals to help with planning the project, how to get other services on board to assist and support the project
- Advice and ideas on project feedback documentation
- We felt we could always contact the QNI for advice or suggestions at any time and they responded very quickly
- The level of support provided was invaluable.

What can the QNI do to improve its support to nurse project leaders in the future?

We have been very happy with the support we received from the QNI and don't feel there is anything to change.

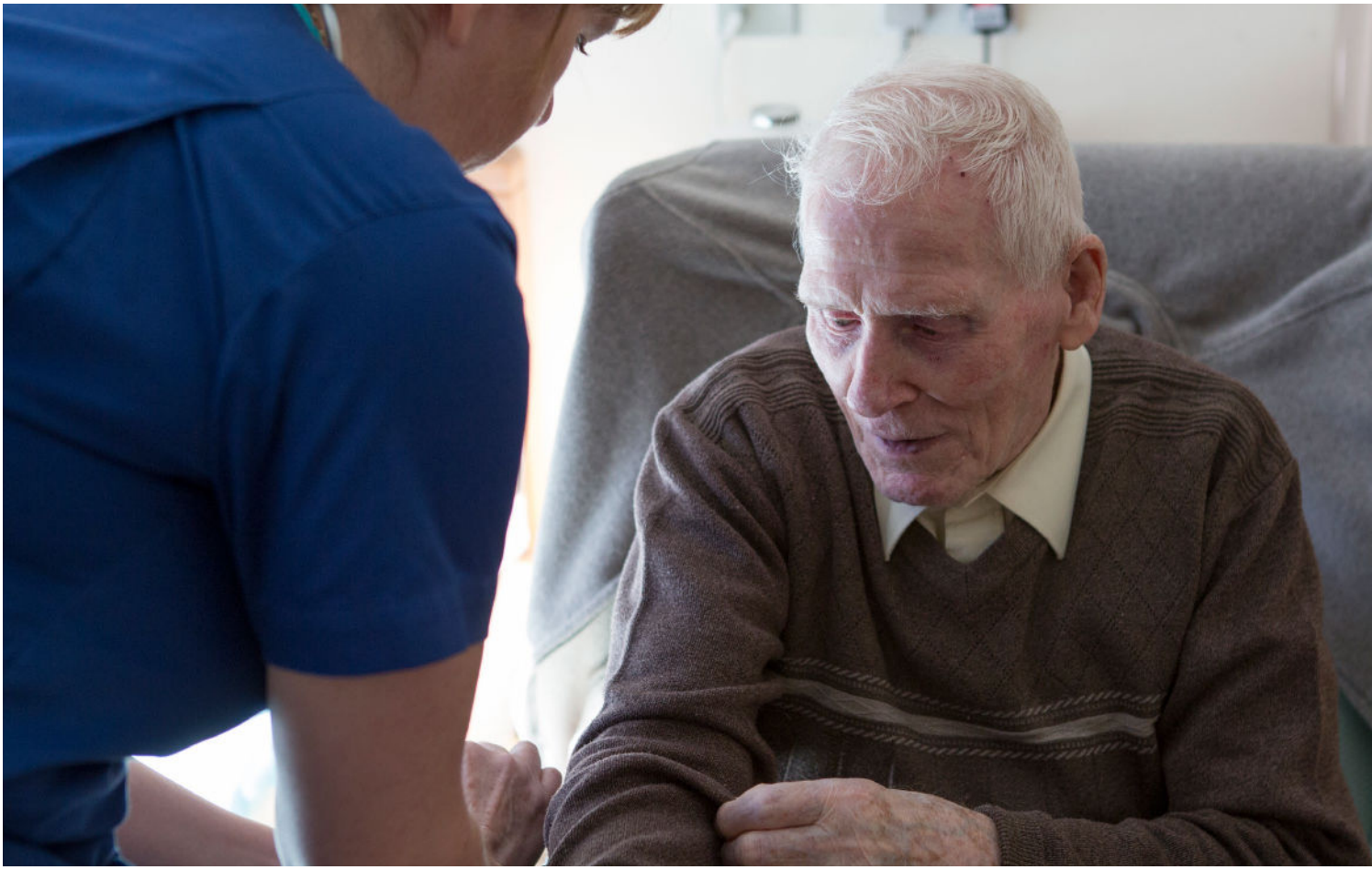
What advice would you give to other nurses starting an innovation project?

Make sure if involving other staff in your project to help see patients/clients that they communicate effectively with you especially if they are struggling to see the patients. We found one locality did not communicate until too late to help.

Do you have any final comments?

This has been a wonderful opportunity to design a project, to facilitate it and to see the outcomes. It has given us the basis for an ongoing service and to see how the patients benefit from this long term.

Hospital Admissions Avoidance



Name of project team

Sharel Cole, Queen's Nurse, Advanced Clinical Practitioner - Community Frailty Team; Hayley Mullan, Queen's Nurse, Advanced Clinical Practitioner - Community Frailty Team, Kent

What was the overall aim of your project?

The overall aim of the care home project is to prevent avoidable hospital admissions for people living with frailty in care homes in East Kent.

The project aimed to proactively identify what is important to people living with severe frailty in care homes and improve their quality of life moving from a reactive disease driven model to a healthy ageing model. This should achieve a reduction in unnecessary admissions to hospital and unnecessary GP appointments.

The initial aim was to reduce the number of overall admissions to hospital for people living with frailty in care homes but due to time constraints, it was felt that the overall aim would be better to prevent avoidable admissions for patients in care homes by raising awareness of the Frailty Home Treatment Service (HTS).

When we first started planning the project, we thought we would be able to cover all of East Kent but as the project progressed it was soon realised this was not feasible. It was decided to raise the profile of the service we provide in a number of care homes which fall under the Canterbury locality and within 3 GP practice populations.

Please provide a brief summary of the project

- Engage and attend regular meetings with key stakeholders (Primary Care Networks, Locality MDT Hubs, GPs, Community Nurses, Care Home Managers, Ambulance Leads, Acute Trust ACPs, Clinical Commissioning Group, Volunteer Sector, End of Life Care Nurse Consultant, Administrators, Clinical Resource Manager, IT Support)
- Test for Change Pilot with Ambulance Service with twice weekly MDTs to reflect on cases who may have benefited from HTS rather than conveyance to hospital and learn together

'This project gave insight into the support needed by care home staff and highlighted the importance of good communication amongst all stakeholders to avoid unnecessary hospital admissions. It definitely improved patient experience, increased support for care home staff and relatives, and also provided continuity of care.'

- Review data and evaluate after 6 weeks with recommendations
- Ongoing in reach with care homes to raise the profile of the Frailty HTS

What were the key outcomes?

- To avoid inappropriate hospital admissions
- To increase the number of Comprehensive Geriatric Assessments of patients in care homes
- To ensure advance care plans reflecting what is important to patients are in place

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

In addition to the intended outcomes, this project gave insight into the support needed by care home staff and highlighted the importance of good communication amongst all stakeholders to avoid unnecessary hospital admissions. This can be challenging due to many factors including the turnover in care home staff, the impact of Covid-19 and system-wide pressures. It definitely improved patient experience, increased support for care home staff and relatives, and also provided continuity of care. Another unintended outcome may be increased numbers of patients identified as requiring palliative care or approaching end of life and who were given the opportunity to die in their preferred place of care.

I was made more aware of a local care home for people with a learning disability who may also be living with frailty.

What have been the challenges in delivering your project?

- Staffing shortages due to Covid
- There was a lack of momentum between April to June as services and staff were exhausted due to the Covid-19 pandemic; many stakeholders couldn't commit to the project.
- A few other projects running in East Kent care homes
- Managing change
- Data collection
- New staff
- Steep learning curve
- Lack of planning due to time pressures
- Academic pressures on trainee ACPs as they are a significant part of the workforce
- Limited administrative support

What have been the positive benefits either personally or professionally in the undertaking of this project?

This project has impacted positively on my personal and professional development. It gave me the opportunity to contribute to the service development for the Frailty HTS where there is a clear vision to offer people living with frailty an alternative to hospital admission.

Professionally, it enabled me to network outside the Kent Community Healthcare Trust; create excellent links with the Ambulance leads, Clinical Commissioning Groups, Primary Care Networks, Care Home Nurses and the hospital trusts. This built my confidence when doing mostly virtual meetings using video conferencing apps, developed my communication skills; tenacity and ability to deal with criticism when problems arose.

It also enabled me to refresh some of my project management skills as a leader but also identify areas for further development such as budget management, understanding procurement and business planning.

Please provide details of how you have you promoted your project?

This project was promoted both formally and informally at meetings, care home visits, on the trust intranet.

What do you feel have been the outstanding achievements of the project to date?

Person-centred care

In East Kent, the Frailty Home Treatment Service places patient choice and anticipatory care at the heart of the support they provide for people with frailty.

We have a motto – 'we find out what you would want, and then we try to provide it'.

Raising the Profile of the Frailty Home Treatment Service

This project contributed to raising the profile of the Frailty HTS to care home staff and has empowered care home staff to refer directly to the service which allows assessments, diagnostics and care planning with patients and carers in a proactive and timely manner.

