

Clinical improvement programme:

Hollister
Education™



Transforming practice and patient outcomes



An educational supplement in association with

BJN
British Journal of Nursing

Hollister
Education™



Contents

- S3** **Understanding change management: a clinical improvement programme to transform your practice**
Camila Fronzo Editorial Project Manager and Coordinator, MA Healthcare
- S5** **Improving a service for men requiring hormone therapy**
Sithembile Ncube Deputy Prostate Clinical Nurse Specialist, Guy's and St Thomas' NHS Foundation Trust
- S6** **Trial without catheter referral pathways: using local district nursing services**
Katie Heavens Clinical Nurse Advisor, Fittleworth Medical, Littlehampton
- S8** **Introducing a referral pathway and proforma for trial without catheter**
Colette Cavanagh Urology Specialist Nurse, Royal Bolton NHS Foundation Trust
- S9** **Setting up a service for men with benign prostate disease**
Ameena Firoz Urology and Continence Nurse Specialist, Imperial College Healthcare NHS Trust
- S10** **Reducing the local use of indwelling urinary catheters in Wolverhampton**
Lindsey Pearson Nurse Manager, Continence Care Service, Royal Wolverhampton NHS Trust



Declaration of interest

Sithembile Ncube, Katie Heavens, Colette Cavanagh, Ameena Firoz and Lindsey Pearson are all independent clinicians who did not receive payment for their contributions to this supplement

How to cite this document

British Journal of Nursing. Clinical improvement programme: transforming practice and patient outcomes. Br J Nurs 2018; 27(6 Suppl 1):S1–12

MA Healthcare, St Jude's Church,
Dulwich Road, London SE24 0PB, UK
Tel: +44 (0)20 7501 6726.
Web: www.markallengroup.com

© 2018 MA Healthcare

Publisher: Andrew Iafrati (andrew.iafrati@markallengroup.com)
Editor/associate publisher, medical education: Tracy Cowan

All rights reserved. No reproduction, transmission or copying of this publication is allowed without written permission from the publisher. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, mechanical, electronic, photocopying, recording, or otherwise, without the prior written permission of MA Healthcare or in accordance with the relevant copyright legislation.

Although MA Healthcare and Hollister Education have taken great care to ensure accuracy, neither MA Healthcare nor Hollister Education will be liable for any errors of omissions or inaccuracies in this publication.

Published on behalf of Hollister Education by MA Healthcare.

Cover picture: Feng Yu, Adobe Stock.

Editorial project manager and coordinator: Camila Fronzo
Designer: Lindsey Butlin

Understanding change management: a clinical improvement programme to transform your practice

Improving the patient experience often involves changing aspects of service delivery. Hollister Education organised a symposium designed to help clinical nurse specialists in urology implement vitally needed change. **Camila Fronzo**, Editorial Project Manager and Coordinator, MA Healthcare, describes its themes

On 27 November 2017, the British Journal of Nursing (*BJN*) attended a breakfast symposium, sponsored by Hollister, at the British Association of Urological Nurses (BAUN) conference in Glasgow, Scotland. The event, which was targeted at specialist urology nurses, sought to inform attendees about approaches to change management. The session focused on a programme, part of Hollister Education, which supports health professionals to meet their Nursing and Midwifery Council's (NMC) revalidation and continuing professional development requirements. It also aimed to help them to:

- Develop skills in identifying, planning and implementing service improvement change
- Boost their reflective skills, to aid their personal and professional development
- Increase their networking opportunities and share best practice with the clinical community at national conferences
- Acquire project management tools to plan and lead successful change projects in their service area
- Improve their communication skills with peers, patients and colleagues involved in these projects
- Become more confident when presenting service improvement plans to the diverse clinical community.

Rita Bailey, Consultant Facilitator and Coach, began her presentation by describing the five steps involved in the process of undertaking a clinical improvement project:

- Identify a problem or issue
- Set criteria and standards
- Observe practice and collect data
- Compare performance with the criteria and standards

- Implement change.

The motivations for carrying out a clinical improvement within a urology service, she added, should be to maintain high-quality care, improve the quality of the patient experience and safety, and reduce risks, variations in care and waste. Once the decision to apply such improvements has been made, it is important to ensure that changes are successfully implemented, especially considering that nearly 70% of change programmes in organisations do not meet their goals and only 25% are successful in the long term (Kotter, 2008).

