

**Kidney Quality Improvement
Partnership (KQuIP) #KQuIPNW**

Quality Improvement

**Training Day Two – Sharing and
Learning**

19th June 2019



KQuIP

Housekeeping and survival



**Fire alarms
and exits...**



Car Park ...



Toilet location...



Mobiles



Breaks...



Photos...

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Welcome

**Rosie Donne, Consultant
Nephrologist, Salford**

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Today's aims and objectives

- **Informal sharing and learning**
- **Cross pollination of knowledge and improvement ideas**
- **Conversations around the two projects and implementing the proposed QI tools**

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KQIP Update

**Ron Cullen, CEO Renal
Association**

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Process Maps

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Process maps - instructions

- **Has any one attended a poster session during a conference?**
- **One key person stands and presents their process map to others**
- **Lets get moving around the room.**
- **Try and get to see as many process maps as you can**
- **Your opportunity to ask questions and learn**



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Revisiting Driver Diagrams

**Leeanne Lockley, RA QI Programme
Manager**



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Driver Diagrams

The Kings Fund describe a driver diagram as a “Visual model that highlights all the factors that influence the patient’s experience, to enable you to structure your thinking about how to affect the experience. It helps you to identify existing improvement initiatives that could influence the experience, and to select current and future priorities for action.”

A driver diagram illustrates a “theory of change” that can be used to plan improvement activities.

A visual display of a team’s theory of what drives or contributes to achievement of a project aim

Translates a high level goal into a logical set of related goals and sub-projects

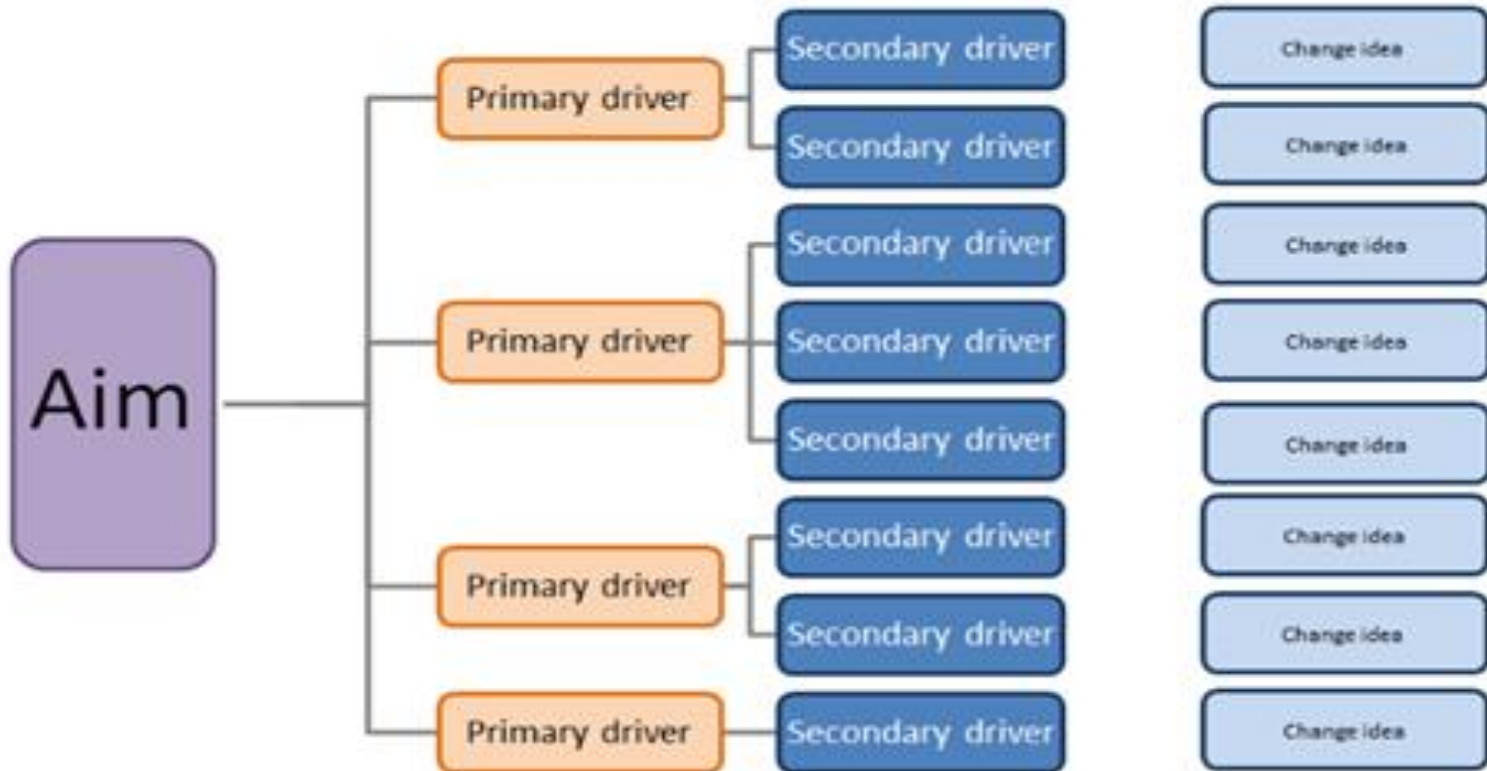
Driver Diagram Template

AIM

PRIMARY DRIVERS

SECONDARY DRIVERS

CHANGE IDEAS



What is it?

An aim statement is documentation of what you want to achieve from your project.

How to develop an AIM statement?

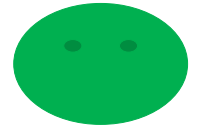
- Is it SMART? Specific; Measurable; Achievable; Relevant; Time bound
- Define your population and scope
- Don't include solutions in your statement
- Be fluid with your AIM as it can change over time

Driver Diagram – AIM Examples

We aim to reduce harm and improve patient safety for all of our internal and external customers



By June 2020, we will reduce the incidence of pressure ulcers in the critical care unit by 50%



To promote good cannulation practice and improve the patient experience of cannulation



95% of all CKD5 patients will have a documented transplant decision by March 2020



Driver Diagram

Primary Driver

- Big topic areas
- Key areas of the system that you need to influence within your project

Secondary Driver

- What needs to be in place to positively influence primary driver
- Help to identify change ideas

Change ideas

- What you and the team are going to do, test and measure

Driver Diagram - your turn

For the next 40 mins work on your driver diagram

Think about the:

- **AIM – is it Specific, Measureable, Achievable, Relevant, Time bound**
- **The PRIMARY DRIVERS (the HOW) needed to achieve your aim?**
- **The SECONDARY DRIVERS (the WHAT) that will achieve the primary drivers?**
- **What IDEAS do you have to make the aim reality?**