Reduction in the unplanned admission rates

- The benefits identified by the patients and carers were that the service was quick and responsive to need. A high standard of care was delivered and patients were treated at home.
- During the second covid wave we initiated the active treatment bundle in over 200 patients, (85% in care homes). We supported the staff and monitored all positive patients daily
- 100% of patients assessed by our team had comprehensive geriatric assessments and a discussion about their wishes about future care documented in a Treatment Escalation/Advanced Care Plan
- The major impact was to allow people to receive care at home, instead of in a hospital, avoiding environmental change and allowing normal family contact, which was particularly important for those vulnerable patients living with cognitive impairment
- Dying in their preferred place of care.

What will happen to your project now?

The benefits of the project have been highlighted and will be shared. The Frailty Team will continue working with all stakeholders to support people living with frailty in care homes to provide non-urgent proactive case reviews as well as urgent care assessments when unwell in order to avoid admission to hospital where appropriate. It is evident that East Kent has a very high number of care homes and this in reach needs to continue due to staff turnover and keeping them informed of our service.

The changes made as a result of the project are sustainable as the Frailty Team is recruiting more staff and recognise the demand for the Home Treatment Service. We will continue working closely with the ambulance service, clinical commissioning groups and hospital trusts to share our learning and review cases together.

A 3-day pilot with the ambulance service was undertaken in early November. Care homes were asked to contact the Frailty HTS directly if a resident may need conveyance to hospital (with some exclusions). Data from the Single Point of Assessment looking at A&E attendances for people living in care homes during this time was that from the 11 people conveyed to accident and emergency, 4 cases could have benefited from input from the Frailty HTS and avoided hospital admission.

We met to review the patient stories. Out of the 11 taken to accident and emergency, 4 cases could have benefited from input from the Frailty HTS and avoided hospital admission.

What did the QNI do well to support you?

The Project Management Sessions were excellent. Aga, Sue and Amanda were always available for email or phone support or advice.

What can the QNI do to improve its support to nurse project leaders in the future?

The QNI has been fantastic and supportive. Unfortunately, due to child care commitments I was unable to join the drop-in sessions as they were 5pm. It would be great to have some a bit earlier or later. We missed meeting up face to face but hopefully we will be able to do so in future.

What advice would you give to other nurses starting an innovation project?

Keep It Simple! Don't give up! You can do it!
Gather colleagues to be part of your project team and share the responsibilities! Keep a reflective diary and seek support from other experienced colleagues who have managed projects - they are the best resource, have good recommendations and advice and are truly inspirational……ask for help!
Many things take longer than anticipated so plan well ahead!

Do you have any final comments?

It has been a hugely rewarding project and I am so pleased with the feedback received so far. The Frailty Home Treatment Service is making a huge difference to patient care by treating patients in their homes.

Joint multi-professional working across East Kent has shown encouraging data so far that our work is increasing referrals to community teams from SECAMB and direct from care homes. This work will continue as part of an ongoing Quality Improvement project alongside other initiatives. I look forward to continuing the care home in reach work in the Canterbury Locality.

Well Come Home

Name of project team

Carla Smith, Service Development Clinical Lead for Community Matrons and Case Managers; Helen Muff, District Nurse - Community team leader, West Yorkshire

What was the overall aim of your project?

In line with Enhanced Health in Care Homes document (NHSE/I, 2019) the overall aim for the Well Come Home project is:

- To support care home staff and patients with wellbeing initiatives, education for self-care, frailty and management of long term conditions
- To enhance community care and multidisciplinary team support for those living in care homes and improve the experience, quality, and safety of care for people living in care homes, their families and their carers

The project aims were initially outlined to:

- Improve self-care approaches for people living in care homes
- Create a supportive network of community nursing leads for care homes in our area
- Create a sustainable twice monthly wellbeing group for people with complex care needs in care homes and their carers
- Encourage patients living in care homes to join in the twice monthly sessions with their carers to discuss and engage in self-care approaches
- Include a family forum for questions and answers in the twice monthly sessions.

The overall aims of our project remained the same throughout but the focus shifted in response to the pandemic. Our community nursing services and teams highlighted an increased incidence of depression, dementia and physical impairment amongst older people who are living in a care home (BDCFT 2020). There remain a number of unmet

'People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners.'

health needs amongst older people living within this setting which include fatigue, sleep disturbance, deconditioning, undetected malnutrition, Diabetes, poor oral health, dehydration, constipation and foot care problems.

Locally services vary greatly (Glendinning et al, 2002) with GPs visiting either weekly for a 'round' to when requested. Weekly rounds now account for the GP care provided to the homes within this project in line with Enhanced Health in Care Homes guidance (NHSE 2021).

Please provide a brief summary of the project

The population of older people is steadily growing and by the year 2025 the number of older people (above 80 years old) is expected to double (Department of Health 2001). Banning (2007) affirms that people over 90 will indeed increase fivefold. Consequently, the population of older people living within a care home setting has expanded (Royal College of Physicians et al 2000). This continues to pose significant challenges for health professionals and undoubtedly places pressure on services for people with long term conditions; this became especially evident during the Covid 19 pandemic, where face to face contact with heath professionals and each other has been restricted. This has also led to an increase in the number of, frail elderly people with complex health needs, living within a care home setting (nursing and residential care) requiring support not normally provided by mainstream community nursing services such as fatigue management and mindfulness which are included in the project sessions outline.

Covid has brought challenges and telemedicine/telehealth are becoming an acknowledged supportive platform for patients and care home staff. Utilising telehealth devices, groups of care homes and their residents can join sessions with the district nursing and community matron teams which focus on long term condition management, frailty, dementia, delirium, wellbeing, decision making, moving forward in the digital age, all to reduce hospital admissions.

We have learnt that services can and must work differently, to support the needs of our patients in more creative ways and this project brings innovation, multi professional, individualised sessions, and is patient focussed.

What were the key outcomes?

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners. The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved with the collaboration of multi professional teams and the staff in the homes experiencing a partnership approach.

The reasoning for our project outcomes include:

- 1 in 7 people aged 85 or over live in a care home
- Residents of care homes account for 185,000 emergency admissions each year, 35-40% of which are potentially avoidable
- Care home staff are in a somewhat isolated position with covid, with limited face to face contact with professionals
- Care homes are often privately funded so staff and residents may not have access to some health resources or voluntary services, meaning that some patients can 'miss out'
- Community nursing teams are ideally placed to lead educational, wellbeing, support groups for this cohort of staff and patients (NHSE 2020)

Our outcomes were to:

- Improve understanding of long-term conditions

- Reduce unnecessary GP call outs/hospital admissions
- Improve self-management of conditions eg possible UTI
- Improve health and social wellbeing
- Relaunch care home care pathways
- Improve relationships for community nursing teams and care homes
- Increase multi professional support and networks for local care homes

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

We have met these outcomes throughout the project and will continue to progress them moving forward. As with any project involving people, the ideas and plans at the beginning, are often altered along the way to meet the needs of the project participants. We are content that our project has grown with our team's engagement and will continue to evolve to meet the needs of our local care homes, always building on the relationships we have forged.
We also now have included participation in the project for our 3rd year nursing students, and DN students which incorporates the development pathways required for both undergraduate and post graduate students. This will support both the learning and development of our future nursing workforce and provide and strengthen relationships with our colleagues in care homes.

What have been the challenges in delivering your project?

We have encountered 3 main challenges during the progression of this project:

- The main challenge for us has been the current state of the NHS and social care environment due to Covid 19. Our staff and the homes included in the project have shown immense focus, commitment, and resilience, but Covid has taken over and the project has had to be postponed numerous times. Our plan is not to be defeated by this, but to continue. QNI has provided us with a platform to start a really important piece of work, which will not end as the project timeline is completed. The homes and staff are engaged to continue this work and network regardless of what difficulties are placed in our way.
- Another challenge was getting associated teams on board and dealing with things in a timely manner, for example our finance department who did not prioritise our project which delayed us getting the tablets to give to the homes.
- Obtaining data from GP/CCG has been impossible. GP practices in the project area, would not provide us with any data to measure our project against which is how we collaborated with a digital care hub who supported us with data around call outs.

What have been the positive benefits either personally or professionally in the undertaking of this project?

The project leaders conclude that the implementation of the community nursing link nurse and Well Come Home project in care homes has had a positive impact on care and patients. Some care staff reported a better service than that of the GPs during the pandemic crisis and have thanked teams for their support face to face and virtually. Homes are engaged to participate in the sessions and are allowing staff not able to attend, time to listen back to the recordings and access the joint resources.

What do you feel have been the outstanding achievements of the project to date?

The outstanding success of this project, we feel, has been that we have continued, in what has felt at times like wading through treacle.

Our team and link nurses have maintained support and motivation throughput what has been a tough time due to the pandemic. I do not believe this commitment can be underestimated. The homes have had widespread covid infection, with high numbers of severe illness and deaths, yet have embraced the nursing care and support we have provided across all homes, and especially more locally for the homes within our project. The pure dedication to the project in times of adversity is to be applauded.

Moving forward, we have plans to continue and evolve the sessions, creating bespoke packages for care homes. To maintain and build the networks we have developed and relaunch the self-care care pathways and the education that accompanies these. The community nursing teams will lead this ongoing work, with support from AHPs, CCG and students.