Over the years, several change theories have been developed to achieve these goals. John Kotter's model, for instance, introduced eight steps for change to take place: establishing a sense of urgency, creating a powerful coalition, developing a vision for change, communicating the change vision, removing obstacles, generating quick wins, building gains to produce more change and anchoring change in the corporate culture (Kotter, 1996).

Another model worth considering is Kurt Lewin's force-field analysis (Lewin, 1951). Lewin emphasised there are forces that both drive and restrain change, and that change occurs when the driving

“Motivations for implementing change in urology include to reduce risk, waste and variations in patient care”

“Six participants were given tools, resources and coaching on clinical improvement. The aim was to achieve sustainable change in their organisations”

force exceeds the restraining force. His change management model identified three stages that are required for change to happen:

- Unfreeze: examining the status quo, preparing the organisation to understand that change is necessary, and motivating the driving forces for change
- Move: accepting change, involving people and taking action. This is the transition period from the unfreeze stage to the actual change stage
- Refreeze: making change permanent by establishing new ways of working.

Where to start

When applying change management theory to practice, several factors should be considered. First, defining ‘what good should look like’ will help health professionals understand what a service should be delivering in terms of standards and outcomes (NHS England, 2015). These standards require the following to be in place: good care processes; interested, competent staff; patients understanding what is going on; and everyone knowing who is involved in care decisions.

In addition to establishing desired standards and outcomes for clinical services, Bailey recommended using improvement tools, such as the SWOT analysis, to successfully implement a clinical improvement programme. This involves identifying a service’s strengths (S), weaknesses (W), opportunities (O) and threats (T).

Bailey also highlighted questions inherent in Langley et al’s (1994) ‘plan, do, study and act (PDSA)’ framework (Deming, 1993), which the person leading the change must consider:

- What are we trying to accomplish?
- How will we know that a change is an improvement? (That is, what do we need to measure?)
- What changes can we make that will result in an improvement?

To answer these questions, it is necessary to design a strategy for the change that is to be trialled (plan), conduct a trial of the proposed change (do), evaluate the impact of the trial (study), and implement the changes that have been proven to be effective (act).

Last, another key tool to use when applying new procedures in urology services is process mapping, a widely used technique for quality improvement. This consists of a flowchart comprising detailed steps of how work is currently done, compared with how it should be done to achieve better quality care, safety and efficiency, among other factors. It is also used to show where improvements can be made, eliminating bottlenecks, delay, waste, duplications, gaps and overlaps.

Case studies

Six specialist nurses who took part in Hollister Education’s clinical improvement programme were asked to present projects for the hospitals they worked in. The participants looked into the theories of change management described above and discussed how to translate them into practice. They were given tools, resources and coaching on what clinical improvement is and how to set up processes. The hope was not just for a one-off, but for sustainable change in their organisations. When the project was over, they shared their results in different areas. The following case studies illustrate their outcomes.

- Deming WE. *The new economics for industry, government education*. Cambridge (MA): MIT Press; 1993
- Kotter JP. *Leading change*. Boston (MA): Harvard Business School Press; 1996
- Kotter JP. *A sense of urgency*. Boston (MA): Harvard Business Press; 2008
- Langley GJ, Nolan KM, Nolan T. *The foundation of improvement*. *Quality Progress* 1994; 27(6):81–86
- Lewin K. *Field theory of social science: selected theoretical papers*. New York (NY): Harper & Brothers; 1951
- NHS England. *Excellence in continence care: practical guidance for commissioners, providers, health and social care staff and information for the public*. 2015. <https://tinyurl.com/p5oldk8> (accessed 6 February 2018)

Improving a service for men requiring hormone therapy

Sithembile Ncube, Deputy Prostate Clinical Nurse Specialist, Guy's and St Thomas' NHS Foundation Trust

Rationale

Men with prostate cancer are given hormone therapy as a treatment option, which can be used in different ways, depending on the stage of the cancer (Prostate Cancer UK, 2015). The first injection of androgen deprivation therapy (ADT) and a holistic needs assessment (HNA) are undertaken by the clinical nurse specialist (CNS) in a dedicated clinic. In my trust, a number of issues were highlighted by staff and patients referred for ADT:

- Lack of medical documentation regarding treatment plans was affecting waiting times and communication with men and GPs
- Long waits were occurring in the clinic due to multiple appointments, scheduling and the routine inclusion of additional patients to the list
- Inconsistent and incomplete information was given to patients
- Lack of time to address unmet needs.