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Identifying where to start

**Julie Slevin, RA QI Programme
Manager**



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Date for the diary

16th October – QI Training Day 3

- **Sharing and Learning**
- **How to maintain momentum**
- **Measurement**

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Fishbone Diagram

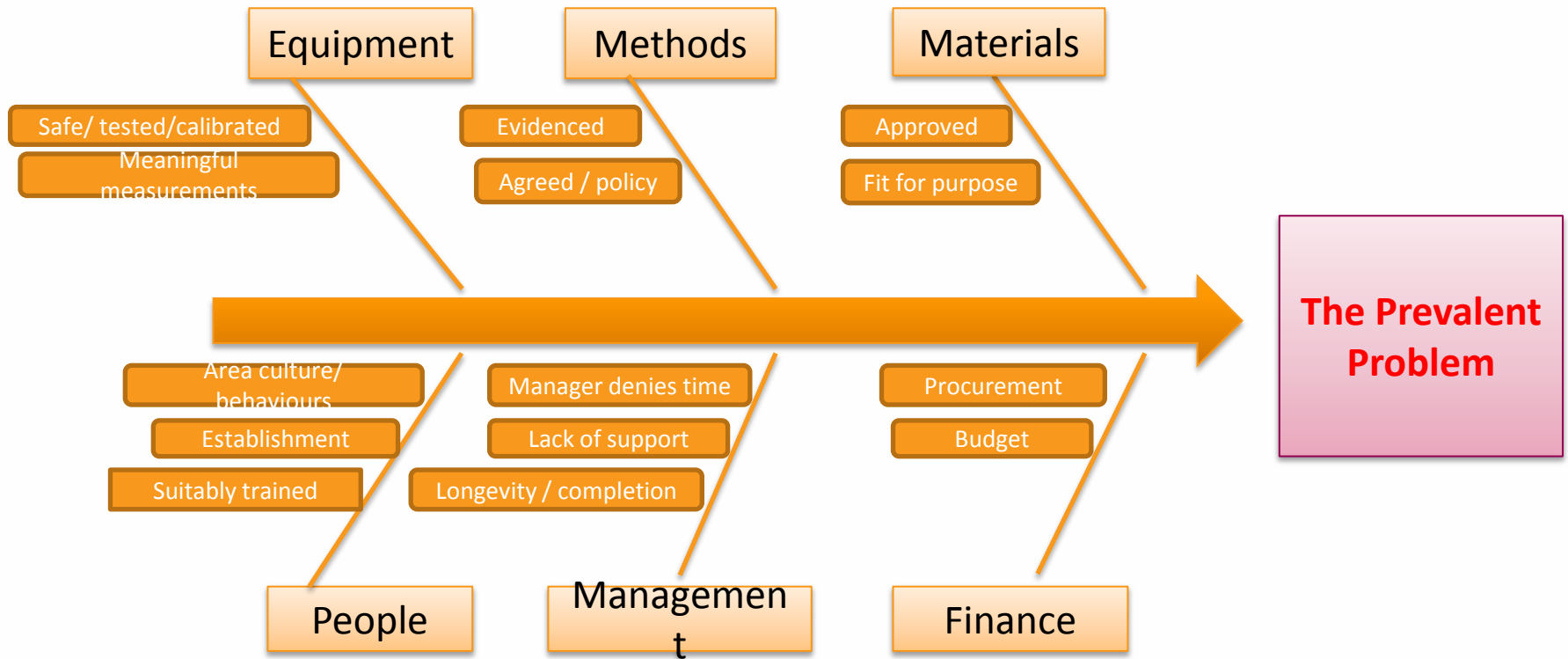
**Terry Simons, Haemodialysis Are
Support Nurse Manager, Aintree**

MAGIC PROJECT
Terry Simons
Aintree Renal Unit
The Fishbone Diagram
(Ishikawa Diagram)
19.06.2019

What is the Fishbone Diagram and why do we use it?

- It is a tool/visual diagram to review the cause and effect of any problem we need to resolve.
 - Look at a problem
 - Look at possible causes
- Generate ideas into categories to consider an outcome
 - It is a Root Cause analysis of the problem

An example - How to develop your own fishbone diagram



Teams exercise to create your own fishbone

Start with the problem

Choose a category for each bone eg: Manpower

Choose sub-categories eg: ideas/possible causes

Discuss why these problems occur

You can add and remove problems as you dig deep into them to determine their probability

Focus on the problem not the symptoms of the problem

Thank you for listening !

Don't forget tools get filed ... use this one often to solve your problems, for an engaged and satisfied outcome !!

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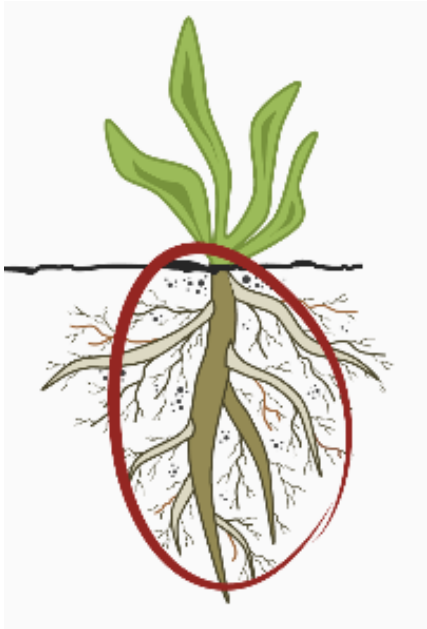
THE WHY
5 WHY
WHY
WHY
WHY's

Rosie Donne,
Consultant Nephrologist, Salford

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The 5 whys – find out why things really happen



THE
5
WHY
WHY
WHY
WHY
WHY's

...and then design improvements in ways you can measure

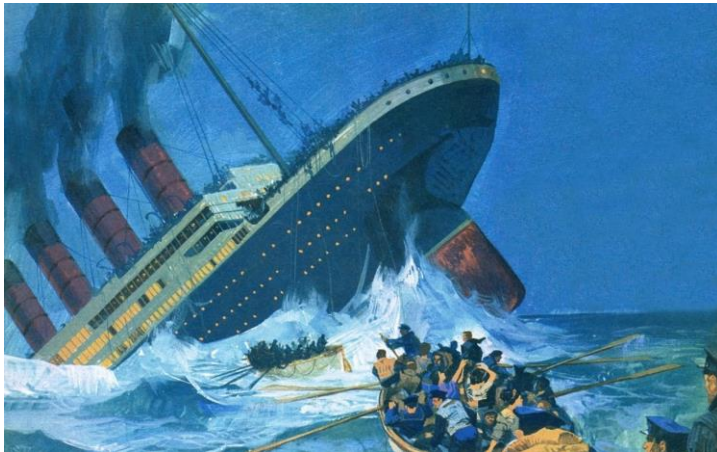
Why did it happen?

Unsinkable... ???> Unthinkable...



Why did the titanic sink?

1
Why?

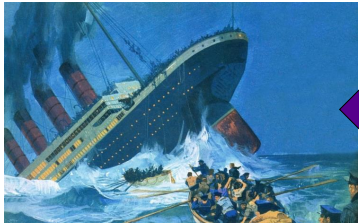


Hit an iceberg

Why did the titanic sink?