What will happen to your project now?

The project has many beneficial outcomes, not least the performance measurements identified via digital care colleagues. For the community nursing teams and care home staff, the quality changes have had the biggest impact on care and that having a bespoke package and link nurses dedicated to care homes does indeed improve the care for people in care homes.

In the local trust, systems are being developed to share the good practice highlighted within this project. A service portfolio is being developed to show case the initiatives the project has implemented. The development of this project has provided levers to share this practice across the district and has provided evidence to implement small initiatives to make big changes.

The community nursing teams, and care homes have ongoing plans to develop aspects of the project, develop bespoke training needs analysis and action plans for education and care to really improve the care they provide.

What did the QNI do well to support you?

The QNI provided us with detailed workshops to set us up to do well, ongoing support and communication and when Amanda came to our session on teams, her enthusiasm and affirmation of the benefits of the project were very much welcomed.

What can the QNI do to improve its support to nurse project leaders in the future?

I can't think of anything more we would have needed, you have been on hand all the way to support us.

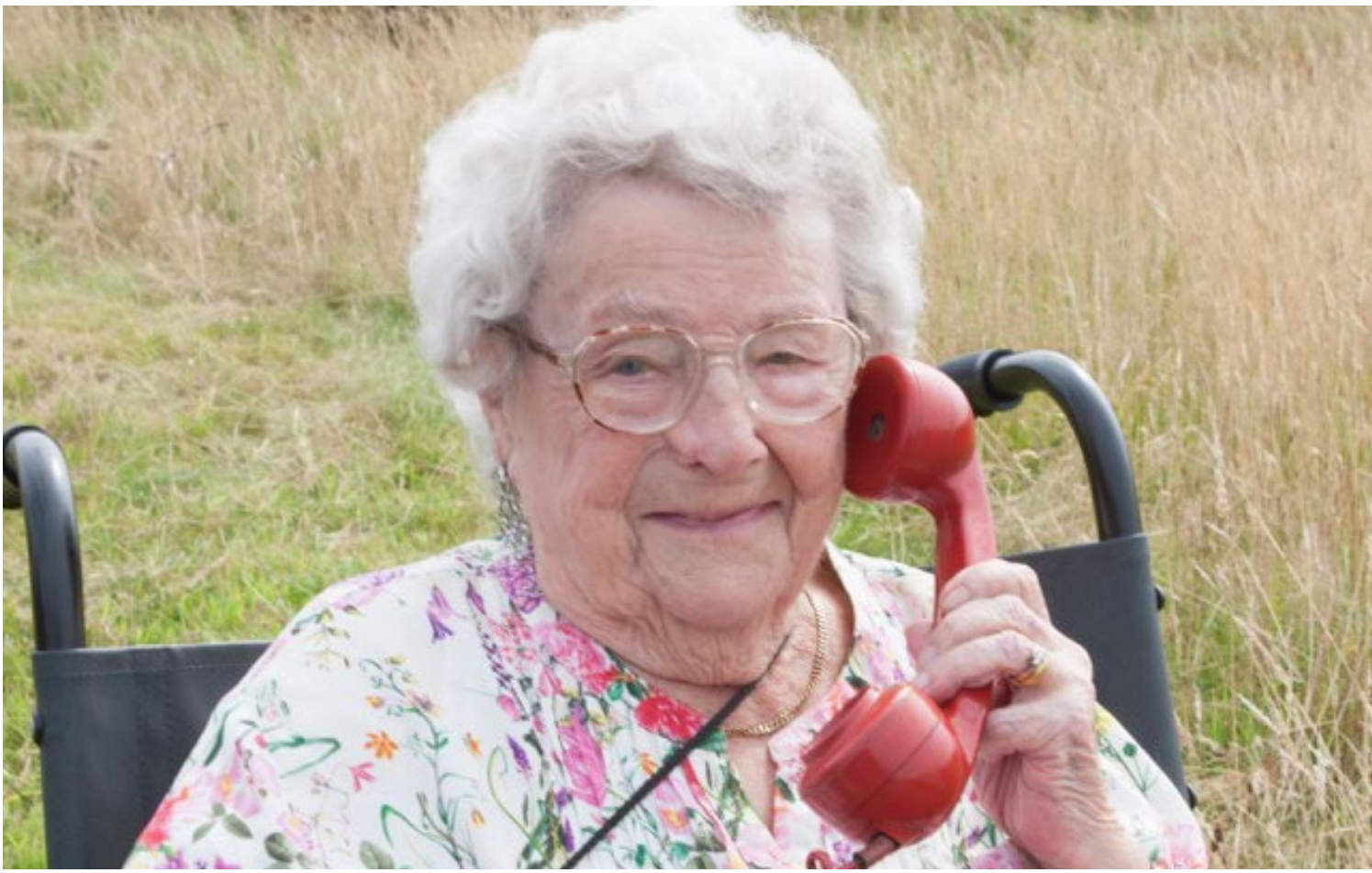
What advice would you give to other nurses starting an innovation project?

Don't be hard on yourself when "life" gets in the way. Sometimes, timelines need to be altered to meet the needs of the people involved.

Do you have any final comments?

Just a note of sincere thanks, for the opportunity to develop this project that we have been aiming for, for some time.

Single Point Of Contact



Name of project team

Llio Glyn Griffiths, District Nurse Caseloadholder; Angharad Mair Jones, Community Nurse, Wales.

What was the overall aim of your project?

To create a coordinated, person centred, seamless service, closer to home through a District Nursing Single Point of Contact (SPOC).

The project will improve communication, care coordination and integrated assessments through early intervention and "What Matters" to meet the needs of people with complex needs in primary care.

This project will utilise resources within the patient's community. It will eradicate waste, duplication of work, prevent hospital admission and expedite hospital discharge.

It will enable the members of the Community Resource Team (CRT) to react flexibly to the changing needs of the patient within their own community setting by focusing on 'what matters' to the patient in a timely manner.

Please provide a brief summary of the project

- to include specialist members of the CRT, at the right time, in the right place, incorporating both health and social care
- prioritising /co-ordinating care closer to home
- quicker intervention
- seamless service
- led by District Nurses who are known to the patients with complex care needs and familiar with the areas resources
- single point of contact focusing on what matters to our patients and their families

Photo courtesy of Angharad Mair Jones

Our innovation has enabled us to help achieve Fred's personal outcomes in that he is able to remain in his own home and maintain his wellbeing with support from various members of the Community Resource Team.

This project has confirmed the vital role of the District Nurse as the main care co-ordinator for patients with complex needs in the community.

What were the key outcomes?

- Established District Nurse single point of contact Monday to Friday 9-5pm
- A dedicated phone line and email address was created
- District nursing priority of visits template created.
- Improved communication and co-ordination for all members of the CRT in achieving what matters to patients and their families
- Handover at 3 points throughout the day
- Improved Communication with all CRT members which included a trial of the Pando app and daily virtual CRT meetings
- Reduction in preventable admissions.
- Implementation of pathways to support assessment and care management from first point of access
- Less readmission and crisis intervention.

Briefly describe your experience of implementation: what changes if any had to be made?

It has been challenging to drive change and innovation within our health board due to the governance constraints of a large organisation. Some individuals within the organisational structures have not been conducive to change and service development which has proved extremely challenging and difficult to move some aspects of the project forward.

Implementing the change has required perseverance, team working and constant support and engagement with all colleagues on the frontline from numerous disciplines to make our vision possible.

Covid has caused extreme challenges throughout the project due to reduced staffing, this has affected the amount of time we have had to develop our project and has resulted in a lot of work being done at home as well as working full time and overtime to try and ensure patient needs have been met.

Implementing the project has been a learning experience, we have had opportunities to complete data protection impact assessments, standard operating procedures, gained an awareness of organizational constraints, planning triangles and monitoring frameworks all of which will be extremely useful for future projects and developments.

Has access to healthcare improved for people helped by the project?

Yes. Please see data (links below) from patient and staff evaluation.

Patient evaluation link, click here.

Staff evaluation link, click here.

How much user involvement has there been in your project?

The entire District Nursing caseload of 215 were sent a letter explaining the development of the District Nursing Single Point of Contact project, and what it entailed. Involvement was also facilitated through staff engagement sessions for all CRT members. There was also a press release by the trust discussing the innovation and development of the project and the new way of working.

As this was a quality improvement project, patient evaluation questionnaires were sent out to 184 patients with complex needs on the caseload with a 50% response rate, with a 74-88% satisfaction rate on key aspects of the service provided. CRT staff member surveys are still coming in however currently the response rate stands at 46% with a 75-100% positive evaluation on various key aspects of the service.

We have found the response to the project to be a very positive experience for the majority of the patients with complex needs and also the staff who responded throughout the service evaluation. We had some lovely comments and this has given us confirmation that our project has been a success.

What have been the challenges in delivering your project?

COVID has caused problems in the delivery of this project due to the lack of staff. We have not been able to meet our projected time table or be released from clinical work hence have had to deliver this project mostly in our own time on top of working overtime to ensure the safety of our patients and team. Leading change within the organisational governance constraints has also been extremely challenging.