It is essential that, at this key point in the patient pathway, men receive the correct information and support, and undergo treatment in a timely manner. Long waits and lack of time to address individual needs impair patient satisfaction with care.

The project

A project was undertaken to enhance the patient experience and quality of care by reducing waiting times, improving documentation and enhancing the provision of education and support for men starting ADT. The service development model used Kotter's eight-step model for managing transformational change (Kotter and Cohen, 2002). This describes what individuals can do to transform their organisation and the core problems that may be encountered when leading change. Aspects of the project comprised:

- Undertaking an analysis of the current situation using patient and staff feedback
- Analysing waiting times
- Standardising patient information

- Redesigning the scheduling system and clinic preparation
- Evaluating service development using:
 - Tools, including a patient feedback questionnaire
 - Documentation audit
 - Staff interviews to measure the impact of the service development.

Changes implemented to achieve the desired outcomes included:

- The service manager and team agreed criteria for booking men with two appointments
- The oncology team devised a format for their documentation that would ensure all men left the clinic with the necessary information
- The prostate CNSs created a proforma with generic information to which additional detail about the needs of individual men could be added
- The clinic would undergo comprehensive preparation before the scheduled day of clinic
- During clinic, each man would complete a holistic needs assessment for discussion with the nurse.

Outcomes

- Waiting times have been reduced, improving the men's experience in clinic
- Quality of care has improved due to better documentation and information
- Education and support for men starting therapy has improved
- The number of holistic needs assessments and care plans completed has increased.

Use of a change model and engagement with staff has meant that small and easy changes, which required no additional resource, have significantly improved patient and staff experience and clinical care.

Kotter J, Cohen D. *The heart of change*. Boston (MA): Harvard Business School Press; 2002
 Prostate Cancer UK. *Living with hormone therapy: a guide for men with prostate cancer*. London: Prostate Cancer UK Publications; 2015

Trial without catheter referral pathways: using local district nursing services

Katie Heavens, Clinical Nurse Advisor, Fittleworth Medical, Littlehampton

Rationale

A urogynaecology specialist centre in London was referring patients, who had undergone surgery at the centre and required trial without catheter (TWOC), back to its outpatient department for the procedure. The high demand for the TWOC procedure had resulted in a long waiting list, and patients often told staff that having to return to the centre, which could involve travelling vast distances following extensive surgery, was a painful and traumatic experience.

The project

In 2016, a service improvement project was undertaken to address these issues. It was led by an experienced urology nurse specialist who, however, had little experience in service improvement. Langley et al (1994) model of improvement—Plan, Do, Study, Act (PDSA)—was used to support the change.

The initial planning stage was undertaken in a group meeting attended by key stakeholders: the clinical commissioning group (CCG) commissioners and operation leads, the urogynaecology surgical team, district nurses (DNs) and the urology/urogynaecology nurse specialist. This was followed up with emails and telephone calls. During the planning stage, current practice was questioned and the need for change, and what changes should or could be made, were explored.

A variety of interventions to improve the TWOC service were considered, including:

- Increasing TWOC appointments in the centre
- Identifying additional staff who could perform the procedure in the centre
- Delaying patient discharge until the TWOC procedure had taken place.

All of these options would have incurred additional costs, for which no funding was available. Another option was to use local DN-led catheter clinics that undertook TWOC procedures. It was anticipated this would improve post-discharge care by ensuring

the timely removal of the urinary catheter and thus reducing the risk of catheter-associated urinary tract infections (CAUTIs). It was assumed this would increase patient satisfaction. Other potential benefits included:

- Reduced demand for the TWOC procedure at the specialist centre's outpatient department
- A reduction in the number of DN visits for catheter care and management
- Reduced need for catheter drainage products and to change indwelling urinary catheters
- Reduced demand on ambulance transportation.