1
Why?

2
Why?

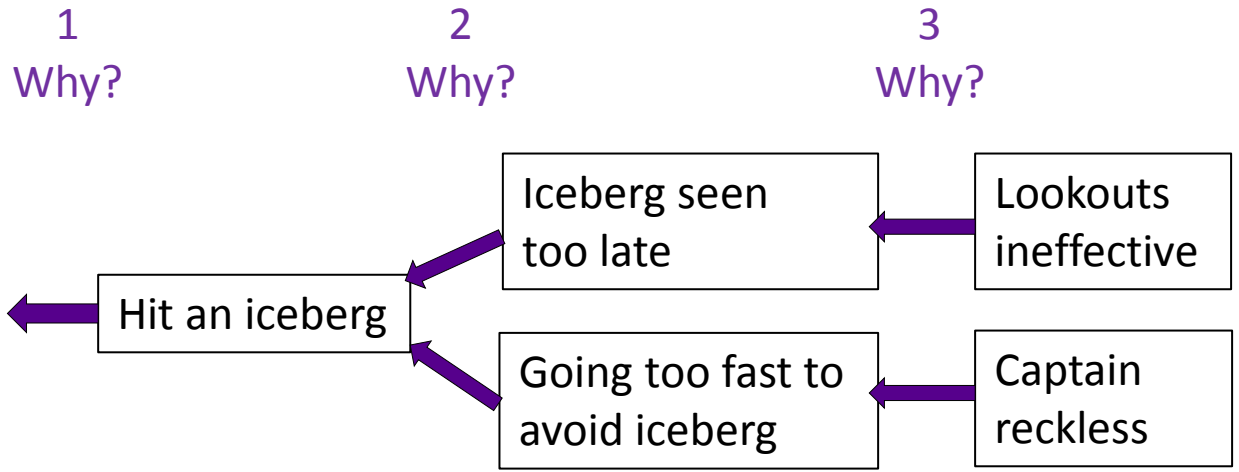


Hit an iceberg

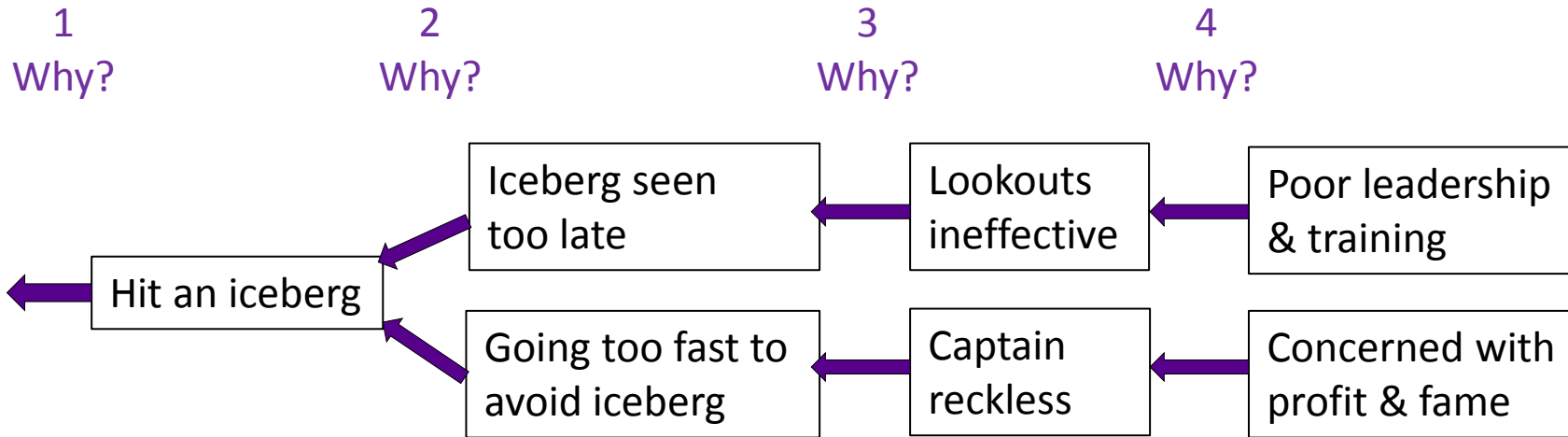
Iceberg seen too late

Going too fast to avoid iceberg

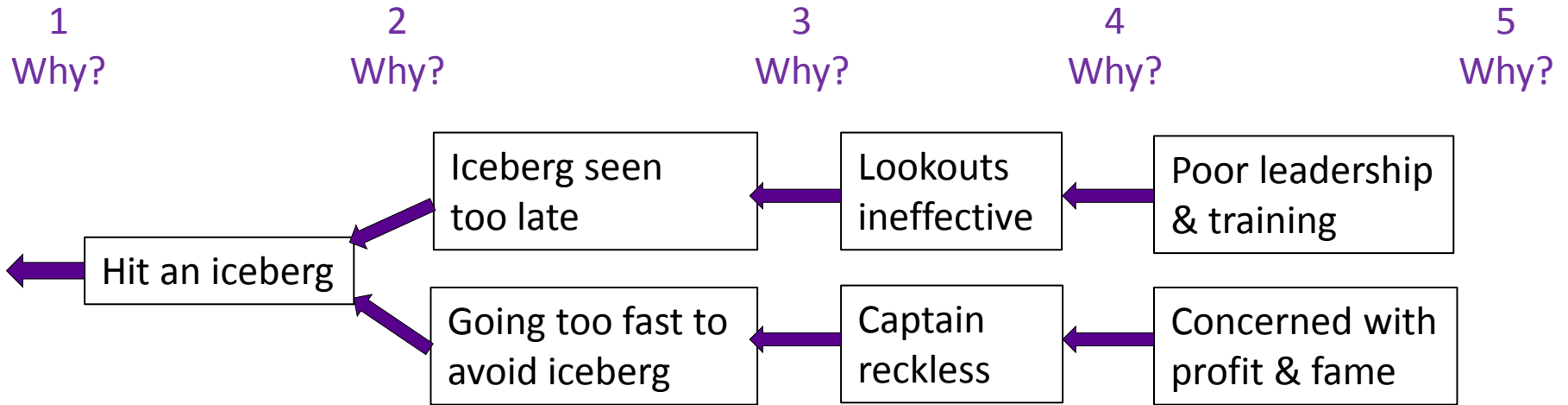
Why did the titanic sink?



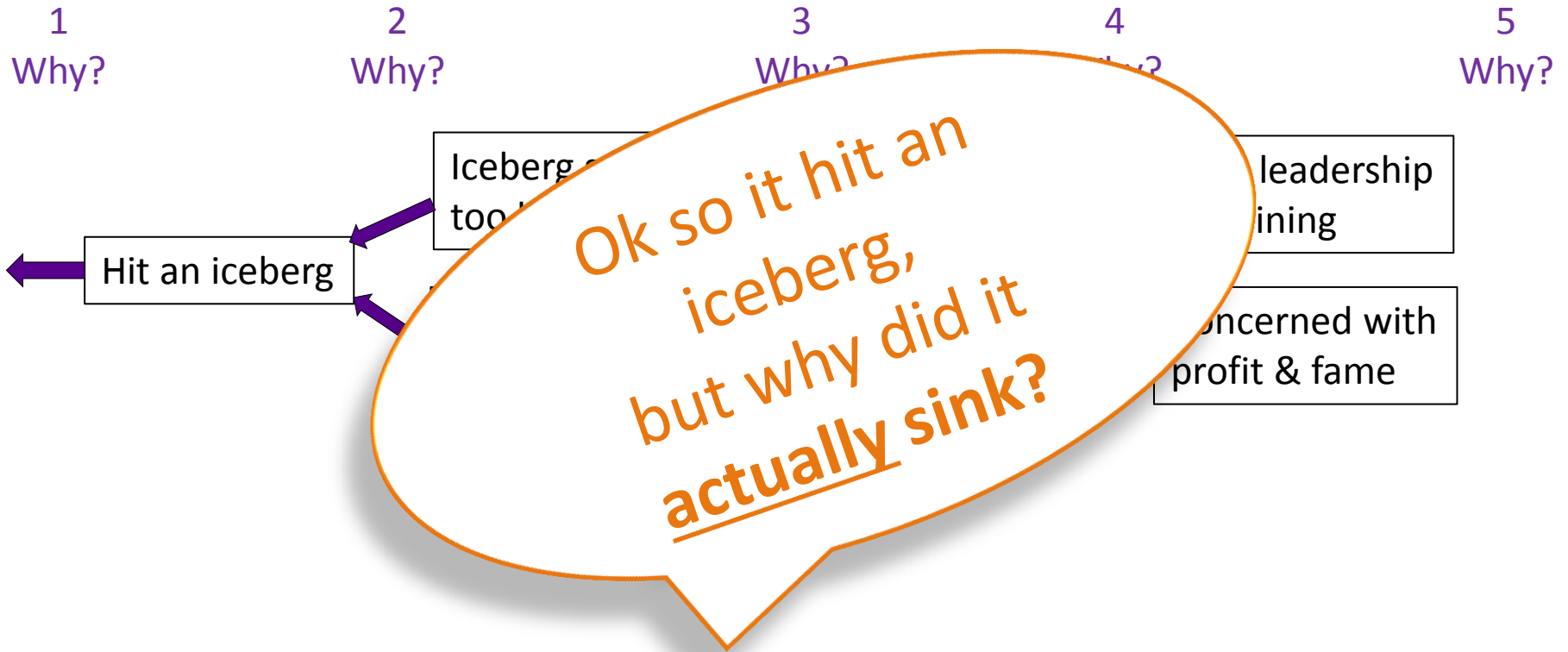
Why did the titanic sink?