What have been the positive benefits either personally or professionally in the undertaking of this project?

Personally, undertaking this project has been a great achievement and it has been an honour to have been selected for this award. Through great determination we have been able to follow the innovation through. Being professionally able to deliver a project of this scale through a pandemic has been extremely positive; we are now more aware of governance constraints, challenges within the organisation, and the impact of lack of staffing and the pandemic on delivery and implementation and that through transformational leadership we have successfully supported and guided staff through the service change and made it a positive experience for all.

Please provide details of how you have you promoted your project?

Through engagement events with relevant Community Resource Team members and leaflets devised bilingually explaining the new service and sent to the entire district nursing caseload. Additionally via local newspapers, social media and NHS trust bulletin/website coverage of the innovation.

What do you feel have been the outstanding achievements of the project to date?

The set up and roll out of the project as it has been an extremely challenging time during the pandemic.

The proactiveness of the District Nursing Team in embracing the innovation, making it a success and improving the life for people with complex needs within the community.

Developing priority of care guidelines and care pathways to support staff members staffing the SPOC to deploy quicker care intervention to those in greatest need in a bid to reduce hospital admissions.

The willingness of the community resource team members from numerous disciplines to provide their support and commitment to making the project a success.

Being the first team in the trust to trial a clinical messaging app, which has made a significant improvement to communication through instant messaging.

Being the first team in West Wales to have a daily virtual CRT meeting to discuss people with complex needs in need of support on the day.

It is rewarding to see how this has developed from having only a small amount of buy in from CRT members at the beginning of the project to now having an array of CRT members attending daily.

The Primary Care Cluster for our locality also supported our project in providing funding for a CRT administrative role.

What will happen to your project now?
This is a sustainable initiative, and could be rolled out to further teams.

The findings are being taken to senior management/leadership meetings in order to discuss further.

What did the QNI do well to support you?
The workshops were extremely valuable as were the support meetings throughout the year. We have gained valuable knowledge about leading a project, monitoring outcomes, impact assessments, data collection methods of which prior to this we were unfamiliar.

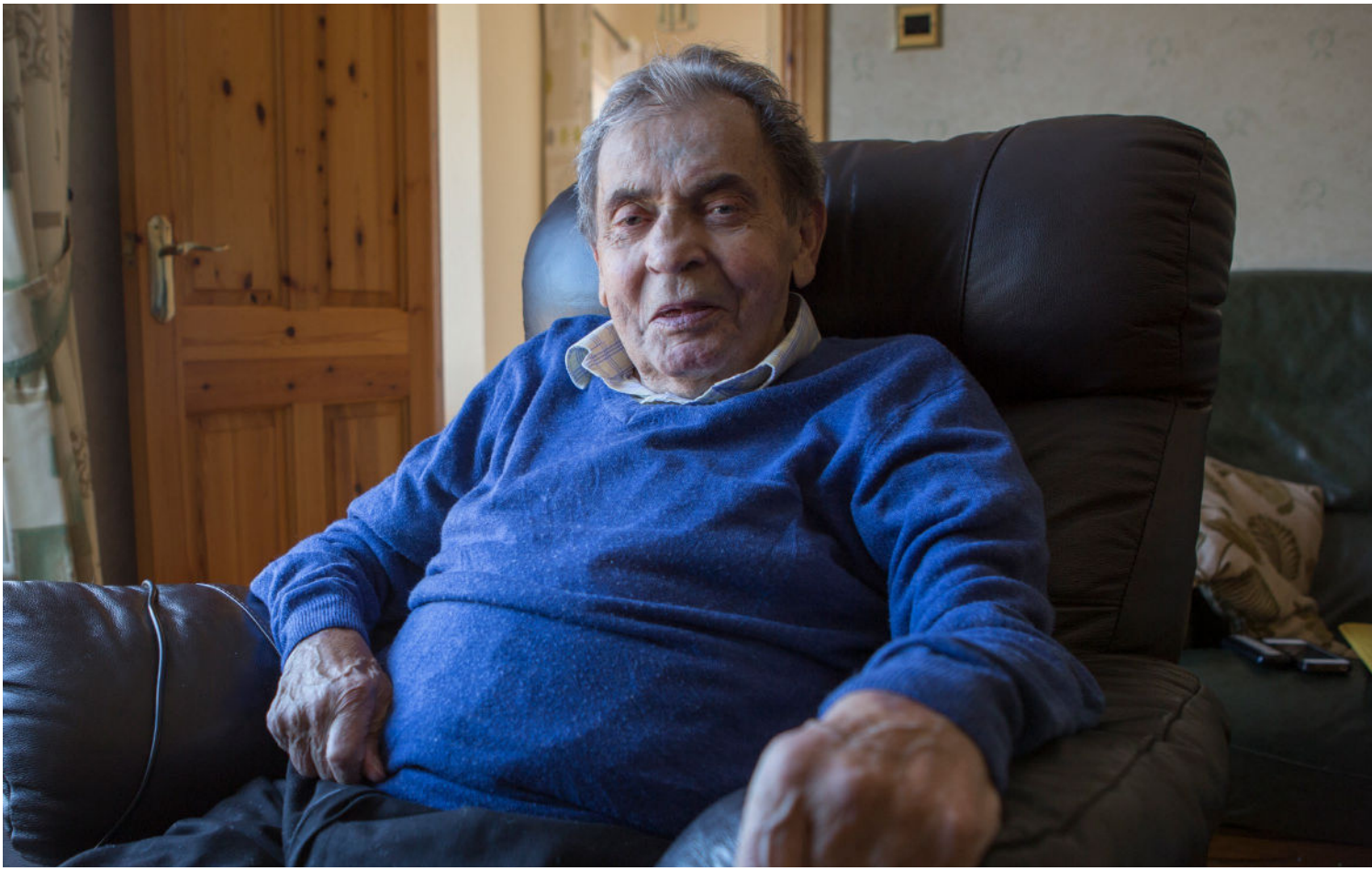
The QNI were also always available when we struggled with aspects of implementation.

What can the QNI do to improve its support to nurse project leaders in the future?
It would be beneficial to have had a half day workshop near the end of the project and some 1:1 time to go through the case study / final report. It would also be really good to have all project members to present their achievements to the group and meet in London as it has been particularly challenging during COVID.

What advice would you give to other nurses starting an innovation project?
To plan and be as organised as possible. They also need a lot of will power, motivation, determination and perseverance to make their project a success. Organisational governance barriers at times can be extremely challenging however, the fruition, success and positive feedback from service users of the project makes it all worthwhile.

Do you have any final comments?
Thank you for allowing us the opportunity to complete the project and improve the lives of patients with complex needs in our locality. We will forever be grateful for this experience and we will hopefully utilise the leadership skills we have gained in the future.

Flex, Connect and Share



Name of project team
Alexandra MGarvey, Lead Nurse, GP Practice, Bedfordshire

What was the overall aim of your project?
To decrease loneliness and isolation expressed by frail older housebound patients of Leighton Buzzard.

Please provide a brief summary of the project
Virtual coffee mornings and Pilates classes were carried out, with IT equipment being supplied to those patients who did not have access. 30 Patients benefitted between 17 March and 15 December 2021.

What were the key outcomes?
- The project was successful in attracting patients from every surgery in the town
- Every participant expressed feelings of increased wellbeing following their interaction with the virtual coffee morning
- 26 participants reported that their physical mobility had improved following the Pilates sessions
- One patient who has a diagnosis of Multiple Sclerosis reported that the facilitator was extremely good at adapting the exercises to meet her needs
- Two participants reported that they felt they had made genuine friendships in the group
- 15 participants expressed that their knowledge of digital media had improved as a direct result of the project.
- The project attracted carers as well as housebound patients and every carer expressed gratitude for being part of the project
- The educational session on fraud, facilitated by the local police officer was evaluated as being the most beneficial.
- Our oldest participant in the project was 95 years of age
- The practice team was utilised to enable more vulnerable patients to access the sessions, (HCAs and the complex

Photo courtesy of Pexels, Cliff Booth

A key feature of the project was to offer friendship as well as physical and educational benefits and therefore patients were not required to "sign up" for sessions and a "drop in" culture was promoted.

care matron were released from clinical duties to support and enable patients to access the project).

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

Better liaison with voluntary organisations and the patient participation group.

What have been the challenges in delivering your project?

- COVID-19 remained prevalent in the local community for the lifespan of the project.
- The Patient Participation Group and other local groups are comprised of retired and older residents, who themselves felt vulnerable to COVID-19 and who were therefore unwilling to go into other households, this resulted in lack of support for some of our housebound patients.
- Due to lockdown the need for physical, face to face interaction became increasingly important and patients expressed feelings of becoming tired of digital engagement.
- The primary care network was not established and therefore there was no support available for patients through social prescribing or patient engagement roles.