It was anticipated that using a local service for this routine procedure would be more cost-effective.

The stakeholders met to discuss the referral process and identify strategies that would need to be in place before a pilot could be undertaken. The patient criteria were identified, as was the training required to increase the DNs' knowledge of urogynaecological procedures. Communication pathways were also agreed. Dates for the pilot were confirmed. The urogynaecology nurse specialist liaised with the consultants to ensure their collaboration and support.

The urology and urogynaecology nurse specialists devised a referral pathway to ensure:

- Patient suitability for the procedure
- Effective and safe communication about patient data, surgical notes and the plan of care
- Patients were assessed before catheter removal
- DNs were given a care plan for patients who were unable to pass urine.

Effective communication between the urogynaecology consultants, nurse specialists and DNs was paramount to ensure that the care prescribed for patients was readily available at the post-surgical follow-up appointment.

Within the service, the nurse specialists and DNs were key to implementing successful change. The simplicity of the change helped motivate them, as it offered a clear advantage to the current system.

While most of the DNs felt the change would enable clinical staff from the acute trust to recognise their skills, knowledge and abilities, a few were reluctant to participate in the pilot due to confidence issues. To develop their confidence, it was agreed they would observe rather than undertake the procedure.

In addition, there was some resistance from the service managers at the acute trust due to the loss of income associated with carrying out the TWOC procedure in the specialist unit. To alleviate these concerns, they were informed of other specialist treatments/procedures they would provide instead of the TWOC.

The urogynaecology nurse specialist embraced the changes as she recognised that the referral pathway would improve quality of care, reduce the risk of infection and complications (and thus delayed recovery times) and decrease demand on the urogynaecology service.

A major motivator for the CCG was the potential to reduce costs by:

- Reducing prescriptions for catheter products
- Reducing risk of CAUTIs and the number of antibiotic prescriptions
- Reducing the number of DN visits
- Enabling the TWOC procedure to be carried out at home or in a community clinic, which was cheaper than the patient attending the national specialist urogynaecology centre.

Pilot project

The project was now in the 'Do' stage of the PDSA cycle. Another meeting was arranged to ensure that all strategies were in place before the pilot was due to start. Difficulties were experienced identifying the exact number of patients for the pilot—it was not clear who, from the Essex area, would meet the inclusion criteria within a given time frame. It was therefore decided to pilot the referral process on the first three patients to meet the criteria.

Single point of access booking administrators were responsible for arranging the TWOC appointments in the community catheter clinics. They used a secure NHS email account to book appointments for patients in a clinic: patients were contacted and an appointment was arranged for the date requested by the specialist centre. Patients had two appointments on the same day: one for the catheter removal and the second to assess voiding 4–6 hours later. The results of the assessment were emailed (using the same secure account) to the urogynaecology nurse specialist for discussion with the consultant urogynaecologists.

The first patient referred to the DN following urogynaecology surgery required a home visit for the TWOC procedure due to immobility and pain following extensive pelvic surgery. The two other patients attended the DN clinic.

All of the patients were asked to complete a post-procedure feedback form. A summary of the outcomes was also emailed to the urogynaecology department to ensure continuity of care and effective communication. The DNs were surveyed to highlight any concerns or examples of quality care.

The third and fourth stages of the PDSA cycle involve studying and action. This would allow the project leads and stakeholders to analyse information from the pilot. The six dimensions of quality healthcare (that is, it is patient-centred, equal, efficient, safe, timely and effective) were used to identify positive and negative outcomes, as described by staff and patients.

During an evaluation meeting, concerns were raised about the initial referral process by the single point of access booking team. Delays were occurring when the referral was being processed, the patient's details were input and the appointment booked into the electronic booking system. As catheter clinics are extremely busy, one of the patients had been added as an 'extra patient' and the DNs felt that, despite excellent patient feedback, the appointment had been rushed and chaotic. It was therefore agreed that the secure net email account would be used to send referrals to the urology nurse specialist, who would advise on how they should be booked into the catheter clinic.

Outcomes

The patient and DN feedback showed no evidence of any CAUTIs. The timely removal of the urethral catheter reduced recovery time in the three patients. In comparison, previous patients have found indwelling catheters to be painful and uncomfortable, which had a psychological impact on their rehabilitation.