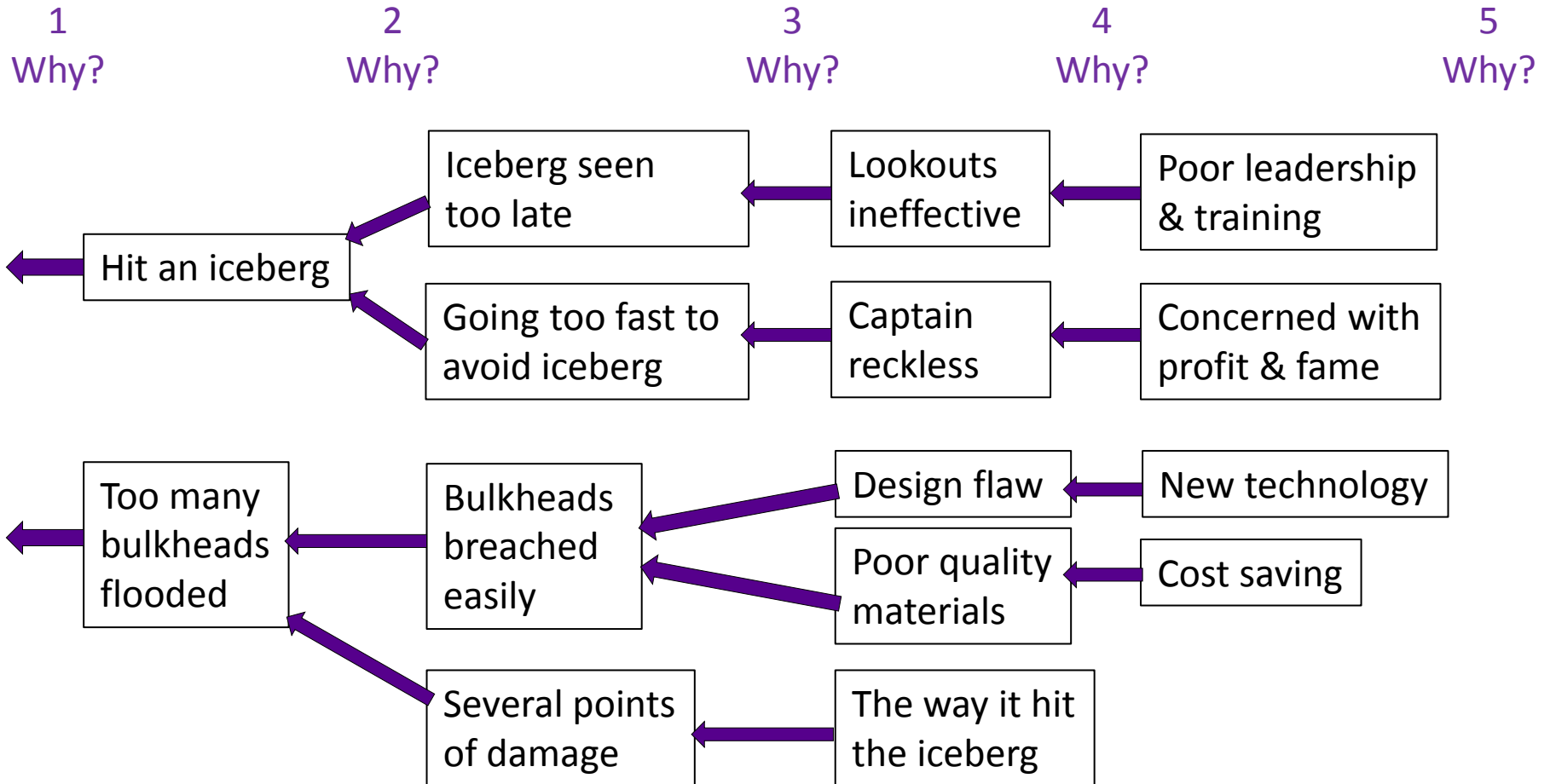
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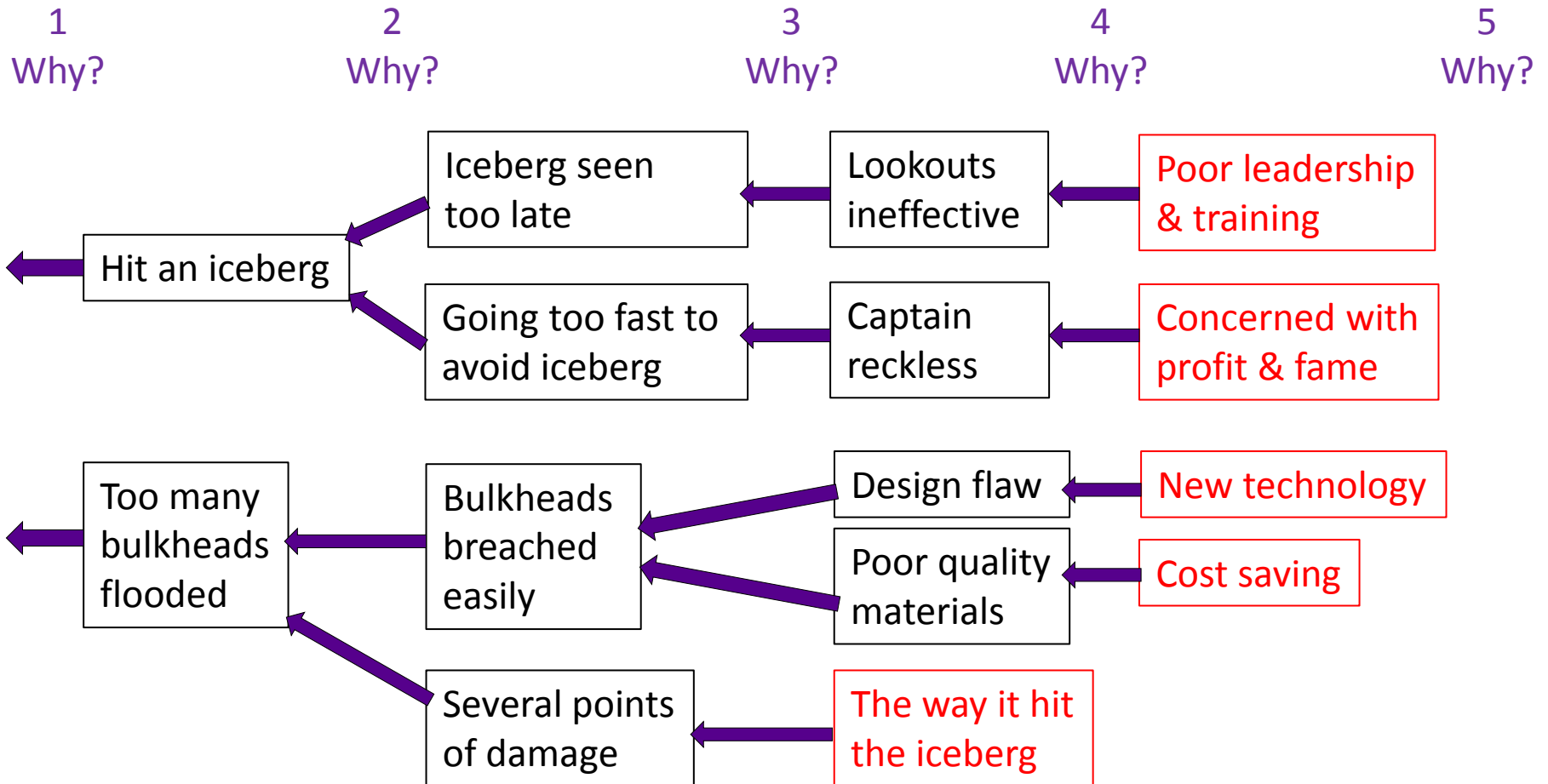
Why did the titanic sink?