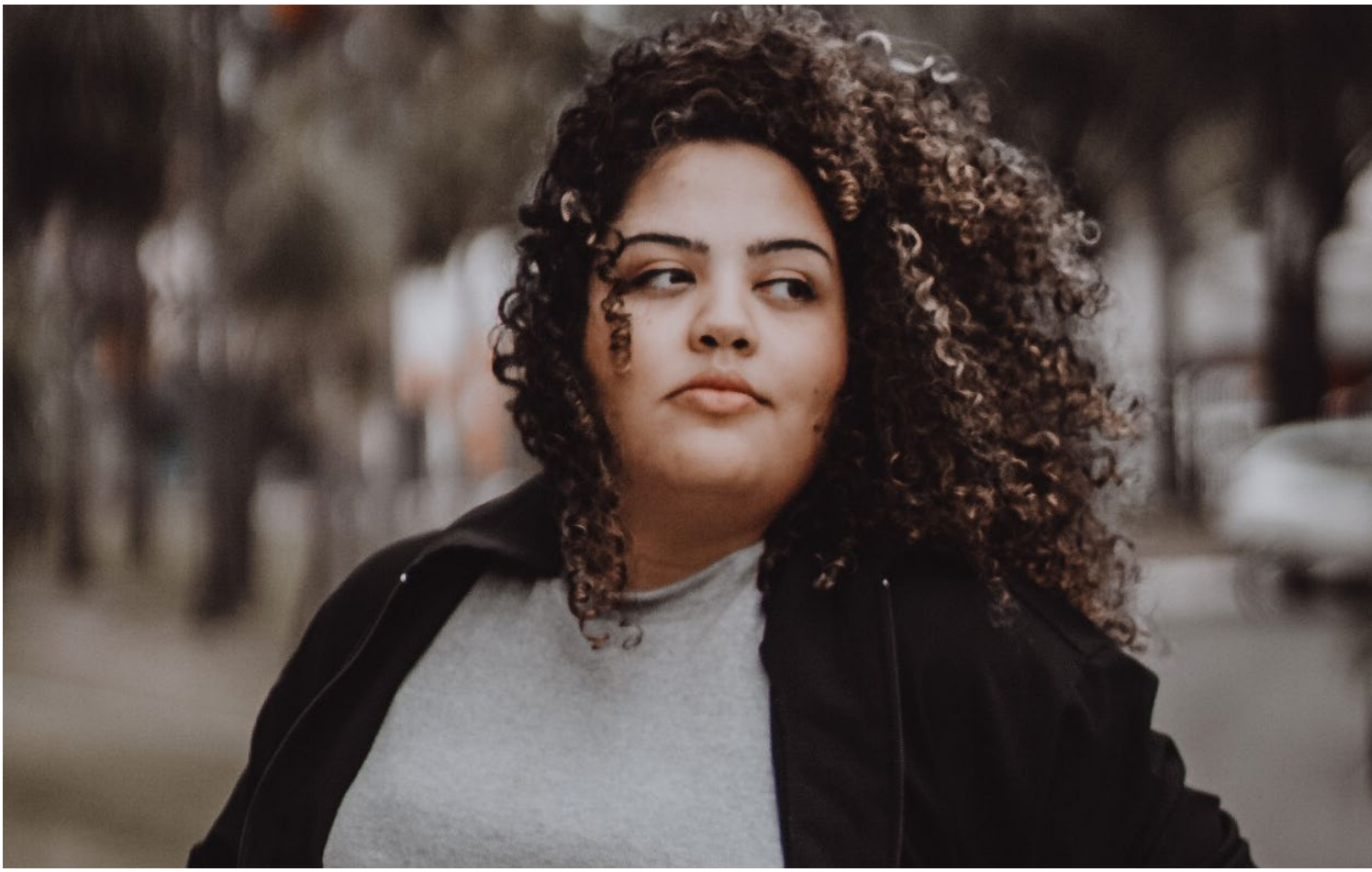
What do you feel have been the outstanding achievements of the project to date?

A key feature of the project was to offer friendship as well as physical and educational benefits and therefore patients were not required to "sign up" for sessions and a "drop in" culture was promoted. Any patient who was unable to access the project due to lack of IT was identified and iPads were made available from the practice.

What will happen to your project now?

The Primary Care Network has now employed 5 care co-ordinators and 2 social prescribers, who are keen to adapt the project to offer face to face sessions for elderly patients.

Digital Diabetes Lifestyle Modification Programme



Name of project team

Yemisi Osho MBE, Founder/CEO Diabetes Action, London

What was the overall aim of your project?

The aim of this project was to explore the impact of digital technology with an integrated virtual lifestyle modification programme in improving the uptake of a Diabetes Prevention Programme and mitigate the risks and complications associated with Diabetes among participants from a Black, Asian and Minority Ethnic background who have complex needs.

Please provide a brief summary of the project

Participants were recruited using social media, via Diabetes Action Website, direct contact with General Practitioners and Social Prescribing Services. Interested individuals were emailed for potential participation and advised to complete a self-reporting questionnaire of physical activity, food habits and knowledge of Diabetes prior to participation. A further meeting was arranged via a digital platform to discuss the aim of the project with interested participants, followed by an interview and discussion of inclusion and exclusion criteria with information about their Diabetes Risk Score assessment.

The inclusion criteria for participants were those aged 18 – 65 years with a BMI > 25 kg/m2 and pre-Diabetes confirmed by HbA1c (42-47mmol) and people with Diabetes (PWD) with a HbA1c above 48mmol.

35 participants attended the initial online meeting. Subsequently, 30 participants who met the inclusion criteria and agreed to take part were invited to participate in the programme.

The programme has thus far shown impressive results with the number of participants (90%) indicating that they have improved their diet and made changes to their lifestyle. A majority indicated that they have reduced high glycemic carbohydrate foods, fatty foods and increased vegetable and fruit intake.

A total of 25 participants continued in the project, following a combination of physical activities, healthy diet plans and behavioural changes over a 12 month period, achieving significant and improved health outcomes, based on their original biometric data.

The lifestyle modification programme consisted of 5 components - virtual peer support, health education for Diabetes prevention and risk factors, online cookery, fitness, and mindfulness coaching.

At the commencement of the programme, participants were encouraged to set realistic goals for weight loss and behavioural changes. In the first 6 months, the core interventions consisted of 12 weekly online group-based sessions followed by one-hour bi-weekly sessions for 3 months, twice monthly fitness classes for 3 months led by a trained fitness instructor; monthly behavioural lifestyle change sessions facilitated by a mindfulness coach and 3 monthly online cookery sessions. The online cookery sessions included demonstrations of cooking healthy meals and reinforcement of the importance of good nutritional food. Participants were also provided with information about culturally healthy diets and low fat, low carbohydrate and low glycaemic index recipes, increasing vegetables and fruit intake as well as an understanding about food labelling, food hygiene and safety.

What were the key outcomes?

The programme has thus far shown impressive results with a number of participants (90%) indicating that they have improved their diet and made changes to their lifestyle. A majority indicated that they have reduced their intake of high glycaemic, carbohydrate and high fat foods and increased their vegetable and fruit intake.

A mean weight reduction of 5 kg for each participant has been achieved within 6 months, across both genders and different age groups. 50% of participants achieved a demonstrable weight loss and improved BMI, total cholesterol and HbA1c through maintaining a good diet and physical activity. With an intended 5-7% weight loss expected within 12 months and a mean weight loss of 5kg considered favourable, 50% of the participants identified with pre-Diabetes have reported HbA1c <47mmol and a significant reduction of total cholesterol. These findings indicate that the expected health outcomes are on the right track.

One other significant achievement is the integration of a digital virtual platform compared to a standard face to face Diabetes Prevention Programme which has provided an opportunity for people who might not normally engage face to face or access health care when they need to, to participate in the programme. The virtual platform has provided the participants the incentive to fully participate in the programme from the comfort of their home, particularly with the constraints of lockdown since the covid-19 pandemic which has prevented face to face activities.

The implementation of a digital platform as a vehicle for fitness sessions in contrast to a traditional face to face physical activity session has also provided an opportunity for engagement with participants, increased adherence and has supported the potential to achieve aims, objectives and intended health outcomes.

In addition, the participants have been provided information about behavioural strategies such as goal setting, barriers to lifestyle changes and healthy eating, self-control, monitoring of dietary intake and increased physical activities. The mindfulness coaching also includes emotional and psychological support which has empowered participants to adhere with the lifestyle interventions.

Telephone monitoring and follow up has also helped to increase participant adherence to the whole programme. These preliminary results, together with participant feedback indicate that this innovative project can help individuals at risk of long-term conditions and complex needs to achieve good health outcomes.

The project indicates that through an integrated virtual platform and a culturally modified Diabetes Prevention Programme, people at risk of and people with Diabetes can reverse their status from preDiabetes to a normal glucose level (<42mmol) with a total cholesterol level of less than 200mg/dl and remission of Diabetes (<47 HbA1c) if the participants continue to adhere to lifestyle interventions at the end of a 12 month period.

Apart from your intended outcomes, what other unexpected outcomes happened as a result of your project?

There has been interest in this project from care homes, General Practice and community outreach organisations requesting information and especially the opportunity to access online cookery and fitness sessions. A significant achievement has been an increased number of participants from BAME background compliance with lifestyle interventions.

What have been the challenges in delivering your project?