Cost savings were achieved by the reduced need for catheter drainage products, hospital transport, hospital appointments, delayed discharge, antibiotics and pain medication.

The TWOC referral pathway has now been implemented in the local acute trust. It has reduced the waiting list for patients needing a TWOC procedure post-urological surgery.

Langley GJ, Nolan KM, Nolan T. The foundation of improvement. *Quality Progress* 1994; 27(6):81–86

Introducing a referral pathway and proforma for trial without catheter

Colette Cavanagh, Urology Specialist Nurse, Royal Bolton NHS Foundation Trust

Rationale

The urology department at Royal Bolton Hospital is a self-contained unit with its own theatre, day ward, endoscopic suite and outpatients area. It has a well-established referral pathway for patients with acute urinary retention admitted via the accident and emergency department. However, no referral pathway or proforma was in place for patients in other wards within the hospital. This and a lack of communication between the hospital wards and the urology department led to a large number of clinically unsuitable referrals, straining the capacity of the department. Patients were waiting for up to 6 weeks for an appointment, increasing their risk of developing a catheter-associated urinary infection (CAUTI). Complaints from patients increased due to waiting times of up to 6 weeks, compounded by lack of information on discharge. Inappropriate referrals resulted in a high rate of did-not-attend (DNAs) and cancellations, which could have been avoided if a referral pathway/proforma had been in place.

In the light of this, we set out to improve the 'journey' from hospital discharge to referral to the outpatient urology clinic for all patients requiring a trial without catheter (TWOC). This would require the development of a referral pathway that could be accessed electronically and thus audited. It was hoped this would increase patient satisfaction with the service and reduce the number of DNAs and cancellations. If successful, the aim was to implement additional referral pathways for other indications.

The project

Numerous issues with the present system needed to be addressed. To achieve this, a urology nurse specialist created a small steering group to implement the proposed changes. This comprised myself, another urology specialist nurse, the deputy urology ward manager, the continence advisor from the bladder and bowel team, the community sister, the

community clinical manager and the trust's practice and development lead. The group used Lewin's (1951) process of change management, which entails creating the perception that a change is needed, moving toward the new desired level of behaviour and then solidifying that new behaviour as the norm.

Using this model, the department stopped accepting referrals. Instead, it advised all wards that the urology consultant on call would be available to offer guidance on patient assessment until a referral pathway/proforma had been developed and piloted. To facilitate this, a generic TWOC email account was set up, which was also used by community staff when caring for patients in the first week after discharge.

It took approximately 6 months to implement the referral pathway/proforma, which will be audited in the near future. The pathway was based on the National Institute for Health and Care Excellence (NICE) guidelines for the management of lower urinary tract symptoms (NICE, 2015). It was designed by the urology specialist nurse, the urology consultant and the deputy manager, and needed to be authorised by the urology and trust's matrons governance meeting. In addition, a step-by-step guide on how to fill in the proforma was developed for the hospital intranet. This is being supplemented by a workshop for ward staff.

Throughout this period, the clinic continued to receive referrals from all other wards in the hospital. Patients were assessed by the urology consultant, resulting in more appropriate referrals, although this caused a significant increase in the consultant's workload. Referrals that came through on paper were triaged, which again was time-consuming as the limited information provided made it necessary to access discharge information and recent blood results.

Outcomes

Six months after this project was started, the following have been achieved:

- The referral proforma/pathway has been implemented. It can be downloaded from the trust's intranet, filled in and emailed to the urology department
- This has resulted in a reduction in cancellations and DNA rates
- Waiting lists have reduced to 2–3 weeks
- The catheter policy has been updated and is available online
- The catheter passport is available
- Patients are discharged with a take-home pack and TWOC information. To increase awareness, the availability of these packs is highlighted in the trust's catheter policy and catheter passports
- The generic TWOC email account has worked well:

all referrals are sent electronically, so there are no longer any problems with missing referral papers, and communication between staff is both quicker and easier.

In addition to the present audit, future plans include finalising a TWOC pathway for DNAs, which is in development.

The urology nurse specialist will continue to lead the group to improve the TWOC pathway and provide an integrated service within the hospital and to the community.