Why did the titanic sink?



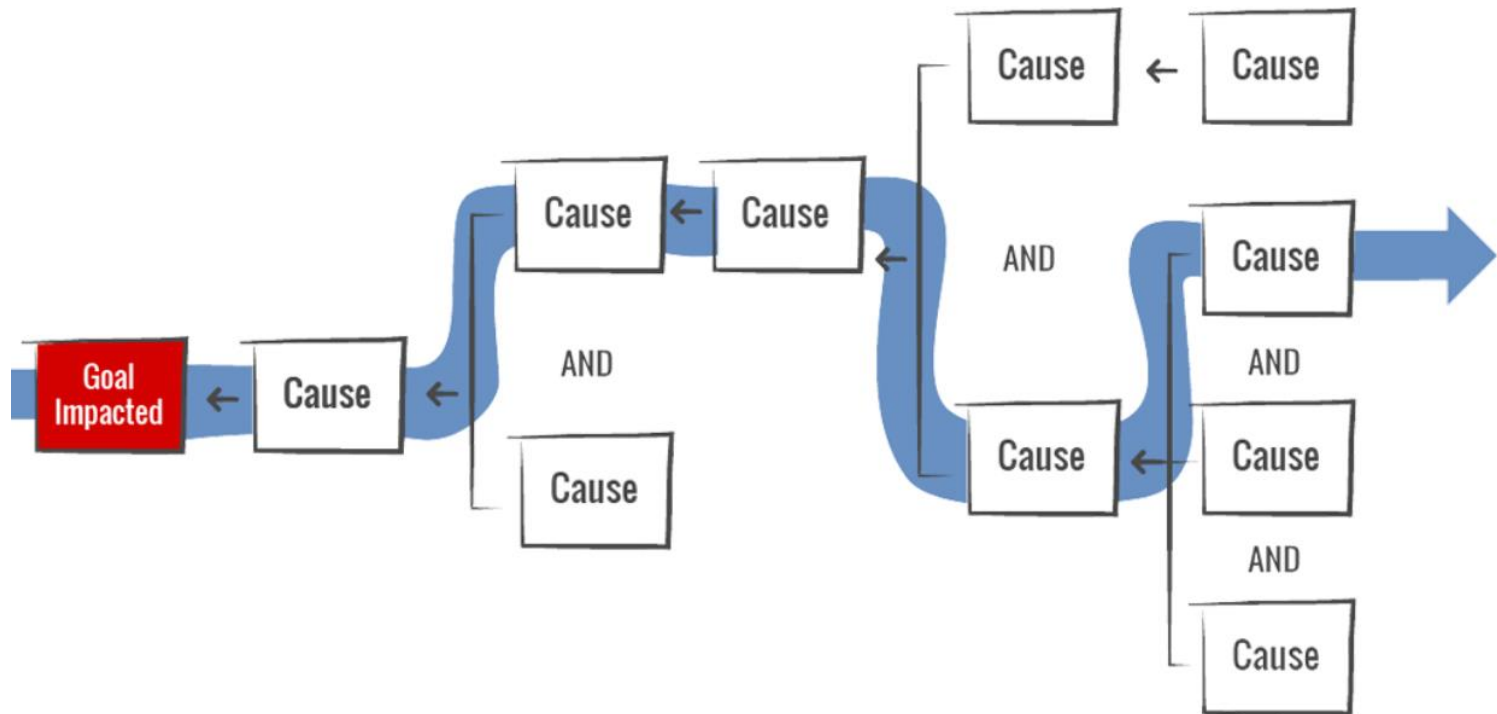
Understanding of the Titanic disaster has protected thousands of ships and passengers ever since!



Practical tips on using the 5 whys in healthcare

1. Invite those with **practical experience**, including patients, to a meeting to discuss a **defined problem**.
2. Appoint a **facilitator** and a scribe
3. **Define the problem** and stay focussed
4. Expect **multiple parallel causes** and **ask “5 whys” for each**
5. Listen to everyone & note the causes
6. **Discuss ideas for improvements (PDSA cycles) to address the causes**

You may end up with something like this...



Now you try

if you don't know where to start, try one of these!

Transplant First

- Patients miss their tests
- Complex patients not on transplant list before starting dialysis
- Delays between seeing surgeon and entering transplant list

MAGIC

- Area puncture being used
- Fistula not being cannulated
- Patient is refusing cannulation



**‘THINK
KIDNEYS’**

Date for the diary

16th October – QI Training Day 3

- **Sharing and Learning**
- **How to maintain momentum**
- **Measurement**

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PDSA Cycles

**Azri Nache, Consultant
Nephrologist, Aintree**



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Fundamental rule

All improvement will require change,
but not all change will result in improvement
Therefore we need to 'test' change
It is more efficient to 'test' change in small scale rapidly

Model for improvement

What are we trying to accomplish?