Barriers to healthy lifestyle:

- Adherence to a healthy diet
- Compliance with physical activity programmes
- Poor accuracy of dietary assessment
- Lack of affordability due to high cost of fresh and healthy food
- Individual barriers reported included: low incomes; unemployment particularly due to Covid-19 pandemic
- Lack of knowledge about what constitutes healthy and unhealthy food
- Unhealthy eating habits due to convenience of "cheap" and "junk" food;

Barriers to Physical Activity and Participation:

- Lack of access to sporting/gym facilities constrained due to lockdown
- High cost of participating in organised sport/gym activities
- Lack of motivation

Social-Economic Factors

- Cultural barriers to healthy eating amongst the BAME community
- Unemployment
- Low self-esteem. This factor has impact across all the barriers listed above.
- Keeping the drop-out rate from the programme as low as possible.

What have been the positive benefits either personally or professionally in the undertaking of this project?

To facilitate the cookery sessions, having to attend cookery classes and become a "mini" chef. This has enabled me to feel confident enough to demonstrate and teach basic cooking skills that include, food hygiene, food safety, and the importance of a healthy diet.

I have also learnt various aspects in the utilisation of digital platforms to reach a wider audience and online cookery demonstration.

Community Nursing Innovation Programme: Complex Needs

Summary of Final Reports 2022

Case Studies

BEAT Diabetes **case study**

Name of project team

Sheree-Leigh Woodall, Staff Nurse; Chelsey Went, Staff Nurse, West Midlands

Case study

Jack has been an inmate of HMP Oakwood for 4 years. He was invited to join the project at the beginning due to having a BMI of 54.9 and an HbA1c of 48, he was also hypertensive with a BP of 167/90 and although he was not diagnosed as having type 2 Diabetes, he was identified as being high risk with a family history of Diabetes. Jack held the belief that he would not get Diabetes as he thought it would skip his generation. His diet consisted of mainly starchy, sugary foods with a reliance on chocolate snacks and fizzy drinks with no exercise. He had not been to the gym since secondary school.

He was interviewed and signed up to the programme, and started his food diary which made him realise that he was often eating for the sake of eating rather than being hungry and actually the feelings he recorded about some of the food made him realise that the food did not make him feel better. A diary of blood glucose levels, weight and BP was also started so that progress was visible.

He was really motivated to keep up the diet plan and the exercise regime, admitting that sometimes going to the gym was a real effort. He soon noticed the benefits of having more energy and less pain in his back and joints. In the first month his HbA1c came down to 42 and his BP started to come down. The BEAT Diabetes information book provided a lot of information that he had not previously known about Diabetes and this really motivated him to keep going. At the end of the programme he had lost 20 kgs in weight, his HbA1c was 36 and his BP was within normal range.

He explains that his mental health has improved and he is more positive about his future health realising he can do things, and be in control. He feels that the programme has really changed his mindset which means he now rarely eats sugary snacks, only drinks diet drinks or water, really enjoys salads and vegetables and plans to continue with this even though the project has now finished. Jack believes that the project has also highlighted issues in the provision of food in the prison as since it has started a traffic light system to identify healthier food options to help inmates make healthier food choices has been implemented. There are also healthy snack options on offer which were not available before. Jack also reports that his success was mainly due to the positive feedback from the nurses on the project which encouraged him and enabled him to take control of his own health and he thinks that all inmates with Diabetes could benefit from this level of support.

'Jack says that his mental health has improved and he is more positive about his future health realising he can do things, and be in control. He feels that the programme has really changed his mindset.'

Promoting Oral Health in Care Homes **case study**

Name of project lead

Pauline Rawle, Community Services Matron, Leicestershire

Case study

Ms F is an 82 year old lady who was transferred to a dual registered care home, on 23rd October 2020. She was diagnosed with Type 2 Diabetes, with advancing Alzheimer's dementia and was bed bound, unable to mobilise. Ms F was nursed in a bariatric bed.

Ms F was referred to the Community Nursing Service by the GP in July 2019. Due to the nature of the care setting, the Community Nursing Service supported care with insulin administration and latterly with wound care, undertaking daily visits for insulin administration, twice weekly visits for a category 2 pressure ulcer and a weekly visit to update the pressure ulcer prevention care plan. She was described as a pleasant lady, happy to receive her care including prescribed insulin twice daily.

As Ms F's care needs increased and her mental capacity decreased, the care home requested an assessment of needs from the Local Authority. Ms F was subject to a Deprivation of Liberty Safeguard (DoLS).

The care home had a high turnover of staff and appreciated the offer of additional resources, refresher training and support for new starters about oral health care. The care homeowner had arranged oral health training before the start of the Covid pandemic and had expressed a need for refresher training. The manager stated he was concerned as he had observed that some of the carers were not performing oral health care to the required standard. It was thought that this was due to a lack of confidence, knowledge and not recognising the importance of oral health care.

The care home manager also expressed ongoing frustration about a lack of access to NHS dental services on behalf of the residents, many of which were closed to new patients and contacting the NHS 111 service for advice was not appropriate. The residents with financial means were able to access private dental care.

Ms F was bed bound and her carers noted that she appeared to be experiencing toothache. The dentists in the locality declined to perform domiciliary visits leaving Ms F with no access to treatment. The carers reported that she took it upon herself to remove her own tooth to relieve the pain and discomfort. Sadly, the project intervention did not help Ms F directly, however it is hoped that the need for such an extreme measure will cease as oral care delivery and access to regular dental care improves.

If the project had not gone ahead, I would not have appreciated the true extent of the plight of our most vulnerable in society and the lack of awareness of the need for regular oral health care for the care home residents. Access to NHS dentistry was significantly hampered by the Covid-19 pandemic and care home managers and leads also find access to NHS dental services confusing and difficult to navigate. From this project, a comprehensive flow chart has been drafted and distributed to enable care homes to understand that there are 3 separate dental services, with advice on how to access them appropriately.

I have promoted the project outcomes with Consultants in Public Health, Local Authority, NHS Providers, Local Dentists, Primary Care Networks (PCNs) and other stakeholders across the health and social care system. I am heartened to know that there is an appetite to support a long term robust oral health training offer for care homes in LLR. This is a great legacy that was not predicted and a great outcome for residents and care home staff. In addition, oral health resources are available on the new website designed for care providers.

'It is heartening to know this is being taken seriously at a strategic level and I have the support and encouragement to continue this work, long term.'

Digitalising Clinical Care **case study**

Name of project lead

Anita Astle MBE, Managing Director/Registered Manager; and Damian Mann, Nursing Associate (co lead), Nottinghamshire

Case study

MH has lived at Wren Hall for over a year and was highlighted as someone who could benefit directly from the use of digital technology due to the increase in incidents/accidents from 12 to 30 during a five week period.

Initially, a baseline of clinical care was created and discussed. This included clinical observations, incidents/accidents, fluid intake, bowel movement, medication changes and emotional/close support from staff. This was discussed by our project team and it was decided that further investigation was needed to find a way of implementing care that could reduce the ill-being demonstrated by MH.

Further investigation showed that 245 activity interactions had been recorded by staff during the period reviewed. When interventions relating to nutrition, mobility and personal care were removed, this reduced interactions to 133. By matching up the recorded interactions to the incident times there were at least 14 separate occasions when no personal engagement was given up to an hour before an incident occurred. This raised the question as to whether MH's behavioural incidents were triggered out of boredom or lack of stimulation. It was noticed that MH had poor fluid intake, being below 1200ml, increasing the risk of dehydration and potentially having a major effect on behaviour or the ability to communicate wants/needs.

We agreed to present this case study to our clinical leadership team to explore such information that could be used in the future. This included;

- Speaking to staff about the importance of engagement.
- Showing staff behaviour charts and information/data collected through the study to make them aware of the correlation of times and events.
- Discussing with staff ways of stimulating/engaging with MH, involving family and finding out likes/dislikes/meaningful activities.
- Organizing medication reviews with GP and referral to the Dementia Outreach Team.
- Involving the catering team about the importance of their support with fluid intake.

Over the space of the next month all plans were implemented. This involved MH's medication being changed and staff becoming more proactive in finding ways to stimulate MH. This increased activity interactions to over 559 and when nutrition, mobility and personal care help were removed, interactions remained increased at 337. Incidents or episodes of unpredictable behaviour reduced to 8 over the next month, due to this MH's diet and fluid intake increased as he was more willing to accept help from staff.

Without being able to analyze the data and look back on what is happening from a distance we believe that this period would have gone on for longer than it did. By having the technology in place we were able to act quickly and make a plan of care that included MH, his family and the staff supporting him.

' By having the technology in place we were able to act quickly and make a plan of care that included MH, his family and the staff supporting him.'

Recognition of Good Respiratory Health **case study**

Name of project team

Fiona Sharp, Strategic Health Facilitator; Paula Spooner, Nurse Consultant, West Yorkshire

Case study

I work with a large care provider in Wakefield, who provide a range of services including domiciliary care, care homes and supported living to adults with a learning disability. There were inconsistent approaches to annual health checks in two care homes, with 3 female residents not receiving checks and another 3 having checks but no follow up. I met the care home staff and residents and the initial contact gained their experiences of General Practice. Both homes reported difficulties in ordering prescriptions, making appointments and inconsistency in who reviewed residents, resulting in seeing different GPs and nurses who lacked understanding of the level of need. Staff who had supported the annual health checks felt these were not followed up, and lacked health outcomes or goals for the year ahead.