Lewin K. *Field theory of social science: selected theoretical papers*. New York: Harper & Brothers; 1951
National Institute for Health and Care Excellence. *Lower urinary tract symptoms in men: management*. 2015. <https://tinyurl.com/y7lm7yn6> (accessed on 6 February 2018)

Setting up a service for men with benign prostate disease

Ameena Firoz, Urology and Continence Nurse Specialist, Imperial College Healthcare NHS Trust

Rationale

At Imperial College Hospital Healthcare NHS Trust, men with symptoms of urinary obstruction due to an enlarged prostate attended a busy general urology clinic for their consultations. The clinic was run by two consultants and accommodated 30 patients per session, allowing only approximately 10 minutes per consultation. If transurethral resection of prostate (TURP) surgery was indicated, the consultant would explain the surgery and its potential side-effects, undertake or organise standard investigations including international prostate symptom score (IPSS), a flow rate and bladder scan, a flexible cystoscopy and urodynamic studies, and outline the follow-up procedures required. Follow-up appointments routinely took place 8–12 weeks after TURP surgery, when the consultant would explain the histology results to the patient. Despite this, men were ringing the clinical nurse specialist (CNS) with questions pre-surgery, pre-investigation and after the follow-up consultation, which was taking up time and consuming telephone slots.

To address these issues, the CNS decided to develop a nurse-led clinic for men with benign prostate

disease, including those undergoing TURP. The clinic aimed to:

- Improve men's knowledge and understanding of TURP by providing written information about the procedure, its follow-up and prognosis
- Reduce waiting times for outpatient appointments following surgery
- Give men an opportunity to fully absorb and discuss the implications of surgery.

The project

Lewin's model of change management was used to implement the changes (Lewin, 1951). A brief description of this model is given on page S8.

The nurse-led clinic aimed to undertake many of the investigations and information-giving formerly conducted by the consultants. It was proposed that, in the pre-surgery consultation, the patient would initially meet the consultant and then be introduced to the CNS, who would administer the IPSS screening tool, measure flow rate and post-void residuals, undertake a bladder scan, perform urodynamic studies if advised by the consultant and give the

patient written information about TURP and its expected outcomes.

The CNS would next see the patient 4 weeks post-surgery for a 30-minute follow-up consultation. Before the clinic appointment, the CNS would discuss the histology results with medical staff. A definitive treatment plan would then be devised, and the CNS would complete a proforma. The CNS would have access to a consultant for advice whenever needed. During the follow-up consultation, the CNS would explain the histology results to the patient. If the results were negative, the CNS would reassure him and, if no further specialist intervention was required, discharge the patient back to his general practitioner (GP). If the results were positive, the CNS would refer the patient to a cancer CNS. Men would be encouraged to ask questions in the clinic, so that any concerns could be dealt with.

It was anticipated this would save consultant time and be more supportive for patients.

This structure for nurse-led clinic was proposed in a urology meeting involving the urology matron, consultants and the business manager. It was decided to pilot the clinic; the CNS therefore rationalised her workload to accommodate the extra work. Additional support was received from the outpatient manager, who provided a room for the patient consultations, and the administrative staff, who typed and sent the invite letters.

Outcomes

Some 15 men have been referred to the clinic during a one-month period. A patient satisfaction survey was undertaken to evaluate the nurse-led service, and 14 of the 15 patients reported they were very satisfied with the nurse-led follow-up, which gave them the opportunity to ask questions and did not make them feel rushed.

Lewin K. Force theory in social science. New York (NY): Harper and Row; 1951

Reducing the local use of indwelling urinary catheters in Wolverhampton

Lindsey Pearson, Nurse Manager, Continence Care Service, Royal Wolverhampton NHS Trust

Anecdotal evidence indicates that many indwelling urinary catheters are used without clear indications, placing patients at unnecessary risk of complications, including physical and psychological discomfort, bladder calculi (stones), renal inflammation and, most frequently, catheter-associated urinary tract infections (CAUTI) (Gokula et al, 2007). As part of a project to reduce the risk of Gram-negative bacteraemia, the Wolverhampton infection prevention service monitored the number of patients

with an indwelling urinary catheter. The resulting data showed that the number was increasing, making it vital to implement change to reduce this.