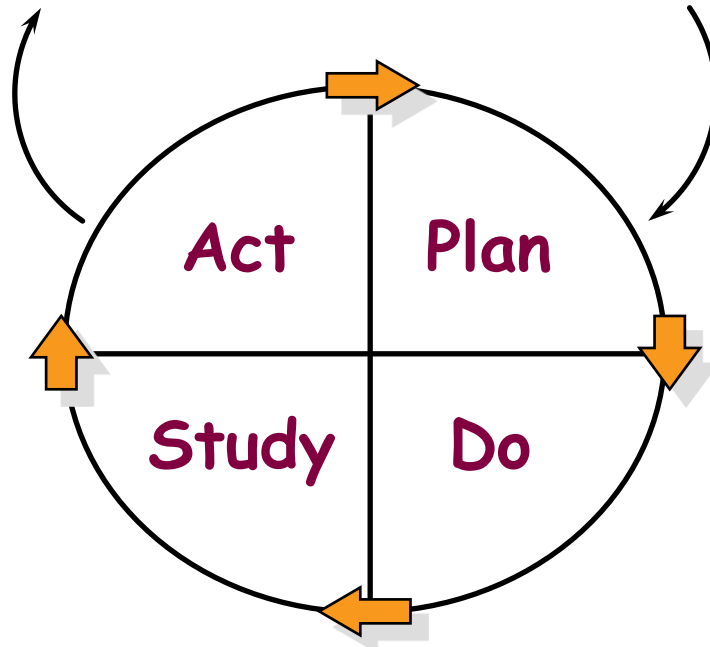
aims

How will we know that a change is an improvement?

measurements

What changes can we make that will result in the improvements that we seek ?

changes



What is a PDSA?

A structured approach for making small incremental changes to systems

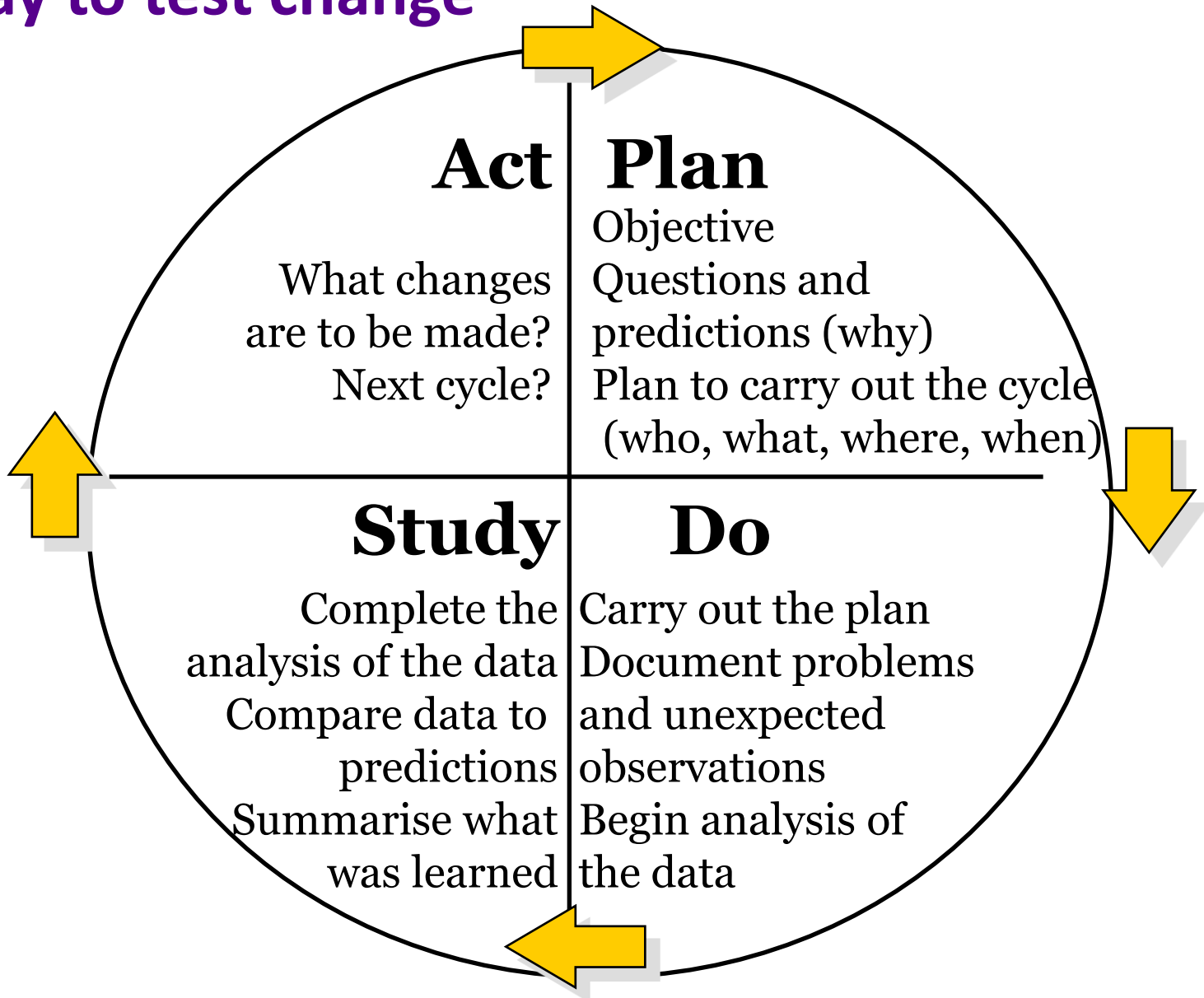
A full cycle for planning, implementing, testing and identifying further changes

A common sense, easy to understand tool for bringing about change

A tool which can reduce anxiety to change

The PDSA Cycle

A way to test change



Let's look at an example

Take 'weight loss' as an example

Plan:

- I want to run 1-mile within 15 minutes every day
- Prediction: Some difficulty in the beginning, particularly motivating myself

Do:

- Able to convince myself to do it daily. Was difficult initially, but it became easier as time goes on.

Study:

- I was able to run 1-mile within 20 minutes – may need to do it faster next week. Needed some motivation from friends during rainy days.

Act:

- Put in schedule to run every day from now on.

A PDSA Cycle

A: Put run in daily schedule from now on.

P: Run 1 mile in 15 minutes

**Prediction:
Likely difficult at beginning**

Act

- What changes are to be made?
Next cycle?

Plan

- Objective
- Questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)