Annual Health check booklets were provided, and My Respiratory Care Plan was shared to enable staff to prepare for the next annual health check, which staff found beneficial. My Respiratory Care Plan was completed for the residents and carers felt behaviour and epilepsy sections required adding as two residents had needs in these areas which impacted upon their breathing. The feedback gained from staff completing the respiratory care for the women was invaluable in identifying new areas to consider and areas which required further clarification.

The two care home managers also agreed to present at one of the online sessions about their experiences of General Practice and supporting residents with complex health needs. Staff shared the NHS proxy access and easy-read document with paid carers and families who all gave consent for staff to explore, to improve access to healthcare. I assisted managers to gain proxy access for paid carers and arranged for the digital lead GP to support practice managers with setting up digital access to care. Consequently, all residents now have proxy access to their GP. After contacting the practices and explaining the complex needs of residents who had not received health checks all 3 residents were offered one on the phone, with follow up appointments made for physical examination in their own homes. This approach also enabled the staff supporting the women to use the booklets to capture all the relevant health information as well as the timely review of 2 residents whose deteriorating physical health meant prompt treatment. All 6 residents received a health check and health action plan in 2021. The practice nurses from the two practices accepted the invitation to join the specialist learning disability online training. The care managers also set up email communication with the General Practice nurses to review the health action plans following the annual health checks. Care managers felt this was a huge improvement in their relationship with General Practice clinicians.

Care managers were unaware that each General Practice has a Learning Disability register and the care provider has 120 people in their care with a learning disability, 20 of whom were not included on their GP LD register. All 20 have now received an annual health check for the first time. This information was fed back to the CCG and the importance of the LD register and the annual health check at the care provider network and contracting meetings. Due to the pandemic some of our plans for engagement did not take place. To increase engagement, information on the importance of annual health checks was given at a lunch with a design a badge competition with residents with a learning disability at both care homes participating in the project. Although the project residents were not able to produce drawings themselves, we ensured a quiet focused activity where staff and residents were present and engaged in drawing.

We received 20 entries and the winning badge has now been produced. The wording on the badge has led to a movement within General Practice of 'Learning Disability Champions' because the winner chose these words. We have planned to develop a LD Champion Network, supported by the next educational programme, a quarterly electronic newsletter, and quarterly sessions to discuss improvements in the delivery of learning disability care in General Practice. All LD Champions will wear the badge and it is hoped this will become recognisable for people.

'I feel the outstanding achievement of the project is the passion it ignited for reducing inequalities in health for people with a learning disability.'

Reducing Inconsistencies in Respiratory Care **case study**

Name of project team

Siân Jones, Karen Vennard, Lead Nurses, Primary Care Respiratory Team, Wales

Case study

This housebound patient is an elderly lady (88 years old) with asthma living in supported living accommodation. She moved into the accommodation (upstairs flat) due to the fact that she could no longer self-care.

Context

She is an ex-smoker, diagnosed with asthma in 2005, with chronic kidney disease, impaired left ventricular function, type 2 Diabetes, lymphoedema, and is frail, experiencing frequent falls. She is on multiple medications, is mobile with aids for very short distances and has recently been seen by frailty services for shortness of breath on exertion and was treated with antibiotics, steroids, and diuretics.

First visit beginning of August 2021

A very pleasant lady who has all within her supported living environment, and by regular family contact, she has full mental capacity. She was referred by the GP and consent was given for the subsequent discussion and examination. Her oxygen saturation was 90-92% despite being peripherally warm and sitting upright. Other observations were within normal parameters. She was using her short acting inhaler 4-5 times per day (which is considered a risk according to National Review of Asthma Deaths, (NRAD report), she was also deconstructing her inhaler to aid usage (she had an easy-breath inhaler, not a metered dose inhaler (MDI), but she was trying to use it as an MDI. She was not using her preventative medication (steroid based, recommended for asthma treatment), but was using a dual bronchodilator inhaler daily, which is a risk factor for asthma when not using an inhaled steroid. Her technique was poor using a dried powder inhaler (DPI) as well as MDI making teaching and usage difficult, due to the technique being different.

She says she gets breathless on very short distances including getting up to use the commode. On the initial visit and after discussing with her and the GP the inhaler was changed to triple therapy (Trelegy Ellipta inhaler) to aid usage. This is safer for the patient and more cost effective for the health service. An MDI inhaler via an aero chamber was provided for use in an emergency, and she was taught the correct technique to use it.

Follow-up 4 weeks later August 2021

Oxygen saturation remained low, so referral to the home oxygen team for assessment was made. Inhaler technique was reassessed and correct use reiterated. She was assessed by the home oxygen nurse the next day and fulfilled the criteria for home oxygen and was prescribed 2 litres oxygen which was reduced to 1 litre following her post instillation check which established she was safe to use it and aware of the process for reordering and who to contact with any concerns.

Follow-up visit 3 months

Correct inhaler technique is now being used, and she is managing 15 hours of oxygen per day to achieve the maximum benefit. Her blood gases remain stable with oxygen saturation 96% on 1 litre oxygen. She is clinically well, a lot less breathless and her family are very happy with the improvement. She rarely needs her short acting inhaler anymore as the Trelegy inhaler (3 in 1 inhaler) is controlling her asthma. She remains on the frailty watch list in case of any issues and she and the family have contact details if there are any concerns.

Discussion

The teams intervention and education on inhaler technique and usage has improved the quality of life for this lady, by decreasing her breathlessness and stabilising her condition by referral for home oxygen. The team's intervention has reduced the need for medical intervention or hospital admission.

Hospital Admissions Avoidance **case study**

Name of project team

Sharel Cole, Queen's Nurse, Advanced Clinical Practitioner; Hayley Mullan, Queen's Nurse, Advanced Clinical Practitioner - Community Frailty Team, Kent.

Case study

John, is an 85 year old gentleman with vascular dementia, who has deteriorating cognition at home and was admitted to the care home following an unwitnessed fall and for assessment due to his safety, living alone. He has a history of anxiety and war related hallucinations. He mobilises with a Zimmer frame which he forgets to use. He needs promoting with all activities of daily living. The care home staff referred him as he had been having problems passing urine and the GP wanted him to go to hospital, but his daughter, who has lasting power of attorney wanted him assessed at home first, as paramedics who had been called the previous day said he was dehydrated, although he had drunk 2 litres of fluid.

The initial assessment was carried out with John's consent. He was anxious and kept expressing the need to urinate, but he did not appear to be in any pain. An abdominal assessment and bladder scan were normal. A digital rectal examination found stool high up and glycerine suppositories were administered with good effect.

His skin was intact but thrush was diagnosed in the groin and umbilical area. A urinary catheter was inserted, and 120 ml of residual urine drained. Unfortunately, due to John's distress the catheter had to be removed. The assessment found he had poor urinary flow, possibly caused by an enlarged prostate, a mass, infection or constipation, and that his anxiety was due to dementia, delirium or due to being in a new and unfamiliar environment.

Advance care planning was discussed with his daughter, and it was agreed that hospital admission should be avoided and all care would be provided by primary care unless he sustained a major bone fracture. A DNA CPR form was in place and it was agreed that John lacked capacity to make complex decisions for himself. A MDT decision to undertake blood tests to check PSA and infection markers was made and a second visit arranged. Infection was ruled out but his anxiety seemed worse, so a psychiatrist advised a change with his medication. Frailty team would review him in a week unless the carers had any further concerns.

Feedback from John's daughter, ' Thank goodness we found this team and avoided a return to hospital. Hospital is a terrifying and confusing environment for someone living with dementia – exacerbated as (due to Covid-19) my father was allowed only one visitor per day for a maximum of an hour. I cannot thank XXX enough for her exceptional care'.

'This project gave insight into the support needed by care home staff and highlighted the importance of good communication amongst all stakeholders to avoid unnecessary hospital admissions. It definitely improved patient experience, increased support for care home staff and relatives, and also provided continuity of care.'

Well Come Home **case study**

Name of project team

Carla Smith, Service Development Clinical Lead for Community Matrons and Case Managers; Helen Muff, Case Manager; Lisa Singleton, District Nurse Community Team Leader, West Yorkshire

Case study

JB is the manager of one of the local care homes within the Bradford District. The home over the past few years has seen multiple managers coming in, with frequent turnover of staff. This has led to increased pressure of providing an holistic care approach which the home would want to aim for. On top of that, the relationships with district nurses, general practitioners and other community nursing services has at times been difficult and frustrating.

JB has been the manager for the past 18 months, and with covid playing a significant part in the lives of their residents, staff, and families, it has seen the home struggling to cope with the enormity of covid, trying to manage the residents on a day to day basis, being able to access medical intervention, ensuring that the staff had access to PPE, and just that everyday fear that hit the whole of the world.