Rationale

Between 2013 and 2015, the number of patients in Wolverhampton with an indwelling urinary catheter rose by 96%. As a result, district nurses (DNs) were struggling to manage the number of unscheduled calls for catheter-related problems. Meanwhile, indwelling urinary catheters were the second highest and top contributors to device-related bacteraemia in the hospital and community, respectively.

In view of this and the recently announced target to reduce the number of Gram-negative bloodstream infections by 50% by 2021 (NHS England, 2017),

“Fourteen of 15 patients were very satisfied with the nurse-led service”

a clinical improvement project was undertaken to identify the prevalence of indwelling urinary catheters in Wolverhampton and reduce the number through robust policy, education and improved patient assessment. The project also set out to understand the reasons for the increased use of indwelling urinary catheters in the local area.

The project

The project was devised and initiated by the catheter group, who were the key stakeholders. This comprised myself, district nurses, a urologist, the urology at home team (who undertake trial without catheter (TWOC) in the community), the continence care service, pharmacists and infection prevention specialists. It was decided to use Kurt Lewin's three-step change model (Lewin, 1951) and the Plan, Do, Study, Act (PDSA) cycle to implement the project. The PDSA cycle is a simple yet powerful tool for accelerating quality improvement. More information on the Lewin's model is provided on page S8.

The catheter group decided to start the project with a process mapping exercise—that is, to scope current practice relating to the use of indwelling catheters in Wolverhampton. This involved identifying key information about the catheter journey from insertion onwards. Data gathered included the number of patients catheterised, the frequency of catheterisation, the patient information and support provided, the clinical documentation used, referral processes and the nature of the liaison between hospital staff and the DNs.

During the mapping exercise, it became evident that a large number of different catheters were being used. The catheter group therefore decided to streamline the selection available on the 'preferred list' (previously known as the formulary). Product selection was determined by cost-effectiveness, efficacy, the manufacturers' literature and practical experience of use. In addition, the group developed a catheter documentation package incorporating a catheter diary, a troubleshooting guide and patient education literature. Key components of this package were available on the trust's intranet. Drop-in days were arranged for DNs and care home staff, giving them information about these developments, as well as support.

The catheter group's next objective was to assess all patients in Wolverhampton with an indwelling urinary catheter and ascertain if the catheter was necessary. The aims included determining the:

- Number and frequency of continence assessments
- Number of patients who were suitable for TWOC.

“The aim is to develop a service that assesses all patients for TWOC 2 weeks after inserting an indwelling catheter”

It was anticipated this would demonstrate the impact of the revised preferred list and the catheter documentation package.

It soon became apparent that a large number of patients with indwelling catheters, many of them living at home or in care homes, were likely to be suitable for TWOC. To address this, the catheter group introduced a pathway whereby these patients would be assessed for their suitability for TWOC and, if appropriate, referred to the urology at home team for catheter removal. Unfortunately, this approach proved too time-consuming to achieve the desired outcome in many cases. Many patients either changed their mind, or their personal and health circumstances had altered by the time the urology at home team was able to remove the catheter.

An alternative arrangement, whereby the continence care service would visit residential homes to assess patients and then immediately implement TWOC if appropriate, was also often unsuccessful. By this stage, many patients had simply become too dependent on their indwelling catheter to change. Clearly, a different approach was required.

Outcomes

The catheter group is therefore now in the process of making a business case to implement a service whereby all patients are assessed 2 weeks after the insertion of an indwelling catheter to determine their suitability for TWOC. It is proposed this will increase the incidence of TWOC and, in turn, avoid the risk of patient complications. This phase of the project is still ongoing. However, our experiences to date illustrate the challenges and benefits of change management.

Gokula RM, Smith MA, Hickner, J. Emergency room staff education and use of a urinary catheter indication sheet improves appropriate use of foley catheters. *Am J Infect Control.* 2007; 35(9):589–93

Lewin K. *Force theory in social science.* New York (NY): Harper and Row; 1951

NHS England. Next steps on the NHS five year forward view. 2017. tinyurl.com/mfl4td7 (accessed 22 February 2018)



MA HEALTHCARE

A MARK ALLEN GROUP COMPANY