D: Difficult at first, but manage to complete

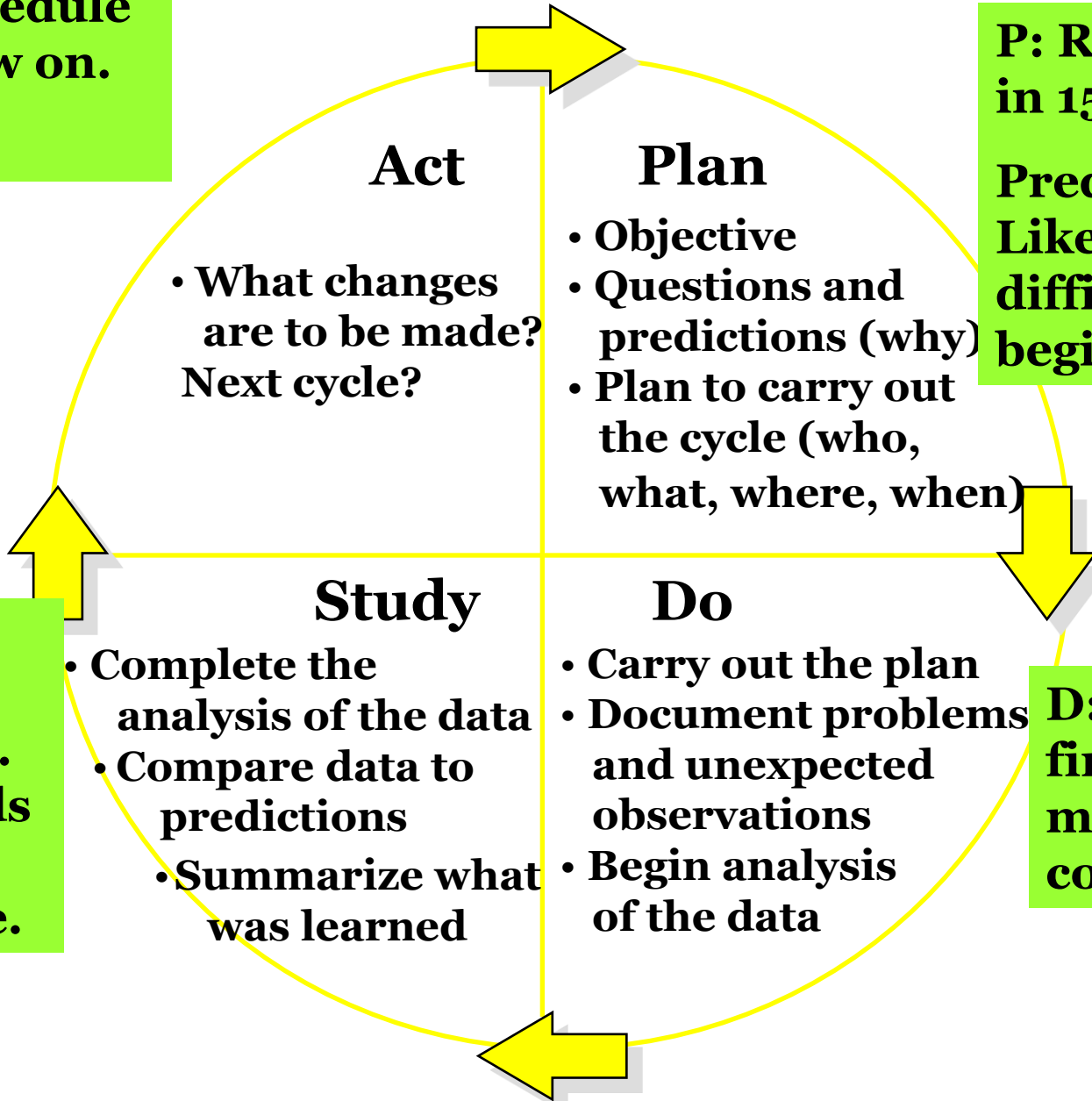
Do

- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

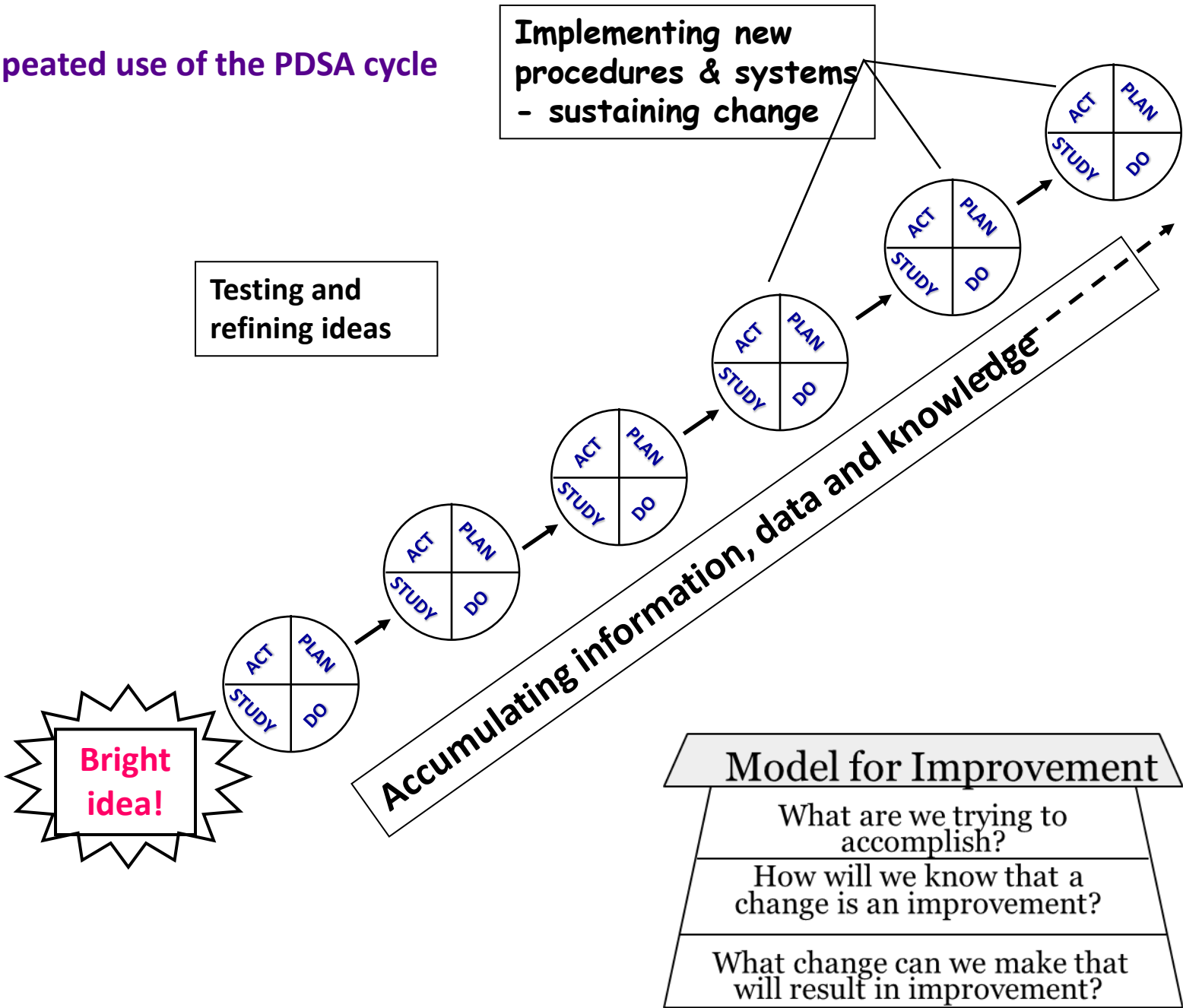
Study

- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

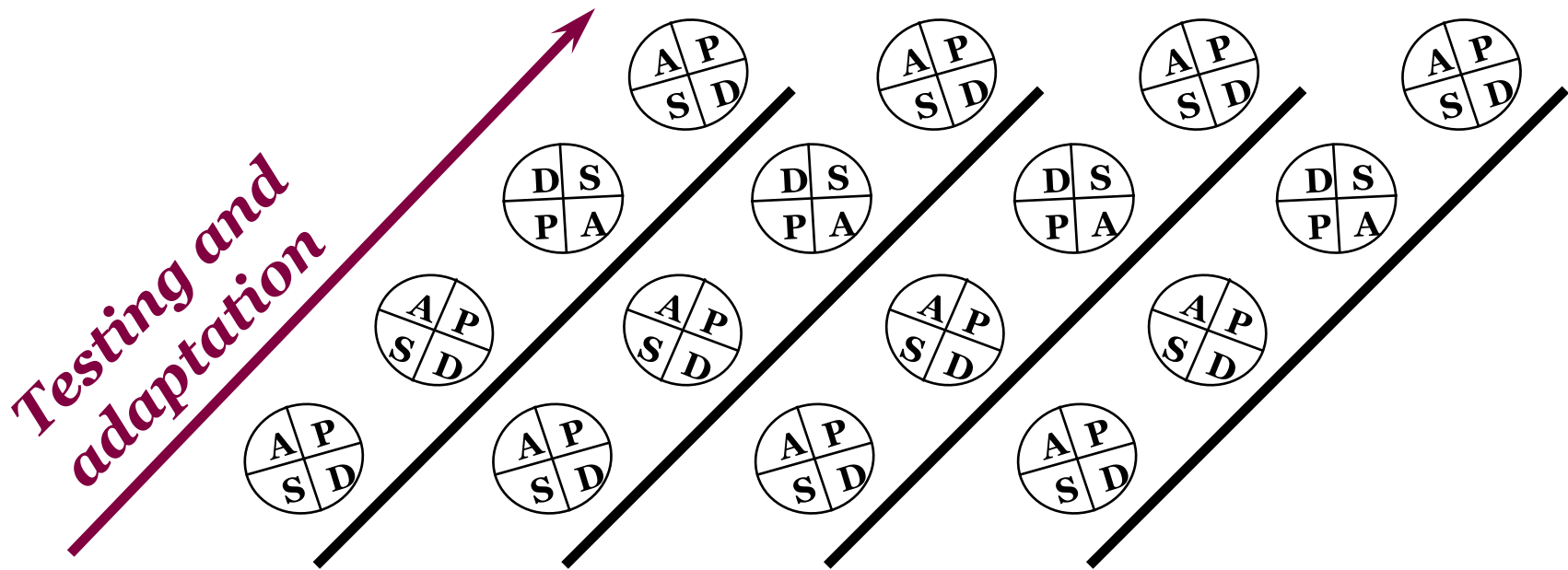
S: Need to be faster next week. Use friends to help encourage.



Repeated use of the PDSA cycle



Multiple PDSA Cycle Ramps – example for MAGIC



Staff
needling
training

Protocol for
needling

Patient
feedback

Managing peak
on dialysis

Change Concepts

Move quickly to testing changes

Year

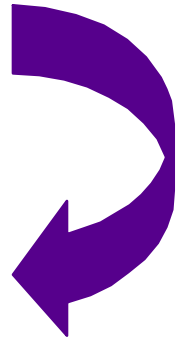
Quarter

Month

Week

Day

Hour



“What tests can be completed by next Tuesday?”

Worksheet for Testing Change

Aim: (Overall goal you would like to reach)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change	Person Responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change	Person Responsible	When to be done	Where to be done