JB describes the first resident to be tested positive, felt like the room was caving in. The fear and concern from the staff and other residents was so terrifying that they could not look beyond the week to plan and that then became a daily fear. How do you juggle life and a pandemic? The numbers of positive cases within the home began to rise, and the questions being asked of JB was how she keeps her residents and staff safe. Having multiple residents on end of life care pathway, they did not understand that they needed to stay in their rooms to stop the spread of Covid. JB spoke with health professionals about how she could keep the most vulnerable residents safe, to the point that she asked if they should be sedated, just to keep them safe. That was a conversation with a person who was desperate and fearful about the future of the residents, her staff and their families. As a health professional, the context of the conversation was one of disbelief that they could possibly be asking these questions, but on reflection was one of need and desperation.

Following the initial outbreak and working closely with our care homes, we recognised the need for a supporting arm, that could be utilised not only for the residents but for what felt like a forgotten cohort of staff.

'People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners.'

Single Point Of Contact **case study**

Name of project team

Llio Glyn Griffiths, District Nurse Caseloadholder; Angharad Mair Jones, Community Nurse, Wales

Case study

The focus of the QNI District Nursing Single Point of Contact (DNSPOC) Project was to keep patients with complex needs in the community, utilising the Community Resource Team (CRT) appropriately. All patients on the DN caseload were sent information on the service.

Fred is an 86 year old gentleman, who lives in warden controlled accommodation and is estranged from his family, and in receipt of twice daily care visits and support from a friend. He requires assistance with all activities of daily living and has a complex medical history of chronic kidney disease stage 3, type II Diabetes, atrial fibrillation, osteoporosis, and ischemic heart disease. He had been on the district nurse caseload for 3 years, for continence management, pressure area monitoring, leg care, NEWS monitoring and equipment provision. His carers contacted the DNSPOC as he had been struggling to stand and had been unwell for 24 hours. A DN was deployed and on assessment his temperature was 38.7 degrees Celsius, pulse 111, BP 98//52, respiratory rate 20 and oxygen saturation 94% and a NEWS score of 5 indicating a possible diagnosis of sepsis. Fred was adamant he wanted to stay at home and agreed to be assessed by the CRT. He was reluctant to have an electric profiling bed but agreed after the benefits and risks were explained. This was authorised by the DNSPOC and delivered with a commode within four hours. The GP was informed and requested to urgently review the situation. He subsequently prescribed antibiotics. Fred was then discussed at the daily virtual CRT meeting where the Occupational Therapist (OT) and Physiotherapist were requested to urgently review this patient. The OT visited later that day with the DN and the room was prepared for the bed and a steady aid was provided for mobility. An increase in Fred's package of care was also requested by the care provider and duty social worker to safely support this gentleman at home. A visit from the DN out of hours was requested to provide support overnight due to a high NEWS score and as Fred had lost his mobility. The neighbour agreed to give access out of hours in the short term.

Prior to setting up of the DNSPOC and CRT meetings the carers message would not have been picked up until later in the day and liaison and assessment would not have occurred resulting in a possible admission to hospital and a delay in getting appropriate support. This project has made a difference through a quicker, more co-ordinated response led by an experienced community nurse with the right knowledge and clinical expertise, demonstrating improved communication and pulling in the expertise of relevant CRT members at the right time at the right place and which enabled Fred to remain at home as this is what matters to him. Fred admitted that he would not be at home without the bed and is very grateful for the care input he has received. Our innovation has enabled us to help achieve Fred's personal outcomes in that he is able to remain in his own home and maintain his wellbeing with support from various members of the CRT.

Limitations for the project included a lack of suitably trained personnel staffing the DNSPOC, also a lack of availability of relevant CRT members to respond to patients needs and buy in to the new way of working. The clinical value of the SPOC needs to be promoted and articulated with the provision of training to improve care outcomes for our patients.

There is scope to roll out the innovation to other CRT localities in the health board, as its value in rural North Wales has been demonstrated and further work is needed to evaluate its effect in urban areas.

Our innovation has enabled us to help achieve Fred's personal outcomes in that he is able to remain in his own home and maintain his wellbeing with support from various members of the Community Resource Team.

Flex, Connect and Share **case study**

Name of project lead

Alexandra MGarvey, Lead Nurse, GP Practice, Bedfordshire

Case study

I met Janet, a 63 year old lady with complex care needs during a home visit in January 2021, prior to the launch of the Flex, Connect and Share Project. A pseudonym has been used to maintain the patients right to privacy and confidentiality. Janet lived alone and was a frequent user of the acute home visiting service offered by the practice. During my visit, Janet appeared withdrawn and low in mood. She was struggling with her mobility but was resistant to many interventions suggested by the multi-disciplinary team.

When Flex, Connect and Share was launched on March 17, 2021, I suggested to Janet that she should join the project. Initially Janet was sceptical about the benefits of the project and thought that due to her limited mobility she would be unable to take part in the exercise part of the sessions. I encouraged her to 'give it a go' and offered a member of staff to enable her to join the session and support her with the exercises. Janet reluctantly agreed.

Flex, Connect & Share comprises three elements; an armchair exercise class, followed by a short educational session and then a fun quiz. At the initial session, Janet was supported by a member of the practice team, who took part in all activities, however, Janet remained withdrawn during the educational and exercise parts of the programme. She did however appear more relaxed during the quiz.

Surprisingly, Janet continued to engage independently with the programme weekly and it was a pleasure to watch her grow in confidence. It was obvious that she had good general knowledge and her success in the quiz sessions appeared to improve her confidence in taking an active part in the exercise sessions. The Pilates instructor often adapted the exercises for Janet, which obviously encouraged her. Often, Janet would join the session and give the instructor an update on how she had been practicing the exercises.

In July 2021, Janet was admitted to hospital for a planned procedure and I was overjoyed to receive an email from her to say that she was so sorry to miss the Flex Connect & Share session but 'could I please tell her new friends that she would join again as soon as she was able to'. The use of the words 'new friends' proved to me that these sessions were meaningful for Janet.

I observed that during the programme, Janet did not request any home visits from the practice team which was encouraging, because although she had weekly contact with the practice through the virtual sessions, she did not use these sessions to engage with health professionals about her health issues. Janet reported that she felt that her balance and posture had improved as a direct result of participating in the programme and I observed that she appeared engaged and happy during the Flex, Connect and Share Project.

A key feature of the project was to offer friendship as well as physical and educational benefits and therefore patients were not required to “sign up” for sessions and a “drop in” culture was promoted.

Digital Diabetes Lifestyle Modification Programme - case study

Name of project lead

Yemisi Osho, Founder/CEO Diabetes Action, London

Case study

Mr Sam Johnson (pseudonym) is a 45 year old male of Afro-Caribbean decent with a history of Type 2 Diabetes Mellitus (T2DM) for the past 2 years. He is currently unemployed and reports mainly eating fast foods with hardly any physical activity due to depression.

Social History: Single, unemployed, lives alone, smokes 15 cigarettes/day for the past 10 years, no history of alcohol or illicit drug use.

Family History: Mother had T2DM

Drug History: Occasional over the counter medicines, Metformin

Allergy: No known food or drug allergies

Sam was enrolled as he was very enthusiastic and motivated to participate in the lifestyle modification programme via online technology.

Sam was encouraged to set realistic goals prior to the commencement of the lifestyle modification program. In the first 6 months, the core interventions consisted of 12 weekly online group-based sessions followed by one-hour bi-weekly sessions for 3 months, twice monthly fitness classes for 3 months led by a trained fitness instructor; monthly behavioural lifestyle change sessions facilitated by a mindfulness coach and 3 monthly online cookery sessions.

Sam's biometric baseline was as follows: Weight 103KG, BMI >30, HbA1c 58mmol. The initial priority for Sam was to reduce his HbA1c by 20%, by increasing his weekly physical exercise with initial slow/brisk walking of 150 minutes/week and then to build up the pace steadily to achieve a target reduction in excessive body weight and BMI baseline.

It is reported that 150 minutes/week of moderate-intense physical activity, such as brisk walking, showed beneficial effects in those with pre Diabetes and those with Diabetes and has been demonstrated to improve insulin sensitivity and reduce abdominal fat. Sam was advised to consume a healthy, low fat, low carbohydrate diet with a daily target of 1800 Kcal, to include foods with 70g-90g of protein per day, vegetables, fruit, and a low salt intake. He was advised to keep a diary of his food intake, take daily exercise, weekly physical activities such as gardening and to continue to take his prescribed medication.

Sam also participated in the core interventions as planned over the initial 6-month period, he attended the monthly online group activities, supervised fitness classes, mindfulness sessions, and cookery classes.

Sam remained steadfast with his involvement in the activities, and he achieved his target goals within the first 6 months which was remarkable. He continued with daily physical exercises and kept the food diary until the end of the 12-month period. At the end of the 12 months of the lifestyle modification program, Sam had achieved incredible weight reduction, his BMI had reduced to 25 and HbA1c to 45mmol with total cholesterol <200 mg/dl.

Sam reported that he has benefitted immensely from participating in the Diabetes Lifestyle Modification Program. As a result of the motivation, his confidence has improved along with improved health outcomes. He has been able to secure full time employment due to his emotional and mental stability which he has gained from participating in individual counselling sessions and lifestyle changes. He has been motivated to join a local gym and now attends weekly physical activities. He has continued to cook a variety of healthy meals at home inspired by the online cookery classes and he is also appreciative of the significant savings in his monthly food expenditure.

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