1- 2- 3- 4- 5-			

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
1- 2- 3- 4-	1- 2- 3- 4-

Do

Describe what actually happened when you ran the test

Study

Describe the measured results and how they compared to the predictions

Act

Describe what modifications to the plan will be made for the next cycle from what you learned

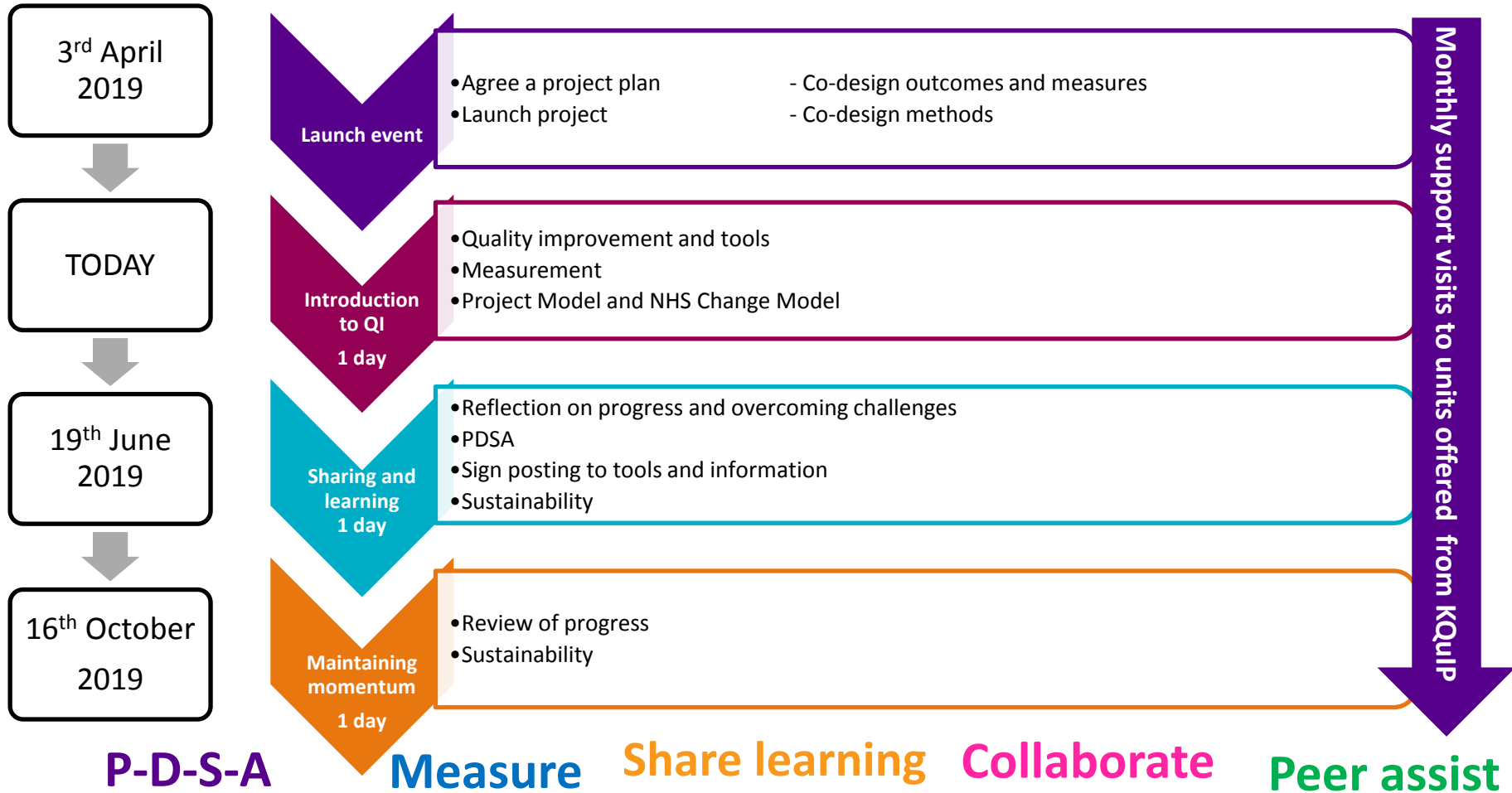


For the next 50 mins plan your PDSA cycle.

Think about:

- **The aim of the cycle**
- **Predict what you want to see happen**
- **Who will collect the data**
- **Who will lead and be responsible**
- **When will it happen and how long will the test take?**
- **What tasks do we need to do**

Project phase





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Thank you for coming today

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